Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

Safeguarding Children Partnership
LEICESTERSHIRE & RUTLAND

# Leicester, Leicestershire and Rutland (LLR)

# Child Death Overview Panel (CDOP)

# Terms of Reference 2020

# Terms of Reference for LLR Child Death Overview Panel

These terms of reference apply to the Child Death Overview Panel for Leicester City SCPB and Leicestershire and Rutland SCP and its constituent agencies. The Leicester, Leicestershire & Rutland Child Death Overview Panel has been set up by the Child Death Review Partners (Leicester City Council, Leicestershire County Council, Rutland County Council, Leicester City CCG, West Leicestershire CCG, and East Leicestershire and Rutland CCG) to review the deaths of children under the requirements of the Children's Act, 2004 in accordance with *Working Together to Safeguard Children* (2018) & Child Death Review Statutory & Operational Guidance (England) 2018

## 1. Key functions

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

- Review all deaths (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law) of all children usually resident in the area (and where appropriate as agreed by CDR Partners the deaths of non-resident children) irrespective of their place of death.
- 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 LSCPBs;
- Identify and share learning across agencies;
- 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 in accordance with Child Death Review Statutory and Operational Guidance (England) 2018, 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 deaths requiring a Joint Agency Response.
- Engage with regional and national initiatives to identify lessons on the prevention of child deaths (e.g. East Midlands Regional CDOP Network).

To provide specified data to the National Child Mortality Database and make recommendations (to be approved by the LSCPBs) for any additional data to be collected locally.

## 2.2 Case level

The CDOP will seek to:

- Analyse the information obtained, including the report from the Child Death Review Meeting, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
- Notify the Child Safeguarding Practice Review Groups of the two Safeguarding Childrens' Partnerships and local Safeguarding Partners when it suspects that a child may have been abused or neglected.
- Notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- Inform the Chair/s of the LSCPs 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 (including the named Key Worker) 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:

- Make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.
- 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.
- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learned and actions taken, and the effectiveness of the wider child death review process.
- 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.
- Seek assurance that the needs of the family in terms of follow up and bereavement support, have been met.
- Identify and inform the LSCPs 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 actions 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 Safeguarding Practice 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 LSCP Board.

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

- Be informed of all child deaths & review relevant case information
- 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 LSCPB, 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 LSCPs in ensuring senior management in relevant agencies are aware of their roles and responsibilities in relation to Working Together to Safeguard Children 2018, 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 2018.

**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 & implement any actions arising following CDOP review. 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 basis.

| Designation | Representing |
|---|---|
| Consultant in Public Health | Leicestershire and Rutland County Councils (Public Health) |
| Consultant in Public Health | Leicester City Council and CDOP Chair |
| Consultant Neonatologist | UHL – Neonatal Panel |
| Consultant Obstetrician | University Hospitals of Leicester (UHL) – Neonatal Panel |
| Consultant Intensivist | UHL – children's hospital |
| Consultant Paediatrician | UHL – emergency department |
| Head of Safeguarding | Leicester City Council |
| Head of Service- Family Support social care | Rutland County Council |
| Head of Safeguarding | Leicestershire Council |
| Consultant Designated Nurse Safeguarding | Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs & CDOP Vice Chair |
| Detective Inspector | Police |
| Lay Member | Leicestershire SCP |
| Consultant Community Paediatrician | Designated Doctor for Child Death |
| General Practitioner (electronic representation) | LLR GPs – Named GP for Safeguarding Children |
| Safeguarding lead EMAS | EMAS |

**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 12 weeks; they will be administered by the CDOP office and will run for two 3 hour sessions. 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 a Public Health Consultant. The Vice Chair is the CCGs representative. The chair and vice-chair will be selected by the CDOP members and agreed annually.

### 5.3 Quoracy

The Child Death Overview Panel will be quorate if there are five or more core members present at the meeting and must include attendance by lead professionals from three organisations (including health and the local authority). The final decision will be made by the CDOP Chair.

### 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

All information discussed at the Child Death Overview Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

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 2018’ 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 jointly to:
1. The Directors of Public Health for Leicester City Council and Leicestershire County Council; and
2. The CCG Executive Partnership

LLR CDOP will provide a report to the Leicester shire and Rutland Safeguarding Children Partnership and the Leicester Safeguarding Children Partnership summarising any recommendations from the reviews of child deaths.

## 8. Conflict Resolution

The CDOP chair should encourage panel members to form a consensus in their assessment and analysis of child deaths. In the event of a disagreement, a vote of members will be taken. In the event of a failure to resolve the issue, the Chair will have the casting vote or discuss with the Vice Chair, Designated Doctor and Child Death Review Manager a resolution of outstanding issues.

## 9. Escalation process

*See additional paper*

## 10. Conflict of Interest

Panel members must declare any conflict of interest at the outset of each meeting and panel members should not lead discussions if they are the named professional with responsibility for the care of the child.

## 11. Review of the LLP CDOP Terms of Reference

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