### Bury Health and Wellbeing Board

| Report Title                           | Child Death Overview Panels and 2018 Annual Report |  |          |
|--|--|--|----------|
| Meeting Date                           |  |  |          |
| Contact Officer                        | Wendy Meston , Rochdale Council                    |  |          |
| HWB Lead                               | Lesley Jones                                       |  |          |
| 1. Executive Summary                   |  |  |          |
| Is this report for                     | ? Information                                      | Discussion<br>x  | Decision |
| Purpose of report:                     |  |  |          |
|  |  | To inform the Board of the findings of the 2018 CDOP Annual Report |          |
| Key Actions:                           |  | To note the report and consider the                                |          |
|  |  | recommendations and any further action for the Locality            |          |
| What requirement is there for internal |  | To share the report with the Local                                 |          |
| or external communication?             |  | Safeguarding Board   |          |
| Assurance and tracking process:        |  | The report has been considered by the                              |          |
|  |  | Greater Manchester CDOP group                                      |          |

# 2. Introduction / Background

The Bury, Rochdale and Oldham (BRO) CDOP has been set up by Child Death Review (CDR) Partners, the Bury, Oldham and Heywood, Middleton, Rochdale CCG's and Bury, Oldham and Rochdale Council's to review the deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018. The tripartite approach covers a population of 641,846. The sector operates within a Greater Manchester (GM) framework for CDOP which includes the production of a GM CDOP Report and development of agreed standards and processes across GM.

### **Purpose**

The purpose of the BRO CDOP is to undertake a review of all child deaths up to the age of 18 years, normally resident in Bury, Oldham and Rochdale/HMR, irrespective of the place of their death. The BRO CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018:

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The three Councils and the three CCGs have agreed operational arrangements with partners based on the existing model that we have had for some years across Greater Manchester.

## 3. key issues for the Board to Consider

The Health and Wellbeing Board are asked to note the Child Death Overview Panel Statutory Responsibility and the changes to governance and the transfer of accountability for the Child Death Review Panel reports moving in line with national guidance from Safeguarding Boards to the Health and Wellbeing Boards in Bury, Rochdale and Oldham. The current working arrangements are attached in Appendix 1

The most recent Annual Report (Appendix 2) takes data from the four CDOP panels that cover GM to make observations about causes and modifiable factors in order to inform action to promote child safety and reduce child deaths in GM and the Board are asked to note the report and consider the recommendations

#### 4. Recommendations for action

- That the Health and Wellbeing Board note their responsibility and schedule future Annual reports to be presented to the Board
- That the Board note that arrangements have been put into place to discharge our statutory responsibilities and that this will be subject to further development in 2019/20.
- That the Board seek assurances that plans are in place to address
  potential modifiable factors including smoking in pregnancy, obesity, drug
  and alcohol misuse, domestic abuse, safe sleeping, and consanguinity.
- That the Board seek assurances that suicide prevention plans are in place in line with the Greater Manchester Suicide Prevention Strategy
- That the Board seek assurances that good quality services are in place to support families and others affected following the death of a child or young person

# 5. Financial and legal implications.

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

**CONTACT DETAILS:** 

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