21.40 hours. He was alert, pink and well perfused with CRT <2. The baby's abdomen was soft, not distended and bowel sounds were heard.
A diagnosis of GI bleed was made, ? cause. The plan was for IV ranitidine, add metronidazole (at risk of NEC) and for close observation. Consultant Paediatrician was updated and was happy with this plan.
At 23.00 hours there was a further GI bleed and the baby desaturated to 70%. 13ml of blood stained fluid was obtained from the NGT on free drainage. The baby's blood pressure remained stable (Mean BP 43) and he had a heart rate of 140 – 160, with SaO2 60 – 70% in 100% FiO2. The baby was making a good respiratory effort and was crying.

The plan was to replace losses and for elective intubation with drugs. For CXR and AXR. To discuss the baby with surgeons once had x rays. Consultant Paediatrician updated and happy with plan.
The baby had a sudden deterioration at 23.40 hours with a bradycardia down to 80 – 90 bpm and SaO2 of 60% with poor perfusion. There was a noted colour change over the abdomen, purple discoloured patches.
The baby was intubated as an emergency at 23.45 hours. There was good air entry and chest movement, and a colour change was seen on capnograph to confirm the tube was in.
The baby continued to have SaO2 60 – 70% which improved to 80% following a bolus of morphine.
The purple discolouration of the abdomen remained. The mean BP dropped to 36 (cuff BP).
The plan was for a further bolus of 10ml/kg. Inotropes were not given as it was noted that may worsen bleeding. Administration of FFP was considered, but there was no coagulation screen – bloods were sent for urgent coagulation and cross match.
Consultant Paediatrician updated. Was happy with management and advised would come and review the baby.
Consultant arrived at approximately 00.25 hours and documented in retrospect. She noted the CXR showed the ETT was in a good position and the NGT was in the stomach. Baby on Cefotaxime and metronidazole; to add teicoplanin but did not have a chance to administer as baby deteriorated.
00.36 hours – poor saturations, poor perfusion. This was followed by cardiac arrest. CPR and resuscitation commenced:
5 x adrenaline
2 x sodium bicarb
1 x dextrose bolus
1 x saline bolus
1 x blood bolus
Weak heart rate obtained approximately 30 minutes into resuscitation but rapidly lost this and required CPR again. Discussed with parents. Decision made to stop resuscitation after 45 minutes and death was confirmed at 01.40 hours on 4th August 2015.

Discussed with Coroner. No PM/inquest required

Assessment	The initial impression is that Child E had NEC
Recommendation	SBAR completed for consideration of the SI Panel
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 is 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.
SBAR Date	04/08/2015
SBAR: By Name	Debbie Peacock
SBAR: Presented To	Ruth Millward

SI Panel Meeting

Incident Review Panel	Yes
Date of Meeting	13/08/2015
Attendees	☑ Mr Ian Harvey - Medical Director

☑ Alison Kelly - Director of Nursing & Quality

☐ Sian Williams - Deputy Director of Nursing & Quality

☑ Ruth Millward - Head of Risk & Patient Safety

COCH/104/007/000013

- [x] Dean Bennett - Compliance Manager
- [x] Sarah Harper-Lea - Head of Legal & Patient Services
- [ ] Geraint Jones - Head of Complaints and PALS
- [ ] Janet McMahon - Patient Experience Lead

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

SI Tracker

Incident Lead	Janet McMahon
Level of Investigation	SBAR
Title	Unexpected neonatal death of a twin aged PD (NNU)
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	
Date Report Completed	16/12/2015
All Actions Complete and Incident Closed?	Yes

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.	