Annual Report on the work of the Child Death Overview Panel (CDOP)

2014/2015

Aim: To inform the Leicester Local Safeguarding Children Board and the Leicestershire and Rutland Local Safeguarding Children Board on activity, standards, outcomes and statistics in relation to the work of CDOP.

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In consultation with Dr Jasmine Murphy (CDOP Chair) and Mr Rob Howard (CDOP vice chair)

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Glossary

Abbreviation	Explanation
CAIU	Child Abuse Investigation Unit
CDOP	Child Death Overview Panel
CDR	Child Death Review Manager
DI	Detective Inspector
DfE	Department for Education
DS	Detective Sergeant
HM Coroner	Her Majesty's Coroner
LLR	Leicester, Leicestershire and Rutland
LPT FYPC	Leicestershire Partnership Trust Families Young People and Children's Services
LRI	Leicester Royal Infirmary
LSCB	Local Safeguarding Children's Board
NNU	Neonatal Unit
PED	Paediatric Emergency Department
PMR	Perinatal Mortality Review
SCR	Serious Case Review
SILP	Serious Incident Learning Process
SLA	Service Level Agreement
SUDIC	Sudden Unexpected Death in Childhood
SUI	Serious Untoward Incident
UHL	University Hospital of Leicester
WTE	Whole Time Equivalent

1.0 Introduction

1.1 The Children Act (2004) places a statutory duty on local authorities in England to set up LSCBs. One of the duties of the LSCB is to ensure a review is undertaken on the deaths of all children who are normally resident within their area.

1.2 The duties undertaken by the LLR CDOP are as outlined in chapter 5 of 'Working Together to Safeguard Children 2015'. The functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004.

1.3 The child death overview process has been established within LLR since February 2009. 'Working Together to Safeguard Children 2006' outlined the duties of the LSCB to undertake a review of any child death resident within their area. 'Working Together to Safeguard Children 2015' re-emphasised the need to ensure a process is in place to undertake this work.

1.4 The remit of the child death overview process is to co-ordinate a systematic review of the death of children between 0 and 18 years of age (the review does not include stillbirths).

1.5 The process incorporates two interrelated pathways that allow for expected and unexpected deaths to be reviewed ('Working Together to Safeguard Children 2015' p81). The purpose of which allow for;

"(a) collecting and analysing information about each death with a view to identifying-

-any case giving rise to the need for a review mentioned in Regulation 5(1) (e);

-any matters of concern affecting the safety and welfare of children in the area of the authority; and

-any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death." (HM Government, 2010).

1.6 The child death overview process is not an investigation and does not supersede the need for organisations to undertake their own reviews following the death of a child. It is intended that the child death overview process will incorporate issues identified within the SCR and SILP processes to ensure shared learning.

2.0 Accountability and Assurance

2.1 LLR CDOP is a sub group of the LSCB and as such is accountable to the Independent Chairs of the respective LSCBs. Accountability is assured in a number of ways:

- Under current arrangements the CDR Manager is an officer of the respective LSCBs. Reports are submitted to the Boards (in consultation with the CDOP Chair) at agreed timescales to provide assurance in relation to the effectiveness of the work of the panel.

- The DfE requires LSCBs to provide annual data in relation to the number of notifications their respective child death overview panels receive. For LLR this data is provided on behalf of the respective LSCBs by the CDR Manager. The latest report from the DfE is due for release in July 2015.

- The CDR Manager meets with both LSCB Board Managers to deal with issues arising. To date the meetings have looked at ways of establishing a consistent unified reporting system to both LSCB Boards, identifying ways of capturing 'the voice of the child' and reviewing the CDOP records management policy

- As part of the accountability and assurance offered by CDOP, the CDR Manager attends the SCR Subgroups for both Leicester City and Leicestershire and Rutland on a monthly basis to ensure there is early notification of cases and effective sharing of information. Under current arrangements CDOP will not undertake a review until the Serious Case Review (SCR) or Significant Incident Learning Process (SILP) process has been completed.
  Note: For all cases that may be subject to a parallel review (e.g. SCR, SILP, Serious Untoward Incident (SUI) or Criminal Investigation (CI)), the CDR Manager provides a briefing to panel outlining the facts of the case. A monthly update regarding progress will then be made.

- Close links remain with both HM Coroners with jurisdiction within LLR in order to ensure there is an agreed process for mutual sharing of information. Enabling information to be shared proportionally and appropriately in order to provide a fuller understanding of the factors associated with child deaths.

- During 2013 it was agreed, with representatives from the commissioning body for CDOP, that the reports compiled by the named nurses following a home visit would be reviewed by commissioners (on a 3 monthly basis). Following an initial pilot to assess the feasibility of this, the CDR Manager meets with an identified

Designated Nurse Safeguarding Children to review and audit the reports and identify any key areas to address.

3.0 Panel membership

3.1 CDOP is currently chaired by Dr Jasmine Murphy, Consultant in Public Health employed by Leicester City Council. The current chairing arrangement is supported by both LSCBs.

3.2 CDOP has a permanent core membership of the appropriate level of seniority, including public health, child health, police and social care. 'Working Together to Safeguard Children 2015' is not prescriptive regarding the composition of panel members. In order to assure appropriate representation is maintained at panel, the membership of the LLR CDOP panel is reviewed on an annual basis and a record of attendance at panel is logged. This information is made available to the LSCBs – please see Appendix 1

3.3 The terms of reference along with panel membership were reviewed in December 2014 and signed off (by the CDOP Chair) in April 2015. Leicestershire and Rutland LSCB have also reviewed and signed off the documents. Leicester City LSCB is due to review the documents at their July meeting.

Current membership of the panel comprises representation from:

- Leicestershire Constabulary Child Abuse Investigation Unit (CAIU)
- Leicester City Council Children and Young Peoples Services (CYPS)
- Leicestershire CYPS
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- Community Paediatricians
- Designated Doctor for Safeguarding
- Designated paediatrician for unexpected deaths in childhood
- Consultant Neonatologist
- Designated Nurse for Safeguarding
- Named Nurse Safeguarding Children
- Local Authority Public Health (Leicester City Council and Leicestershire County Council (the latter also undertake the public health function for Rutland Council).
- Lay Member
- Chair
- Child Death Review Manager

3.4 CDOP currently meets 4-6 weekly for 3 hours per panel. At the beginning of each meeting panel members are reminded of the need to observe confidentiality with regard to the information they review.

4.0 Procedures

4.1.1 Currently all child deaths are reported to the CDR Manager. As the designated person to whom child death notifications are forwarded the CDR Manager's name and e-mail address is held by the DfE, who coordinate a national contact list. A notification can be made to the CDR Manager by any professional involved in the care of the child.

4.2 As outlined in chapter 5 of 'Working Together to Safeguard Children 2015' registry offices are required to provide a weekly report to CDOP on deaths they are aware of. These reports ensure that information is received (on behalf of the LSCB by the designated professional) no later than 7 days from the date of registration of death. In addition the CDR Manager provides information to HM Coroner for Leicester City and South to allow for cross reference of notifications on a weekly basis. Following discussion, HM Coroner for the County does not wish to receive this.

4.3 The CDR Manager reports to the LSCB all circumstances where abuse has been identified as, or suspected to be, a factor in the death of a child. Where appropriate CDOP will recommend consideration of an SCR.

4.4 For cases undergoing a SCR or SILP, formal agreement is sought from the respective Chairs of the SCR subgroups to identify when the case can be received and presented to the CDOP panel. A professional from the subgroup will be identified to aid the CDR Manager with the completion of the analysis proforma that panel members receive.

4.5 For cases undergoing the SUI process a single point of contact has been identified (within health) to provide the CDR Manager with information for panel and assurance around progression of actions identified.

4.6 For cases undergoing criminal review there is a single point of contact identified within the Police to provide information to be presented to panel.

4.7 'Working Together to Safeguard Children 2015' (chapter 5) provides guidance for LSCBs in regard to how child death reviews should be undertaken. For unexpected cases 'Working Together' suggests a timescale of 1-6 months for the case to reach the phase 3 (final case discussion) stages. Following this there may be an inquest before the case reaches panel.

4.8 Locally it has been agreed with all partner agencies that:

- Expected cases will be ready for panel within 12 weeks.

- Unexpected cases will be ready for panel within 26 weeks. This time period is guided by the time taken for post mortem results to be made available to the CDR Manager. This is a process which is reflected nationally. The current arrangement of awaiting the results of the post mortem before presenting a case to panel has been agreed within LLR by all panel members.

- All neonatal cases will be reviewed by the Perinatal Mortality Review (PMR) Group prior to being heard at the CDOP. To provide congruency between the two processes the CDR Manager attends the PMR meetings. This process was instigated following close liaison with UHL and continues to be supported by panel members as a means of providing a more robust approach to the review of such cases.

- The number of deaths reviewed during the year does not equate to the number of notifications received by CDOP in a calendar year, as a death will be reviewed number of months after it has occurred, as it has been agreed locally that deaths can only be reviewed once all relevant information has been received and relevant investigations (such as those undertaken by the police or HM Coroner) have been concluded.

Table 1 – duration of time taken for review to be completed 2014-15

The figures contained within table 1 relate to the 75 cases that were reviewed at CDOP panel during 2014-15

Timescale	Number ready for review at panel - in timescale	Number reviewed at panel - in timescale	Comments
Under 6 months	17	0	Due to time capacity cases were not able to be placed on the agenda
6-7 months	8	7	
8-9 months	4	7	
10-11 months	10	7	
12 months	4	3	
Over 12 months	32	51	The majority of these cases were neonatal cases that were awaiting review by PMR. It also include some cases that were under parallel review (such as SCR or CI)

4.9 The CDOP Chair and the CDR Manager were acutely aware that improvements and amendments to the process were required in order to address the figures highlighted

in table 1 – therefore over recent months (with the support of panel members) actions have been undertaken to address this.

- Previously the CDOP panel met 6 weekly for 2 hours and reviewed a maximum of 10 cases (on occasion only 6 were completed).
    - *CDOP panel now meet on a monthly basis and complete 15 reviews at each panel.*
- Phase 3 meetings (which are required to be completed on all unexpected cases prior to them being reviewed at panel) occurred on a 6-8 weekly basis and a maximum of 3 cases were reviewed.
    - *Phase 3 meetings now occur on a monthly basis (unless there are exceptional circumstances) and 4 cases are reviewed at each meeting.*
- All neonatal cases are required to be reviewed at the PMR meeting prior to being reviewed at CDOP. During 2012-13 the Chair of the PMR was on maternity leave and whilst meetings still took place a considerable backlog accumulated. In addition to this CDOP held specialist panels twice a year to review only neonatal cases
    - *PMR has held extra ordinary meetings in order to address the backlog of cases*
    - *CDOP now review 5 neonatal cases at each panel meeting.*

4.10 As part of the assurance around CDOP, the CDR Manager maintains a database outlining the progression of each case. Within the report details are included on;

- Requested information from professionals that is still outstanding.
- Other processes being undertaken (for e.g. SCR or Coronial review).
- Date case ready for panel and date scheduled for panel

As noted under sec 4.9 there will still remain a number of cases where CDOP are required to await the outcome from parallel reviews before progressing the case to panel. However, as detailed above, where CDOP are able to influence factors, measures have been undertaken.

5.0 Sudden Unexpected Death in Childhood (SUDIC) arrangements

5.1 Following local consultation with partners the 'rapid response' process that was referred to within 'Working Together to Safeguard Children 2010' (and remains within 'Working Together 2015') is termed locally as the SUDIC response. This outlines our local agreed response that is initiated following the sudden/unexpected death of a child.

5.2 All notifications are received by the CDR Manager whose role it is to coordinate the initial SUDIC response. The work of the CDR Manager is supported by the project support officer for the CDOP process. Both posts are 1 WTE.

5.3 As part of the SUDIC response a home visit is considered. Within LLR this function is undertaken by a member of the named nurse safeguarding team (as an agreed part of their safeguarding role). Where possible this visit will coincide with visits that are being undertaken by the police, in an attempt to provide minimal intrusion to the family. The nurses provide cover during office hours (9am – 5pm) Monday to Friday (excluding bank holidays). During 2015 there were a number of changes within the named nurse work force and at present there are 4 nurses providing cover for the rota. It has been agreed that as part of the development of the named nurse team, each family will be allocated a nurse who will act as a contact point for the family until the case is reviewed at panel. This will help to ensure bereavement needs are identified and supported and that families are able (if they wish) to link into the CDOP process and receive feedback.

5.4 The designated paediatrician for unexpected deaths in childhood role is covered by one community paediatrician, who is available to provide medical advice in relation to notifications received, chair any initial meetings to discuss the case and chair the final case discussion. The designated paediatrician for unexpected deaths in childhood is in contact with the CDR Manager to discuss 'active cases' as well as prior to panel meetings to review the cases to be presented. This arrangement is reviewed as part of the doctor's job plan on an annual basis in order to ensure services are being utilised effectively. Cover by the designated paediatrician for unexpected deaths in childhood is currently provided on:

- Monday/Tuesday/Wednesday – AM
- Thursday – PM

5.5 In addition, to aid with the notification process, promote the CDOP process and facilitate the prompt obtaining of information, a specialist nurse (0.5WTE) is located within the UHL Safeguarding Team.

5.6 The Service Level Agreement for CDOP provision within LLR with the CCGs has been reviewed and is due for final sign off in July (2015) – it continues to support current working arrangements.

6.0 Data

6.1 As referenced to in section 2, LLR CDOP submitted data to the DfE in relation to cases ***reviewed at panel*** between 1st April 2014 and 31st March 2015. The report from the DfE is due for release in July 2015. CDOP has effective data management systems in place to record, analyse and monitor childhood deaths and meet its intended purposes and outcomes, as directed by the DfE. Data analysis is used intelligently to recognise local risks and issues. A project was undertaken (in 2013) to meet the DfE tender specification to identify the most effective way of utilising the data currently collected. As part of the recommendations included in the report it was noted that a 'national database should be established to allow for the collation, analysis and interpretation of CDOP data at a national level'. LLR CDOP was invited to attend the first of a number of meetings to identify the key requirements for such a database. A report is scheduled for release in 2016.

6.2 During the time period outlined in the DfE statistical analysis **75** cases were reviewed by LLR CDOP and 8 panel meetings were held, compared to 46 cases in the previous time period.

6.3 Table 1 provides an overview of the classifications of the cases reviewed (categories 1-10 as directed by the DfE)

6.4 Table 2

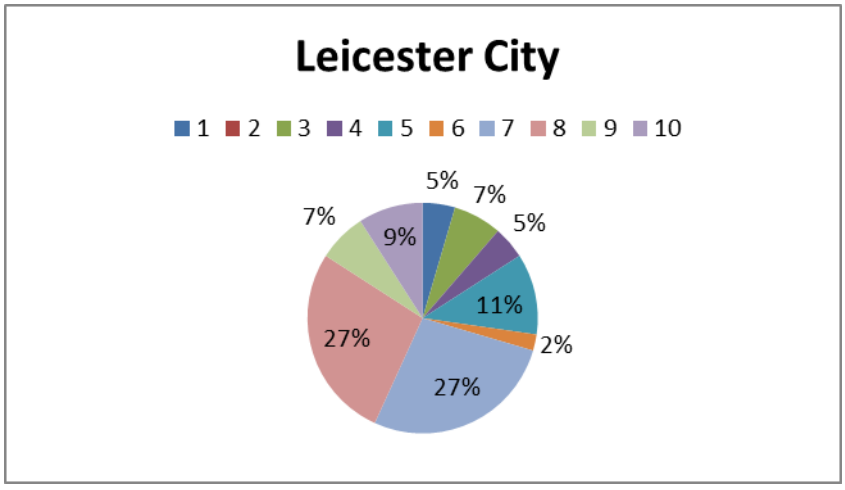
The 75 cases reviewed at panel (in the time period outlined) were categorised as follows;

Categorisation (as outlined by the DfE)	**Number of cases categorised**
1 Deliberately inflicted injury, abuse or neglect	2
2 Suicide or deliberate self-harm	5
3 Trauma & other external factors	9
4 Malignancy	4
5 Acute medical or surgical condition	10
6 Chronic medical condition	2
7 Chromosomal genetic & congenital anomalies	17

8 Perinatal/neonatal event	15
9 Infection	4
10 Sudden unexpected unexplained death	7

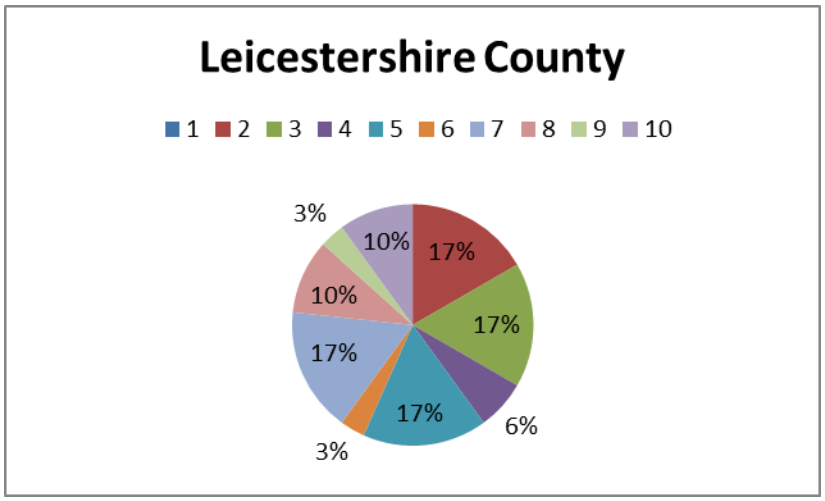
6.5 Table 3 – cases relating to Leicester City

Category	Total No. Deaths reviewed	Total for Leicester
1 Deliberately inflicted injury, abuse or neglect	2	2
2 Suicide or deliberate self-harm	5	0
3 Trauma & other external factors	9	3
4 Malignancy	4	2
5 Acute medical or surgical condition	10	5
6 Chronic medical condition	2	1
7 Chromosomal genetic & congenital anomalies	17	12
8 Perinatal/neonatal event	15	12
9 Infection	4	3
10 Sudden unexpected unexplained death	7	4



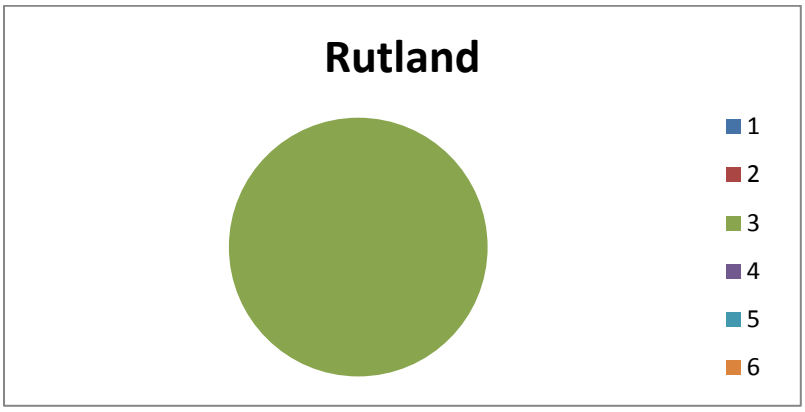
6.6 Table 4 – cases relating to Leicestershire

Category	Total No. Deaths reviewed	Total for Leicestershire
1 Deliberately inflicted injury, abuse or neglect	2	0
2 Suicide or deliberate self-harm	5	5
3 Trauma & other external factors	9	5
4 Malignancy	4	2
5 Acute medical or surgical condition	10	5
6 Chronic medical condition	2	1
7 Chromosomal genetic & congenital anomalies	17	5
8 Perinatal/neonatal event	15	3
9 Infection	4	1
10 Sudden unexpected unexplained death	7	3



6.7 Table 5 – cases relating to Rutland

Category	Total No. Deaths reviewed	Total for Rutland
1 Deliberately inflicted injury, abuse or neglect	2	0
2 Suicide or deliberate self-harm	5	0
3 Trauma & other external factors	9	1
4 Malignancy	4	0
5 Acute medical or surgical condition	10	0
6 Chronic medical condition	2	0
7 Chromosomal genetic & congenital anomalies	17	0
8 Perinatal/neonatal event	15	0
9 Infection	4	0
10 Sudden unexpected unexplained death	7	0



6.8 Positive factors noted as part of the reviews included:

- Relevant professionals receive feedback via quarterly meetings.
- Children and families supported around their choices for end of life care.
- Close liaison with other professionals to ensure on-going bereavement support offered to families including siblings.
- Appropriate referrals being made for genetic counselling for families.
- Awareness raising campaign regarding treatment following the ingestion of disc button batteries. Please see section 8.5 for further details.
- Review of emergency service responses to callers where English is not the callers first language including escalation of this to the DfE for consideration. Please see section 8.5 for further details.

6.9 Preventable Child Deaths

A 'modifiable' death is where factors are identified following a CDOP review which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. For all deaths where there are 'modifiable factors' it is important that learning takes place to make changes which could help make children safer. Of the child death reviews completed during 2014-15 there were **24** deaths identified as having modifiable factors. The key modifiable factors highlighted by CDOP related to issues such as:

- Smoking
- Co sleeping
- Consanguinity
- Risk taking behaviour
- Poor supervision
- Earlier detection of illness
- Revision of protocols

6.10 Due to the numbers involved it is difficult to identify key themes/areas for change. As CDOP now have at least 5 years of completed data available, it is proposed to undertake a more detailed analysis of this in order to extrapolate key areas of learning and areas to target. Initial work has already commenced on this project and it is envisaged that a draft overview will be available for review within 6 months.

7.0 Overview of cases notified to CDOP – April 1st 2014 – March 31st 2015

7.1 The data referred to in section 2 and 6 relates only to those cases that have undergone a review at panel during the time period outlined, it does not reflect the of notifications CDOP receives during that time – nor does it outline the work/learning that occurs in preparing cases for panel.

7.2 As previously mentioned LLR CDOP has a duty to ensure there is a review conducted into the death of ALL children 0-18 years (excluding still births), normally resident within LLR.

7.3 Between April 1st 2014 – March 31st 2015 LLR CDOP were notified of 108 cases. Of these, they were required to undertake a review on 77 (the remainder of numbers relate to those babies born at less than 23 weeks gestation and children who died within the LLR borders but who were not residents of LLR).

7.4 As part of the CDOP process information is gathered from professionals/agencies involved with the child and family in order to prepare the case for review. If any areas are identified as requiring action this will be undertaken, CDOP does not wait for the case to reach panel before ensuring learning has been identified and disseminated and any areas of concern have been addressed.

7.5 Of those cases still requiring review there are a number of factors that will be influential in the timing of them reaching panel;

- CDOP may still be awaiting the PM results (which can take 6 months).
- Some may be subject to parallel reviews (such as SUI or CI) and CDOP will await the outcome of these reviews before completing panel review.

8.0 **Learning and dissemination arising from the work of CDOP**

8.1 The following sections relate to learning and dissemination arising from the work of CDOP relating to cases that were reviewed between 1st April 2014 and 31st March 2015 as well as cases notified but not yet completed.

8.2 The remit of CDOP panels nationally is to provide an overview of cases and identify learning that seeks to reduce future deaths and as such views the 'wider picture'. It is not the intention of CDOP panels to identify a list of failings or review the cases under the same criteria as that considered during an SCR process. Therefore in the majority of cases it is acknowledged that there will be no recommendations to be made by CDOP. This does not mean that significant work has not been undertaken in assuring that all cases are reviewed appropriately. It is important to note that even in cases where specific recommendations or learning is noted and acted upon, from a statistical viewpoint it is almost impossible (due to the low numbers involved) to demonstrate a direct correlation between action undertaken as a result of a recommendation from CDOP and a decrease in the number of deaths in a particular category year on year.

8.3 As part of the review of all of the cases, the panel monitors the appropriateness of the professionals' responses to each unexpected child death to ensure thorough consideration of how such deaths might be prevented in the future is undertaken. It also monitors the support and assessment of services offered to the families of children who have died.

8.4 Alongside determining if modifiable factors can be identified within a case, CDOP members are also asked to consider if there are additional actions, learning points or

recommendations that can be drawn from the review. The panel seeks to help identify and report on any public health issues that may pose risks to children's health or development. In order to ensure learning is identified themed panels are held throughout the year. Cases that have already been reviewed will be brought back to panel alongside new cases with similar contributory factors. As part of this work the CDR Manager along with public health professionals look at current CDOP cases and seek to establish if/how they mirror the national picture. Following discussions at CDOP panel it has been agreed that a report will be produced reviewing the data that CDOP has attained over the past 5 years with a view to providing a more detailed comparative analysis of the data and finding made at panel.

8.5 As part of a standing agenda item all panel members are asked to provide evidence of any learning from their organisation, related to a CDOP case (e.g. minutes of meetings, amended guidelines etc). This is then used by the CDOP office to build up a portfolio.

8.6 **Shared Learning**

8.6.1 Disc button batteries

Following the tragic death of a young child caused by ingesting a button battery the CDOP panel instigated a local awareness raising campaign and the development of leaflets and electronic resources. The issue was also raised with Public Health England who, in response, issued a national alert.

Public Health teams also ensured the resources were in line with emerging national evidence that and key messages were disseminated to relevant stakeholders including health visiting teams and children's centres.

See Leicestershire and Rutland Safeguarding Boards - Learning from case reviews

8.6.2 999 calls – where English isn't the first language

One of the deaths the panel reviewed identified that there was a delay in calling emergency services because the mother did not speak English and waited for her husband to return home before he made the call. This led to the Panel seeking assurance from EMAS that appropriate systems and procedures were in place for providing information in relevant community languages and to ensure where practical, calls could be traced (when calling from a landline) and action taken where the caller is unable to communicate clearly.

8.6.3 Change to policy

Following the review of a case by the PMR and CDOP work was undertaken to amend the EMAS transportation policy (with regard to pregnant women) to ensure that transportation should be to the most appropriate hospital (as opposed to the nearest).

8.6.4 Suicide and self-harm

Work is underway to incorporate the findings from CDOP reviews into the work and reports of the LLR suicide audit prevention group in order to ensure there is shared learning.

8.6.5 Infant mortality

An Infant Mortality Strategy (for Leicester City) is currently being developed in partnership with key agencies with the CDR Manager being a contributor. This work is in the initial stages and progress will be reported to the Boards. During 2014-15 Infant mortality/ Health in Pregnancy and Infancy roadshows took place in each County District to highlight the modifiable risk factors (including smoking, screening/immunisation uptake, healthy weight, teenage pregnancy, breastfeeding, and other SUDIC factors; and to promote the services available to support tackling these risk factors and offer support for bereaved parents. Roadshows took place in Leicester City during the previous year.

8.6.6 Bereavement support/resources

As part of the development of the named nurse role, work is being undertaken to establish an index of key contacts that could be shared with organisations, outlining who may be able to provide support and information to families and professionals

9.0 Awareness raising

9.1 This falls within two categories;

- The need to ensure that professionals are aware of the CDOP process and the role they play within it.
- The need to ensure that lessons that are identified during the review of a case are disseminated appropriately and embedded within practice.

9.2 In each instance the key is to utilise already established information sharing forums alongside identifying new arenas. The information needs to be relevant and accessible to the professional in order for them to access and retain it. This can take a variety of forms such as presentations, leaflets, newsletters, e–bulletins, discussions within professional forums and attendance at study days.

In addition the CDOP Panel has identified, for its own development, the need to gain a better understanding of:

- How to interpret data and make inferences about the deaths that are reviewed (e.g. are they higher than expected; what is the evidence that they could have been potentially prevented), and
- The most effective way of using this evidence to lead to behaviour/process/systems change to implement these lessons.

9.3 Public Health are in the process of developing a CPD session for panel members that will cover these issues and lead to a more robust process for learning and disseminating lessons and interventions to reduce those unexpected deaths that are classified as preventable.

10.0 Areas for continued action in 2015-16

- Ensuring CDOP continue to support the work of the LLR suicide audit prevention group and the development of the Leicester City infant mortality strategy.
- Ensure the data that is captured is robust and accurate. At present many agencies do not appear to record ethnicity routinely in the information they supply to CDOP.
- Continue to develop and strengthen the role of the named nurse in ensuring families and professionals are supported following the death of a child.
- Engage in regional and national initiatives to identify trends and themes
    - LLR CDOP have been approached by an associate professor from Northampton University (who is currently working with 1 other CDOP) to look at how lessons are disseminated and how impact can be measured. Formal costings have now been received and the CDOP Chair/CDR Manager will be approaching both LSCBs to seek support for this.
    - A National Confidential Inquiry into Suicide and Homicide is to be undertaken. LSCBs will be contacted for information. Ethics approval has been sought. CDR Managers have asked that they are also included in any correspondence.

11.0 Recommendations

11.1 The LSCBs note and support the proposal of a supplementary report outlining the 5-year findings of CDOP.

11.2 The LSCBs note and support the work being undertaken by CDOP to strengthen and maintain links with partners to ensure shared learning; utilising the findings of CDOP to enhance work being undertaken (with specific reference to the suicide audit prevention group and the development of the Infant Mortality Strategy).

11.3 The LSCBs note and support the continued engagement of LLR CDOP in influencing the development of a national CDOP database.

11.4 The LSCBs review and consider the request for financial support to allow LLR CDOP to participate in identified research projects.

Appendix 1

During 2014/15 CDOP met on 8 occasions. Representation at the meetings is shown in table 2 below.

Following review of the CDOP Terms of Reference (in December 2014) it was agreed that from January 2015, a representative from Leicestershire Partnership Trust FYPC and UHL Obstetrics doctor would be invited to attend CDOP panels.

Table 3

Representation	Attendance
Chair (Leicester City Council – Public Health)	8
Leicester City, Leicestershire Council & Rutland Children and Young Peoples Services (CYPS)	8
Leicestershire Partnership Trust FYPC (Invited Jan 2015)	1
University Hospitals of Leicester NHS Trust Children's Emergency Department Consultant Consultant Paediatrician /Neonatologist Named Doctor for Safeguarding (invited Jan 2014)	 5 5 3
Consultant Community Paediatrician	6
Designated Paediatrician for Unexpected Deaths in Childhood	8
Designated Nurse for Safeguarding	7
Public Health Leicestershire and Rutland County Councils	8
Lay Member	7
Leicestershire Constabulary Child Abuse Investigation Unit (CAIU)	8