

## Summary Report of Mortality Review Sub Group to QIPP Group

### Mortality Review Period: Quarter 3 2013/14

Report:	Network discharges broken down by discharge type and destination.
Neonatal Network:	Staffordshire, Shropshire and Black Country Newborn Network
Date Range:	Babies discharged from 1 Oct 2013 to 31 Dec 2013.
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### Network Discharge Summary Q3 2013/14

Unit name	Died
Mid Staffs NHS Foundation Trust	0
Russells Hall Hospital	0
The Shrewsbury and Telford Hospital NHS Trust	1
University Hospital of North Staffordshire NHS Trust	1
Walsall Hospital NHS Trust	1
Wolverhampton NHS Trust, New Cross Hospital	7
<b>Total</b>	<b>10</b>

### Network Deaths Q 3 2013/14

Gestation	24	25	26	28	29	30	32	37 - 42	Total
Died (<7 days)	1	1	1	1	2	1	1	0	<b>8</b>
Died (> 28 days)	0	0	0	0	0	0	0	0	<b>0</b>
Died (7-28 Days)	2	0	0	0	0	0	0	0	<b>2</b>
<b>Total</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>10</b>

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

- Re-intubations in labour ward are a recurring theme and may warrant review of practices
- Good Practice to Recheck clotting post treatment for deranged clotting
- HIE management is not just cooling, fluid management is especially important for pre-terms less than 36/40 (as these babies do not meet the cooling criteria).
- Good practice to see sickest patients first on ward rounds
- Good practice if a baby who dies was a transfer in from another hospital to copy letters to both the neonatal and obstetric teams at the referring hospital to let them know the outcome (with a copy of the badger summary)
- If having difficulty oxygenating any baby consider cardiac defect and start Prostin for babies >28 weeks gestation if there is no response to HFO and NO