Terms of Reference: Child Death Overview Panel

Review: These terms of reference will be subject to review by the Strategic Child Death Overview Committee in September 2022

1. Purpose

Through a comprehensive and multi-agency review of deaths of Essex, Southend and Thurrock resident children the Child Death Overview Panel aims to better understand how and why children in the locality die and use these findings to:

- identify the presence of modifiable or notable factors
- identify lessons learnt and issues of concern or note
- consider in all reviews whether appropriate recommendations can be formulated
- provide feedback to the child's parents on occasions when this is considered appropriate
- review the follow up plans for the family.

2. Statutory Basis

In carrying out activities to pursue this purpose, the Panels will meet the functions set out in paragraph 5 of *Working Together to Safeguard Children 2018* in relation to the deaths of any children normally resident in Southend, Essex and Thurrock. Namely, collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Child Safeguarding Practice Review

(ii) any matters of concern affecting the safety and welfare of children in these areas

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in these areas.

The requirement on LSCBs to carry out this activity is contained in Regulation 6 of the *LSCB Regulations 2005* and the *Children Act 2004*.

3. Structure

In Essex (incorporating the local authority areas of Southend, Essex and Thurrock) the Child Death Overview Panel covers the CCG areas of:

North East Essex, Mid Essex, West Essex, Castle Point & Rayleigh, Basildon & Brentwood, Southend and Thurrock

There is one Strategic Child Death Overview Committee (SCDOC) which provides the overarching governance structure for the CDOP across Southend, Essex and Thurrock.

4. Scope

The Panel will assess data on the deaths of all children and young people from birth (excluding both those babies who are stillborn (unless not attended by a healthcare professional and subject to a JAR) and planned terminations of pregnancy carried out within the law) up to the age of 18 years, who are normally resident in Southend, Essex and Thurrock. This includes neonatal, expected and unexpected deaths of known and unknown causes.

Where a child normally resident in another area dies within Southend, Essex or Thurrock, that death shall be notified to the CDOP for the child's area of residence following a Joint Agency Response being commenced in Essex. It is an expectation that, when a child normally resident in Southend, Essex and Thurrock dies outside of these areas, the Southend, Essex and Thurrock CDOP should be notified following a Joint Agency Response being undertaken by the area in which the child has died. In both cases an agreement should be made as to which Review Panel will take the lead on reviewing the child's death and how they will report on it but in most circumstances the review will be undertaken in the area in which the child was resident.

5. Functions

The functions of CDOP include:

- to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;

- to analyse the information obtained, including the report from the Child Death Review Meeting, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;

- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;

- to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partnerships/Board when it suspects that a child may have been abused or neglected;

- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;

- to provide specified data to the National Child Mortality Database;

- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

6. Anonymisation / Confidentiality

Information discussed at the local review panel meetings will be anonymised prior to the meetings. All members adhere to strict guidelines on confidentially and information sharing. Information is being shared in the public interest for the purposes set out in Working Together to Safeguard Children and is bound by legislation on data protection.

All Panel members, including ad-hoc or co-opted members, will be required to sign a confidentiality agreement before participating in the review panel.

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

7. Membership

7.1 Core Membership

The following represents the core membership of panel.

- Public Health
- Designated Paediatrician for Child Deaths
- Social Care
- Police
- Designated Nurse Safeguarding Children
- Nursing and/or midwifery
- Child Death Review (Health) team
- Primary care
- Additional professionals should be considered on a case-by-case basis, for example from: coroner's office, education, housing, council services, health and wellbeing board, ambulance services, or hospices.

The appropriate level of seniority of the representatives should be determined by the relevant organisation. However the Chair may raise concerns with the organisation should the nominated representative not demonstrate the professional expertise and decision making authority required to effectively contribute to the Panel.

In addition to the core membership, relevant experts from health and other agencies should be invited as necessary to inform discussions.

7.2 Chairing

Each panel will be chaired by a Public Health Consultant. The Vice Chair will be the attendant Designated Doctor for Deaths in Childhood, who will chair meetings in the Chair's absence.

7.3 Quoracy

Quoracy will usually demand attendance by lead professionals from health and Public Health/Local Authority. However, when a themed panel is discussing exclusively medical concerns, the attendance of police and social care might not be necessary. In such situations those agencies not present might review the cases being discussed, and bring to the panel's attention relevant issues, as required.

7.4 Substitutes

Where a member is unable to attend a meeting it is an expectation that they should arrange for a substitute from the same professional background to attend in their place. The substitute should be of equivalent seniority or where this is not possible of an appropriate seniority as determined by the organisation.

Panel members should seek to identify in advance other professionals who could substitute for them in the event of their unavailability. The Panel member should ensure their substitute has received sufficient briefing to undertake the task and are in receipt of the relevant paperwork.

If a member required to make a meeting quorate, is not present but they have provided an appropriate substitute the meeting shall be deemed quorate.

8. Accountability

Each CDOP Chair will be accountable for their panel's work to the Chair of the Strategic Child Death Overview Committee. The Strategic Overview Committee will monitor the work of the CDOPs and will raise concerns as required.

9. Frequency of meetings

The CDOP meetings will be scheduled to be held monthly. Additional meetings may be arranged by agreement of the panel depending on the work load of the panel. The meeting frequency will be reviewed on a yearly basis.

10. Administration

The administration of meetings – to include arrangement of meeting dates / venues, collation of agendas and meeting paperwork and minute taking will be undertaken by the CDR Manager.

The CDR Manager will work closely with the chair of the panel and the Designated Doctor for Child Deaths. The latter has responsibility for the wider child death review

process and advising the CDOP in relation to themed panels. The CDR Manager should be notified according to local protocol whenever a child dies.

A CDOP, on behalf of the CDR Partners, may request any professional or organisation to provide relevant information to it, or to any other person or body for the purposes of enabling or assisting the performance of the child death review partner's functions. Professionals and organisations must comply with such requests.

11. Classification system / tools

The Child Death Overview Panel will use the national data collection forms and additional forms developed on a local basis to guide their case discussions. A CDR Analysis form will be completed for each case reviewed.

12. Legal Advice

Legal advice will be sought on a case by case basis as required from the most appropriate source, e.g. Local Authority or CCG.

It is expected that advice will be sought when there is uncertainty amongst panel members about assessments being made on deaths, particularly in relation to preventability and on the appropriate communication of panel findings back to family members.

Panel members should seek legal advice from their own agency where they are concerned about the information that should be supplied for the child death review process and the implications of this.

13. Venues

Where possible panel meetings will be held in the local offices of agencies represented on the membership.

14. Expectations of Panel Members

14.1 Expectations of Panel Chairs

- To Chair meetings of the panel and if unavailable to do so to arrange a substitute chair of appropriate professional background and seniority to do so.
- To provide the CDR Manager with a secure email address to send panel documentation to.
- To manage panel meetings to ensure the effective fulfilment of panel functions through agreed processes and procedures.
- To monitor and ensure the completion of actions agreed by Panel meetings.
- To refer issues as agreed at the Panel meetings to the Strategic Child Death Overview Committee, other agencies and organisations.
- To liaise with the CDR Manager to ensure the effective administration of meetings.

- To be available to the CDR Manager to assist with the resolution of problems / issues in connection with the administration of panels.
- To monitor the contribution made by agencies to review panel meetings and raise concerns to SCDOC where problems are identified with this.
- To enforce confidentiality requirements as necessary.
- To sign off minutes of meetings within an agreed timescale.
- To make required reports to the SCDOC, and other strategic organisations as agreed.

14.2 Expectations of Panel Members

- To attend meetings and where unable to do so to arrange a substitute of appropriate professional background and seniority to attend in their place.
- To provide the CDR Manager with a secure email address to send documents for the CDOP.
- To develop and maintain, within their professional sphere, an effective level of knowledge and experience relevant to deaths in childhood so as to enable a effective contribution to the meeting.
- To read meeting paperwork prior to attendance and attend meetings with an in depth knowledge of the information provided.
- To contribute fully to the work of the panel.
- Within the member's own agency, to coordinate work to address agreed actions.
- To feedback relevant information to colleagues as requested.
- To uphold confidentiality and data protection requirements.

Specific Roles and responsibilities of the Designated Doctors are set out in **Appendix A.**

APPENDIX A

Roles and Responsibilities
Designated Doctor for Child Death

- To attend quarterly meetings of Strategic Child Death Overview Committee and to attend the Child Death Overview Panel (CDOP) meetings in the venue closest to their working base. (In the event that the Designated Doctor in the area of the meeting is unable to attend, it is expected that they should liaise with the SET area Designate Doctors to arrange a substitute to attend in their place. If a Designated Doctor is not available then a substitute Consultant Paediatrician may attend, although he or she should have knowledge of the Child Death Review process):

- To fulfil the expert clinical role for the Child Death Overview Panel, including providing advice around themed panels and the identification of modifiable contributory factors;

- To advise on the appropriate response to a death in an adult ICU;

- Assist CDOP on the development and implementation of appropriate preventative strategies to reduce child deaths;

- Advise CDOP regarding necessary experts required to inform ordinary and themed panels;

- Liaise, as appropriate, with regional clinical networks to ensure that themed panels are properly co-ordinated;

- To ensure through collaboration with key stakeholders (including Public Health, Children's Services, CCG commissioners, Designated Doctors, Safeguarding Designated Nurses, Looked After Children Designated Nurse, Quality Teams) that learning from the overview process is embedded into the commissioning strategy and that NHS providers embed learning into daily practice and that this is monitored.

- To play a key role in the resolution of differences of opinion between health professionals and with key statutory agencies in relation to the deaths of children.

- To contribute to the development of local multiagency policy and procedures relating to the child death overview process and provide advice, as appropriate, to the CCGs and NHS providers in relation to the development of health specific policies.