Sandwell
Safeguarding
Children
Board

Sandwell Child Death Overview Panel (CDOP)

Terms of Reference

Status

Re-draft v1	June 2013
V2	July 2013
V3	July 2015
	Updated Membership List February 2014

1. Legislation

The Regulations relating to Child Death Reviews – Working Together to Safeguard Children 2015, Chapter 5

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) Collecting and analysing information about each death with a view to identifying—

(i) Any case giving rise to the need for a review mentioned in regulation 5(1)(e)

(ii) Any matters of concern affecting the safety and welfare of children in the area of the authority

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

b) Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

2. Overall Principles of CDOP

Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The Review will help to prevent further such child deaths

The responsibility for determining the cause of death rests with the Coroner or the Doctor who signs the medical certificate of the cause of death and therefore is not the responsibility of the Child Death Overview Panel.

- Families (and the child who has died) must be treated with sensitivity, discretion and respect at all times, and professionals must approach enquiries with an open mind.

- Parents should be informed about the review and invited to contribute or ask questions as appropriate; it is, however, not appropriate for them to attend a CDOP meeting.

- The unexpected death of a child who has died from a life limiting or life threatening condition should be managed as any other unexpected death to determine the cause of death and any contributory factors. This will respect both the child and family and fulfil any statutory requirements.

- All data will be stored securely by the Child Death Coordinator and anonymised prior to discussion at CDOP

- Any formal recommendations made will be Specific, Measureable, Achievable, Relevant and Timely (SMART).

3. Definitions

- **An unexpected child death is one which:**
  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 lead to the death. (Working Together 2015; 5:12)

- **Modifiable factors:**
  These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. (Working Together 2015; 5:11)

4. Functions of CDOP (from Working Together 2015)

The functions of the CDOP include:

• reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;

• collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;

• discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;

• determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;

• making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;

• identifying patterns or trends in local data and reporting these to the LSCB;

• where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;

• agreeing local procedures for responding to unexpected deaths of children; and

• cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

5. Scope of CDOP

- To have a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigation is known – such as Serious Case Reviews or criminal proceedings.

- To monitor the appropriateness of the response of professionals to an unexpected death of a child.

- Where there is an ongoing criminal investigation, the Crown Prosecution Service may be consulted about the appropriateness of information for CDOP to consider preventing prejudicing any criminal proceedings.

- Where specific new information, such as concerns of a criminal or child protection nature are identified, to inform and advise the Chair of the SSCB that this information should be passed to the police, Coroner or other appropriate authorities

- To identify significant risk factors, modifiable factors and trends in individual child deaths and in the overall patterns of deaths in Sandwell, 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

- To monitor any assessment services offered to families of children who have died.

- To monitor bereavement support offered to families following the death of a child within the guidelines of any regional Bereavement Care Pathways.

- To advise the SSCB on any resources and training required locally to ensure an effective inter-agency response to and prevention of child deaths.

- To identify any public health issues and consider, with the Director of Public Health, how best to address these and their implications for the provision of services.

- To ensure that arrangements are made for the family to have the opportunity to meet with relevant professionals, e.g. a professional known to the family before their child died or a paediatrician or police officer; to help answer their questions.

- To be responsible for producing an Annual Report of relevant information for the SSCB, to include total numbers of deaths reviewed, recommendations made by CDOP about future required actions to prevent child deaths, and any further description of the deaths as the CDOP think appropriate. It should also include a review of actions taken to implement recommendations from the previous year's report and set out any recommendations which have not yet been fully implemented and are to be carried forward. The report should be written in a way as to ensure confidentiality of personal information and sensitivity to bereaved families.

- To ensure that there is a clear relationship and line of communication between CDOP and the local coronial service.

- Where a child, normally resident in another area dies within the Borough of Sandwell, that death shall be notified to the CDOP in the child's normal area of residence. Similarly, when a child normally resident in Sandwell dies outside Sandwell, the Sandwell 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

- If a child, normally resident in Sandwell, dies abroad, it may take some time for the Registrar General to be informed about the death; in these circumstances, the CDOP may use other sources, e.g. Professional contacts or the media, to start to review the death

6. Accountability

- CDOP will be accountable to SSCB

- The Chair of CDOP:
    - Acts on behalf of the Chair of the SSCB
    - Will be an SSCB member
    - Will report as required to the SSCB on behalf of CDOP
    - Will not provide direct services to children and families in Sandwell
    - Is responsible for ensuring an effective process for child death notification for the deaths of all children normally resident in the Borough of Sandwell.

7. Membership

- Permanent members must be senior representatives from each organisation and have responsibility to advise their organisations on implementation of local procedures to respond to child deaths

- Members may nominate a deputy to attend on their behalf, but must ensure that their deputy is briefed on their responsibilities and is able to respond and act on behalf of their organisation

8. Core membership:

- Sandwell MBC – Children and Young People's Services
Education (including Early Years):
Public Health

- Police – (Sandwell Public Protection Unit)

- Health - Sandwell and West Birmingham CCG
Sandwell and West Birmingham NHS Hospital Trust
Black Country Partnership Foundation Trust
Lead Nurse for Child Death reviews
Representative from Health Visiting/School Health
Representative from Maternity Services

- Child Death Co-ordinator
- Designated Paediatrician for Child Death
- Designated Nurse for Safeguarding Children

8.1. Permanent independent/voluntary members

- Children's Centres
- SSCB Lay member
- Probation
- Youth Offending Services
- Representative from Drug and Alcohol Services
- SSAB representative
- Domestic Abuse Strategic Partnership representative

8.2. Other people who may be invited for expertise/advice include:

- Representative of the coroner's office
- Representative from Sandwell MBC legal services
- Community representative/s
- Fire/Ambulance services
- Accident and Emergency staff
- Consultant Obstetrician

If a CDOP member is unable to attend a meeting apologies must be sent or a representative should attend in their place. If a second consecutive meeting is missed, with no apologies, the Chair will write to the senior person of that agency seeking a replacement.

9. Confidentiality

- CDOP is likely to receive information that is sensitive personal data within the meaning of the Data Protection Act 1988 for the purposes of the child death review.

- Information circulated for CDOP meetings will be anonymised prior to the meetings as will the meeting minutes. However, within the confines of a CDOP meeting members are likely to discuss sensitive personal data and may refer to actual names

- Any reports, minutes and recommendations from CDOP will be anonymised and steps taken to ensure no personal information can be identified.

- All members of CDOP will agree to adhere to the guidelines on confidentiality and information sharing outlined in Working Together 2015.

- At the start of every meeting CDOP members will sign a confidentiality agreement which will cover information discussed at the meeting and any papers, minutes, reports and any other documents circulated for consideration at the meeting. Any ad-hoc or co-opted members will also be required to sign this confidentiality agreement.

- Papers circulated by email will be both anonymised and password protected.

10. Administration

The Child Death Co-ordinator will provide administrative support