West of England
Child Death Overview Panel
Terms of Reference

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the West of England Child Death Overview Panel (CDOP) aims to better understand how and why children in our locality die and to use our findings to take action to prevent other deaths and improve the health and safety of our children.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.4 of *Working Together to Safeguard Children* in relation to the deaths of any children normally resident in our locality. Namely, collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Serious Case Review

(ii) any matters of concern affecting the safety and welfare of children in our locality

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the locality

Objectives

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths.
2. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in the locality and, where relevant, to seek additional information from professionals and family members.
4. To evaluate data on the deaths of all children normally resident in the locality, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
5. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.

6. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the locality, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.

7. To identify any public health issues and consider, with the Directors of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.

8. To identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

9. To increase public awareness and advocacy for the issues that affect the health and safety of children

10. Where concerns of a criminal or child protection nature are identified, to ensure that the police and coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of the relevant LSCB of those concerns and advise the chair on the need for further enquiries under section 47 of the Children Act, or of the need for a Serious Case Review

11. To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.

12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family

13. To monitor the support and assessment services offered to families of children who have died

14. To monitor and advise the LSCBs on the resources and training required locally to ensure an effective inter-agency response to child deaths

15. To co-operate with any regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH) – in order to identify lessons on the prevention of child deaths.

16. To ensure coherence with other death review processes, where appropriate

17. The CDOP will take the lead in promoting preventative services and strategies in the region

Scope

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in the locality. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within the locality, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the locality dies elsewhere, the CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

Team Membership

The Child Death Overview Panel will have a core membership determined by and drawn from the key organisations represented on the four LSCBs. Other members may be co-opted to contribute to the discussion of certain types of death when they occur. The core membership of the panel will sit for one year, with the membership rota drawn up to reflect the need to transfer expertise between panels. The Designated Doctor for Child Deaths will be a permanent member of the panel.

Confidentiality and Information Sharing

Please see detail in Governance Arrangements and Confidentiality Statement

Accountability and Reporting Arrangements

The CDOP will be accountable to the chairs of the Local Safeguarding Children Boards.

The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the LSCBs. It will prepare an annual report for the LSCBs, which are responsible for publishing relevant, anonymised information.

The LSCBs take responsibility for disseminating the lessons to be learnt to all relevant organisations, for ensuring that relevant findings inform the Children and Young People's Plans, and for acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The LSCBs will supply data regularly on every child death as required by the Department for Education and Skills to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Chairing arrangements

The West of England CDOP will be chaired by the LSCB chairs on a rotational basis as follows:

- 2008-9 Bristol
- 2009-10 Bath and North East Somerset
- 2012-11 North Somerset
- 2011 -12 South Gloucestershire

Frequency of panels

The Child Death Overview Panels will take place on a monthly basis, for up to 3 hours.

Panel Administration

The West of England CDOP will be supported by the Designated Doctor for Death in Childhood and CEMACH in the determination of which cases are reviewed at which Panel meeting. The aim will be to group together similar types of death around thematic areas.

Review

The Terms of Reference for the West of England Child Death Overview Panel will be reviewed on 1st April 2010.

Agreed by:

Ian McDowall, Chair of Bristol LSCB……

Maurice Lindsay, Chair of Bath & North East Somerset LSCB……

Therese Gillespie, Chair of South Gloucestershire LSCB……

Philip Durban, Chair of North Somerset LSCB……