[redacted]

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Doncaster Royal Infirmary
Armthorpe Road, Doncaster
South Yorkshire, DN2 5LT

[redacted]
www.dbth.nhs.uk

13 September 2022

[redacted]

Dr E A Didcock
HM Assistant Coroner
Coroner's Office, Nottingham City Council
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Dr Didcock

Jade Hart - Regulation 28 Report to Prevent Future Deaths

Thank you for your correspondence of the 26 July 2022 addressed to me, [redacted], Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust enclosing the Regulation 28 (Report to Prevent Future Deaths) which was issued to the Trust, following the conclusion of the inquest into the death of Jade Michelle Hart on the 1st June 2022.

This is a tragic case and in the first instance, may I repeat my sincere condolences to Mrs Hart's family for her very sad death. I have met with the relevant teams at the Trust to discuss the issues which have been identified in relation to the care provided to Mrs Hart and the investigation which followed her death. I have set out below information in response to the Regulation 28 report, which I trust will provide you with assurance as to the learning which has already taken place at the Trust and indeed the ongoing improvements.

Accordingly, I can respond to the matters of concern you have raised as follows:

1. Conduct of the Trust Serious Incident Investigation

- ***Outstanding concerns as to the methodology, findings and conclusions and concern that the investigation was flawed as it was taken without including, nor giving due weight to, the family evidence, in the analysis and conclusions of the report***

We apologise for the lack of due weight given to the evidence of the family in the drafting of the report. In view of the particular circumstances of this case, the investigation was taken out of our usual Trust processes in order to facilitate as supportive an approach as possible. A senior member of staff was appointed to facilitate the investigation and act as family liaison officer with the intention of making the process more personal and inclusive. Unfortunately, unforeseen changes in Trust personnel, and the complexity of the investigation meant our contact with the family became inconsistent, resulting in an inevitable loss of confidence and a failure to fully incorporate the family's concerns within the final draft of the report. This clearly compounded the family's loss significantly and the Trust is deeply sorry for this and has learned from the deficiencies in this approach.

I can assure you that incidents of this kind are no longer investigated by the Trust and are now escalated to the Healthcare Safety Investigation Branch (HSIB) to carry out the investigation. As stated in the evidence provided in the inquest by [redacted], Executive Medical Director, the Trust did approach HSIB shortly after the incident to request their involvement. However, they were unable to support us at that time, as their northern branch had not been established and they were only operating in the South of England.

Importantly for learning, HSIB now work with Trusts directly and support Trust investigation teams to improve their safety investigations. They also collate findings from reports nationally to identify themes and influence change across the national maternity healthcare system.

Outside of maternity services, and from a general perspective, investigations within the Trust have changed significantly since 2018 and the improvements made include the following:

- we now involve families more directly and incorporate comments from families within investigation reports. A family's recollection of events along with the clinicians' recollection of events are both included to enable the author to draw reasonable conclusions based on the available evidence. Recollections may differ and reports will display these differences, balance any supportive evidence, and draw conclusions over the most likely description of events. There is expected to be evidence included to support the rationale for the conclusion.

- The Trust is open and transparent and complies with the Duty of Candour requirements, this is monitored via Clinical governance and the monthly Patient Safety Report, which is shared across all divisions and discussed at governance meetings.

- ***It was undertaken without any immediate written accounts taken of what had happened, and very limited and delayed interviews of key staff involved***

Unfortunately, due to unforeseen circumstances, the senior member of staff identified to lead the investigation left the Trust abruptly and the Medical Director in post at that time, stepped in to maintain the personal contact with the family and progress the investigation. Having initially sought assistance

from HSIB who were unable to help, the Trust then sought support from the Royal College of Obstetrics and Gynaecology, to determine how the investigation should be conducted. This process of seeking advice and assistance unfortunately caused a delay in the commencement of the Trust investigation and the Trust investigation commenced much later than anticipated, hence the delay in retrieving statements from staff.

The Trust has already sought to improve existing processes at the Trust and backed by NHS England, the Trust invited Consequence UK to deliver three one day training courses 'Introduction to Patient Safety Investigations' in 2019. The training was very insightful and instructive with approximately 60 members of staff attending the events which included the Patient Safety Team, Matrons and Clinical Governance Leads.

In 2021 the Trust Patient Safety Leads attended the Baby Lifeline Healthcare Incident Investigation Training which provided further updates on specialist training in investigations.

More recently in 2022, all our investigators and a number of matrons have undertaken further training delivered by HSIB. The Patient Safety Lead will also be attending the HSIB Conference on 21 September 2022.

As a result of the training programmes delivered across the Trust, many aspects of our approach to investigations changed. Families have always been contacted by the investigators; however we now fully reference their view and recollections in the reports. These programmes have ensured our investigating team remain up to date on current investigation techniques and refresh their knowledge.

Furthermore, the Trust recognises how vital it is to document factual accounts of events at the earliest opportunity and that this should be done without delay. When an incident occurs within the organisation, this is immediately scoped which includes requesting a recollection of the event from all staff involved in the incident. To support this process, a **memory capture document** (please see attached) was developed and is accessible on the Trust's Incident Reporting System (DATIX) for ease of access and is utilised in addition to undertaking initial interviews and obtaining factual accounts in the form of written statements.

The memory capture document was shared widely with teams for awareness at the time of its development and re-introduced at the time of the Consequence UK training event. Further awareness and education of the memory capture document has been shared again recently within the Trust, to ensure staff use the document at the time of events and the Maternity Team maintain evidence of its usage.

- ***The Trust commissioned an expert to assist with the Investigation. This was provided by a well-respected Royal College of Obstetrics and Gynaecology recommended expert, and was then ignored, simply because there were aspects of the expert report that the Trust did not accept***

The Trust took the decision to seek an early external opinion for this case to ensure the investigation was both robust and comprehensive. We initially approached the Royal College of Obstetricians and Gynaecologists to ask them to conduct a review. They declined to do so, but were able to suggest the names of people who could assist and review the case, including [redacted]. We therefore approached [redacted] who was provided with copies of the clinical records. We are mindful that clinical opinions can vary significantly, however the conclusion of [redacted] report was at odds with the emerging evidence that we were subsequently gathering through the interviews and statements of

staff who were present at the time of the incident. The Trust provided further evidence to [redacted], but at the point the investigation report was completed, the Trust formed a view that [redacted] opinion, was not as informed as those directly involved in the incident and the investigation.

We note that differing opinion in clinical matters may well be present in cases and fully acknowledge that a reference to [redacted] invited opinion should have been included within the investigation report, with a rationale as to why this opinion was not used within the conclusion.

- ***All of these omissions in the Investigation process, led to serious omissions in the analysis, conclusions, recommendations and actions that following in the report, in my view***

We accept that the Trust's best intentions of taking the investigation outside of the usual process to provide more comprehensive support for the family has unfortunately resulted in a number of gaps that otherwise would have been addressed had we followed our systems and processes in place at the time. The Trust now ensures that investigations are not taken outside of the established process, and we acknowledge that there were omissions in the investigation process which included a delay in obtaining factual accounts from staff; a failure to fully incorporate the family's concerns; and a failure to reference the instruction of [redacted] and provide a rationale as to why her opinion was not relied upon within the report.

As HMAC will be aware, the processes and procedures for investigating patient safety incidents occurring within the NHS are subject to significant change. The national NHS Patient Safety Strategy was published in 2019 and sets out the Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. This is considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to improve the quality of investigations by taking the time to conduct systems-based investigations by people that have been trained to undertake them. Of note is that the accountability for Patient Safety Investigations will no longer sit with the Clinical Commissioning Groups but with the local Board of Directors. The Trust has 3 Patient Safety Specialists, who are leading on the implementation of the PSIRF.

The Trust has also reviewed 3 years of data in order to design the Patient Safety Incident Response Plan (PSIRP), which identifies the key priorities for the Trust. This in turn has led to the formation of specific committees, which lead on the delivery of the work to meet these key priorities.

Furthermore, the NHS-wide Patient Safety Syllabus is now live and has been added to the Electronic Staff Record (ESR) for all staff to enable them to access the level 1 training. The NHS Patient Safety Syllabus is a Health Education England initiative with the aim of helping to save lives and protect patients by outlining a new approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors.

The syllabus is multi-professional. It is intended to cover all the patient safety training and educational needs of people currently working in the NHS or those in training to work in the NHS. This includes both clinical and non-clinical staff and covers the voluntary sector and social care. Level 1 of the syllabus is for all NHS staff. The Trust is currently devising a strategy as to which staff cohorts will access the other levels of training as they are released nationally. Communication about the Patient Safety Syllabus has also been

shared with divisional governance leads for further dissemination and communication to their teams and has been included in the Trustwide newsletter.

The Patient Safety Team and others involved in investigations within the Trust access relevant training as available, for ongoing development, including Consequence UK, HSIB, the Patient Safety Syllabus etc.

- ***Also, the Trust, on the evidence of [redacted], Executive Medical Director likely did not share with either the CCG or the CQC, the fact that they had received a detailed, but critical, expert report, that they had not included, nor referred to in the final investigation report***

It is very difficult to evidence at what point the report had or had not been shared with the CCG, or CQC as the Medical Director at the time has now retired. We are aware that there was open dialogue with both organisations during the course of the investigation of this case and NHS England representatives were present at meetings with the CCG. We have therefore also improved our documentation to ensure that a clear record of correspondence with stakeholders is maintained on DATIX.

As noted above, where an expert opinion is sought for the purposes of a Serious Investigation, it will now always be referenced within the report. Where the authors of the investigation report determine that the expert opinion provided cannot be reconciled with the evidence obtained through interviews and within statements, then the rationale for that determination will be included within the report.

- ***At the Hearing, there was no reflection on this latter issue by senior Trust staff, no acceptance that the inadequacies of the report had caused huge distress to the family, and more importantly insufficient learning***

Unfortunately, from the point of the incident to the point of the investigation report being released to the family, the movement of senior staff members was considerable and had a significant impact on this case. However, an overview of the situation was clearly lacking and the Trust acknowledges that had the investigation not been taken out of the usual process, the investigation would not have been affected by workforce matters. Then and now the investigation would have been progressed and monitored differently. It is with sincere regret that what was initially intended to be a more supportive measure for the family, actually resulted in considerable delays in the investigation process and the production of an investigation report of poorer quality than we would expect. Furthermore, we acknowledge the omissions in the investigation process as referenced above.

The Trust has learned from this incident and regrets the inadequacies in the report and the distress that this has caused Mrs Hart's family.

- ***If there is insufficient learning from a tragic and avoidable death such as this, what reassurance is there that there will be sufficient learning by the Trust in the future. In my mind this poses a continuing risk of similar deaths occurring in the future if the investigation process does not change***

As referenced, the investigation of this case was not to the standard we would have wanted nor expected in 2018. Since then, there have been many changes and improvements in how we structure our patient safety team, how we train our investigators, how we conduct investigations and analyses and how we track and monitor appropriate progress and how we engage with families and incorporate their concerns.

As referenced above, as a Trust we are currently preparing for the full implementation of the PSIRF which will govern patient safety investigations moving forward.

Nationally the Ockenden report produced a list of improvements for maternity services across the NHS. At the Trust the maternity service is continuing to implement the 7 immediate and essential actions (IEA) from the first Ockenden report. An assurance visit undertaken by the regional midwifery, and local maternity and neonatal team on 29 April 2022 assessed good progress against these actions. Work is ongoing with continued progress.

The service has undertaken a gap analysis against the further 15 IEA in the final Ockenden report. An action plan has been developed and work is ongoing. The action plans and progress are monitored by the internal governance meetings, Trust board and the Local Maternity and Neonatal System (LMNS).

2. Insufficient support for newly appointed Obstetric Consultants

We accept that support for staff working at any level in the Trust will be required at times and this applies to the consultants we employ, at any stage after their appointment. We have two main receiving sites in the Trust and run two integrated services with linked, but separately staffed, maternity services at Doncaster Royal Infirmary and at Bassetlaw Hospital in Worksop. Each site has a consultant obstetrician available 24 hours a day. It is now embedded in obstetric practice that when a consultant on call on either site requires advice and support, they will contact the on-call consultant on the other site. This is normally to discuss a patient and is often for ethical advice over a hysterectomy in a young woman, as in this case. If physical presence is required, the consultants' on-call liaise and agree on the best way to proceed and then contact the other consultants for assistance.

The Trust does offer and actively encourages mentoring to newly appointed Consultants, and others, this is referenced in our job descriptions and mentoring is available for as long as it is required. The Trust offers induction to all new consultants. The specialty holds regular consultant meetings where discussions take place and working relationships are maintained.

We are also in the process of setting up a Trust wide "new Consultants" group for helping staff to establish wider linkages into the organisation and offer more generic support for newly appointed consultants, should it be necessary. As part of this initiative, a new consultant's forum is being developed. This will be held every 4 or 6 months depending on the number of new starters.

Further, as part of the forward planning agenda for the Trust's Medical Advisory Committee, newly appointed Consultants have the opportunity to present to the committee to provide their observations following their first few months in post. This provides valuable feedback to the committee and helps identify what further support and direction newly appointed Consultants may require in the future.

Conclusion

The Trust acknowledges and regrets the failings in terms of the investigation process adopted for this case. We acknowledge that this created unnecessary additional distress for the family of Mrs Hart and for that we sincerely apologise. Immediate actions were implemented to address deficiencies in the process used and other cases were not investigated in this manner. Moving forward further robustness will be provided with the implementation of national Patient Safety Incident Response Framework.

I trust that this letter has addressed the concerns raised, but please do contact me if I can be of further assistance.

Yours sincerely

Chief Executive
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

MEMORY CAPTURE DOCUMENT

The purpose of this form: It is for the member of staff to recall the events of an incident as they remember them from the start of their involvement to the end. Ideally this will accomplished as soon as possible after the event but at least within 72 hours of an incident occurring.
A memory capture document is not a statement. Its purpose is as its title suggests - to preserve your memory. Therefore, it is a protective factor, and allows the widest appreciation of the situation at the time the incident occurred.

What is required:
You may find it helpful to write your memory capture in two parts:
1: What I can recall about the care and treatment I was giving to the patient, before during and after the incident

2: What I can recall of the shift – what it was like from when I came to work, to when I went home. No patient receives their care in a vacuum. There are always other activities going on. It is important that 'this incident' is considered with a good understanding of what else was happening. This type of information can (and does) enable effective team working, exceptional leadership under difficult circumstances etc to be recognised. It also enables wider areas for improvement to be identified and acted on that may have no bearing on the outcome for the patient.

Confidentiality: It is important to understand that this document, as with all statements, reflective diaries etc are disclosable and can be requested by the Coroner, and representatives of the patient. This should not deter you from giving a complete account of your involvement in the patient management, or your experience of the environment, team working etc on the day. It should however remind you to write correctly, so that what you write is not misinterpreted or misconstrued.

Your memory recall: