Countess of Chester Hospital NHS
NHS Foundation Trust

Level 2 Root Cause Analysis Investigation Report

Baby born in poor condition

STEIS 2015/ PD **Datix** PD

Incident date: 20/06/2015
Incident type: Clinical
Specialty: Obstetrics and Neonatal
NHS No: Mother: Mother D Baby: Child D
Healthcare specialty: Planned and Urgent Care
English / Welsh: PD
Effect on patient: Baby died
Severity level: Severe

The investigation team:

Obstetric Secondary Review team:

Dr J Davies Consultant (Obstetrics & Gynaecology)

J Fogarty Head of Midwifery

D Peacock Risk & Patient Safety Lead

Neonatal Review Team:

Dr S Brearey Consultant (Paediatrics)

E Powell Neonatal Unit Manager

Y Griffiths Deputy Neonatal Unit Manager

D Peacock Risk & Patient Safety Lead

This report is made following review of the clinical notes by each speciality in relation to care provided to the mother and the baby.

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

Care and Service Delivery Problems

Obstetric:

- The woman was not offered aspirin for two risk factors for pre-eclampsia.
- Some of the stickers in the maternal records (for VE and CTG) had not been fully/accurately completed by the locum Registrar, but this did not have any effect on the management or outcome of the labour.
- Non-approved abbrieviations were used in the notes but this had no impact on the care delivered

Neonatal:

- The Paediatrician did not identify that the baby had two risk factors for sepsis when he initially reviewed the baby and therefore did not admit the baby to the NNU as the baby appeared to be clinically well at that point. However, as soon as the observations were noted to be outside normal limits, the baby was transferred to the NNU, investigations were undertaken and IV antibiotics were administered.

Contributory Factors

None

Root Causes

No root cause has been identified. The care given to the woman was in accordance with Trust guidelines and NICE guidance. The baby was admitted to the NNU once it became clinically unwell and antibiotics were commenced soon after admission.

At the time of review of the obstetric and neonatal care, the post mortem results were awaited. Once received, the report might identify gaps or areas where further assurance is required.

Lessons Learned

Obstetric:

- To correctly identify risk factors in women and commence aspirin if indicated
- Only approved abbreviations to be used in notes
- Stickers to be fully and accurately completed

Neonatal:

- To correctly identify risk factors for sepsis in the newborn

Recommendations

Obstetric:

- All staff to be reminded about risk factors and the indications for aspirin
- Staff to be reminded about use of abbreviations in notes
- Induction pack for locum doctors to include the use of stickers