Message

From: Groggins Peter (NHS ENGLAND) [/O=MAIL/OU=NHSFB04/CN=RECIPIENTS/CN=UASR1R8J]
Sent: 30/06/2016 4:32:26 PM
To: SEDGWICK, Marie (NHS ENGLAND) [/o=MAIL/ou=NHSFB05/cn=Recipients/cn=E8Y7HKH6]; VALJALO, Barbara (THE WALTON CENTRE NHS FOUNDATION TRUST) [/o=MAIL/ou=NHSFB12/cn=Recipients/cn=I3TTR6IU]; DAVIES, Dee (EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST) [/o=MAIL/ou=NHSFB07/cn=Recipients/cn=ERDIGRDA]
Subject: Countess Incident

Dear Colleagues

The Countess have reported 2 similar incident the first is below. These relate to the deaths of 2 triplets.

I have requested the CCG include further details.
Thanks

Peter

Serious Incident Reporting Document

Created by URJR on 06/30/2016 at 04:02:33 PM

[Exit] [Save and Submit] [Save and mark as closed]

Organisation reporting SI on STEIS:	Countess Of Chester Hospital NHS Foundation Trust	**Log No:**	Child O
Region (Geography):	Cheshire and Merseyside	**Status:**	Ongoing
CCG/CSU: [Select from list]	NHS West Cheshire CCG	**Commissioner leading oversight of investigation:**	NHS West Cheshire CCG
BF/wd Date:	29/08/2016	**Organisation leading investigation**	Countess Of Chester Hospital NHS Foundation Trust

When, Where & Your Details

Date of Incident:	06/23/2016	**Reporter Name:**	Dean Bennett
Time of Incident:	05:47 PM	**Reporter Job Title:**	Compliance Manager
Site of Incident:	Neonatal Unit	**Reporter Tel. No.:**	01 I&S
Location of Incident:	[Healthcare premises \/] Please provide more info :	**Reporter Email:**	deanbennett@ I&S

Date Incident Identified:	06/29/2016		

Who

Care Sector:	[Acute/general \/] Please provide more info :	**Type of Patient at time of incident:**	[Other \/]
Clinical Area:	[Paedi \/] Please provide more info :	**Gender:**	[Male \/]
Date of Birth (dd/mm/yyyy, N/A or Not Known):	PD 06/2016	**Ethnic Group:**	PD
Patient's GP Practice:	PD	**Legal Status of patient at time of incident:**	[No healthcare-related legal restrictions/provisions \/]

What Happened?

Reason for Reporting:	[Unexpected / potentially avoidable death \/]		
Type of Incident:	[Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus. neonate and infant) \/] Please provide more info :		
Where is patient at time of reporting::	[Deceased \/]	**Never Event:**	[Not a Never Event \/]
Internal Investigation Required:	[internal comprehensive \/]	**Expected SIRI Completion date :**	09/23/2016 Read Only This will be calculated 60 days from date report submitted
Independent Required:	( )Yes (X)No ( )Unknown ( )Pending Review	**Expected date of Completion**	
Non-health led investigation required	[Not applicable \/]	**Expected date of Completion**	
Description of what happened :	Unexpected deterioration and death of a neonate		
Immediate action taken:	Escalation of unexpected death to Lead Clinician and Executive Team. Discussions held in light of thematic mortality review of neonates in February 2016 and March 2016 with agreement for investigation of patientâ€™s clinical management involving Registered Professional Bodies (Royal College of Paediatricians and RCN)		