



Child Death Overview Panel

Terms of Reference

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Wandsworth Child Death Overview Panel (CDOP) aims to better understand how and why children in Wandsworth die and 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 chapter 5 of *Working Together to Safeguard Children 2015* in relation to the deaths of any children normally resident in Wandsworth. 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 Wandsworth.
- (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Wandsworth.

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 5 of *Working Together 2015* on enquiring into unexpected deaths.
2. To ensure the accurate reporting of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in Wandsworth 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 Wandsworth, 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 Wandsworth, 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 Director(s) 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 WSCB 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 WSCB 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 in order to identify lessons on the prevention of child deaths.

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 Wandsworth. 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 Wandsworth, that death shall be notified to the single point of contact (SPOC) for the CDOP in the child's area of residence. Similarly, when a child normally resident in Wandsworth dies outside Wandsworth, the SPOC for Wandsworth 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.

Membership

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

The Wandsworth CDOP currently consists of the following core membership:

Wandsworth CCG

Consultant in Public Health Medicine

Designated Doctor for Safeguarding (Chair)

Designated Nurse for Safeguarding

DESS & WSCB

Manager for Safeguarding Standards Unit

Children's Specialist Services

WSCB Development Manager



St George's University Hospitals NHS Foundations Trust

Designate Paediatrician for Child Death

Named Nurse for Child Safeguarding

Named Doctor for Child Safeguarding

Named Midwife for Child Safeguarding

CDOP Manager

CDOP Bereavement Counsellor

Metropolitan Police

Detective Chief Inspector – Borough Police OR

Detective Inspector – Child Abuse Investigation Team (CAIT)

Quoracy

CDOP meetings require the following members to be quorate.

- Chair
- Designated Paediatrician for Child Death
- One representative from each of the following areas:
 - Social Care
 - Metropolitan Police
 - Health

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 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 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.

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.

Accountability and Reporting Arrangements

The CDOP will be accountable to the chair of the Wandsworth Safeguarding Children Board.

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

The WSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform service planning and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

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