

**Child and Family Services Joint** **Mortality / Morbidity Meeting**

**Wednesday 14th December 2016**

**Minutes**

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| **Initials**  **KD** | **Pt No.** | **Age**  **29** | **BMI: 17** | **Gestation: 25/40** | **Parity: G2 P1** |
|  |  |  | **PMH:** Loop excision since last childbirth  **POH:** Para 1 (Previous emergency LSCS after failed instrumental) | | |
| **Synopsis of events** | | | | **Learning Points** | **Action** |
| Presented at 25 weeks in advanced labour having attended with recurrent episodes of mucousy blood stained show in the preceding weeks.  During arranging transfer, the membranes ruptured.  Emergency classical CS carried out as SROM and transverse lie.  Baby in NNU for considerable length of time. | | | | * LSCS at full dilatation can compromise the integrity of the cervix if the incision on the uterus is not high enough * LLETZ is an additional risk factor for pre-term birth. These two factors may well have contributed to weakening of the cervix in this case. * Typical presentation in mid-trimester with multiple shows followed by advanced labour is characteristic of cervical incompetence   **MK review**  Although the patient has been seen for a de-brief and there is a plan in place for cervical length scan in a subsequent pregnancy, patient should be offered a cervical suture at 14 weeks based on her history and presentation. Vast majority of patients with similar history end up with USS indicated cervical cerclage. | * Patient should be informed about the plan for next pregnancy. |
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| **Initials**  **LC** | **Pt No** | **Age**  **30** | **BMI:** | **Gestation: 35+4** | **Parity: G2 P1** |
|  |  |  | **PMH:**  **POH:** Previous spontaneous vaginal delivery at 41+0 | | |
| **Synopsis of events** | | | | **Learning points** | **Action** |
| Para 1, previous delivery at term.  Presented at 35 weeks with some contractions, palpated, small for gestational age.  A growth scan confirmed baby below the 10th centile with liquor just below 95th centile.  Heart was displaced to right with mass seen within the chest.  The right side of the heart was also dilated.  Stomach was seen low in abdomen, just above the bladder.  Differential diagnosis: Diaphragmatic hernia or Congenital Adenomatoid Malformation of Lungs (CAML).  Discussion with FMU regarding review following scan in the afternoon.  Although patient did not obviously appear to be labouring, she continued to have irregular tightenings.  With the change of shift, the night team liaised with NNU and made them aware of the patient.  Plans were made for transfer to St Mary’s.  Shortly before transfer, the patient ruptured her membranes, there was fetal bradycardia.  The cervix was found to be fully dilated but the head was high and in the occipito-transverse position.  An emergency LSCS was carried out. | | | | * Involve NNU early * Low threshold to perform repeat vaginal examination to confirm labour especially in a multip. |  |
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| **Initials** | **Pt No** | **Age** | **BMI:** | **Gestation: 35+5** | **Parity:** |
| **JC**  **Case 1** |  |  | **PMH**:  **POH:** | | |
| **Synopsis of events** | | | | **Learning points** | **Action** |
| Born 19/07/16, grade 1 CS; presumed fetal compromise  Pale/blue, no respiratory effort, HR >100 (at the right side)  NGT passed  Only one artery noted in umbilical cord  Potential congenital diaphragmatic hernia or ‘cystic’ lesion  Transferred to NNU  Transferred to St Mary’s for ongoing care – repair of CDH (July) and also repair of incarcerated inguinal hernia (Aug)  Repair of co-arctation at Alder Hey Hospital (12/9)  FU planned at Stepping Hill | | | | * Managed well * No opportunity for AN discharge |  |
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| **Initials** | **Pt No.** | **Age** | **BMI:** | **Gestation: 25/40** | **Parity:** |
| **KD**  **Case 2** |  |  | **PMH:**  **POH:** | | |
| **Synopsis of events** | | | | **Learning Points** | **Action** |
| Fetal anomaly scans NAD  Emergency crash section for placental abruption, failure to progress and transverse lie.  Pale, floppy, no respiratory effort HR<60bpm  Transferred to NNU  Transported to Bolton  Transferred back to Stepping Hill NNU at 7+ weeks age and discharged home from SHH at 16 weeks age on Home Oxygen therapy – Oxygen discontinued in Summer  Good progress since discharge  Ongoing Paediatric FU until corrected age of 2 years | | | | * Managed well * No opportunity for AN discharge * SHH is LNU so care for babies from 27+0 weeks gestation – Potential deliveries <27 weeks should be transferred antenatally if possible and postnatally after stabilisation if AN transfer not possible. |  |
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| **Presentation – Carrie Heal** | | | | **Learning points** | **Action** |
|  | | | | * Please see discussion points within presentation. |  |
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| **Feedback from inquest** | | | | **Learning points** | **Action** |
|  | | | | * Rising baseline could be associated with intra partum sepsis. * Discussion around definitions of pyrexia in labour and threshold for treatment. |  |
| **The A-Equip Model – Professional Midwifery Advocate (PMA)** | | | |  |  |
|  | | | | * Presentation attached for information. Verbal update given by Marie Dooley re cessation of Supervision of Midwifery from March 2017. * Current SOMs are reviewing services currently offered. |  |
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| **Date and time of next meeting**  **Level 3 Safeguarding – 18th January 2017**  **1.30pm – 3.30pm** | | | | | |