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