GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Your Ref/eich cyf: DR/JJF/Reg28
Our Ref/ein cyf: 18/2759/INQ
Date/dyddiad: 10th July 2019
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Private & Confidential
Mr David Regan
Her Majesty's Coroner
Pontypridd Coroners Court
Court House Street
Pontypridd
CF37 1JW

Dear Mr Regan

Re: Regulation 28 – Jenson James Francis

Thank you for the correspondence in relation to the above Regulation 28 received by the Health Board on 17th May 2019.

Please be assured that the Health Board has taken this matter extremely seriously. Lessons have been learnt, following investigation and further informed by the findings of the inquest.

The details provided below align with the numerical order in which you presented your concerns and aims to capture actions taken to minimise the risk of any recurrence:

Actions implemented

1 **The root cause analysis characterises the presence of a "dysfunctional team without a clear leader". Evidence at the inquest and in the report of the Royal College of Obstetricians and Gynaecologists dated 16th April 2019 identified a culture of unclear leadership and a perceived inability on the part of more junior staff to challenge or review decisions.**

There is an Organisational Development Action Plan to focus on many areas of the multiprofessional teams in maternity services. Within the plan there is support for multidiscipliary team working and clinical leadership. Included in the plan are two study days in July and October 2019 supported by the Royal College of Midwives to improve clinical leadership and team working within the department. The mandatory professional training days include sessions on communication, record keeping and documentation and esclation. This plan focuses on individual team members as well as groups. PROMPT is now fully implemented into the Health Board with all staff booked for training before the end of March 2020. Training compliance is monitored through the HB Maternity Improvement Board.

2. **There was a poor standard of CTG interpretation, with insufficient training and review**

The Health Board has implemented the All Wales Intrapartum Fetal Sureillance Standards which includes a minimum of 6 hours of taught training on CTG monitoring & intrepretation. WRP are supporting the introduction of a competency based assessment for CTG intrepretation. Training compliance is being monitored through Maternity Improvement Board.

3. **There was unclear communication as to whether a category 1 or 2 caesarean section was required.**

The importance of ensuring the team communicate the level of urgency for caesarean section has been communicated to all staff via feedback on cases – newsletters and at clinical review meetings. The multidisciplinary team attend PROMPT training on a monthly basis which has a clear focus on the management of emergency clinical situations with clear team communication. Clinical incident review meetings and multidisciplinary reflection sessions gives an opportunity to review clinical decision making and communication in relation to the level of urgency of a caesarean section. Monitoring of the categorisation of caesarean section is included on the clinical audit plan for 2019/20.

4. **NEWS chart and partograms were not completed, and there was a poor standard of record keeping.**

The maternity services have commenced a record keeping audit as part of the audit plan. The findings of the audit will be shared with all staff and actions taken where improvements need to be taken. The senior midwives are undertaking assurance audits on the maternity wards monitoring the standards of records and completion of NEWS charts and other risk assessments. Any areas identified at the time of the monthly assurance audits are being managed at the time of finding an error or incomplete record. Clinical Supervisors for Midwives are conducting monthly group supervision sessions with a focus on the standard of record keeping.

5. **There were insufficient staffing levels, and very high acuity, despite which there was no consultant attendance and the escalation policy was not used. There was evidence that there was no clear line of responsibility for identifying and ameliorating it.**

Staffing has significantly improved since August 2018 with ongoing recruitment of midwifery staff. The merger of the two units has assisted in managing any staffing shortfalls as we are no longer providing cover for two units.

Midwifery and medical staffing are being reported on a monthly basis via the Maternity Improvement Board. We are currently undergoing a Birth Rate Plus Asessessment of our workforce needs in the new unit. The final assessment report will be available in September 2019.

Consultant cover has increased significantly and the Health Board has recently recruited 3 new consultants. There is 60 hour labour ward presence on the labour ward since the merger.

There is a new escalation policy and staff are incident reporting times of high acuity this is being monitored via datix reporting. There is a senior midwife on call rota to support staff with any concerns in clinical practice out of hours and for concerns about escalation.

Birthrate plus acuity system for labour ward has been implemented into the unit and staff are currently being supported to use this to support timely escalation.

6. **The recent merger of the maternity units of Prince Charles and the Royal Glamorgan hospitals, while potentially creating a future single centre of expertise, does risk causing a period of institutional stress to maternity services which have exhibited some significant shortcomings.**

As part of the Organisational Development work being undertaken a Clinical Psychologist has been approved to assist in undertaking some targeted work with staff. Continued monitoring and support from Human Resources is also in place. An improvement plan has been in place since September last year and is monitored by Welsh Government and the Maternity Improvement Board to ensure continued safety of the maternity department.

I sincerely hope that this information will reassure you that the Health Board has learned important lessons from the investigation into the care provided to Jenson James Francis and that effective action has now been taken to prevent further deaths.

I would like to convey, once again, my deepest sympathy and sincere apologies to the family of Jenson for the failings identified.

Yours sincerely

Greg Dix

Greg Dix
Acting Chief Executive Officer