University Hospitals Bristol NHS
NHS Foundation Trust

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RW/yq

25 October 2013

M E Voisin
Her Majesty's Senior Coroner for the Area of Avon
The Coroner's Court
The Courthouse
Old Weston Road
Flax Bourton
BS48 1UL

Dear Mrs Voisin

Regulation 28 Report Ref 00231/20012 and Ref 03754/2012

Further to the recent inquests, into the deaths of Jared McDowall and Rose Coles, please find attached a composite action plan addressing the matters of concern addressed within the two Regulation 28 Reports issued to the Trust on the 1st October 2013. The Trust is confident that the actions described, many of which are already in hand, will address the concerns expressed and mitigate the risk identified of future deaths attributable to these factors. The action plan will be monitored through the Trust's governance procedures to ensure its full implementation.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

Robert Woolley
Chief Executive

University Hospitals Bristol NHS Foundation Trust

Action Plan for Maternity and Neonatal Services – Regulation 28 Reports JWM and RJC

Action Plan Owner: Sarah Windfeld, Head of Nursing and Midwifery
Oversight by: Women's Clinical Governance Committee

Objective	Inquest	Actions Required	Lead	Timescale
Improve formal communication between NICU and Cardiac Unit.	RJC	Develop Structured Cardiac Transfer Pack for use between two units.	[redacted]	30th November 2013
Facilitate care of premature infant on cardiac ward if appropriate for baby to be there	RJC	Provide feeding guideline for premature infants and appropriate staff training to paediatric cardiac ward	[redacted]	30th November 2013
		Confirm NICU/BCH link consultant through regular circulation of rota to cardiac ward.	[redacted]	28th October 2013
		Confirm that NICU nurse in charge available 24 hours per day for telephone advice if requested to all cardiac ward staff	[redacted]	28th October 2013
Improve identification of new-born infants at risk of hypoglycaemia	JWM	Implement the plotting of birth weight for every new-born infants on gender specific centile chart to identify those at risk of hypoglycaemia	[redacted]	31st December 2013
		Education of midwifery staff in plotting birth weight centiles	[redacted]	31st December 2013
		Review of implications of change to centile specific at risk pathway on workload for postnatal ward midwifery staff	[redacted]	30th November 2013
		Update clinical guidelines for at risk new born infants, secure sign off through appropriate governance channels and disseminate with training as required	[redacted]	31st January 2014
		Update newborn observation chart to request blood sugar on poorly feeding new-born infant	[redacted]	30th November 2013
		Include specific competencies for recognition of the unwell postnatal ward newborn infant in the current annual midwife training and education update.	[redacted]	31st December 2013

Objective	Inquest	Actions Required	Lead	Timescale
Improve Joint working between NICU and Postnatal wards	JWM	Improve the use of SBAR communication tool by midwifery staff to neonatologists and paediatricians , through dedicated training	[redacted]	31st December 2013
		Develop and deliver joint education of common NICU & midwifery newborn issues across relevant staff groups	[redacted]	31st January 2014

Prepared by:
[redacted] Head of Nursing and Midwifery for Women's Services
[redacted] Neonatology Consultant for Clinical Governance
21st October 2013

Version Control and Date:

Version 1	16th October 2013
Version 2 -DL Amends	21st October 2013
Version Final – Executive Sign Off	24th October