Review of neonatal deaths and stillbirths at Countess of Chester Hospital – January 2015 to November 2015

1. Background

In response to a perceived increase in number of Stillbirths and Neonatal deaths at the Countess of Chester Hospital (COCH) in 2015, it was decided to set up a panel to independently review all of these cases again on an individual basis to identify any common themes or trends and lessons to be learnt. COCH has historically had low rates of Still births and Neonatal deaths when compared with other similar trusts in the region. The latest MBRACE report also supports this, with our rates being upto 10% lower than the average rates for similar trusts and health boards [1]

All of these cases had had previous multidisciplinary review in the form of Perinatal Mortality/ Morbidity review, Obstetric Primary/ Secondary review and Level 1 / 2 NPSA review.

2. Review Team

Dr S Brigham – Consultant Obstetrician and Gynaecologist, Lead for Obstetric Risk – Chair

Dr J Davies– Consultant Obstetrician and Gynaecologist, Clinical Lead for Obstetrics and Gynaecology

Mr J McCormack - Consultant Obstetrician and Gynaecologist, Lead for Obstetrics and Gynaecology Risk

Julie Fogarty - Head of Midwifery

Gwenda Jones – Supervisor of Midwives

Lesley Tomes – Retired Head of Midwifery and External Supervisor of midwives

Debbie Peacock- Patient Safety Lead

Lorraine Milward – Practice Development Midwife

3. Methodology

All stillbirths and Neonatal deaths were identified utilising Neonatal Badger system and DATIX reporting systems. Reports from Perinatal mortality / morbidity meetings, Obstetric review meetings were then retrieved and reviewed by the panel. Patient case notes were also available for further cross examination. Any issues with care were identified and reviewed to identify the impact that that care had on the outcome. Any lessons learnt/ to be learnt were identified and all the information was

entered onto a standardised proforma. Utilising the standardised proforma any common themes or trends were identified and an action plan drawn up. See appendix 1

4. Results

18 cases were identified of either stillbirth or Neonatal death. 3 of these cases did not need to be included in the review as one was diagnosed with antenatal hydrops, one had antenatal multiple anomalies on USS and the last case underwent Termination of pregnancy for early pre-labour premature rupture of membranes. Of the remaining 15 cases all had been reviewed previously at a multidisciplinary review apart from 3. The three cases that had not been previously reviewed were still birth cases and were due for review at the next Perinatal Mortality and Morbidity meeting. In two cases issues were identified with the care that it was felt had impacted on outcome, both of these involved misinterpretation of Cardiotocograph recordings. The clinical staff involved in these two cases were not the same staff and have already been through supervision, with individual learning and action plans.

The external reviewer – Lesley Tomes, (Retired Head of Midwifery and Supervisor of Midwives) felt that our review process was extremely robust and open and transparent. No new issues were identified from the review

5. Conclusions

Continue to review each case of still birth or neonatal death on an individual basis within the multidisciplinary review processes in place – Obstetric Primary review, Obstetric Secondary review, Perinatal Mortality and Morbidity and Neonatal reviews. Some additional actions have been identified from the review and will be completed as per action plan

Dr Sara Brigham

Consultant Obstetrician and gynaecologist

Lead for Obstetric risk

November 2015