

Any immediate lessons learnt

Recommendation	SBAR completed for consideration of the SI Panel
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Family Awareness of Incident	The parents were present during resuscitation and resuscitation was only stopped after discussion with them. They requested that twin 2 Child F transferred to I&S NNU as soon as a cot is available as they do not wish him to remain at CoCH where they have to walk past the room where Child E died.
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SBAR Date	04/08/2015
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SBAR: By Name	Debbie Peacock
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SBAR: Presented To	Ruth Millward
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SI Panel Meeting

Incident Review Panel	Yes
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SI Panel Date of Meeting	13/08/2015
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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
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SBAR Available	Yes
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Meeting Discussion Points	Likely cause of death was NEC. No PM, has been discussed with Coroner. Will be discussed in Neonatal review. Await OPR.
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Level of Investigation	SBAR & Action Plan
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Name of Investigating Officer	Debbie Peacock
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Report on STEIS	No
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SI Tracker

Incident Lead	Janet McMahon
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Level of Investigation	SBAR
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Title	Unexpected neonatal death of a twin aged PD days (NNU)
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Incident Status	SBAR Completed
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Is this a Never Event?	No
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Is This a Near Miss Never Event?	No
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Has this incident been reported to STEIS?	No
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Lead Investigator	
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Patient Nationality	
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Date Report Completed	16/12/2015
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