GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Your Ref/eich cyf:
Our Ref/ein cyf: 18/2636/INQ
Date/dyddiad: 5th March 2019
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Dept/adran: Patient Care & Safety Unit

Private & Confidential
Mr David Regan
Assistant Coroner
Pontypridd Coroners Court
Court House Street
Pontypridd
CF37 1JW

Dear Mr Regan

RE: Regulation 28 – Calary Fern Davis

Thank you for the correspondence in relation to the above Regulation 28 received on 11th February 2019, which details the areas of concern following the conclusion of the inquest held between 6th – 8th February 2019.

Please be assured that the Health Board has taken this matter extremely seriously. Lessons have been learnt, following investigation and further informed by the findings of the inquest.

The detail provided below align with the numerical order in which you presented your concerns and aims to capture actions taken to minimise the risk of any recurrence:

Actions implemented:
The action plan annexed to the root cause analysis remained incomplete. It is understood that this arises in part from the merger of the Maternity Services of the Royal Glamorgan and the Prince Charles Hospitals.
A corrective Action Plan for Improvement was developed following Calary Davis' death. This has been updated to reflect the concerns identified within the Regulation 28 Report. The individual action plan has a completion date of August 2019, however, work is ongoing for the overarching maternity services action plan. All plans will be monitored through the Impovement Board and the Quality Safety Board.

1. **It was accepted at the Inquest that the merger of the maternity units of the two hospitals, while potentially creating a future single centre of expertise, it does risk causing a period of institutional stress to maternity services which have exhibited some significant shortcomings.**

An overarching action plan was developed which identified the ongoing needs for the merger of the two sites. This plan is monitored weekly within the directorate and monthly from the Executive Director of Nursing, Midwifery and Patient Services.

Work has been ongoing for the last five years in preparation for the Paediatric, Neonatal and Obstetric change to services. This is monitored monthly through the Service Change Board as part of the South Wales Programme.

2. **There is a review of 43 such cases which was said to be considering them individually rather than analysing common themes and trends.**
The 43 cases have been reviewed, common themes and trends idenitified and these have been incorporated into the overarching action plan for maternity services. A review of all neonatal and stillbirths from January 2016 was undertaken to offer assurance that all cases had been through the governance process and enabled learning. The review has been undertaken with a multidisciplinary approach and monitored weekly through the Maternity Assurance Group. The review of these cases has been overseen by the Welsh Government Delivery Unit. The Delivery Unit has undertaken assurances of the methodology applied to ensure a system learning from the incidents.

3. **In Mrs Davis' case proceeding to Artifical Rupture of Membranes would have been possible but there was a culture in the unit not to perform this at night.**
All delays for planned activity are now monitored and datix reported. The Health Board is introducing a live acuity tool which allows for delays to be captured. The Senior Midwife is responsible for ensuring that all delays are escalated. This is then reviewed during the weekly incident reporting meeting. The Organisational Development Plan is centred around addressing custom and practice leading to ineffective cultures. The plan has already been implemented and work will continue with all disciplines through the year.

4. **There was a reluctance from mid ranking midwife staff to challenge decisions made by the labour ward coordinators.**
The Health Board has developed an Organisational Development Plan addressing human factors and to work with all staff grades to develop a positive culture of challenge and openess. The Health Board also implemented a new Escalation Policy with work specifically focussed on midwives being able to jump call to the Obstetric Consultant and Senior Midwife on call. The Clinical Supervisor for Midwives is undertaking escalation work within group settings.

5. **Decisions by those coordinators were made without full information as to the clinical needs of the patients awaiting transfer to the Labour Ward.**
A new electronic whiteboard is being implemented. This will have red flags to identify and review women in a timely manner. The whiteboard allows for accurate data capture of all inpatients and the date and time of admission. This is a proven quality improvement programme which ensures a multidisciplinary approach in patient safety. Consultants are calling the Labour Ward out of hours and discussing each case with both the Middle Grade and the Band 7 Midwife Co-ordinator to ensure plans are in place and support is given. This is occurring at 10pm every night in addition to the daily ward rounds undertaken by the Obstetric Team.

6. **There was a poor standard of safety briefing, provision of information on patient handover and multi-disciplinary team assessment.**
   A quality improvement programme to ensure handover and safety briefings are delivered to a high standard, has been incorporated into our maternity action plan. The action plan is monitored weekly through our Assurance meetings and audits are undertaken from the Senior Midwifery Team. All safety briefings are retained for audit purposes. These are working well and have a multidisciplinary focus, which is improving communication and team working.

7. **There were insufficient staffing levels, despite which, the escalation policy was not used.**
   Staffing has significantly improved since August 2018. We have a rolling advert for recrutiment of midwives and this is monitored closely. The merger of the two units assists with the difficulties of the shortfall. Currently the Health Board has a vacancy of 15 WTE Midwives with midwifery staffing now at 90% of the required midwifery levels for the service. Staffing is monitored weekly through our Assurance Board and a Senior Midwife on call rota is in place and was implemented in July 2018. Please refer also to point 5.

8. **There was a lack of Band 7 Midwife and Obstetric Team leadership.**
   The Organisational Development Action Plan and two planned leadership study days in June and July 2019 are being undertaken to improve clinical leadership and team working within the department. The Organisational Development Plan will focus on multidisciplinary team working and clinical leadership. Our mandatory training includes communication, documentation and escalation as part of the yearly updates.

I sincerely hope that this information and enclosed action plan will reassure you that the Health Board has learned important lessons from the investigation into the care provided to Calary Davis and that effective action has now been taken to prevent further deaths.

I would like to convey, once again, my deepest sympathy and sincere apologies to the family of Calary Davis for the failings identified.

Yours sincerely

Ann Hopkins, Interim Director of Nursing.
On behalf of:

Mrs Allison Williams
Chief Executive Officer