NHS
Gloucestershire Hospitals
NHS Foundation Trust

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[redacted]

12th December 201

Ms K Skerrett
HM Senior Coroner for Gloucestershire
Gloucestershire Coroner's Court
Corinium Avenue
Barnwood
Glocuester GL4 3DJ

Dear Ms Skerrett

Elisa Fuller deceased

I am writing in response to your letter dated 18 October 2019 in which you raised concerns arising from the evidence heard during this inquest. It is your view that there is a risk that future deaths will occur unless action is taken about these concerns.

The matters of concern are:

1. Whether there is appropriate support and systems in place to encourage junior midwives and junior doctors to escalate any concerns they have to more senior colleagues

2. Whether there is sufficient understanding of the need to retain placentas post-delivery for a specified time period prior to disposal

The Trust's responses are as follows:

1. Whether there is appropriate support and systems in place to encourage junior midwives and junior doctors to escalate any concerns they have to more senior colleagues

   In addition to the training and practice which midwives and doctors undertake during their professional qualifying courses and degrees, the Trust provides the following events and tools for the support and ongoing education of clinical colleagues about the importance and clear expectations of the need for escalation of all concerns which have the potential to impact upon the safety of patients in our care:

I. Mandatory Update day - Midwives

The midwives mandatory update day for 2018 - 2019 included a focussed presentation from the Divisional Risk Manager on lessons learned from recent inquests and clinical incidents. The poster highlights five situations where practice has been improved through embedding learning from incidents. Two of these situations ('Syntocinon' and 'documenting') included reference to the importance of escalating concerns. Attendance level for midwives was 94.4% for the year.

- Enclosure 1 – Midwives Mandatory Update Day Programme 2018/2019
- Enclosure 2 – Poster presented by Risk Manager

II. SBAR referral tool - Midwives and Doctors

The escalation which is encouraged should be undertaken in the form of the 'SBAR' (Situation/Background/Assessment/Recommendation) referral tool. The tool suggested on Enclosure 2 for the 'Documenting...' case is the 'RSVP' referral tool. This has been replaced in the Trust by the 'SBAR' referral tool, explained in Enclosure 3. In this tool, the reasons for the referral i.e. the escalation and the plan for review of the patient (as a result of the escalation) are formalised in the 'S' and 'R' parts of the tool.

This is a structured referral tool widely used nationally, across maternity services.

- Enclosure 3 - SBAR (Situation/Background/Assessment/Recommendation) referral tool

III. Rotation Day programme - Midwives

This is a programme directed at midwives new to the Trust, recently qualified midwives, those returning to work after a break or midwives moving to work in a new clinical area. These colleagues are required to attend this programme twice during their 'preceptorship period'. Preceptorship is the period immediately following qualification, and extra support given in that period is intended to guide the newly qualified practitioner through a successful transition from student status, and to develop their practice through a structured program of support, lasting between 18 months and 2 years. This teaching day covers professional issues including escalation, documentation, time management and professional behaviour such as assertiveness and communication.

- Enclosure 4 - Rotation Day programme June and November 2018; June and December 2019

IV. Practical Obstetric Multi-Professional Training – PROMPT' - Midwives and Doctors

This is an emergency skills study day attended by both midwives and medical staff. The PROMPT day included a session looking at 'human factors' i.e. the relationship between human beings and the systems with which they interact and a 60 minute presentation on

'resilience' both of which can impact on a clinicians ability and attitude to escalation. Attendance for the year was midwives 96.4% and obstetric doctors 80.6%

All drills are delivered with a focus on team work and effective communication. The course is endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) with further information available from on the PROMPT website and RCOG.

- Enclosure 5 – PROMPT training programme for 2018-2019

V. Newborn Early Warning Observation charts – documented by Midwives, consulted by Doctors

The New Early Warning Observation Chart for Newborn Infants (NEWS chart) has been in use in clinical areas for a number of years and has escalation criteria clearly presented on the reverse of the chart. This has recently been updated as the Newborn Early Warning Trigger and Track chart (NEWTT chart) and includes details of observation frequencies and conditions that trigger an immediate clinical review.. The specific question as to whether the infant is exhibiting 'grunting' is made clearer on the first page; grunting is a sign of respiratory distress and was a feature of this case as it should have been effectively escalated.

The NEWTT chart will be launched in all relevant clinical areas on December 30th 2019.

- Enclosure 6 – Newborn early Warning Observation Chart
- Enclosure 7 – Newborn early Warning Trigger and Track chart

2. Whether there is sufficient understanding of the need to retain placentas post delivery

At the time of Elisa's birth, the placenta was not retained as it appeared that she was born in good condition. Current guidelines on retention for pathological examination (dated October 2019) indicate that on the basis of prematurity (32 to 36+6 weeks) it "may be desirable" to refer placenta for examination (Appendix A). Elisa was born at 36 weeks, marginally premature, but also with none of the conditions that that require 'essential' referral for placental examination (Appendix A).

The policy in place at the time of Elisa'a death required placentas to be retained only if certain criteria were met at the time of birth. Unfortunately Elisa's placenta was not retained as concerns did not become apparent until some hours after birth

However, in response to the evidence heard at the inquest from the pathologist that his determination of the cause of death was considerably limited by the absence of the placenta, the Trust has revised its policy on retention of placentas so that all placentas are retained for 24 hours after birth, and are sufficiently identified so that they can be reliably retrieved in the event that there are any subsequent adverse clinical events affecting the baby.

The Trust's proposed process for retention of placentas is as follows:

- At birth, the placenta is placed in a bag and labelled with the patient's details on a sticker. Patient details are also written on the bag with an indelible pen to safeguard against the loss of the patients identification sticker
- The bagged placenta is placed inside the usual human waste disposal container (usually to a maximum of 5 placenta) the lid is NOT sealed.
- When the 5th or last placenta is added to the waste disposal container, a sticky label is placed on the lid with the date and time of when the lid is due to be sealed shut ie 24 hours after the last placenta is placed in the container .
- The lid is closed securely 24 hours after the addition of the last placenta. The container is then disposed of.

There is no national guidance on how long we should retain a placenta, but a reasonable time might be 24 hours, after which before the waste disposal container can be removed in the usual way.

This new procedure is in place in the Trust, supported by teaching sessions on the delivery suite and birthing units. A brief guide to undertaking this procedure, and relevant signage to assist colleagues, has also been developed. The formal Trust policy has yet to be ratified but it is hoped this will be finalised in early 2020.

- Enclosure 8 – Tissue pathway for histopathological examination of the placenta (RCOG October 2019)

Finally, I can also add that as a result of the inquest into Elisa's death, the following additional review and learning has taken place, for the clinical staff involved, and for any interested colleagues:

a) There has been a 'debrief 'with the midwifery staff to further explore and understand barriers to escalation

b) A 'Black Box' event is planned for January 2020 led by the Trust Safety Department. This is a bespoke learning event (originating in the risk management processes of the aviation industry) and will focus on how to better understand and improve multi professional learning from incidents. The aim is to further explore barriers to escalation and what we could do to improve escalation in all care settings across the Trust.

c) A "What Matters to you?" event took place on 6th December 2019 to provide an opportunity for staff to further consider and address issues in the working environment that impact on professionals' performance e.g. understanding the roles and responsibilities of the whole team, the need for kind and respectful communication and support from core staff for less experienced staff working in specialist areas such as delivery suite.

I am confident that there has been considerable reflection, learning and changes in practice as a result of Elisa's death all of which will significantly contribute to the reduction in the likelihood of such an incident occurring in the future.
I hope this response adequately answers your questions but please do not hesitate to return to me if you require any further information

Yours sincerely

Deborah Lee

Deborah Lee
Chief Executive