Leicester, Leicestershire and Rutland Child Death Overview Panel (CDOP)

CDOP Arrangements

Overview

The Leicester, Leicestershire and Rutland CDOP has been set up by Child Death Review (CDR) Partners (Leicester City Council, Leicestershire County Council, Rutland 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 Act, 2004 and Working Together to Safeguard Children, 2018.

Purpose

The purpose of the Leicester, Leicestershire and Rutland CDOP is to undertake a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Leicester, Leicestershire and Rutland, irrespective of the place of their death. The Leicester, Leicestershire and Rutland CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england.

CDOP Responsibilities

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- To analyse the information obtained, including the report from the Child Death Review Manager (CDRM), 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;

- 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 notify the Child Safeguarding Practice Review Groups of the two Safeguarding Partnerships and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- To 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;
- To provide specified data to the National Child Mortality Database;
- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- 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.

Operational Responsibilities

- Hold meetings at sufficient intervals to enable the death of each child to be discussed in a timely manner (currently at least every 8 weeks).
- Hold themed meetings where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.
- Ensure that effective arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating each unexpected death of a child.
- Review the appropriateness of agency responses to each death of a child.
- Review relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to relevant organisation (both national and local) in order that prompt action can be taken to prevent future such deaths where possible.

Governance and Accountability

- The Child Death Review Panel is accountable jointly to:
    1. The Directors of Public Health for Leicester City Council and Leicestershire County Council; and
    2. The CCG Partnership Executive

- The Child Death Review Panel will provide a report to the Leicestershire and Rutland Safeguarding Children Partnership, and the Leicester Safeguarding Children Partnership, summarising any recommendations from the reviews of child deaths.

Membership

The Child Death Review Panel will be chaired by a Consultant in Public Health**.** The vice-chair will be the CCGs representative**.** The chair and vice-chair will be selected by the CDOP members and agreed annually.

Panel Membership

Designation	Representing
Consultant in Public Health (Chair)	Leicestershire and Rutland County Councils (Public Health)
Consultant Designated Nurse Safeguarding (Vice Chair)	Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs
Consultant in Public Health	Leicester City Council
Consultant Neonatologist	UHL
Consultant Obstetrician	University Hospitals of Leicester (UHL)
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
Detective Inspector	Police
Lay Member	Leicestershire LSCB
Consultant Paediatrician	Designated Doctor for Child Death
Named GP Safeguarding Children (CCG) - General Practitioner (electronic representation)	LLR GPs
Safeguarding lead EMAS	EMAS
Child Death Review Manager	

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions.

Quoracy

The Child Death Review Panel will be quorate if there is 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.

Responsibilities of Panel Members

Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings.

Decisions and Disputes

Decisions will normally be reached by consensus. 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 CDRM a resolution of outstanding issues.

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.

Confidentiality

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

Publication

The LLR Child Death Overview Panel (CDOP) arrangements will be published on the Leicestershire and Rutland Safeguarding Children Partnership, and the Leicester Safeguarding Children Board websites.

Review Date and Next Review Date

The terms of reference of The LLR CDOP will be subject to annual review, or more frequently, if required.

Last Reviewed: 25th June 2019

Next Review Scheduled: June 2020