Themes identified during discussion of all cases

There was no common theme identified in all the cases. One baby had severe HIE and the Trust's rate of HIE in 2015 was low and similar to previous years. One baby had severe multiple congenital abnormalities with a very poor prognosis. One baby had a significant congenital heart disease and probable sepsis. 2 babies (possibly 3 pending PM result) died of sepsis despite timely antibiotic treatment. 2 babies (possibly 3 depending on PM result) the cause of death is uncertain despite having PMs. Themes identified in more than one baby reviewed included:

1. **Sudden deterioration**
   Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM.

2. **Timing of arrests**
   6 babies (from 9 deaths reviewed) had arrests between 0000 – 0400.

   Action: SB and EP to review all these cases focusing on nursing observations in the 4 hours before the arrests. Aim to identify if unwell babies could have been identified earlier. Identify any medical or nursing staff association with these cases.

3. **Delayed cord clamping in preterm deliveries**
   3 babies had delayed cord clamping when hospital guidance says this is only for term babies. There is national recommendations and evidence to support delayed cord clamping in preterm babies but the obstetric, midwifery and paediatric teams have not yet been able to ensure adequate temperature control for all preterm babies close to Mum during delayed cord clamping. Hypothermia is associated with increased neonatal preterm mortality However, there were no cases of severe hypothermia and only one case of mild hypothermia in the cases reviewed.

   Actions: Teams have already agreed and disseminated current policy
   Multidisciplinary work to enable safe delayed cord clamping in preterm babies

4. **Ranitidine in preterm babies**

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sepsis guideline at inductions and teaching.			
Discussion with midwifery team re introduction of pulse oximetry in NEWS charts.	Brearey Grimes		Dec 2016
Network to discuss case I&S of multiple transfers between hospitals	Subhedar	Table top meeting took place on 26th Feb – awaiting report	
To discuss with Microbiology re I&S why all micro samples were negative.	Brearey		April 2016
Discussion regarding Pharmacist cover on NNU as inappropriate advice given	Green Brearey		April 2016
Transport problems reviewed by neonatal network. Alternatives to Cheshire and Merseyside Transport team to be circulated to staff.	Powell	Staff notified and poster on NNU with process	Complete
Antibiotic policy discussed at network level. ? Align policy with APH.	Brearey Webster		Dec 2016
SB and EP to review all these cases focusing on nursing observations in the 4 hours before the arrests. Aim to identify if unwell babies could have been identified earlier. Identify any medical or nursing staff association with these	Brearey Powell	Only one case identified possible delay in starting second line antibiotics earlier based on nursing observations. 1 Action below has come from this review	Complete  Observations prior to collapse review.docx

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