Lincolnshire Child Death Overview Panel Terms of Reference

Purpose

The Child Death Overview Panel will fulfil the requirements as described in Chapter 5 of Working Together to Safeguard Children to collect and analyse information about every death of a child aged under 18 years of age in Lincolnshire with a view to:

- identifying any matters relating to the death or deaths that are relevant to the welfare of children in the area and to public health and safety
- considering whether it is appropriate for any action to be taken by anyone in relation to their findings
- taking action to inform the necessary person

Functions

- to collect and collate information about each child death, seeking relevant information from professionals;
- to analyse the information obtained, including the report from the Child Death Review Meeting (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 local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- To notify the Significant Incident Review Group (sub-group of the LSCP) where there has been an incident that may require further review, this may include examples of good practice.
- to notify the Medical Examiner (when appointed) and the doctor who certified the cause of death (to be removed when Medical Examiner appointed), 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 NHS Digital and then, once established, 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.

Additionally, the Lincolnshire CDOP will:

- Monitor and evaluate routinely collected data on the deaths of all children, and make recommendations for any additional data to be collected locally.
- Identify any Public Health issues, and consider with the Lincolnshire Director of Public Health and/or LSCP how best to address these and their implications for both the provision of services and for training.
- Monitor and advise the Lincolnshire LSCP on the resources and training required locally to ensure an effective inter-agency response to child deaths.

Membership

The following will be members of the Child Death Overview Panel;

Name	Job Title	Agency
Dr Julian Saggiorato (Chair)	Designated Doctor for Children and Adults	SWLCCG
Dr Mujeeb Pervez (Vice Chair)	Consultant in Community Paediatrics/SUDIC Lead, Pilgrim Hospital Boston	ULHT
Andy Fox	Acting Consultant in Public Health, LCC	LCC
June Nur	Deputy Named Nurse	LCHS
Penny Snowden (Julie Bulteel acts as deputy)	Divisional Head of Midwifery & Nursing	ULHT
TBC	Coroner for Lincolnshire	HM Coroner
Dr Margaret Crawford	Named Doctor	ULHT
Jo Casey (Phillipa Gallop acts as deputy)	Children's Services Manager – East Lindsey	LCC
Claire Saggiorato	Children's Safeguarding Lead Nurse	LCC
Perce Bosworth/Helen Bennett	Quality Auditor and SCR Author	Lincolnshire Police
Dr Frances Senthil	Named Doctor	LPFT
Business Support	Administrator & Minutes	LSCP, LCC

Case Specific/Optional Membership:

Name	Job Title	Agency
Steven Batchelor	LRSP Manager	Road Safety Partnership
Jill Chandar-Nair	Children's Services - Education	Lincolnshire County Council
Clare Rowley	Business Manager	LSCP
Zoe Rodger-Fox / Lucy Gascoigne	Head of Safeguarding / Head of Child and Young Person Safeguarding	EMAS
Dr Rahab Omer	Community Paediatrician/SUDIC Doctor	ULHT

Other members may be co-opted as appropriate.

The Lincolnshire LSCP will select one of its members to chair the panel, annually at the AGM.

Constitution

The Child Death Overview Panel is a sub-committee of the Lincolnshire LSCP.

The frequency of panel meetings should aim to enable the circumstances of all child deaths to be discussed within 6 weeks following receipt of the Child Death Review Meeting (CDRM) such as the SUDIC or hospital mortality meeting, or from conclusion of a Coroner's inquest. For the most part, the meetings should take place at least quarterly. Where the number of deaths is low, the panel meeting can be deferred for up to 3 months (minimum 4 panel meetings a year).

Where other investigations are ongoing that will be likely to inform the overview, such as criminal investigations or serious case review, the case may be deferred until 6 weeks after these have been concluded.

Administrative support will be provided by the Lincolnshire LSCP.

Approval

Date	Status	By
21.05.19	Approved	CDOP