NHS
Birmingham Women's and Children's
NHS Foundation Trust

Dr Fiona Reynolds
Chief Medical Officer
Executive Team
Birmingham Women's and Children's NHSFT
Steelhouse Lane
Birmingham
B4 6NH

www.bwc.nhs.uk

Mrs Louise Hunt
HM Senior Coroner
Birmingham and Solihull
50 Newton Street
Birmingham
B4 6NE

[redacted]

12 October 2018

Dear Mrs Hunt

Kiarah Faith Adora Allen – Regulation 28 Report to Prevent Future Deaths

I write further to the inquest touching the death of Kiarah Faith Adora Allen which you held on 20 August 2018 and your subsequent Report to Prevent Future Deaths, dated 21 August 2018.

Firstly, I would like to reiterate the Trust's sincere and profound condolences to Kiarah's family.

Further to the evidence presented to you on 20 August, you concluded that Kiarah died from an inadvertent fluid overload of Parenteral Nutrition (PN) given via an umbilical venous catheter (UVC) as a result of unsafe staffing levels, not correctly following procedure and failing to learn from a previous incident. Her death was contributed to by neglect.

Your Report dated 21 August 2018 highlighted concerns in regards to funding for the unit and specifically highlights that the unit is funded for 85% occupancy.

I have had sight of the response from NHS England in regards to the neonatal commissioning arrangements and can confirm that we are continuing to work with our colleagues at NHS England to better understand and improve the commissioning and funding arrangements to support our neonatal service.

Alongside these discussions we continue to invest a significant amount of time and effort into improving our Neonatal Intensive Care Unit (NICU) at Birmingham Women's Hospital to enhance the service afforded to our patients and their families, and to prevent a recurrence of the circumstances which led to the devastating incident and Kiarah's tragic death.

I would like to take this opportunity to update you on progress against the action plan which was developed in response to our root cause analysis (RCA) investigation into this incident and submitted to you prior to the inquest (also attached to this response for ease of reference).

You will be aware from the RCA and action plan submitted to you prior to the inquest that many changes have been recommended and these changes are being implemented as part of an on-going work plan.

Referring to the action plan, the following actions have been completed and new practices dictated within those actions are being embedded;

- Action 1; A new nursing competency for safe administration of PN has been developed and all staff have been retrained and assessed against the competency before being allowed to continue administering PN.
    - All eligible staff have been re-educated and assessed against the up to date trust wide PN competency. All new members of staff will attend the study day as part of the new NICU Foundation programme. This has been in place since July 2018

- Action 2; Nurses are allocated to specific babies each shift.
    - The nurse in charge (NIC) is allocating babies to nurse every shift. This is being reinforced though the staff weekly newsletter.

- Action 3; Each shift a specific nurse should be allocated to hold the bleep and their name is documented on the NIC paperwork.
    - The bleep is allocated to a specific nurse, and there is also a back up nurse every shift. This is embedded within daily practice.

- Action 4; The Nurse in charge handover is to be shortened to ensure that the Situation report (SITREP) is completed and babies are moved, if required.
    - A new sit rep form has been finalised and is in use.

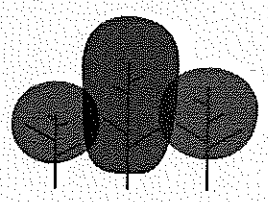
- Action 5; A new workforce plan will be developed by the senior leadership in neonates.
    - The workforce plan is live, but recovery through increased recruitment is on-going.

- Action 6; A shift planner to be incorporated on the back to the new handover checklist.
    - The shift planner and handover checklist is launched and in use.

- Action 8; The use of the trolley when completing PN to be embedded into the competency for PN.
    - Trolley use is embedded, with a guide and labels attached.

- Action 10; Include the disposal of the old PN in the training competency for PN.
    - The competency document has been approved and is in use.

- Action 11; A checklist is to be created when PN is being changed, this allows the person to check in and check out of the task.
    - The competency document has been approved and is in use



- Action 14; An Education Plan will be produced to include the care of the sick neonate and embed learning. A student liaison role has also been created to support delivery of training.
    - The education plan began in October 2018

- Action 20; There should be a member of staff with the parents during witness resuscitation
    - Witnessed resuscitation is part of our standard practice and is being reinforced in simulation training

- Action 24; Head of Nursing to complete and implement a NICU workforce plan.
    - The Workforce plan is being implemented and the NICU e-roster has been reconstructed and aligned to the workforce plan.

With regards to the remaining actions, I would like to update you as to the progress of this change as follows;

- Action 7; Observation charts with a RAG rated ward round jobs list are to be created and implemented.
    - This project is on-going; the NICU team are working with the medical illustration department to devise a draft chart for piloting.

- Action 9; Previous shift NIC to review babies and move them where necessary.
    - Within current practice, the NIC is moving babies where ever possible to permit the safest possible care, however this is not yet fully embedded

- Action 12; The doors of the clinical rooms are to be left open, during key tasks, when infection control allows.
    - Culture change is on-going

- Action 13; Head of Nursing to price the vocera system for staff to be able to summon support from colleagues, if required.
    - Pricing for Vocera for all clinical areas is a current on-going task

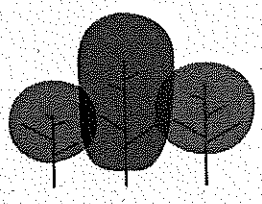
- Action 15; The Women's site requires site management service cover.
    - In planning

- Action 16; Band 7 (special care) or discharge liaison lead to work weekends to ensure leadership is more visible on the NICU.
    - The Neonatal Head of Nursing or Matron are sending daily sit rep to Managers for neonatal RAG status. Currently, this occurs on week days only.

- Action 17; Standardise practice for lumen use when completing PN changes.
    - Not yet achieved

- Action 18; Label all the lines near to the Baby.
    - Additional labels were ordered in September. This is embedded in in nursing practice, where we have appropriate labels

- Action 19; Always have a leader during resuscitation who is not task focussed and therefore is able to have situational awareness.
    - The resuscitation equipment is being checked daily and regularly being reviewed by the Leadership and Resuscitation team. Advanced Resuscitation of Newborn Infant (ARNI)



course and team training is focussing on resuscitation team leadership and human factors to ensure the team leader does not get involved in tasks but maintains a leadership role for better situational awareness

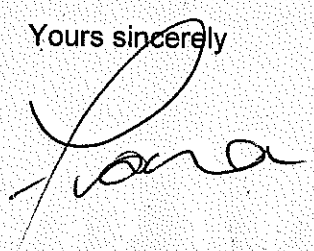
- Action 21; Head of Nursing to price the ARNI training for NICU nurses to replace Newborn Life Support (NLS) course
    - ARNI was not to replace NLS, but to complement it as both are required. This will form part of the suite of resuscitation courses available across the trust. ARNI implementation is on hold whilst the Resuscitation Team at the Trust is recruited to.

- Action 22; Human factors training:
    - The annual staff training day has been redesigned and Human factors will be included in this training which began in September. It will take a year to deliver this to all staff.

- Action 23; Blood gas checking to be incorporated into the simulation training.
    - Two nurses have attended training to become able to run simulation training. A plan is being put in place to devise the training package together with a Neonatal Consultant.

I hope that this serves to reassure you that the Trust has taken this incident, and Kiarah's subsequent tragic death, very seriously and that we are working hard within the current financial constraints to improve our service.

Yours sincerely



Dr Fiona Reynolds
Chief Medical Officer
Birmingham Women's and Children's NHS Foundation Trust