Matthew Downey

Datix

Datix Admin & Management Form

PD

Name and reference

Current approval status	Finally approved
ID	PD
Name	Child C
Ref	PD
Reported Date (dd/MM/yyyy)	14/06/2015
Opened date (dd/MM/yyyy)	15/06/2015
Submitted time (hh:mm)	19:00
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	Low Potential Harm

Details

Incident date (dd/MM/yyyy)	14/06/2015
Time (hh:mm)	05:53
Description	Sudden deterioration of an infant following full resusciatation.
Action taken	Parents nursing and medical team all present. Hospital coordinator aware.
Notify	Neonatal Incident Review Group Obs Secondary Review
Report to NRLS?	Yes

RIDDOR?	No
Last updated	Mr Dean Bennett 06/12/2016 00:00:00

Duty of Candour - Reporter Disclosure

Was a patient involved in this incident?

Incident Investigation
Please use this field to document ALL updates in relation to the investigation.

No progress notes.

Patient Details

	ID	Forenames	Surname	Email	Job Title	CC Number	NHS No.	Date of birth	Type
▶	I&S	Child C				Child C	PD	PD 06/2015	Patient

Employees Involved

	Approval status	Title	Forenames	Surname	Type	Status	Contact role
▶	Approved	MRS	AMY	USHER	Midwife		Employee
▶	Approved	M/W	Rosalind	Harris	Midwife		Employee
▶	Approved	Mr	David	Semple	Consultant		Employee
▶	Approved		Lauren	Whitham	Employee		Employee
▶	Approved	Dr	Victoria	Finney	Consultant		Employee
▶	Approved	Dr	Lorraine	Dinardo	Consultant		Employee
▶	Approved	Mr	Jim	McCormack	Employee		Employee

Incident Reporter

	Approval status	Title	Forenames	Surname	Type	Status	Contact role
▶	Approved		Yvonne	Griffiths	Employee		Reporter

Linked Records

Linked claims (1)

ID	Handler	Name	Opened date	Description	Link Notes	
I&S	Chloe Delbarre	Child C	29/06/2017	Potential claim - neonatal. The patient was born prematurely and was half the weight of babies his gestational age. He was given his first milk feed nasogastrically at PD days old. Shortly after this feed the patient collapsed: oxygen		

				saturates dropped and he did not have a pulse rate. CPR was performed and he was intubated. The patient did not respond to the resuscitation.		

Documents

Created	Type	Description	ID
11/08/2015	E-Mail	OSR report	I&S

Communication and Feedback
Can be used for sending out emails ONLY! All responses will be sent back to your inbox

Recipients

Message

Message history				
Date/Time	**Sender**	**Recipient**	**Body of Message**	**Attachments**
No messages				

Divisional Meeting Review

Date of Review Meeting

Patient Safety Lead

DoC: Has the patient/family been notified?

Meeting Discussion Points

Meeting Action Points

Level of Investigation

Name of Person Investigating?

Can This Incident be Closed?

Obstetric Secondary Review Report

OSR

Date of Meeting

Review Group

- ☐ Sara Brigham - Consultant Obstetrician
- ☐ Julie Fogarty – Head of Midwifery
- ☐ Annemarie Lawrence – Risk Midwife
- ☐ Lorraine Millward – Practice Development Midwife
- ☐ Kathie Grimes - Labour Ward Manager
- ☐ Jo Davies – Consultant Obstetrician
- ☐ Gwenda Jones – Supervisor of Midwives
- ☐ Other

Summary of Case

Review

SI Grade

Lessons Learnt

Action Plan

Duty of Candour

Neonatal Incident Review Group

Date of Review

Review Group

- ☐ Steve Breary – Consultant Paediatrician
- ☐ Eirian Powell – Neonatal Unit Manager
- ☐ Annemarie Lawrence - Risk Midwife
- ☐ Other

Summary of Case

Review

Action Plan

Duty of Candour

Medical Education

Date Incident Received

Does this apply to more than one Doctor?

Grade

Supervisor

Date Sent to Supervisor

Date Requested Return

Feedback Returned on Time

Incident Feedback

Feedback Sent to Risk Team

Incident Closed for Medical Education?

SBAR

Situation

Background

Assessment

Immediate Action taken following incident

Any immediate lessons learnt

Recommendation

Family Awareness of Incident

SBAR Date

SBAR: By Name

SBAR: Presented To

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 present. Paed M&M by Steve Brearey: Apgar 9 at delivery Born at 30 weeks, severe IUGR 800 grams weight - discussed with LWH Mum had high risk factors - absent end diastolic flow and oligohydramnios Developed respiratory distress - intubate and given surfactant Extubated following day Baby high risk - lactate raised, low platelets, low neut count IVABs and TPN commenced - all appropriate Bowels not opened - neonates at risk of NEC, treated cautiously Long line - x-ray shows distended small bowel Documentation excellent using sticker system Fluid bolus Arterial access would have been ideal to monitor blood pressure but wasn't possible however UVC was in place; invasive access would have been an indicator for transferring baby out Cons review - over weekend Went into respiratory arrest - documentation of respiratory arrest excellent. Decision made to stop after 30 mins. Awaiting PM but likely acute bowel distention/sepsis Coincidental Findings: delayed cord clamping at delivery [not hospital policy yet for pre-term babies] No recorded use of CPAP in delivery room Small delay in IVABs [1 hour delay] and TPN commencing Glucose high on one occassion [above 10] however delay in repeat monitoring the glucose levels AXR = NGT not in place, baby 'lively' and pulling at lines [only settled in 'kangaroo care' IV Ranitidine prescribing 24 hour Cons to Cons discussion for babies on ventilator - learning point for when non-vented babies are not improving? OSR by Jo Davies: No issues re management IUGR identified early on [at anatomy scan 19/40] and monitoring in place via JMc Follow-up scans = confirmed small baby, normal liquor Some incidental findings in the OSR re completeness of sticker during labour CTG not repeated whilst Mum was having Magnesium infusion

	Met criteria for Dawes Redman Mum understanding of awareness: Will attend pregnancy risk clinic at 6/52 by Cons Obs [Jmc] Steve Brearey to discuss with Murthi Saladi re feedback to ensure undertaken
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	Sudden deterioration of an infant
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	English
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.

Has this incident been reviewed at the CCG SIRG?	
Date of Meeting	
Incident Outcome	
Are the CCG satisfied with the report?	
Can this incident be closed?	

Table Top Meeting

Table Top Meeting	
Table Top Meeting Date	
Table Top Attendees	

Table Top Actions

Duty of Candour Assessment

The patient and family have been supported to deal with the consequences and have a key named contact	
The investigation has been appropriate to the incident investigation criteria for L1 and or L2 incidents.	
The patient/family have been informed once it has been known that a moderate/severe incident has occurred within 10 working days.	
The initial notification was provided face to face?	
The verbal notification was accompanied by an offer of written notification and that this is documented in the notes.	
An apology has been has been provided and that this has been checked that it is documented in the notes by the Lead Investigating Officer	
A step by step explanation has been offered as soon as possible pending the investigation:	
Full written documentation of all meetings with the patient/family have been taken and filed in Datix for future reference. Note: These notes may be requested by Solicitors/Police/Coroner	
Full written documentation has been kept of all staff interviews and meetings about the incident and filed in the incident/complaint in Datix. Note: These notes may be requested by Family/Police/Coroner	
The final investigation has been shared within 10 days of it being approved under governance arrangements.	
The submitted action plan contains action points to address each root cause and with a named lead and timescale for implementation.	
The incident/complaint identifies Trainee Doctors and information has been entered into Datix as a	

contact to allow for reports to be sent to the Deanery.	
The incident involved an adult or child abuse and has been referred to local safeguarding arrangements. Any actions are consistent with the local multi-agency safeguarding protocol and policies.	
Does the incident involved a locum Doctor and if so has this been reported to Medical Staffing as required for Appraisal & Revalidation?	

Action Plan

No actions

Datix Common Classification System (CCS)

Stage of care	Other - please specify in description
Detail	Other
Adverse event	Other - please specify in description

Incident Outcome & Closure

Please fill in these fields when you are closing the incident.

Remember to change the status to Finally Approved when you are closing the incident.

Outcome of Incident Investigation Use this field to record the outcome of the investigation. **PLEASE NOTE: THIS FIELD WILL BE USED AS FEEDBACK TO THE REPORTER**	
Closed Date (dd/MM/yyyy) Click on the calendar icon to add the closed date.	10/08/2015
Has this incident been sent to any external organisation(s) for review?	
Are there any Lessons Learned?	No

Notifications

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job title
No notification e-mails sent					