

# **SALFORD, BOLTON AND WIGAN CHILD DEATH OVERVIEW PANEL**

## **ORGANISATIONAL AND OPERATIONAL INFORMATION**

# CONTENTS

Membership	3
Terms of Reference	4
Pro Forma and Flow Charts	10
Appendices	20

## Membership

Organisation	Name	Deputy	Contact Details
Chair	Pamel Shelton		<a href="mailto:pamela.shelton@waitrose.com">pamela.shelton@waitrose.com</a>
Public Health	Paul Turner		<a href="mailto:paul.turner@alwpct.nhs.uk">paul.turner@alwpct.nhs.uk</a>
Children's Services	Jane Booth		<a href="mailto:jane.booth@bolton.gov.uk">jane.booth@bolton.gov.uk</a>
	Kate Rose		<a href="mailto:kate.rose@salford.gov.uk">kate.rose@salford.gov.uk</a>
	Sean Atkinson		<a href="mailto:s.atkinson@wigan.gov.uk">s.atkinson@wigan.gov.uk</a>
Police	D.S. Mick Lay		<a href="mailto:Michael.Lay@gmp.police.uk">Michael.Lay@gmp.police.uk</a>
Legal	Lorraine Ashton		<a href="mailto:lorraine.ashton@salford.gov.uk">lorraine.ashton@salford.gov.uk</a>
Designated Dr.	Hilary Smith		<a href="mailto:Hilary.Smith@CMMC.nhs.uk">Hilary.Smith@CMMC.nhs.uk</a>
Designated Nurse	Jean Rollinson		<a href="mailto:jean.rollinson@salford-pct.nhs.uk">jean.rollinson@salford-pct.nhs.uk</a>
Adult Mental Health and Substance misuse services	Marie Boles		<a href="mailto:Marie.Boles@gnw.nhs.uk">Marie.Boles@gnw.nhs.uk</a>
Neonatal Services	Simon Power Dr Ravi Bhadoria		<a href="mailto:simon.power@rbh.nhs.uk">simon.power@rbh.nhs.uk</a> <a href="mailto:ravi.bhadoria@wwl.nhs.uk">ravi.bhadoria@wwl.nhs.uk</a>
Early Years Services	Jayne Acton		<a href="mailto:j.acton@wigan.gov.uk">j.acton@wigan.gov.uk</a>
Acute Services Named Nurse	Jackie Brennan or Susan Holland		<a href="mailto:jackie.brennan@rbh.nhs.uk">jackie.brennan@rbh.nhs.uk</a> <a href="mailto:susan.holland@rbh.nhs.uk">susan.holland@rbh.nhs.uk</a>

# TERMS OF REFERENCE

## 1. Purpose

Salford, Bolton and Wigan Child Death Overview Panel (CDOP) is responsible for collecting and analysing information about the deaths of all children normally resident in Salford, Bolton 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

The Panel will operate in accordance with the functions set out in Chapter 7 of Working Together to Safeguard Children (2006)

The purpose of Salford, Bolton and Wigan Child Death Overview Panel 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
- Contribute to the improvement in the health and safety of all children

## 2. Objectives

Salford, Bolton and Wigan CDOP, on behalf of their respective LSCB, will: -

- Develop and implement, in consultation with the local coroner, local procedures and protocols enquiring into unexpected deaths, and evaluating 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 Salford, Bolton 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 learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children
- Evaluate specific cases in depth, identifying local lessons to be learnt 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 Salford, Bolton 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 to ensure a thorough consideration of how such deaths might be prevented in the future
- Ensure that where concerns of a criminal or child protection nature are identified the police, coroner and other relevant organisations are aware and are 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 of whether 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 their respective Safeguarding Boards 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 how best to address these and their implications for both the provision of services and for training
- 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

### **3. Scope**

Salford, Bolton and Wigan CDOP will gather and assess 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 Salford, Bolton, or Wigan. This will include neonatal

deaths, expected and unexpected deaths in infants and in older children.

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

Similarly when a child, normally resident in Salford, Bolton or Wigan dies outside the area, the Salford, Bolton and Wigan CDOP administrator should be notified by their equivalent in the area where the child died.

In both cases the administrator of Salford, Bolton and Wigan CDOP should notify the Chair and provide contact details of their equivalent in the identified area. An agreement should be reached between the Chairs of the respective panels as to which CDOP will review the child's death and how they will share and report the outcomes and lessons to be learnt.

#### **4. Membership**

Salford, Bolton and Wigan CDOP will have a permanent core membership which consists of representatives from:-

- Public Health
- Children's Social Care
- Greater Manchester Police
- Local Authority Legal Services
- Designated Doctor
- Designated Nurse
- Adult Mental Health and Substance Misuse Services
- Neonatal Services
- Acute Services Named Nurse
- Coronial Service

Each core member has very clear roles and responsibilities in relation to the Panel and these are outlined in Appendix 1.

Additional members may be co-opted onto the Panel as required. This will be agreed with the Chair of Salford, Bolton and Wigan CDOP with their roles and responsibilities outlined.

Each member should hold a senior position within their organisation enabling them to implement the recommendations across their organisation.

## **5. Chairing Arrangements**

Salford, Bolton and Wigan CDOP will be chaired by Pamela Shelton (Independent Chair). The Chair will be responsible for ensuring the Panel operates effectively and that all outcomes and learning points from all Child Death Reviews are shared with the Salford, Bolton and Wigan LSCB.

A comprehensive summary of the Chair's roles and responsibilities are in Appendix 2.

## **6. Confidentiality and Information Sharing**

While information discussed at Salford, Bolton and Trafford CDOP will be anonymised prior to the meeting, it is essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

Members will all be required to sign a confidentiality agreement before participating in the Panel. Any co-opted members and observers will also be required to sign the confidentiality agreement.

At each meeting of the Salford, Bolton and Wigan CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

Any reports, minutes and recommendations arising from the Panel will be fully anonymised to ensure that, as far as possible, no individual can be identified from the information presented.

Appendix 3 provide further practice guidance.

## **7. Accountability and Reporting Arrangements**

Salford, Bolton and Wigan CDOP is accountable to the Chair of their respective LSCB. The Panel is responsible for developing its work plan, which will be approved by each of the Boards.

An annual report will be prepared highlighting the findings and outcomes from the Panel, as well as identifying areas of good practice and new initiatives. Copies of the report will be shared with relevant regional and national government bodies, including Government Office North West, NHS North West and DCSF.

Each Board should ensure that the annual report is shared with the Children and Young People's Partnership Board, Trust or equivalent.

Salford, Bolton and Wigan Safeguarding Children Board's are each responsible for the following within their local area:-

- Disseminating the lessons to be learnt to all relevant organisations
- Ensuring that relevant findings inform the Children and Young People's Plan
- Developing action plans on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children

Each Board is responsible for tracking and reviewing the progress of any action plans developed as a response to the findings and recommendations of Salford, Bolton and Wigan CDOP.

Each LSCB is responsible for submitting regular data on every child death, as required by the Department for Children, Schools and Families, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

This may also be required on a regional level to allow for comparisons and wider trends and patterns to be identified, as well as sharing practice and lessons learnt across the North West.

## **8. Communications and Media**

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 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 Local Authority or other agency 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.

Further information regarding media and communication can be found in Appendix 4

## **9. Relationship with Serious Case Review Process**

The findings and recommendations from Serious Case Reviews held in each area should be shared with Salford, Bolton and Wigan CDOP.

These will contribute to the overall identification of patterns and trends relating to childhood deaths.

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.

Where the Panel identify a case where the information collated suggests a Serious Case Review should be considered, this matter and the supporting evidence should be referred to the Chair of the respective LSCB. The final decision lies with the Chair of that LSCB.

## **10. Decision Making**

Salford, Bolton and Wigan CDOP, in all situations, will 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 shall have a vote. Where the vote is split, the Chair shall have a second or casting vote.

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

## **11. Working with Parents and Carers**

Salford, Bolton and Wigan CDOP recognise that the death of a child is a tragedy for parents/carers and all those who know the child. It is committed to:-

- Providing relevant information to parents and carers about Child Death Review Processes and how they can be involved
- Ensuring that the rapid response team provide appropriate support and feedback to meet the needs of individual parents/carers and wider family members
- Making public the findings and actions taken from any themes or trends identified from the review of all child deaths

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

### **Pro Formas and Flow Charts**

# BOLTON, SALFORD AND WIGAN CHILD DEATH OVER-VIEW PANEL

## CHILD DEATH NOTIFICATION FORM

This form should be used to notify Salford, Bolton and Wigan Child Death Overview Panel about the death of a child.

Please note the boxes expand.

### 1. Details of the Person Making the Notification

<b>Name</b>	
<b>Address</b>	
<b>Job title</b>	
<b>Organisation</b>	
<b>Telephone</b>	
<b>E-mail</b>	
<b>Date of Notification</b>	

### 2. Child and Family Details

<b>Name</b>			
<b>Alias</b>			
<b>Address</b>			
<b>Residential status</b>			
<b>Gender</b>			
<b>Date of birth</b>			
<b>Date of death</b>		<b>Time of death</b>	
		<b>Place of death</b>	
<b>Was the death:</b>	<input type="checkbox"/> Expected	<input type="checkbox"/> Unexpected	*(refer to definition below)
<b>Has the death been reported to the Coroner</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>If no, are there plans for a hospital Post Mortem?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Has a Death Certificate been issued?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>NHS Number</b>			
<b>School/Nursery (if applicable)</b>			

\*Definition: An unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. (Fleming et al., 2000; The Royal College of Pathologists and the Royal College of Paediatrics).

<b>Ethnicity</b>					
<b>White</b>		<b>Mixed</b>		<b>Asian/Asian British</b>	
British	<input type="checkbox"/>	White & Black Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Irish	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Other	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
	<input type="checkbox"/>	Any other mixed	<input type="checkbox"/>	Any other Asian	<input type="checkbox"/>
<b>Black/Black British</b>		<b>Other Ethnic Groups</b>			
Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Not stated	<input type="checkbox"/>
African	<input type="checkbox"/>	Any Other Ethnic Group	<input type="checkbox"/>		
Other Black Background	<input type="checkbox"/>				

Child Protection Plan Status	Current		None		Previously		
CAF Status	Current		Closed		None		

Legal Status at time of incident							
Adoption		EPO		PPO		Supervision Order	
Care Order		S20		Ward of Court		Residence Order	
Other		None					

Disability at time of incident				Yes		No	
Mobility		Hand function		Communication		Behaviour	
Hearing		Vision		Learning			

Residential status at time of incident			
At Home		With relatives	
With foster carers		Children's home	
Mother and baby unit		Hospital	
Other (specify)			

Family Composition				
Name	DOB	Relationship to child	Ethnicity	Parental responsibility

Additional services - including GP			
Name	Post	Address	Contact details

### 3. Incident Details

Reason for Notification (please provide a narrative of the circumstances leading to the child's death)

Additional information – please include any relevant information from your organisation	
Child's health and development	
Parenting capacity	
Environmental factors	

**FOR OFFICE USE ONLY**

To be completed by the Safeguarding Unit upon receipt of notification:-

<b>Unique Identifier</b>	
<b>Date received</b>	
<b>Date entered on database</b>	

# BOLTON, SALFORD AND WIGAN LSCB CHILD DEATH OVERVIEW PANEL

## AGENCY REPORT

This report should be used to outline your agency's involvement with the child and their family.

Please note the boxes expand.

### 1. DETAILS OF THE PERSON COMPLETING THIS REPORT

<b>Name</b>	
<b>Address</b>	
<b>Job title</b>	
<b>Organisation</b>	
<b>Telephone</b>	
<b>E-mail</b>	
<b>Date of Notification</b>	

### 2. CHILD AND FAMILY DETAILS

<b>Name</b>	
<b>Alias</b>	
<b>Address</b>	
<b>Residential status</b>	
<b>Gender</b>	
<b>Date of birth</b>	
<b>NHS Number</b>	
<b>School/Nursery (if applicable)</b>	

FAMILY COMPOSITION including siblings or other children in the household and any additional carers				
Name	DOB	Relationship to child	Ethnicity	Parental responsibility

ADDITIONAL SERVICES - including GP			
Name	Post	Address	Contact details

## FACTORS IN THE CHILD

No relevant information- go to next page

Long term health needs

- No concerns
- Known health needs- give details of peri-natal problems, diagnoses, hospital attendance or admissions, attendance at appointments etc

Development/special educational needs/school attendance

- No concerns
- Identified concerns- give details

Emotional or behavioural factors

- No concerns
- Identified concerns- give details

## FACTORS IN THE PARENTS AND WIDER FAMILY

No relevant information- go to next page

Mother's attendance for antenatal care (<1's only)

- No concerns
- Identified concerns- state

Parental health and communication skills (including mental health and substance misuse, and learning, literacy or communication difficulties)

- No concerns
- Identified concerns- state

Parental experiences (e.g. history of domestic abuse, homelessness, being looked after, refugee/asylum seekers, criminal records)

- No concerns
- Identified concerns- state

Other relevant factors in parents, siblings or carers

**FACTORS IN THE WIDER ENVIRONMENT**

No relevant information- please sign and date form and return to CDOP administrator
Housing and home safety <ul style="list-style-type: none"> <li>• No concerns</li> <li>• Identified concerns- state</li> </ul>

Parents' support networks <ul style="list-style-type: none"> <li>• No concerns</li> <li>• Identified concerns- state</li> </ul>

Employment status:-	Father Mother Other adults in household

Neighbourhood safety and play facilities

Access to health care

Other relevant factors

Is your agency providing any continuing care or support to the family? YES / NO (If yes, please state what)

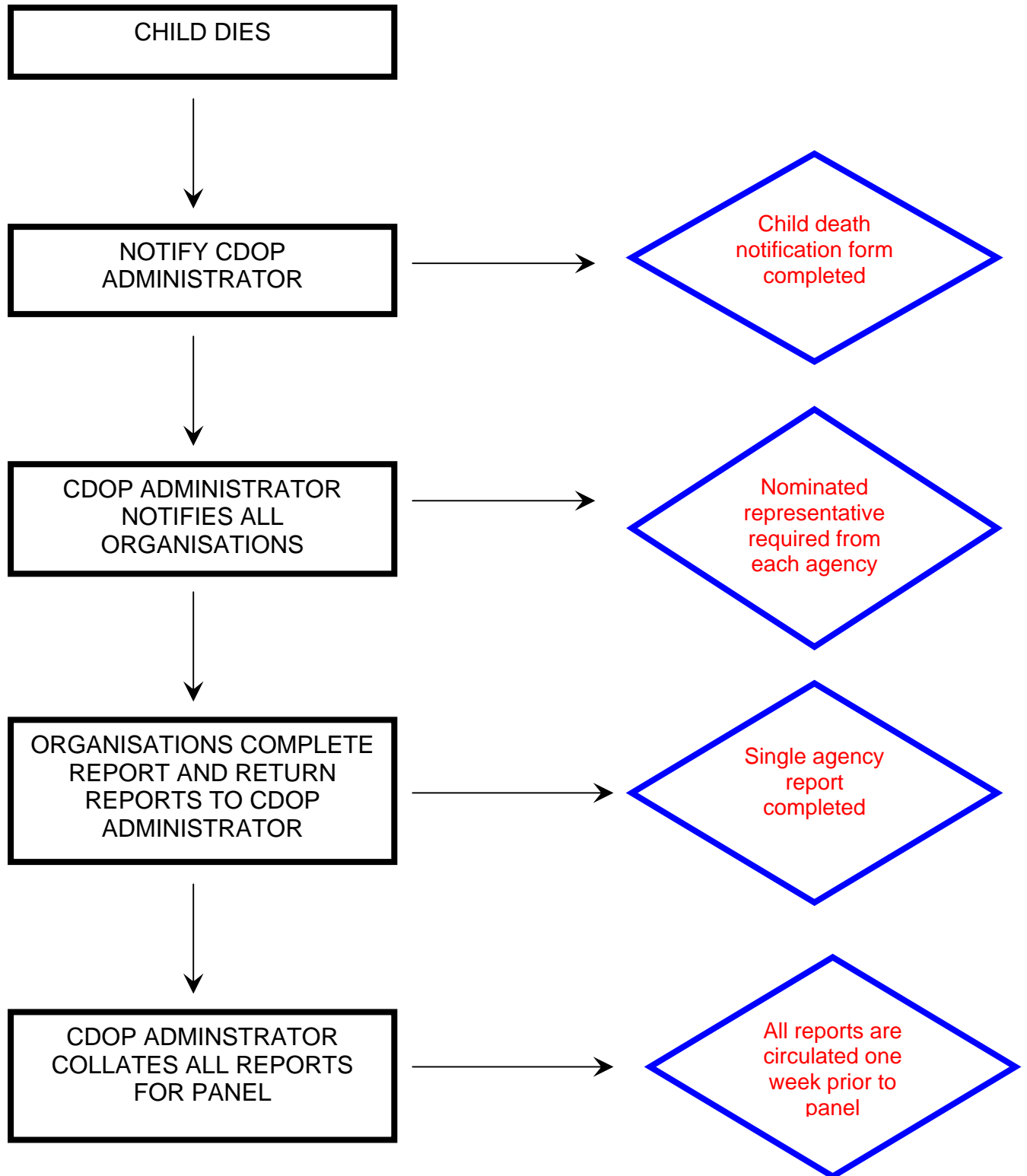
Is your agency taking any internal action as a result of the death? YES / NO (If yes, please state what, e.g. internal agency review)

**FOR OFFICE USE ONLY**

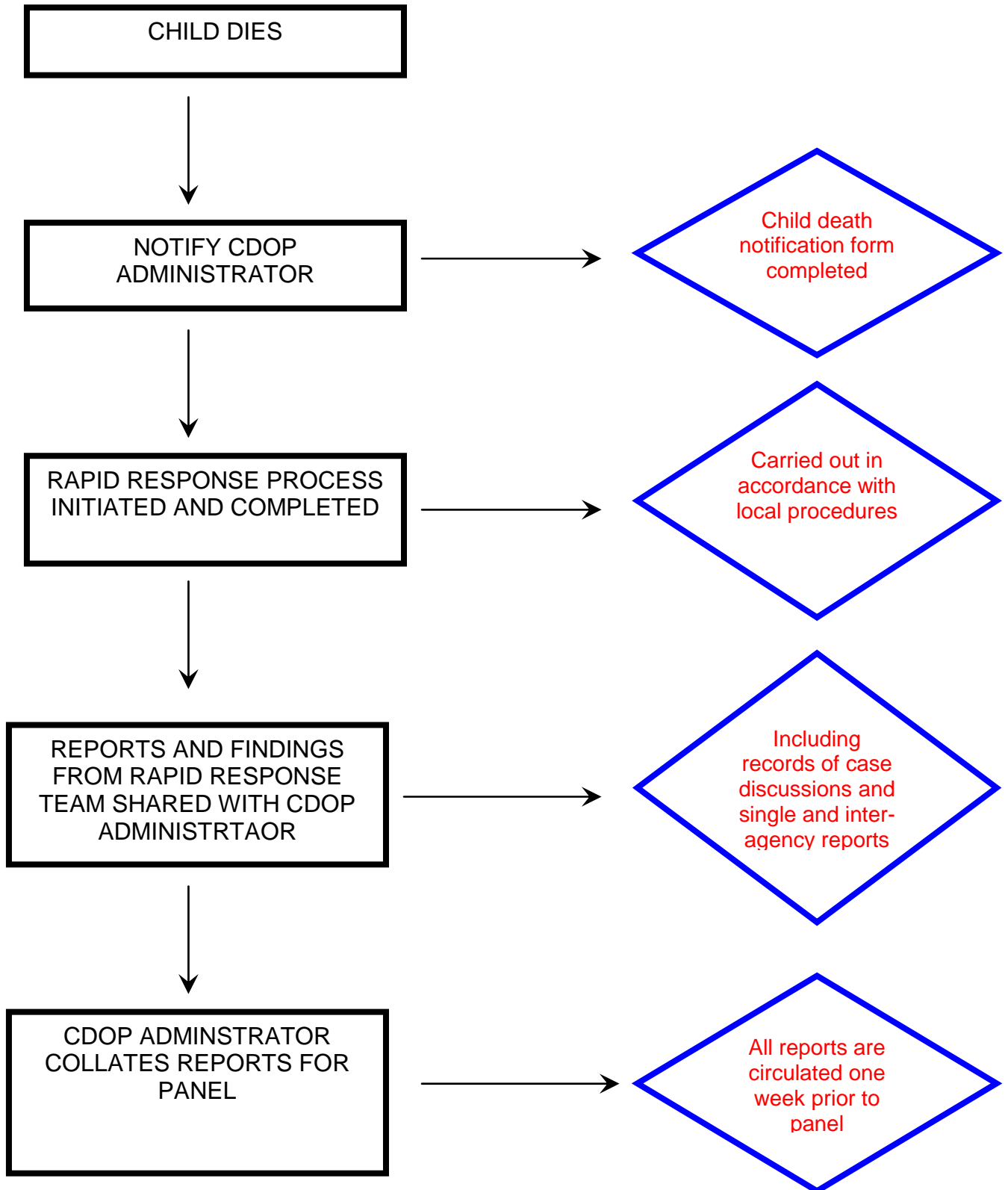
To be completed by the Safeguarding Unit upon receipt of notification:-

<b>Unique Identifier</b>	
<b>Date received</b>	
<b>Date entered on database</b>	

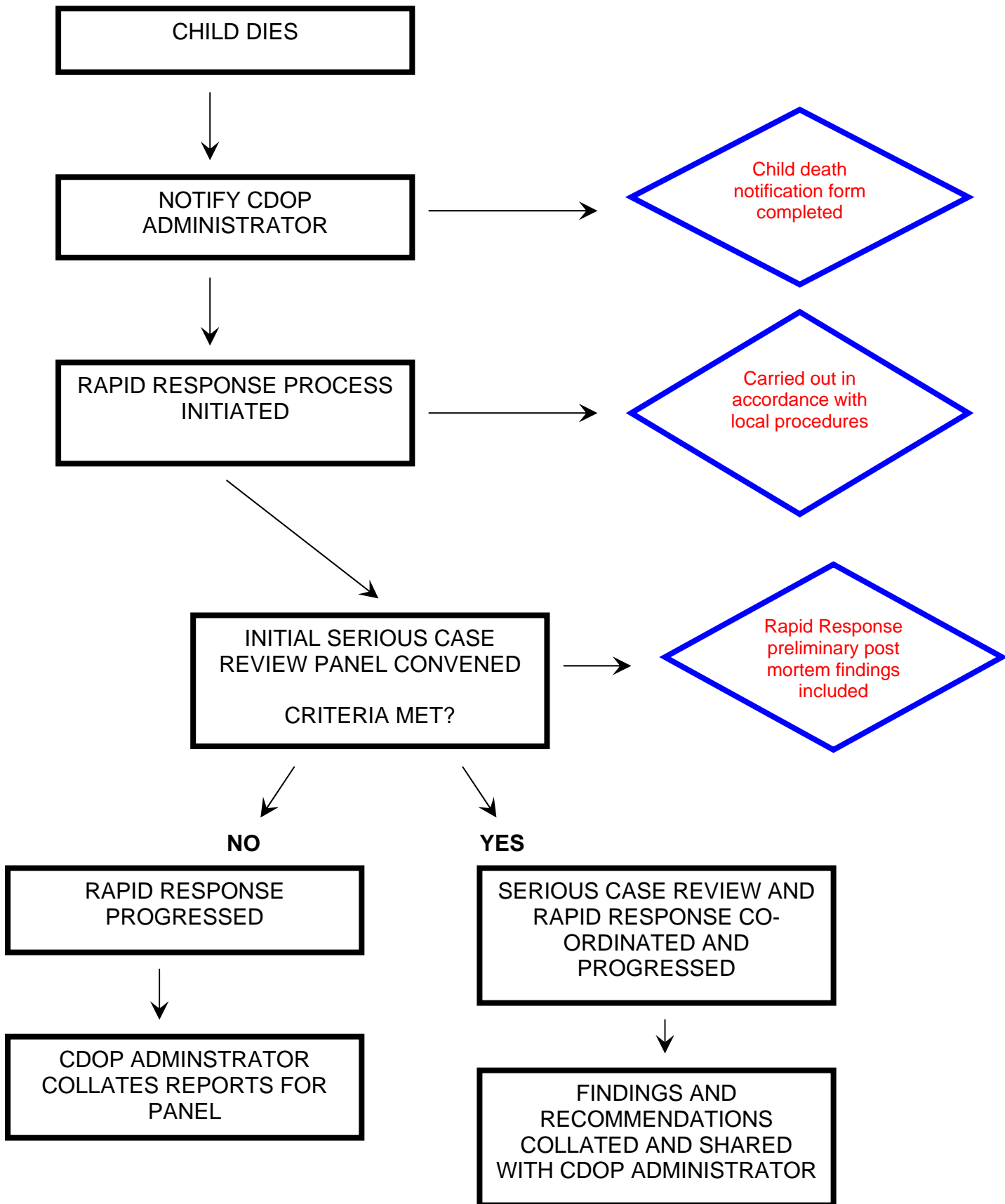
# PROCEDURE FOR RESPONDING TO AN EXPECTED CHILD DEATH



# PROCEDURE FOR RESPONDING TO AN UNEXPECTED CHILD DEATH



# PROCEDURE FOR RESPONDING TO A CHILD DEATH AND SERIOUS CASE REVIEW



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

## **Appendices**

## **ROLES AND RESPONSIBILITIES OF MEMBERS OF SALFORD, BOLTON AND WIGAN CHILD DEATH REVIEW PANEL**

### **Public Health**

The public health representative can:-

- Provide the team with information on epidemiological and health surveillance data
- Assist the team in strategies for data collection and analysis
- Assist the team in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work
- Inform the team of public health initiatives to support child health
- Advise the team on the development and implementation of public health prevention activities and programmes

### **Coroner or Coroner's Officer**

The coroner or coroner's officer can:-

- Provide the team with information on the status and outcome of the coroner's investigation into an unexpected child death and explanation of the determined manner and cause of death
- Provide the team with information from the autopsy and other investigations
- Advise the team on the coronial processes, including appropriate governing legislation
- Assisting in the development and implementation of strategies to improve the investigation of unexpected childhood deaths

### **Paediatrician**

The paediatrician can:-

- Provide the team 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 team 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 team 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 can:-

- Provide the team with information on any social care involvement with the child and family, including any child protection procedures
- Provide the team with information on other children in the home and any previous reports of neglect or abuse
- Help the team to evaluate issues relating to the family and social environment and circumstances surrounding the death
- Advise the team 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 can:-

- Provide the team with information on the status of any criminal investigation
- Provide the team with information on the criminal histories of family members and suspects
- Identify cases that may require a further police investigation
- Provide the team with expertise on law enforcement practices including investigations, interviews and evidence collection
- Help the team 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 can:

- Provide the Team with information on the mental health and/or substance misuse services provided to the child or other family members
- Help the Team to evaluate the mental health and/or substance misuse issues relating to the circumstances of the child's death
- Advise the Team on mental health and/or substance misuse practice related to the child's well being
- Assist the Team 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

## **Child Health Nurse**

The child health nurse representative can:-

- Provide the Team with information on the health of the child and other family members, including primary care services provided to the child and family
- Help the Team to evaluate health issues relating to the circumstances of the child's death
- Advise the Team on nursing practices that may have had a bearing on the child's health or well-being
- Assist the Team 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 can:-

- Provide the Team with information relating to antenatal and perinatal care and support for the child and mother
- Advise the Team on issues around antenatal and perinatal care
- Help the Team 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

### **Early Years Services**

The Early Years Services representative can:-

- Provide the Team with information regarding guidance and standards relating to the delivery of Early Years services
- Advise the Team on issues arising from the delivery of Early Years services
- Liaise with Early Years providers incorporating statutory and private and voluntary
- Provide feedback and support to Early Years providers where there is involvement in individual case management

**ROLES AND RESPONSIBILITIES OF THE CHAIR OF  
SALFORD, BOLTON AND WIGAN  
CHILD DEATH REVIEW PANEL**

The Chair of the Overview Panel is responsible for ensuring that this process operates effectively. They 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 all new CDOP members, ad hoc members and observers sign a confidentiality agreement
- Promote and encourage the sharing of information for effective case reviews
- Chair the CDOP meetings encouraging all team members to participate appropriately, ensure that all statutory requirements are met, and maintain 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

## **BOLTON, SALFORD AND WIGAN CHILD DEATH OVERVIEW PANEL**

### **SHARING OF INFORMATION AT THE CHILD DEATH OVERVIEW PANEL**

Chapter 7 of Working Together sets out the procedures to be followed when a child dies in the area(s) covered by the CDOP.

Para 7.51 page 165 sets out the procedures to be followed by the local Child Death Overview panel (for all child deaths). The procedures include:-

- Collecting and collating an agreed minimum data set and where relevant, seeking information from professionals and family members
- Providing relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family

There is no specific requirement within the procedures for consent to be sought from the family for agencies to share information with each other.

The procedures clearly envisage that in some circumstances there will be communication with the family to provide them with relevant information. It is not immediately obvious what that information would be and there is no requirement to communicate with the family as a matter of routine.

There are a number of Guidance documents:-

- Information Sharing: A Practitioner's Guide
- Information Sharing: Further Guidance on Legal Issues
- An Overview of Cross Government Guidance

There is no general statutory power to share information. Where there is no express statutory power to share information it may be possible to imply such a power from other duties and powers public bodies have.

Having express or implies statutory powers in any particular case does not mean that the Human Rights Act 1998, the common law duty of confidentiality, and the Data Protection Act 1998 can be disregarded.

Article 8 of the European Convention on Human Rights was incorporated into UK law by the **Human Rights Act 1998** and recognises a right to respect for private and family life:-

- Article 8.1: everyone has the right to respect for his private and family life, his home and his correspondence.
- Article 8.2: There shall be no interference by a public authority with the exercise of this right **except** such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the

country, for the prevention of disorder or crime, protection of health and morals or the protection of rights and freedoms of others.

Sharing confidential information may be a breach of an individual's Article 8 right: one must ask whether sharing information would be justified under Article 8.2 and proportionate.

The right to a family life can be legitimately interfered with where it is in accordance with the law or for the protection of health and morals. There is a need to consider the pressing social need and whether sharing the information is a proportionate response to this need and whether these needs can override the individual's right to privacy.

The sharing of information within the CDOP is a function set out in regulation 6 and therefore in accordance with the law.

## **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.

I would suggest that the functions of the CDOP are in the public interest.

## **DATA PROTECTION ACT 1998**

This act deals with the processing of personal data. Personal data is data which relates to a living person, including the expression of any opinion. Sensitive personal data is personal data relating to racial or ethnic origin, religious or other similar beliefs, physical or mental health or condition, sexual life, political opinions, membership of a trade union, the commission of any offence, any proceedings for any offence committed or alleged to have been committed, the disposal of proceedings or the sentence of any court in proceedings.

Organisations which process personal data must comply with the data protection principles set out in Section 1 of the Act. These require the data to be:

- fairly and lawfully processed
- processed for limited specified purposes
- adequate relevant and not excessive for those purposes
- accurate and up to date
- kept for no longer than is necessary
- processed in accordance with individuals' rights
- kept secure

If the information enables a person to be identified, then schedule 2 condition should be met. These are:-

- subject has given consent to share information
- sharing information is necessary to protect a person's vital interests;  
or
- to comply with a court order; or
- to fulfil a legal duty; or
- to perform a statutory function; or
- to perform a public function in the public interest

When information is also sensitive then a schedule 3 condition must also be met. These are:-

- individual has given explicit consent
- sharing information is necessary to establish, exercise or defend legal rights
- sharing information is necessary for the purpose of, or in connection with any legal proceedings
- to protect someone's vital interests
- to perform a statutory function
- processing is necessary for medical purposes and is undertaken by a health professional

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

The main pieces of legislation relevant to agencies and practitioners in Children's services which either contains express or implied powers to share information are:

### **Children Act 2004**

**Section 10** - places a duty on each Children's services authority to make arrangements to promote co operation between itself and relevant partner agencies to improve the well-being of children in their area in relation to :-

- Physical and mental health, and emotional well-being
- protection from harm and neglect
- Education, training and recreation
- Making a positive contribution to society
- social and economic well-being

The statutory guidance for section 10 states that good information sharing is key to successful collaborative working and that arrangements under Section 10 of the Act should ensure that information is shared for strategic planning purposes and to support effective service delivery.

**Section 11** - places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The key people and bodies are:-

- local authorities
- the Police
- the Probation Service
- bodies within the National Health Service
- Connexions
- Youth Offending Teams
- governors/directors of prisons and young offender institutions
- directors of secure training centres
- the British Transport Police

## **CONCLUSIONS**

There are numerous references within Working Together and Children Act 2004 requiring agencies to co operate and work together to safeguard children. The roles and responsibilities of the CDOP are clearly defined within Chapter 7 of Working Together.

Whilst Chapter 7 does not set out explicitly that all agencies are permitted to share information, paragraph 7.55 sets out the functions of panels and this includes collecting and collating an agreed minimum data set and where relevant seeking information from professionals and family members.

It does not require consent from the families to be obtained, although there is reference to the provision of information to those professionals working with the families, so that they in turn can convey the information in a sensitive and timely manner to the family.

The legislation restricting sharing of information is set out above and as indicated each provision provides an exception that in my view applies to the sharing of information within CDOPs.

The more difficult issue is what information should be provided to families. As there is no requirement to inform the family or seek their consent, I do not consider it necessary to contact each individual family whose child is considered at the CDOP.

The approach of producing a publication detailing the role of CDOP would in my view be appropriate and within the law.

Panel should carefully consider the data set and ensure that the information sharing is proportionate and necessary for the purposes of the panel.

# Confidentiality Statement

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in Salford, Bolton 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, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act, including 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 Salford, Bolton and Wigan LSCB procedures for child death reviews stipulate that in no case will any team member disclose any information regarding team discussion outside the meeting 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.

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

Name	Agency	Signature	Date

**Salford Bolton and Wigan Child Death Overview Panel  
Media and Communications Protocol**

- i) **Introduction** - Salford, Bolton and Wigan Child Death Overview Panel (CDOP) is responsible for collecting and analysing information about the deaths of all children normally resident in Salford, Bolton 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).
- ii) **Definition** - Publicity - 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.
- iii) **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.
- iv) **Principles of relationship with the media** – Local authorities and their partners in Salford, Bolton 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.
- v) **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 it is suggested that power of approval be designated 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, where appropriate.
- Only designated CDOP spokespeople should speak directly to the media.

vi) **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 reflected upon and assessed if a wider audience would be interested in the release and the information it contains is in the public's interest.
- With any media and publicity it is advisable that you try and determine when it will be publicised and in all cases reach agreement with the reporter/interviewer on what is to be said to ensure quality and accuracy.
- Spokespeople – the designated public relations officer will approach the correct spokespeople in order to deal with media requests quickly and maximise coverage. The PR officer has the responsibility of ensuring 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 mentioned 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.

vii) **Responding to inquiries** – 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.
- Use of embargoes – These 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.

viii) **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 proactively 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 proactively assess any public relations requirements.