**Lancashire & Blackburn with Darwen Coroners**
**Dr James Adeley**
**Senior Coroner**

Date: **21 March 2025**
Our Ref: [redacted]

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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**THIS REPORT IS BEING SENT TO:**

1. **The Department of Health and Social Care** for the attention of The [redacted], **Secretary of State for Health and Social Care**

2. **University Hospitals of Morecambe Bay NHS Foundation Trust** [for the attention of]:

   a. [redacted], Chief Executive;
   **b.** [redacted], Interim Director of Governance and Assurance;
   **c.** [redacted], Chief Nursing Officer;
   d. [redacted], Director of Midwifery

3. **NHS Lancashire and South Cumbria Integrated Care Board**

4. **NHS England**

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| 1 | **CORONER**<br><br>I am Dr James Adeley, Senior Coroner for the Coroner area of Lancashire & Blackburn with Darwen. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br><br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>The investigation into Ida Jean Lock was opened on 24 November 2020<br><br>The inquest into Ida Jean Lock was opened on 27 May 2021<br><br>The inquest was concluded on 21 March 2025 following 19 days of evidence. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>[redacted], who was pregnant with her daughter, Ida, attended Royal Lancaster Infirmary Labour Ward, operated by University Hospitals of Morecambe Bay NHS Foundation Trust, on 8 November 2019 when she should have been offered induction of labour to provider additional monitoring during delivery. [redacted] re-attended the Labour Ward on 9 November 2019 when due to a report of reduced foetal movements, she should have received obstetric care and additional monitoring during delivery. During the course of the labour on 9 November 2019 there were multiple missed opportunities for enhanced care and obstetric input including a failure to act on bloodstained liquor, a rising foetal |

heart rate before 10 am, failing to act on clinical signs that made it inadvisable for [redacted] to enter the birthing pool, failure to act on a significant slowing of the baby's heart at 10:15 am, a lack of urgency both in asking [redacted] to leave the pool and on obtaining CTG monitoring equipment, failing to summon obstetric help at an appropriate time, the midwives becoming task focused on obtaining a foetal heart rate and deriving reassurance from unreliable heart rate readings that lead to avoidable delay. The obstetric delivery of Ida was of high quality but, due to the delay involving obstetricians, Ida was born pale in colour with a low heart rate and severe hypoxic ischaemic brain damage.

The initial resuscitation for 3 ½ minutes led by the Labour Ward Coordinator was wholly ineffectual and Ida's condition at the time of arrival of the paediatric registrar was consistent with ineffective ventilation where chest rise could not be seen, the heart rate was less than 60 bpm and she was grey in colour. The paediatric registrar took over the resuscitation, Ida responded quickly to ventilation and from this point onwards the resuscitation was of high quality.

The conclusion of the inquest is as follows:

***On 9 November 2019 [redacted], who was pregnant with Ida, attended the Royal Lancaster Infirmary Labour Ward in early labour. Ida was a normal child whose death was caused by a lack of oxygen during her delivery that occurred due to the gross failure of the three midwives attending her to provide basic medical care to deliver Ida urgently when it was apparent she was in distress and contributed to by the lead midwife's wholly incompetent failure to provide basic neonatal resuscitation for Ida during the first 3 1/2 minutes of her life that further contributed to Ida's brain damage from which she died on 16 November 2019 at the Royal Preston Hospital neonatal intensive care unit.***

The inquest was one in which Article 2 was fully engaged as a result of the Trust's clinical governance arrangements, inadequate investigations, a lack of transparency and openness, a failure to respond to a detailed complaint letter, a

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| | failure to comply with the Duty of Candour, disputing the findings of the Secretary of State for Health's independent review panel (HSIB now MNSI), failing to notify external monitoring bodies and failing to comply with internal protocols.<br><br>The Trust's lack of compliance with clinical governance requirements in the investigation into Ida's death had significant similarities with the criticisms made in 2015 of the Trust as set out in The Report of the Morecambe Bay Investigation, otherwise known as the Kirkup Report. [redacted], who gave evidence at the inquest, expressed the view that there was a deep seated and endemic culture of defensiveness in respect of maternity incidents at the Trust. [redacted] also said that the investigation showed elements of failing to identify significant care issues, brevity, defensiveness and was conducted by unskilled investigators.<br><br>During the course of the Investigation NHS Resolutions, an arm's length body of the Department of Health and Social Care obtain independent reports to disagree with the independent body established by the Secretary of State for Health to investigate maternal and baby adverse and unexpected incidents.<br><br>The detailed review of the evidence heard at the inquest is set out in a 60-page summing up dealing with the clinical care and clinical governance issues. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>I have considered all the documents, evidence and information that the Trust has provided as to current systems and ways of working and yet I am still not satisfied that the Trust has addressed the significant concerns I have. |

The MATTERS OF CONCERN are as follows:

**A: Culture of Candour [Trust, ICB and DHSC]**

1. I am concerned that 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

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. [redacted]'s Investigation report was published in 2015, the Trust is ten years on and still issues and themes identified in 2015 were very much in issue in 2019 and still exist at the Trust as identified by Ida's inquest.

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.

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 .The matter was reported to the Coroner a year after Ida's death by the family after the Trust took no action to do so, despite being on notice of failures in treatment from the HSIB report Ida's harm was at no point categorised by the Trust as a harm event that caused "death".

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., Together

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.

**B: Clinical Governance and Maternity Governance [Trust, ICB and DHSC]**

6. I consider 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.

7. As a result of the Trust's deficient processes, the Trust did not undertake any examination of its own clinical governance processes, which were a principle area of concern and which was identified to the Trust five months before the inquest commenced. The Trust's clinical governance arrangements were extracted piecemeal during the course of the inquest. The deficiencies included lack of version control and audit of documents, untrained staff, chaotic clinical governance arrangements, defensive attitudes and inappropriate self-congratulation. The clinicians' reports to the inquest only answered the questions they were asked rather than trying to assist with a holistic view of the evidence, did not provide relevant information until it was extracted from the witness in testimony, that resulted in rolling disclosure of documents and additional witness evidence. This approach caused additional distress to the family who had to sit through an extended court hearing to address these issues

8. [redacted] is now Head of Compliance and Assurance at the Trust but that there has been no investigation into her role in respect of reneging on the Trust's acceptance of the HSIB report at senior management level and with the family as was indicated by her approval of the July 2021 position statement. Similarly, [redacted] is now Head of Midwifery at the Trust and there has been no investigation in respect of her disputing the HSIB findings and submission of challenge to the HSIB report in Ida's case.

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.

10. The Trust's clinical governance capability has been the subject of repeated and often severe criticism in the Flynn Review 2009, Fielding Report 2010, Central Manchester Hospital Report 2011, Price Waterhouse Cooper 2012 and Kirkup Report 2015. [redacted] in his evidence to the inquest said that the Trust focus on process, which means that you can comply with the process requirements and still produce an inadequate investigation, rather than focussing on outcome, which measures the quality of the investigation and the patient experience. [redacted] noted that the Trusts culture impeded transparent and open investigation. I am told that 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.

**C: Mandatory Training, expired training and remedial training [Trust and ICB]**

11. The Band 5 midwife supporting [redacted] in Labour had not undertaken her required mandatory training and this fact had not been provided and was only revealed at the inquest as part of the evidence of the Head of Midwifery in March 2025. I was also concerned to learn that in 2025 non-completion of mandatory training was still an issue as [redacted] had not completed her mandatory training.

12. It concerns me that 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.

13. There was no remedial training was 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 for [redacted], [redacted], [redacted] and [redacted].

**D: Grading of harm for incident reporting: Babies who have sustained hypoxic brain injury and undergo cooling [Trust, ICB, DHSC, NHSE, [redacted]]**

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 fetal bradycardia.

**15.** The 2024 NHSE Learn **from** patient safety events (LFPSE) guidance that replaced the National Reporting and Learning System (NRLS) confirms that the recording and analysis of patient safety events that occur in healthcare support the NHS to improve learning from patient safety events to help make care safer. 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 fetal bradycardia in labour and who require cooling and clarification guidance would assist prevent further

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| | maternity deaths and ensure full and proper investigation of hypoxic injuries sustained in labour.<br><br>**E: Funding for MSNI [DHSC and [redacted], NHSE and ICB]**<br><br>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.<br><br>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.<br><br>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. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the **16th May 2025**. I, the Coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1. [redacted] and [redacted] – Ida's parents<br>2. The Care Quality Commission<br>3. Midwives: a. [redacted] and b. [redacted]<br>4. [redacted] – Head of Compliance and Assurance<br><br>I have also sent it to:<br><br>5. [redacted]<br>6. MSNI – Maternity and Newborn Safety Investigations<br>7. NHS Resolution<br><br>who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | Signed:<br><br>**James Adeley**<br><br>**HM Senior Coroner**<br><br>**Lancashire & Blackburn with Darwen** |

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