

STEIS Incident Record for Countess of Chester (Child D)	
CQC Core Service Field	Maternity and Gynaecology
Log number	Child D
Created on	03/07/2015 18:47
Organisation reporting SI on STEIS	Countess Of Chester Hospital NHS Foundation Trust
Reporting organisation code	RJR
Region - geography	Cheshire and Merseyside
Status	Closed
Date of Incident	PD Jun-15
Time of incident	Blank
Site of Incident	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Location of incident	Healthcare premises
Date incident identified	02-Jul-15
Care sector	Acute/general
Clinical area	Obstetric
Clinical area (other)	Blank
Type of incident	Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)
Type of incident (other)	Blank
Never Event	Not a Never Event
Description of what happened:	<p>Baby born at 37+1/40 admitted to NNU. Background - Baby born by emergency c/s following failed induction of labour [for prolonged rupture of membranes - PROM]. Baby born in good condition. At 12 mins required resuscitation as floppy and apnoeic. Initially responded to inflation breaths with paediatric team input. Admitted to NNU PD</p> <p>PD with poor perfusion and oxygen saturation levels. Commenced on IV antibiotics, fluid bolus and CPAP. Received mechanical ventilation overnight and respiratory status improved. Baby cardiovascularly unstable with inflammatory markers suggestive of infection. Acute episode of poor perfusion prior to respiratory arrest and asystole. Unsuccessful resuscitation. Awaiting PM but most likely diagnosis of early neonatal sepsis following PROM.</p>
Immediate action taken:	<p>Review of obstetric management of Mum: Mum = CTG tracing - normal, apyrexial, didn't meet criterion for IVABs in labour Review of neonatal management of Baby: GP Trainee doctor overseeing baby initially Midwife escalated to SpR for senior review Developed mottling, Consultant Paediatrician review - amended IV antibiotics in line with potential sepsis Awaiting PM findings Incident discussed at Executive Serious Incident Panel on 02/07/15 - identified as serious incident, for reporting to StEIS and for NPSA L2 patient safety incident review</p>