IN THE NORTH EAST KENT CORONER'S COURT

In the matter of the inquest touching the death of HARRY RICHFORD

A regulation 28 report- ACTION TO PREVENT FUTURE DEATHS

This report is being sent to:- The Secretary of State for Health

NHS England

The Chief Coroner

The East Kent Hospitals NHS Foundation Trust ('the East Kent Trust')

[redacted]

The Royal College of Obstetricians and Gynaecologists

The Care Quality Commission

The General Medical Council

1. **Coroner:- Christopher Sutton-Mattocks**, HM Assistant Coroner for North East Kent.

2. I make this report under paragraph 7 (1) of Schedule 5 to the Coroners and Justice Act 2009.

3. The inquest into the death of Harry Richford was opened and adjourned on 3/9/18. It was resumed on 6/1/20 and concluded on 24/1/20

The cause of death was **1a Hypoxic Ischaemic Brain Encephalopathy**. There was a narrative conclusion setting out some seven failures in the care of Harry Richford together with a conclusion that his death was contributed to by neglect.

4. The circumstances of the death:-

Harry Richford was born at the Queen Elizabeth the Queen Mother Hospital (QEQM), Margate, Kent on 2/11/17. He died on 9/11/17 at the William Harvey Hospital, Ashford to where he had been transferred. He was the first child of [redacted] both of whom were young, fit teachers. When [redacted] was admitted to hospital for Harry's birth she was assessed as being at low risk. She was admitted on 31/10/17 at 18.55 and placed in the midwifery led unit. She remained there until11.20 the next day when a decision was made to transfer her to the labour ward as there had been no progress since an examination four hours earlier. Due to decelerations on the monitoring the emergency buzzer was pressed at 11.57 and she was transferred to the labour ward. She remained there and the cardiotocaphy was assessed (CTG) and syntocinon was prescribed to her (syntocinon is a drug which can be used to induce labour).

At 1.30 on the morning of the 2/11/17 the CTG had become pathological (CTG readings can be reassuring, suspect or pathological). With a pathological CTG there is a need either to perform a foetal blood sample (a small sample taken from the foetal scalp) to see if the baby is acidotic, or to

expedite delivery. According to the independent expert instructed by the court, [redacted], a consultant obstetrician and gynaecologist who is President of the British Maternal and Foetal Medicine Society, the foetal blood sample should either have been taken immediately (and could have taken up to 20 minutes for analysis),or the delivery of Harry should have been expedited. In any event Harry should have been delivered urgently at 2.00 am and, at the most, within 30 minutes. He was not in fact delivered until 3.32.

[redacted] overall interpretation of the CTG was that Harry had been put under stress due to the excessive use of syntocinon and the resulting hyperstimulation. That occurred frequently between 17.20 on the 1st to delivery some 10 hours later. This hyperstimulation made Harry more susceptible to problems at delivery.

Harry was delivered by a locum registrar on his third night of employment at the hospital. The registrar assessed and confirmed Harry was lying in an OP position. An OP position is when the back of the baby's head is against the mother's back. The registrar, [redacted], intended to attempt to deliver Harry by the use of non -rotational forceps. That was, in [redacted] opinion, unacceptable and sub-standard. Had he actually used the forceps there was a risk of traumatising both mother and baby. Fortunately, the blades did not lock and no attempt was made to use them. The registrar then commenced a caesarean section delivery. He asked one of the midwives to push Harry's head up vaginally. The midwife had only done this twice in 11

years. The registrar should, according to [redacted], have briefed the midwife how to do this as the baby's head needed to be de-flexed as well as pushed. He should also have requested the anaesthetist to have the drug tocolysis available to relax the uterus. The registrar accepted in evidence that he had overlooked tocolysis. When the midwife attempted to push Harry's head up she had a difficulty in that the registrar's fingers were in the way. The registrar then asked a GP trainee to extend the uterine incision. That instruction was, according to [redacted], completely inappropriate. The incision should have been larger to begin with and, if not, then the registrar should have extended it himself. In the event the GP trainee did not know how to do it. All of these actions were indications to [redacted] that the registrar was inexperienced.

This was a difficult caesarean section. It was clear that it would be in advance. [redacted] telephoned [redacted], the consultant on call that night. There is some discrepancy about the exact time, but it was between 2.10 and 2.20. [redacted] if he wished her to attend. He replied by telling her that he wanted to try an instrument delivery or to deliver the baby by way of a caesarian section. He told the consultant that the mother had been fully dilated since 23.55. He said he was happy to deliver the baby himself. [redacted] was not asked about his experience by [redacted] or by anyone else. In their evidence [redacted] accepted that he had made a misjudgement in not asking the consultant to attend and [redacted] accepted that she should have attended earlier than she did. She arrived too late to assist the delivery of Harry having been called in during the delivery itself at the suggestion of one of the midwives. The guidelines published by

the Royal College of Obstetricians and Gynaecologists state that the consultant should attend in person or should be immediately available if the trainee has not been assessed for (inter alia) a trial of instrumental delivery in theatre or a caesarean section at full dilatation.

No one at the East Kent Trust appears to have assessed [redacted]. He himself stated that he had never been assessed. The medical director of the East Kent Trust said that he had not been able to establish who had employed [redacted] and there was no record of any assessment. [redacted] had only ever performed 3 such OP deliveries before and only one of them unsupervised. That, he said, was earlier in 2017 and had not been as difficult [redacted].

When Harry was delivered at 3.32 he appeared to all intents and purposes lifeless.

Mr Taylor stated that 'but for the failure to deliver Harry at 2.00 am and expedite delivery in good hands I believe Harry would have been born in good condition and would have survived'.

The attempted resuscitation of Harry then took 28 minutes before the anaesthetist left [redacted] to help the paediatric team. By that time the damage had been done. A second expert instructed by the court was [redacted], clinical lead for neonatology at University College Hospital. He reported that 'had the resuscitation afforded to Harry been of an appropriate

standard he would have almost certainly survived and, on the balance of probabilities, had a normal neurological outcome'.

The resuscitation team was led by [redacted]. He was a relatively junior doctor. He accepted in his evidence that he should have called for assistance from his consultant, [redacted], earlier than he did once the resuscitation became problematic after the initial intubation had failed. The atmosphere within the theatre during the attempted resuscitation was described as chaotic by one staff nurse and as 'panic' by a midwife. [redacted] agreed in evidence that he had lost control and situational awareness.

[redacted] gave his opinion as follows:-

a) There was an unacceptable delay in requesting consultant support
b) An unsecured airway was handed over from the only trained member of the neonatal resuscitation team to an inexperienced and untrained junior doctor without the skills required to support the airway and maintain ventilation
c) Due to the failure to secure an airway and achieve effective ventilation there was a prolonged period of postnatal hypoxia. This continued up to the point that Harry was successfully intubated by the anaesthetist at around 28 minutes of life.
d) The prolonged period of postnatal hypoxia compounded Harry's condition at birth and directly resulted in hypoxic

ischaemic encephalopathy, irreversible brain injury, and Harry's subsequent death.

[redacted] described Harry's condition at birth as being within the normal range taken from the cord gases. He estimated that there had been a period of between 10-15 minutes after birth when, if properly ventilated, Harry would have not only survived but would have been likely to have had no irreversible brain injury.

The consultant paediatrician, [redacted], was on 30 minutes call as set out in her contract. She, however, habitually slept in her office when on call. She attended within 10 minutes of being contacted. She arrived at 3.57. The hospital switchboard had the wrong consultant listed as being on call and it was only on their third call that she was contacted. Time in resuscitation is of crucial importance according to [redacted]

During the resuscitation no one was keeping a note, no one was keeping a log as to times and it has proved impossible to determine who or how many people were present. The highest estimate was 20- 25 people present. [redacted] described that if he had been presented with that scenario in a training exercise, he would have failed them on a life support course.

[redacted] arranged for Harry to be taken in an incubator to the special care baby unit and then to be transferred to the more specialist unit at the William Harvey Hospital. There he had an MRI scan and specialist advice was

received from [redacted]. There was no criticism of his care at the [redacted]. He died there on the 9/11/17.

Following Harry's death, the East Kent Trust noted Harry's death as 'expected' and the Coroner was not informed. Only the efforts of Harry's family eventually brought his death to the attention of the Coroner.

The Coroner's concerns: - there are a number of concerns and I intend to set them out in respect of each recommendation.

Concern 1

[redacted] was recruited as a locum registrar by the Hospital Trust without there appearing to have been any assessment of his skills and abilities or any supervision of him at the hospital. This was not an emergency appointment after, for example, a doctor calling in sick at the last minute. [redacted] gave evidence that the recruitment, assessment and supervision of locums is a national problem and that there is a need for a review on a national level. This raises concerns that there may be a risk to other lives both at this trust and at other trusts in the future.

Recommendation 1

NHS England and the Royal College of Obstetricians and Gynaecologists consider a review at a national level into the recruitment, assessment and supervision of locum on obstetric and gynaecology wards together with the publication, if appropriate, of new guidelines. Particular emphasis should be

considered upon delineating the permitted scope of locums' activities before they are left responsible for out of hours care of women in labour.

Concern 2

The current policy of the East Kent Trust states that it is the responsibility of the healthcare professional who will be supervising the locum to assure themselves of his/her competence. This did not happen in this case. There is at present no requirement for a locum to be assessed on a day shift by a consultant before being left in charge overnight. There is no clear direction that it is the responsibility of the assessing consultant to satisfy themselves of the locum's experience and capability. One specialist from outside the East Kent Trust, [redacted], also stated that it would assist the assessing consultants to be able to see not only the locum's CV but also their references and any training records available.

Recommendation 2

The East Kent Trust should consider taking action to ensure that there is a dedicated consultant responsible for reviewing the CVs and references of prospective new locums before they are appointed or employed. A record should be kept of the consultant concerned together with a copy of the consultant's written opinion. The East Kent Trust should also consider making the locum's CV, references and training records (where there are any) routinely available to all consultants with whom the locum will work. Wherever possible a locum should be assessed by a consultant upon a day shift before being left in charge overnight. It is also recommended that the East Kent Trust

should consider making it clear that it is the supervising consultant who is at all times responsible for ensuring that the locum working under their supervision is both competent and experienced for the role.

Concern 3

[redacted] had worked two night time shifts at the QEQM before the night of Harry's birth. The extent to which there was any feedback from the consultants on call those two nights to [redacted] is unclear. She, erroneously, believed the East Kent Trust had employed [redacted]. There is no record of any written feedback. From the evidence of the medical director of the East Kent Trust it appears that the current locum recruitment policy is not being checked or audited. There is a potential for further risks to life arising from these shortfalls.

Recommendation 3

Pending any possible review by NHS England and any new guidelines upon the assessment and recruitment of locum doctors it is recommended that the East Kent Trust consider taking action to ensure that consultants who have supervised a locum whether on a day or a night shift should provide written feedback upon the locum's competence and experience to be made available to the relevant HR team at the East Kent Trust and also to any other consultants who may be working with the locum in the future. The East Kent Trust should consider a review of its current procedures as to compliance with policies on the recruitment of new locums, including any new locum recruitment checklist, are being complied with. That review should include

consideration of whether there should be a regular audit of compliance. The East Kent Trust should also consider a review of its current procedures relating to the assessment and recruitment of locums to ensure that they meet all current professional guidelines. The East Kent Trust should also review the means by which locums have access to all their policies and procedures including the need for the escalation of care to the consultant, when necessary. There should be consideration of a computer sign in system so that there can be a check that the locum has in fact seen and read the policies.

Concern 4

There is a risk to the life of both mothers and babies if there is a lack of clarity as to the processes or the need to take prompt action where it is necessitated in the event of an obstetric concern or emergency developing.

Recommendation 4

There should be consideration of a review by the East Kent Trust of the obstetric policies, procedures and protocols which relate to the actions which are mandated by the East Kent Trust in the event of a pathological intrapartum CTG including, specifically, those actions which are required, and the relevant time frame, when the 'expedition of delivery' is called for.

Concern 5

There appeared to be from the evidence given at the inquest substantial confusion amongst staff as to when a consultant should be called at night.

The East Kent Trust now has some 70 hours a week consultant attendance on the wards. That leaves 14 hours a day when there is no consultant present. Staff, whether doctors, nurses or midwives should know the circumstances in which consultant help should be sought and should not feel inhibited from making their views known. If staff are unaware or unsure of when the consultant should be called that potentially poses a continuing risk to life.

Recommendation 5

The East Kent Trust should consider a review the procedures in place to ensure staff understand the circumstances in which consultant attendance is required and, if necessary, deliver specific training upon this issue

Concern 6

The current contracts at the East Kent Trust permit consultants to live up to 30 minutes travel time from the hospital. This poses considerable problems and risks for night time emergencies.

Recommendation 6

The East Kent Trust should consider research into any technological solutions which could be found to assist in, or ameliorate, the difficulties of on call consultants living some distance away from the hospital, for instance the use of video link technology or skype connections to the theatres and/or computer terminal readouts from home.

Concern 7

The evidence of [redacted] raised substantial concerns about the quality of training and learning in respect of neonatal resuscitation at the East Kent Trust. His evidence was that it would be desirable for middle grade doctors to attend the ARNI course (the advanced resuscitation of the new born infant). He also recommended that there should be simulated drills in neo natal resuscitation.

Recommendation 7

The East Kent Trust should consider a review of the current procedures for all relevant staff to attend regular drills and simulation training events covering neo natal resuscitation. The East Kent Trust should consider whether such training should be mandatory and that attendance at such courses is clearly recorded.

Concern 8

Prior to Harry's death both [redacted], a senior member of staff who had the care of Harry at the William Harvey Hospital, accepted that there were no opportunities for cross site working between QEQM and the William Harvey Hospital. Currently two out of eight middle grade doctors have had the opportunity to spend time at the William Harvey, which has a much higher specification neo natal unit. [redacted] described the lack of opportunities before Harry's death as ‘at best, very surprising'.

Recommendation 8

The East Kent Trust should review the provision of cross site paediatric working so as to ensure that, where possible, within the next two years all middle grade doctors who aren't on the “run through specialist training programme in paediatrics” have spent a period of time at the level 3 William Harvey Hospital.

Concern 9

The resuscitation of Harry was eventually carried out by [redacted], the anaesthetist looking after [redacted]. His evidence was that leaving his own patient to help the paediatric team was an unusual action to take in the UK although he had often performed such actions in Nepal. Doctors at QEQM indicated that there was an informal policy that if a middle grade paediatrician found themselves in an emergency, they could seek help from their anaesthetic colleagues. It was unclear whether the anaesthetists were aware of this informal policy. This informal policy should be clarified, and guidance given because there is a risk, that in an emergency, it will be overlooked.

Recommendation 9

The East Kent Trust should consider a review the circumstances in which anaesthetists are expected to attend and assist neonatal emergencies and to ensure that all relevant members of staff are aware of the policies.

Concern 10

There appeared to be considerable confusion among members of staff as to which, if any, guidelines and policies affected them. While two senior

members of staff, [redacted] (consultant), said that the East Kent Trust has systems in place to ensure knowledge of and compliance with Trust policies neither of them was able to say whether this was effective. Significant issues remain as to the knowledge of staff as to which guidelines govern their behaviour (this was also a finding of the Health and Safety Investigation Board in 2019). Such confusion or lack of knowledge increases the risk of future deaths.

Recommendation 10

The East Kent Trust should consider a review of obstetric and paediatric staff's awareness of the governing clinical and operational guidance. The East Kent Trust should also consider keeping a register of when and if every member of staff signed off the relevant guidelines as read and understood. This could take place, for instance, at formal training sessions within the unit.

Concern 11

There was a lack of knowledge within the paediatric team of guidelines issued by the Department of Women's Health. The evidence from the East Kent Trust doctors was that the guidelines issued by the department directed to 'all maternity and neonatal staff who may be involved with the immediate care and support of a collapsed neonate' would not have been known to the paediatric team at the relevant time. Even senior clinicians, such as [redacted], were not aware of the relevant guidelines.

Recommendation 11

The East Kent Trust should consider taking action to ensure that the current neonatal resuscitation guidelines are brought to the attention of the neonatology and paediatric teams at the QEQM. Guidelines issued by one department, but which are relevant to staff in a different department should be disseminated and understood by those staff. This could take place during senior management meetings, organised cross department training or electronically with the recipient confirming receipt, reading and understanding of the material.

Concern 12

The placenta of Harry was not retained. Examination of the placenta will in some circumstances assist in cases of severe foetal distress. The Royal College of Pathologists states that it is 'essential' for the placenta to be sent for examination in cases of severe foetal distress requiring admission to a neo natal unit.

Recommendation 12

The East Kent Trust should consider amending its neonatal guidelines to reflect the mandatory nature of the Royal College guidelines to ensure that the placenta is always kept and sent for histology and a record should be kept of each and every such instance.

Concern 13

The standard of record keeping on the obstetric unit was substantially sub-standard. The quality of the note taking and records is of considerable

importance to new staff taking over responsibility for mother and baby. Without there being clear accurate records there is a risk of further mistakes being made leading, at the worst, to the risk of death. An example of this in Harry's case is that the record of the syntocinin prescribed to [redacted] over a long period of time is inconsistent with the evidence of the midwives and the registrar who gave it to her.

Recommendation 13

The East Kent Trust should consider an audit of the quality of record keeping and documentation and consider whether further training is required so that staff understand the crucial importance of clear and accurate record keeping.

Concern 14

There are no current records kept by consultants who are telephoned at home for advice. In this case there was a dispute about the number of calls made to [redacted] and as to the content of these calls. The advice given and the actions taken as a result are important for the preservation of life.

Recommendation 14

The East Kent Trust should consider whether consultants should be asked to keep full records of advice given to junior doctors over the telephone and to time and date them.

Concern 15

The East Kent Trust should consider a review as to the use or otherwise of a resuscitation pro forma. A pro forma has since Harry's death been adopted by the East Kent Trust which, on the evidence of [redacted], has improved the oversight of neo natal training and governance. It is not clear whether that pro forma is being audited or logged, or what actions are being done to ensure its completion and preservation.

Recommendation 15

The East Kent Trust should consider keeping clear records of the use of the pro forma and checking the efficiency of it. The East Kent Trust should also consider whether further training is necessary to ensure the best use of it to prevent further deaths occurring.

Concern 16

In order to try to prevent future deaths it is important that there are clear records and statements made when a death occurs so that lessons can be learnt. In this instance many of the statements were very scanty in their content and some were made a long time after the event. In some instances, staff had to make statements from memory without the advantage of seeing the medical notes. Contemporaneous (or as near as possible) notes are also very much in the interests of the staff involved so that they can give clear accounts of their actions and reasons for them if required to do so at a later date.

Recommendation 16

Where there has been a serious incident staff should be asked to make statements as soon as possible after the event. They should be provided with the medical records to do so. The statements should then be timed and dated and kept in a secure place by a third party.

Concern 17

The child death notification form was incorrectly completed in that Harry's death was recorded as 'expected'. No notification was made to the Coroner. No details were filled in on the notification form giving any detail of the problems leading to Harry's death. As a result, the Child Death Overview Panel would have been unaware of the problems encountered and could not have shared learning to prevent other such deaths occurring. I make no recommendation in respect of the lack of notification to the Coroner as I am aware that the Senior Coroner has already dealt with this.

Recommendation 17

The East Kent Trust should consider a review of its policies so that all staff members who fill in Child Death Notification forms are aware of what to enter into the form and of the details required. All such forms should be logged and audited, including those since Harry's death.

Concern 18

The MBRRACE form in respect of Harry Richford was inaccurate in a number of important areas. The form is important to provide robust national data to support the delivery of safe, high quality maternal and new born care as well

as identifying errors and faults, if any, where there has been a maternal or infant death so that future deaths can be avoided.

Recommendation 18

The East Kent Trust should consider a review of all MBRRACE forms filled in since Harry's death were accurately completed and reported. The East Kent Trust should also consider whether it would be advisable to have a second person checking and signing off an MBRRACE form before its submission.

Concern 19

Important independent reports do not appear to have been shared within the East Kent Trust's staff, for instance the HSIB report into Harry's death appeared during the inquest to be unknown to a number of the staff.

Recommendation 19

The East Kent Trust should consider a review of its policies in respect of the sharing of important investigations amongst all relevant staff so that important learning takes place to prevent any future deaths.

C J SUTTON-MATTOCKS

3/2/20