Homerton Healthcare
NHS Foundation Trust

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His Majesty's Coroner for Inner North London
HM Coroner's Court
Poplar
127 Poplar High Street
London
E14 0AE

11.09.2023

Dear Ms Hassell,

Response to Regulation 28 Prevention of Future Deaths Report
Deceased: Baby Phoenix Grace Chapman

I am writing in response to your Prevention of Future Deaths Report issued to Homerton Healthcare NHS Foundation Trust ('the Trust') following the conclusion of the inquest into the death of Baby Phoenix Grace Chapman.

This response has been prepared with input from the Chief Nurse/ Director of Clinical Governance, and various members of the maternity team.

Firstly, on behalf of the Trust, I would like to extend my condolences to the parents of Baby Phoenix Grace Chapman and recognise how devastating his death has been and continues to be for the family and all the professionals involved.

You raised the following two areas of concern in your letter which I hope will be addressed below:

1) ***At inquest, there was not a shared understanding among the clinicians within the Trust about how such a situation should be approached.***

   The obstetricians were clear that, given her very high-risk status, Phoenix' mum needed to come into hospital as soon as she showed the first signs of labour. And even if she had started to deliver, she could still only be treated effectively, and Phoenix given the best chance of a good outcome in hospital.

   However, some of the midwives felt strongly that, when Phoenix' dad could see the baby's leg emerge, they should have been allowed to go out to the home to give whatever assistance they could.

   All the clinicians need have the same understanding of the correct protocol.

2) ***A related point is that, before Phoenix was born, some of the midwives felt that their views of what should happen in the event of precipitous labour had not been taken seriously.***

   If they are to be effective in their role, and if necessary to understand why a protocol does fully reflect their feelings and views, the midwives' ability to communicate with senior management needs to be enhanced.

If the team as a whole is to move forward in a way that provides the best possible care for women in labour and their babies, questions and differing opinions need to be in some way acknowledged and dealt with before the correct protocol can be embedded.

You heard evidence at the inquest that a multi-disciplinary meeting (MDT) meeting took place surrounding this birth and a detailed birth care plan was drawn up for the mother in advance of Baby Phoenix Grace Chapman's birth.

You also heard evidence that prior to this inquest, the Trust individualises patient care plans in line with the mothers' wishes, a Consultant Midwife institutes a birth plan for women choosing to birth outside of guidance. Following the death of Baby Phoenix Grace Chapman, the Trust has employed a Specialist Birth Options Midwife. Any mother requesting a birth out of guidance is referred to the Birth Options Midwife. She then consults extensively with those individuals, to formulate a birth plan and ensures that these birth plans are sent to the relevant neonatology, anaesthetic, obstetrics, and midwifery teams as appropriate, so that there is familiarity and a shared understanding with the plans prior to labour and birth. These plans are also documented on the electronic medical records, and copies are sent to the mothers, with a request for agreement to be provided before the plan is finalised. The mothers are aware that their plans will be re-visited in the event of changes to the clinical picture. These plans ensure that all clinicians, including the midwives involved in the care of the mother, have the same understanding of the care plan that is in place and the correct protocol to follow.

In addition to this, our Birth Options Midwife and the community matron have formulated a process and criteria with timings for midwives to escalate the out of guidance patients if there are any concerns regarding the current birth plan that is in place. This is again to ensure that there is a clear understanding regarding the birth plan.

We would also like to reassure you that the homebirth midwifery team already meet monthly, and that meeting is attended by all the homebirth midwives unless they are attending a homebirth or on annual leave, in which case they can review the outcomes of the meeting on a shared drive. During this meeting they discuss any management issues or service updates, for example if there are any new guidelines. At this meeting, they also discuss all women booked in with them that are out of criteria for homebirth and review any new referrals that are out of criteria. This information is held and updated on a spreadsheet in a shared drive. The Matron for the Community Midwifery team attends this meeting, together with the Director of Midwifery, the Birth Options Midwife, and the named Midwife for Safeguarding.

To improve communication between the homebirth midwives and the consultant obstetricians, the Trust has now assigned a senior consultant obstetrician to the homebirth midwifery team who will also attend these monthly meetings. The presence of a consultant obstetrician will provide an opportunity for the midwives to discuss complex cases with the obstetrician, explore more ways of working collaboratively, help to ensure their views are heard and that they are being listened to and will also provide an opportunity to share learning and understanding between other members of the team.

The Trust would like to reassure you that in addition to the existing communication and escalation pathways that the Trust has in place, there are a number of additional actions that the Trust has now embedded following this inquest in order to ensure the midwives feel supported and that they have the ability to communicate their feelings and views with senior management. In addition to those discussed above, we detail the various actions below:

- Following this inquest, our Chief Nurse / Director of Clinical Governance has met with the homebirth midwifery team specifically to listen to how they feel and to see what support can be provided to them. The new Director of Midwifery started at the beginning of September and will lead further meetings with the homebirth midwifery team, together with the Chief Nurse monthly so that there is a forum to discuss any concerns that the midwives have. The next meeting is scheduled for 13th September 2023.

- The Trust has also discussed with the midwives the process by which they are able to escalate their concerns or any disagreements that they have in respect to birth care plans. The homebirth midwifery team have been reassured that the Trust want them to feel confident and safe to escalate concerns if they feel there is a risk to the patient, and that there is an escalation pathway for them to use if they have any concerns.

- In addition to the monthly team meetings referred to above, each midwife has a one-to-one meeting with the Matron for Community Midwifery where they have the opportunity to raise any concerns that they have. However, there is always the opportunity to raise concerns with their manager at any point.

- The Trust has a consultant email inbox which has three consultant obstetricians who can offer the midwives a second opinion if they are concerned about any cases. This email inbox is reviewed daily.

- The Trust also has an open-door policy, and members of the Trust Board and in particular, the Director of Midwifery, the Chief Nurse, the Medical Director and the Chief Executive are available to discuss any concerns that staff may have.

- The Trust has a Freedom to Speak Up Guardian, and six Freedom to Speak up Champions who are there to provide confidential advice and support to staff regarding concerns they may have, assist staff to raise concerns in the Trust and to make sure that staff receive feedback about the concerns that they have raised. The Trust Executive Team has a daily live communication on MS Teams for all Trust staff called 12 at 12. This is a live broadcast that takes place daily at midday for 12 minutes. Following this inquest, this communication reminded all Trust staff that they have access to the Freedom to Speak Up Guardian service if they would like to confidentially discuss any concerns.

- The maternity team specifically have the Professional Midwifery Advocate (PMA) team. At this Trust we have one lead PMA and 8 sessional PMAs. The PMAs are linked to a clinical area, so for example, the home birth team, birth centre, or delivery suite or antenatal clinic. However, a midwife can contact any of the PMAs that they choose. PMAs are experienced, practicing midwives who have undertaken additional training to the A-EQUIP model of Midwifery Supervision at a Trust level. They are employed locally by our Trust and work within a team to offer support and guidance to midwives to deliver care and support safe practice. Their role is to support staff to provide safe care by offering restorative clinical supervision to allow space to think through and reflect on issues, concerns, or difficult cases. They also provide support to staff with work or personal issues. They help midwives access additional education and training as necessary and support midwives with revalidation, appraisal preparation, career development, statement writing and be a listening ear.

- The maternity team also have a quarterly “Candour and Cake Café” and the next one is planned for mid-September 2023. The idea around this is for staff to be able to speak out about their thoughts and feelings, check in with staff, create a positive working culture and an open environment that avoids judgment with the aim to enhancing safety and support. This is attended by all levels of staff within the maternity and obstetric team.

- The Trust also has exit interviews in place for all staff to ensure feedback is obtained so that the team can learn from this and implement any improvements to practices.

In addition to the responses we have provided above, I would also like to take the opportunity to update you on behalf of the Trust on a few others matters which were raised in evidence at the inquest.

Since the death of Baby Phoenix Grace Chapman, the Trust has been alerting the London Ambulance Service NHS Trust (LAS) in respect of any birth plans in place where mothers choose to birth outside of guidance so that they are aware of these cases and the plans for emergency management.

As highlighted in the Prevention of Future Deaths Report, national maternity guidance is soon to be published which is to deal with the situation where a baby is 'Born before Arrival'. The Trust has been working collaboratively with the LAS, and the North East London Local Maternity and Neonatal System (LMNS) to formulate a separate standard operating procedure and guidance for cases where the birth is imminent as there is currently no national guidance on this. Although this is being worked on at a local level, it is proposed that this will be part of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidance and shared nationally with the LMNS and national maternity units. This guidance would be specifically for cases of birth imminent and advancing and cases where labouring women decline to be transferred to hospital, against the clinical advice of the paramedics. The aim of this guidance is to provide a clear understanding for all clinicians including the midwifery staff that are called to attend these births regarding their remit of care and also provide some clarity to the paramedics. This guidance will also provide a clearly formalised escalation pathway if a midwife is not able to attend.

I hope that the content of this letter addresses the two areas of your concern and reassures you that lessons have been learnt and that the Trust takes improving patient safety very seriously. Please do not hesitate to contact me if you require any further information.

Yours Sincerely,

[redacted]

[redacted]
Chief Executive and Place Based Leader
Homerton Healthcare NHS Foundation Trust