**NCMD Joint Agency Response (JAR) training assessment form**

**Please complete this form and send to** [ncmd-programme@bristol.ac.uk](mailto:ncmd-programme@bristol.ac.uk). **On successful completion, you will receive a certificate and the answers to the workbook.**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

A child death review process is a statutory process to review the deaths of all live born children in England who die of any cause before their 18th birthday. Its purpose is to understand how and why children die and to identify national learning to inform policy and practice at a local, regional and national level.

**True False**

**Please tick all that apply:**

The role of the Police and lead police investigator

|  |  |  |  |
| --- | --- | --- | --- |
| Establish how a child has died on behalf of the coroner |  | Collects samples |  |
| Completes the post-mortem |  | Investigate the possibility of criminal offences relating to the death |  |
| Identifies the cause of death |  | Conduct investigation with sympathy and support |  |
| Attends place of death and contacts the family |  | Present for careful examination of the body along with the lead healthcare professional |  |
| Takes a careful a careful history of the events leading up to and after the child's death should be taken alongside the lead health professional |  | Is part of the JAR process |  |
| Commissions background research to understand the incident |  | Works alone and instructs other professionals |  |

It is a legal requirement for the coroner to be informed of any death that is apparently unnatural, or unexpected, or for which the doctor cannot immediately give a clear medical explanation based on their prior knowledge of the patient (who they must have seen for their final illness in the past 14 days)

**True False**

**Please tick the correct column for each of these statements:**

|  |  |  |
| --- | --- | --- |
| **Task** | **JAR process** | **CDRM** |
| To ensure that CDOP and, where appropriate the coroner is informed of the outcomes of any investigation into the child’s death. |  |  |
| What parents or carers think may have occurred and how they reacted to this |  |  |
| To review the support provided to the family and to ensure the family are provided with:  -the outcomes of any investigation into their child’s death  -a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken.) When the death remains unexplained the family must be informed of what this means, and not left without information.  -any learning from the review meeting |  |  |
| Review the background history, treatment and outcomes of investigations, and to determine as far as possible the likely cause of death |  |  |
| Who did what before and after the death? |  |  |
| In every case, the Statutory Analysis Form should be drafted at this meeting and sent on to the relevant CDOP to review |  |  |
| Ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery. |  |  |
| Describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any if the organisations involved to improve the safety or welfare of children or the child death review process |  |  |
| Review the support provided to staff involved in the care of the child. |  |  |
| What happened and how it happened? |  |  |
| Review the background history, treatment and outcomes of investigations, and to determine as far as possible the likely cause of death. |  |  |
| Identify and record the sequence of events preceding the death |  |  |