Sheffield Teaching Hospitals
NHS Foundation Trust

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Ms Combes
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The Medico-Legal Centre
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Dear Ms Combes

Prevention of Future Deaths Report – Mojeri Adeleye

In response to your Prevention of Future Deaths (PFD) Report dated 16 May 2023 following the very sad death of Mojeri Adeleye, I wanted to express how saddened I was by Mojeri's death and how sorry I am for the distress and upset which this has no doubt caused his parents. I would like to assure you that we have learnt from this case and taken actions to ensure that as far as is possible, nothing similar happens again.

We have reviewed the actions identified in your report and our response is as follows:

The lack of regard towards Mojeri's mother's knowledge of her own pregnancy and the estimated due date for Mojeri.

We acknowledge that due regard was not given to the information provided by [redacted] in respect to her due date. As confirmed in evidence to the court following our serious incident investigation, we have revised our policies to ensure that where there is any conflicting information with regard to due dates we would check the findings of a validated dating scan and communicate with the mother to ensure that the information is correct.

We believe that in this case the staff involved displayed a degree of confirmation bias and in order to ensure that staff are more alert to the potential risk of this we have included human factors in our mandatory training. Since January 2023, human factors have been included in our mandatory multidisciplinary PROMPT training. PROMPT is a nationally recognised course for staff in Maternity aimed at supporting safe and effective care and communication. This training includes amongst other topics, awareness of confirmation bias and the importance of "fresh eyes" discussions. In addition, the Trust has launched a one-day Human Factors Masterclass, which runs 3-4 times a month, to develop further expertise and, to date, 46 members of the maternity team have attended and three members of Maternity staff are part of the faculty who will deliver this training in future.

To further support this approach, from 1st January 2023 the service introduced a consultant of the week; each week a consultant is allocated to provide an enhanced level of senior obstetric support to the Maternity Unit to oversee the care of women in antenatal and postnatal areas, allowing the on-call consultant to focus on intrapartum care. This ensures that there is additional senior support to provide a "fresh eyes" approach, particularly in complex cases and ensures that there is continuity of care.

In addition, the use of "fresh eyes" on an hourly basis for CTG monitoring, which is now well-embedded and supports a culture of improving communication and encourages staff to put their own judgement in doubt. To support this process hawse have invested in a matron for fetal surveillance, who, along with an obstetric lead, provides ongoing training and expert support to the multidisciplinary team.

The service has also started to implement the "teach or treat" approach; this is a cultural safety improvement supported by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists which promotes a collaborative understanding of clinical situations, whenever there is disagreement between professionals, turning it into a learning opportunity which in turn encourages respect for the opinion of others and improves psychological safety.

In order to further develop a culture of listening and involvement, working with women and partners is one of the five strands of our maternity improvement programme. This work includes:

- Working with the Maternity Voices Partnership (MVP) to co-produce services which supports a culture of listening and engagement. In addition, we now have MVP presence at a number of quality and safety meetings to ensure that the service user voice is heard in these fora and they are working with the unit to ensure open and honest complaint responses which effectively address the concerns raised.
- Undertaking training with Birthrights, a charity which promotes human rights during pregnancy and childbirth, with a focus on women as equal partners in care. Members of maternity staff have attended this training in June 2023, and we are now looking to fund a bespoke session for the Jessop Wing Maternity teams.

The lack of discussion with Mojeri's parents about the possible measures that could be taken in the event of premature labour before the 22 week mark.

As you identify there were missed opportunities to discuss possible measures both following rupture of membranes at 17 weeks and following [redacted]'s admission in spontaneous labour.

At present there is no consistent approach across the region with regard to the management of cases of extreme prematurity (before 22 weeks), including where care is delivered, what level of support is offered and whether there is involvement from fetal medicine. In order to address this, we are working with the Yorkshire and Humber Joint Maternity Clinical Forum and the Local Maternity and Neonatal System to formalise and standardise pathways of care which includes the level of counselling families receive and the measures that are taken.

In order to support discussions on the unit, in addition to the measures identified above to improve communication hawse have:

- Introduced twice-daily multidisciplinary ward rounds which include a neonatologist. These rounds include a discussion regarding any premature births. These are undertaken at the bedside to ensure inclusion of the mother and birth partner. These have been embedded since December 2022 as evidenced by positive audit data.
- Included specific training regarding the management of extreme prematurity in our Bereavement Study Day to support staff to advocate effectively for women in this situation and provide appropriate comfort care. At present this study day is only provided to midwives, however with the introduction of the new national core competency framework for maternity which will be rolled out over the next 3 years, we are planning a framework which will support delivery of this training to the multidisciplinary team.

Having outlined the actions we have already taken, and those which we plan to take in response to your report, I hope that I have been able to convey how seriously we have viewed this matter. We are committed to learning from this sad case and implementing these actions.

Finally, I hope that my response has addressed the concerns and actions you identified in your report. Please contact me if you have any queries or points of clarification.

Yours sincerely

[redacted]

[redacted]
Chief Executive