THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Network Mortality Governance Review

Complete for any death occurring in the neonatal unit (include transfer out of the neonatal unit for palliative care), and all neonatal deaths where the neonatal team are involved in providing newborn resuscitation

DEMOGRAPHICS					
Location of Birth: Exact Location (hospital):	Hospital …… / Home/ Other …… A+E/MLU/Labour ward/ Maternity Ward/ Other ward/ Other……				
Location of Death	Hospital…….. NNU/ Delivery suite/ Hospice/ Home/ Other……				
Date of Birth		Time of Birth			
Gestational Age (GA)		Birth weight (g)		Gender	M / F
Singleton(S) or order if multiple (e.g. 2 of 3)		Date & time of Admission NNU (last admission if >1)			
Date of Death		Time of death			
Age at death (days)		Corrected (GA) at death			

DEATH DETAILS	
DEATH CERTIFICATE (<28 days/ *>28 days)*	
a) Main diseases or conditions in infant *1a) Disease or condition directly leading to death*	
b) Other diseases or conditions in infant *1b) Other disease or condition , if any leading to (1a)*	
c) Main maternal diseases or conditions affecting infant *1c) Other disease or conditions, if any, leading to (1b)*	

d) Other maternal diseases or conditions affecting infant *2) Other significant conditions contributing to the death*	
e) Other relevant causes	
Other significant co-morbidities (not on death certificate)	
Was the coroner Informed or consulted? Yes/No	Reason:
Did a Coroner's Post mortem take place? Yes/No	Findings:
Did a hospital post-mortem take place? Yes/No	
END OF LIFE CARE	**Brief Comments**
Was a decision made to move to end of life care?	Yes / No
Were the parents offered access to hospice?	Yes / No/ NA
Were the parents offered a post-bereavement consultant follow-up appointment?	Yes / No
CASE REVIEW DETAILS	**Brief comments**
Has there been an internal mortality review process?	Yes / No Date of review:
Was there appropriate consultant supervision?	Yes / No
Was there any delay in diagnosis or delivery of care?	Yes / No
Any evidence of HCAI ?	Yes / No
Was a SIRI or internal serious incident investigation performed? Please forward a copy of any neonatal investigations to the network once completed.	Maternal SIRI
	Neonatal SIRI
	Internal Neonatal Investigation (red/ serious harm)

CASE REVIEW CONCLUSIONS	Brief comments
Was death anticipated?	Yes / No
Was death explainable?	Yes / No
Highlight notably good elements of care	
Highlight areas where care could have been improved	
Any other learning which might be helpful to share with network colleagues?	

Score for mortality care assessment 1-5	
Definitions: • Neonatal care good – death inevitable/unpreventable = 5 • Neonatal care good with one or two minor areas for improvement – not likely to have influenced outcome =4 • Potentially preventable complications present which may have contributed to the outcome, e.g. sepsis, although the pre-existing risk of mortality was high = 3 • Preventable complications are likely to have had a significant influence on the outcome =2 • Death would have been preventable if care had been different = 1	

Version Control:

Version	Date	Details	Author(s)	Comments
1	May 2015	Final agreed with Thames Valley & Wessex Neonatal ODN Clinical Forum members	Dr Eleri Adams Dr Victoria Puddy	Approved
Review Date:	**May 2018**			