If calling please ask for:
Professor [redacted]

Direct line / Ext:
[redacted]

Trust Headquarters
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Our reference: HMC1951

Date: 22nd August 2016

Confidential

Mrs L Hashmi
H M Area Coroner
The Phoenix Centre
L/Cpl Stephen Shaw Way
Heywood
OL10 1LR

Dear Mrs Hashmi,

Re: Baby Dominic Christopher Smith (formerly Dominic Fisher) – Date of birth 02/06/2015 – Date of death 02/06/2015

Please find herewith a response to your concerns as outlined in the Regulation 28 (Prevention of Future Deaths) Report served on the Trust following the Inquest into the death of the above named baby which was held on 20 – 22 June 2016. The matters of concern are listed below with the accompanying response; I have provided a supplementary document with specific evidence for each concern raised.

Coroner's concerns

1 Inadequate communication, handover and record keeping.

Response from the Trust:

The Division of Women and Children's is undertaking a programme of rolling audits on communication and documentation. The purpose is to ensure compliance with policy standards and to identify areas where there are challenges in order to implement remediating measures.

The division has commissioned an improvement programme of work focusing on these three areas in order to fully embed effective and reliable processes into clinical practice.

2 **Staff did not follow the Trust's protocols/guidance and did not document their rationale where they exercised clinical discretion.**

Response from the Trust:

The findings from the RCA and in particular the lack of adherence to protocols are part of a process which aims to embed learning from incidents within the division. In this particular case, a lessons learned proforma was sent to all midwives and medical staff within obstetrics to share more widely the key themes around care delivery within the Division.

3 **Midwives did not carry out a speculum examination, on two separate occasions, in order to establish whether there had been a rupture of membranes. The time between rupture and delivery was, more likely than not, miscalculated as a result of this.**

Response from the Trust:

There has been guidance issued to all practitioners to reiterate the need to obtain a thorough, probing history from the patients to ensure questioning covers the potential rupture of membranes in line with policy and carry out an appropriate speculum examination. The incident and investigation has been widely discussed with the birthing centre and community midwives, in particular.

4 **Early warning scores were i) miscalculated, ii) not acted upon.**

Response from the Trust:

Undertaking correct acute monitoring of patients condition, through using early warning scores is currently a Trust wide project to improve practice.

The work will include a suite of improvement measures and is part of the first improvement collaborative for the Trust in response to CQC findings (August 2016). The intended outcomes are to align practice to ensure compliance with best practice standards and sustain improvements.

Within the maternity services, a specific Maternity Early Warning Scoring Chart (MEWS) has been revised which has greater sensitivity to the needs of the physical parameters of women during pregnancy. This tool is in the pilot phase currently to enable any necessary alterations to be implemented prior to being fully embedded in practice.

5 **Neonatal observations were not carried out when it became apparent that there had been a material change in baby's condition. Signs and symptoms relating to the deterioration were also missed.**

Response from the Trust:

The neonatal services has developed a module of training entitled Care of the Compromised Infant, which now forms part of each midwife's mandatory training; the

aim is to ensure early detection of the deteriorating infant and appropriate response to this.

There has been an audit as part of the divisional yearly programme looking at compliance with the Early Onset Sepsis Guidelines. Actions put in place following the audit was to introduce a new observation chart based on the Newborn Early Warning Score recommended by British Association of Paediatric Medicine (BAPM) and this work is in progress. Once completed there will be further audits to monitor compliance.

6 **Maternal observations were not carried out after delivery, despite a spike in temperature.**

Response from the Trust:

The Division have developed a programme of training to emphasise recognition of signs and symptoms or deviations from normal physiological observations.

The training focuses on the escalation to a medical practitioner and having clear clinical management plans in place, which are monitored.

7 **Midwives did not escalate to or consult with the Obstetrician/Paediatrician/Neonatologist.**

Response from the Trust:

The training referred to in points 4 and 5 above involves emphasising the importance of escalation to the appropriate medical teams, where deviations from the normal physiological parameters are recognised.

The Critical Care outreach team are also supporting the Division where elevated early warning scores are identified. This involves direct care by the outreach team and subsequent follow up to ensure stabilisation of the patient.

8 **Inadequate preceptorship for newly qualified (and particularly part-time) Midwives.**

Response from the Trust:

The Preceptorship programme has been updated in order to provide a competency based framework to support newly qualified midwives to become confident practitioners. This has been adjusted most recently following feedback from recent cohorts, with a view to embedding lessons learned from incidents and complaints into clinical practice.

The current framework provides for preceptor staff to rotate every four months with an identified preceptor to meet and formalise objectives within the clinical placement for newly qualified midwives and where support is now offered within a structured supportive environment.

A practice development midwife has been recruited to support the preceptorship programme and to act as a reference point for new midwives in practice.

The majority of concerns identified by the Coroner were raised as part of the Root Cause Analysis investigation into Baby Dominic's death, and actions were subsequently put in place to prevent reoccurrence. Therefore, and in order to support the information provided above the Trust would, if required be able to provide a significant amount of evidence against each of the areas of concern. These are listed for your information in Appendix 1.

The investigation into Baby Dominic's death identified a number of system and organisational learning opportunities as well as individuals who needed to reflect on their practice and address shortcomings. These areas have all been addressed and individuals have had the opportunity to reflect on their practice and make improvements as part of their supervisory arrangements.

It is hoped that the Trusts response provides you with the assurance that the Trust has, and will, continuously strive to ensure patient safety.

May I take this opportunity to again convey our sincere condolences to the family of Baby Dominic for the failings in the care provided.

Yours sincerely

[redacted]
Executive Medical Director