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NHS Foundation Trust

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Our ref: 17/18.Inq.11

Your ref: KLD/WRD/STRACHAN/3024

22 July 2019

HM Senior Coroner Mrs Karen Dilks
Newcastle upon Tyne Coroners
Civic Centre
Barras Bridge
Newcastle upon Tyne
NE1 8QH

Dear HM Senior Coroner Mrs Dilks

Inquest into the Death of Maia Hazel Ann Strachan

On 17 April 2019 you held an inquest into the death of Maia Hazel Ann Strachan in which you concluded a narrative conclusion advising that Maia Strachan died due to complications of shoulder dystocia to which missed opportunities to reduce the risks of and diagnose severe fetal macrosomia contributed.

You acknowledged that actions had been taken by the Trust in respect of the issues identified in this case; however you had a number of concerns that remained outstanding and which you wished to be drawn to the attention of the Trust, which are details below along with our response, as follows:

1. **There was evidence of sub-optimal documentation in the medical notes and you therefore require information from the Trust as to how this issue will be addressed by midwives and Doctors.**

   Current training around the required standard for documentation has been reviewed and is provided as part of the PROMPT annual training for all team members including midwives and obstetricians. The content of the training is informed by the findings of a recently completed documentation audit.

   This audit has until recently been completed annually however this has been superseded by a recent agreement within the Surgical Business Unit for an ongoing monthly audit of a specific number of notes in each speciality. There will be a

quarterly report generated and presented to the Board, the themes and learning will be shared with the wider MDT team and this will also influence the training around documentation.

2. **You raised concern about the midwifery care in the second stage of labour; and planned to share a redacted copy of the export report provided by Dr Sparey for circulation to inform future practice.**

   Thank you for sharing the redacted report which I can confirm has been shared with all Obstetrics & Gynaecology staff, including midwives to inform future practice.

3. **You considered the issue of reporting a stillbirth, stating that it was expected in future that all stillbirths would be referred to a Coroner and that whilst this is not currently mandated this is likely to change. You therefore outlined your expectation that any birth involving potential and avoidable intrapartum events should be reported to or at least discussed with a coroner. You anticipate that stillbirths will require an independent review initially by the medical examiner and subsequently by the coroner and will therefore provide an increase in investigations. You advise that you plan to contact the Trust directly to advise of the need for Coronial input into training in anticipation of additional stillbirth inquests.**

   The Trust has recently appointed medical examiners and discussions are in progress to identify whether there is a requirement to include them into the current pathways following bereavement in maternity services. Any further requirement to notify the Coroner of any stillbirth would also be incorporated into local pathways. We look forward to further discussions with you regarding Coronial input into training.

   In addition to this the Healthcare Safety Investigation Branch (HSIB) has been asked by NHS Improvement to undertake independent investigations into cases where the inclusion criterion for Each Baby Counts has been met. The Trust was included in the roll out of this reporting going live in March 2019.

   The criterion for reporting cases to HSIB includes but is not limited to:

   All babies born at or after 37+0 weeks gestation following labour with the following outcome:

   - **Intrapartum stillbirth**: when the baby was thought to be alive at the start of labour but was born with no signs of life. This includes when:
     - Labour was diagnosed by a healthcare professional. This includes the latent
     - phase of labour, i.e. less than 4cm dilatation
     - The mother called the unit to report any concerns of being in labour, for
     - example (but not limited to) abdominal pains, contractions or suspected
     - ruptured membranes
     - The baby was thought to be alive at induction of labour
     - The baby was thought to be alive following suspected or confirmed premature
     - rupture of membranes (PROM).

   - **Early neonatal death**: when the baby died within the first week of life (i.e. days 0–6) of any cause

I hope this response is sufficient to address the additional concerns you raised and provides you with assurances you require.

If I am able to assist you further, please do not hesitate to contact me.

Yours sincerely

Marion Dickson

Marion Dickson
Executive Director of Nursing and Midwifery/Chief Operating Officer (Surgery)
On behalf of Sir James Mackey, Chief Executive