NHS
Calderdale and Huddersfield
NHS Foundation Trust

5th May 2022

VIA EMAIL

Ms Mary Burke
HM Assistant Coroner
West Yorkshire- Western Division
City Courts
The Tyrls
Bradford
BD1 1LA

Dear Ms Burke,

REGULATION 28: RESPONSE TO REPORT TO PREVENT FUTURE DEATHS ARISING FROM THE DEATH OF EDWARD ARTHUR AKROYD

Thank you for your letter dated 4th March 2021 enclosing a Regulation 28 report following your investigation into the death of Edward Arthur Akroyd.

I am sorry to note that evidence raised a number of concerns and hope that the responses below will provide you with reassurance of the steps already taken by the Trust to improve patient safety and minim.ise the risk of future deaths. Addressing your concerns individually (and adopting your numbering):

1 ***Whilst Mrs Akroyd was being cared for at Huddersfield Birthing Centre, her blood pressure was not checked, and fresh eyes review was not undertaken at the appropriate time in accordance with the trust guidance. I am concerned that if this were to reoccur there is a real risk of missed opportunities to identify significant changes which could impact upon both the mother and unborn baby's wellbeing.***

There are two issues here, although the concern with both is actions not being taken in accordance with timings in Guidance. It is important to say that care in labour should be a holistic process and that here are times when one aspect of care may take precedence over another even if that means the timings in guidelines are not strictly followed.

The first issue relates to checking maternal blood pressure. The Trust's Guidelines for both the latent phase of labour and normal birth in place at the time state, as now, that maternal

blood pressure should be recorded at least four hourly. This is in line with NICE Guidance, last updated in 2014.

The first maternal observations, including blood pressure, were taken at 07.40, the next would be by 11.40 and the one after that by 15.40. In fact, the next set of observations were taken at 10.57, some 43 minutes earlier than the end of the 4 hour window. That would mean the next observations would be re-timed to before 14.57.

At 14.46 the birthing pool was being filled at Mrs Akroyd's request and between 15.00 and 15.58 various steps in urinary care were being undertaken. Other clinical care was therefore being given within the time period in which maternal observations, including blood pressure should have been repeated under the Guidelines. Urinary care is an important part of the holistic care of the mother. There is not always time to do everything all at once.

The observations, including blood pressure, were in fact repeated at 16.05. Although this was just over 1 hour later than the end of the 4 hour window from the previous observations, it was only 25 minutes later than it would have been if the previous observations had not been done early. The blood pressure reading obtained was raised for the first time. The evidence at the inquest was that it could not be said the blood pressure would have been raised if taken earlier, and it can rise quickly. Therefore, in this case, had the blood pressure been taken in line with the guidance the first raised blood pressure may well not have been identified until 3 hours later than it in fact was.

The above illustrates the point that, while Guidance is based on best evidence of appropriate time intervals, the ability of observations to detect issues is somewhat arbitrary.

The second issue is the fresh eyes review. The Trust's Maternity Services regularly review and update local guidelines.

The service has also developed a Standard Operating Procedure for Fresh Eyes review in Labour in the Birth Centre. The SOP states: for women in labour the clinical review including fresh eyes is to be performed at HOURLY intervals or sooner if there are identified concerns or until the second stage of labour is identified.

In terms of disseminating guidance, refreshing the knowledge of staff and monitoring compliance: All new and revised guidelines are placed on the Trust's intranet and are available at any time electronically. The weekly Maternity Risk Management Newsletter will have a notice about new or revised guidelines. The compulsory annual Obstetric Emergency Training Day contains reminders about these guidelines.

All Midwives also have compulsory annual training on monitoring CTGs, which also covers the guidelines on monitoring the mother.

The implementation is monitored through the Trust's system of weekly Maternity Governance Meetings. Those meetings include senior management and clinical staff and review any cases falling within a range of incidents. All cases involving the relevant criteria are reviewed irrespective of whether harm actually occurred to mother or baby. Part of that review is consideration of whether applicable guidance, including monitoring, was followed. If any issues are identified there is a process to feedback to individual staff members and more widely across the maternity services.

2 ***At the time of transfer of care between midwives, following arrival at Calderdale Royal hospital, the attendant midwife did not enter a complete handover record in Mrs Akroyds notes, as she understood that it was the duty of the receiving midwife to make a record within the notes. At the inquest, the same midwife who continues to practise, gave evidence that she remained of the view that that was trust policy.***

The lack of entry in the notes led to confusion and a lack of clarity of previously prescribed medication I heard evidence at the inquest, that the practise undertaken by the midwife was not trust policy at the time nor subsequently and it is the role of the midwife handing over care to complete a medical record within the patients notes.

I am concerned that if complete and effective medical notes and records are not made, this may impact on decision making and treatment and in turn to the wellbeing of expectant mothers and their unborn child.

This process remains the same. It is the responsibility of the transferring midwife to complete a documented structured (SBAR) handover in the clinical records, as well as giving a verbal handover. Since 2018 the Trust has done a lot of work within the Maternity Service and more widely on SBAR handovers, including what to document; where to put the information in the computer records and how to access the information. There is now a specific designated part of the computer records for the recording of the information.

Insofar as this concern relates to a particular Midwife the Trust can confirm that the Head of Midwifery met with the midwife concerned who has reflected on her understanding of the necessity for a documented handover of care along with a verbal handover of care. The Head of Midwifery reiterated that the guidance in this area has never changed and it has always been a requirement that the handover of care is documented by the midwife handing over care. The midwife has reflected that it would be useful for her to refresh her training in the use of the Guardian Intrapartum element of the maternity electronic patient record. For personal reasons the midwife in question has not yet undertaken this training but will be supported to do so as soon as she is in a position to do so.

3 ***After a diagnosis of pre-eclampsia was made at Huddersfield birthing centre and Prior to transfer, various samples were obtained and sent for laboratory analysis, some of the results were received at Huddersfield Birthing Centre and phoned through to the labour ward at Calderdale Royal Hospital.***

From the evidence presented, the results were not passed to Mrs Akroyds attendant midwife or treating registrar. The subsequent internal review did not appear to investigate and determine the reason why this did not occur.

I am concerned that if this were to reoccur, important information may not be provided which could pose a risk to the wellbeing of an expectant mother and or their unborn child.

It should be noted that there was no diagnosis of pre-eclampsia at the Huddersfield Birthing Centre. High blood pressure was recognised. Nevertheless, the results of the blood tests should have been accurately passed on. It was not felt possible to pursue the matter in the

Trust's SI investigation because it was not possible to identify the person to whom the information was said to have been given at Calderdale Royal Hospital.

The computer system for reporting results has changed since 2018. As soon as results are put on to the laboratory computer system those results are pulled through to the primary patient record and can then be seen on the "home" screen of the Trust wide system. Any doctor or midwife can therefore check on the blood test results, including remote access, for example, an on call consultant accessing the system from home. This means there is no need for the results to be phoned through or passed on verbally.

4 ***In evidence, Mrs Akroyd attendant midwife at Calderdale Royal Hospital did not appear to acknowledge that there was a need for her to continue to undertake regular monitoring of Mrs Akroyds Blood pressure in light of earlier readings and to escalate to either a doctor or labour ward co-ordinator, I am concerned that if similar circumstances were to re-occur, this poses a risk to the wellbeing of expectant mother and her unborn child.***

The same midwife also in evidence appeared to state that there was no need to review Mrs Akroyds earlier records as a verbal handover had been made, once again I am concerned that if this were to reoccur, it may pose a risk to the wellbeing to expectant mother and child.

The Head of Midwifery met with the midwife concerned and is assured that she has reflected on this case. The Head of Midwifery also commissioned a review of the role specific safety training undertaken by the midwife since this incident occurred and can confirm that the midwife has completed the fetal wellbeing training package (K2) annually, has completed the Obstetric Emergency training (PROMPT) annually and has also completed the Maternal Advanced Illness Management training programme in 2020. The Head of Midwifery also commissioned a review of high risk cases that the midwife has provided care for since this incident and is assured about her practice and that the midwife has learnt from this incident.

The Trust has no concerns about this midwife.

5 ***The registrar who was seized of Mrs Akroyds care following transfer to Calderdale Royal hospital, in evidence stated that both at the time and also from the position of hindsight, considered Mrs Akroyds blood pressure both prior to and post transfer was only marginally elevated and he based his treatment plan on this view. I heard evidence from various consultants, that Mrs Akroyds blood pressure was significantly elevated, which required urgent treatment and careful review. I am concerned that if similar circumstances were to reoccur, and the same clinician were to hold similar views this may pose a risk to the wellbeing of the expectant mother and unborn child.***

Concerns 5 to 9 relate to the same Registrar and so the response to this concern in relation to the doctor's reflection and practice should also be read as applying to the responses to concerns 6 to 9, with the addition of specific relevant information.

This was the doctor's first inquest, and he acknowledges that he found the experience confusing as well as intimidating to a degree. He was recalling events that had taken place

almost 4 years before and did not intend to give the impression that his practice has not changed.

He has reflected on this case with his clinical supervisors and with a number of consultant colleagues. He has had annual appraisals and undergone the vigorous process of assessment and was awarded a CESR certificate and recognised on the specialist register by the GMC on 30 November 2020. Since his involvement in Mrs Akroyd's care, he has since progressed to a substantive Consultant post at the Trust.

He has safely practised obstetrics for the last 4 years since this event without any concerns or adverse outcomes. The Trust have reviewed a number of cases relating to his management of women with preeclampsia in labour as well as cases with abnormal CTG and no concerns have been identified. The Trust are satisfied with his competency and current practice.

In relation to the management of blood pressure and pre-eclampsia the doctor is aware of current guidelines for the management of patients with severe pre-eclampsia and, as a Consultant in Calderdale Royal Hospital, has treated patients with pre-eclampsia without any concerns with his management. He attended the Managing Obstetric Emergencies and Trauma (MOET) course in 2017 which provides training and awareness around recognition, resuscitation and treatment of emergencies in patients with the altered physiology and anatomy of pregnancy. Since them, he has attended annual Practical Obstetric Multi-Professional Training (PROMPT) Training organised by the Trust since joining the Trust and is competent in the management of pre-eclampsia.

6 ***The same registrar in evidence stated that he was not aware of the recommended treatment for elevated blood pressure at this stage of labour and that he had recognised that Mrs Akroyd had pre-eclampsia and that he understood that the appropriate treatment of pre-eclampsia was the delivery of the baby. I am concerned that if the same facts were to reoccur, and the same registrar were to adopt the same treatment plan within similar time scales, it may present a risk to the wellbeing of the expectant mother and her unborn child.***

Please see the response to concern 5 above.

7 ***The same registrar in evidence stated that it was his view at the time and also from the position of hindsight, that the CTG trace showed no significant cause for concern until shortly before he made the decision that Mrs Akroyd Should undergo a forceps delivery. I heard evidence from a number of consultants that the CTG trace from shortly after its commencement was showing non reassuring signs which should together with other facts have resulted in an earlier delivery of Edward and if this had occurred it is likely he would have survived.***

I am concerned that if the same facts were to reoccur, and a similar interpretation of a CTG trace was to be made, it poses a risk to the expectant mother and her unborn child.

Please see the response to concern 5 above.

Additionally, the doctor has completed appropriate CTG courses over the last 4 years and has remained up to date with his K2-CTG training. He has also attended advanced CTG interpretation courses to improve his understanding of CTG interpretation and acumen.

8 ***The same registrar in evidence stated that at the time he initially assessed Mrs Akroyd he expected the attendant midwife to provide to him a full verbal update and that there was no necessity for him to have undertaken a review of Mrs Akroyds Medical notes and records. The attendant midwife did not provide a comprehensive summary of Mrs Akroyds medical notes and records. I am concerned that if the same circumstances were to reoccur, there presents a risk to the expectant mother and unborn child.***

Please see the response to concern 5 above.

Additionally, the doctor has attended communication skills courses. He has made changes to his practice adopting a more pro-active approach to reviewing and checking information when taking handovers.

9 ***The same registrar stated in evidence that he was aware that samples had been taken at Huddersfield Birthing Centre but didn't think there was a need to obtain the results to assist in determining an appropriate treatment plan. I am concerned that if similar circumstances were to reoccur it may pose a risk to the wellbeing of the expectant mother and their unborn child.***

Please see the responses to concerns 5 and 8 above and also the change in the way in which tests results are now made available, in the response to concern 3.

10 ***From the evidence presented, and in accordance with trust guidelines, a second midwife should have undertaken a fresh pair of eyes review at 18.40 hours. this did not occur. I understand that such guidelines are put in place so as to ensure that key features are not missed and appropriate treatment plans are put in place. I am concerned that if such reviews do not occur it presents a risk to the wellbeing of expectant mothers and their unborn child.***

A fresh eyes assessment should be undertaken by a second person qualified to assess the CTG. This does not have to be a midwife, an Obstetrician at registrar level would be regarded as suitably qualified to undertake a fresh eyes assessment. In this case the Registrar reviewed Mrs Akroyd at 18.53. This was however 13 minutes later than the best practice of 60 minutes.

For the reasons given in response to concern 4 above the Head of Midwifery is satisfied the midwife concerned is requesting fresh eyes reviews appropriately.

I do hope that I have addressed your concerns and that I have reassured you that the steps taken by the Trust will prevent the recurrence of a similar set of circumstances as those in the case of Edward Akroyd.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me. I am again sorry that your investigation into this death caused you such significant concern to issue a Regulation 28 Report and hope that you are now reassured.

Yours Sincerely

[redacted]
Deputy Chief Executive
Calderdale and Huddersfield NHS Foundation Trust

[5th May 2022]