Lewisham and Greenwich NHS

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Chief Executive's Office

Dr P Barlow
Her Majesty's Assistant Coroner
Inner South District, Greater London
Southwark Coroner's Court
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17TH April 2015

Dear Dr Barlow

Re: Regulation 28 to Prevent Future Deaths report re Archie Hexall

I am writing in response to your Prevention of Future Deaths (PFD) Report dated 6th March 2015 received following the inquest into the death of baby Archie Hexall.

Your report informed me that at the inquest it was established that Archie, the eldest of twins had been born on 24th March 2013 at Queen Elizabeth Hospital Woolwich by forceps delivery in seemingly good condition. About 2 hours later he suffered a respiratory arrest. He was found to have had extensive brain haemorrhage and hypoxic ischaemic encephalopathy, although the underlying cause of these remains unknown. He was transferred to SCBU then to St Thomas' Hospital where he died on 29 March 2013 at the age of 5 days. Breakdowns in communication between healthcare professionals and with Archie's parents contributed to the delay in recognising Archie's deteriorating condition. The Trust undertook a Serious Incident investigation following the incident.

You further expressed concern that future deaths could occur should the following issues not be acted upon:

1 - Communication had been lost during handover between two midwives, contributed to by the fact that notes of observations of Archie's condition at the time had been written on a loose piece of paper then later transcribed into the clinical notes once they had become available. Not all the observations were transcribed

across and it appears that important information about possible further signs of respiratory distress had been lost. The loose piece of paper was not retained in the medical records and you were concerned that it ought to have been.

2 – The midwife who had noted some concerns about Archie's breathing had not expressed these concerns to his father; had Archie's father been aware of the concerns he would have raised the alarm earlier when he later noticed that Archie's breathing had become more irregular. It is important that clinicians share relevant information with parents to enable them to make important contributions to their child's care; such an opportunity was lost in this case.

I am now writing to set out what we have done within the Trust, and indeed were already in the process of doing in relation to communication issues, to act upon these concerns, and reduce the likelihood of avoidable harm to future patients.

I have been assisted in this response by [redacted] Head of Midwifery for our Maternity Service which is now run across two hospital sites (Queen Elizabeth Hospital Woolwich and University Hospital Lewisham) making up the current Lewisham and Greenwich NHS Trust.

1 – Documentation

This issue was raised by the PFD report in relation to loose paper being used to document observations contemporaneously and later transcribed into the clinical notes. In this case the observations taken from Archie were transcribed into the clinical notes by a different person to the member of staff who had performed the observations. All members of staff have been reminded that any loose documentation must be secured into the main clinical notes even if written on a small piece of paper.

2 – Wider Communication issues

Communication is recognised by the Maternity service as a vital component to the care we deliver. Communication both between teams of professionals and between professionals and families for whom we are caring can be challenging at times, especially during emergency and complex situations. It is however recognised as very important.

Just 5

This daily communication meeting is held daily (Monday to Friday) and is attended by all staff working in the maternity unit that day. Issues such as recent clinical incidents, complaints and user feedback are discussed.

After Action Reviews

An AAR is held following incidents, complaints or when a complex case has gone very well, to help learn lessons and share good practice. The maternity unit is working hard to embed the AAR technique in everyday working life to encourage learning to be initiated by front line staff.

Midwifery Mandatory Training

Communication issues are presented and discussed at the mandatory training days. In addition all staff attend training on communication in various forms. Conflict resolution training is also a Trust mandatory training element and there is strong focus on communication skills and strategies.

SBAR

Work is currently underway to embed the use of this communication tool (Situation, Background, Assessment, Recommendation) within the maternity service. This is a simple tool used by many NHS organisations to ensure that communication between healthcare professionals is clear and concise, and to support effective escalation of situations when necessary.

This technique is already underway in the Children's Division, the Maternity Service, and has been incorporated into a wider Trust initiative under the umbrella of the national Sign Up To Safety campaign and our pledge to reduce harm to the 'deteriorating patient'. Progress will be monitored at the Trust's Quality and Safety Committee where quarterly updates will be presented by the pledge leads. This committee is chaired by the Trust's Deputy Medical Director for Quality and Safety.

May I express on their behalf to Archie's parents the condolences of the staff involved, and hope that they too will be reassured that the Trust is trying hard to improve communication with parents within the Maternity Service, and thank them for their contribution to raising awareness of these important issues.

Within the maternity service there are several forms of training and updating for both obstetric and midwifery staff to ensure that communication skill remains high on our agenda. Within the medical workforce the consultants undergo a yearly appraisal. One domain assessed is communication with colleagues and other health professionals. In addition it is now mandatory that a 360 degree appraisal is completed every three years. The appraisal focuses on working relationships as well as communication.
Communication skills are addressed as part of junior medical staff training with 360 degree feedback being mandatory every two years.

Several communication workshops have been held over the past few years both multidisciplinary and involving women and their partners who have used our service. Feedback from service users is considered a very important part of learning. Some other initiatives which have been used to improve communication between staff and service users include:

Goldfish Bowl

This initiative has been held three times within our Trust with excellent feedback from those who attended. Members of the multidisciplinary team are invited to listen to the experience of women who have used the service. These may be positive or negative experiences. After this the audience discuss who women felt about the care they received and what improvements could be made.

'Whose Shoes?'

This was piloted by Lewisham and Greenwich NHS Trust as an initiative across London to improve women's experience of maternity services. Again the audience is multidisciplinary and each small group includes one or two service users. There is debate about how care is delivered, the impact of the language we use, and how we involve families in their care. Following the event pledges are made by those attending as to what they will change . This event was held in November 2014, and second session is planned for spring / summer 2015.

Joint Teaching Session

Biannual joint teaching sessions are held for midwives and medical staff on communication skills. These sessions are facilitated by a consultant obstetrician and a supervisor of midwives.

I hope that this information about the initiatives that have been started since Archie's death provide you with assurance that the Trust is actively using different techniques to help improve communication both within and between clinical teams and between clinicians and patients and their carers. We have also raised awareness about the importance of retaining all clinical documentation. The Trust is also actively participating in the national Sign Up to Safety campaign with a Trust wide initiative to reduce avoidable harm from failure to identify and act on the deteriorating patient.

Yours sincerely

Tim Higginson
Chief Executive