4.4.19 There is currently no nationally-agreed template or guidance on conducting perinatal mortality and morbidity reviews in obstetrics and neonatology The perinatal mortality tool being produced by the RCOG `Each Baby Counts` programme[12] and ongoing findings from the MBRRACE[13] programme may assist.

Safeguarding arrangements.

4.4.20 The Board lead is the Director of Nursing who chairs the bi-monthly Safeguarding Strategy Board. The Named nurse and Doctor attend the LSCB and the Named Doctor is also the Designated Doctor for child deaths and attends the Child Death Overview Panel. The locality was reported to have a high level of Domestic Abuse and substance misuse.

4.4.21 The Review team was impressed by the processes and links made by the Link Health Visitor, who ensures engagement of families and supports professionals in health and social care to work effectively together.

Child death process.

4.4.22 When an unexpected paediatric death occurs the paediatrician on call contacts the senior investigating officer on site. For neonates the Designated Doctor for Unexpected Child Death is notified directly and he is responsible for advising the Pan Cheshire Child Death Overview Panel (CDOP) administration of all deaths, whether expected or unexpected. There is no automatic rapid response home visit but this is considered, and a meeting to determine next steps is organised within 24 hours.

4.4.23. For the cluster of 13-14 deaths (1 excluded) being considered in this review, not all has been reported to the Pan-Cheshire CDOP, as some were resident in Wales and therefore reported to the Welsh authorities.

4.4.24 The CDOP meets quarterly and has a remit is around learning inter-professional lessons rather than individual case investigation of internal management. The Form B submissions were reported to be very robust, and where possible the CDOP will enlist specialist advice,

4.4.25 The RCPCH Review team was concerned that the CDOP did not appear to be alert to the cluster of neonatal deaths, and for at least some there should have been a Rapid Response Meeting within 5 working days of notification. If the cause of death is not clear than no death certificate can be written and the case must be referred to the coroner. Some CDOPs ask for a copy of the report from M&Ms via the Clinical Risk/Governance team to feed into their panel meetings

Recommendation: The CDOP should consider whether its processes could have detected the cluster of deaths and initiated external review more swiftly

[12] see www.RCOG.org.uk/eachbabycounts
[13] https://www.npeu.ox.ac.uk/mbrrace-uk