	audience and therefore we need to allocate attendees to tables to ensure we have a spread of professional representation at each table. It was agreed that a further task & finish group meeting needed to be arranged to ensure that the event runs smoothly on the day.		
	Action: A task & finish group to be set up and a meeting arranged for the 5th April 2017 at Westfield's	Anne McKenzie	Meeting has been arranged
5.	**COSH Neo natal review**		
	DISCUSSION: The Countess of Chester has carried out a review of the neo natal department following a cluster of deaths over a sixteen month period. The meeting discussed in depth the deaths, the geographical area the children lived in and the CDOP process and what could be done within the CDOP process to ensure that trends can be or should be identified by the Pan Cheshire panel. The children who were included in the review were not all Cheshire children and would be subject to review at other CDOP panels. The systems currently in place for reporting child deaths are not constructed to record the death of a child who resides in another CDOP area. Due to the sixteen month period that was reviewed it would be difficult for the panel to notice a trend as the individual cases would come to panel at different time. It was agreed by members that we are reliant on the quality of the recording of information by professionals within the Form B's when reviewing a case. Gill Frame asked the panel if the CDOP process could be improved. It was suggested that the Form A could be amended to record place of residence as well as place of death and this will be collated and reported to panel on a half yearly basis. A letter will be sent from the Chair to hospitals requesting that all perinatal mortality reports are provided to the CDOP panel. The learning event will be used to enforce the quality of the reporting from professionals we require on the Form B's and the part that all professionals have in ensuring that we have the greatest amount of data to make an informed decision to close a case following the death of any child. GF suggested that the panel should invite Ian Harvey to the CDOP panel meeting to discuss the report and this was agreed as an action for the next meeting. The panel discussed SUDI deaths within hospital and whether it was felt that deaths are not always treated with the same concern. It was agreed that a discussion between professionals should always occur and if there was a concern over the death the SUDI protocol should be followed. The panel is aware that on a number of occasions the rapid response process is not followed. GF suggested that the SUDI process for hospital deaths should be identified within the guidelines. GF asked the Chair to write to Alison Kelly outlining the recommendations the panel have made and confirm that the panel would not have had oversight of the death and an update to be added to the Chairs report		
	Action: The place of residence to be recorded and reported bi-annually to the panel	Anne McKenzie	
	Action: A letter to be sent to Hospitals requesting the perinatal reports are provide to CDOP	Hayley Frame	
	Action: The Learning Event to discuss the quality of the information on Form B's	Hayley Frame	
	Action: Ian Harvey to be invited to the CDOP panel meeting on the 23rd June	Hayley Frame/Anne McKenzie	