

Northern Lincolnshire Child Death Overview Panel Meeting

**Terms of Reference 12.05.2020**

**Purpose**

The Child Death Overview Panel (CDOP) is a multi-agency panel set up to review the deaths of all children resident in their area, and, if appropriate and agreed between Child Death Review (CDR) partners the deaths in their area of non-resident children. The panel are guided by the specifications detailed in **Working Together to Safeguard Children 2018,** chapter 5.

The purpose of the CDR process is to capture the expertise and thoughts of all individuals involved with the case to identify matters relating to each child death, to consider whether any modifiable factors could have reduced the risk, determine what lessons can be learned, share findings with the NCMD to establish thematic learning and take appropriate steps improve future outcomes for children.

**Scope**

A child Death Review must be carried out for all children who were born alive, and a death certificate has been issued. It does not include babies who are stillborn, late fetal loss or any lawful termination of pregnancy. A child is defined in the **Children Act 2004** as a person who is under 18 years of age.

**Quoracy**

CDOP meetings should be attended by lead professionals from health and the local authority. However, when a themed panel is discussing exclusively medical concerns (e.g., Cardiac), the attendance of police and social care, beyond the core panel membership, might not be necessary.

**Frequency**

The CDOP should meet on a regular basis, determined by the number and types of deaths to be reviewed across the year.

**Panel membership**

The members of the Child Death Overview Panel identified by Northern Lincolnshire CDR partners is a multi-professional panel and current members are listed below:

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| --- | --- |
|  Chairs | Stephen.pintus@nelincs.gov.ukPenny.spring@northlincs.gov.uk  |
| Managers | Julie.forrest@northlincs.gov.uk Cathy.thompson@nelincs.gov.uk |
| Admin | Kelly.crow@northlincs.gov.uk Sally.greetham@nelincs.gov.uk Anna.cramer@nhs.net  |
| Designated Doctor | ahmed.mohammed4@nhs.net |
| Designated Nurses | Julie.Wilburn@nhs.net Sarah.glossop@nhs.net (Angela.rawlings3@nhs.net) |
| GPs | marciapathak@nhs.net Elisabeth.alton@nhs.net  |
| Children’s Social Care | Sarah.blanchard@nelincs.gov.uk Charlene.sykes@northlincs.gov.uk  |
| Education | Nathaniel.heath@nelincs.gov.uk Eleni.Triantafyllou@nelincs.gov.uk Darren.chaplin@northlincs.gov.uk Ruth.illman@northlincs.gov.uk  |
| Police | Peter.thorp@humberside.pnn.police.uk |
| Hospice | Karen.higgins2@nhs.net  |
| Senior Nurse/ Midwife | tbc |

**Panel responsibilities at the CDOP meeting**

* To analyse the information obtained, including the report from the CDRM (Draft analysis form, previously Form C), in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the CDR 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 Panel 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 eCDOP and then, once established, to the National Child Mortality Database NCMD.
* 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.
* 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.

**Schedule**

The process of the Child Death Review starts from the moment a child dies to the completion of the CDOP as shown in the Flowchart attached.

**Accountability**

All information gathered contributes to local, regional and national learning to help understand why children die and to put necessary interventions in place to help prevent future deaths.

An annual report is produced to identify local themes and interventions needed.

Regional thematic learning is established with partnership CDOPs in Humber Coastal Vale Integrated Care System.

 All information gathered by the CDR is automatically fed into the National Child Mortality Database (NCMD) via eCDOP to enable thematic learning at national level.

**Northern Lincolnshire Child Death Review (CDR) Process and Child Death Overview Panel (CDOP) flowchart**

March 2020

