Waltham Forest-Child Death Overview Panel (WF-CDOP)

Terms of Reference
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Introduction

These are the terms of reference that apply to the Child Death Overview Panel (CDOP) of London Borough of Waltham Forest. The Child Death Overview Panel was established in April 2008 and is a sub group of each Local Safeguarding Children Board (LSCB), The government requires each LSCB to carry out a review of all child deaths in their area, following the processes set out in Working Together to Safeguard Children (2013).

Purpose

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

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in Working Together to Safeguard Children (Chapter 5) in relation to the death of any children who are residents of the borough.

(a) Collecting and analysing information about each death with a view to identifying:
   - Any case giving rise to the need for a serious case review
   - Any matters of concern affecting the safety and welfare of children in the area;
   - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths;

(b) Establishing procedures for ensuring a coordinated response to an unexpected child death.

Objectives

Notification and data collection

The CDOP will seek to do the following:

- Ensure in consultation with the local Coroner’s office, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in chapter 7 of Working Together 2006 on enquiring into unexpected deaths.
• Ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.

• Collect and collate an agreed minimum data set of information on all child deaths in the area, and where relevant, to seek additional information from professionals and family members.

• Ensure that these information gathering processes minimise distress to families

• Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths (e.g. London learning from information about child deaths initiative)

Case level

The CDOP will seek to

• Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt

• 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 new information that may influence their inquiries: to notify the Chair of the LSCB of those concerns and advise the chair on the need for further enquiries under section 47 of the Children Act or of the need for a serious cases review.

Population level, prevention and advocacy

The CDOP will seek to:

• Evaluate data on the deaths of all children normally resident in the local area, 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

• Identify significant risk factors and trends in individual child deaths and in overall patterns of deaths in the local authority areas, 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 thorough consideration of how such deaths might be prevented in the future

• Identify any public health issues and consider with the Directors of Public Health, and other professional agencies, on 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 to promote child health and safety and to prevent child deaths.

- Increase public awareness and advocacy for the issues that affect the health and safety of children.

**Service improvement**

The CDOP will seek 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.

- Monitor and review the support and assessment services offered to families of children who have died.

- 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.

- Identify and inform the LSCB on the resources and areas where training may be required to improve an effective inter-agency response to child deaths.

**Scope**

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years old who are normally resident in the local area. This will include neo-natal deaths, expected and unexpected deaths in infants and in older children. Where a child, normally is resident in another area, dies within the area, that death shall be notified to the CDOP in the child’s area of residence. Similarly, when a child normally resident in the area dies outside the local authority area, the CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child’s area of residence) will review the child’s death. In both cases, an agreement should be made as to how the two CDOPs will report to each other.
The Child Death Overview Panel will have a permanent core membership drawn from the key organisations represented on the LSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Core membership will consist of senior management representatives of the following (for each Borough):

- Director of Public Health (Chair)
- PCT safeguarding representative, designated/named nurse for safeguarding children
- Police Child Abuse Investigation Team (CAIT)
- Local Authority Safeguarding Managers
- Designated paediatrician for unexpected deaths in childhood

The role of each core CDOP member:

The Public Health representatives can:

- Provide the panel with information on epidemiological and health surveillance data.
- Assist the panel in strategies for data collection and analysis
- Assist the panel in evaluating patterns and trend in relation to child deaths and in learning lessons for preventive work
- Inform the panel of public health initiatives to support child health.
- Advise the panel on the development and implementation of public health prevention activities and programmes.

The Paediatrician can:

- Provide the panel with information on the health of the child and other family members, including any general health issues, child development, and health services provided to the child or family.
- Help the panel interpret medical information relating to the child’s death including offering opinions on medical evidence, provide a medical explanation and interpretation of the circumstances surrounding a child’s death.
- Assist with interpreting the autopsy findings and results of medical investigations.
- Advise the panel on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices.
- Chair rapid response meetings and provide assistance support in the rapid response process.
- Provide feedback and support to medical practitioners involved in individual case management.
- Liaise with other health professionals and agencies and where there are child protection concerns.
- Present cases and concerns to the CDOP
- Liaise with families, when deemed appropriate.

Police representatives can:

- Provide the panel with information on the status of any criminal investigation.
- Provide the panel with information on the criminal histories of family members and suspects.
- Identify cases that may require a further police investigation
- Provide the panel with expertise on law enforcement practices, including investigations, interviews and evidence collection.
- Help the panel evaluate any issues of public risk arising out of the review of individual’s deaths.
- Liaise with other police departments, and the Crown Prosecution Service,
- Provide feedback to police officers involved in individual case management.

Children’s Social Care representative can:

- Provide the panel with information on any social care involvement with the child and family, including any child protection concerns
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death
- Advise the panel on children’s rights and welfare, and on appropriate legislation and guidance relating to children.
- Identify cases that may require a further child protection investigation, or a serious case review.
- Liaise with other local authority services.
- Provide feedback to social workers and other local authority staff involved in individual case management.

Single Point of Contact

Each CDOP must nominate a Single Point of Contact (SPOC) to be informed of all child deaths, in the LSCB area, regardless of whether the child is resident in the area. The SPOC will receive referrals, and record accurate details, for The London Borough of Waltham Forest.

The SPOC will:
- Be the designated person to whom the death notification and other data on each child death in the boroughs is sent to:
- Ensure the effective running of the notification, data collection and storage systems
- Determine meeting dates and send notices to Panel members
- Prepare and circulate papers for distribution at each meeting and take and circulate minutes
- Ensure that all CDOP members, ad hoc members and observers sign a confidentiality agreement
- Prepare information on cases to be reviewed and with the Chair, agree cases for in depth review
- Ensure that new members receive orientation to panel before their first meeting
- Liaise as necessary with all relevant agencies and other local authorities to ensure smooth running of the notification system and panel operation
- Facilitate the Rapid Response process
- Ensure that effective cover is in place for absence
- Liaise regularly with other Local Authorities through individual SPOCs/ Administrator and the London SPOC group
- Support the Chair by providing information as required and assisting in the compilation of the annual report

The role of the CDOP Chair

The chair of the CDOP will be responsible for:

- Chairing the CDOP meetings, encouraging all team members to participate appropriately.
- Ensuring that all statutory requirements are met.
- Maintaining a focus on preventive work.
- Ensure that members are clear about their role, and facilitating resolution of agency disputes.
- Ensuring that this process operates effectively.
- Complete and submit annual report to each LSCB

The role of the CDOP officer

The administrator is responsible and accountable for the smooth running of all child death review processes.

- To ensure and monitor the effective running of the notification, data collection and storage systems.
- To identify and agree with key personnel of all agencies their engagement and responsibilities within the model.
- To assist the LSCB in ensuring senior management in relevant agencies are aware of their roles and responsibilities in relation to Chapter 7 Working Together to Safeguard Children, discussing any problems with the chair as they arise.
- To facilitate the establishment of structures to support the CDOP as outlined in chapter 7.
The CDOP will meet bi-monthly, throughout the year, drawing on comprehensive information from all agencies on the circumstances of each child death. The team will review this information in order to meet the objectives set out above (Page 1)

For the meeting to be **quorate** there needs to be a representative from each of the core disciplines of Child Death Overview Panel

Terms of Reference will be reviewed and updated annually by the Child Death Overview Panel 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.

CDOP members will be required to sign a confidently agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will be required to sign the confidentiality agreement. At each meeting of the CDOP, all participants will be required to sign an attendance sheet confirming that they have understood and signed the confidentiality agreement.

Any reports, minutes and recommendation arising from a CDOP meeting will be fully anonymised and steps taken to ensure that no personal information can be identified.

### Accountability and reporting arrangements

The CDOP is accountable to its LSCB

The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the LSCB. It will prepare an annual report for the LSCB, which is responsible for publishing relevant, anonymised information.

The LSCBs take responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring that relevant findings inform the Children and Young People’s Plans and acting on any recommendation 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, e.g. by:

- The London Learning Board child deaths initiative to collate and analyse information about child deaths across London, in order to identify lessons on the prevention of child deaths.

- The Department for Children, Schools and Families to bodies commissioned by the department to undertake and publish nationally comparable, anonymised analyses of child deaths

Conflict Resolution

The CDOP chair should encourage panel members to form a consensus in their assessment and analysis of child deaths, if necessary by taking up issues outside the panel meeting. However, where a consensus is not agreed, the Chair’s decision is final
# Names and positions of core members on the WF-Child Death Overview Panel

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<tr>
<th>Name</th>
<th>Position</th>
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<tr>
<td>Vicky Hobart <em>(Chair)</em></td>
<td>VH</td>
<td>Joint Director of Public Health for Redbridge and Waltham Forest,</td>
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<tr>
<td>Dr Christine Sloczynska</td>
<td>CS</td>
<td>Designated Doctor for Childhood Deaths, ONEL CS Waltham Forest</td>
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<tr>
<td>Dr Nic Wilson</td>
<td>NW</td>
<td>Children’s Clinical Health Doctor, Whipps Cross University Hospital</td>
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<tr>
<td>Dave Spence</td>
<td>DS</td>
<td>Detective Superintendent, Waltham Forest Borough</td>
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<tr>
<td>Sue Li</td>
<td>SI</td>
<td>Consultant Paediatrician, Whipps Cross University Hospital</td>
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<tr>
<td>Dawn Johnston</td>
<td>DJ</td>
<td>Director of Midwifery for Barts health Trust</td>
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<tr>
<td>Christine Twomey</td>
<td>CT</td>
<td>Director of Nursing, Haven House Children’s Hospice</td>
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<tr>
<td>Karen Barker</td>
<td>KB</td>
<td>Designated Nurse for Safeguarding Children, WF CCG</td>
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<tr>
<td>DI Caroline Jackson</td>
<td>CJ</td>
<td>Child Abuse Investigation Team Metropolitan Police, Waltham Forest</td>
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<tr>
<td>Catherine Parry</td>
<td>RN</td>
<td>Head of Safeguarding and Family Support Service, LBWF</td>
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<tr>
<td>Sabrina Kelly</td>
<td>SK</td>
<td>Single Point of Contact (SPOC) administrator</td>
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<tr>
<td>Pru Barnes</td>
<td>PB</td>
<td>Deputy Head of Newport Primary School</td>
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