Western Sussex Hospitals NHS
NHS Foundation Trust

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12 September 2016

Ms B Dolan QC
Assistant Coroner for the County of West Sussex
Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

Dear Ms Dolan

RE: Regulation 28 Report to Prevent Future Deaths – Baby Leilani CHUTE

I write to formally acknowledge receipt of the Regulation 28 report to Prevent Future Deaths and to respond to your three matters of concern. Please be assured that the specific issues have been considered in depth by the clinical leadership team, explored further at a very well attended governance event dedicated to these issues and that an action plan is being implemented. The concerns are addressed individually below.

1. ***That the practice of manually pushing back the cervix was one adopted by two junior doctors. The practice was not in accordance with standard training and was conducted without the knowledge of the consultant.***

i. Audit of current practice

An audit of instrumental deliveries undertaken in the operating theatre was completed in August to establish whether manually pushing back the cervix is part of our clinical practice. Case notes from 641 patients from the Chichester and Worthing sites from the last 12 months were reviewed.

The practice of pushing back the anterior lip of the cervix was used infrequently and found in 15 women most of whom were primiparous. The procedure was usually undertaken by middle grade doctors rather than midwives or consultants. The vast majority of these women proceeded to deliver vaginally. No harm was identified from the practice.

Feedback from the audit will now take place at both departmental level and for the individuals concerned.

ii. Feedback for the two individuals involved in baby LC's delivery who used the practice of manually pushing back the cervix

Initial feedback with the supervising consultants has taken place for both the trainee doctors who used this procedure prior to them leaving the Trust. Further formal meetings are scheduled to take place that include their educational supervisors from their time at WSHT and their new supervisors. Your concerns will also be shared with the deanery to ensure there is wider learning.

iii. Policy and guidance

A statement has been circulated by email to the medical and midwifery staff highlighting the Trust position that manually pushing back the cervix is not an acceptable practice.

This has also been highlighted at the maternity safety huddles. Safety huddles are daily meetings that take place on each ward to raise safety issues with staff and anticipate risk in daily workload.

In addition, local guidelines have been amended to state clearly that pushing back the cervix is not acceptable practice.

2. ***That the manner in which consent was sought from women in labour where there was a choice to be made between attempted instrumental delivery and going straight to CS did not appear to provide them with the relevant facts in order to come to an informed choice, but presented those facts that favoured the doctors preferred approach to management.***

i. Policy and guidance

In view of your concerns the Trust has reviewed both the overall Trust guidance and the relevant specialty guidance on consent. The existing overall Trust guidance gives clear guidance on informed patient choice and fully reflects the implications of the recent *Montgomery* judgment.

Work is underway to strengthen the Trust's specialty guidance on instrumental delivery and caesarean section to fully reflect Royal College of Obstetrics and Gynaecology (RCOG) guidelines on consent in these specific circumstances and places appropriate emphasis on informed patient choice.

ii. Training

The service has introduced a more in depth online training module for obstetric staff alongside the existing Trust mandatory annual online e-learning on consent. The recently introduced EIDO Healthcare online learning contains a specific module on consent in obstetrics and all obstetric and gynaecological medical staff are now required to undertake this training every three years. The uptake of training will be monitored by the Division and a link to the training is shown below. http://www.beinformedplus.com/

iii. Feedback and learning for the individuals involved in the consent process

See item 1.ii. Reflection on the consent process has formed and will form part of these meetings with trainees. Other senior staff involved will use the appraisal process for reflection and learning.

3. ***That neither or the above items had been identified as a 'Care and Service Delivery problem' by the Trust's Root Cause Analysis investigation and hence no steps had been taken by the Trust to address these issues.***

i. Processes for planning investigations when perinatal deaths have occurred

A review of existing processes for these investigations is underway using existing models of best practice from the RCOG and CQC with a half day governance meeting scheduled for October to consider any emerging proposals. The Trust governance team has also been asked to provide support for the division to ensure that RCA's undertaken for Serious Incidents are rigorous and objective.

From late 2017 it is anticipated the planned NHS England/Department of Health National Perinatal Mortality tool will become available and will be implemented at the Trust. The newly developed tool adopts a standardised approach for the investigation of perinatal deaths and will incorporate national reporting and learning.

We hope that the above provides sufficient assurance that the Trust continues to strive to learn from Baby Leilani's death.

Yours sincerely

Marianne Griffiths
Chief Executive

(signed for and on behalf of Marianne Griffiths, by [redacted] Medical Director and acting Chief Executive)