Matthew Downey

Datix Admin & Management Form

PD

Name and reference

Current approval status	Finally approved
ID	PD
Name	Child A
Ref	PD
Reported Date (dd/MM/yyyy)	09/06/2015
Opened date (dd/MM/yyyy)	10/06/2015
Submitted time (hh:mm)	11:26
Handler	Kenny, Miss Siobhan
Manager	Peacock, Debbie

Location

Division	Urgent Care
Specialty	Neonatology
Location (exact)	Neonatal Unit

Coding

Type	Clinical Incident
Category	Neonatal Unit (Pick List)
Sub Category	Expected and unexpected death
Is this a Safeguarding concern?	
Did this incident occur as a direct result of staffing levels?	No

Risk Grading

Result	No Harm
Actual Harm	None (no harm caused)
Potential for Harm	High Potential Harm

Details

Incident date (dd/MM/yyyy)	08/06/2015
Time (hh:mm)	20:58
Description	Sudden and unexpected deterioration and death of a patient on the Neonatal Unit after full resuscition. Requiring post mortem.
Action taken	see medical notes for details
Notify	Neonatal Incident Review Group Obs Secondary Review

SBAR

Situation	An incident has been submitted regarding the unexpected death of a twin baby at PD day of age.
Background	Mum [I&S] had been under the management of Cons Obstetrician [JD] during her pregnancy, with monitoring and involvement of other specialities at COCH and in other centres due to Irrelevant & Sensitive Mum was admitted for monitoring on 25/05/15. On PD/06/15, Mum experienced raised BP requiring magnesium infusion and emergency c/s at 31+2/40. Twin 1 was transferred to NNU at 20:47 hours on PD/06/15. Twin 1 went onto rapidly deteriorate at approx. 20:00 on 08/06/15 requiring full resuscitation but died at 20:58 hours despite efforts. Cons Paediatrician [MD] has referred the death to HM Coroner and the initial findings of the PM at Alder Hey [on 10/06/15] has not identified any significant pathology.
Assessment	The mother's background of I&S makes this a complex case; however the initial review demonstrates a clear management plan, close monitoring and the involvement of other specialities. At present, there is no explanation for sudden cardio respiratory arrest. Twin 1 was stable until then, receiving the usual type of support in keeping with his prematurity i.e. on CPAP and receiving IV fluids and antibiotics. The initial PM findings did not give any answers, however we are awaiting results of pathology slide examination. However, if it was due to an cardiac arrhythmia, then this would not show on this examination.
Immediate Action taken following incident	
Any immediate lessons learnt	
Recommendation	SBAR to be forwarded to the SI panel for review and to determine the level of investigation required. OSR requested by Cons [JD] and the case will be reviewed in the perinatal M&M meeting on 24/06/15.
Family Awareness of Incident	Parents are aware of the PM findings and that further pathology is outstanding at this time. Family are being supported by the Trust as Twin 2 remains in NNU.
SBAR Date	12/06/2015
SBAR: By Name	Ruth Millward
SBAR: Presented To	SI Panel

SI Panel Meeting

Incident Review Panel	Yes
SI Panel Date of Meeting	02/07/2015
SI Panel Attendees	☐ Mr Ian Harvey - Medical Director ☐ David Semple - Associate Medical Director, Quality & Safety ☑ Alison Kelly - Director of Nursing & Quality ☐ Julie Fogarty - Associate Director of Risk & Safety ☐ Melanie Kynaston - Associate Director of Nursing, Corporate ☐ Sarah Harper-Lea - Head of Legal Services ☐ Matthew Downey - Compliance Manager

SBAR Available	Yes
Meeting Discussion Points	Steve Brearey, Julie Fogarty and Debbie Peacock also present Paed M&M review by SB: Mum- I&S , 31 week twin baby - bradycardic at birth, on NNU, UVC inserted, peripheral long line inserted, baby deteriorated/respiratory arrested, initially thought possibly linked to line therefore UVC length amended however but baby went onto have cardiac arrest PM expedited = nil identified on macroscopic PM, UVC in liver with no thrombus evident, no perforation evident Twin 2 had similar difficulties, now recovered and ready for home OSR review by JMc and JF: Complex case with external support from UCH London re I&S delivered at 31 weeks due to worsening pre-eclampsia Family support and understanding of incident: SB discussed with Mum 01/07/15 Aware a/w PM findings [finalised] May be related to maternal disease [I&S] Debrief with staff being arranged OH input provided
Level of Investigation	M&M
Name of Investigating Officer	Debbie Peacock
Report on STEIS	No

SI Tracker

Incident Lead	Janet McMahon
Level of Investigation	M and M
Title	Baby born in poor condition
Incident Status	SBAR Completed
Is this a Never Event?	No
Is This a Near Miss Never Event?	No
Has this incident been reported to STEIS?	No
Lead Investigator	
Patient Nationality	I&S
Date Report Completed	10/08/2015
All Actions Complete and Incident Closed?	Yes

CCG Serious Incident Review Group

The Group's remit is to determine:

1. If the incident has been adequately investigated
2. If the root causes and contributory factors have been identified
3. If the recommendations and action plan adequately address the root causes and contributory factors
4. If any theme can be identified with previous Serious Incidents
5. If the action plan has been completed in a timely manner
6. If there are any concerns that need escalating to Quality & Performance or Clinical Leads.