Actual effect on patient and/or service:

A term baby has died within the first week of life; this will have a severe impact on the parents and family.

The Trust also recognises the potential psychological impact to the staff directly involved and this, in conjunction with the potential impact to the reputation of the Trust, is considered severe harm.

Actual severity of the incident:

The death of a baby is a catastrophic event and the Serious Incident Framework recognises the wider psychological effect associated with distress and anxiety to the bereaved parents and family and this is considered severe harm.

Detection of Incident

The baby appeared to be in good condition at birth but began to show subtle signs of compromise and was subsequently transferred to the Neonatal Unit (NNU). A Datix form (the Trust's Risk Management System) was completed by staff at the time of the unexpected admission to the NNU. All babies born at term who are unexpectedly admitted to the NNU have their mother's antenatal and intrapartum care (care in pregnancy and labour) assessed to determine whether problems could have been anticipated or there are any lessons to be learnt. The Trust is monitored on this by the Clinical Commissioning Group (CCG).

When the baby sadly passed away, a further Datix form was completed by staff and a telephone call was made to advise the Risk Management Team of the incident. As with all unexpected neonatal deaths, the incident was escalated to senior members of the Obstetric and Midwifery Team, and the Neonatal Team to enable immediate support to be put in place for the family. They also offered support to the staff involved.

An Obstetric Secondary Review (OSR) led by the Obstetric speciality was undertaken within 24 hours of the incident occurring, and a Neonatal Review led by the Neonatal Team was also undertaken. All aspects of care provided to the woman was scrutinised to assess whether there were lessons to be learnt.

The incident was escalated to the Medical Director and Director of Nursing & Quality and was subsequently discussed at an extraordinary Executive Serious Incident Panel on 2nd July 2015; there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there was any commonality which linked the deaths. Two of the babies had medical conditions which could be clearly seen to have contributed to their deaths. The third baby appeared to be an unexplained death and, at this time, this baby's cause of death was unknown. It was agreed that no further investigation was warranted at this stage as there were no concerns highlighted in the obstetric or neonatal reviews; however the SI Panel were of the opinion that the Obstetric Secondary Review findings and the Neonatal Review findings should be consolidated into one report on a Level 2 template.

Once the Post Mortem report is available the report is to be re-assessed to identify if any gaps have been identified or if further assurances are required.

Terms of reference for both reviews

1. To establish the facts of the incidents
2. Assess whether actions taken were appropriate and, in particular, consider whether actions of the staff comply with individual Trust policies/guidance and external policy/guidance in place at

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