



**Leicester, Leicestershire and Rutland (LLR)  
Child Death Overview Panel (CDOP)  
Terms of Reference 2016**



## Terms of Reference for LLR Child Death Overview Panel

These terms of reference apply to the Child Death Overview Panel for Leicester City LSCB and Leicestershire and Rutland LSCB and its constituent agencies. The Child Death Overview Panel is a sub-group of the LSCBs, established in accordance with the LSCB Regulations (made under section 14 (2) of the Children Act 2004) and following the processes set out in *Working Together to Safeguard Children* (2015).

### 1. Key functions

#### The key functions of the LLR CDOP are to:

- Review all child deaths (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law) resident in the area
- Determine whether the death was preventable (if there were modifiable factors which may have contributed to the death)
- Identify patterns or trends in local data and reporting these to the LSCBs
- Identify and advocate for needed changes in legislation, policy and practices,

or public awareness, to promote child health and safety and to prevent child deaths.

### 2. Objectives

#### 2.1 Notification and data collection

The CDOP will seek to do the following:

- Ensure the accurate identification 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.
- 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 *Working Together* on enquiring into unexpected deaths.
- Engage with regional and national initiatives to identify lessons on the prevention of unexpected child deaths (e.g. East Midlands Regional CDOP Network).
- Organise and monitor the collection of data for the nationally agreed minimum data set and make recommendations (to be approved by the LSCBs) for any additional data to be collected locally.

## **2.2 Case level**

The CDOP will seek to:

- Review the available information on all child deaths to determine whether the death was preventable (as defined in Working Together to Safeguard Children 2015) by identifying any factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.
- Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt.
- Refer to the Chair/s of the LSCBs any deaths where, on evaluating the available information, the Panel consider there may be grounds to undertake further enquiries, investigations or a SCR.
- Inform the Chair/s of the LSCBs where specific new information should be passed to the coroner or other appropriate authorities.
- 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.
- Establish mechanisms for appropriately informing and involving parents and other family members in the child death review process.

## **2.3 Population level, prevention and advocacy**

The CDOP will seek to:

- Evaluate data on the deaths of all children normally resident in the local areas, 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 wellbeing 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 change 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.

## **2.4 Service review and improvement**

The CDOP will seek to:

- Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each death of a child and providing the professionals concerned with feedback.
- Monitor and review the support and assessment services offered to families of children who have died.
- Identify and inform the LSCBs on the resources and areas where training may be required to improve an effective inter-agency response to child deaths.
- Encourage and facilitate contribution of parents and family members to the review process with a view to informing the panel as to the services and support received by the child and their family and any recommendations that could be made to advocate for improvements in this area, as well as to highlight and promote good practice by professionals.
- Seek to understand the experience of the child (and family) and highlight the voice of the child.

## **3. 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 and planned terminations of pregnancy carried out within the law - Abortion Act 1967) up to the age of 18 years old who are normally resident in the local area. Where a child, normally resident in another area, dies within LLR, that death shall be notified to the relevant CDOP in the child's area of residence. Similarly, when a child normally resident in this area dies outside LLR, the LLR CDOP office will 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.

#### **4. The role of CDOP members**

Members of the panel have been appointed to panel in order to bring specific areas of knowledge and expertise to the review process. In addition they will act as a conduit for ensuring information is disseminated and auctions are progressed within their organisation/agency as required.

The following professionals can offer specific contributions to the panel;

##### **4.1 The role of Public Health representative(s) is to:**

- 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.

##### **4.2 The role of the Acute and Community Health representative(s) is to:**

- 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 post-mortem 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.
- Provide feedback and support to medical practitioners and allied health professionals involved in individual case management.
- Liaise with other health professionals and agencies.

##### **4.3 The role of the Police representative(s) is to:**

- 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, the Crown Prosecution Service and the local Coroner.
- Provide feedback to police officers involved in individual case management.

**4.4 The role of the Children’s Social Care representative(s) is to:**

- 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.

**4.5 The role of the Clinical Commissioning Group representative(s) is to:**

- Provide information from a commissioning perspective (relevant to the cases being discussed), with regard to the local health economy and service provision.
- Provide safeguarding information and guidance as required.
- Identify cases that may require a further child protection investigation, or a serious case review.

**4.6 The role of the CDOP Chair is to:**

- Chair the CDOP meetings, encouraging all team members to participate appropriately.
- Ensure that all statutory requirements are met.
- Maintain a focus on preventive work.
- Ensure that members are clear about their role, and facilitating resolution of panel disputes.
- Ensure that the CDOP process operates effectively.
- Ensure the submission of the annual report to each LSCB.

**4.7 The role of the Designated Doctor for Child Death is to:**

- Be informed of all child deaths (by the CDR manager).
- Chair meetings to ensure all relevant information has been gathered.
- Prepare and present cases for review at panel in collaboration with CDR manager.
- 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 provide an interpretation of the circumstances surrounding a child’s death.
- Interpret the post-mortem findings and results of medical investigations.
- Provide feedback and support to medical practitioners involved in individual case management.
- Liaise with other health professionals and agencies.
- Liaise regularly with CDOPs nationally and regionally.
- Provide feedback to parents where appropriate.

**4.8 The role of the Child Death Review (CDR) manager is to:**

- Provide assurance to the LSCB, that as an officer of the Boards they are maintaining responsibility and accountability for the effective running of all child death review processes and specifically:
- Be the designated person to whom the death notification and other data on each child death in the area are sent.
- Prepare information on cases to be reviewed.
- Ensure and monitor the effective running of the notification, data collection and storage systems.
- Identify and agree with key personnel of all agencies their engagement and responsibilities within the model.
- Liaise regularly with CDOPs nationally.
- Support the Chair by providing information as required and in the compilation of the annual reports and returns for DfE monitoring and other regional and national initiatives.
- Assist the LSCBs in ensuring senior management in relevant agencies are aware of their roles and responsibilities in relation to Working Together to Safeguard Children 2015, discussing any problems with the Chair/s as they arise.
- Facilitate the establishment of structures to support the CDOP as outlined Working Together to Safeguard Children 2015.

**4.9 The role of the CDOP Administrator is to:**

- 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.

#### 4.10 Current members of LLR CDOP

Core members must be senior representatives from each organisation and have responsibility to advise their organisations on implementation of local procedures to respond to child deaths. The Panel has a fixed core membership drawn from key agencies within the LLR LSCB; however they have the flexibility to co-opt other professionals to become Panel members on a case by case

Designation	Representing	Contact details
Consultant in Public Health	Leicestershire and Rutland County Councils (Public Health) and CDOP	<a href="mailto:Rob.Howard@leics.gov.uk">Rob.Howard@leics.gov.uk</a>
Consultant in Public Health Consultant Neonatologist	Vice Chair Leicester City Council UHL	<b>Person to be appointed</b> <a href="mailto:Elaine.boyle@uhl-tr.nhs.uk">Elaine.boyle@uhl-tr.nhs.uk</a>  <a href="mailto:Akuma.O.Akuma@uhl-tr.nhs.uk">Akuma.O.Akuma@uhl-tr.nhs.uk</a>  (to attend for neonatal panels) <a href="mailto:Penelope.mcparland@uhl-tr.nhs.uk">Penelope.mcparland@uhl-tr.nhs.uk</a>  (to attend for neonatal panels) <a href="mailto:Jeremy.Tong@uhl-tr.nhs.uk">Jeremy.Tong@uhl-tr.nhs.uk</a>
Consultant Obstetrician	University Hospitals of Leicester (UHL)	<a href="mailto:Rachel.Rowlands@uhl-tr.nhs.uk">Rachel.Rowlands@uhl-tr.nhs.uk</a>
Consultant Intensivist	UHL – children’s hospital	<a href="mailto:Steven.gauntley@leicester.gov.uk">Steven.gauntley@leicester.gov.uk</a>
Consultant Paediatrician	UHL – emergency department	<b>Person to be appointed</b>
Head of Safeguarding	Leicester City Council	<a href="mailto:Chris.nerini@leics.gov.uk">Chris.nerini@leics.gov.uk</a>
Head of Service- Family Support social care Head of Safeguarding	Rutland County Council Leicestershire Council	<a href="mailto:Adrian.Spanswick@LeicesterCityCG.nhs.uk">Adrian.Spanswick@LeicesterCityCG.nhs.uk</a>
Consultant Designated Nurse Safeguarding	Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs	<a href="mailto:john.gray@leicestershire.pnn.police.uk">john.gray@leicestershire.pnn.police.uk</a>
Detective Inspector	Police	<a href="mailto:pathandi@ntlworld.com">pathandi@ntlworld.com</a>
Lay Member	Leicestershire LSCB	<a href="mailto:Sue.hughes@leicspart.nhs.uk">Sue.hughes@leicspart.nhs.uk</a>
Consultant Community Paediatrician	Designated doctor for child death	<a href="mailto:SS.Jassal@GP-C82026.nhs.uk">SS.Jassal@GP-C82026.nhs.uk</a>  Sat Jassal to review and comment on GP specific cases. <a href="mailto:Lucy.Spencer@emas.nhs.uk">Lucy.Spencer@emas.nhs.uk</a>  (to attend if unexpected cases are being discussed)
General Practitioner (electronic representation)	LLR GPs	
Safeguarding lead EMAS	EMAS	

basis.



### **Ad Hoc Members**

Professionals can be co-opted to attend as required

### **In attendance**

Designated Doctor for Child Death  
Child Death Review Manager  
CDOP Administrator

## **5. Meeting arrangements**

### **5.1 Frequency**

Meetings will be held at least every 8 weeks; they will be administered by the CDOP office and will run for 3 hours. All members are required to notify the CDOP office that they have received and read the papers and where they have any significant concern; these should also be notified to the office.

The CDOP will arrange for extra meetings or extension of planned meetings where necessary. For each child's death, comprehensive information will be collated and sent to all panel members before each meeting. All panel members are required to have read all papers before the meeting in order for the Panel to review cases and to meet their objectives.

### **5.2 Chairing arrangement**

The Panel will be chaired by the Chair of the LSCB or his/her representative. In the case of LLR CDOP the Chair of CDOP is a Public Health Consultant.

### **5.3 Quoracy**

Representation from at least 3 of the listed agencies/organisations is required in order for the meeting to be quorate.

- UHL
- LPT
- Social Care (from either Leicester City, Leicestershire County or Rutland)
- Police
- Public health (from either Leicester City, Leicestershire County & Rutland)

### **5.4 Attendance**

In order to ensure the effectiveness of meetings panel members are requested to;

- Inform the Chair in advance if they are unable to attend.
- Members may request a deputy to attend on their behalf, but must ensure that their deputy is briefed on their responsibilities and is able to respond and act on behalf of their organisation. This then needs to be agreed by the CDOP Chair.
- Read panel papers (even if unable to attend) and forward any comments to the CDR Manager ahead of the meeting.

If a meeting is not quorate, the Chair can request that the meeting still take place and defer any issues requiring (quorate) decisions to be deferred.

If a CDOP member is unable to attend a meeting apologies, must be sent or a representative should attend in their place. If a second consecutive meeting is missed, with no apologies, the Chair will write to the senior person of that agency seeking a replacement.

The Designated Doctor for child deaths is required to attend all Panel meetings.

## **6. Confidentiality and Information Sharing**

Information discussed at the CDOP meetings will be anonymised prior to the meeting. Information is shared in the public interest for the purposes set out in 'Working Together to Safeguard Children 2015' and is bound by legislation on data protection.

CDOP members will all be required to sign a confidentiality agreement before participating in a CDOP (this will be reviewed on an annual basis). Any ad-hoc or co-opted members and observers will be required to sign the confidentiality agreement also. At each meeting of the CDOP, all participants will be required to sign an attendance sheet confirming that they have read and understood the confidentiality agreement and will adhere to it.

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

## **7. Accountability and reporting arrangements**

LLR CDOP is accountable to each of the two respective LSCBs.

The CDOP is responsible for developing a work plan, which should be approved by the LSCBs. It will prepare annual reports for the respective LSCBs, who in turn are responsible for publishing relevant, anonymised information in their LSCB annual reports (which are public documents).

## **8. Conflict Resolution**

The CDOP chair should encourage panel members to form a consensus in their assessment and analysis of child deaths. However where a consensus is not agreed, the Chair's decision is final.

## **9. Review of the LLP CDOP Terms of Reference**

The terms of reference will be reviewed on an annual basis.