

**STOKE-ON-TRENT AND STAFFORDSHIRE**

**CHILD DEATH OVERVIEW PANEL (CDOP) - TERMS OF REFERENCE**

**PURPOSE**

The Stoke-on-Trent and Staffordshire Child Death Overview Panel (CDOP) was established in April 2008, in accordance with the requirements of the Children Act, 2004 and Working Together to Safeguard Children 2018. The panel has created local structures and processes to review all deaths of children normally resident in Stoke-on-Trent and Staffordshire. (A pragmatic approach is taken to reviewing the deaths of children not normally resident with agreement with their local CDOP).

The CDOP is the final, independent scrutiny of a child's death by professionals. It is there to analyse information from all deaths reviewed - consider what, if any, action should be taken in relation to any modifiable factors identified, and make recommendations’ to multi-agency safeguarding arrangements , health and wellbeing and other relevant strategic partnerships and boards.

The panel provides oversight and assurance of the whole Child Death Review (CDR) processes in accordance with the National Child Death Review Statutory and Operational Guidance (England) 2018 <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

**MEMBERSHIP**

The Child Death Overview Panel will have a fixed core membership drawn from the key organisations Social Care, Health and the Police. **The role of attendees is to represent their wider organisation / agency at a level that they can make decisions and take on board actions and embed learning. Where they are unable to resolve or influence change, issues must be brought back to CDOP for escalation to the safeguarding board.**

Additional members could be housing, education, health and wellbeing, and hospice. Other relevant professionals will be co-opted to discuss certain types of death as and when appropriate. The CDOP will be chaired by a representative from Staffordshire Police. A ‘lay’ member will also sit on the panel and be involved in group activity and direction.

Panel members must declare any conflict of interest at the outset of each meeting and panel members should not lead discussions if they are the named professional for a specific case.

The CDOP membership will be reviewed annually at every second meeting of the year by members ascertaining membership and engagement appropriate for activity.

Additional CDOP specialist meetings, with CDOP member representation and ad hoc professionals will be arranged, e.g. neonatologists for neonatal deaths, police collision investigators for road traffic deaths. A LeDeR representative will be invited to Child Death Review (CDR) meetings.

Quoracy should usually demand attendance by lead professionals from CDOP partners e.g. Health, Public Health and local authority. Themed panels will be developed in line with local circumstances and may have a different membership.

**ACCOUNTABILITY AND REPORTING ARRANGEMENTS**

The CDOP will be accountable to Child Death Review (CDR) partners.

The Performance and Quality Assurance Framework sets out how the Board uses data and intelligence to assess the effectiveness of the help being provided to children and families, including early help (Working Together 2018).

* An overview of the meeting, minutes and matters arising will be shared with partners after every CDOP meeting. This information will relay performance and quality actions taken by CDOP to note good practice in the child death processes, where practice needs to improve and how we effect initiatives to keep processes (and mortality) on an improving track eg through writing guidelines, ensuring guidelines are appropriate and enhancing education and support. Public Health will provide information epidemiological and health surveillance data and assist in evaluating patterns and trends in relation to child deaths and in implementing public health prevention initiatives and programmes.
* Good practices and recommendations to prevent future deaths and promote the welfare of children are shared and appropriate action taken through updates, alerts, newsletters and campaigns.
* The CDOP is responsible for developing a business plan and annual report. The annual report will give a strategic overview of the work of the CDOP, and where differences and adjustments to practice / service have improved the lives and experience for families, led to reductions of serious injuries and death etc. Modifiable factors and learning from reviews informs CDOP future work and milestones for CDOP. Our communications plan for the following year will be developed from our findings, as well as from updates and alerts regionally and nationally.
* CDOP members are responsible for disseminating the lessons to their relevant organisation, ensuring that relevant findings inform the strategic plans of both local authorities and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
* Child death review partners will agree locally how the child death review process will be funded in their area.

**FUNCTIONS**

* to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
* Ensuring effective multi-agency reviews of sudden deaths and processes in a timely and effective manner to ensure the cause of death is determined as accurately as possible, modifiable factors identified and any lessons are learned and shared.
* Ensuring mortality reviews take place for all child deaths, including within specialist areas such as NICU, palliative care and neurodisability.
* to analyse the information obtained, including the report from the Child Death Review Meeting (CDRM), 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 Partners when it suspects that a child may have been abused or neglected;
* to provide specified data to the National Child Mortality Database;
* to produce an annual report for Child Death Review (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
* 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.

**RESPONSE**

* To ensure, in consultation with the local Coroner(s), that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 5 of Working Together 2018 on enquiring into unexpected deaths; and Royal College of Paediatrics and Child Health Sudden Unexpected death in infancy and Childhood Multiagency guideline for care and investigation
* to continue to improve agency responses to all child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced and providing the professionals concerned with feedback on their work; ensuring that arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating each unexpected death of a child.
* Electronic systems are utilised and updated to manage child deaths and share information through eCDOP and the National Child Mortality Database,
* Where concerns of a criminal and/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 SSSCB of a possible a learning review ; to inform Children’s Social Care of the need for further enquiries under section 47 of the Children Act 1989;

**PARENTS AND CARERS**

* Parents and family members are invited to be appropriately involved in the child death review process.
* Parents/ carers should be allocated a ‘Key worker’ who will be the main contact throughout the review process. This could be a professional from various agencies or organisations. The role holder should be reliable and accessible and are responsible for communicating information, coordinating any meetings between the family and professionals, act as advocate for the family and sign post the family to bereavement support. CDOP have a role in ensuring support is available locally or elsewhere as needed for families.
* Parents are encouraged to contribute any comments or questions they might have to the review of their child’s death and should be assured by their key worker that any information concerning their childs death which they believe might inform the review would be welcome and can be submitted to CDOP.
* Parents and carers will not be invited to attend the panel meeting. Any specific learning or recommendations from the review will be feedback to families on an individual case basis, routine feedback after each review will not be given.

**CONFIDENTIALITY AND INFORMATION SHARING**

* All panel members, ad-hoc and new members must sign a confidentiality agreement.
* All information discussed at all Joint Agency Response (JAR) and Child Death Review (CDR) meetings is strictly confidential.
* The CDOP will conduct an anonymised secondary review of each death and identifying details of the child and treating professionals will be redacted.
* Panel members must declare any conflict of interest at the outset of each meeting and panel members should not lead discussions if they are the named professionals.

**LEGAL IMPLICATIONS**

* Any single agency information requests should be directed to the specific agency involved and not through CDOP.
* Local Authority Legal Services will be consulted in the event of any specific disclosure issues.
* CDOP documentation is not subject to Freedom of Information requests.