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Pan Cheshire Child Death Overview Panel Meeting
Date: 16th September 2016
Time: 9.30 – 1.30pm
Venue: Room R1 & R2 Westfields, Middlewich Road, Sandbach

Attendance Log			Meetings 2015 - 2016						
			25/09/2015	11/12/2015	29/01/2016	26/02/2016	06/05/2016	15/07/2016	16/09/2016
Chair	Hayley Frame	Independent CDOP Chair	✓	✓	✓	A	✓	✓	R
Health	Dr A Thirumurugan	Designated Doctor	✓	✓	✓	A	✓	✓	A
	Dr R Mittal	Designated Doctor	✓	✓	✓	A	✓	✓	✓
	Dr N Mir	Designated Doctor	✓	✓	✓	✓	✓	A	A
	Janice Bleasdale	Cheshire East Specialist CDOP Nurse	✓	✓	✓	✓	✓	✓	✓
	Sharon Dodd	Cheshire West Specialist CDOP Nurse	✓	✓	✓	✓	✓	✓	A
	Pauline Owens	Warrington Designated Nurse Safeguarding	✓	✓	✓	A	✓	✓	A
	Esther Golby	Halton Designated Nurse	A	A	D	A			
	Ann Dunne	Designated Nurse Halton CCG (Representing Esther Golby)					✓	✓	✓
	Catherine Sales	Supervisor of Midwives CWAC					✓	A	A
	Karen Brown	Warrington Safeguarding Nurse		A	✓	✓	A	✓	✓
Local Authority	Lucy Heath	Public Health Consultant	✓	✓	✓	✓	✓	✓	R
	Kate Rose	Cheshire East Head of Service – Children's Safeguarding	✓	✓	✓	A	A	✓	R
	Nicola Avery	LSCB Business Manager for Warrington Borough Council (retired)	✓						
	Mark Tasker	LSCB Business Manager for Warrington Borough Council		✓	✓	✓	✓	✓	
	Rosie Lyden	Safeguarding Adults and Children Board Manager						✓	✓
Police	Nigel Wenham	Detective Superintendent, Public Protection Unit	✓	✓	A	A	✓	A	R
	Serena Kennedy	Detective Chief Superintendent Public Protection Unit	✓	R	✓	A	A		
	Paul Broadhurst	Detective Superintendent				R		✓	A
Note Taker	Anne McKenzie	CDOP Business Support	✓	✓	✓	✓	✓	✓	✓

✓ = Attended
R = Designated Rep
D = Did Not Send Apologies
A = Apologies

Dr R Mittal	Chair (Representing Hayley Frame)

Also in attendance:

Paul Hughes	Detective Superintendent, Public Protection Unit (Representing Nigel Wenham)
Guy Hayhurst	Cheshire East Public Health (Representing Lucy Heath)
Janice Kirkham	CP Chair (Representing Kate Rose)
Christine Hurst	Cheshire Coroner Office

No	NOTES/ACTION LOG UPDATE	OWNER	DEADLINE
1	**ENDORSEMENT –** The group endorsed the notes from the last meeting as an accurate record. **SCRUTINY –** The group scrutinised and challenged progress on actions. Updates to the action log were noted and completed accordingly.		
	Action: A reminder to be given by the Police to the FME contactors who attend SUDIC deaths that a Form A must be completed at all times	Paul Hughes	
2	Annual Report		
	INFORMATION: The annual report was not discussed due to a number of apologies received from the Chair and panel members		
3	Review of Children Cases		
	DECISION: The panel reviewed a number of cases		
	Action: Case deferred: **I&S** Request the coroner to provide a report on the child, once received the case will be returned to panel for consideration	Coroner/Anne McKenzie	
	Action: Closed Case **Child I** Childs details to be sent to coroner for review of case notes, the child case to be referred to once the Royal College report is presented by Dr Mital	Dr Mital	
	Action: Item to be added to the November meeting asking if the panel consider that unexpected deaths in Hospital should be referred for RR meetings	Anne McKenzie	
	Action: Closed **I&S** The CCG to be contacted to ensure that the RCA report for the child has been signed off as the true record, the learning point to be added to the Form C and at November panel confirmation that the actions have been completed	Anne McKenzie	
	Action: Closed Case No: 1 **I&S** the conclusion in the inquest report to be added to the Form C	Anne McKenzie	
	Action: The hospitals to be questions on: Is there a back up plan if transport fails to arrive or is delayed and do they have figure currently highlighting any issues with transportation between hospitals	Anne McKenzie	
	Action: : Item to be added to the November meeting could the terms of reference be reviewed to ensure that it reflects how	All	

Case No: Child I

Cause of Death: Hypoxic ischemic damage of brain & chronic lung disease of prematurity, extreme prematurity

ANALYSIS SCORES		
	Intrinsic to child	3
	In family and environment I&S	2
	In parenting capacity	1
DOMAINS	In service provision	1
CATEGORY	***8. Perinatal/neonatal event***	
PREVENTABILITY	Modifiable factors identified	

Summary of Discussion: This child's death is subject to a review at COCH by the Royal College and therefore should be referred to when the report from the Royal College is received I&S I&S. There was some discussion by the panel on whether a RRM should be carried out when there is an unexpected death in hospital. The officer for the coroner will review the report on our behalf. After the discussion the panel felt that the case could be closed.

Actions: Childs details to be sent to coroner for review of case notes, item for next panel meeting to discuss if unexpected deaths in hospital should be considered for a RR meeting, the child to be referred to once the Royal College report is presented by Dr Mittal

Form C completed – Case closed (unexpected)

Case No: I&S

Cause of Death: Prematurity with sepsis, maternal rupture of membranes with chorioamnionitis

ANALYSIS SCORES		
	Intrinsic to child	3
	In family and environment	2
	In parenting capacity	1
DOMAINS	In service provision	1
CATEGORY	***8. Perinatal/neonatal event***	
PREVENTABILITY	Modifiable factors identified	

I&S