Date: 15 September 2023

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted] **Chief Executive of the George Eliot Hospital NHS Trust, Nuneaton, Warwickshire**

The Secretary of State for Health and Social Care (concern 6 only)

The Chief Executive of the Royal College of Midwives (concern 6 only)

The Chief Executive of the Royal College of Obstetricians and Gynaecologists (concern 6 only)

The Chief Executive of the National Institute for Health and Care Excellence (NICE) (concern 6 only)

CORONER

I am Linda Karen Hadfield Lee, assistant coroner, for the area of Warwickshire.

CORONERS LEGAL POWERS

I make this report under paragraph 7, schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

INVESTIGATION AND INQUEST

Eclipse Morrison died on 21 July 2021, the day after her birth on 20 July 2021.

A referral was made to the coroner on 27 July 2021 and an investigation commenced into the death of Eclipse Morrison aged one day. The investigation concluded at the end of the inquest on 28 July 2023.

The conclusion of the inquest was a narrative conclusion:

Eclipse Morrison died from Perinatal Asphyxia. Her mother had been diagnosed with Gestational Diabetes Mellitus (GDM) after a blood test at 21 + 4 weeks. The mother's blood glucose levels remained high throughout the pregnancy with the insulin dose being increased at each diabetic review.

Serial growth ultrasound scans identified that Eclipse's growth was above the 95th customised centile and at the last scan at 37 + 3 weeks showed increased growth velocity. The mother went into spontaneous labour at 38 + 1 weeks and there was a shoulder dystocia during which there was a fracture of the humerus.

Eclipse weighed 5,800g at birth and showed no signs of life. Her Apgar scores were zero at 1, 5 and 10 minutes. Advanced resuscitation was carried out and Eclipse was transferred to the regional neonatal intensive care unit in Nottingham. Eclipse had cardiomegaly as a result of the GDM and her condition was unstable.

Eclipse died a natural cause of death; however, the evidence leads me to find that the following three circumstances may have contributed to her death:

1. Missed appointments by the mother were not followed up and subsequent appointments were not arranged with the appropriate teams. She only had one appointment with a consultant at 28 weeks.
2. As the mother was not seen by a consultant at two-week intervals (as required) in the latter stages of her pregnancy, appropriate modes and timing of delivery, such as elective Caesarean Section were not considered and as a consequence, not discussed with the mother.
3. Once the mother was in labour, the triage midwife relied on the information given by the mother on the telephone and was not aware of the mother's risk factors. As a consequence, she did not ask the mother to come to hospital immediately.

Finally the CTG traces from 16.44 were of poor quality and a fetal scalp electrode (FSE) was not available in the delivery room to monitor Eclipse's condition. Once an FSE had been obtained it was not properly attached. It is possible that Eclipse suffered the cerebral hypoxia-ischaemia either in the period after 16.44 before the shoulder dystocia occurred or after the shoulder dystocia occurred at around 17.10.

CIRCUMSTANCES OF THE DEATH

The deceased died at 28 hours and 12 minutes on 21 July 2021 at Nottingham City Hospital. She had been transferred from the George Eliot Hospital NHS Trust (GEH) following her birth on 20 July 2021.

Prior to Eclipse's birth, her mother had received ante-natal care at GEH and was receiving treatment for Gestational Diabetes Mellitus.

CORONERS CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows –

Evidence was given at the inquest and it is accepted, that many of the concerns identified in relation to Eclipse's birth have now been addressed, but some remain.

1. Risk analysis / mode and timing of birth

A significant factor was the failure to consider an elective Caesarean Section (CS). It is not clear why on this history and consideration of mode of delivery did not include a consideration of an elective CS at any stage, by any of the doctors involved.

Evidence was given that existing policies in place at GEH were not followed and the reason for this failure has not been identified.

Whilst Badgernet could be a useful tool, the evidence suggested that it is being regarded as a first line of defence rather than a failsafe. I am told that the Badgernet maternity system implemented in October 2021 will resolve the problems relating to mode and timing of birth, in that the system will require a consultant to approve a decision for CS/induction of labour (IOL) and that IOL's will not be approved by the labour ward coordinator unless the paper booking has been approved on paper. However, on the evidence received it is not clear how this will assist if the risk factors and the need to consider IOL/elective CS have not been identified, by junior staff, thus triggering the need for escalation to/approval by a consultant.

I am not clear what has been done to ensure that junior doctors and locums have sufficient technical knowledge to ensure that they are able to identify serious risk factors and alert the consultant to these, so that the consultant may consider the appropriate mode of delivery. No information was provided as to the availability of regular face to face training for all grades concerning high-risk pregnancies not just for career trainees and foundation doctors.

I am told that a memo was sent to all junior doctors reminding them that any plan for either IOL or elective CS must be approved by a consultant and that an induction pack containing that information is provided to new starters and locums.

I have seen the Women's and Children Clinical Education Guideline introduced in November 2022. I am told that the information was placed in a prominent position on notice boards, staff rooms and in blogs.

It is not clear how the assimilation of this knowledge is tested. It was suggested that this may be in appraisal, but this seems only likely to identify problems after they arise. In any event it seems these methods of dissemination of information and the appraisal system were in place at the time of Eclipse's birth but did not ensure that the doctors involved in her mother's care appreciated the impact of the risk factors in this pregnancy.

It was not explained how Badgernet or any policy or procedure in place, would ensure that there is a holistic review (including ultrasound scan findings) when planning for timing and mode of birth.

The concern remains that there will be further failure to ensure that appropriate timing and mode of delivery will be provided in high-risk pregnancies.

2. Access to Badgernet portal / full implementation of the Badgernet software

It seems that the Badgernet system is being relied on to address a number of issues which were identified in this case, and heavy reliance is being placed on a system which is not yet fully implemented. The concern remains that a critical aspect of this system, access to the portal, will not be in place until autumn of 2023 at the earliest.

3. Quality Assessment

I am informed that Badgernet can easily identify fields which have not been completed and will prevent a record being closed until the field is completed, but it cannot identify the quality of any such entries. I am told that the quality checks are made on ten sets of notes per month out of an estimated 3,000 records that will be open at any one time. The concern remains that there is insufficient quality assurance in this system.

4. Procedure for escalating concerns arising out of Ultrasound Scans (USS)

I understand that the procedure for escalating concerns arising out of a USS where it is not possible to obtain an accurate measurement in a high-risk pregnancy is currently under review. I am told that the new policy is not in place. The concern remains that no date has been set for its implementation.

5. Counselling for mothers at increased risk of shoulder dystocia

I have not seen any indication that all mothers identified to have an increased chance of shoulder dystocia now receive counselling regarding the risks and benefits associated with vaginal birth or CS. Assisting mothers to understand the implications of risks they face is fundamental to supporting them to make fully informed decisions, in accordance with Montgomery. The concern remains that there is no clear plan in place to ensure mothers receive the support they require to make fully informed decisions in relation to mode of delivery where there is risk of shoulder dystocia.

6. Interpretation of Montgomery

Ante-natal care is unique in that decisions have to be made for the benefit of two patients (the mother and the baby) and the treatment options for each may, as in this case have competing risks and benefits. In addition, in ante-natal care, the circumstances may change and action may need to be taken very quickly.

On the basis of evidence given at the inquest, there seems to be a lack of clarity as to the way in which Montgomery guidelines are interpreted. It was acknowledged in evidence that parents often want a steer as to the best/safest course of action and that may require medical professionals to express opinions as to the weight to be placed on different risk factors. In some cases, parents may prefer to rely on the viewpoint of an experienced medical professional. It seems that medical professionals do not feel they can offer this assistance as it might be interpreted as trying to impose their opinion on the parent. The way in which Montgomery is interpreted and the extent to which medical professionals can offer an opinion is of wider concern than just the actions of those at GEH and should be considered by those who produce the guidance and deliver training to medical professionals.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the addressees have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 November 2023. I, the assistant coroner, may extend the period.

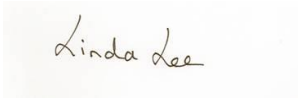
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and **PUBLICATION**

I have sent a copy of my report to the Chief Coroner, Eclipse Morrison's family and the HSIB.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the assistant coroner, at the time of your response, about the release of the publication of your response by the Chief Coroner.

15 September 2023



Linda Karen Hadfield Lee

HM Assistant Coroner

Warwickshire