

BOLTON, SALFORD AND WIGAN CHILD DEATH OVERVIEW PANEL

ORGANISATIONAL AND OPERATIONAL INFORMATION INCLUDING INFORMATION-SHARING PROTOCOL

Updated 26/06/2009

CONTENTS

1.	TERMS OF REFERENCE	
1.1	Introduction	4
1.2	Objectives	4
1.3	Scope	6
2.	PANEL PROCESSES	
2.1	Membership	6
2.2	Chairing Arrangements	6
2.3	Decision Making	7
2.4	Confidentiality and Information Sharing	7
3.	ACCOUNTABILITY AND REPORTING ARRANGEMENTS	7
4.	COMMUNICATIONS AND MEDIA	8
5.	RELATIONSHIP WITH SERIOUS CASE REVIEW PROCESS	9
6.	RESOURCES AND BUDGET	9
7.	WORKING WITH PARENTS AND CARERS	10
8.	PRACTICE GUIDANCE	10
8.1	Introduction	10
8.2	Agency representatives	11
8.3	Workers completing agency reports	11
9.	TRAINING AND SUPPORT FOR STAFF	12
	Flowcharts	
	Child death overview Process	13
	Procedure for responding to an unexpected child death	14
	Procedure for responding to a child death and serious case review	15
10.	INFORMATION-SHARING PROTOCOL	
10.1	Introduction	16

10.2	Data collection: initial notification	16
10.3	Data collection: agency report	17
10.4	Data management	18
10.5	Child Death Overview Panel	19
10.6	Legal Framework to Information Sharing	19
10.7	Monitoring compliance	20

APPENDICES

1. Bolton, Salford and Wigan CDOP Membership
2. Roles and responsibilities of members of Bolton, Salford and Wigan CDOP
3. Roles and responsibilities of the Chair of Bolton, Salford and Wigan CDOP
4. Confidentiality statement for Bolton, Salford and Wigan CDOP members
5. Confidentiality statement for those with authorised access to the Virtual Workgroup System operated by the Greater Manchester e-Government Partnership (GMeP)
6. Bolton, Salford and Wigan CDOP Media and Communications Protocol
7. Bolton, Salford and Wigan CDOP Agency Leads
8. Letter and information leaflet for parents
9. Audit tool to measure compliance with information sharing protocol

1. TERMS OF REFERENCE

1.1 Introduction

- 1.1.1 The statutory requirement for Local Safeguarding Children Boards (LSCBs) to undertake the functions relating to child deaths is set out in Chapter 7 of *Working Together to Safeguard Children* (HM Government 2006). There are two interrelated processes for reviewing child deaths: a rapid response by key professionals to enquire into each unexpected child death, and an overview of all child deaths in the LSCB area(s) undertaken by a panel.
- 1.1.2 Bolton, Salford and Wigan LSCBs agreed to form a tri-partite panel for the purpose of reviewing the deaths of children resident in these three areas. The Panel membership comprises representatives from the relevant disciplines across the three local authority areas (that is, there is not a representative from each discipline from each authority).
- 1.1.3 The Child Death Overview Panel (CDOP) is responsible for reviewing information from a range of sources, including those who were involved in the care of the child, both before and immediately after the child's death, with a view to identifying:
- any matters of concern affecting the safety and welfare of children in the area of the authority, including any case giving rise to the need for a serious case review
 - any general public health or safety concerns arising from the deaths of children.

The purpose of the CDOP is to:

- better understand the reasons for deaths in childhood;
- use the findings to take preventative action to minimise the likelihood of further deaths in childhood;
- ensure an appropriate response to bereaved families, and
- contribute to the improvement in the health and safety of all children.

1.2 Objectives

The Panel has agreed the following objectives with the respective LSCBs that will form the basis of an annual work plan:

- Develop and implement, in consultation with the local coroner, local procedures and protocols to enquire into unexpected deaths, and evaluate these, together with information about all deaths in childhood.
- Ensure consistent reporting in relation to all deaths in childhood, which includes a standard format for identifying and reporting the cause and manner of every child death.

- Collect and collate an agreed minimum data set of information on all child deaths in Bolton, Salford and Wigan and, where relevant, seek additional information from professionals and family members.
- Evaluate collated data on the deaths of all children, identifying local lessons to be learned or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- Review specific cases in depth, identifying local lessons to be learned or issues of concern.
- Monitor the appropriateness of professionals' responses to the unexpected death of a child: reviewing the reports produced by the Rapid Response Team and providing the professionals involved with feedback on their work; and, where necessary, taking action to improve agency responses to unexpected deaths in childhood.
- Identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the Bolton, Salford and Wigan area, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being in order to ensure a thorough consideration of how such deaths might be prevented in the future.
- Ensure that the police, coroner and other relevant organisations are made aware of concerns of a criminal or child protection nature, and are kept informed of any specific new information that may influence their inquiries.
- Refer to the Chair of the relevant LSCB any deaths where the Panel considers there may be grounds to undertake further child protection enquiries, other investigations or a Serious Case Review, and explore why this had not previously been identified.
- Inform the Chair where specific new information should be passed to the Coroner or other appropriate authorities.
- Monitor the support and assessment services offered to families of children who have died.
- Monitor and advise the respective LSCB about the resources and training required locally to ensure an effective inter-agency response to child deaths.
- Identify any public health issues and, in partnership with the Director(s) of Public Health and other providers, agree the implications for both the provision of services and for training, and how best to address these.
- Contribute to and co-operate with regional and national initiatives to minimise the likelihood of future deaths in childhood.
- Increase public awareness about the issues that affect the health and safety of children.
- Identify and advocate for identified changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

1.3 Scope

- 1.3.1 Bolton, Salford and Wigan CDOP gathers and reviews data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident within Bolton, Salford or Wigan. This includes neonatal deaths and expected and unexpected deaths of infants, older children and young people.
- 1.3.1 The detail of the process for sharing information is set out in the Information-sharing protocol in section 10. The Panel has agreed pro-formas for aggregating and analysing the data.

2. PANEL PROCESSES

2.1 Panel membership and meeting arrangements

- 2.1.1 The Panel has a permanent membership comprising representatives from:
- Public Health
 - Children's Social Care (one per LSCB)
 - Greater Manchester Police
 - Local Authority Legal Services
 - Designated Doctor PCT
 - Designated Nurse PCT
 - Named Nurse NHS Hospital Trust
 - Adult Mental Health and Substance Misuse Services
 - Neonatal Services
 - Acute Services Named Nurse
- 2.1.2 Current Panel members' details can be found in Appendix 1 and the role and responsibilities relevant to their discipline are set out in Appendix 2. Each Panel member has a named deputy (except for the Adult Mental Health and Substance Misuse representative) and only the identified member or his or her deputy will attend Panel meetings. There is an agreed deputy Chair.
- 2.1.3 Additional members may be co-opted onto the Panel as required. This will be agreed with the Chair of the Panel and their roles and responsibilities will be clearly identified.
- 2.1.4 The local Coroner's representative attended the initial Panel meetings in order to ensure that satisfactory arrangements were established for the provision of information that allowed the Panel to complete its tasks. The representative remains available to the Panel on a consultative basis and coronial staff liaise with the Panel Administrator as necessary.

2.1.5 Each partner agency (or each discipline therein) in each of the three authority areas has identified a senior person with responsibility for matters relating to child death review arrangements. However, one representative of each discipline sits on the Panel and acts on behalf of the three areas with a mandate to make decisions on their behalf.

2.1.6 The Panel meets quarterly and holds a full day meeting dealing with business matters in the morning and the case discussion in the afternoon. Additional meetings are arranged as the need arises.

2.2 Chairing arrangements

2.2.1 An independent person chairs the Bolton, Salford and Wigan CDOP. The independence fulfils the requirement that the chair has no involvement in direct service provision, and, additionally, is in a position to challenge local practice or arrangements in the interests of safeguarding children and promoting their well-being.

2.2.2 The Chair is responsible for ensuring that the Panel operates effectively and that the outcomes and learning points from all Child Death Reviews are shared with the Bolton, Salford and Wigan LSCBs.

2.2.3 A statement of the Chair's roles and responsibilities, together with information relating to the recruitment and employment process, can be found in Appendix 3.

2.3 Decision-making

2.3.1 The Panel will, in all situations, seek to reach decisions by consensus as this best reflects and encourages the underlying principles of partnership working. However, in situations where a consensus cannot be reached, each member will have a vote. Where the vote is split, the Chair will have a second or casting vote.

2.3.2 Voting will be by a show of hands, except when a ballot is requested by two or more members.

2.3.3 Panel meetings will be quorate when one half plus one of the full membership is present.

2.4 Confidentiality and information sharing

2.4.1 Due to the sensitive nature of the information presented at the Panel, all panel members are required to sign a confidentiality agreement at the beginning of each meeting (Appendix 4).

2.4.2 Any reports, minutes and recommendations produced by the Panel are anonymised to ensure that, as far as possible, no individual can be identified from the information presented.

2.4.3 Information is stored and shared electronically using Sharepoint technology. It is located within the Virtual Workgroup System operated by the Greater

Manchester e-government Partnership (GMeP). CDOP member organisations have agreed to operate via this system. All personnel identified to have access to the system are required to sign a confidentiality agreement (Appendix 5).

2.4.4 Additional information about the Virtual Workgroup System can be found in section 10 of this document.

3. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

- 3.1 Bolton, Salford and Wigan CDOP is accountable to the Chairs of the respective LSCBs. The independent Chair of the Panel is a member of each LSCB and attends LSCB meetings as required and, as a minimum, once a year in order to present the annual report and work plan.
- 3.2 There are established lines of communication between the CDOP Chair and each LSCB Chair to facilitate contact at other times as the need arises. This includes referring to the LSCB Chair any deaths where the Panel considers there may be grounds to undertake further child protection enquiries, other investigations or a Serious Case Review.
- 3.3 In addition, the Panel representatives from Children's Social Care (one from each area) act as the conduit for sharing information between the CDOP and the respective LSCB. This appropriately reflects their lead responsibility in relation to safeguarding matters.
- 3.4 The Panel is responsible for developing an annual work plan, which will be approved by each LSCB.
- 3.5 An annual report will be prepared that identifies:
- significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the Bolton, Salford and Wigan area;
 - areas of good practice and new initiatives;
 - the quality and effectiveness of services offered to families of children who have died;
 - the appropriateness of the professionals' responses to each unexpected child death;
 - recommended changes to policy and practice as appropriate, and the nature of services provided by agencies; and
 - the level of resources and training requirements required to deliver the child death review arrangements effectively.
- 3.6 Copies of the annual report will be shared with LSCBs and relevant regional and national government bodies, including the Government Office North West, NHS North West and the Department for Children, Schools and Families (DCSF).

- 3.7 Each LSCB should ensure that the annual report is shared with the Children and Young People's Partnership Board and Children's Trust or its equivalent. In addition, the LSCBs are individually responsible within their local area for:
- disseminating the lessons to be learnt to all relevant organisations;
 - ensuring that relevant findings inform the Children and Young People's Plan; and
 - developing action plans on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- 3.6 The LSCB is responsible for submitting regular data on every child death, as required by the DCSF, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths. The LSCBs will also cooperate in providing data at a North West regional level to allow for comparisons and wider trends and patterns to be identified.
- 3.7 They will, in addition, share across the region good practice in relation to the CDOP and lessons learnt.

4. COMMUNICATIONS AND MEDIA

- 4.1 Child deaths can lead to interest from the media and potentially other interested parties, such as the local community. All requests for information, from whatever source, should be directed to the Panel Chair who will, in turn, seek advice and support from the appropriate marketing and communication team.
- 4.2 Details of individual case discussions are confidential and in no circumstances will information be passed to the media or other interested parties. Any data emanating from the work of the Panel will be formulated in a way that conceals the identity of any individual child or family.
- 4.3 Serious Case Reviews are managed by the relevant LSCB who will consider the need for a media strategy in each instance. The Panel will receive information about such cases but will not otherwise be involved.
- 4.4 Positive communication and good media relations will be beneficial when implementing some of the recommendations made by the Panel. In these instances, it will be important to seek the advice of the Local Authority or another agency's marketing and communication team to ensure that any publicity campaign achieves maximum impact and is effective in safeguarding and promoting the welfare of all children.
- 4.5 Further information regarding communication and the media can be found in Appendix 6.

5. RELATIONSHIP WITH SERIOUS CASE REVIEW PROCESS

- 5.1 The findings and recommendations from Serious Case Reviews held in each area will be shared with the CDOP. These will contribute to the overall identification of patterns and trends relating to childhood deaths.
- 5.2 Cases where an initial Serious Case Review Panel was convened but the criteria for a full Serious Case Review was not met should be clearly identified to the Panel and the reasons for not progressing to a Serious Case Review recorded.
- 5.3 If the Panel identifies a case where the information collated suggests a Serious Case Review should be held, the CDOP Chair will refer it to the Chair of the respective LSCB, together with the supporting evidence. The final decision lies with the Chair of that LSCB.

6. RESOURCES AND BUDGET

- 6.1 Bolton, Salford and Wigan have agreed to pool their respective CDOP budgets in order to maximise effectiveness and manage resources efficiently. The pooled budgets will fund:
 - the independent Chair;
 - the joint Administrator, including supervision and support for that post;
 - other administrative costs of running the Panel;
 - joint publicity campaigns; and
 - joint training.
- 6.2 The LSCBs will have access to resources from the budget in order to support local responses to the recommendations from CDOP reviews and annual reports. The Panel will agree these requests and the Administrator will raise the purchase order to meet the invoice costs.
- 6.3 The use of the resources, including the budget available to the Panel, is a standing item on the Panel agenda. Bolton MBC has assumed responsibility for administering the Panel resources and will provide a financial report at each Panel meeting.

7. WORKING WITH PARENTS AND CARERS

- 7.1 The Panel recognises that the death of a child is a tragedy for the parents and carers and all those who knew the child. The Panel is committed to:

- providing relevant information to parents and carers about the child death review process and how they can be involved;
- ensuring that the Rapid Response team provides appropriate support and feedback to meet the needs of individual parents and carers and other family members; and
- making public the findings and actions arising from themes or trends identified from the review of all child deaths, whilst maintaining confidentiality in respect of individual cases.

7.2 The Panel is clear that its function is not to delve into the cause of death in individual cases. Rather, its purpose is to focus upon the reasons why children die, in the interests of seeking to prevent similar deaths in the future. As such, it should be careful about the manner in which it invites parents to contribute to the process in order not to create confusion.

7.3 The Panel has an additional role in assessing the performance of the Rapid Response Team in respect of unexpected deaths and will seek parents' views about this.

7.3 The Panel has produced a letter and leaflet that explains the Panel process and how parents and carers can be involved. The Panel Administrator will send the letter and leaflet to every family within two weeks of the notification of the death of a child or young person, unless an agency representative advises her that a Serious Case Review is being considered or held. In the latter case, no information will be sent out in order to avoid the potential for confusion between the two processes. The letter and leaflet are included at Appendix 8.

7.4 The Greater Manchester *Procedure for the Management of Sudden Unexpected Death in Childhood (Rapid Response)* is a useful source of information for what happens after the death of a child. It also provides advice about dealing with parents and gives information about other sources of help. It can be found at www.gmsafeguardingchildren.co.uk

8. PRACTICE GUIDANCE

8.1 Introduction

It is the responsibility of the relevant statutory organisations to submit an agency report to the CDOP following the death of a child in its area. Agency reports are a vital element in ensuring that the Panel has the information upon which to make informed decisions and recommendations about individual child deaths and emerging themes and trends in deaths that occur across the child population.

The procedure set out in the information sharing protocol in section 2 describes which form to complete and how to submit it. This guidance is intended to:

- support agency representatives in completing the agency report for submission to the Panel Administrator;
- support the worker who will be required to provide an overview of their agency's or service's involvement with the child and family at the time of death and/or prior to the child's death.

8.2 Agency representatives

Each agency that has responsibility for submitting reports about a child death has nominated representatives whom the Panel Administrator can approach in the event of a death. They have the responsibility to:

- review their agency's or service's involvement with the child and/or family;
- notify workers of the death and consider what bereavement and counselling services may be required for family members and staff affected by the death;
- advise administration of the death, ensuring the date of death is recorded and any future appointments are cancelled;
- make a 'nil return' to the Panel Administrator where a child or family is not known to the service;
- request a member of staff in a service involved with the child and family at the time of death and /or prior to the child's death to complete 'form B': (a copy of form B should be made available and a return date stipulated);
- ensure that all reports are returned;
- create a combined report where more than one service is provided by that agency;
- audit and amend the report to ensure that any duplication is deleted; the information included is relevant and factual; and any judgement is based on clearly stated evidence;
- ensure that significant events in the child's life are summarised and analysed;
- place the completed report on the GMeP share point system within 28 days of being notified of the death (see section 10 for details).

Contact details for agency representatives are included in Appendix 7.

8.3 Workers completing agency reports

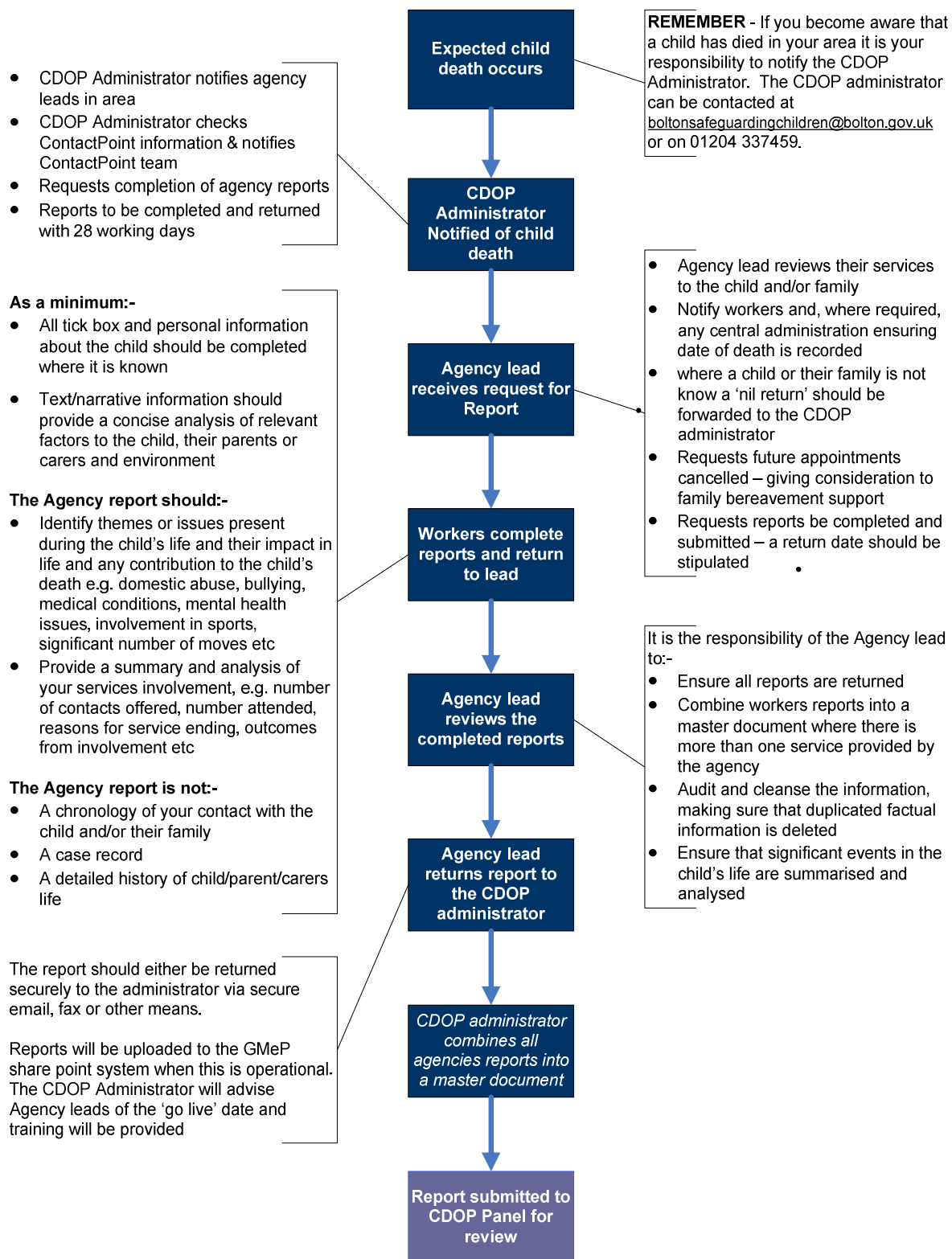
When completing an agency report (form B), workers should identify factors within the immediate environment that might have a bearing upon the child's death: for example, domestic abuse, bullying, medical conditions, mental health problems, involvement in sports, or a significant number of family moves. The report should include a summary of the child or family's involvement with the service, including the number of contacts, any non-attendance for appointments, and an analysis of the outcomes achieved.

The agency report is not a chronology of the service involvement with the child and family, a case record or a detailed history of the child and family's life.

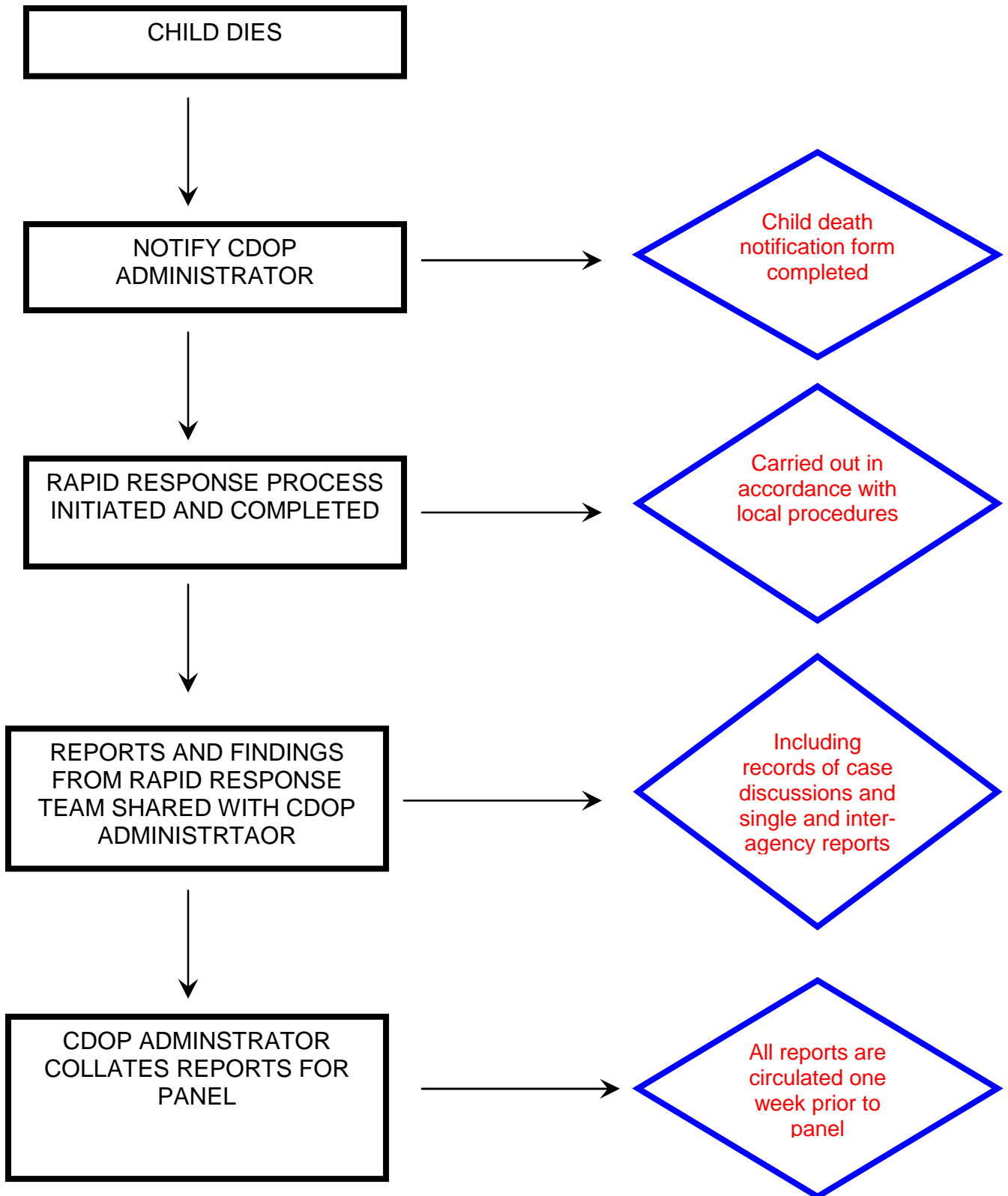
9. TRAINING AND SUPPORT FOR STAFF

- 9.1 The Panel recognises that child deaths have an impact upon the staff who have been involved with the child and family prior to the death, or become involved as a result of the death. The Panel is committed to ensuring that staff understand their role in the process and know whom they may approach for help and support in dealing with an individual death that affects them personally.
- 9.2 The Panel is producing an e-learning training package that will be available to any staff in Panel agencies in order to inform them about the purpose and general functioning of the CDOP.
- 9.3 The Panel is also providing inter-agency training for all those who may have involvement in the child death processes outlined in Working Together to Safeguard Children (chapter 7). This includes the Rapid Response team and staff directly involved in completing the agency reports.
- 9.4 Individual agencies are providing training within their own agency as appropriate.
- 9.5 Each agency has its own arrangements for supporting staff who require additional help in dealing with a death.

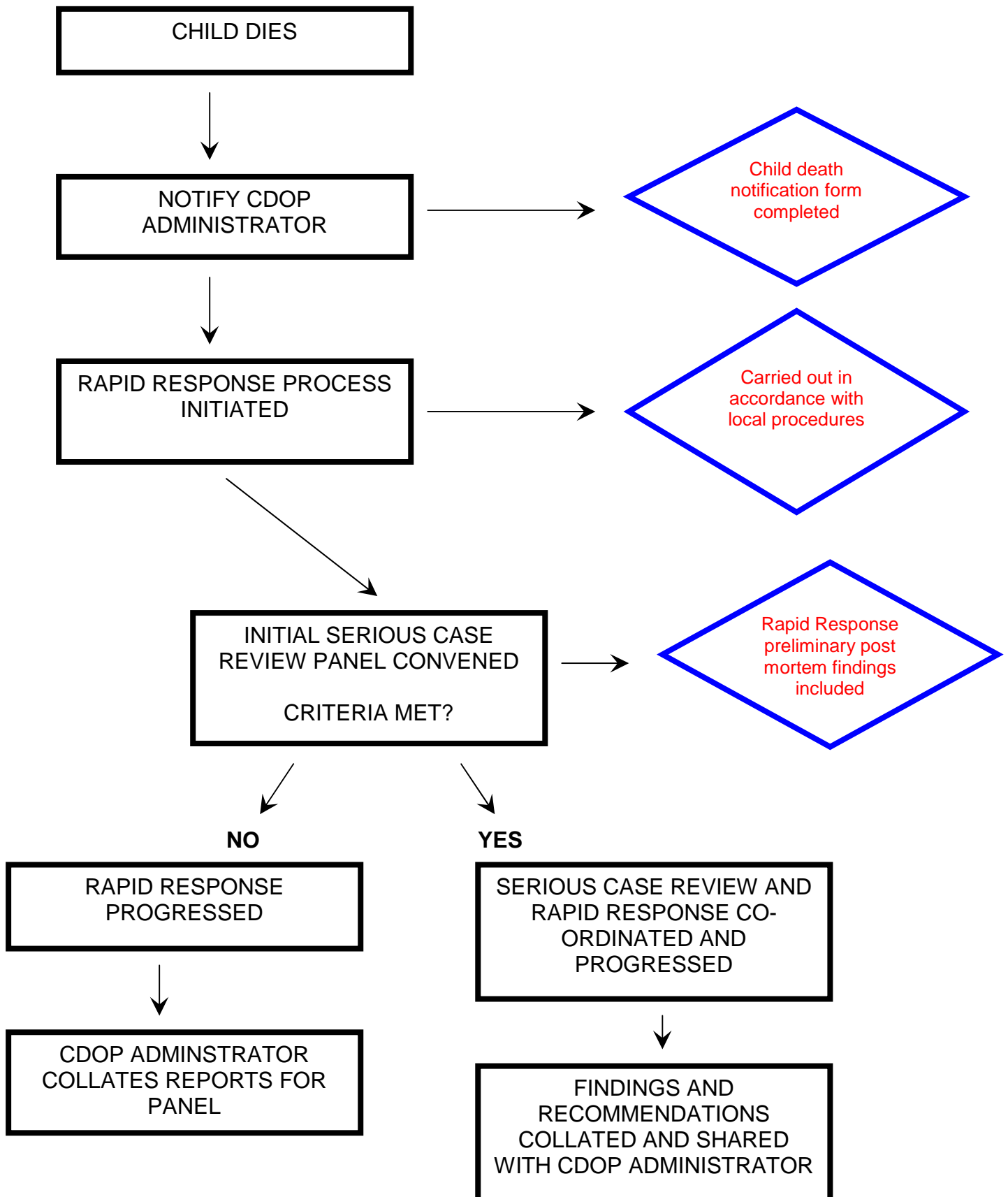
Child Death Overview Panel (CDOP) Process Flowchart



PROCEDURE FOR RESPONDING TO AN UNEXPECTED CHILD DEATH



PROCEDURE FOR RESPONDING TO A CHILD DEATH AND SERIOUS CASE REVIEW



10. INFORMATION SHARING PROTOCOL

10.1 Introduction

10.1.1 The following sets out the agreement reached by the agencies who constitute Bolton, Salford and Wigan CDOP for sharing and maintaining the confidentiality of information necessary for the Panel to perform its function. It identifies the data management systems established to record, analyse and monitor child deaths and to meet intended purposes and outcomes.

10.2 Data collection: initial notification

10.2.1 All child deaths occurring within Bolton, Salford and Wigan are to be notified to the Coroner by the professional confirming the fact of the child's death. This will usually be via a telephone call.

10.2.2 The person confirming the child's death will also notify the Panel Administrator within 24 hours and provide her with as much information as possible, such as name, age, address and circumstances of death of the child or young person. This will be followed up by electronic submission of the Initial Notification Form (Form A) within 48 hrs. As there is a requirement that this form is sent using the agreed Virtual Workgroup System (see section 3), it will be necessary for the person confirming the child's death to contact their agency representative for the Child Death Overview Panel (see Appendix 7).

10.2.3 As of 01 April 2009, the Registrar assumed responsibility for notifying the Panel Administrator of any deaths of children occurring within the Bolton, Salford or Wigan areas.

10.2.4 Any professional (or member of the public) hearing of a local child's death in circumstances that may mean it is not yet known about (for example, the death of a child abroad) can notify the Panel Administrator (see 10.2.8).

10.2.5 When a child who is normally resident in another area dies in Bolton, Salford or Wigan, it is the responsibility of the Bolton, Salford and Wigan Panel Administrator to notify her equivalent in the child's area of residence.

10.2.6 Similarly, when a child normally resident in Bolton, Salford or Wigan dies outside these areas, the Bolton, Salford and Wigan Panel Administrator should be notified by her equivalent in the area where the child died.

10.2.7 In both instances, the Panel Administrator should notify the Chair and provide contact details of their equivalent in the identified area. The Chairs of the respective Panels should agree which Panel will review the child's death and how they will report and share the outcomes and lessons to be learned. In the event of a failure to reach agreement on this matter, the Coroner will be the final arbiter.

10.2.8 Where a child dies abroad, the UK coroner only becomes involved if the child's body is brought back to this country, in which case the procedure is the same as for any other child death. Any such deaths will usually involve an inquest except when the death is from natural causes. Deaths that occur abroad are not registered in the UK. This means that, in a very small number

of cases (that is, those that do not involve an inquest), the Panel may not become aware of a death in its area unless it is reported by the local media or brought to the Panel's attention by another means.

- 10.2.9 The Panel Administrator requests reports directly from the nominated agency representatives in respect of all child deaths up to 18 years minus 1 day. The Panel Administrator will continue to inform CEMACH (Confidential Enquiry into Maternal and Child Health) of all child deaths so that they can fulfil their national responsibility to investigate the causes of still births and neonatal deaths, and can collate data regionally.
- 10.2.10 On receipt of the initial notification form, the Panel Administrator will contact the relevant local agencies who may have been involved with the child in an attempt to gather as much information as is relevant, necessary and proportionate, in line with the Data Protection and Human Rights legislation. This should include information regarding all members of the household, and should identify the key professionals, in particular the child's GP and paediatrician, if one has been involved. The Administrator will ascertain the child's NHS number as a unique identifier (together with name, address and date of birth) so as to minimise the risk of mistaken identity or duplication of notifications. Once this information has been collated, the Administrator will update the Initial Notification Form.

The notification form (form A) is available at:

<http://www.everychildmatters.gov.uk/resources-and-practice/TP00045/>

10.3 Data collection: agency report

- 10.3.1 The Panel Administrator will complete section A 'Identifying and Reporting Details' of the Agency Report (Form B). This information will be taken from the Initial Notification Form.
- 10.3.2 The Panel Administrator will place the Agency Report Form onto the Virtual Workgroup System notifying the relevant agency representatives for the CDOP. This will enable all relevant information on the case to be collected and collated to form a case summary, which will act as the 'input data set' for the Panel. Additional forms may also be sent depending on the cause of the child's death.
- 10.3.3 All representatives for each key agency should complete as much as they are able, drawing on a review of their agency records and discussions with individual practitioners. Whilst some aspects of the form are specific to individual agencies (for example, health), all agencies should be able to prepare summaries of relevant information available to them. Completed forms should be returned to the Child Death Overview Administrator within four weeks, again using the Virtual Workgroup System.
- 10.3.4 Once all agency reports are received, the information should be collated onto one form by the Administrator, either through local case discussion, or in discussion with the individual agency representative. Where there are any discrepancies or disagreements between agencies as to any of the factual information, this should be noted and where possible, a consensus reached.

10.3.5 The collated Agency Report Form will form the case summary and will be made available on the Virtual Workgroup System to Panel members at least 10 working days before the Panel meets.

Agency report (form B) is available at:

<http://www.everychildmatters.gov.uk/resources-and-practice/TP00045/>

10.4 Data management

10.4.1 Information system for the storage and transfer of electronic data

The Virtual Workgroup System operated by the Greater Manchester e-Government Partnership (GMeP) will be the means by which information is stored and transferred across agencies. Access to a dedicated site on the system will be by means of a unique ID and password. **Membership to the site will be strictly controlled by the CDOP.**

Individuals identified as an agency representative for gathering information and core CDOP members will be required to sign a confidentiality agreement regarding use of the system (Appendix 4).

10.4.2 Security of the system

The system is operated under the standard Internet Security system, utilising SSL 3.0 and Thawte Certificate software and is password controlled utilising a verification matrix based on 6 – 15 characters containing upper case, lower case and numeric characters with optional special characters.

Though the system has not been formally certified to handle UK Protectively Marked material, it does utilise similar security to that used by on-line banking systems, and is considered adequate for storage of 'restricted' material.

10.4.3 Security and data management

- All information stored and transferred (externally) for the purpose of the CDOP will be via the Virtual Workgroup System.
- Partners will keep confidential all personal data supplied pursuant to this protocol.
- Partners will take steps to avoid any breach (intentional or otherwise) or disclosure to third parties outside the remit of this protocol. Where internal agency breaches occur, they will be fully investigated by the host organisation and the relevant agency lead for information governance. Depending on the outcome of the investigation, disciplinary or legal action may be taken. The Chair of the Panel will be kept informed of all breaches and subsequent investigations.
- Data will only be used for the purpose for which it was requested.
- Data will be securely stored, must not be retained for an excessive period and destroyed when no longer required for the original purpose for which it was supplied or requested. This translates into a commitment that all hard and electronic copies of individual case documentation will be destroyed 12 months after the receipt of any legal documents (such as Death Certificates and Coroners' Reports).
- Panel members will destroy any paper documents relating to cases immediately after each Panel meeting, the exception being where a Panel

member is asked to follow up an individual case in order to obtain more information or clarify the information received.

- The Chair and Panel Administrator will keep paper copies of individual cases for as long it takes for them to update the anonymised schedules that record the progress of cases.
- The host organisation (AGMA/Wigan Council IT) will destroy all back-up files after a period of no more than four months.
- Partners will ensure that information exchange and use of information at a local level is handled in a secure environment. Retention and destruction of individual agency reports (Forms A&B) will be covered at the local level by the agency's own file policies.

10.5 Child Death Overview Panel

10.5.1 The Overview Panel has the advantage of being able to review each individual child death in the context of other deaths of children in their area and, thereby, identify any potentially contributory or recurrent themes and circumstances, or possible limitations in service provision by one or more agencies.

The Panel will therefore:

- Consider any relevant factors identified from the combined Agency Report Form and consider the degree to which they may have contributed to the child's death: factors intrinsic to the child; factors in parenting capacity; factors in the family and environment; factors in relation to service provision. During the meeting, the Panel Administrator will collate a summary of factors on the Analysis Proforma produced by the Panel for this purpose. This proforma includes the information that appears on the national Form C as well as the headings from the DCSF Data Collection templates that feature on the Every Child Matters website.
- Categorise the child's death using the hierarchical scheme within the Analysis Proforma. This will form part of the national core data set and enable analysis of information in relation to different types of death.
- Make a decision on the degree to which each death is considered preventable. It is important to recognise that this categorisation is to inform any efforts to reduce childhood deaths. It does not in itself carry implication of blame in respect of any individual party, but acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.
- Request additional information where necessary in order to make a decision about the category of death and whether or not it was preventable.
- Decide whether to refer the case back for further child protection enquiries or other investigations, or request the relevant LSCB to initiate a Serious Case Review.
- Identify any lessons to be learned, recommendations to be made or actions to be taken in response to the review of the death. The focus of

these actions and recommendations are on lessons learned at population-level as it is anticipated that, in most cases, any individual action in relation to specific case management will have been identified and addressed through local case discussion or other related processes.

- Following the Panel meeting, the Panel Administrator will transpose the key information from the Analysis Proforma on to a spreadsheet to facilitate the identification of trends and significant factors in the occurrence of child deaths. Any identifying details will be removed and replaced by a unique identifier in order to maintain confidentiality.

10.5.2 The Panel will also monitor the support and assessment services offered to the families of children who have died, including the operation of the Rapid Response Team. It will review the reports provided to the Panel and give feedback via the agency representative.

10.6 Legal framework to information sharing for the CDOP

10.6.1 The sharing of information within the CDOP is a function set out in regulation 6 under s13 Children Act 2004. The sharing of information within the Child Death Overview processes is designated a proportionate response in relation to the pressing social need for the protection of health and morals or the protection of rights and freedom of others. The functions of the Panel are, therefore, considered to be in the public interest.

10.6.2 The following legal frameworks are relevant to information sharing:

- **Children Act 2004 (Section 10):** statutory guidance for section 10 states that good information sharing is key to successful collaborative working and that arrangements under s10 Children Act 2004 should ensure that information is shared for strategic planning purposes and to support effective service delivery.
- **Children Act 2004 (Section 11):** places a duty on bodies within the NHS to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children
- **Working Together to Safeguard Children (Paragraph 7.55):** (HM Government 2006) sets out the functions of the CDOP. This includes collecting and collating an agreed minimum data set and where relevant seeking information from professionals and family members.
- **Human Rights Act 1998 (Article 8. 2):** the right to respect for private and family can be legitimately interfered with where it 'is in accordance with the law and is necessary ... in the interests of ... the protection of health and morals or the protection of rights and freedoms of others'.
- **Common Law Duty of Confidentiality:** The common law provides that where there is a confidential relationship, the person receiving the confidential information is under a duty not to pass on the information to a third party. The duty is not absolute and can be shared without breaching the common law duty if there is an overriding public interest in disclosure.

- **Data Protection Act 1998**

Information sharing within the CDOP is a statutory function and the Data Protection Act, therefore, permits the sharing of information without the express consent of the subjects.

10.7 Monitoring compliance

10.7.1 Compliance will be measured by annual audit with specific reference to individual roles and responsibilities as outlined in earlier sections of this document.

10.7.2 The chair of the Panel will monitor the effectiveness of these procedures.

APPENDICES

Appendix 1

Bolton, Salford and Wigan CDOP Membership

Organisation	Name	Deputy	Contact Details
Chair	Pamela Shelton		pamela.shelton@waitrose.com
		Kate Rose	kate.rose@salford.gov.uk
Public Health	Paul Turner		paul.turner@alwpct.nhs.uk
		Nicki Lomax	nicki.lomax@bolton.nhs.uk
Children's Services	Jane Booth		jane.booth@bolton.gov.uk
		Shona Green	shona.green@bolton.gov.uk
	Kate Rose		kate.rose@salford.gov.uk
		Chris Broadbent	chris.broadbent@salford.gov.uk
	Sean Atkinson		s.atkinson@wigan.gov.uk
		Kath Vereycken	k.vereycken@wigan.gov.uk
Police	Phil Owen		philip.owen@gmp.pnn.police.uk
		Dave Riddick (1 st)	david.riddick@gmp.pnn.police.uk
		Nick Howarth(2 nd)	nicholas.howarth@gmp.pnn.police.uk
Legal	Lorraine Ashton		lorraine.ashton@salford.gov.uk
		Ceri Owen	ceri.owen@bolton.gov.uk
Designated Dr.	Hilary Smith		Hilary.Smith@CMMC.nhs.uk
		Gabi Lipshen	gabi.lipshen@bolton.nhs.uk
Designated Nurse	Jean Rollinson		jean.rollinson@salford.nhs.uk
		Pam Jones	pam.jones@bolton.nhs.uk
Adult Mental Health & Substance Misuse Services	Marie Boles		marie.boles@gmw.nhs.uk
		None	
Neonatal Services	Simon Power		simon.power@rbh.nhs.uk
		Jonathan Moise	jonathan.moise@srft.nhs.uk
Named Nurse	Susan Holland		susan.holland@rbh.nhs.uk
Senior Nurse Safeguarding		Jackie Brennan	jackie.brennan@rbh.nhs.uk

Appendix 2

ROLES AND RESPONSIBILITIES OF MEMBERS OF BOLTON, SALFORD AND WIGAN CDOP

Public Health

The public health representative should:-

- 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 trends 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

Paediatrician

The paediatrician should:-

- 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; providing a medical explanation and interpretation of the circumstances surrounding a child's death
- Assist with interpreting the autopsy 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 involved in individual case management
- Liaise with other health professionals and agencies

Children's Social Care

The children's social care representative should:-

- Provide the panel with information on any social care involvement with the child and family, including any child protection procedures
- Provide the panel with information on other children in the home and any previous reports of neglect or abuse
- 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 Serious Case Review
- Liaise with other Local Authority services
- Provide feedback to social workers and other Local Authority staff involved in individual case management

Police

The police representative should:-

- Provide the panel with information on the status of any criminal investigation
- Provide the panel with relevant information relating to 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 deaths
- Liaise with other police departments, and the crown prosecution service
- Feed back to police officers involved in individual case management

Mental Health/Substance Misuse

The Mental Health and Substance Misuse representative should:

- Provide the Panel with information on the mental health and/or substance misuse services provided to the child or other family members
- Help the Panel to evaluate the mental health and/or substance misuse issues relating to the circumstances of the child's death
- Advise the Panel on mental health and/or substance misuse practice related to the child's well being
- Assist the Panel in the identification of associated risk issues and preventative strategies
- Liaise with other professionals and agencies as appropriate
- To identify learning and areas of good practice to inform future training and service development

Designated/Named Nurse

The designated/named nurse representative should:-

- Provide the Panel with information on the health of the child and other family members, including primary care services provided to the child and family

- Help the Panel to evaluate health issues relating to the circumstances of the child's death
- Advise the Panel on nursing practices that may have had a bearing on the child's health or well-being
- Assist the Panel in developing appropriate preventive strategies
- Liaise with other nursing and allied health professionals
- Provide feedback and support to nursing colleagues involved in individual case management

Neo Natal Services

The neo natal services representative should:-

- Provide the Panel with information relating to antenatal and perinatal care and support for the child and mother
- Advise the Panel on issues around antenatal and perinatal care
- Help the Panel to evaluate perinatal deaths
- Advise on any preventive strategies involving antenatal care or support
- Liaise with other midwifery and obstetric colleagues
- Provide feedback and support to midwifery and obstetric colleagues involved in individual case management

Appendix 3

ROLES AND RESPONSIBILITIES OF THE CHAIR OF BOLTON, SALFORD AND WIGAN CDOP

1. ROLES AND RESPONSIBILITIES

The Chair of the Panel is responsible for ensuring that the Panel operates effectively. He or she will:

- Ensure and monitor the effective running of the notification, data collection and storage systems
- Co-ordinate meeting dates and ensure Panel members receive timely notification
- Ensure that new members receive an orientation to the Panel prior to their first meeting
- Ensure that new Panel members, ad hoc members and observers sign a confidentiality agreement
- Promote and encourage the sharing of information for effective case reviews
- Chair Panel meetings effectively, encouraging all panel members to participate appropriately; ensuring that all statutory requirements are met; and maintaining a focus on preventive work
- Facilitate resolution of agency disputes
- Co-ordinate the development of the annual report
- Monitor and evaluate the effectiveness of recommendations and prevention initiatives and activities

2. RECRUITMENT AND EMPLOYMENT

The chair of Bolton, Salford and Wigan CDOP will be recruited by a small group of Panel members that represents the various interests of the Panel.

The chair is contracted on a sessional basis with a minimum of 21 days work per year, which can be increased by mutual agreement. The term of contract will be renewed on an annual basis.

Either party can terminate the contract by providing a minimum of four weeks notice.

Appendix 5

Confidentiality statement for those with authorised access to the Virtual Workgroup System operated by the Greater Manchester e-Government Partnership (GMeP)

The purpose of the Child Death Overview Panel is to conduct a thorough review of all child deaths in Bolton, Salford and Wigan in order to better understand how and why children die and to take action to prevent other deaths.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding child deaths, any relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act. This includes historical information concerning the deceased child, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The Bolton, Salford and Wigan LSCB procedures for child death reviews stipulate:

1. Designated persons with authorised access to the Virtual Workgroup System will NOT:
 - disclose their password/s to any other persons;
 - disclose any information gathered for the purpose of the CDOP other than pursuant to the mandated agency responsibilities of that individual. Public statements about the general purpose of the child death review process may be made, as long as they are not identified with any specific case.

2. Greater Manchester e-Government Partnership will :
 - take all reasonable steps to ensure that the site is not breached at any time
 - will destroy all back up files after a period of no more than four months
 - ensure that the system is operated, as a minimum, under the standard Internet Security system, utilising SSL 3.0 and Thawte Certificate software and is password controlled utilising a verification matrix based on 6 – 15 characters containing upper case, lower case and numeric characters with optional special characters

The undersigned agrees to abide by the terms of this confidentiality policy.

Name	Agency	Signature	Date

Appendix 6

Bolton, Salford and Wigan CDOP Media and Communications Protocol

Introduction

Bolton, Salford and Wigan CDOP is responsible for collecting and analysing information about the deaths of all children normally resident in Bolton, Salford and Wigan with a view to identifying:

- Any matters of concern affecting the safety and welfare of children in the area of the authority, including any case giving rise to the need for a serious case review.
- Any general public health or safety concerns arising from the deaths of children.

This protocol is governed by provisions in the Local Government Act 1986, the Local Government Act 1988, the Local Government Act 2000, and the Code of Recommended Practice on Local Authority Publicity (revised version April 2001).

Definition

Publicity is any communication intended for the public or a section of the public, such as media releases, brochures, leaflets, adverts, newsletters, internal and external websites and the staging of events that provide a platform for media publicity.

Scope

This protocol covers all media work including press launches, arranging interviews for both print and broadcast with a CDOP spokesperson, clearance of press releases and responses to media inquiries.

Principles of relationship with the media

Local authorities and their partners in Bolton, Salford and Wigan are committed to effective communication to ensure that citizens are well informed about the services that affect their lives. The media plays a valuable role, including the ability to reach large numbers of local residents. The individual authority members of the CDOP recognise this and aim to provide services to the media which are responsive to their needs. The principles are based on the desire to be open and transparent about decisions and who is accountable for those decisions

Standards

- All enquiries from the media should be directed to the appropriate designated public relations officer for the relevant local authority area.
- The public relations officer aims to manage the press coverage but in some cases the press may contact partner members of the CDOP directly. In such cases the inquiry should be directed to the relevant press officer.
- Any draft media releases should go through the correct channels, usually the entire CDOP. However, if a quick response is needed and full consultation is not possible, power of approval is devolved to the chair and

vice chair of the CDOP in consultation with the relevant public relations officer.

- Press statements and media releases should be clear and concise and should follow the Plain English Standards.
- Only designated CDOP spokespeople should speak directly to the media.

Process

- Each child death is a tragedy for both the child's parents and wider family and for those professionals working with the child and their family. For this reason, all requests for information whether from the media or other interested parties should be directed to the chair of the Bolton, Salford and Wigan CDOP.
- Details of individual case discussions are to be kept confidential and in no circumstances will such details be passed to the media.
- Each Child Death Review should include a consideration of whether the circumstances surrounding the death are likely to raise public interest and agree a strategy for managing this. It may be appropriate in some cases to consider seeking the advice of the local authority or other agency marketing and communications team.
- Positive communication and good media relations will be beneficial when implementing some of the recommendations made by the Panel. In these instances it is important to seek the advice of the designated public relations officer, local authority or other agency marketing and communications team to ensure that any publicity campaign achieves maximum impact and is effective in safeguarding and promoting the welfare of children.
- Media releases should be assessed as to whether a wider audience would be interested in the release and whether the information it contains is in the public's interest.
- With any media and publicity, it is advisable to determine when the item will be publicised and, in all cases, reach agreement with the reporter or interviewer on the subject matter in order to ensure quality and accuracy.
- Spokespeople: the designated public relations officer will approach the appropriate spokespeople in order to deal with media requests quickly and maximise coverage. The PR officer has responsibility to ensure that spokespeople are fully prepared and briefed for any interview. It is suggested that the designated media spokespeople for the CDOP should be the Chair and Vice-Chair.
- Use of spokespeople: those referred to above can be used as spokespeople in the issuing of press statements, media releases and giving interviews. In addition, officers of the various partner organisations that make up the CDOP can be used as spokespeople when their particular area of expertise is called upon.

Responding to enquiries

- The PR officer will respond to an enquiry as promptly as possible, taking into account the media's deadlines. Information will be gathered from the Chair or Vice-Chair of the CDOP or other designated member.
- Clearance: all news releases and statements should be cleared with the CDOP or with Chair or Vice-Chair when necessity dictates.
- News embargoes should only be used when considered essential. This is typically when a release is linked to a launch event; when an issue of confidentiality requires it; or when a third party requires it. Please note that embargoes are not legally enforceable.
- Contacts: an appropriate contact should be provided at the end of any media release.
- Media briefings: the use of media briefings to explain CDOP findings and recommendations should be encouraged where appropriate. This fits with the principle of good relationships with the media.
- Media training: the designated PR officer, local authority or other marketing and communications team will provide training as required.

Monitoring and evaluation –

- This procedure will be monitored by members of the CDOP to ensure compliance. Any identified areas of non compliance will be addressed.
- The quality of information will be monitored on a regular basis by members of the CDOP in conjunction with the designated PR officer.
- Use of information issued by the CDOP both reactively and pro-actively will be monitored and the extent to which it is used by the media in order to evaluate the extent of the coverage.
- The designated PR officer will hold a database of all media enquiries. The content of this database and the nature of the enquiries will be reviewed to assess if there are any seasonal trends and recurring stories. This will enable the CDOP to pro-actively assess any public relations requirements.

Appendix 7

Bolton, Salford and Wigan CDOP Agency Leads

+

Agency	Name	Contact Details
Health		
Salford PCT	Jean Rollinson	jean.rollinson@salford.nhs.uk
Salford Royal Foundation Trust	Beverley Tabernacle	Beverley.Tabernacle@srft.nhs.uk
RMCH	Hilary Smith	Hilary.Smith@CMMC.nhs.uk
Bolton PCT		
Royal Bolton Hospital	Susan Holland	susan.holland@rbh.nhs.uk
Mental health	Marie Boles	Marie.Boles@gmw.nhs.uk
Wigan PCT	Alison Burt	alison.burt@alwpct.nhs.uk
Wigan acute	Elham Abbas	elham.abbas@wwl.nhs.uk
Children's Social Care		
Salford	Kate Rose	kate.rose@salford.gov.uk
Bolton	Jane Booth	jane.booth@bolton.gov.uk
Wigan	Sean Atkinson	s.atkinson@wigan.gov.uk
Police		
GMP Public Protection Section	Phil Owen	philip.owen@gmp.police.uk
GMP Public Protection Section	Dave Riddick	david.riddick@gmp.police.uk

Appendix 8

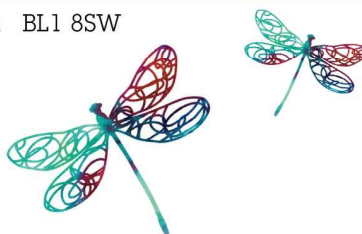
INFORMATION FOR PARENTS

Bolton, Salford and Wigan Child Death Overview Panel

Endeavour House 98 Waters Meeting Road Bolton BL1 8SW

Tel: 01204 337479 Fax: 01204 337495

Email: boltonsafeguardingchildren@bolton.gov.uk



Date:

Our Ref:

Mr & Mrs J Bloggs
92 Anywhere Ave
Anytown
Anyshire
AT4 9FT

Dear **(parents)**

As Chair of the Bolton, Salford and Wigan Child Death Overview Panel, I have been told about the death of your son/daughter, **(name)**. I should like to offer my sincere condolences to you and your family at this very sad time.

Every council in England now has to have a Panel that looks at the circumstances of each child or young person under 18 who dies in their area. This is not about deciding the cause of death (something for doctors and coroners) but, rather, to see if there are changes that agencies, such as Health and Social Care, can make to improve services for children and families in the future: for example, improvements in maternity services to reduce the risk of premature births. We also review the help and support you received immediately after **(name)** died, again to see whether any changes are needed to the current arrangements.

I'm enclosing a leaflet that tells you more about what the Panel does. I want to assure you that any information we receive about **(name)** and your family is treated with due respect and in the strictest confidence.

You may wish to let the Panel have your views about what would have helped you both before and after **(child's name)** death. If so, you can write to me at the above address, or you can talk to the person who is supporting you currently and he or she can pass on your views to me.

If you have any questions or concerns, please do contact me at the above address.

Yours sincerely

Pamela Shelton
Chair of Bolton, Salford and Wigan Child Death Overview Panel



**Bolton, Salford and Wigan
Child Death Overview Panel**

What we have to do when a child dies

Information for Parents, Families and Carers

The death of a child is tragic: we don't expect children to die before their parents. Talking and thinking about a child's death is a sensitive and painful subject, particularly for parents, families and carers.

The following information helps explain what has to happen following the death of a child or young person under 18 years.

What is a review and why is it needed?

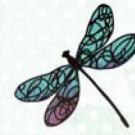
Government legislation now requires every council to review the death of each child or young person (under 18 years) who lived in their area. This is because in doing so we may find ways of doing things differently that help other children and families in the future.

How does a review happen?

Information about each child and how they died is collected together and summarised into a short report. The information comes from records held by hospitals, local health services (GPs and health visitors), schools, police, children's services or other agencies whose staff knew the child. The report also includes something about the family circumstances so that the Panel can understand the death in its context.

A Child Death Overview Panel that includes doctors, other health specialists, children's services staff and the police meets regularly to look at the reports. They want to be clear what caused the child's death so they can decide whether to recommend changes or improvements to services for children that might prevent similar deaths in the future. Any recommendations are passed on to the people who are responsible for planning and managing services for children locally. They might go as well to specialist agencies such as the fire service or traffic authorities, where appropriate.

The Panel also looks at what support and treatment was offered to the child and their family up to the time of the death; and also what support was offered to the family after the death. The Panel can recommend changes to these arrangements where need be.



What does this mean for you?

As part of this process, our Panel has been informed of your child's death. We'll be looking at a report about what happened and some information about your home circumstances. It may take several months before we have finished our work, as we have to wait until the other enquiries about the death are completed, such as the work of the pathologist and coroner, or any legal processes.

In the meantime, we'll be checking that you and your family are receiving the support that you need.

Can you contribute?

You can write to us to give us your views, share any information that you may have or ask any questions. We'll try to deal with your questions but we are not involved in deciding how your child died or if anyone is to

blame. If you prefer it, you can ask whoever is supporting you currently to pass on your views to us.

Unfortunately, it is not possible for parents or family representatives to attend the Panel meetings.

All the information we gather will be treated with the greatest respect and in strictest confidence. We promise that none of our findings, recommendations or reports will name or identify your child or family. We cannot give you individual feedback about your child's death but you are welcome to read our annual report that is available on each council's website or in hard copy from Endeavour House (see overleaf).



The Councils, Hospitals and Primary Care Trusts in Bolton, Salford and Wigan have agreed to have a joint Child Death Overview Panel.

You can contact the Panel at Endeavour House,
Watersmeeting Road, Bolton BL1 8SW.

Further information about the role of Child Death Overview Panels can be
found on Bolton, Salford and Wigan's websites and from the Government
Guidance Working Together to Safeguard Children from Harm 2006.

www.boltonsafeguardingchildren.org.uk

www.salford.gov.uk

www.wigan.gov.uk

www.everychildmatters.gov.uk/workingtogether

Useful resources - October 2008

www.childdeathhelpline.org.uk

www.uk-sands.org - tel 0800282986

Coping with loss for parents (how to help your child)

Pat Elliot

Sad isn't Bad: a good grief guidebook for kids dealing with loss

Michaelane Mundy

Losing a Child

Linda Hurcombe

Water Bugs and Dragonflies: explaining death to young children

Doris Stickney