Central Manchester University Hospitals NHS
NHS Foundation Trust

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Room 217
Medical Directors Office
Trust Headquarters
Manchester Royal Infirmary
Oxford Road
Manchester, M13 9WL
[redacted]

24th September 2014

Mr J S Pollard
HM Coroner Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

Dear Mr Pollard

Re: Antonio Jerome ALLEN (Deceased)

Thank you for your letter to Sir Michael Deegan of 31st July 2014, he has asked me to reply on his behalf. I instructed the clinical team to review the case and have set out the answers to the points noted in the Regulation 28 notification below.

The priority of the maternity directorate is to provide safe and high quality maternity care for all women and their partners regardless of their choice of place of birth. Options for place of birth are discussed fully with the woman and her partner/family to enable women to make an informed choice. At the booking consultation a full medical, surgical, obstetric and social history is taken to support women in their decision by discussing the risks and benefits of choices available. Women are also given an information leaflet to enable them to discuss their options further with their family.

Maternity staffing is managed to ensure that the community midwifery team can respond to requests from women at any time of the day or night when a home birth is planned in order to ensure women and their family receive optimal care and support.

On the 17th June 2013 at approximately 04:20 hours community midwife [redacted] was informed by a fellow midwife, working on the midwifery led unit, of the imminent delivery at [redacted] home address.

Midwife [redacted] immediately collected the emergency equipment and attended Patient A's home. On arrival at 04:44 hours [redacted] was on the kitchen floor with her baby placed on her abdomen (skin to skin). Midwife [redacted] performed a full risk assessment once [redacted] and her baby were comfortable and settled and made the decision that it was safe for both to remain at home.

The mother of [redacted] informed Midwife [redacted] that she had telephoned the dedicated telephone number from approximately 04:00 on four occasions until approximately (04:20 / 04:30 hours) but her call was not answered. (All women who are booked for a planned home birth are given a dedicated number to contact. This telephone line is normally in operation 24 hours/day). [redacted] mother reported that she then called the Triage department who transferred her call to the community midwifery team.

Following her return to the hospital Midwife [redacted] alerted the radio telephone administration staff of the difficulties experienced by the family. On investigation it was identified that there had been a known fault on the telephone line earlier in the day but this had been resolved by the engineers. There is a process in place to ensure that the essential telephone lines are checked at the beginning of each shift; it was apparent that the administrator did not follow the process for checking the phone line at commencement of their shift so was unaware that the fault had reoccurred.

On being informed by Midwife [redacted] of the unanswered phone calls the administrator notified switchboard of the fault on the line and immediate action was taken to reconnect the telephone line. To ensure that this never happens again women are now given two telephone numbers to call in case one line is busy or faulty. A standard operating procedure in place to check that the essential telephone lines are fully functioning.

Yours sincerely

[redacted]

[redacted]
Medical Director

cc. [redacted] Clinical Head of Division, Saint Mary's Hospital
[redacted] Divisional Director, Saint Mary's Hospital