Child Death Overview Panel
Terms of Reference - May 2018

1 Purpose

Through a comprehensive and multidisciplinary review of child deaths, the BSCB Child Death Overview Panel (CDOP) aims to better understand how and why children in Buckinghamshire die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

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

(i) any case giving rise to the need for a Serious Case Review
(ii) any matters of concern affecting the safety and welfare of children in Buckinghamshire
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Buckinghamshire.

2 Functions

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in *Working Together* on enquiring into unexpected deaths.
2. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in Buckinghamshire.
4. To supply data on every child death as required by the Department for Education and Skills.
5. To evaluate data on the deaths of all children normally resident in Buckinghamshire, thereby identifying 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.

6. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Buckinghamshire, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a through consideration of how each death might be prevented in the future.

7. To identify any public health issues and consider, with the Director(s) of Public Health and any other provider services how best to address these and their implications for both the provision of services and for training.

8. To identify and advocate the needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

9. To increase public awareness and advocacy for the issues that affect the health and safety of children.

10. Where concerns of a criminal or child protection nature are identified:

    - To ensure that the police and coroner are aware and to inform them of any specific information that may influence their enquiries;

    - To ensure that social care are aware and to inform them of any specific information that may influence s47 enquires or other action to be taken.

    - To notify the Chair of the BSCB and the Chair of the Strategic and Serious Case Review Sub Committee – for Serious Case Review consideration.

11. To 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.

12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.

13. To ensure that all reviews extend to the learning for early help / intervention.

14. To agree an annual work plan with the BSCB as part of its business planning process.

15. To provide an annual report to the BSCB on child deaths and to escalate to the BSCB any other concerns relating to the inter-agency response to child deaths.

16. To work within the Learning and Improvement Framework of the BSCB; to inform and enhance front line practice.

17. To co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

3 MEMBERSHIP

The Child Death Overview Panel will have a permanent core membership (listed below) drawn from key organisations represented on the BSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

- BSCB (CDOP Coordinator)
- Buckinghamshire CCGs
- Buckinghamshire Coroner's Service
- Buckinghamshire County Council (Child & Family Service)
- Buckinghamshire County Council (Education)
- Buckinghamshire County Council (Public Health)
- Buckinghamshire Healthcare NHS Trust (Designated Doctor)
- Buckinghamshire Healthcare NHS Trust (Antenatal Care/Maternity)
- Thames Valley Police

A chair and vice chair should be elected from within the panel membership. These roles will be reviewed on an annual basis.

4 OPERATIONAL ARRANGEMENTS

Quoracy: The meeting will be deemed quorate if either the Chair or the Vice Chair is present plus the following members:

- Designated Doctor
- Children's Social Care
- Sufficient representation from other members to effectively discuss the specific caseload for each meeting. The members required for this may vary for each meeting.

It is possible for a non-quorate meeting to proceed providing that sufficient and appropriate people are present. Each case should be considered individually and any case where a key person is absent must be deferred.

Frequency: Meetings are normally bi-monthly, but more frequent meetings may be scheduled dependent upon the number of outstanding cases to be reviewed.

Terms of Reference: The Terms of Reference will be reviewed on an annual basis. Date of next review: May 2019.