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Our ref: JH/SW/151123

23rd November 2015

**Private and Confidential**
Mr Tom Osborne
HM Coroner
Civic Offices
1 Saxon Gate East
Milton Keynes
MK9 3EJ

Dear Mr Osborne

**Re - REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

Thank you for your letter of 29th September 2015, raising concerns following the Inquest into the death of Ethan Johnson. The Trust is always willing and eager to develop and make changes to improve the care it provides to the local population and has considered the matters you raise and responds as follows:

1. *That the most junior member of staff (midwife) was left to look after* [redacted] *even though the CTG trace was deemed abnormal. The midwife felt unsupported.*

In this particular case the concerns were identified and appropriately escalated within a few minutes. All our junior midwives are fully qualified and are conversant with the escalation process and how to summon help in an emergency. All staff have been reminded of this process.

In response to your concern, however, the new Head of Midwifery has strengthened the preceptorship period for newly qualified midwives. This means that they are supernumerary for several weeks and will be supported by experienced senior practice development midwives, whilst being familiarised in departmental processes.

Furthermore, 2 hourly 'intentional rounding' of all patients undergoing 1:1 care (antenatal, labour, and postnatal) by a Band 7 Co-ordinator is now in place to ensure that appropriate care is being given through support of the patient's individual midwife.

In addition, a 'safety huddle' has been implemented. This is a meeting at the delivery suite whiteboard, consisting of the Labour Ward coordinator and medical teams, including the Consultant. This ensures that all staff are aware of each patient's clinical status and their

management plan. The department is also in the process of changing the existing patient whiteboard, to include time of doctor review in cases where the CTG trace is deemed suspicious.

*2. Two further members of staff reviewed the CTG trace and yet it appears that no one was in a position of leadership to require a doctor to attend and review the trace and* [redacted]

On the ward the CTG did not require immediate intervention, so when the doctor had not attended within a reasonable timescale it was escalated appropriately. We have written to every member of staff clarifying their responsibilities if they are asked to review a patient, as well as what to do if senior help has been unable to attend. This includes timescales for upward escalation.

'Fresh eyes/ears' stickers have been introduced to ensure hourly senior review of both intermittent and continuous fetal monitoring.

Central Electronic Fetal Monitoring has now been installed and an internationally renowned expert on fetal monitoring has delivered training in the Trust.

*3. When the consultant on call was requested to attend he indicated that he would do so later. No one on the unit had the leadership role to insist upon his attendance.*

The Consultant attended delivery suite within 14 minutes of being called. This is an appropriate time for the case for which he was called (i.e. not [redacted]).

A new, specifically dedicated Matron for Labour Ward has ensured that a revised handover communication tool (SBAR) is embedded in practice, so that a succinct common language is in place to enable the medical staff to make an appropriate assessment of when to attend. There is now a Manager of the Day on the Maternity Unit.

*4. No one on duty in the unit was able to assume the leadership role and be in a position to offer advice, support and to direct the course of events.*

[redacted] arrived on delivery suite at 13.10 hours, monitoring was commenced at 13.13 hours, and concerns became apparent with the acute fetal bradycardia (low heart rate) at 13.25 hours when [redacted] (Consultant) was already on delivery suite managing a separate maternal emergency. At this point he directed [redacted] (the Registrar) to deal with [redacted] in the first instance and the appropriate management plan was carried out by taking her immediately to theatre to expedite delivery of the baby.

Therefore [redacted] appropriately directed [redacted] to deal with one problem whilst he dealt with the other. [redacted] is an experienced obstetrician, and the difficulties encountered during the procedure (caesarean section) could not have been predicted.

*5. There appeared to be a lack of understanding by members of staff as to Labour Ward management because of the lack of effective leadership.*

We note [redacted] concerns about the apparent chaotic situation; however, the situation had changed from needing routine intervention, to the recognition that an extreme emergency had developed, requiring the baby to be delivered within 30 minutes.

Our staff practice emergency scenarios such as this on a regular basis where each member of the multidisciplinary team has a clearly designated role, but in this case the unexpected difficulties encountered at delivery of Ethan Johnson could not have been foreseen.

We fully acknowledge that we should have de-briefed [redacted] so that this situation could have been clarified.

*6. There still appears to be a hierarchical approach to escalation of care within the unit.*

There are existing clear instructions for all midwifery staff, from new Band 5 Midwife to Matron level and also for all levels of medical staff in respect of escalation to a Consultant.

Please see copy of written policy which has been recirculated to all staff.

Joint leadership training for Senior Midwives and Consultants will be undertaken in January 2016 which will further strengthen multidisciplinary team-working.

We are also currently reviewing of role of our Consultant Midwife in terms of supporting clinical leadership on Labour Ward.

We trust that this addresses your concerns. Should you wish the Trust to provide any further information in respect of this issue, please contact me.

Yours sincerely

Joe Harrison
Chief Executive

c.c. [redacted]