Mortality Review Group (MRG)
Learning Points – 4 February 2020

Resuscitation

- Following category 1 LSCS – full neurological findings should be documented especially if transfer to the PNW is considered a safe option.

- Preterm babies expected to need surgery for perforation should be intubated and ventilated early as part of the stabilisation process.

Equipment

- All cranial ultrasound or other imaging should be recorded and stored.

Guidelines

- If the UVC has been in the liver and is low lying it needs replacing as per BAPM guidance or as a minimum risk assessed if the position is considered to be good. www.BAPM.org/resources

- All units should have guidelines for LISA and should monitor which babies are being given this treatment

- Units should have escalation policies where multiple cannulation attempts are required and monitor that this is followed

Sepsis

- 2 cases this quarter in 2 different units of overwhelming Herpes simplex sepsis: When sepsis is a possible diagnosis, treatment needs to remain broad and all possible causes of sepsis should be considered including viral. Antiviral agents should be considered in severe cases especially late onset sepsis.

- When women or babies are transferred from other units, microbiology results for mother and baby from the referring unit should be reviewed as part of the admission process.

- Sepsis should be considered in all deteriorating patients and antibiotics should be started proactively.

Anticipated Palliative Care Pathways

- In cases of antenatal diagnosis of inoperable complex cardiac disease, delivery in the cardiac centre should be discussed even if a palliative care pathway is the most likely outcome. This allows for confirmation of the diagnosis soon after birth.

- In conditions where death is expected but not immediately after birth, palliative surgery e.g. stoma for imperforate anus, should be offered for quality of life even if no active treatment can be offered for the underlying condition.

Patient Flow pathways

- Units where ED is located away from L&D Units should look at patient flow pathways to ensure pregnant women presenting to ED can be transferred to obstetric services as soon as possible after the decision for this is made.

Communication

- Where there is a difference in opinion between parents and medical staff regarding care pathways, early 2nd consultant input is essential.

- Post mortem should always be offered when the cause for sudden deterioration is not clear. Discussion with a coroner may help to support this discussion

PMRT

- After a baby has died, a full copy of the clinical notes should be retained for the purpose of PMRT as the originals will be required for post mortem/safeguarding/child death reviews.