Countess of Chester Hospital NHS
NHS Foundation Trust

Thematic Review of Neonatal Mortality 2015 – Jan 2016

Contents

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

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Purpose of Meeting:

There was a higher than expected mortality rate on NNU in 2015. 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
- 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:
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	

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