NHS
Portsmouth Hospitals
NHS Trust

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MS S Marsh
Assistant Coroner for Portsmouth & South East Hampshire
The Coroner's Court
1 Guildhall Square
Portsmouth PO1 2GJ

16 August 2019

Our Ref: MC/JH/Q13/19

Dear Ms Marsh

Regulation 28: Report to Prevent Future Deaths, concerns arising out of evidence heard at the Inquest into the death of Ezra James Boulton

Following the inquest into the death of Ezra James Boulton, which was concluded on 21st June, you issued a regulation 28 report addressed to myself and the Director of Midwifery and Maternity at Portsmouth Hospitals NHS Trust (PHT), asking us to respond to a list of 4 concerns. Those concerns have been taken from your report dated 1st July 2019 and are listed below followed in each case by our answers on behalf of Portsmouth Hospitals NHS Trust (PHT).

(1) At Ezra's Inquest I was told in evidence that throughout her pregnancy (this being her first pregnancy), [redacted] (Ezra's mother) did not see the same midwife twice. I believe that there should be some level of continuity of care in antenatal appointments to ensure that all of the necessary checks are preformed and appropriate antenatal advice is shared with the mother.

Nice Guidance "Antenatal care for uncomplicated pregnancies" CG62 sets out at Appendix D a schedule of appointments which should be provided for women with uncomplicated pregnancies. The requirement is for 10 appointments for nulliparous women and 7 for parous women. The schedule sets out in detail which checks and advice should be provided at each of the appointments. Each patient has their own hand held notes which are retained by them and brought to every antenatal appointment. As such each healthcare professional who meets a woman will have access to all the information they need to enable them to ensure that all necessary checks are performed and appropriate advice is shared with them.

"Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care" (Better Births) published by NHS England in 2016 sets out a number of key recommendations for improvement in maternity care. This includes a move towards personalised care and the aim of every woman having her own midwife, who is part of a small team of midwives, based in the community, who can provide continuity throughout her pregnancy. Annex B of the *"NHS Operational Planning and Contracting Guidance 2019/20"* (NHSE) has set a national aspiration to increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2020, 35% of women will be booked onto a continuity of carer pathway, PHT is on track to achieve the target of 35% of women being booked on the pathway by March 2020.

As a first step towards achieving this, PHT is setting up 2 continuity of carer pathway teams, of 6-8 community midwives, with each midwife having a caseload of approximately 40 women. This will enable these women to have a named midwife and a "buddy" who will coordinate care throughout the antenatal, birth and postnatal period. The first team will be in place by the end of August with the second team being established towards the end of 2019.

Those patients who have more complex pregnancy needs such as those with diabetes and multiple birth pregnancies already receive continuity of care because they have their antenatal appointments carried out in the hospital environment with a small team of specialised staff.

(2) I also heard that [redacted]'s own personal pregnancy was uneventful but I am concerned that the distinct lack of continuity of care appears to expose a risk that should there be any abnormalities and/or risk factors to either mother or baby as the pregnancy develops, that these have the potential to be missed; either entirely missed or not properly communicated to whichever midwife conducts the next antenatal appointment, causing significant risk to both mother and baby. I believe that there is a serious risk of future death posed by this lack of continuity of care.

As stated above, PHT is striving to achieve the model of continuity of care for women set out in Better Births, the aim of which is to provide hands on care for the woman and her baby with greater coordination and the development of a relationship between the woman and the midwife caring for her and her baby.

There is already in place a well established process which seeks to ensure that abnormalities and risks are picked up during pregnancy. Each woman has her own handheld notes which are taken to every antenatal appointment and all checks and assessments are recorded in them. This information is therefore available to every healthcare professional caring for the woman during the course of her pregnancy. The NICE guidance referred to in answer to concern 1 above sets out in detail the appropriate checks for assessment for each antenatal appointment depending on the stage of the pregnancy. Every midwife employed by PHT is very familiar with the format of the notes and the checks and assessments required at each stage of the pregnancy. They are expert practitioners in normal pregnancy and birth and are trained to pick up any deviation from normal and escalate as appropriate. Women are also given details of the maternity assessment unit at PHT which they can contact for support and advice if they are concerned about the progress of their pregnancy and if needed they will then be asked to attend hospital for clinical assessment.

(3) At Ezra's inquest I was told that as baby had been delivered safely with no significant injuries to mum (i.e. no significant tearing or blood loss) that the family were encouraged to leave fairly rapidly. On discharge, the focus of information sharing and care was distinctly focused on after-care for the mother. The family did not recall being given any information directly on safe-sleeping; either at antenatal appointments or at a post-natal stage from any midwife or Health Visitor. Any information they were given was provided almost as an after-thought and given in the form of a leaflet which it was suggested that they read. I was told that the first HV appointment the family received was approximately seven weeks after Ezra had been born. I believe that making safe sleeping information readily available to all parents at an early stage may significantly reduce the risk of future infant deaths due to co-sleeping.

PHT has a discharge checklist sticker which is placed in the woman's medical records following birth and includes "safe sleeping" and must be ticked by the midwife on discharge to confirm that the woman has been advised about safe sleeping. There is also a safe sleeping leaflet which is usually given to women on discharge as part of a package of advice leaflets. However, The Hampshire Safeguarding Children's Board is currently reviewing the Safe Sleeping Leaflet with a view to producing a more engaging version that raises the profile of this important issue.

In the meantime, on discharge after birth, PHT midwives are giving women a separate photocopy of page 9 of the Child Health Record (red book) which contains advice about safe sleeping as well as details of the Lullaby Trust and NHS Choices where further advice can be obtained. This handheld book is normally given to women by their health visitor and not PHT midwives.

Generally speaking the post natal care of women is handed over to the Health Visitor Service at around day 10 post birth, which is extended to up to 28 days where the woman has additional need for midwifery support. The Health Visitor Service is provided by Solent NHS Trust and I am therefore unable to provide any further information about those visits.

(4) I also heard that midwives are unaware that causing the death of an infant due to co-sleeping becomes an automatic criminal offence of "overlay" (under section 1(2) of the Children and Young Person's Act 1933) if alcohol and/or drugs are involved. I believe that making this information readily available to midwifery practitioners may reduce the risk of future infant deaths due to co-sleeping but may also reduce the need for Police involvement (with a view to prosecution) in what is already a tragic time for a family who have lost their child.

We recognise the importance of ensuring that midwifery staff are familiar with the components of the criminal offence of "overlay" and in response to your comments the Director of Midwifery and Maternity has emailed all midwives and neonatal nursing, medical and support staff to alert them to that definition.

With regard to your concerns about Police involvement, the *"Sudden unexpected death in infancy and childhood - Multi – agency guidelines for care and investigation"* published in November 2016 sets out guidelines on the multi-agency approach to investigating unexpected deaths in childhood and infancy and includes a requirement at paragraph 2.4 that the "Police should be contacted as soon as possible after the arrival of the infant in the emergency department, if this has not already been done." In those circumstances it is impossible to avoid Police involvement. However the guidelines also stress the importance of ensuring that these situations are handled with sensitivity for the grieving family, which is of course always a primary consideration for this organisation.

I hope that this response provides you with the reassurance you require that the issues you have raised are already priorities for the Trust but please do not hesitate to contact me if you require further clarification on any of the information provided.

Yours sincerely

Mark Cubbon
Chief Executive