Countess of Chester Hospital NHS
NHS Foundation Trust

After death/debrief/counselling/PM/duty of candour etc: Hot debrief immediately after resus. Bereavement pathway followed. Pm results as above.

Tick relevant Box		
Grade 0		No suboptimal/substandard care
Grade 1	**x**	Suboptimal care, but different management would have made no difference to the outcome
Grade 2		Suboptimal care, different care may have made a difference (possible avoidable death)
Grade 3		Suboptimal care, different care would reasonably be expected to have made a difference (probably avoidable death)

Lessons Learnt/Actions

1. No definite indication for commencing iv antibiotics after birth. Reason given was respiratory distress in preterm infant requiring CPAP. Cautious approach to starting antibiotics would not have caused harm.
2. Decision on day PD to start TPN. No indication for this based on criteria of <1200g or <32 weeks but may have fulfilled criteria of unlikely to be on full enteral feeds by 7 days of age. Decision to start TPN should have been followed by decision to insert a peripheral long line or UVC.
3. No record made by registrar of his examination at 0732 on 23rd Jul.
4. Nursing notes usually entered at end of shift onto Meditech. Record of care entered in 3 different areas: Meditech, case notes and Badger net. Simplification of note keeping and anything that might help nursing staff enter notes more contemporaneously would be helpful.
5. All radiographs to be reviewed again in view of probable enlarged liver and importance of timing of films taken.
6. To request review by obstetric team regarding delivery and possibility of liver sub-capsular haematoma occurred in perinatal period.
7. Email from Coroner's officer regarding parents' concerns was discussed. DEBM that triplets received unlikely to be contributory but batch has been isolated and will be analysed. Alleged consultant cough into hands and examined baby without washing hands first – unlikely to be contributory to outcome but has been discussed with consultant and clinical lead.
8. Areas of good practice included excellent medical and nursing documentation of care around the time of the acute deterioration. Good practice of having parents present during resus, communication with them and timely baptism. 3 consultants present for most of resuscitation. Good team working.
9. There is uncertainty regarding cause of death as Child O deteriorated and received antibiotics, blood tests and an AXR which did not seem to show any evidence of hepatic enlargement at that time.

Reviewers: S Brearey, E Powell, S Williams, Y Griffiths, Doctor U, Doctor ZA, H Cooper

Date: 5th July 2016