Croydon Safeguarding Children Board

Child Death Overview Panel

Terms of Reference

The Child Death Overview Panel is a sub-group of the Croydon Safeguarding Children Board (CSCB) and oversees the Rapid Response Meeting Process. This document should be read in conjunction with "Working together to Safeguard Children" Chapter 5 (2015) HM Government.

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Croydon Child Death Overview Panel (CDOP) aims to better understand how and why children in Croydon die, providing relevant knowledge and skills to interpret the information gained and use our findings to take action to prevent other deaths and improve the health and safety of our children.

Responsibilities of CDOP

- Review all child deaths up to the age of 18, excluding babies who are stillborn and planned terminations of pregnancy carried out within the law.
- Collect, collate and review information on each death to identify:
    - the need for a further review
    - any matters of concern affecting the safety and welfare of children in Croydon
    - wider public health or safety concerns arising from a particular death or from a pattern of deaths in Croydon
- Ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
- Determine if the death was deemed preventable, where modifiable factors may have contributed to the death and decide whether any actions could be taken to prevent future deaths
- Make recommendations to CSCB and other relevant bodies promptly so that action can be taken to prevent future such deaths
- Identify significant risk factors and trends in individual child deaths including and report these to CSCB
- Refer to CSCB Chair any deaths where, from the available information, the panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.
- Identify 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.
- Enquire and constructively challenge how each organisation discharged their responsibilities to an individual child's death, and whether there are any lessons to be learnt

- Evaluate specific cases in depth where necessary, to learn lessons or identify issues of concern.
- Identify significant risk factors and trends in individual child deaths and in overall patterns of deaths in Croydon, including relevant environmental, social, health and cultural aspects 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.
- Identify public health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both provision of services and training.
- Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- Increase public awareness and advocacy for the issues which affect the health and safety of children.
- Where concerns of a criminal or child protection nature are identified, confirm that the police and coroner are aware and inform them of any specific new information that may influence their inquiries and inform the Chair of the CSCB
- 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.
- Advise CSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
- Co-operate with any London-regional and national initiatives
- Collect a minimum dataset as required by the Department for Education and submit this annually for national data collection.
- Prepare an annual report for the Croydon Safeguarding Children Board who is responsible for disseminating the lessons to be learnt to all relevant organisations, and ensure that relevant findings inform the Children and Young People's Plan. They will also action any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children
- Develop and implement a work plan approved by Croydon Safeguarding Children Board.

Membership

Core attendees:

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Public Health Principal (Chair)
- Police
- Social Care Quality Assurance Manager

Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Members may nominate a deputy to attend on their behalf, but must ensure that their deputy is fully briefed on their responsibilities

Confidentiality

- Information circulated and discussed at the meeting will be anonymised prior to the meeting and where possible all Form B information be amalgamated onto one form.
- 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
- Any information that is being shared in the public interest for the purposes set out in Working together to Safeguard Children (2013), is bound by legislation on data protection.
- CDOP members will be required to sign a confidentiality agreement before participating in the CDOP and at the start of each meeting
- Any ad-hoc or co-opted members and observers will also be required to sign an attendance sheet, confirming that they have understood (and signed) the confidentiality agreement.

Accountability

- The CDOP is accountable to the chair of Croydon Safeguarding Children Board.

Frequency of Meetings

- CDOP is scheduled monthly but subject to cancellation if business determines appropriate.

- There must be a minimum of two agencies in attendance in addition to the Designated Doctor for Child Protection & Child Death Review Coordinator

Relevant papers

Croydon Multi-agency Child Death Notification Protocol
Form A - Initial Notification of the death of a child
Form B – Agency Report Form
Form C – Analysis Proforma
CDOP Confidentiality Statement

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