Position Paper – Neonatal Unit Mortality

2013 - 2016

1.0 Executive Summary

The purpose of this paper is to provide the Executive Team with key mortality data and supplementary narrative to enable an assessment of the patient safety concerns identified by the neonatal clinicians relating to an apparent increase in the number of neonatal deaths during 2015/16 and 2016/17 (year to date).

2.0 Background

The Trust provides a range of paediatric and neonatal services. The neonatal unit has 20 cots and provides critical care, high dependency care, special care and transitional care for newborn babies.

The Trust provides a Local Neonatal Unit service (Level 2 care) providing short term ventilation. The Neonatal Unit provides care to 27/40 gestation; any baby born below this criterion is transferred to the nearest Level 3 unit. The critical care and high dependency care cots are interchangeable and can therefore flex according to the needs of the unit.

In June 2015, the Neonatal Unit identified 3 deaths during a 2 week window. These cases were subject to individual case review by the specialty. Due to these deaths occurring within short succession, and that no neonatal deaths had been reported by the Neonatal Unit during 2014/15, an additional Executive Serious Incident Panel was held on 3 July 2015. The summary of care provided to the 3 babies can be found in Appendix 1.

A comprehensive case review was undertaken in February 2016 following the deaths of 10 neonates (including one who died shortly following transfer). A Consultant from Liverpool Women's Hospital was present during this review (See Appendix 2).

2 of the neonatal deaths reported in 2015/16 occurred in February and March 2016 and are therefore missing from this comprehensive case review.

An action plan was drafted by the specialty. Within this, a further 'deep dive' was undertaken by the Neonatal Unit Manager to consider the nursing interventions prior to the neonatal death and included a further review of the health record, vital signs monitoring, feeding charts and blood gas results (See Appendix 3).

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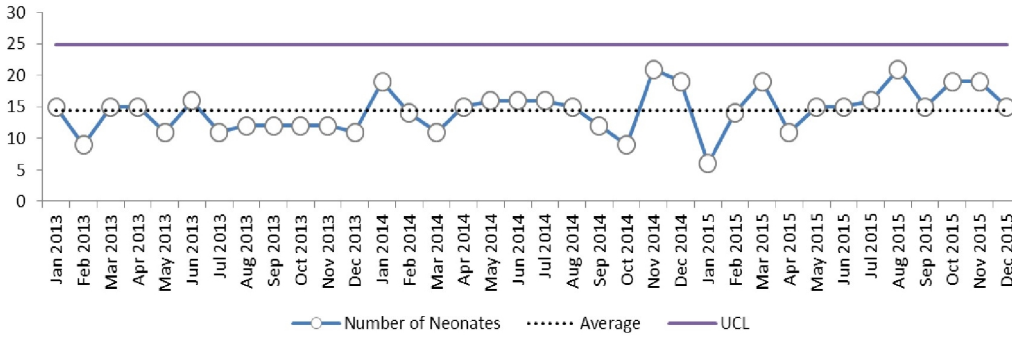

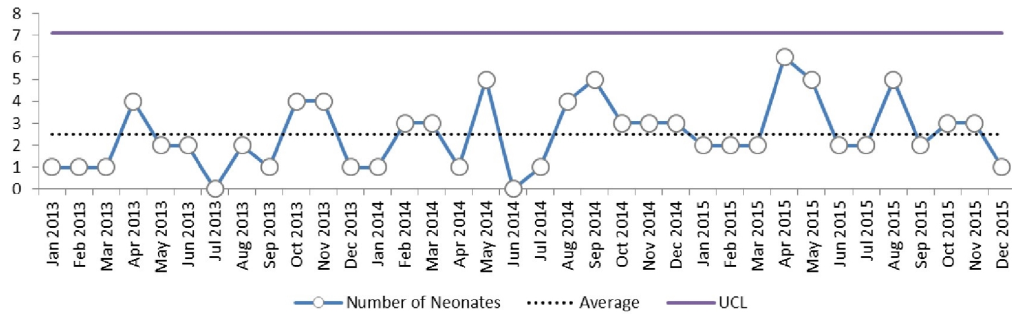

3.2 Incident Reporting – Neonatal Deaths and Sudden Deterioration

Analysis of Datix for incidents reported confirms that there were incident reports logged regarding various aspects of care in 10 of the 11 neonatal deaths reported in 2015/16. The death of two babies (CC Child D nd CC I&S was subject to a NPSA Level 2 patient safety investigation and this included a review of the antenatal care and labour.

Of the 16 neonatal deaths identified during the 36 month period up to and including June 2016, 8 (50%) are from 'out of area' with 6 Mother's being resident in I&S **.

Of the 16 neonatal deaths identified during the 36 month period up to and including June 2016, 5 (31%) are multiple pregnancies, predominantly of twins**.

**The neonatal deaths include two neonates from a set of triplets from the same Mother, resident in I&S

The specialty have identified that during 2015/16, a further 3 neonates died shortly after transfer to a Level 3 unit. These are CC I&S, CC I&S and CC Child K The specialty have also identified a further 4 neonates who experienced a sudden deterioration in their condition during the period January – June 2016 (2015/16 = 1; 2016/17 = 3); none of these had been reported via the Datix incident reporting system and therefore these require further case review. These are CC I&S, CC Child M, CC Child Q and CC Child N.

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