Appendix 1: Model terms of reference

These terms of reference are presented as an example that LSCBs may wish to adapt for their own local CDOP.

…….. *[name of borough]* **Safeguarding Children Board**

Child Death Overview Panel

Terms of reference

1. Purpose

1.1 Through a comprehensive and multidisciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to improve the understanding of how and why children in …….. *[name of borough/s]* (the area) die and use the findings to take action to prevent future child deaths and more generally to improve the health and safety of the children in the area.

1.2 In carrying out activities to pursue this purpose, the CDOP will meet the Local Safeguarding Children Board (LSCB) functions, as set out in paragraph 7.4 of *Working Together to Safeguard Children (2006) (Working Together)*, in relation to the deaths of any children normally resident in the area:

(a) 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 the area

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

(b) Establishing procedures for ensuring a coordinated response to an unexpected child death.

2. Objectives

Notification and data collection

2.1 The CDOP will seek to:

a) Ensure, in consultation with the …….. *[name of borough]* coroner's office, 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;

b) Ensure the accurate identification of every child death in the area;

c) Ensure uniform, consistent reporting of the manner and cause of every child death in the area;

d) Collect and collate the agreed national minimum data set of information on all child deaths in the area and, where relevant, to seek additional information from professionals and family members;

e) Ensure that these information gathering processes minimise distress to families; and

f) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and the Confidential Enquiry into Maternal and Child Health (CEMACH)[2].

Case assessment and review

Case level

2.2 The CDOP will seek to:

g) Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt; and

h) Where concerns of a criminal or child protection nature are identified, ensure that the police and coroner are aware and inform them of any specific new information that may influence their inquiries; notify the Chair of the relevant LSCB of those concerns and advise them on the need for further enquiries under section 47 of the *Children Act 1989*, or to recommend a serious case review.

Population level

2.3 The CDOP will seek to:

i) Evaluate data on the deaths of all children normally resident in the area, 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.

Service improvement

2.4 The CDOP will seek to:

j) 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 Child Death Rapid Response Team and providing the professionals concerned with feedback on their work (for a description of a rapid response service see the *London Rapid Response Procedure (London Board, 2009)*);

k) 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; and

l) Monitor the support and assessment services offered to families of children who have died.

Prevention and advocacy

2.5 The CDOP will seek to:

m) Identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the area, including relevant environmental, social, health and cultural aspects of each death, and any systemic or

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[2] See www.cemach.org.uk/

structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future;

n) 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;

o) Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

p) Increase public awareness and advocacy for the issues that affect the health and safety of children; and

q) Monitor and advise the Local Safeguarding Children Boards on the resources and training required locally to ensure an effective inter-agency response to child deaths.

3. Scope

3.1 The CDOP will gather and assess data on the deaths of all children from birth (excluding those babies who are stillborn) up to their 18th birthday who are normally resident in the area. 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 area, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the area dies outside the area, the CDOP should be notified. In both cases, an agreement should be made as to how the two CDOPs will report to each other.

4. Panel membership

4.1 The Child Death Overview Panel will have a permanent core membership. Other members may be co-opted to contribute to the discussion of certain types of death when they occur. Core membership will consist of senior management representation from:

- Designated paediatrician for unexpected deaths in childhood;
- Public health;
- Community child health or designated nurse for safeguarding children;
- LA children's social care;
- Police;

5. The role of core CDOP members **Public health**

5.1 The public health representative can:

- Provide the panel with information on epidemiological and health surveillance data;
- Assist the panel in strategies for data collection and analysis;
- Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work;
- Inform the panel of public health initiatives to support child health; and

- Advise the panel on the development and implementation of public health prevention activities and programmes.

Paediatrician

5.2 The paediatrician can:

- Provide the panel with information on the health of the child and other family members, including any general health issues, child development, and health services provided to the child or family;
- Help the panel interpret medical information relating to the child's death, including offering opinions on medical evidence; providing a medical explanation and interpretation of the circumstances surrounding a child's death;
- Assist with interpreting the autopsy findings and results of medical investigations;
- Advise the panel on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices;
- Provide feedback and support to medical practitioners involved in individual case management; and
- Liaise with other health professionals and agencies.

Police

5.3 The police representative can:

- Provide the panel with information on the status of any criminal investigation;
- Provide the panel with information on the criminal histories of family members and suspects;
- Identify cases that may require a further police investigation;
- Provide the panel with expertise on law enforcement practices, including investigations, interviews and evidence collection;
- Help the panel evaluate any issues of public risk arising out of the review of individual deaths;
- Liaise with other police departments, and the Crown Prosecution Service; and
- Feedback to police officers involved in individual case management.

Children's social care

5.4 The children's social care representative can:

- Provide the panel with information on any social care involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;

- Advise the panel on children's rights and welfare, and on appropriate legislation and guidance relating to children;
- Identify cases that may require a further child protection investigation, or a serious case review;
- Liaise with other local authority services; and
- Provide feedback to social workers and other local authority staff involved in individual case management.

Bereavement agency representative:

5.5 The bereavement representative can:

- Advise the panel on ongoing bereavement support needs for the family or others involved;
- Be an advocate for the family;
- Assist the panel in monitoring and evaluating the appropriateness of professional responses to child deaths;
- Provide support to other panel members, ensuring appropriate member care; and
- Facilitate the provision of support to other professionals involved in individual case management.

6. Duties of the CDOP Chair and manager

6.1 The Chair of the CDOP is responsible for:

- Chairing the CDOP meetings, encouraging all team members to participate appropriately;
- Ensuring that all statutory requirements are met;
- Maintaining a focus on preventive work;
- Facilitating resolution of agency disputes; and
- Ensuring that this process operates effectively.

6.2 The CDOP manager will be responsible for the smooth running of all child death review processes. S/he will:

- Be the designated person to whom the death notification and other data on each child death in the area should be sent;
- Ensure and monitor the effective running of the notification, data collection and storage systems;
- Determine meeting dates and send meeting notices to team members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two to three weeks prior to each meeting;
- Select, in consultation with the CDOP Chair, cases for in-depth review by the CDOP, following the principles set out in core functions;
- Ensure that notifications of child deaths are available for team review;

- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Encourage the sharing of information for effective case reviews;
- Compile and disseminate notes from each CDOP meeting;
- Maintain the rota for the Child Death Rapid Response Team;
- Complete and submit an annual report to the LSCB; and
- Monitor the outcome of recommendations and prevention initiatives and activities.

8. Confidentiality and information sharing

7.1 Information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

7.2 CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP. Any ad hoc or co-opted members, observers and administrative and clerical staff will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

7.3 Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

8. Accountability and reporting arrangements

8.1 The CDOP will be accountable to the chair of the LSCB.

8.2 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 LSCB, which is responsible for publishing relevant, anonymised information.

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

8.4 The LSCB will supply data regularly on every child death as required, e.g. by:

- The London learning from information about child deaths initiative to collate and analyse information about child deaths across London, in order to identify lessons on the prevention of child deaths; and
- The Department for Children, Schools and Families to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of child deaths.

9. Conflict resolution

9.1 The CDOP Chair should encourage panel members to form a consensus in their assessment of child deaths (e.g. whether a case should have been handled differently or whether the criteria for a serious case review, as set out in *Working Together* Chapter 8, are met in the opinion of the CDOP). However, where a consensus is not agreed, the Chair's decision is final.