EXCELLENCE STARTS HERE

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

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Jacqueline Lake
Senior Coroner for Norfolk
County Hall
Martineau Lane
Norwich
NR1 2DH

13th January 2023

Dear Mrs Lake,

Re Bonnie Webster – Regulation 28 Response

Thank you for the report in this case following the hearing which concluded on 21st November.

Firstly, may I take this opportunity to express how seriously we take the facts of this case, and your report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. Honesty and transparency are at the heart of what we do, and we believe that in seeking to learn from these experiences, we can improve patient care and safety and embed these lessons in a way which we hope will provide reassurance to our patients, as well as their families and loved ones. We are conscious that Bonnie's family has had an extremely difficult time as a result of this case, and I extend our sincere sympathies to them once again.

In my role as Acting Chief Executive Officer of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust I now set out the Trust's responses to the three concerns you raised in box (5) of the report.

1. **The evidence of Mr and Mrs Webster is they were unaware of the seriousness of the situation. Caesarean Section was discussed but was not advised or recommended at the meeting at 06.50 hours. This was clearly a traumatic meeting and Mr and Mrs Webster were upset which would have impacted on their ability to understand and take in important information. In such a situation clear language and ensuring an understanding of the whole situation is paramount.**

In addition to using existing meetings within the department and across the Trust to share the learning in connection with this incident, the senior team has incorporated the learning into the Multi-Disciplinary training day (PROMPT). We believe the MDT approach will support continued improvement in this area, to ensure the whole team is using the same language and feel empowered to use words that are unambiguous. We recognise this is especially important when communicating a potential poor outcome for either the mother or their baby, as was the case in this incident.

Our Head of Nursing and Midwifery for the Division of Women and Children, Amanda Price-Davey, will be leading these training sessions through 2023 to ensure she has the opportunity to discuss this with each and every member of the team. This will commence in January 2023. For the part of the training which specifically relates to this case, Mrs Price-Davey is leading the human factors session for a one-hour training session and will discuss the events in detail to evidence how language used can impact on safety. The session will also look at informed consent and the language we use to impart the information needed to ensure *Montgomery* compliance.

2. **Antibiotics were prescribed at the initial review meeting at 09.35 hours. These were not given until 12.30 hours**

This point has been thoroughly investigated and all staff involved have received a debrief. It was found that whilst some staff were aware the prescription had been written, this was not communicated to, or handed over to the nurse directly caring for Bonnie. We are currently using the facts of this case and learning from the incident to assist in a new training programme for all Neonatal Intensive Care Unit (NICU) staff, both nursing and medical, to ensure clear and concise handover of information using the SBAR approach (Situation-Background-Assessment-Recommendation).

3. **Evidence was heard that staff alerted the paediatric team on foot, rather than using the emergency "bleep" system.**

The facts of this element of the case have been considered in detail and we have ascertained that there was a new member of staff in theatres when Bonnie was born, acting as a "runner". This team member had received her induction training which included training on how to make emergency calls. However, in this difficult situation, the staff member had forgotten how to make the call and instead took action to go next door to the NICU to raise the alarm instead.

Due to the theatre being immediately adjacent to NICU there was no measurable difference in efficiency between using the "bleep" system and notifying the paediatric team in person. All clinical staff are trained on using the "bleep" system and at any time there will be multiple staff members in theatre able to make this call, rather than this responsibility resting on one

person who could be a single point of failure. In this case another senior member of the theatres team had already put an emergency call out. There was therefore no delay in the arrival of the Consultant Paediatrician.

We recognise that for the runner to have been unable to make the call there is potential additional clinical risk, but we consider that the risk is fully mitigated; firstly, by the fact that in default there are other staff in theatre other than the runner who can and do call the emergency number. Secondly, on all occasions where a non-elective caesarean section is being performed, staff trained in resuscitation, namely midwives and junior paediatric staff, are present before birth takes place. We therefore do not think that any change to our system is required with reference to additional appropriately qualified staff being present at birth or securing the attendance of the Consultant Paediatrician.

I would be happy to assist further should you require any additional update or information.

Yours Sincerely,

[redacted]

[redacted]

Acting CEO