BOLTON, SALFORD AND WIGAN CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT
2008 – 2009
AND
BUSINESS PLAN
2009 – 2011

Keeping children safe IN Salford

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Foreword from the Chair

Welcome to what is the first annual report of the newly established Child Death Overview Panel for Bolton, Salford and Wigan.

The Panel has been set up by the Local Safeguarding Children Boards in Bolton, Salford and Wigan as part of their widened remit to protect children. In scrutinising why children die, the Panel hopes to be able to recommend changes and improvements to services to prevent future deaths. We know, however, that it is not possible to prevent all deaths as many result from conditions that are present from birth and cannot be treated in our current state of medical knowledge. Another aspect of the Panel's work is to ensure that the services provided to parents and other family members affected by the death are appropriately supportive and sensitive.

I believe we have made good progress in our first year and have grappled with difficult issues such as how to gather the information we need to do our work whilst maintaining an appropriate level of confidentiality. At all times we seek to manage the process in a way that is respectful to the children who have died and their families.

I am indebted to the Panel members who have given generously of their time over and above attending the Panel meetings. I am aware that these new responsibilities have been added to their current workloads. In addition, the Panel would not function without the unstinting efforts of the Panel Administrator and our thanks are due to her.

The Annual Report explains more about why the Panel exists and how it undertakes its work. It also sets out what we have achieved in the first year of operation and our work plan for the next two years is included at the end of the report. We are happy to receive comments and queries about the report and our future plans.

Pamela Shelton
Independent Chairperson

What is a Child Death Overview Panel?

The Child Death Overview Panel (CDOP) is responsible for looking at the circumstances of each child or young person under 18 who dies in its area. This is not about deciding the cause of death (which is the role of doctors and coroners) but, rather, to see if there are changes that agencies can make to improve services for children, young people and families and prevent future deaths.

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

The purpose of the 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;
- ensure an appropriate response to bereaved families; and
- contribute to the improvement in the health and safety of all children.

Every Local Safeguarding Children Board (LSCB) is required to set up a Panel. The guidance for doing so is in Chapter 7 of *Working Together to Safeguard Children* (HM Government 2006).

How does the Bolton, Salford and Wigan Panel work?

A tripartite Panel

Bolton, Salford and Wigan LSCBs agreed to set up one Panel to review the deaths of children resident in the three areas because they decided that this was a more efficient use of resources. It also means that the Panel is looking at a greater number of deaths and can, therefore, more easily identify trends in the circumstances leading to the deaths.

The Panel 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 (babies up to four weeks of age) and expected and unexpected deaths of infants, older children and young people.

Panel membership

The Panel has representatives from the relevant disciplines across the three areas (that is, there is not a representative from each discipline from each authority). They include Public Health, Health, Children's Social Care, Greater Manchester Police and Local Authority Legal Services. A full list of Panel members is in Appendix 1.

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 work. The representative remains available to the Panel on a consultative basis and staff from the Coroner's office liaise with the Panel Administrator as necessary.

Panel Chair

An independent person chairs the Bolton, Salford and Wigan Panel. 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.

The Panel 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.

Funding

Government funding has been provided within each local authority's Area Based Grant for a period of three years to set up and run its Panel. Bolton, Salford and Wigan agreed to pool their respective CDOP budgets in order to maximise effectiveness and manage resources efficiently. The budget is used to employ a full-time administrator, pay the fees of the Panel Chair and other costs of managing the Panel; and fund staff training and any publicity associated with the work of the Panel, including public campaigns on specific topics.

Greater Manchester Rapid Response Team

LSCBs are also required to set up Rapid Response Teams to manage any sudden unexpected deaths of children or young people in their area. Again, Chapter 7 of *Working Together to Safeguard Children* sets out what they have to do. The objectives are:

- To ensure parents receive appropriate support
- To facilitate the Coroner's team in establishing the cause of death
- To identify factors contributing to the death.

It is the responsibility of the CDOP to receive the reports from the Rapid Response Team about individual cases and to review how well the team is achieving its objectives, particularly in respect of the support to parents and carers.

The Primary Care Trusts that cover Greater Manchester agreed to use the funding allocated by the Department of Health to commission a team that operates across most of Greater Manchester. This allowed the creation of a team of 10 consultant paediatricians who are available 24 hours a day seven days a week on a rotating basis. In addition, a Greater Manchester Protocol underpins the work of the team and provides a framework for a multi-agency response, particularly between the acute hospitals, Greater Manchester Police and the Coroners, the rapid response paediatricians and Children's Social Care.

The Rapid Response Team has been operational since 1 January 2009. Activity to 30 June 2009 is summarised below.

	Total across GM area	**Salford/Bolton/Wigan**
Total unexpected deaths	43	17
Total referred to rapid response	38	16
Age 0-6mth	12	6
>6mth-12 years	14	7
>12 years	12	3

Of the five cases across the service area that were not referred to the team, three were teenagers who were found hanged. Two of these deaths occurred in the first month of the service, when the need for a paediatric response for under 18-year olds was not fully appreciated. The third teenager was originally understood to be 18 at the time of death and hence would not fall within the remit of the team. The two other children who were not referred died of acute infections some days after admission to hospital, and there was uncertainty about whether they met the criteria for an unexpected death. This demonstrates that defining an unexpected death is not entirely straightforward.

The team members have met monthly to discuss cases and share experience. It is recognised that further discussion is needed about the role of the rapid response doctor in road deaths, and when a death occurs in hospital from medical causes where the diagnosis is known and treatment has been unsuccessful.

Relatively few of the cases have yet reached the point of final case discussion after which further information about the cause of death can be provided to parents. The main reason for this delay is the long time scale for receipt of

final post mortem reports, and the need to await the outcome of any inquest before conclusions can be shared.

Among the unexpected deaths of children from Bolton, Salford and Wigan, eight children under one year died unexpectedly in their cot or a bed (two of them were sleeping with an adult); two children were pedestrians who died after being hit by a car, and four children had long-term medical problems, although the relevance of those problems to the death is currently uncertain.

There appears to be widespread knowledge of the service amongst practitioners, and an understanding that the new arrangements require new ways of working. Rapid Response Team members have undertaken home visits in the majority of cases in order to understand better the child or young person's home setting. Visits are usually undertaken with police officers, and have not presented difficulty. A small number of deaths required detailed criminal investigation and, in those cases, the police led the enquiries. Feedback to the steering group would suggest that the work of the rapid response team is also enhancing the police investigation process and that this should lead to better outcomes.

It is too early to draw conclusions about contributory and avoidable factors from the deaths investigated so far, apart from co-sleeping with an adult.

What have we achieved?

The Panel

It has taken time to sort out the membership of the Panel in order to ensure the right representation to deal with the work of the Panel and a balance of people from the three areas. Because of the highly sensitive nature of the information being discussed, there was an early agreement that each Panel member would have a nominated deputy who would attend in his or her absence. Other people do not attend (for example, as observers) unless invited for a specific matter.

Operational document

The Panel has produced a document (Organisational and Operational Information including an Information-sharing Protocol) covering all aspects of how it is organised and operates. It is available for reference on Bolton's, Salford's and Wigan's Local Safeguarding Children Board's website. The Panel will review and amend this document as part of its annual evaluation of its performance using the Government Office North West criteria for monitoring the effectiveness of the Child Death Review arrangements.

Information-sharing arrangements

AGMA (Association of Greater Manchester Authorities) is a partnership between the ten local authorities within the Greater Manchester area. These ten authorities co-operate on a number of issues where they consider that they can improve service delivery by working together.

One development is the establishment of a secure website that allows agencies to exchange and share information securely. A number of authorities are using this facility in relation to their safeguarding functions for which they need to share highly sensitive information.

The Bolton, Salford and Wigan Panel is making use of this arrangement in order to gather and share the information it needs about individual child deaths. The Panel has a dedicated site on the system, access to which is strictly controlled, on which it stores the reports and other data about child deaths within its area. The cases are anonymised for discussion at Panel.

The information is only used for the purpose for which it was requested and is only retained until that purpose is achieved. This translates into a commitment to destroy individual case documentation 12 months after the receipt of any legal documents, such as death certificates and Coroners' reports that allow the Panel to conclude its consideration. The Panel Administrator maintains a spread sheet of all the cases that come to the Panel's attention that itemises (anonymously) key data so that the Panel can track and assess trends that are emerging about the causes of deaths amongst children and young people and their social circumstances.

Information leaflet and letter for parents

The Panel is very much aware that it is discussing highly confidential and sensitive information about the circumstances of the deaths of children and young people. The reports it considers also include some information about the family background to enable the Panel to view the death in its context.

The Panel has produced a letter and leaflet, using a design commissioned specifically for this purpose, that explains the Panel process and how parents and carers can make a contribution. The Panel Administrator sends the letter, personally signed by the Chair, 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 both available for reference on Bolton's, Salford's and Wigan's Safeguarding Children Board's website and form an appendix to the Operational document. They are also reproduced for reference at Appendix 3.

The Panel does not communicate further with the parents following its discussion at Panel. Communication with parents about the cause of death

falls within the remit of the Rapid Response Team for sudden unexpected deaths and, for expected deaths, to those providing support to the family.

Training

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. To this end, the Panel has produced a training programme.

The training on child death review processes started in January 2008 when staff from Health, Social Care and Police, who were leading on the new arrangements, attended an initial training event to provide them with the skills to run an effective Child Death Overview Panel. This was based on the materials produced by Warwick University Medical School to support child death review processes.

Following the implementation of rapid response procedures across Greater Manchester in January 2009, the Panel took a lead in developing and delivering a one-day training programme. The aim was to provide participants with the skills required to carry out an inter-agency investigation into unexpected child deaths in accordance with the Greater Manchester Protocol referred to above.

The learning objectives of the course were to enable participants to:-

- Describe in detail the different components of the rapid response to an unexpected childhood death.
- Discuss their role and that of other professionals involved in the process.
- Collect and share relevant information for the investigation through the taking of a thorough history, review of background information from their own or other agencies, and evaluation of the scene and circumstances of a child's death.
- Explain to families the purpose and process of the rapid response, including what will happen to their child.
- Collate and evaluate information from the investigation in the light of the knowledge about the nature and causes of unexpected childhood death.
- Recognise and respond appropriately where there are suspicious circumstances surrounding the death of a child.

Trainers delivered nine one-day sessions across the three areas. There was flexibility about which course practitioners attended (whether within their own area or not) in order to maximise attendance. There were approximately thirty attendees per session. Further consideration will be given to providing this

same training and additional training in the future. Evaluation sheets completed by participants are to be reviewed as part of this process.

It is recognised that not all workers will be able to attend training or it may not be appropriate for their requirements and responsibilities. As a consequence, Panel members have commissioned an e-learning training package whose development is nearing completion. It provides an accessible method for raising awareness of child death review processes and incorporates learning in respect of both the Rapid Response Team and the Child Death Overview Panel.

Our performance

Number and format of Panel meetings

Panels were required to operate from April 2008. Arrangements for the establishment of the Bolton, Salford and Wigan Panel were well in hand ahead of this deadline and the Panel began meeting in the first quarter of 2008. It met five times in the year from April 2008 to March 2009, although the normal pattern will be four meetings a year. The independent Panel Chair was appointed in April and took up her responsibilities from the time of the June Panel.

At each meeting, the Panel considers the deaths that have occurred in one quarter of the year. There is a time lag in gathering the necessary information in order to complete reports for presenting to the Panel. As a consequence, the Panel did not look at the deaths occurring in the quarter April – June 2008 until its meeting in September. It used the meeting in June to consider deaths that had occurred in the period January - March 2008 as a means of testing out the arrangements. It did not complete its review of all the deaths occurring in 2008/09 until the meeting in June 2009.

It became clear very quickly that a half-day meeting was insufficient to do justice to the cases for discussion (an average of 25 per meeting) as well as handling other business that inevitably arises as part of the process. This has been particularly so in the early days of establishing the Panel. From November 2008, therefore, the Panel has dealt with business matters relating to the running of the Panel (for example, setting up the information-sharing arrangements) in the morning and re-convened for the case discussions in the afternoon. This format has worked better.

The Panel is fulfilling its responsibilities as set out in Working Together to Safeguard Children but intends to assess its performance against the criteria established by GONW - an action that features in the business plan for the current year.

Attendance at external events

Panel members have attended external events in order to enhance understanding of their role and share experience with members from other Panels. Events include:

- Supporting implementation of the child death and serious case review functions': a North West Regional Seminar arranged by the Department for Children, Schools and Families in October 2008.
- A Child Death Overview Briefing Day organised by the Government Office North West in March 2009.

Regional link with CMACE

CMACE (Centre for Maternal and Child Enquiries) has undertaken the national surveillance of neonatal deaths (deaths of babies up to 28 days) for many years. With the inception of the child death review arrangements, it offered to fulfil the Panel function of gathering and reviewing the information for all children and young people aged from 28 days to less than 18 years. Some LSCBs in the North West opted for this full service in the first year of operation whilst the others chose to gather their own data for children aged 28 days and above and submit them to the CMACE regional office. The result will be a regional analysis of all child deaths occurring in the North West.

The Bolton, Salford and Wigan LSCBs opted for the latter proposal, preferring to begin collecting the information about deaths of children aged 28 days and above in order to build up the Panel's expertise and understanding of the causes of child deaths that occurred locally. The appointment of a full-time administrator has been crucial to this decision as she is the conduit on behalf of the Panel for receiving the notifications of deaths and requesting and gathering the reports thereafter for submission to the Panel.

Equally, the Panel recognises the importance of having data about child deaths across the region for comparison purposes, both locally and nationally. The larger population allows for a more meaningful analysis of the causes of death amongst children and young people that could potentially inform regional developments in addition to local initiatives. The Panel has, therefore, been happy to cooperate in the compilation of regional data.

CMACE continued to collect the data relating to neonatal deaths on behalf of all CDOPs during 2008/09. There have been some difficulties in the quality of the data stemming from the information provided by the relevant agencies. This led to the decision of the Panel to suspend its discussion of these cases for the last two quarters of the year.

CMACE received funding to provide its services in the first year of operation of CDOPs and other arrangements will pertain from April 2009 onwards. It has offered to continue collecting child death data on behalf of Panels or to

provide quarterly and annual reports based on the data collected and submitted by Panels, including data about neonatal deaths. The Bolton, Salford and Wigan Panel has agreed to undertake its own data collection for all child deaths including neonatal deaths but will continue to submit information to the regional CMACE office for the purpose of regional analysis and comparison. This decision will have implications for the data collection process and will require discussion with local neonatologists.

Members of the Bolton, Salford and Wigan CDOP sit on the CEMACE regional steering group and this provides a useful channel of communication as well as ensuring that developments are informed by the local experience.

Financial report

Apart from the staffing costs, the main expenditure thus far has resulted from producing the letter and leaflet for parents and providing training.

At this juncture (end of March 2009), the Panel has not yet considered a full year of child because of the time lag in collating and then analysing the data. As a consequence, there is insufficient information upon which to identify a trend and hence a particular issue on which to recommend or take action. This will be a priority in the next and coming years.

The funding outstanding from this first year is subsumed into the budget for 2009/10 and provides a good sum upon which to plan action, such as a publicity campaign, either at a local or regional level.

Child Death Overview Panel Spend 2008/09

Income		
Bolton Council	41,888.00	
Wigan Council	38,000.00	
Salford Council	37,054.00	
		116,942.00

Expenditure		
Staffing costs	25,418.33	
Management time/Administrator cover	2,500.00	
Bolton training	5,000.00	
Wigan training	5,000.00	
Salford training	5,000.00	
Room hire	608.55	
Petty cash	18.00	
Letterheads/leaflets	692.00	
		44,236.88
Balance remaining		**72,705.12**

Data analysis

The following is an analysis of Child Death Overview Panel data for April 2008 to March 2009 and summarises the data collected on the 100 cases reviewed by the Panel during its first full year of operation. The analysis is limited due to the small numbers and limited time frame. In future years it should be possible to begin to consider trends and to identify issues that may be significant for local policies and service provision. Some of the cases remain 'open' in that the Panel had not received final notification of the cause of death (for example, where the inquest was not concluded) at the point of producing the annual report.

Methodology

The data was collected using the national forms (A and B and B2-B10) as well as standard notification letters, interim death certificates etc from the Coroner's Office. The Panel used its own pro forma (based on national form C) to complete its case analysis of individual cases following discussion at the Panel. Key data items were then extracted and collated into a spreadsheet (developed locally) for analysis. There are a number of data quality issues that limit the analysis, including the extent of missing data for a number of fields: social factors, parenting capacity, and health needs of the child.

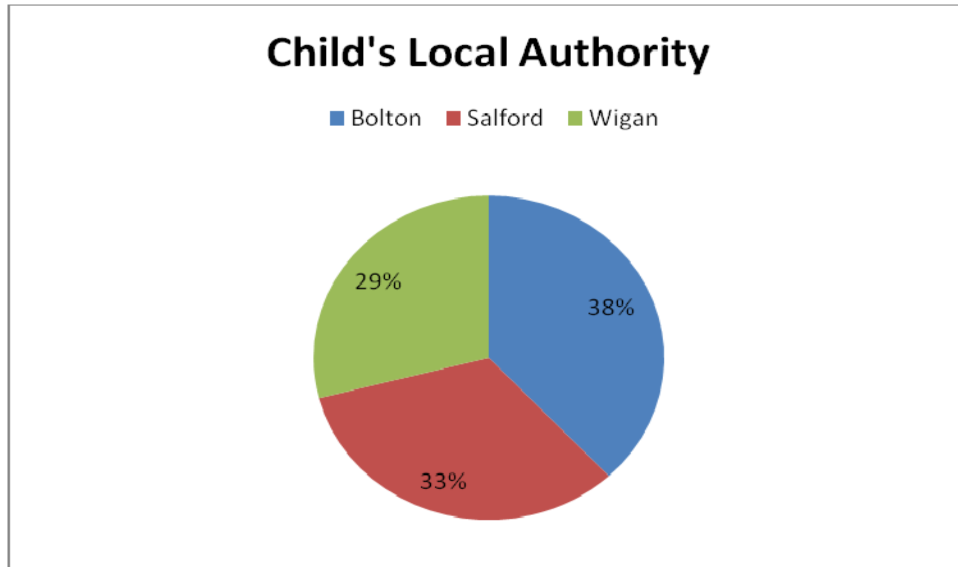
The main items summarised in the analysis include:

- Local Authority
- Status of individual cases
- Gender
- Age at death
- Ethnicity
- Categorisation of death
- Categorisation of preventability of death
- Cases per Panel Meeting

Analysis

Local Authority

Of the 100 cases, 38 were from Bolton, 33 from Salford and 29 from Wigan.



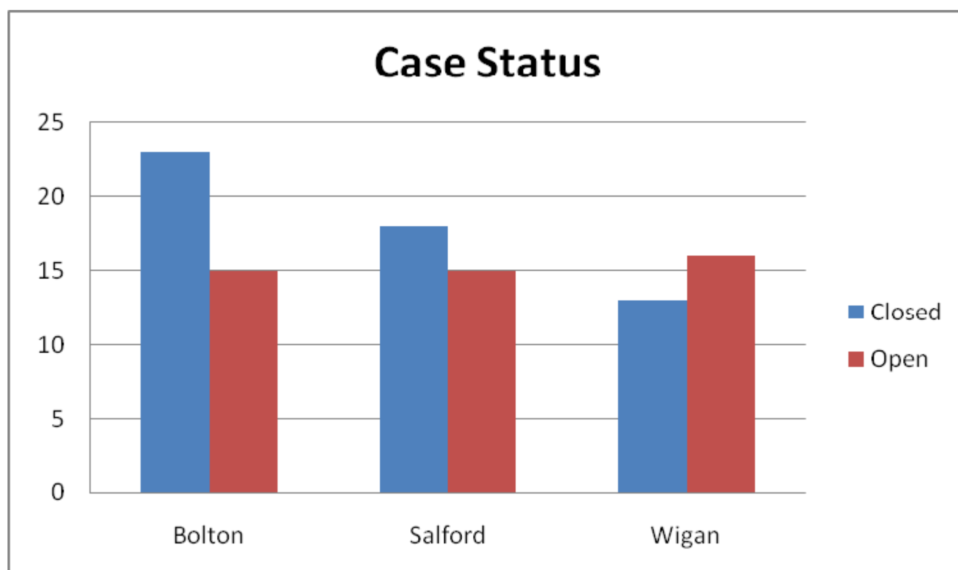
Status of individual cases

By the end of the period 1 April 2008 to 31 March 2009, 54 of the 100 cases had been closed and 46 remained open.

'Closed' cases have a Coroner's decision, in the majority of cases, and have been reviewed and signed off by the Panel.

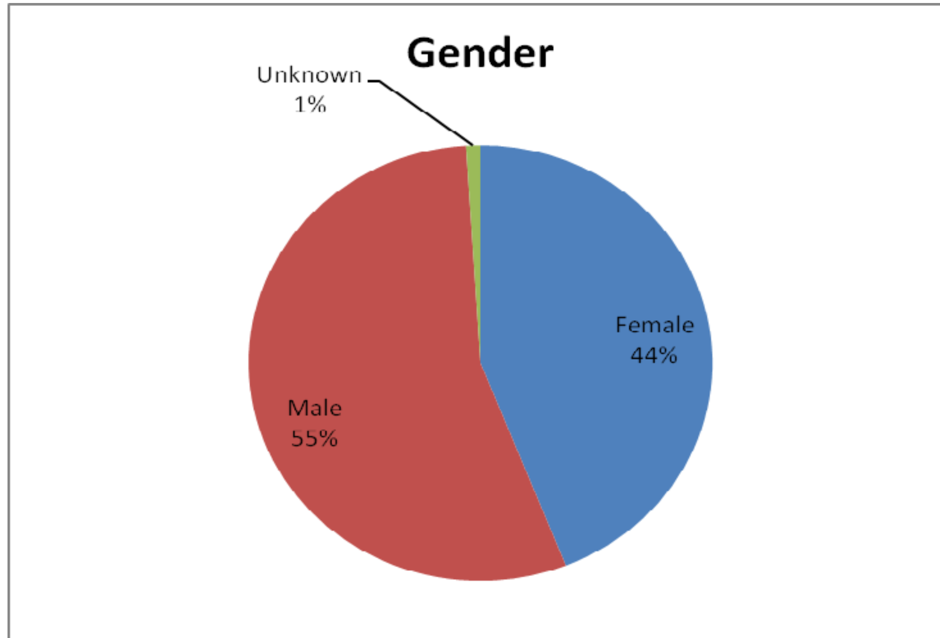
'Open' cases are retained awaiting either a Coroner's decision or further information.

Of the 46 open cases, 28 (61%) were neonatal cases. Early in 2009 a decision was made to suspend the review of neonatal cases due to difficulties with the current method of data collection and pending further discussion about ways to improve this system.



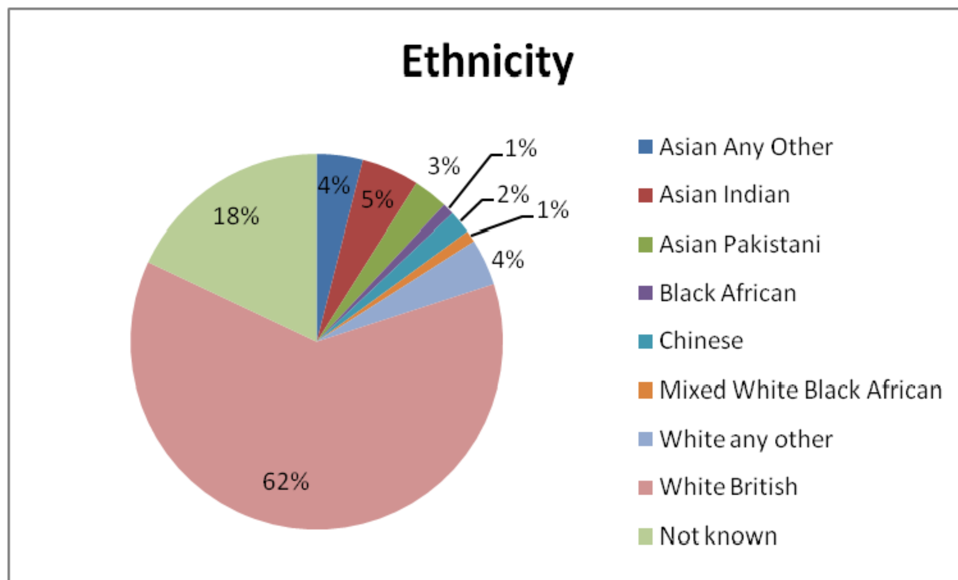
Gender

The gender was given for all but one case. Deaths referred to the Panel in 2008-09 included a higher number of males (55) than females (44).



Ethnicity

The majority of cases considered by the Panel during 2008-2009 were of White British ethnic origin (62%). Almost a fifth of cases (18%) had no record of ethnicity.

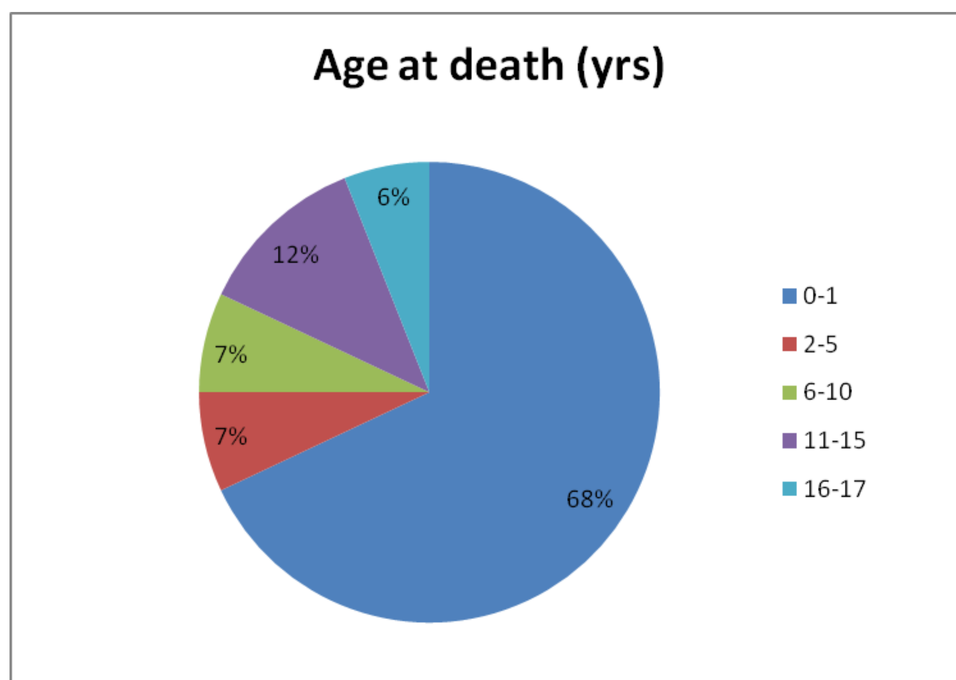


Age at death

The majority of deaths considered by the Panel in 2008 to 2009 were of children aged 0-1 years (68%). Of these, 40 were neonatal deaths and 22 were post-neonatal deaths.

Table 1: Definitions

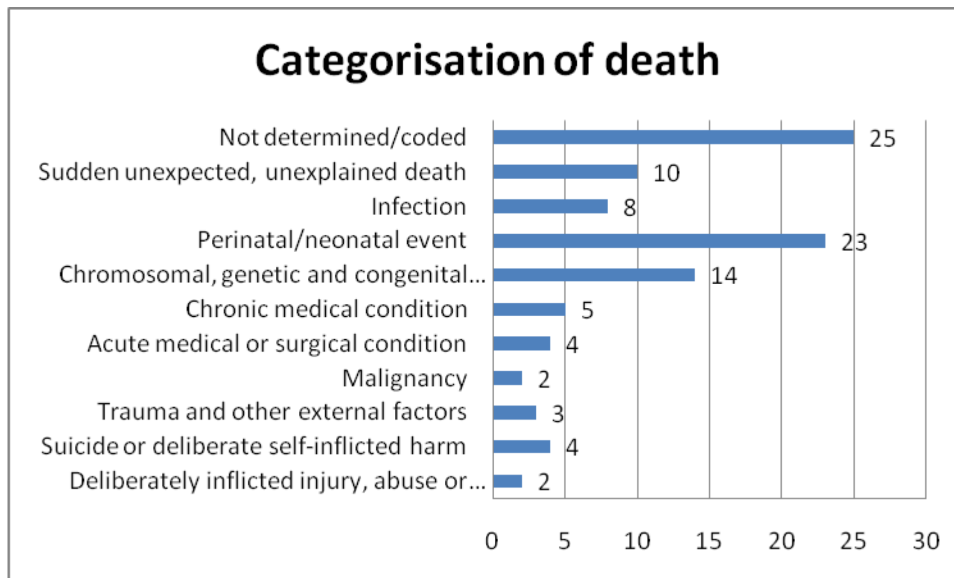
Infant death	Death within the first year of life. Infant deaths are further classified as neonatal and post-neonatal deaths.
Neonatal death	Death of a live born infant within the first 28 days of life.
Post-neonatal death	Death on or after the 28th day of life and before the first birthday.



Categorisation of death

The proformas provide information that allows the Panel to decide the category and sub-category of death (see Appendix 2 for detail).

A quarter of cases had no categorisation of death (25/100). Of these, 9 were open cases and the remaining 16 were neonatal deaths left un-categorised (as noted above).



Categorisation of preventability of death

Cases referred to the Panel were further categorised for preventability (Table 2).

Table 2: Categorisation of preventability of death

Preventable	4
Potentially preventable	11
Not preventable	56
TBC/open	29
Total	100

'Preventable' and 'Potentially Preventable' deaths: further analysis

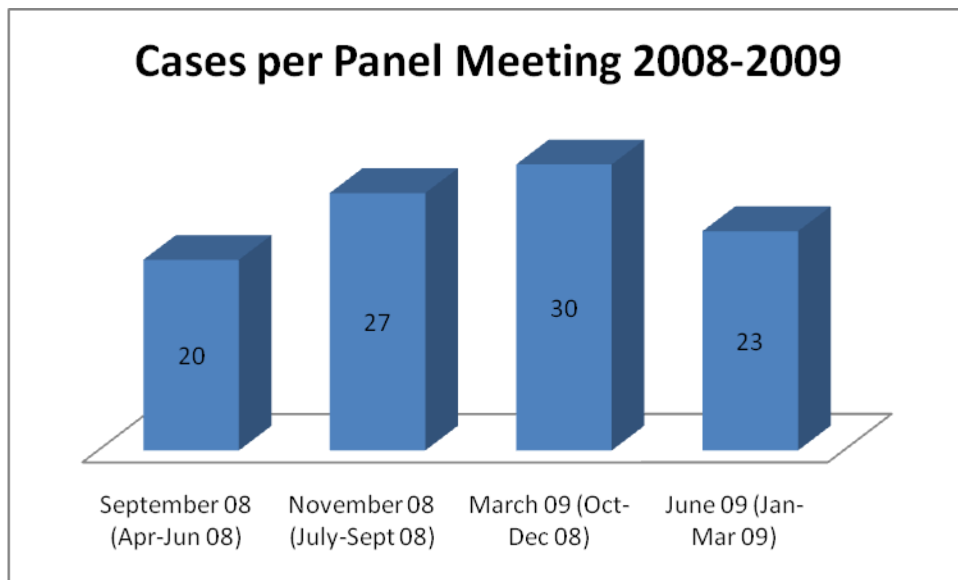
The categorisation of the death as preventable, potentially preventable or not preventable has caused considerable debate within the Panel and was a subject for discussion at the briefing day organised by the Government Office North West in March. Each LSCB was required to submit a return to the DCSF providing the number and brief details about each death designated as preventable. As a consequence, the Panel agreed to hold an additional Panel meeting in order to discuss the matter further and review the cases it had designated as preventable or potentially preventable. The data included in this report (and submitted to the DCSF) reflect the changed decisions made in a small number of cases although the meeting itself took place outside the reporting year. It will be the subject of continuing debate in the coming year and the Panel will compare its decisions with other areas in the region and nationally.

The majority of deaths categorised as ‘preventable’ or ‘potentially preventable’ were of infants aged 0-1 year (9/15). Eight of the 9 deaths aged 0-1 year were categorised as a sudden unexpected and unexplained death for which the cause was unascertained.

The age of death ranged from 16 to 80 days, with an average of 56 days; five babies were male and three female. All the babies categorised as a sudden unexpected unexplained death were of White British ethnicity.

The Panel is wary of entering into any greater detail about the deaths that fall into the preventable or potentially preventable categories as the low numbers mean that the individual cases could potentially be identified. Themes emerging from these deaths are dealt with below.

Cases per Panel Meeting



Note on completeness of data

Date of birth, gender, date of death, age at death and cause of death data was complete in the majority of cases. Other fields had a higher proportion of missing data, as indicated in the table below. This limits the analysis in relation to several features, particularly ethnicity, age of the parents and the history of parents, including substance misuse, smoking, mental health and domestic violence. However, it is not clear from the forms submitted whether the person completing the form had failed to include relevant information or whether the category did not apply (for example, there were no mental health problems). This indicates that the form requires revision in order to clarify the position.

Data completion

Data item	% completed
Child protection plan	83%
Child in need	83%
Ethnicity	82%
Age of mother	59%
History of mother (Substance misuse, mental health issues, post natal depression, smoking, domestic violence, learning disability).	21%

Emerging themes

Suicides

It is too early to report emerging trends on the basis of the data. However, there are a number of themes that can be highlighted at this stage. Four young people aged between 11 and 17 years committed suicide by hanging and these cases were the cause of considerable concern to the Panel. In one instance, the action taken occurred almost spontaneously with no previous indication of a problem. In the other cases, there were indications of earlier concerns. This is not to say that the death could have been predicted and potentially prevented but it draws attention to the vulnerability of young people and the nature of the services available to support them. The Panel will be pursuing this particular aspect further with a view to making recommendations about service provision.

Co-sleeping

There were five cases where young children who died had been sleeping with their parent or parents, usually in their bed and sometimes on a sofa. These cases fell into the category of sudden unexpected deaths where the cause of death was unascertained. Whilst there is no established causal connection between the fact of co-sleeping and the death (for which no cause has been found), co-sleeping is seen as a potential causal factor in such cases. The

Panel will, therefore, be considering this aspect further with a view to making recommendations and possibly running a publicity campaign to advise parents of the potential dangers of co-sleeping.

Conclusion

The incompleteness of the data as noted above, taken with the relatively small numbers of cases considered, limits the conclusions that can be drawn at this stage. It also does not allow for meaningful comparison with regional and national data, which have similar limitations. The Panel will focus upon achieving improved data collection over the next two years in order to allow for more effective analysis and conclusions to be made.

The attached Business Plan sets out an ambitious programme of work for the next two years. It includes holding an 'away day' to enable the Panel to review its operation over its first 18 months and look at how it can improve its functioning. In particular, we shall be looking at whether there is more we should be doing to communicate with the parents of children and young people who have died, and clarifying how we relate to the Rapid Response Team. We want also to review the way in which staff are supported in undertaking work with bereaved parents, including considering the effect upon themselves. Finally, we are concerned to learn from other Panels about how they undertake their responsibilities and see potential for cooperation across Greater Manchester and the North West region.

APPENDIX 1

BOLTON, SALFORD AND WIGAN CDOP MEMBERSHIP

Organisation	Name	Deputy	Designation
Chair	Pamela Shelton		Independent Chair
		Kate Rose	Head of Safeguarding, Children's Services, Salford
Public Health	Paul Turner		Public Health Consultant, Ashton, Leigh and Wigan PCT
		Nicki Lomax	Public Health Speciality Registrar, Bolton PCT
Children's Services	Jane Booth		Head of Service, Child Protection and Leaving Care, Children's Services, Bolton
		Shona Green	Safeguarding Board Officer, Bolton Safeguarding Children Board
	Kate Rose		Head of Safeguarding, Children's Services, Salford
		Chris Broadbent	Principal Manger, Child Protection, Children's Services, Salford
	Sean Atkinson		Head of Service, Children and Young People's Service, Wigan
		Kath Vereycken	Acting Group Manager, Independent Reviewing Service, Children and Young People's Services, Wigan
Police	Phil Owen		Detective Superintendent, Lead Vulnerable Persons, Local Policing Improvement Branch, GMP
		Dave Riddick (1st)	Detective Chief Inspector, Safeguarding Vulnerable Persons Unit, Local Policing Improvement Branch, GMP
		Nick Howarth(2nd)	Detective Inspector, Safeguarding Vulnerable Persons Unit, Local Policing Improvement Branch, GMP
Legal	Lorraine Ashton		Principal Solicitor, Children's Services, Salford
		Ceri Owen	Senior Lawyer, Legal Services, Bolton Council
Designated Dr.	Hilary Smith		Consultant Paediatrician, Designated Doctor, Salford PCT
		Gabi Lipshen	Consultant Community Paediatrician, NHS Bolton
Designated Nurse	Pam Jones		Designated Nurse Safeguarding, Bolton PCT
		To be confirmed	
Adult Mental Health & Substance Misuse Services	Marie Boles		Named Nurse, GM West Mental Health NHS Foundation Trust
		None	
Neonatal Services	Simon Power		Consultant Paediatrician, Royal Bolton Hospital
		Jonathan Moise	Consultant Paediatrician, Salford Royal NHS Foundation Trust
Named Nurse	Susan Holland		Divisional Nurse, Royal Bolton Hospital (Named Nurse)
Senior Nurse Safeguarding		Jackie Brennan	Senior Nurse Safeguarding, Royal Bolton Hospital

APPENDIX 2

CATEGORIES OF DEATH

Category 1: **Deliberately inflicted injury, abuse or neglect**

- Suffocation ☐
- Shaking Injury ☐
- Knifing ☐
- Shooting ☐
- Poisoning ☐
- Severe neglect ☐
- Other ☐ Specify:

Category 2: **Suicide or deliberate self-inflicted harm**

- Hanging ☐
- Shooting ☐
- Poisoning (paracetamol) ☐
- Self-Asphyxia ☐
- Solvent Inhalation ☐
- Alcohol Abuse ☐
- Drug Abuse ☐
- Other ☐ Specify:

Category 3: **Trauma and Other External Factors**

- Isolated Head Injury ☐
- Multiple Trauma ☐
- Burn Injury ☐
- Drowning ☐
- Unintentional Self-Poisoning ☐
- Anaphylaxis & other Extrinsic factors ☐

Category 4: **Malignancy**

- Solid Tumours ☐
- Leukaemias & Lymphomas ☐
- Histiocytosis ☐
- Infection ☐
- Haemorrhage ☐

Category 5: **Acute Medical or Surgical Condition**

- Kawasaki Disease ☐
- Acute Nephritis ☐
- Intestinal Volvulus ☐
- Diabetic Ketoacidosis ☐
- Acute Asthma ☐
- Intussusception ☐
- Appendicitis ☐
- Epilepsy ☐

Category 6: **Chronic Medical Condition**

- Crohn's Disease ☐
- Liver Disease ☐
- Neurodegenerative Disease ☐
- Immune Deficiencies ☐
- Cystic Fibrosis ☐
- Infection ☐
- Haemorrhage ☐
- Other ☐ Specify:

Category 7: **Chromosomal, genetic and congenital anomalies**

- Trisomies ☐
- Chromosomal Disorders ☐
- Single gene defects ☐
- Cardiac ☐
- Other ☐ Specify:

Category 8: **Perinatal / Neonatal Event**

It includes cerebral palsy without evidence of cause, includes congenital or early-onset bacterial infection (onset in the first postnatal week)

- Sequelae of Prematurity ☐
- Antepartum & Intrapartum anoxia ☐
- Bronchopulmonary Dysplasia ☐
- Post-haemorrhagic ☐
- Hydrocephalus ☐

Category 9: **Infection**

Any primary infection, not a complication of one of the above categories, arising after the first postnatal week, or after discharge of a preterm baby

- Septicaemia ☐
- Pneumonia ☐
- Meningitis ☐
- HIV infection ☐

Category 10: **Sudden unexpected, unexplained Death**

Excludes Sudden Unexpected Death in Epilepsy (category 5)

- SIDS ☐
- Unascertained ☐

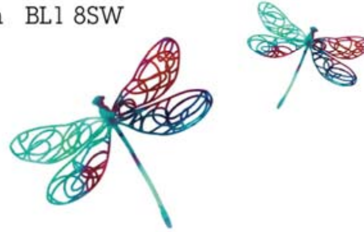
APPENDIX 3

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

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

Large print, interpretations, text only and audio formats of this publication can be produced on request. Please call **01204 337459** or email **boltonsafeguardingchildren@bolton.gov.uk**

Business Plan 2009-2011

Ensure effective operation of the Panel	1. Hold ‘away day’ to review current functioning 2. Check performance against GONW assessment criteria 3. Agree amendments as appropriate and implement changes 4. Amend operational document in line with changes
Make effective use of the data on child deaths	1. Review data collection process, in particular under and over-supply of information 2. Review link with CMACE under new contract 3. Develop means to gather necessary information on neonatal deaths to allow effective analysis of cases 4. Review our performance against national and regional data 5. Explore implications of emerging themes for local services and make recommendations as appropriate to LSCBs 6. Attend workshop at Warwick University to assist in process of data analysis
Evaluate the work of the Rapid Response Team in child deaths occurring in Bolton, Salford and Wigan	1. Clarify responsibility for overseeing and evaluating the work of the team, initially by inviting Dr Lizzie Dierckx to attend a Panel meeting

Review the relationship with the parents of children who die	1. Watch GMC presentation re parental consent and consider the implications for the work of the Panel 2. Review the arrangement for communicating with and involving parents in the work of the Panel 3. Liaise with GONW and other CDOPs to learn how they are handling this issue 4. Explore the implications of the Freedom of Information legislation
Ensure appropriate support to staff in undertaking work in relation to child deaths	1. Evaluate the current training programme including taking account of the comments of attendees 2. Plan a new training programme building on the experience of year 1 3. Implement the e-learning programme and plan its review on a regular basis
Ensure efficient use of the resources available to the Panel	1. Review the expenditure for 2008/09 2. Plan expenditure for 2009/10
Maintain relationships with other Panels and agencies in the region to enhance learning and provide mutual support	1. Seek advice from other Panels and GONW as appropriate 2. Participate in regional events 3. Maintain representation on the GM Safeguarding Partnership