team westHerts

NHS
West Hertfordshire Hospitals
NHS Trust

3 June 2020

PRIVATE AND CONFIDENTIAL

Watford General Hospital

Vicarage Road
Watford
Hertfordshire
WD1 8HB

Mr G Sullivan
Senior Coroner for Hertfordshire
The Old Court House
St Albans Road East
Hatfield
Herts AL10 0ES

Dear Mr Sullivan

Jack Postle – Regulation 28 Report

I am writing to you in my capacity as Chief Executive of West Hertfordshire Hospitals NHS Trust (WHHT) to respond to the concerns you raised following the investigation into the circumstances surrounding the tragic death of Jack Postle, which led you to making the Regulation 28 Report dated 26 February 2020.

The concerns raised were as follows:

1) That there is insufficient capacity at the WGH maternity unit to provide a safe level of care to patients

2) That the guidance provided to consultants, for outlining options to an expectant mother, seek to limit the availability of caesarean section, even following failed induction. Of the three options, LSCS is the only one to include the caveat 'but not as first choice'. This caveat is included without reference to any other clinical considerations which might affect the appropriateness of the options, (Para.10 *Induction of Labour out-patient and use of intrapartum oxytocin*, 1st September 2016, Version 3.1).

The actions of the Trust are primarily focussed on improving the pathway that Jack's mother, [redacted] experienced at WHHT. The Trust recognises that these actions will not change what happened, but it hopes that these actions will give Jack's family some comfort and reassurance that the Trust has learnt from his death and continues to do so to ensure that all patients at the Trust receive the highest standard of care.

The Trust has developed a Prevention of Future Deaths Action Plan for 2020/21, which I hope will provide assurance that the areas highlighted in your Regulation 28 Report are being adequately managed. The actions which the Trust has taken, and those actions which are currently in progress have been summarised below:

- A baseline audit of the Induction of Labour pathway has been completed and was due to be presented at the Women's Governance and Divisional Governance meetings in March 2020. Unfortunately this was not possible due the Covid-19 pandemic and has been re-scheduled for presentation in June 2020; this data will under pin the Induction of Labour Guideline and pathway.

- Consultant job plans are being reviewed to ensure a dedicated consultant lead ward round will be undertaken on the Antenatal ward on a daily basis. The consultant will have oversight of all the women on the Antenatal ward and will ensure care plans are in place in event of any delays.
- The Induction of Labour Guideline is being updated to reflect changes in the process for induction to have Cervical Ripening as first line management and also to offer women induction of labour at 39 weeks with any episode of reduced fetal movements. This update will ensure the option for LSCS is given equal weighting when an induction of labour fails. A date for completion of this action will be set when the baseline data has been presented in June 2020.
- The Maternity Escalation guideline (2018) is being reviewed to ensure it is explicit about transfer from Antenatal ward to Delivery Suite. This should be complete by July 2020.
- The Maternity Service plans to introduce an Electronic white board as part of the Trust roll out program, to enable Delivery Suite to have a real-time overview of patients in all maternity areas. The service is working towards its implementation in September 2020.
- Our Director of Midwifery is working with the Local Maternity Services (LMS) to develop a Standard Operating Policy (SOP) for transferring women to maternity units within the LMS in cases of delay or lack of capacity. It is hoped this will be completed by in June 2020.
- A scoping exercise is to be undertaken to assess the possibility of a three bedded induction bay on the current Delivery Suite; however this is included in the acute redevelopment of West Hertfordshire Hospitals NHS Trust's estate.

I had hoped that more of the actions in the improvement plan would have been completed by now, however there have been a number of challenges presented by the Covid-19 pandemic to business continuity within the Trust's maternity services, requiring alterations to be made to the patient pathways in response. Whilst governance activities were maintained throughout to provide assurance about quality and safety standards, some actions in the action plan have not been progressed as quickly as was intended, however many were considered as a high priority in the division and a number of key personnel have been working on them.

The actions outlined in this letter will be scrutinised through our internal governance processes including:

- Women's Governance meeting (Chair: The Obstetric and Gynaecology Clinical Directors and Director of Midwifery & Gynaecology Nursing);
- Divisional Governance meeting (Chair: Divisional Director);
- Quality & Safety Group (Chair: Chief Nurse);
- Quality Committee (Chair: Non-Executive Director);
- External scrutiny will be undertaken by our Clinical Commissioning group and the Care Quality Commission (CQC).

The CQC will be updated regularly as part of relationship management meetings. The Trust would also be willing to provide Jack's family with regular updates (either directly or through their solicitors) on the progress that has been made, if they would find that beneficial.

I hope that this response provides you with the assurance you require that the issues you have raised are 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

Christine Allen
Chief Executive