Template for Terms of Reference for a Child Death Overview Panel

These terms of reference apply to the Child Death Overview Panel of **ENTER LSCB NAME HERE LSCB**(s) and [its/their] constituent agencies. The Child Death Overview Panel is a sub-committee of the LSCB, established in accordance with the LSCB regulations (Children Act 2004) as set out in Working Together to Safeguard Children (2006).

Date:

Purpose

The purposes of the Child Death Overview Panel are to: collect and analyse information about each child's 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; and

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

The Panel will review deaths of all children aged 0-18 (excluding stillbirths) normally resident in the Local Authority area. Where the Panel is made aware of the death of a child in their area who would normally be resident in another Local Authority area, or the death of a child in another area who would normally be resident in their area, the Panel manager will liaise with his/her opposite number in the other Local Authority area to ensure both Panels are notified of the death, and to determine which Panel is best placed to carry out a review of that child's death.

Functions

The Child Death Overview Panel will:

- Meet regularly to complete a multi-agency evaluation of all child deaths in their area;
- Where appropriate undertake a detailed and in-depth evaluation into specific cases, including all unexpected deaths, assessing all relevant social, environmental, health and cultural aspects, or systemic or structural factors of the death, along with the appropriateness of the professionals' responses to the death and involvement before the death, in order to complete a thorough consideration of whether and how such deaths might be prevented in future;
- Collect and collate information using the template (DCSF, 2008) and where relevant seek further information from professionals and family members;
- Identify local lessons and issues of concern, requiring effective inter-agency working;
- Identify and report any local 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;
- Identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths
- Ensure concerns of a criminal or child protection nature are shared with the police, children's social care and the Coroner;
- Ensure any case identified as meeting criteria for a Serious Case Review are referred to the chair of the LSCB;
- Provide information to professionals involved with families so that this can be passed on in a sensitive and timely manner;
- Implement, review and monitor the local procedures for rapid response arrangements in line with Working Together 2006;
- Monitor the quality of information, support and assessment services to families of children who have died
- Co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

Accountability

The Child Death Overview Panel will be responsible, through its chair, to the chair of the Local Safeguarding Children Board. The Panel will provide to the LSCB and all constituent agencies, an annual report (in which all information should be aggregated and anonymised) which shall be a public document. In addition, the Panel will report to the LSCB any matters of concern arising from the course of its work as set out above.

The LSCB will take responsibility for disseminating the lessons to be learnt to all relevant organisations; ensuring that relevant findings inform the Children and Young People's plan; and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The LSCB will supply data regularly on every child death, as required by the Department for Children, Schools and Families, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Administration

The Panel will be chaired by the Chair of the LSCB or his/her representative. The work of the Panel will be co-ordinated by the panel manager, supported by a clerical assistant.

Membership

The Panel will have

- a fixed core membership drawn from key organisations within the LSCB
- will have the flexibility to co-opt other professionals to become panel members on a case by case basis

Core members:

Co-opted members:

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.

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.

Child Protection Concerns
Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings.

If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with LA children's social care. It may be decided that it is appropriate to initiate an initial assessment using the Framework for the Assessment of Children in Need and their Families (2000). If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the inter-agency procedures set out in Chapter 5 of Working Together should be followed. The police and Coroner must be informed immediately that there is a suspicion of a crime or evidence comes to light that the death may be of a suspicious nature. The Chair of the LSCB should be informed of the case to ensure that appropriate procedures are followed and to consider the need for a Serious Case Review.

Partner Agency Responsibilities
Each partner agency of the LSCB will identify a senior person within their organisation who has responsibility for representing the agency on the CDOP. Each agency will ensure their representative is allocated sufficient time in their job plan to attend all Panel meetings, having prepared in advance of the meetings, and is able to report back to the agency any specific recommendations arising from the panel.

Partner agencies will ensure that staff in their agency who become aware of the death of a child will report that child's death to the Panel. Partner agencies will ensure that relevant staff are made aware of the child death review functions of the LSCB and are able to access appropriate training.

Working with the media
Media interest in the work of the CDOP or in individual cases will be dealt with by the press officer for the LSCB. The annual report of the CDOP will be a public document and as such will have no identifiable information contained within. Details of individual case discussions are to be kept confidential and in no circumstances will such details be passed to the press. The LSCB press officer will work proactively with the media to promote the work of the CDOP alongside that of the LSCB in safeguarding and promoting the welfare of children in the area.

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