management. (No surgical review) NBM, cont antibiotics, phosphate infusion. Transferred back to CoCH.

17th Oct – 23rd Oct – CoCH

Optiflow. CF gene test. To arrange contrast study.

20th Oct d[PD] – trial off optiflow AXR improved on previous. Completed 7 days iv antibiotics.

21st Oct – discussion with con surgeon: possible colonic stricture, suggests contrast study as "park and ride"

22nd Oct – SVIA, 150ml/kg/d PN via long line, NBM. Normal examination.

23rd Oct 0030 – further arrest. CPR intubation. Vigorous and resisting ventilator – therefore extubated.

0118 – further arrest, CPR sats 70s HR 50-60/min. Adrenaline doses given.

0145 brachial and femoral pulses palpable >100 – compressions stopped.

0150 further bradycardia and CPR recommenced, adrenaline.

0210 HR 40 on monitor, no pulse. No resp effort. Resus stopped.

0230 in parents arms – no signs of life.

Summary

[Child I] was a 27 week preterm baby who is likely to have died from abdominal pathology, probably NEC or its complications. However, I believe post mortem examination has been requested and might give further information. She was transferred a number of times between hospitals and had a number of different specialists involved with her care. It is hard to judge whether the number of transfers affected the sad outcome. However, I don't think transferring a preterm baby 5 times between 3 hospitals and planning further transfers if she had survived is sensible or in the baby's best interests. There was also an apparent delay in decisions to transfer which seem to be due to the three way communication process between referring centre, surgical centre and tertiary neonatal centre(s). I will bring both these points to the mortality review with the Cheshire and merseyside neonatal network. Also to be discussed at PMM.

S Brearey

31st Oct 2015