

Local Safeguarding Children Board



Joint Child Death Overview Panel for Kingston, Richmond and Hounslow

Child Death Overview Panel Terms of Reference



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Introduction

These are the terms of reference that apply to the Child Death Overview Panel (CDOP) of the London Borough of Hounslow, Royal Borough of Kingston and the London Borough of Richmond. The Child Death Overview Panel was established in April 2008 and is a subgroup of each borough's Local Safeguarding Children Board (LSCB). The government requires each LSCB to establish a Child Death Overview Panel to carry out a review of all child deaths in their area, following the processes set out in *Working Together to Safeguard Children (2010)*.

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to better understand how and why children in the London Borough of Hounslow, Royal Borough of Kingston and the London Borough of Richmond die and use the findings to take action to prevent other deaths and improve the health and safety of children in the three Boroughs.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in *Working Together to Safeguard Children 2010 (paragraph 7.13)* in relation to the death of any children who are residents of the three boroughs;

- (a) Collecting and analysing information about each death with a view to identifying-
- any case giving rise to the need for a serious case review;
 - any matters of concern affecting the safety and welfare of children in the area; and
 - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; and
- (b) Putting in place procedures for ensuring that there is a coordinated response within the area to an unexpected death.

An unexpected death is defined by *Working Together to Safeguard Children 2010* as the death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility for example, 24 hours before the death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

Objectives

Notification and data collection

The CDOP will seek to do the following:

- Ensure the accurate identification, and uniform consistent reporting, of the cause and manner of every child death;
- Collect and collate an agreed minimum data set of information on all child deaths in the area, and where relevant, to seek additional information from professionals and family members;
- Ensure that these information gathering processes minimise distress to families;
- Ensure in consultation with the local 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;
- Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths (e.g. London SPOCs and London CDOP Chairs Networks); and
- Organise and monitor the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by the LSCBs) for any additional data to be collected locally.

Case level

The CDOP will seek to:

- Review the available information on all child deaths to determine whether the death was preventable (as defined in paragraph 7.23 of *Working Together to Safeguard Children 2010*) by identifying any factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths;
- Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt;
- Refer to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel consider there may be grounds to undertake further enquiries, investigations or a SCR;
- Informing the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities; and
- 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.
- Establish mechanisms for appropriately informing and involving parents and other family members in the both child death overview and the rapid response processes.

Population level, prevention and advocacy

The CDOP will seek to:

- Evaluate data on the deaths of all children normally resident in the local 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;
- Identify significant risk factors and trends in individual child deaths and in overall patterns of deaths in the local authority areas, 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;
- Identify any public health issues and consider with the Directors of Public Health, and other professional agencies, on how best to address these and their implications for both the provision of services and for training;
- Identify and advocate for needed change in legislation, policy and practices to promote child health and safety and to prevent child deaths; and
- Increase public awareness and advocacy for the issues that affects the health and safety of children.

Service review and improvement

The CDOP will seek 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;
- Monitor and review the support and assessment services offered to families of children who have died; and
- Identify and inform the LSCB on the resources and areas where training may be required to improve an effective inter-agency response to child deaths.
- Encourage and facilitate contribution of parents and family members to the review process with a view to informing the panel as to the services and support received by the child and their family and any recommendations that could be made to advocate for improvements in this area, as well as to highlight and promote good practice by professionals.

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 and planned terminations of pregnancy carried out within the law - Abortion Act 1967) up to the age of 18 years old who are normally resident in the local area. Where a child, normally resident in another area, dies within this 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 local authority area, the CDOP should be notified by the single point of contact in that area. 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. In both cases, an agreement should be made as to how the two CDOPs will report to each other.

Panel Membership

The Child Death Overview Panel will have a permanent core membership drawn from the key organisations represented on the LSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur, and will also welcome observers.

Core Members

Core membership will consist of senior representatives as follows (for each Borough):

- Public Health Associate Director or consultant;
- Designated Paediatrician for unexpected deaths in childhood.
- Health safeguarding representative, designated/named nurse for Safeguarding children;
- Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police Service; and
- Local Authority Safeguarding Managers;

The Panel will also, where possible, have a representative of a bereavement agency or similar.

The Panel is to be chaired by a representative from one of the three borough's Public Health Teams on a yearly rotating basis. The Chair is a member of each of the three LSCBs.

The Chair and the Panel are supported by an Administrator.

The role of each CDOP member

The Public Health representative(s) 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 trend 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.

The Paediatrician and Health safeguarding representative(s) 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, provide 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.

The Police representative(s) 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's deaths;
- Liaise with other police departments, the Crown Prosecution Service and the local Coroner; and
- Provide feedback to police officers involved in individual case management.

The Children's Social Care representative(s) 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.

The Bereavement agency representative(s) (when present) 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.

The Single Point of Contact and Administrator

Each CDOP must nominate a Single Point of Contact (SPOC) to be informed of all child deaths, in the LSCB area, regardless of whether the child is resident in the area. The SPOC will receive referrals, and record accurate details, for the London Borough of Hounslow, the Royal Borough of Kingston and the London Borough of Richmond. Locally, this role is combined with that of CDOP Administrator.

The SPOC/Administrator will:

- Be the designated person to whom the death notification and other data on each child death in the three Boroughs is sent;
- Ensure the effective running of the notification, data collection and storage systems;
- Determine meeting dates and send notices to Panel members;
- Prepare and circulate papers for distribution at each meeting and take and circulate minutes;
- Ensure that all CDOP members, ad hoc members and observers sign a confidentiality agreement;

- Prepare information on cases to be reviewed and, with the Chair, agree cases for in depth review;
- Liaise as necessary with all relevant agencies and other local authorities to ensure smooth running of the notification system and panel operation;
- Facilitate the Rapid Response process;
- Ensure that effective cover is in place for absence;
- Liaise regularly with other Local Authorities through individual SPOCs/Co-Ordinators and the London SPOC group; and
- Support the Chair by providing information as required and assisting in the compilation of the annual report and returns for DfE monitoring and other regional and national initiatives.

The role of the CDOP Chair

The chair of the CDOP will be 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;
- Ensure that members are clear about their role, and facilitating resolution of agency disputes;
- Ensuring that this process operates effectively; and
- Complete and submit annual report to each LSCB.

The role of the CDOP manager

The CDOP manager is based in Richmond and manages the CDOP process on behalf of the three Boroughs.

The manager is responsible and accountable for the smooth running of all child death review processes through supervision of the SPOC/Administrator, and specifically:

- To monitor the SPOC to whom the death notification and other data on each child death in the area should be sent;
- To ensure and monitor the effective running of the notification, data collection and storage systems;
- To identify and agree with key personnel of all agencies their engagement and responsibilities within the model;
- To assist the LSCB in ensuring senior management in relevant agencies are aware of their roles and responsibilities in relation to chapter 7 of

Working Together to Safeguard Children 2010, discussing any problems with the Chair as they arise; and

- To facilitate the establishment of structures to support the CDOP as outlined in chapter 7.

Meeting arrangements

The CDOP will meet bi-monthly to enable each child's case to be discussed in a timely manner and will arrange for extra meetings or extension of planned meetings where necessary. For each child's death, comprehensive information will be collected, collated and presented at the meetings and this information will be reviewed by the Panel in order to meet the objectives set out previously.

For the meeting to be quorate there needs to be a representative from each of the core disciplines of Child Death Overview Panel, however this is a local agreement and is not stipulated in the *Working Together to Safeguard Children 2010* guidance.

Confidentiality and Information Sharing

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 to Safeguard Children 2010* and is bound by legislation on data protection.

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

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

Accountability and reporting arrangements

The CDOP is accountable to each of the three LSCBs.

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 three respective LSCBs, who in turn are responsible for publishing relevant, anonymised information in their LSCB annual reports (which are public documents).

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

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

- The London Safeguarding Children Board Child Death Chairs' and SPOCs' Networks - to collate and analyse information about child deaths across London, in order to identify lessons on the prevention of child deaths.
- The Department for Education, and to bodies commissioned by the department to undertake and publish nationally comparable, anonymised analyses of child deaths.

Conflict Resolution

The CDOP chair should encourage panel members to form a consensus in their assessment and analysis of child deaths, if necessary by taking up issues outside the Panel meeting. However, where a consensus is not agreed, the Chair's decision is final.

Names and Positions of Core Members on the Child Death Overview Panel

Representatives from the London Borough of Richmond upon Thames		
Karen Neill	KN	Head of Safeguarding Quality & Performance, LBRuT
Anna Raleigh	AR	Consultant in Public Health, NHS Richmond
Trisha Roe	TR	Designated Nurse for Safeguarding Children, NHS South West London (Richmond borough)
Representatives from the London Borough of Hounslow		
Dr Daniela Lessing	DLe	Designated Paediatrician, HRCH (and interim DP for Richmond)
Sally Philips	SPh	Head of Safeguarding, London Borough of Hounslow
Clarisser Cupid	CC	Designated Nurse for Child Protection, NHS Hounslow
Deborah Langdon	DL	Detective Inspector, Feltham CAIT, Metropolitan Police Service (also covering Richmond Borough)
Representatives from the Royal Borough Kingston upon Thames		
Christine Robjohn	CR	Lead Nurse for Child Protection, NHS Kingston
Anne Boatman	AB	Named Nurse for Child Protection, Kingston Hospital
Teresa Defanis	TD	Detective Inspector, Barnes CAIT, Metropolitan Police Service
Dr Suzanne Luck	SL	Designated Paediatrician (job share), Kingston
Dr Rowan Heath	RH	Designated Paediatrician (job share), Kingston
Dr Jane Scarlett	JS	Consultant In Public Health, Kingston
General		
Dr Catherine Heffernan	CH	Chair
Veronica Etherington	VE	Safeguarding Lead, Shooting Star Chase Children's Hospice
Sarah Bennett	SB	Single Point of Contact & CDOP Administrator