



BURY, ROCHDALE & OLDHAM

CHILD DEATH OVERVIEW PANEL

Terms of Reference

1. The Child Death Review Process

The child death review functions became compulsory for Local Safeguarding Children Boards (LSCB) on 1 April 2008. The terms of reference for the Child Death Overview Panel (CDOP) was agreed by the three local authorities Bury, Rochdale and Oldham who came together to establish the CDOP Steering Group in line with [Chapter 7 Working Together to Safeguard Children 2006](#).

They functions of the CDOP include:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- agreeing local procedures for responding to unexpected deaths of children; and
- cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

Initially CDOPs were required to collate and review terminations of pregnancy where the child had taken a breath. Further guidance from the Department of Education was provided and it was agreed that terminations of pregnancies would no longer fall under the remit of CDOP.

The CDOP operates in line with Chapter 5: Child Death Reviews of [Working Together to Safeguard Children 2013](#).

2. Aim

The aim of CDOP is to collate and analyse information about each death with a view to identifying any matters of concern affecting the safety and welfare of children in the area and any wider public health or safety concerns arising from a particular death or pattern of deaths

3. Membership

The CDOP is made up of representatives from Bury Safeguarding Children Board (BSCB), Oldham Local Safeguarding Children Board (OLSCB) and Rochdale Borough Safeguarding Children Board (RBSCB);

Position	Agency	Local Authority
Independent Chair	CDOP	All 3 areas
SUDC Paediatrician	Rapid Response Team	All 3 areas
Child Safeguarding Lead	Pennine Care Trust (Mental Health)	All 3 areas
Safeguarding Practitioner	North West Ambulance Service	All 3 areas
Named Nurse for Safeguarding Children	Pennine Acute Trust	All 3 areas
CDOP Officer	CDOP	All 3 areas
DCI, Public Protection Division	Greater Manchester Police	All 3 areas
Paediatrician	Pennine Care Trust	Oldham
Safeguarding Advisor to School	Education	Oldham
Service Manager, Safeguarding	Social Care	Rochdale
Public Health Programme Manager	Public Health	Rochdale
Designated Nurse Safeguarding	Clinical Commissioning Group	Rochdale
Bury LSCB Development Manager	LSCB	Bury

Membership of the panel is rotated every 3 years across the three boroughs. Some panel members such as the North West Ambulance Service are opted onto the panel when requested to discuss specific cases.