From:	Powell Eirian Lloyd (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
To:	Rees Karen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc:	Griffiths Yvonne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Brearey Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Murphy Anne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject:	NNU Mortality
Date:	05 May 2016 15:21:12
Attachments:	LUCY"S SHIFTS 2016.docx NNU mortality 2015.docx NNU monitoring mortality 14 04 16.docx Neonatal Unit review 2015 assurrance.docx

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Hi Karen,

Thanks for seeing us this lunchtime regarding this matter.

I have attached the relevant documents to state the relevant information .

1. Lucy's shifts
2. NNU Mortality document
3. Continued NNU monitoring process
4. Neonatal Unit review assurance

Obviously we would like to have a meeting with Alison Kelly and Ian Harvey as a matter of urgency primarily for reassurance and to ensure that we have covered all the relevant actions.

Kindest regards

Eirian

Eirian Lloyd Powell

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Neonatal Unit review 2015-16

1. There is no evidence whatsoever against LL other than coincidence. LL works full time and has the Qualification in Speciality (QIS). She is therefore more likely to be looking after the sickest infant on the unit. LL also avails herself to work overtime when the acuity or unit is over capacity.
2. There are no performance management issues, and there are no members of staff that have complained to me or others regarding her performance
3. I have found LL to be diligent and have excellent standards within the clinical area.
4. Whilst our mortality rate has risen in the January 2015- January 2016 we have had x3 mortalities from January 2016 to date (May 2016) x2 died due to congenital abnormalities.
5. Dr. H and Dr. G (Consultant) appears to be involved in many of the mortalities.
6. The Cheshire and Mersey transport service have been involved in a few of these mortalities and they may have survived if the service was running adequately.
7. Alderhey's children's hospital's failure in facilitating a cot also added to the complexities of these mortalities. If there had been a bed sooner the infant may not have died.
8. Some of the issues were related to midwifery problems
9. Two of the babies PM's diagnosed Congenital Pneumonia – transport team issue
10. 4 babies had congenital abnormalities
11. 1 maternal syndrome
12. 2 with ? necrotising enterocolitis
13. 1 Overwhelming sepsis – transport team issue
14. AHCH cot availability – 6 admissions between LWH/APH and COCH
15. Of all the post mortem results there was no evidence of foul play.

Actions:

1. A debrief was held for all the staff involved in the mortalities
2. Dr. Brearey/Debbie Peacock and myself have reviewed all the mortalities
3. A thematic review was held and led by an external Neonatologist (Nim Subedhar) from the level 3 Unit at Liverpool Women's hospital
4. These mortalities have also been highlighted to the ODN and discussed at the meetings
5. Debbie Peacock was aware of the commonalities of both the nursing and medical staff.
6. In order to ensure that we support this particular practitioner I have brought her onto days to ensure that she is well supported. (I have included her shift pattern since January 2016).
7. Any profound event is monitored closely irrespective of members of staff involved

Discussion with Dr. Brearey/Anne Murphy and Eirian Powell

Karen Rees requested that we discussed exactly what the issues (if any) where other than coincidence that was evident.

Despite highlighting the usual factors there was not real evidence or statement that could confirm whether there was an issue here.

The only consensus was that we needed advice and support as to what (if any) do we do next? We felt that we had highlighted any commonalities or themes and have escalated as necessary to the relevant health professionals to ensure transparency.

1. Risk facilitators
2. Datix
3. Clinical incident reviews
4. Debrief
5. Individual Review
6. External thematic review
7. Network mortality group

Advice sought:

1. Risk facilitators
2. External neonatologist
3. Network
4. Higher management