NHS
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NHS Foundation Trust

Private & Confidential

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Response to Regulation 28 Report to Prevent Future Deaths

Dear Mrs Connor

I am writing in response to the Regulation 28 Report issued following the Inquest into the death of Raniya Rizwan Khan. We hope that this response provides reassurance that the Trust has acknowledged the concerns raised and responded appropriately and timeously to them.

1. The current position with regard to :

a. Storage of all placentas for 48 hours, and SoP around this

Following the regulation 28 report sent to the trust on 20th June 2022 actions were taken to enable a robust process for sending placentas for histological examination. This included a process to ensure the storage of all placentas for 48 hours from the time of birth. The Standard Operating Procedure (MATSOP064) detailing these changes was ratified at the maternity clinical governance meeting on 7th October 2022.

The placenta fridges were procured in August 2022 however they were both found to be faulty and replacements had to be requested. These arrived on 31st October. These were placed in the Delivery Suite and Birth Centre and fitted with appropriate alarms to allow automated monitoring and alerts to be received in the clinical areas should there be any concerns with the temperature of the fridge. Unfortunately these alarms were subject to interference from another automated system used within the Trust. This was identified at the end of December 2022. We would like to apologise for not updating the Coroner of this unexpected issue which prevented the implementation of the new process.

The issue was resolved by 1st February 2023 and the new process was fully implemented on Monday 13th February.

In practical terms all placentas are now stored for 48 hours. The midwife coordinating the intrapartum areas is responsible for releasing these to the waste disposal team having identified all placentas that need to be sent for examination during this time. The Daily Safety Huddle is held in the middle of the day by the midwife coordinating the delivery suite.. The huddle identifies and discusses any babies that

have died, or have been admitted to the neonatal unit requiring ventilation or cooling, and are under 48 hours of age. The placentas of these babies are then retrieved and sent for histology by a member of midwifery staff. All other placentas beyond 48 hours from the birth, are highlighted with a green sticker and moved to the bottom of the fridge. Only placentas stored on the bottom two shelves displaying the green stickers are released to the waste management team.

b. Review of policies and staff awareness regarding mandatory sending of placentas for pathological examination.

The Placenta Examination Guideline (GL886) has been amended to signpost to the new SOP and this was ratified on 7th October 2022.

From 1st February 2023 various communication strategies have been used to highlight the new processes with all midwifery and support staff. This focusses on highlighting the circumstances in which placentas must be sent for examination, the need for all placentas to be stored for 48 hours and processes for disposal. Posters are displayed on the communication boards and fridges and verbal communication has been undertaken at each handover. A series of training videos were made which show how to store the placentas following a home or hospital birth, how to send a placenta for histology and how to retrieve a placenta within 48 hours for sending for histology or safe disposal. The training videos also signpost the member of staff to the new SOP. Initially these videos were sent to staff via social media however from 13th February 2023 they have been included on the Trust Learning Matters platform and all midwives have been made aware through multiple communication channels that they are required to undertake this training.. This will be evidenced through reports pulled from the platform by the practice development team each week and forwarded to the Director of Midwifery. To date 98% of midwives have received this training and individual reminders have been sent to those who still need to do so.

2. Training and awareness regarding these new policies – to include practical arrangements around ensuring a placenta is retrieved and sent to histology subsequently if needed.

These points are addressed above in response to 1 (a) and 1 (b).

3. The Trust should refer concerns about this individual agency midwife as a matter of urgency both NHS Professionals, and to the Nursing and Midwifery Council. This is in addition to raising of the possibility of an individual 'passport' to prevent a midwife moving between agencies to work elsewhere after significant concerns have been raised.

The Trust raised the concerns about the individual agency midwife on Friday 10th February 2023 and have received confirmation that the agency are meeting with the midwife to investigate these concerns. The Trust have taken advice from the NMC employer link service and a referral was submitted on 22nd February 2023.

The Trust accepts that it should have made every effort to feedback the findings of the internal investigation to the agency irrespective of whether the midwife was continuing to work for the Trust. The Trust have processes in place for providing feedback to agencies and we are now doing this in all situations. We are also strengthening the policy around reporting concerns in situations where staff no longer work at the Trust, and ensuring that the Policy is explicit in its requirement to do so. The Trust's learning culture and transparency was recognised by an Ockenden Assurance and Insight visit led by

the Regional Chief Midwife in September 2022. This was fed back verbally to members of the maternity senior leadership team and Trust exec at the time of the visit.

The issue of how, and where, to feedback on temporary staff when they have left a specific Trust after a period of employment was raised at a regional Buckinghamshire, Oxfordshire and Berkshire Local Maternity and Neonatal System (BOB LMNS) Serious Incident Review meeting soon after this investigation was concluded. It was deliberated if a joint set of standards and/or processes for Agency staff should be drafted on a regional or national level in collaboration with the Nursing and Midwifery Council (NMC). This was an action that the regional LMNS team were considering.

Upon further deliberation and reflection, the Trust considers that this is a matter for the regulator because a national solution is required and this is beyond the means of a single Trust. The Director of Midwifery has raised this with the Regional Chief Midwife, [redacted], who has discussed this with the Chief Midwife for England and the NMC. As a result recommendations will be sent to organisations reminding them that serious concerns over practice of an agency member of staff should be referred to the agency and NMC. In addition there are plans in place to convene a group including providers, LMNS, region and Health Education England to ensure there is a standardised approach to the orientation and immediate support provided to agency staff.

The Trust are committed to continually improving our midwifery and obstetric care, and believe the points outlined above demonstrate our dedication to doing so. In summary, the Trust have implemented a robust process for sending placentas for histological examination, including the Standard Operating Procedure (MATSOP064) ensuring storage of all placentas for 48 hours from the time of birth, ratified at the maternity clinical governance meeting on 7th October 2022. As of 13th February 2023, the new process is now fully operational. A variety of strategies have been used to communicate these processes to relevant staff. The Trust are also strengthening the Policy for feedback of concerns raised about temporary agency staff. The wider issue was raised with the BOB LMNS and Regional Chief Midwife to take forward.

We hope this response allays the concerns you have raised, and provides you and the family of Raniya with assurances that the Trust have taken your concerns for future patients' safety seriously by implementing actions surrounding the storage of placentas, training and awareness of new policies and procedures, and the feedback of concerns raised about agency staff. We hope this demonstrates the Trust's commitment to the continuous improvement of our services. If you require any further information or evidence, please do not hesitate to contact us.

Yours Sincerely,

[redacted]

Acting Chief Executive Officer