[denisesandiford @ 185]; Smith Karan (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [karansmith1@\_\_\_\_\_\_; Stowell-Smith Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [debbie.stowell-smith@ I&S ; Williams Carys (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [caryswilliams@\_\_\_\_\_\_\_]; Yates Samantha (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [samantha.yates2@\_\_\_\_iss\_\_]; Fogarty Julie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [julie.fogarty@ 185 ]; Grimes Kathleen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [kathleen.grimes@\_\_\_\_\_]; Brigham Sara (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [sara.brigham@\_\_\_I&S\_\_]; Davies Joanne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [joanne.davies10@\_\_\_\_ls\_\_\_]; Dinardo Lorraine (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [lorraine.dinardo@\_\_\_i&s\_\_\_]; Finney Victoria (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [victoriafinney@ 185 ]; Hawe Jed (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [jed.hawe@\_\_\_\_\_\_; Ibraheim Mofid (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [mofid.ibraheim@\_\_\_\_\_\_\_; McCormack Jim (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [jim.mccormack@ I&S ]; Rao Usha (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [usharao@\_\_\_\_\_i]; Semple David (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [david.semple@\_\_\_\_\_\_]; Van Rij Janneke (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [janneke.vanrij@\_\_\_&s\_\_]; Wood Simon (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [simonwood@ **I&S** SB/ NND review

Attachments: NND and SB review 2015 - final.docx

## Importance: High

Hi,

Subject:

Please see the attached thematic review of still births and NNDs here at Chester 2015. The purpose of the review was a perceived increase in the number of still births and neonatal deaths.

The full report is embedded in the action plan and has some very interesting points.

This review highlighted some issues for us all to be aware of:

We must ensure a datix is completed for all neonatal deaths or still births- We need to review these cases whilst the incident is current in our minds. It is better to have multiple datix reports about the same event than to miss reporting an important incident. If you need any help completing a datix, let me know.

Escalation is key- If you have any concerns about your CTG, you must escalate. Remember we can assure ourselves if we need to with tools such as Fetal Blood Sampling (FBS).

This report is also displayed in the seminar room on CLS.