Terms of Reference: Strategic Child Death Overview Committee

Review: These terms of reference will be subject to review in September 2026

1. **Purpose**

To ensure that Southend, Essex and Thurrock have robust arrangements in place for the multi- agency review of all child deaths across the county, and that the process is grounded in a deep respect for the rights of children and their families, with the intention of preventing future deaths.

The Strategic Child Death Overview Committee will:

- provide strategic leadership across Southend, Essex and Thurrock in relation to the child death review process;
- have oversight of compliance with the implementation of national guidance relating to the child death review process, including the auditing of the effectiveness of such guidance
- quality assure the work of the Child Death Overview Panels
- scrutinise and analyse trends and themes emerging from the review of child deaths, to identify underpinning modifiable or notable factors which will inform learning and development;
- have strategic accountability for ensuring that learning from the overview process informs the CDR Partners' commissioning strategies and Public Health initiatives;
- work collaboratively with the Southend Essex and Thurrock Safeguarding Children Partnerships / Board to establish robust pathways for information sharing and escalation.

2. Statutory Basis

In carrying out activities to pursue this purpose, the Strategic Child Death Overview Committee (SCDOC) will ensure the functions set out in paragraph 6 of *Working Together to Safeguard Children 2023* in relation to the deaths of any children normally resident in Southend, Essex and Thurrock are actioned. 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.

3. Structure

The Strategic Child Death Overview Committee covers Essex (incorporating the local authority areas of Southend, Essex and Thurrock

4. Scope

The Child Death Overview Panels (CDOP) 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 Joint Agency Response) 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. Relationship between SCDOC and CDOP

The Child Death Overview Panel will review anonymised data on individual deaths to identify issues connected to each death, case by case. The Strategic Child Death Overview Committee will identify strategic themes and trends.

It is the role of the CDOP to identify whether the cases reviewed indicate that there are changes that could be made in/by agencies which would prevent similar deaths occurring in the future. Where this is identified to be the case CDOP are expected to formulate specific recommendations for the changes that need to be brought about. These can be directed to individual agencies, multi-agency forums and others such as national organisations.

The recommendations made by CDOPs will be provided to the Strategic Child Death Overview Committee who will be responsible for endorsing relevant actions. Following their adoption, the recommendations will be communicated by SCDOC to the relevant agencies / organisations, including the SET Multi-agency Safeguarding Partnerships/Board. This will be the mechanism through which recommendations made at the local level will reach a wider audience.

If they accept the recommendations made by local panels or if recommendations are urgent in nature, local agencies should begin work to implement these immediately and should not wait for them to be endorsed and formally communicated to them via the Multi-agency Safeguarding Partnerships / Board.

The Strategic Child Death Overview Committee should seek assurance from the Multi-agency Safeguarding Partnerships / Board as to how recommendations/ learning have been enacted.

6. Functions

The Strategic Child Death Overview Committee will:

- Oversee and monitor the implementation of the SET protocol on deaths in childhood in line with guidance in Chapter 6 of *Working Together;*
- Evaluate the effectiveness of the child death review and Joint Agency Response process and make recommendations for improvements;
- Monitor and advise the Child Death Review Partners on the resources and training required to ensure effective implementation of the protocol;
- Ensure appropriate liaison is occurring between the child death review and child safeguarding practice review processes for the Multi-Agency Safeguarding Partnerships / Board.
- Ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
- Review aggregated data on deaths occurring in Southend, Essex and Thurrock and analyse this information to identify trends and patterns related to the safety and welfare of children and wider public health and safety concerns.
- Consider, with the Director of Public Health how best to address any public health and safety matters identified through the course of review panel activity.
- Quality assure the work of the Child Death Overview Panels
- Consider recommendations developed by the Child Death Overview Panel and develop strategies for improving practice based on the findings of the panel and from their own investigations.
- Undertake / commission – as appropriate – work in response to recommendations / lessons leant;
- Inform county wide strategic planning in the area by feeding in information to the Multi-Agency Safeguarding Partnerships / Board and other bodies as appropriate.
- Make national representations regarding the need for changes in legislation, policy and practice to promote child health and safety and prevent child deaths.

- Cooperate with regional or national initiatives on childhood deaths as requested.

- Develop a yearly work plan.

- Produce an annual report for CDR Partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and

- Provide yearly reports to the Child Death Review Partners and other appropriate agencies on child death review and joint agency response activity in Southend, Essex and Thurrock which include the aggregated death data.

- Agree funding arrangements for the Child Death Review function for Southend, Essex and Thurrock, to be shared proportionally between the CDR Partners based on the 0-19 population. Any additional service needs arising i.e. specialist legal advice, media campaigns, will be spot purchased and funding shared between relevant CDR partners.

7. Accountability

The Chair of the Strategic Overview Committee is accountable for its work to the Child Death Review Partners for Southend, Essex and Thurrock. The Chair shall provide reports on the work of the Panels according to an agreed timetable and format.

8. Frequency of meetings

SCDOC will meet quarterly with the required frequency of meetings being reviewed yearly

9. Administration

Support for SCDOC will be supplied by the Child Death Review Manager.

Agendas will be circulated one week before the meeting and minutes will be circulated within one month of the meeting. Any member may suggest items for the agenda by contact with the CDR Manager – these will be subject to the agreement of the Chair.

10. Anonymisation / Confidentiality

The information dealt with by the Strategic Child Death Overview Committee will be anonymised. Should a need arise to discuss non-anonymised information the same guidance as that for Child Death Overview Panel is applicable.

11. Membership

11. 1 Core membership

Membership will be drawn from across Southend, Essex and Thurrock. There is only a requirement for one person to be nominated for each of these required positions. Appropriate arrangements should be established to ensure this representative feedbacks information appropriately to other trusts/colleagues.

Required core membership for the Panel is as follows:

- A Director of Public Health (Chair)
- A Director of Nursing / Executive Nurse representing the SET ICSs.
- 5 x Designated Paediatricians for Deaths in Childhood
- The Business Manager from each SET Multi-agency Safeguarding Partnership/ Board
- A representative from the Police
- A Coroner or their representative
- A representative from the East of England Ambulance Service
- Representatives from the SET Local Authority Children's Services
- A Designated Nurse for Safeguarding Children
- The Child Death Review Health Team Lead

Substitutes:
Should a core member be unable to attend, a representative with the appropriate level of seniority should be nominated. 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 Strategic Child Death Overview Committee.

11. 2 Additional membership

The core membership may be added to by agreement of the Committee on a standing or ad hoc basis.

11.3 Chairing

The Chair of the SCDOC will be the Director for Public Health, Essex County Council

A Vice-Chair for the panel will be elected by the membership and reviewed annually.

11.4 Quoracy

SCDOC meetings will be quorate if the following representatives are present (irrespective of the geographical area they represent):

1. The Chair or Vice Chair
2. An ICS Executive Nurse/ Director of Nursing
3. A Designated Paediatrician
4. A representative of the Police
5. A representative from a SET Local Authority Children's Service

If a meeting is inquorate it may proceed however the meeting will be unable to make any binding decisions. Decisions will need to be deferred to the next committee meeting.

12. Expectations of SCDOC Members

12.1 Expectations of SCDOC Chair

- 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 (in most cases this will be the Vice Chair)
- To manage meetings to ensure the effective fulfilment of SCDOC functions through agreed processes and procedures
- To monitor and ensure the completion of actions agreed at meetings
- Where required, to refer issues as agreed at meetings to appropriate Multi-Agency Safeguarding Partnerships / Board, other agencies and organisations
- To liaise with the CDR Manager to ensure the effective administration of meetings
- To be available to the Child Death Review 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 the CDR Partners 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 CDR Partners and other strategic organisations as agreed

12.2 Expectations of SCDOC 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 develop and maintain, within their professional sphere, an effective level of knowledge and experience relevant to deaths in childhood so as to enable 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.

13. Legal Advice

Legal advice will be sought as required from the most appropriate source, e.g. Local Authority or ICS..