Mortality Review Group (MRG)
Learning Points – October 2019

Resuscitation

1. Procedures for alerting the Neonatal team to attend deliveries should be clear and understood by all members of midwifery, obstetric and neonatal nursing teams. Units should review procedures as part of regular MDT discussion with Maternity.
2. In the absence of other signs of HIE, other causes of floppiness at birth should be considered such as neurological or muscular conditions. Cervical cord injuries can present as severe hypotonia and apnoea.

Equipment

1. Do not rely on ventilator leaks as an indication ETT is dislodged. Other possible causes to consider are pneumothorax or insufficient cardiac output. A positive change in ETCO2 is reliable but a negative one is not. If in doubt – visualise ETT directly.
2. Regular review of resuscitation equipment should be carried out by neonatal staff.

Other Aspects of Treatment

1. Even in presence of severe and prolonged oligohydramnios there is merit in stabilising and attempting resuscitation as there is evidence that outcomes are improved with iNO.
2. End of life checklists are useful e.g. to ensure a PM is offered around time of death etc.
3. Paediatric coagulation screen may not include an APTT unless specifically requested. Within neonatal services, options for coagulation requests should only include complete screens.
4. Thickeners should be used with caution in premature babies. Jejunal feeds are a suitable alternative. In addition, caution if feeds hyperosmolar with other additives and in association with a transfer to formula milk.
5. In chorioamnionitis – the placenta should always be sent for full microbiological assessment to guide neonatal treatment.
6. Where irradiated blood is not available, in an emergency, CMV negative, non-irradiated O negative blood can be used.

Communication/PMRT/Bereavement follow up

1. PMRT may identify latent risks by detailed review of first 24 hours. While these may not be pertinent to cause of death, this can allow refinement of guidelines and practices that may increase risk of complications.
2. Safety huddle between neonates and midwifery is vital to ensure opportunities for discussion in place.
3. Consultants in SCBU/LNUs have support from NICU or Embrace when difficult cases present, even if immediate request for transfer not appropriate.