Countess of Chester Hospital NHS
NHS Foundation Trust

Thematic Review of Neonatal Mortality 2015 – Jan 2016

8th Feb 2016

Attendees:

S Brearey	Neonatal lead
Doctor V	Consultant
N Subhedar	LWH consultant
E Powell	NNU manager
A Murphy	Lead nurse Children's services
L Eagles	NNU nurse
D Peacock	Quality improvement facilitator

Apologies:

C Green	Pharmacy

Purpose of Meeting:

There was a higher than expected mortality rate on NNU in 2015. All these cases have been reviewed at NNIRG, perinatal mortality review or neonatal review meetings and action plans have been made (See **Appendix 1**). An obstetric thematic review did not identify any common themes or identifiers that might be responsible for the rise in mortality in 2015. The aim of the neonatal meeting was to review the cases again as a multidisciplinary team with an external reviewer and tertiary level neonatologist to assess:

- Were all action points completed
- Any new areas of care improvement
- Any possible common themes

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- Discuss if further action is required

Patient electronic record, written notes, radiology images and Meditech entries in addition to previous reviews were available.
It was noted by NS that there was a clear and strong governance culture in CoCH which was evident at the meeting and that the number of PMs undertaken was impressive and indicated a willingness to learn and improve.

Summary of mortality cases discussed

Case:	Date of death:	Diagnosis and summary of discussion:	Actions:	Date complete:
Irrelevant & Sensitive PD	5th Apr 2015	**Severe HIE**. Baby transferred to Arrowe Park for continued cooling but died there on day PD Obstetric review identified some areas of care improvement. PMM agreed neonatal care before transfer was appropriate and timely. 2015 audit of HIE identified excellent neonatal care in the 4 cases of HIE and good outcomes in 3 cases. CoCH actively cool babies prior to transfer.	Nil	
Child A	8th Jun 2015	**Coroner's PM: Unascertained** **Irrelevant & Sensitive** aged 22. Twin born at 31 weeks gestation initially in good condition. UVC inserted and lying in left lobe of liver. Peripheral long line inserted with a view to remove UVC once long line in situ. Long line reported later as projected over the junction of the innominate vein and SVC which is satisfactory position. Registrar that evening felt it required withdrawing a little. Sudden unexpected arrest aged PD Twin also arrested 24 hrs later. Delay in staff debrief. No PM evidence of line or UVC related complication. Crossed pulmonary arteries on PM. Agreement today that line related complication very unlikely to have	Inquest 23rd March 16	

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		caused arrest.		
Child C	14th Jun 2015	**PM:** **1a. Widespread hypoxic ischaemic damage to heart** **1b. Immaturity of lung** **1c. Severe maternal vascular under perfusion** 30 week gestation severe IUGR, AEDF and oligohydramnios. Delayed cord clamping. Brief period of ventilation. UVC displaced on handling. Raised lactate and infection markers. Never opened bowels and bile stained aspirates. Respiratory arrest on day 3. Agreed PM report but no cause for deterioration identified.	Delayed cord clamping policy confirm with staff. UVC fixation policy Ranitidine in preterm babies – revise guidance based on evidence. Hyperglycaemia policy.	
Child D	22nd Jun 2015	**PM: 1A: Pneumonia with acute lung injury** PROM from 36^{+6} but delivery at 37 weeks. No antibiotics given before delivery. Dusky episode at 12 min of age probably should have led to admission to NNU. Admitted at 3.5 hrs of age in poor condition but then treated appropriately and improved, being extubated the following day. Arrest and deterioration on **PD** Group felt initial delay in starting antibiotics very unlikely to be contributory to death. Uncertain of cause for deterioration after initial improvement. UVC was withdrawn to a "low" position contrary to draft BAPM guidance. Current guideline (CoCH or LWH) does not specify acceptable position for UVC. Pulse oximetry as part of NEWS chart might help staff detect unwell babies earlier.	Continuing to emphasise to trainee doctors importance of following early sepsis guideline at inductions and teaching. Revise UVC guideline re position T8-9. Discussion with midwifery team re introduction of pulse oximetry in NEWS charts.	
Child E	4th Aug	**1a) Necrotising enterocolitis**	Delayed cord clamping	

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Child I	23rd Oct 2015	**Awaiting PM – preliminary report no evidence of NEC** 27 week gestation born at LWH. Multiple transfers between LWH, COCH and APH. Treated conservatively for NEC. Arrests on 13th, 14th and 15th October, rapid improvement after each arrest. Discussion with neonatologist rather than or as well as surgeon would have been appropriate on 13th Oct. Agreed plan with neonatologist from LWH on 14th Oct to stay in CoCH probably inappropriate in retrospect. Decision to transfer to APH rather than LWH on 15th also probably inappropriate as LWH should be considered surgical centre. Awaiting joint meeting with CoCH, LWH and AH surgical colleagues. Already reviewed at network level.	To clarify neonates with surgical or cardiology conditions should be discussed with LWH and transferred there in preference to APH. Network review of case.	
I&S	13th Dec 2015	**1a) Prematurity with Sepsis** **b) Maternal rupture of membranes with chorioamnionitis (No PM)** Concealed pregnancy, delivered on day of booking, no antenatal steroids or antibiotics. Maternal CRP 266, baby CRP 245. Foul smelling liquor. Antibiotics started. Extubated at 2 hours of age. Gentamicin frequency changed by consultant to 24 hrs. Following day advice by pharmacist to withhold gentamicin until result and if elevated to delay dose. Advice contrary to guideline and prescription sheet but followed by reg and nurse. Arrest at 36 hrs, second dose of gentamicin given at 41 hrs. Antibiotics subsequently changed to second line. Delay in transfer of baby to LWH so that she was too unstable to transfer by the time the transport team arrived. Initial estimate for arrival time given was 4 hrs and they arrived after 10.5 hrs. Difficulties in prioritising transfers for transport team. Discussed alternatives such as NEWTS and Manchester team.	To discuss with Microbiology negative results. To discuss with Pharmacy and clinical team re error in advice given by junior pharmacist and not questioned by clinical team. Transport problems reviewed by neonatal network. Alternatives to Cheshire and Merseyside Transport team to be	

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Themes identified during discussion of all cases:

1. **Delayed cord clamping in preterm deliveries**
   3 babies had delayed cord clamping when hospital guidance says this is only for term babies. There is national recommendations and evidence to support delayed cord clamping in preterm babies but the obstetric, midwifery and paediatric teams have not yet been able to ensure adequate temperature control for all preterm babies close to Mum during delayed cord clamping. Hypothermia is associated with increased neonatal preterm mortality However, there were no cases of severe hypothermia and only one case of mild hypothermia in the cases reviewed.

   Actions: Teams have already agreed and disseminated current policy
   Multidisciplinary work to enable safe delayed cord clamping in preterm babies

2. **Ranitidine in preterm babies**
   NS advised group of increased risk of death in preterm babies given ranitidine. 2 babies in CoCH were given ranitidine. It is still in common usage in most neonatal units and CoCH are unlikely to be an outlier in its use.

   Action: NS to send paper re risk of ranitidine in preterm babies. Practice change based on this evidence.

3. **UVCs in preterm babies**
   3 babies had care issues around UVCs. One was used when too low, one was used when too high and one was displaced and came out. NHS England has recently reviewed UVC incidents and BAPM has recently published draft guidance. CoCH guidance could be improved by revising guidance to include correct position and standardising fixation.

   Action: Revise UVC guidance once BAPM draft guideline finalised

4. **Timing of arrests**
   6 babies had arrests between 0000 – 0400.

   Action: SB and EP to review all these cases focusing on nursing observations in the 4 hours before the arrests. Aim to identify if unwell babies could have been identified earlier. Identify any medical or nursing staff association with these cases.

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APPENDIX 1 : Neonatal Mortality January 2015-January 2016

NEONATAL MANAGER: Eirian Lloyd Powell

Baby's name	DOB	Gest	Review	Reason for admission	DOD & AGE	Cause of death	Staff allocated	Staff on duty
Irrelevant & Sensitive	PD 03/15 14.02hrs	40/40	Level 2 Report I&S .doc	HIE	05/04/15 PD	Severe HIE	Transferred to APH on day 1	NA
Child A Con: MS Resus: RJ	PD 06/15 20.31hrs	31/40	PERINATAL MORBIDITY AND MOF	PREM	08/06/15 21.00hrs PD	Maternal SLE	Care handed to Lucy Letby at 20.00hrs	Caroline Bennion(RN) Nurse T Mary Griffith (RN) Lisa Walker (NN) Liz Marshall (NN)

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