East and North Hertfordshire NHS
NHS Trust

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Hertfordshire
SG1 4AB

5 February 2021

Mr Jonathan Stevens
Assistant Coroner for Hertfordshire
The Old Courthouse
St Albans Road East
Hatfield
Hertfordshire
AL10 0ES

Dear Mr Stevens

Eddie Coffey (Deceased)

I am writing in response to your Regulation 28 report to Prevent Future Deaths, which was received 15 December 2020, regarding the above named. I was saddened to learn of the sad circumstances of Eddie's death on 14 January 2019. I will answer each of your matters of concern in turn.

In relation to the first matter of concern, we are acutely aware that the conclusion of the Serious Incident (SI) investigation was contradicted by the evidence heard at the Inquest. The SI investigation report reflected the information provided by the relevant clinical staff and it was felt that it was a valid and accurate reflection on the care service delivery issues identified. As you know, as part of the SI investigation the Trust requested an external independent opinion on the CTG trace from [redacted]. The scope of that opinion was limited to asking his opinion on what the CTG trace showed. I understand that as part of your Inquest you subsequently obtained a formal report from him that went into more depth and in turn brought with it further criticisms. When obtaining an independent third-party or independent clinical opinion in the future the trust will ensure this is done on a more formal basis with clear terms of reference.

The Trust is fully committed to learning from all SI investigations and part of the report includes a list of 'recommendations' that the author compiles in response to any 'care / service delivery problems' that the investigation has identified. It is the responsibility of the clinical team to prepare an action plan in response to those recommendations and to ensure learning from the incident. Action plans are developed by the multi-disciplinary clinical team and monitored through divisional governance meetings.

In addition, the Maternity team undertake peer reviews, resulting in transparency and ongoing oversight of action plans and learning across the Local Maternity and Neonatal System (LMNS). At monthly LMNS safety meetings all SI's, actions and Quality Improvement (QI) projects from them along with the progress of embedding the QI are discussed. Furthermore,

the Directors of Midwifery and the LMNS Programme Lead have agreed a standard operating procedure for LMNS oversight of SI investigations and action plans going forward.

Taking your second and third points together, we have noted the evidence given at the Inquest by the Trust's Consultant Obstetrician and the independent Consultant Obstetrician. However, as also was discussed at the Inquest and stated in the *'Saving Babies Lives' bundle 2* (NHS England, March 2019), *'CTG monitoring is a well-established method of confirming fetal wellbeing and screening for fetal hypoxia…However, CTG interpretation is a high-level skill and is susceptible to variation in judgement between clinicians and by the same clinician over time. These variations can lead to inappropriate care planning and subsequently impact on perinatal outcomes'*. Differing interpretations of CTG recordings is therefore a recognised risk. In order to mitigate against this risk, the Trust is committed to enhancing our already well established Fetal Monitoring training, and in particular enhancing the training provided to staff with regards to the second stage of labour. The importance of this issue is highlighted in every Fetal Monitoring lecture as maternal pulse features and characteristics are included as well as being included in an element of the Human Factors training that is given. The intended impact of this is to ignite professional curiosity and to encourage clinicians to actively seek out to exclude maternal pulse. Furthermore, since 20 January 2020 the trust has employed a full time fetal monitoring specialist midwife for 12 months. This midwife provides specialist guidance, teaches staff about the physiological approach, works clinically on the unit reviewing CTG's and leads on fetal monitoring education with the Consultant Obstetrician. As a result of the work described above, our internal fetal monitoring assessment which was introduced in 2019 has maintained a pass rate of 98%.

In response to your fourth point, actions have been developed to further strengthen the training in relation to second stage fetal monitoring interpretation. A second stage training update was delivered on 19 January 2021 which focussed on fetal monitoring and recognising the signs to differentiate between maternal pulse and fetal heart rate, highlighting learning from themes and incidents. Further sessions have been planned in this regard. An Intermittent Auscultation and escalation competency package, using added case scenarios including small group sessions and annual training, is being rolled out to the Midwifery-Led-Unit (MLU) midwives supported by a plan to role this out to all midwives. This will include a competency - based assessment and a requirement to record pass rates for ongoing auditing and assurance.

Notwithstanding the training that has been implemented already at the Trust, it is accepted that CTG technology is not straightforward. This has led to a review being undertaken of the CTG machines currently in use within the Trust. As a department, Maternity are working towards standardising equipment in line with best practice. Review of the CTG machines currently in use has identified that 6 new machines are required which would then mean that all of the machines in use are the same and all would record maternal pulse on the CTG trace. Further work towards the procurement of these machines is ongoing and being reviewed by our Capital Equipment Committee. This issue will be added to the risk register which will ensure oversight and enable clear monitoring on a regular basis.

Moreover, in terms of immediate practical steps taken, we are in the process of producing a visual sticker that will go at the front of a CTG machine after a woman is transferred from MLU to CLU. This sticker will include a box for two individuals to check and sign that they have independently palpated maternal pulse. This process will be in place by the end of February 2021.

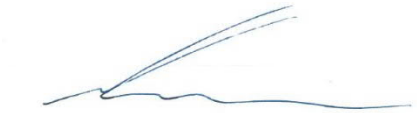
We have also reviewed the emerging findings and recommendations from the first Ockenden Report in their ongoing review of Maternity Services at Shrewsbury and Telford Hospital Trust published in December 2020. As you may already be aware, one action in this report relates

to CTG monitoring with a number of elements in relation to the management of CTG interpretation and escalation. We have planned for a number of actions going forward in order to ensure that we have a robust process in place in respect of these. Please see the attached excel spreadsheet for full sight of the CTG action plan, some of which are detailed above and the work is ongoing.

Lastly, I note your area of concern relating to why 100 maternity units in the country are following the wrong guidelines in relation to managing fetal heart rate morning following the evidence you heard from [redacted] at the Inquest. I am aware that the Department of Health and Social Care will be responding to you on this point however I hope the contents of this letter demonstrates the relevant actions that the Trust have taken in relation to this.

I hope this letter demonstrates the commitment of East and North Hertfordshire NHS Trust to ensuring that we have learnt from this tragic incident and gives you the assurance that we have put a number of measures in place to mitigate against the risk of a recurrence. Our Maternity team are committed to providing the best possible care for women in our area and we continually strive to improve the services available.

Yours sincerely



[redacted]
Chief Executive

C.C [redacted], Acting Deputy Director of Nursing and Quality, NHSE/I
[redacted], Chief Nurse, Herts and West Essex ICS