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14 May 2025

Dr J Adeley
Senior Coroner
Lancashire & Blackburn with Darwen Coroners

Sent via email to: [redacted]

Dear Dr Adeley

Regulation 28: Report To Prevent Future Deaths – Ida Jean Lock
Conclusion of inquest 21 March 2025

Thank you for your letter dated 21 March 2025 sent following the conclusion of the inquest touching the death of Ida Jean Lock.

I know that you will share my response with Ida's parents, and I first want to express my deep condolences to them along with a sincere apology for the added distress they have suffered as a result of the failure in clinical governance processes within University Hospitals of Morecambe Bay Trust.

NHS Lancashire and South Cumbria Integrated Care Board (ICB) are keen to assure the family and the coroner that the concerns raised about the care and clinical governance processes have been listened to, carefully reflected on and appropriately actioned.

Through the Regulation 28 report you have raised a number of matters of concern relating to the care that Ida and her mother received and clinical governance processes/practices in University Hospitals of Morecambe Bay Trust. This letter is in response to these issues, and I will respond to each matter raised separately.

A: Culture of Candour

1. There is not a culture of candour within University Hospitals of Morecambe Bay NHS Foundation Trust (Trust) and the impact that this has on safety, learning and implementing required changes to prevent deaths. Urgent action is required by the Trust to meaningfully embed the Dury of Candour.

Being open and transparent with our population when something has gone wrong within healthcare is a priority nationally, regionally and locally. Measures are in place to monitor compliance with Duty of Candour through the NHS Standard Contract however Lancashire and South Cumbria Integrated Care Board (LSC ICB) also receive updates from the Trust around compliance with Duty of Candour through the Trusts Integrated Performance Report and attendance at their internal Quality Assurance Committee.

The ICB has identified that the Trust is currently showing common cause variation with the lower compliance attributed to staffing capacity. The capacity issue is being addressed through divisional reconfiguration and additional capacity was identified which came into effect on 1 April 2025. An audit has been undertaken and there is an associated action plan in order to improve compliance to ensure every patient/family is served Duty of Candour in a timely and compassionate manner. The ICB are committed to ensuring that compliance improves and will monitor the effectiveness of the action plan through continued mechanisms including attendance at the Trust Quality Assurance Committee providing external challenge and scrutiny.

2. [redacted]'s evidence to the inquest was that a deep-seated and endemic culture within the Trust leads to denial and a failure to learn.

Following the Care Quality Commissions (CQC) Inspection of Maternity Services in 2021, the service was entered onto the national Maternity Safety Support Programme (MSSP). A full diagnostic assessment was undertaken by the Maternity Improvement Advisor (MIA) allocated to the service which identified several areas for focussed improvement work, including governance, culture and leadership. An associated improvement and sustainability plan has been developed, and the oversight and assurance are led by the national MSSP team. The LSC ICB Local Maternity and Neonatal System (LMNS) are integral to the oversight and assurance work reporting internally within the ICB on progress against this work and are committed to ensuring that the Trust are building a culture to ensure learning from all patient safety events and near misses.

In addition, the quadrumvirate completed the Perinatal Culture and Leadership Programme in 2023/2024; this was a national mandated training programme focused on improving the quality and safety of maternity and neonatal care. Following on from this the SCORE culture survey was undertaken with the development of an associated action plan. The service identified five themes and are progressing these via a phased approach. There is 6- monthly reporting to the LMNS on the progress against this action plan including any identified challenges. It is acknowledged that since the original survey there has been a change in the perinatal quadrumvirate, however the current quadrumvirate have been offered support via the Health Innovation Agency to access further training.

As an organisation the trust has worked with the National Recovery Support Programme (RSP) on the Well Led domain and engaged in various programmes of work to improve culture and learning including:

- Improvements to the Freedom To Speak Up (FTSU) service
- 'Leadership For All' development programme
- Stroke service improvements
- Restorative, Just and Learning Culture implementation
- Organisational development work in Maternity Services
- Refresh of organisational strategy and priorities
- Executive leadership development programme
- Service improvement programmes
- Review of medical staffing
- Embedding kindness project in 2022/23 which informed the Patient Experience strategy.

Improvements were monitored through a System Wide Improvement Board leading to movement from a national System Oversight Framework (SOF) 4 position to SOF 3 and there is continued oversight through the System Improvement Assurance Group (IAG).

Additionally, the ICB are sighted on the improvements being made to embed the Patient Safety Incident Response Framework (PSIRF) which is focused on learning and compassionate engagement. We do however acknowledge that progress with PSIRF has been limited which in turn delays learning and improvements. In order to address this the ICB are aware that additional capacity has now been sought to ensure that investigations into patient safety events are conducted in a timely manner, and this is currently being closely monitored with appropriate challenge provided to the Trust at both internal Trust and external assurance meetings. Within the wider organisation the Trust attend and actively participate in the ICS Shared Learning Forum and Patient Safety Specialist meetings. The ICB will ensure that actions taken from these discussions are implemented.

3. The Trust's approach to the inquest has been one of a lack of transparency and openness, failure to provide relevant information and a failure to identify with candour the defective clinical governance processes that have operated at the Trust from 2019 to present day.

The LMNS, (the maternity arm of the Integrated Care Board) has established and embedded a governance and reporting structure for all local maternity services. This includes a bi-monthly Quality Assurance Panel and Patient Safety Learning Group (see attached Terms of Reference). UHMBT maternity service are fully engaged and provide regular reporting on maternity and neonatal outcomes and patient safety incidents in order to maximise learning across the Integrated Care System (ICS).

The ICS Maternity Patient Safety Learning Group is a dedicated forum to share learning from incidents across the system which UHMBT actively participate via their reporting and dedicated case discussions. In addition, the LMNS is a member of UHMBT Maternity &Neonatal Improvement Group, at this meeting a review of evidence is undertaken against the improvement actions in line with MSSP Plan. Also, the LMNS is invited and attends the UHMBT quarterly quality review with MNSI where a review of completed investigations with a focus on the identified learning and improvement actions is discussed.

The ICB is sorry that the family and coroner experienced a lack of transparency and openness throughout; this is not the expectation of LSC ICB where we are working hard to implement and embed a culture of incident reporting to highlight opportunities for patient safety/experience to be improved. Particular attention will be focused with the Trust in ensuring assurance can be evidenced going forward.

4. The Trust did not disclose that they had failed to notify the external bodies namely the CQC and the then CCG [ICB] via StEIS and the Trust's internal Serious Incidents Reporting Investigation panel, none of which was noted by the Trust's Patient Safety Summits.

In line with contractual and regulatory requirements LSC ICB expects all providers to report all patient safety events onto the Learning From Patient Safety Events (LFPSE) platform (this has replaced the National Reporting Learning System – NRLS). Where appropriate and in line with Trust local and national priorities, patient safety events must also be reported onto StEIS where the ICB is then notified. The ICB is very concerned to note from your findings that the Trust failed to fulfil these contractual and regulatory requirements. Since the inception of the ICB there has been a detailed oversight in the reporting of patient safety events from the Trust against expected reporting, with challenge where there has been unexpected variation. The ICB will continue to seek assurance from the Trust through the contractual route and by the ongoing scrutiny of patient safety events.

Please be re-assured that specifically for maternity services, as part of the LMNS Patient Safety Learning Group, UHMBT Maternity service provide a two monthly report on all patient safety incidents. This includes any incidents that have met the national and local priorities of the trust PSIRF plan, MNSI investigations, and all other incidents that have had a maternity patient safety review.

It is understood by LSC ICB that Mersey Internal Audit Authority (MIAA) as external auditors are scheduled to undertake an audit on the Trust's PSIRF progress in 2025/26; the ICB will seek a copy of the audit outcome and monitor the implementation of any resulting action plan.

5. Trust figures to the Board provided in 2025 stated that there were no complaints over 6 months old when the Trust at the time of the inquest have not responded to [redacted] and [redacted]'s 1 June 2020 complaint with the Trust's failure to categorise Ida's death as only "Moderate Harm" (see point 4 above) cause me also to have concern about the reliability of Trust's data.

The ICB acknowledges the concerns of the coroner in respect of reliability of data. In order to be re-assured on the validity of data either supplied to the ICB or in the public domain, triangulation of hard and soft information is undertaken. This also includes the use of a Soft Intelligence System across Lancashire and South Cumbria; issues can be raised that allow for consideration of further interrogation or collation/theme/trending to build a wider view of a service or provider. This system plus all the other information held gives an ability to validate information/data provided and where necessary provide external scrunty and challenge through formal contract meetings and Quality Review meetings.

A clinical audit report is presented to the Trust's Quality Assurance Committee on a quarterly basis which includes audits on documentation. Where audit standards are not being met there are mechanisms in place to track actions and re-audit. The Trust also report on clinical data quality as part of their annual quality account and perform well for data accuracy against peers. The ICB will continue to use this way of working paying particular attention in the ongoing need for triangulation of all data sources.

B. Clinical Governance and Maternity Governance

6. The clinical governance arrangements at the Trust require urgent review to ensure the appropriate personnel are in place, with the necessary training and skills to deliver robust clinical governance to ensure patient safety in maternity care.

As previously described the maternity service is on and remain under the remit of the national MSSP programme. Since being on the programme, a full review of governance has been completed by MIAA with an associated improvement plan developed. A focussed project to develop and implement a Maternity Quality Governance and Accountability Framework was completed in April 2023; the aim of the framework is to ensure that the roles and responsibilities of staff are clearly defined within the outlined risk and incident management process.
The ICB does acknowledge that because of the divisional re-configuration within the Trust particular attention will need to be paid by the LMNS to ensure that clinical governance for maternity services is not negatively impacted.

7. The Trust did not undertake any examination of its own clinical governance processes, which were a principal area of concern, and which was identified to the Trust five months before the inquest commenced. The deficiencies included lack of version control and audit of documents, untrained staff, chaotic clinical governance arrangements, defensive attitudes and inappropriate self-congratulation.

The ICB is deeply saddened that the family of Ida were unnecessarily exposed to an extended court hearing as result of poor clinical governance within the Trust; we were very concerned to read the findings from the inquest and do not support poor governance practices. We are aware that there has been staffing vacancies/absences within the clinical governance team which we would partly attribute to the deficiencies identified. The ICB are assured that key governance posts have been recruited to and staff commenced in post (albeit interim in some cases). The ICB will continue to monitor the impact of this recruitment to assure itself that clinical governance practices are improved, embedded and sustained. Additionally, the ICB will attend internal Trust key committee meetings and ensure scrutiny is afforded and challenge given where these practices are seen.

Specific to maternity the Trust now has an Independent Senior Advocate whose role is to ensure that the voices of women and families are listened to, heard and acted upon by the maternity services. In UHMBT the Advocate provides a report to Trust Quality and Assurance Committee which the ICB attend. Particular focus on the effectiveness of the Advocate role will continue by the LMNS ensuring there is independent challenge and scrutiny.

8. Specific concerns relating to individual members of staff

As these concerns are relating to individual staff members the ICB believes that UHMBT are best placed to respond to the coroner concerns.

9. All investigations conducted by the Trust to date in respect of Ida's death have been unskilled, superficial, brief, failed to identify issues and left the family without answers and were all features identified by the 2015 Kirkup Report. In view of the continuing culture at the Trust, this cause a significant concern that issues of safety and safeguarding are not properly considered, transparently engaged with and then addressed formally in respect of a child fatality and serious injury by the Trust.

As stated earlier in this response the ICB acknowledges that the Trusts journey in implementing and embedding PSIRF, the frameworks principles and the training of investigators in line with national expectations is not as advanced as initially planned or expected. This includes the clear need for compassionate engagement that is timely, open and transparent when care goes wrong. We are re-assured by the Trust that there is a plan in place to address these gaps and will actively and robustly monitor the progress to fully meet the PSIRF expectations using both quantitative and qualitative intelligence sources.

Additional scrutiny is now provided by the ICB through attendance at internal Trust safety panel meetings where learning response reports are shared and discussed as to whether they meet the criteria as outlined in the national framework. Constructive challenge is consistently delivered by the ICB in a supportive manner in order to assure ourselves that the investigation and report are of good quality with particular focus on family/patient engagement and involvement in the process.

In addition, the LMNS have implemented a system wide Patient Safety Learning Group, in which the UHMBT Maternity service provide a two monthly report on all patient safety incidents (as described earlier in this response).

The ICB can confirm that in line with the National Maternity Incentive Scheme the LMNS also undertake quarterly quality assurance visits to review evidence against each of 10 safety actions.

10. The Trust now uses the PSIRF model and is to appoint 3 whole time equivalent Response Leads by 30 September 2025. However, I remain concerned that the Trust has not fully engaged with the duty of candour such that I am not satisfied that the work on PSIRF to date has truly addressed the issues in respect of Trust's investigations.

The Trust implemented PSIRF in line with national guidelines and within the required timescale however the ICB is aware that further progression of this agenda has been delayed due to lack of suitably trained investigators. The ICB is required to assure itself on the quality of the investigation and the quality of the report; this is done through attendance at the Trust internal Learning Response Group where evidence is available of supportive challenge when ICB concerns are raised. Particular attention is focused on the transparency of the investigation/report and the engagement with the patient/family. The Trust recognise that further work is needed to ensure that investigators are trained to use and apply the Systems Engineering Initiative for Patient Safety (SEIPS) framework methodology in their investigations (or a suitable alternative such as the Yorkshire Contributing Factors Framework). We are pleased that the Trust now utilise Patient Safety Partners who are able to offer an independent view on patient safety matters, challenging where necessary and are also aware that [redacted] is providing specific training for staff on compassionate engagement following a patient safety event.

The ICB will continue to scrutinise all patient safety reports, provide supportive challenge to ensure the principles of a positive patient safety culture and the PSIRF are fully embedded and sustained with the Trust.

C. Mandatory Training, expired training and remedial training

11, 12 and 13. The Trust do not have robust systems in place to ensure that any midwife who has not completed her mandatory training is subject to immediate action to ensure that all mandatory training is completed and is in date. There was no remedial training put in place for either the midwives involved in Ida's delivery and resuscitation or for the paediatric SHO after Ida's death. This raises a significant concern that the Trust do not operate a system of remedial training when this inquest has identified remedial training was required.

It is acknowledged that whilst the LMNS has oversight and assurance of training in line with Training Needs Analysis (Maternity Incentive scheme safety action 8), this does not include mandatory training. The Director of Midwifery at UHMBT has provided reassurance to the LMNS that further actions are underway to ensure there is monthly reporting on mandatory maternity training with deep dives to understand those staff not compliant and immediate action taken to remedy this position. As an LMNS we will seek assurance through the monthly reporting process that all staff are compliant and where this is not the case the rationale and actions being taken to ensure patient safety.

D: Grading of harm for incident reporting: Babies who have sustained hypoxic brain injury and undergo cooling

14. The Trust graded Ida's level of harm as "moderate", even after her death. This grading should have been adjusted to "severe" by the Trust before Ida was transferred to Royal Preston Hospital as the consultant paediatrician identified that she had sustained a severe hypoxic ischaemic encephalopathy due to foetal bradycardia.

15. There is a significant risk that if reporting is graded on harm alone, clinical care that resulted in hypoxic brain damage during delivery and which was prevented by therapeutic cooling, will not adequately identify the problems that caused the harm during the delivery.

16. [redacted] confirmed that nationally there is inconsistency in categorisation of harm for babies who sustain a hypoxic injury due to foetal bradycardia in labour and who require cooling and clarification guidance would assist prevent further maternity deaths and ensure full and proper investigation of hypoxic injuries sustained in labour.

As an ICB and LMNS we are aware that the ongoing challenges in the grading of harm, directives from the PSIRF and how this aligns to CQC is a recognised issue both nationally and regionally

The North-West Regional Chief Midwife is developing Maternity Guidance and Principles with the aim to ensure there is a consistent approach in the identification and reporting of incidents. The ICB are supportive of this work and are actively engaged with the regional work to reduce this known risk.

E. Funding for MSNI

17. But for the HSIB investigation report into Ida's death [redacted] admitted that Ida's death due to failures by the Trust would never have come to light or resulted in an inquest.

18. The MSNI is now hosted by the CQC with funding secured for the next two years but no certainty as to ongoing funding after this date. These independent investigations by specialist skilled investigators into the most serious of events is an essential safeguard to the lives of mothers and unborn children.

19. Without an assurance that funding will continue beyond 2027 I am concerned that significant harm events to mothers and babies and deaths such as Ida's will go unrecorded and lessons that should be learned to prevent future maternal and baby deaths will go unnoticed, and there will be a risk of future maternity deaths.

LSC ICB fully support and acknowledge the important role that MSNI play in undertaking truly independent maternity investigations and the value that these investigations have. The funding for this service is led nationally and therefore the ICB are unable to offer any assurances on this matter.

I am grateful to you for highlighting your concerns to me and I hope that by this letter, I have addressed your concerns, but should you require any further clarification or information, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Medical Director (Interim)

Att: Terms of Reference