Badger Mortality Data Quarter 4 2016/17

Neonatal Network Report - Deaths - Gestation simple

Unit	Delivery room deaths	<26	26-30	31-36	>36	Unknown	Total
RSUH	0	1	1	1	0	0	3
RHH	3	0	1	0	0	0	1
SaTH	0	1	1	0	0	0	2
WMH	0	1	0	0	1	0	2
RWH	1	2	4	0	0	0	6
Total	4	5	7	1	1	0	14

Updated 1st April 2016 – 31st March 2017		**NNU Deaths**					
Unit	Delivery room deaths	<26	26-30	31-36	>36	Unknown	Total
Royal Stoke University Hospital	0	6	2	4	1	0	13
Russells Hall Hospital	5	1	2	0	0	0	3
The Shrewsbury and Telford Hospital NHS Trust	0	1	2	1	1	0	5
Walsall Hospital NHS Trust	0	1	0	1	2	0	4
Wolverhampton NHS Trust, New Cross Hospital	2	7	12	1	0	0	20
Total	7	16	18	7	4	0	45

	2015/16				
Unit	<26	26-30	31-36	> 36	Total
RSUH	9	6	2	2	**19**
RHH	0	5	0	1	**6**
PRH	1	1	2	2	**6**
WMH	0	0	2	0	**2**
RWH	10	8	1	4	**23**
Total	**20**	**20**	**7**	**9**	**56**

Emerging Issues/Themes and Lessons to Share in the Network:

- Need to ensure robust neonatal alert process is in place with Obstetric service to alert neonatal team of all pregnancies with antenatally identified fetal issues that would benefit from having a timely neonatal review and management plan before delivery.
- There is an excellent NHS lab service therefore it is useful to contact labs and discuss with experts to reach diagnosis (positive point)
- Consider the benefit of treating PDA's to avoid extension of IVH's in sick babies.
- Currently there are no recommendations about screening of siblings/twins of babies with congenital heart disease. In the absence of any abnormal cardiac examination and pulse oximetry, cardiologists would not offer echocardiographic surveillance for the twin/siblings.
- Transfusion-associated acute gut injury is a recognised but controversial entity. Whether transfusing at higher Hb thresholds or withholding feeds makes a difference remains unproven.