University Hospitals of Morecambe Bay
NHS Foundation Trust

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Your ref: [redacted]
Our ref: [redacted]

16 May 2025

Dear Dr Adeley

Re Ida Jean Lock (Deceased)

Thank you for your Prevention of Future Death Report dated 21 March 2025.

Firstly, we would like to express our deepest condolences to the parents and family of Ida. We want to apologise for the lapses in care that resulted in her tragic death and the further harm we then caused by how we handled the investigation. We recognise the distress this has caused Ida's loved ones and are truly sorry for this.

We have accepted your findings and reviewed our practices, policies and procedures in light of these, so that we can identify where further changes need to be made. We are committed to learning from this tragic event and the issues identified during the inquest.

For ease, our responses to your matters of concern follow under the headings used in your report.

A: Culture of Candour

Following Ida's death, the Trust did not follow its own policies. We should have met with Ida's parents at the start of the investigation process. We should have awaited the outcome of the Healthcare Safety Investigation Branch (HSIB) investigation. The internal investigation relied on flawed and unconventional Root Cause Analysis (RCA) methodology with a narrow scope. This resulted in a failure to identify and address the acts and omissions in care that contributed to Ida's death in the conclusions reached. Once the HSIB report was available, the Trust should have accepted the findings in the report unreservedly and considered why the conclusions differed from those of the internal investigation.

We acknowledge with deep regret that the tragic death of Ida and the manner in which we investigated the case, demonstrated the serious systemic failures that were present within our Trust. It is clear that culture contributed to defensiveness, and a failure to engage in

meaningful learning from adverse events. This impeded our ability to take timely and appropriate action to prevent harm and failed those we were entrusted to care for.

Specifically, we recognise the unacceptable failure to notify key external bodies—namely the Care Quality Commission (CQC) and the then Clinical Commissioning Group (now the Integrated Care Board (ICB) via the Strategic Executive Information System (StEIS). This omission not only breached statutory reporting duties but also deprived the wider health system of critical information necessary for oversight and learning.

To reinforce a culture of candour within the Trust - where openness, honesty, and learning are embedded at all levels - we have implemented a range of measures that go beyond compliance and aim to change behaviours, mindsets, and systems. In addition, we continue to monitor the impact of these changes through ward to board governance arrangements. The changes we have made are detailed below.

By embedding these measures, the Trust is taking deliberate and sustained action to move beyond a culture of defensiveness, towards one of honesty, accountability, and continuous learning. These steps are critical in restoring public confidence, supporting staff wellbeing, and, most importantly, ensuring safer care for our patients.

The Duty of Candour process is now embedded across the organisation. The maternity service has consistently demonstrated that all women and their families receive duty of candour within 10 working days of an incident occurring. This is monitored via the Quality Governance Assurance Framework. There is a standardised formal duty of candour letter, and communication is regular, with a single point of contact for families to raise any questions or concerns.

The completion of Duty of Candour responses across the wider Trust is monitored via the Quality Governance Assurance Framework and reported on at the Quality Assurance Committee.

There has been a pilot project, where families have also been informed about the role of the Maternity and Neonatal Senior Independent Advocate (MNSIA), an external point of contact who provides support and assists with advocacy. The application of this was monitored via the Quality Governance Assurance Framework. This is a national pilot programme that has recently closed and we await information around its continuation.

There was never any intention by the Trust to be lacking in transparency and openness in its approach to the inquest. However, it is recognised that issues were identified at the inquest, which had not been identified by the Trust's own investigations, at which point it became evident that further information was relevant. Every effort was made to locate and share this information as swiftly as possible, as soon as its relevance was identified.

Actions taken prior to the inquest:

Strengthening Freedom to Speak Up (FTSU)

- Enhanced visibility and support: The FTSU Guardians and FTSU Champions are now more visible and accessible across clinical and non-clinical areas, providing staff with safe, confidential pathways to raise concerns.

- Leadership responsiveness: Senior leaders regularly engage with FTSU data and themes to identify systemic issues and ensure swift action is taken.
- The FTSU team reports to the Board of Directors.
- Psychological safety training: Dedicated training has been introduced to help leaders and teams foster environments where staff feel safe to raise concerns without fear of blame or reprisal.

Daily Triage and Cross-Care Group Reviews

- Multi-disciplinary daily triage meetings have been established to review new concerns, incidents, and patient feedback in real time. This ensures timely recognition of risk, early escalation, and coordinated responses.
- These reviews involve cross-care group participation, breaking down silos and promoting shared learning, transparency, and consistency in how patient safety concerns are addressed.
- The daily structure enables tracking of themes and emerging trends, helping to identify issues early and prevent escalation.

Implementation of the Patient Safety Incident Response Framework (PSIRF)

- The Trust is actively implementing PSIRF, which marks a fundamental shift in how we respond to patient safety incidents.
- Focus on learning, not blame: PSIRF prioritises understanding 'what' and 'how' over 'who', reducing defensiveness and enabling open dialogue.
- Flexible, proportionate responses: The framework allows for different types of learning responses (e.g. thematic reviews, case note reviews, patient safety incident investigations), depending on the nature and impact of the incident.
- Co-produced investigations: We are involving patients, families, and staff in shaping the terms of reference and contributing to learning outcomes.
- Training and capacity building: Staff involved in incident responses are being trained under PSIRF principles to ensure quality, compassion, and consistency in approach.

Cultural Leadership and Accountability

- Executive and board-level commitment to candour is now more visible, with regular walkarounds, open forums, and leadership-led safety conversations.
- Leadership performance reviews include assessment of behaviours that support psychological safety, candour, and learning.
- Quarterly culture reviews track staff perceptions and feedback, with action plans developed in collaboration with teams.

Promoting a Culture of Transparency and Accountability

Regular mortality reviews and triangulation meetings reinforce the message that every patient outcome matters, and that the organisation is committed to learning, not blame. When embedded in organisational culture, these forums:

- Foster trust among staff, patients, and families
- Support the principles of the Duty of Candour
- Promote reflective practice and continuous professional development.
- Contribute to better governance oversight and regulatory compliance.

Enhancing Clinical Governance and Risk Management

By ensuring that lessons learned from mortality reviews are discussed alongside other sources of intelligence, triangulation meetings play a central role in:

- Informing board-level decision-making
- Shaping training, staffing, and resourcing priorities
- Anticipating risk and preventing future harm

In 2022, a structured process was implemented to monitor and track complaints within maternity services. This includes weekly meetings between the Patient Experience Team and maternity service representatives to ensure timely review and action.

Service user feedback is collected from multiple sources, including:

- Formal complaints
- Concerns raised with the Patient Advice and Liaison Service (PALS)
- Issues identified by the Maternity and Neonatal Voices Partnership (MNVP) lead
- Findings from the Maternity and Newborn Safety Investigations (MNSI) programme
- Concerns highlighted through the incident management process

All complaints, concerns, and feedback are logged into a central tracking system and monitored through to resolution.

To ensure quality and compassion in our communication, all complaint responses are reviewed by the quadrumvirate leadership team before being sent. We also offer families the opportunity to meet with us to discuss their concerns in more detail, should they wish to do so.

The Trust's Being Open policy, introduced in September 2019, underpins our approach to transparency. It reflects our ethical responsibility and duty of candour, requiring healthcare professionals and managers to inform patients and families when care has resulted in harm.

In 2023, we undertook extensive cultural diagnosis work with Maternity teams to understand the state of the culture and how best to address the issues identified. In 2024, a three phased cultural action plan commenced, overseen by the Chair of Culture, Inclusion and Organisational Development and the Head of Midwifery. Phase one delivered actions against several themes including:

1. Leadership and Governance
2. Well-being
3. Respect and Civility
4. Psychological safety
5. Leadership Development

Increasing leadership visibility and access to leadership colleagues was central to the improvements, with a focus on improving two-way communication with colleagues and setting standards. A lead Professional Midwifery Advocate (PMA) has been appointed with the objective of expanding formal and structured support and education. A number of colleagues have attended training aimed at increasing cultural understanding and

communication skills between team members. Increased visibility of the FTSU team and processes and engagement in PSIRF training has also been central to the cultural plan. Phase one of the plan is complete.

Actions taken after the inquest:

Immediate changes were made to the Being Open policy following evidence given at the inquest.

An audit was completed that looked at all complaints that had been converted to incidents to ensure the correct processes had been followed and that the individuals concerned had received appropriate responses.

We acknowledged that poor handover of maternity events and concerns to level 3 centres would impact on their decisions around reporting to the CQC and the Coroner and so have enhanced our engagement with these centres.

A response to [redacted] and [redacted]s 1 June 2020 complaint was sent on 24 April 2025.

What we are going to do next:

Await the outcome of the Department of Health and Social Care (DHSC) review of the statutory duty of candour for health and social care providers in England. This review aims to assess how the duty is being implemented, monitored, and enforced, and to determine if the policy and its design are appropriate. Once the review is published, we will develop an action plan to address any identified gaps in our processes.

Phase two of the Maternity cultural action plan is commencing with increased focus on teamwork, communication and creating psychologically safe teams.

Organisationally, a key area of focus is to 'create the culture and conditions for success'. This includes creating a sense of belonging and psychological safety in teams so that they are able to speak up when things are not right. Key enablers for delivering this cultural shift are our FTSU service and strategy and our newly implemented People Strategy which sets out the People Strategy deal - outlining what we expect of colleagues and what they can expect of the Trust. The Deal is aligned to NHS People Promise elements, including 'we each have a voice that counts' and 'we are compassionate and inclusive'. Additionally, it sets out our expectations of teams and a two-way dialogue on flexibility, best practice and strengthening team dynamics, with the aim of creating a productive and high performing team environment focused upon patient experience and care.

As part of the 2025/26 internal audit programme, the Board has asked our internal auditors to complete a review of the implementation of the changes proposed following receipt of the PFD in quarter 4.

B: Clinical Governance and Maternity Governance

We fully acknowledge the failings in our clinical governance arrangements that have been identified, including poor version control, absence of document audit trails, disorganised governance structures and an inappropriate tone of self-congratulation in the face of serious incidents. The Trust accepts that it did not undertake a robust examination of its own clinical governance processes in relation to Ida’s death. This is a source of deep regret.

We recognise the validity of [redacted]'s observation at the inquest - that a narrow focus on process over outcomes led to investigations that may have met procedural requirements yet failed to deliver real learning or improve the experience of patients and families. This approach was wholly inadequate and does not reflect the standard of care and transparency that patients deserve.

We are committed to ongoing external oversight and transparent engagement with patients, families, and regulators to ensure changes are sustained and effective. We apologise to those affected by our failings and reaffirm our determination to ensure that the lessons learned lead to lasting change.

Actions taken prior to the inquest:

In 2021, the Trust recognised that there were complex challenges in the organisation that required additional capacity and capabilities. Due to ongoing challenges, the Trust asked to be entered into the national Recovery Support Programme (RSP) in 2021.

As part of the RSP, the Trust has been working with NHS England's Maternity Safety Support Programme (MSSP) since August 2021 and programme leaders have recognised the organisation for improving the maternity service. They have acknowledged and confirmed the measures taken to embed maternity care that is, and feels, safe and effective for women and their families. We progressed to the sustainability phase of the programme in 2024 and await a further assurance visit in the next few months.

The Trust engaged the services of the internal auditors (MIAA) in 2024 to assess the effectiveness of governance processes in the implementation and reporting of the MSSP programme. The auditors concluded that there was a substantial level of assurance that the programme was well implemented, with a good system of internal control designed to meet the system objectives, and that controls were generally being applied consistently. There were two recommendations, one relating to action sign off (medium risk) and one relating to a single point of accountability being identified for actions (low risk); both recommendations were implemented immediately and have been signed off by the internal auditors as complete.

We have undertaken a comprehensive reform of our Trust-wide clinical governance framework. This includes:

- Strengthening document control and audit mechanisms
- Mandatory training for all staff involved in incident investigation and governance
- Restructuring governance oversight to ensure clarity, accountability, and timeliness
- Shifting the organisational focus from process compliance to outcome-driven learning and meaningful improvement
- Embedding a culture of openness, humility, and family-centred care across all services

Staff

The role induction process for colleagues was not consistent and there was a significant lack of support, direction, correction and education from senior leaders at the time. Concerns around the incident review were not shared with the appropriate colleagues in the organisation.

At the inquest, colleagues openly declared that there were several errors of judgement and that they wholly regretted how they had managed the incident. They also apologised to the family.

When responding to the HSIB report, a lack of understanding led to the recording of disputes from the clinicians involved in [redacted]'s and Ida's care as well as the factual accuracy comments. This response was sent to HSIB without internal challenge and included the disputes. The response was submitted to HSIB with the approval of the Governance Business Partner and the knowledge of the Head of Midwifery. In view of the inexperience of colleagues in these matters, it would have been a reasonable expectation for them to have received careful guidance, support and correction in this situation.

We acknowledge the need for further learning and more robust support and mentorship to support development of colleagues moving into leadership roles.

Actions taken immediately after the inquest:

Our Director of Midwifery has taken HR advice and concluded that given:

- The time elapsed from the event
- The disclosures and insights given at the inquest
- That the key senior leadership members no longer work for the Trust

there is nothing further that would be gained from an investigation. The Trust has therefore opted to follow a restorative justice pathway that is bespoke to the individuals. Such pathways may include:

- A skills analysis against the role descriptions
- Individual learning and development plans
- Requirement to provide a reflective statement including key learning points from the matters concerned with [redacted]'s and [redacted]'s care following Ida's death
- An emotional and psychological support plan
- Ongoing support through a professional coach

What we are going to do next:

Our Director of Midwifery has developed a skills analysis framework, which will be undertaken with all existing midwives who hold senior positions and with all newly-appointed senior midwives. This skills analysis will be referred to at the annual performance appraisal and will inform the continuous learning and development plan for each individual.

The Board has asked the internal auditors to:

- review the embeddedness of the Kirkup recommendations or their successor practices.
- provide assurance that the governance arrangements in the three divisions are operating in line with the Trust's Quality Governance Accountability and Performance Accountability Frameworks.
- evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring and reporting of Serious incidents following the adoption of PSIRF.

C: Mandatory Training, expired training and remedial training

During the course of the inquest, it became clear that the midwife providing primary care to [redacted] had not completed every element of her mandatory education. Some elements of the K2 fetal monitoring package had been completed, but not the full package. K2 is an interactive online, e-learning package which offers modules in fetal monitoring and maternity crisis management. All fetal monitoring modules required completion for the staff member to be fully compliant with the K2 training. K2 is no longer in use by the organisation and has been replaced by a fetal monitoring study day, which includes a competency assessment. It also emerged that the senior midwife was, at the time of the inquest, not compliant with the requirement to undertake annual neonatal resuscitation. On hearing this information, the Director of Midwifery immediately issued a direction for this to be rectified within 24 hours. The senior midwife successfully completed her mandatory education the next day.

Each year, the Trust must achieve 10 safety standards in order to be eligible for a 10% rebate of contributions to the Clinical Negligence Scheme for Trusts (CNST). Safety action 8 requires Trusts to have a minimum 90% attendance for three elements of training and education:

- Fetal monitoring training
- Multiprofessional maternity emergencies training (PROMPT)
- Neonatal life support training

The Trust has consistently demonstrated 90% compliance for all three areas.

Previously mandatory education has been considered a personal professional responsibility. However, the fetal monitoring guideline published in 2023 states that any clinician who is not compliant with fetal monitoring will have restrictions placed on their practice until relevant training is completed.

Actions taken prior to the inquest:

The Director of Midwifery commenced a body of work before the inquest concluded which has involved:

- A weekly compliance report

- Personal contact with all clinicians not compliant to remind them of their obligations and agree a plan
- Provision of a plan and timeframe for all clinicians whose compliance had lapsed
- Work with the obstetric education lead to include obstetric medical compliance as well as midwifery compliance
- A requirement for mandatory education to be included in individual annual performance appraisals
- An analysis of mandatory education compliance is now reported to the Board for oversight at the highest level

What we are going to do next:

Map all critical training requirements for clinical areas and ensure compliance across the Trust.

Where there are areas of concern, provide training and development to improve skills, knowledge and behaviours.

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

We acknowledge that the grading of harm of the incident should have been reviewed and updated to severe once the severity of the hypoxic injury was known.

As part of our refreshed Governance processes, we introduced a daily triage of incidents (see also p3). This is attended by members of the Divisional leadership teams, Corporate Clinical Governance team and Chief Nursing Officer team. This daily triage is accountable to the Executive Review Group (ERG). The function of the daily triage is to triangulate events captured through a variety of routes (i.e. incidents, complaints etc.) and agree the most appropriate learning response based on the Trust's Patient Safety Incident Response Plan (PSIRP) which includes the potential for learning, improvement and systemic risk.

Any incident that is graded as moderate harm or above triggers the Patient Safety Incident Response Framework (PSIRF) incident management response - this ensures that a comprehensive independent investigation is undertaken. The Trust has also introduced local maternity PSIRF priorities, since there is a lack of national guidance about the response when an incident falls outside the national reporting structure for MNSI and Perinatal Mortality Review Tool (PMRT). We have triangulated data from complaints, moderate and serious harm incidents to develop our local priorities. Neonatal seizures not meeting cooling criteria is one of those priorities. Any incident that meets the local priorities criteria is escalated for executive oversight of the incident management process.

The ERG is chaired by the Chief Medical Officer or Chief Nursing Officer. The group is convened twice weekly to oversee all incidents reviewed by the Divisions that have been validated as causing moderate or above harm. In addition to this, the group may review other incidents that trigger organisational concern. The group also reviews all complaints and claims received in the previous week. This process enables executive oversight of any immediate issues which need addressing. The group has the power to investigate any

clinical or non-clinical activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the ERG.

What we are going to do next:

We are in the process of employing three full-time Learning Response Leads who will conduct investigations and provide oversight of the PSIRF process.

Embed enhanced quality assurance of Patient Safety Incident Investigations through a structured process involving members of the Chief Nursing Officer and Corporate Clinical Governance teams.

E: Funding for MSNI

Concern not addressed to the Trust.

We hope this information is of reassurance but should you require anything further, please do not hesitate to contact us.

Yours sincerely

[redacted], Interim Director of Governance and Assurance on behalf of

[redacted], Chief Executive

[redacted], Chief Nursing Officer

[redacted], Director of Midwifery

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