Caring for You United Lincolnshire Hospitals NHS
NHS Trust

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Mr S P G Fisher
HM Coroner for Central Lincolnshire
Lindum House, 10 Queen Street
Spilsby
Lincolnshire
PE23 5JE

7 May 2015

Dear Sir

Inquest touching upon the death of Thor Dalhaug

Thank you for providing me with the areas of concern requiring further investigation under Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I write to provide the formal response on behalf of the Trust.

However, knowing that this letter will also be read by the family, I would like to firstly reiterate my condolences to [redacted] for the very sad loss of their child. We would also like to offer the family a chance to meet with the senior representatives from the hospital to revisit and explain the changes that have been put in place since Thor's passing.

In relation to the areas of concern raised, the Trust would like to comment as follows:-

1. **The failure to supervise the operating surgeon on her first day at work for this complex twin delivery. It was stated in evidence that the policy of inducting new staff had changed but this had not been enshrined in any formal document. Such a copy should be produced and a copy submitted to myself**

The Trust's reopened investigation report identified this as a crucial factor. Whilst review of individual factors is important, the Trust thought it appropriate to examine the wider circumstances as to why the Registrar had been left in such a difficult position without appropriate supervision on her first day at the Trust.

Whilst it is important to note that relevant competency checks are undertaken prior to any doctor starting in the department, it is accepted that a new Registrar should

not have been placed in a position where they had to carry out an emergency twin caesarean section without appropriate support and supervision. As you heard in evidence it had been the full intention of the consultant to supervise the birth, but unfortunately she was called away to another emergency.

As indicated in the evidence heard at inquest, the Trust has now taken various steps to significantly reduce the chance of such a situation occurring again. In particular, all junior doctors will now:-

- Have a welcome session conducted by the Royal College of Obstetricians and Gynaecologists Tutor or appropriate, nominated representative.
- Have a comprehensive tour of the department. This will include all clinical areas in which they will be working, including wards, clinics, theatres and secretarial offices. They will also be shown how to use the department equipment, such as defibrillators, computers, and any other relevant equipment required for their role.
- Undergo OSATS assessments in Caesarean section and Instrumental Delivery prior to being able to perform these independently.
- Be shown how to access the guidelines and protocols of the department.
- Be given contact details of who to contact for any further queries.
- Follow up by an informal interview a few weeks into their post to address any outstanding issues or concerns
- Lastly, and importantly, they will undergo a week of supernumerary activity in different clinical areas to orientate themselves to the department and to ensure that they will not be left unsupervised before ensuring that they are both confident, and able, to perform the relevant actions required.

As such, a newly employed Registrar should not now be left unsupervised on their first day of employment. To confirm, these actions are already in place with a newly appointed Registrar having gone through this process in October 2014. We also enclose in appendix 1 the new Trust Junior Doctor Induction document for Obstetrics and Gynaecology, which has received executive Medical Director approval.

2. **The lack of any steps having been taken to discipline the clinicians involved or limit their practice given their decision to adopt a wholly inappropriate, unacceptable and unorthodox technique in delivering Thor, resulting in his death.**

Matters relating to disciplinary proceedings are confidential between the employee and employer. The Trust would, however, like to offer you assurance that appropriate management action has been taken including liaison with the relevant regulatory authorities. The Trust would also like to make it clear that whilst it acknowledges that the forceps delivery should not have been attempted, it did not feel it appropriate to single out or blame any individual for the tragic events that occurred that day during delivery. The Trust wished to analyse the wider context

and the working systems and processes we had put in place. It is by undertaking this wider analysis that more extensive changes can be made. It is hoped that this will ensure wider learning and reflection by the department as a whole which in turn will achieve more resilient improvements in patient safety.

For six months prior to March 2014, the Registrar was absent from work and clinical duties. As was stated in evidence, since her return, there have been regular meetings with the Registrar involved in Thor's delivery. The purpose of these meetings was to review competence and abilities, to provide support, to ensure adequate supervision, and for the Trust to assure itself of an appropriate and safe return to practice. She initially undertook limited non-acute consultant supervised clinical activity in the out-patient setting.

From May 2014, following satisfactory review and discussion with the wider consultant body, it was felt that the Registrar could increase her elective supervised clinical sessions in gynaecology only.

In November 2014, following satisfactory monthly reviews and discussions, it was agreed that an increase in clinical activity to 7 sessions a week, an extension to ward cover, and also assisting in day case surgery was appropriate. This was on the understanding that she should not undertake any acute interventions without the agreement and direct supervision of a Consultant.

It is not until more recently (March 2015) that the Registrar has returned to labour suite and this has been in a supernumerary capacity, with consultant supervision. The Registrar also keeps a log of her activity on the labour suite and has been involved in a detailed reflective practice process as part of the incident. She is fully aware as are the wider consultant body and midwifery staff that currently she must not undertake any independent obstetric activity.

3. **The failure to ensure a full contemporaneous record was kept by doctors involved in a term neonatal death. Such failure has seriously hampered my investigation into the circumstances surrounding Thor's death and has resulted in serious difficulties to Thor's family who clearly struggled and suffered as a result of not being able to understand why their son died shortly after his birth**

It is accepted that contemporaneous recording of all events is important in healthcare practice. By way of reassurance, the doctors who join the Department are informed about the importance of ensuring a full contemporaneous record of any clinical interaction at their Trust and departmental induction. The Head of Service and the Consultant Labour Ward Lead undertake case study learning sessions. Lessons about, but not limited to, documentation problems from this case are included in the lessons learnt section.

In addition to the above, the Clinical Director has also written to the doctors involved in this incident to remind them of their duties. To add to this, however, a reminder has also been sent to doctors within the Directorate reminding them their responsibilities with regards to clinical documentation. This letter has also been circulated, by the Medical director, to all medical staff within the Trust.

Whilst dissemination of learning is important, the Trust will also undertake spot audits of operative notes, once a year for the next 3 years. This will be done after annual change of middle grade doctors and facilitated by audit leads on both sites. Should there be any failures from the audit; appropriate action will be taken until the Trust is satisfied that there is a robust system of recording.

4. **The failure to identify in the immediate aftermath of Thor's death that the operating surgeons had neglected to make full note of circumstances in which he died and to obligate them to provide the same; in particular the SHO was advised to amend the Caesarean pro forma, to include the fact that forceps were used in the interest of candour. He was then dissuaded from doing so by senior management as a result of their concerns as to how this would be perceived if the matter was investigated. This raises very serious concerns as to the degree of candour in disclosing the circumstances of his death. What steps have been taken to obviate a repetition of this behaviour in the future?**

The Trust accepted during evidence that the failure to make a contemporaneous operating note fell below the standard to be expected of its staff. I would like to reiterate the apology given in respect of this failure. This should have been highlighted earlier, and rectified, during the Trust's investigation.

In relation to the steps taken, the importance of ensuring that the operating surgeon writes their own notes and does not delegate it to another surgeon is highlighted in the new induction programme delivered by the Head of Service and Consultant Labour Ward Lead. I refer to response 1 above and appendix 1. Finally, compliance will be audited in the first 3 months of the doctor's employment in the Trust by the Audit Lead.

In relation to the point raised regarding candour, the Trust would like to assure you that this is a matter that is taken very seriously at the Trust. We were dismayed to learn of the potential that a member of staff had been dissuaded from amending the caesarean section pro forma. A thorough investigation has been undertaken, but unfortunately the Trust has been unable to identify the individual who apparently advised the SHO to adopt this practice. It should be highlighted that the SHO completed a detailed statement fully disclosing that the use of forceps had been attempted. Given that the SHO's and Registrar's statement both disclosed the use of forceps, it is believed that the concern may have arisen that it was not appropriate to amend original records some months after the death. The Trust fully accepts, however, that any inference that a later timed addendum should not be added to provide greater clarity to the records was not appropriate. By way of reassurance, whilst reminding staff of the need to complete full contemporaneous notes we will also be auditing the accuracy of information within medical records, the Clinical Director and Head of Midwifery have written to all medical and midwifery staff to remind them of their duties regarding candour.

The duty of candour has been incorporated into our complaints policy. It is also incorporated into our DATIX incident management system for moderate and severe harms. The compliance with the documentation of duty of candour is reported upwardly to the Quality Governance Committee – one of four sub-committees that report to the Trust Board.

5. **The fact that the consultant ultimately responsible for Thor was also charged with undertaking the SUI report into his death. Further, that the consultant signed off the original SUI report without having read any of the statements referred to in that report**

   Please disclose the policy or means by which it has been made clear that this should not happen in future

This was not appropriate and should not have happened. Since 2014 the Trust has significantly reviewed and changed its processes relating to investigations (please see Appendix 2).

No clinician involved with a clinical incident is allowed to lead or be involved with the same investigation; this will be incorporated into Trust policy. The responsible persons to ensure this takes place are the Medical director and our Head of Governance. I believe our Head of Midwifery provided assurance at the Inquest that all clinical incidents are now appropriately managed and investigated. Furthermore, a weekly meeting takes place between the Medical director, the Chief Nurse, Head of Governance and Lead for Risk Management to review and oversee all serious incident investigation. This provides the level of rigour and scrutiny to ensure the investigation is undertaken to a high standard. Furthermore, all SI's are sent to the Clinical Commissioning Group and once these have been signed off they are reported to our Trust Board, (please see appendix 2).

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6. **The fact that the original SUI and the revised version completed after receipt of post mortem failed to disclose that there was no support for the use of forceps to disimpact the foetal head.**

At the time the original SUI was completed the post mortem was not available to the Trust. It did not know, therefore, what the cause of death was. There was, as a result, a concentration on events leading up to the delivery, including an analysis of the antenatal care and the timing of the decision to proceed to delivery.

On receipt of the post mortem and the Registrar's statement an addendum was made to reference the fact that forceps were used. This was a second missed opportunity to reopen and examine in more detail the use of forceps. It was not felt at this time that the forceps had any causative impact on the death, which was corroborated by your expert during the inquest. However, it is accepted that the original SUI report was significantly flawed. Despite the belief that the forceps did not play a role in the death, this should have been fully documented, analysed and

reasons given for the conclusions drawn. The fact that this did not take place is totally unacceptable and the Trust wishes to apologise unreservedly to the family that this did not occur.

As stated above, the Trust's governance and investigation procedures (please see appendix 2) have changed substantially since the time of the initial investigation. The Trust would like to offer its assurances that when a serious incident occurs, there is a robust process behind the investigation with a full timeline and thorough analysis of all actions undertaken.

7. **The fact that no steps have been taken to discipline those involved in the production of this wholly inadequate SUI.**

The Trust has recognised that there were serious failures in the original investigation, but these were compounded by a weak investigation process in place in the Department at the time of Thor's death, rather than an individual failure. It has, therefore, undertaken a wholesale review of the culture, systems and processes. Whilst it is accepted that there is still, and will always be improvements to process, it is hoped that the information above provides assurance that there is now an effective process in place to satisfy your requirements under the relevant legislation.

As discussed at response 2 above the Trust is advised that it would not be appropriate to discuss any disciplinary proceedings.

8. **The fact that none of the statements served by the Trust disclosed that there was no support for the use of forceps to disimpact the foetal head.**

The staff involved were asked to provide factual statements relating to their involvement in Thor's management. The relevant statements relating to the delivery included the fact that forceps were used. The analysis of whether or not the use of forceps was indicated was a matter for the SUI report, not the factual statements. This did not happen, which was wholly inappropriate. The Trust accepts that the initial investigation report should have analysed the use of forceps. The Trust apologises unreservedly for this, but hopes that the fresh SUI report, along with the information detailed above, provides reassurance that the systems are now in place to ensure full and thorough analysis of adverse clinical incidents.

9. **The fact that there was a failure to recognise the inadequacy of the operating surgeon's original statement and SUI and that these inadequacies were not addressed until I directed the Trust to obtain a full statement and undertake a comprehensive SUI**

As indicated above, the Trust apologises for the inadequate investigation that was initially undertaken and would like to reassure you that process changes were already underway at the time it was agreed that a fresh SUI was required. It is hoped that the information that has been detailed above, together with the supporting documentation, reassures you and the family that important and relevant changes have been put into place for the future.

Summary

I would like to conclude by repeating my apology for the substandard care that lead to Thor's death and for the subsequent poor governance that hampered your investigation and clearly caused significant additional distress for the family. This is a matter of great regret. Whilst I know that the actions taken cannot bring Thor back I hope you and the family will be reassured that the Trust has put important changes into place. I would like to apologise for the difficulty the family have faced during this process, but the Trust does and will continue to strive to provide the best care it can for the community it serves. I was very sad to hear of the circumstances of Thor's death and I am sorry that we let Thor and his parents down.

Yours sincerely

[redacted]

Jayne Lewington
Chief Executive
United Lincolnshire Hospitals NHS Trust

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