

Working together to provide the highest standard of care for babies and families

10. Mortality Review

	Background and Lessons Learnt
10.1 Arrowe Park	
10.2 Liverpool Women's Hospital	I&S
10.3 Countess of Chester	<p>29/40 Cause of death - Necrotising enterocolitis and extreme prematurity. Delayed cord clamping 1 min was not appropriate and might have been contributory to temp 36.4 on admission. Teicoplanin not started with cefotaxime on 2/8/15 (long line in-situ) as current policy advises, despite prompt from pharmacist. Although Vit K was given after delivery, a further dose might have been given for GI bleed. FFP might also have been indicated but is unlikely to have made a significant difference to the outcome. GI bleed guideline/protocol might have been helpful. Hyperglycaemia/insulin guideline might have been helpful to staff. Introduction of feeds was more cautious than current CoCH policy</p>

Location:	Paediatric Seminar Room. Children's Outpatients, Whiston Hospital	Page:	6
Meeting Date:	12 th November 2015	Time:	1:30pm – 4:30pm
Meeting Title:	Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group - Minutes	Completed:	L Hughes