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| Title | Medical Director | | |
| Author Responsible Director | Mr E J Neale FRCOG | | |
| Classification | Information | | |
| Purpose | Follow up from the Patient Experience story at the May Board. | | |
| Action required | Nil | | |
| Impact assessment - quality - financial - business - equality/diversity - risk - legal/statutory | | | |
| Relevant Standard for Better Health | | Assurance | Lapse |
| | Safeguarding | x | |
| Conformity to previous decision/ policy | Patient Experience May 2010 | | |

Executive Summary:

Board Members may remember that this story related to a premature baby whose mother wrote to complain that she felt the baby was discharged too early, that the community services were not informed of the discharge and that she was unable to seek help from us and subsequently the baby died.

I have looked further into the detail of events surrounding this unfortunate incident and am assured that:

- The mother was thoroughly prepared for the baby's discharge home.
- She was capable of both administering drugs under supervision and taught such skills as infant resuscitation prior to discharge.
- The mother was noted to not be a regular visitor to the baby whilst she was on the neonatal unit but was good at keeping telephone contact if she was unable to attend.
- Prior to discharge it was impressed upon the mother that she could telephone the neonatal unit 24 hours a day if she was anxious about her baby.
- On the day of discharge (Thursday) we were unable to contact the Health Visitor Service so details of the discharge were faxed across. The following day the discharge was discussed with the Liaison Health Visitor who attended the neonatal ward round.
- The neonatal unit has robust processes for recording all contacts from mothers and there is no evidence that the mother attempted to contact the neonatal unit on the Saturday. Interestingly the neonatal community nurse

was on duty on the neonatal unit throughout that day and would therefore have naturally been the one to respond to such a call if received.

- A Consultant and Staff Nurse from the neonatal unit attended the A & E department when the baby was admitted on the Sunday. At no time during that admission did the mother say she had been trying to contact the neonatal unit the day before.

The child death review panel have investigated this death. Their conclusion was that this was a sudden, unexpected, unexplained death with some factors which could have reduced the risk of death to this child or future children. The points that they raised were:

- Despite detailed advice and teaching, the mother did not appear to understand how much or when to change the volume of the baby's feeds.
- They were concerned about communication between the neonatal unit and the Health Visitors and reassured that it has been further improved.
- They noted that the discharge leaflet had been updated to include verbal advice that parents can phone 24/7 up to four weeks after discharge.
- They acknowledged the mother had been taught resuscitation prior to the baby being discharged.
- They noted both parents smoked.
- They suggested avoiding the transfer of vulnerable babies home at weekends where possible and apparently during their deliberations it became apparent that the mother's in-laws had visited the baby at home on the Saturday, had noted the child's pallor, but had not felt it necessary to seek further help.
- Finally the Child Death Review panel concluded that no other agency or authority (Police, Coroner, HSE or Serious Case Review Panel) should be required to carry out any further investigations.

This baby was not expected to die, but was at greater risk of death due to the fact it had been born prematurely. This had been explained to the mother.

E J Neale FRCOG

Medical Director

21st June 2010 Amended 21 July 2010