care by the Local Authority their Initial Health Assessments (IHA) are completed in a timely way. This is closely monitored as CIC are already at their most vulnerable and all must be done to ensure their health and development is not further impaired. All late IHA requests are escalated & there is a clear process in place to address delays in health assessments. There is regular monthly monitoring of performance on the SAF & all out of area placements are included to ensure they have the same timeliness & quality of care. There is a quality assurance process to ensure children's health plans are reflective of their complex needs. Feedback from the child/young person is sought (Rate My Health Assessment) so the voice of the child is central and a health data form completed to monitor service provision locally for this vulnerable group.

11.5 Child Death Overview panel (CDOP): Update from Rajiv Mittal CoCH

The Pan Cheshire CDOP is a subgroup of the Local Safeguarding Children Board (LSCB), and has a statutory responsibility to review all infant/child deaths 0-18 years who reside in Cheshire, regardless of where the death took place. It also includes perinatal and neonatal deaths which were registered as a live birth.

CDOP representatives are drawn from key multi-agency organisations. Others may be co-opted to contribute to the discussion if appropriate, i.e., neonatologists, microbiologists etc. There are 2 inter-related processes (either of which can trigger a criminal investigation, safeguarding or /and Serious Case Review)

- **Rapid Response :** a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child also called as SUDIC (Sudden Unexpected Death In Infant or Child)
- **CDOP panel meeting** – A comprehensive review of all Child Deaths Expected & Unexpected (0-18 yrs.) and has the ultimate aim to prevent potentially avoidable deaths in the future.

COCH Neonatal Unit Investigation

There were a cluster of neonatal deaths identified between June 2015 and June 2016 at the Countess of Chester Hospital which are being investigated by the Cheshire Police. As a result of this inquiry, some changes have been made to the Pan Cheshire CDOP process called SUDIC protocol. The new protocol will be applicable to any baby who dies in neonatal unit or unexpected collapse in the neonatal unit or any neonatal death > 24 weeks gestation for the next 6 months (till 2017 end). It has also been identified the importance of understanding the CDOP process within North Wales and in maintaining effective communication with colleagues across the border.

The CoCH is represented on the Child Death Overview Panel by the Designated Dr for Safeguarding Children who is informed about all child deaths at the CoCH and all child deaths will be reviewed by the CDOP. Following the "Wood Review 2016", and as only 4% of child deaths relate to safeguarding, the Government has agreed to the transfer of national oversight of CDOPs from the Department for Education to the Department of Health, whilst maintaining the focus on learning in relation to safeguarding children issues if they arise in any child death. There are no open actions in relation to CDOP reviews at the CoCH at present.