Coroners – Prevention of Future Death Regulation 28

Lead:	[redacted] (Consultant in Fetal medicine)
Reference:	PFD – Regulation 28
Deadline Date:	29th December 2021

Coroners Concerns:	**Trust Response:**
Following an investigation into the care of Ms Rose who died on 25th November 2019 , an inquest was held on the 21st October 2021 at Redditch coroners Court , The conclusion was that Ms Rose's death was owing to *'medical complications following feticide'.* During the course of the investigation and inquest the evidence revealed matters giving rise to concern. In the opinion of the coroner there is a risk that future deaths will occur unless action is taken by Worcestershire Acute NHS Trust (WHAT). Therefore a regulation 28 was issued as detailed below. The MATTERS OF CONCERN are as follows:	
1) **Informed consent and maternal choice regarding mode of delivery –** I am concerned that enough emphasis is not being given to maternal wishes regarding mode of delivery. This issue appears to be a recurring theme in obstetric practice, and I am concerned that the culture in this area appears to still not fully accepting of the principles of informed consent set down in case law of the appeal courts *(Montgomery)* and in NICE guidance (Caesarean Section) and of facilitating the wishes of pregnant women and holding full and frank discussions about the risks and benefits and the pros and cons of	A) In relation to Informed consent the National ***I decide tool*** has been considered as a tool to address the concern raised by the Coroner. IDECIDE is a digital framework for use by healthcare professionals and women/individuals and their partners during childbirth that results in the woman making an informed decision about next steps during her labour. It will take users through the following process on a tablet or electronic device as a guide to discussion: I – Identify urgency D – Details of the current situation

the different options. I am concerned that situations might arise, like it appeared happened in Rhian's case, where maternal requests are being made for re-consideration of the mode of delivery owing to feelings of physical weakness, pain or developing ill health. Evidence heard at Rhian's inquest demonstrated that there was very little, if indeed any, recorded (in medical records) discussions held between midwives/obstetricians and Rhian regarding mode of delivery, maternal wishes and risk/benefits of differing management plans.	E – Exchange objective and subjective information (history, organisational context, woman's perspective, healthcare professionals' experience) C – Choices available (evidence based information will be on the tool – generic at first but in time individualised) I – I (the woman) confirm my understanding and seek any further clarification needed D – Decision is made (by woman) and recorded on the tool E – Evaluation takes place a few days/weeks later using a recorded experience measure The I DECIDE tool has already been built into the BadgerNet maternity information system, however NHSX have asked that CleverMed to hold off on making this available to sites in the live BadgerNet mode. NHSX want to ensure other vendors have the opportunity to create a version, and are working on taking the design CleverMed have created into a more generic specification. CleverMed have asked NHSX for a timescale of when they could start a pilot or involve BadgerNet sites however this has yet to be agreed. Worcestershire Acute NHS Trust have expressed an interest in being involved in the pilot. CleverMed has requested that WAHT contact NHSX to inform them of our interest in expediting its launch. See email from CleverMed for further information B) Following on from a Multi-disciplinary discussion, demonstrating maternal perception and understanding of balanced and informed consent from documented evidence is difficult. Therefore we have consulted the local Maternity Voices Partnership (MVP) to include maternal perception of informed consent within their user feedback surveys. The findings from these will help shape future practice and the RCOG eLearning module and Clinical

	Governance advice No 6 – from the RCOG will be used to as a basis for this training if required. C) Personalised care plans are being introduced at WHAT in January 2022, this will give women the ability to complete a birth plan within their BadgerNotes app, the plan must be discussed, reviewed and authorised by a Healthcare professional. D) Training at WAHT in maternity is multi professional and this takes place on a monthly basis. Included within this a section is dedicated to human factors, Informed consent and reference is made to the Montgomery ruling and balanced counselling and documentation. This case highlighted the importance of contemporaneous documentation regarding mode of delivery discussions and decisions. E) Following the Ockenden Review, one of the immediate essential actions is for review of management of maternal request for Caesarean Section for both elective cases and during labour. This is a challenge for all maternity units across the country and is a matter being considered carefully by the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM). The trust performance and progress with this action will be monitored via the Local Maternity & Neonatal System (LMNS) as part of the National Perinatal Quality Surveillance tool. In the first review by NHSEI the trust have received an amber rating for this as we do not currently have a robust audit process for "in labour" requests for Caesarean Section. Our initial action to improve this position would be to develop an achievable process and to appoint an 'Audit & Guideline Midwife'. This appointment is already in progress, aiming to recruit within Q4. We also need to confirm a robust pathway to support maternal request for elective CS which gave us our amber rating.

2) **Infection risk of retained foetus following feticide –** I am concerned that a significant infection risk (retention of a deceased foetus) is not being given due weight in clinical decisions when a mother is attending for delivery (following feticide). There does not appear to be any specific or detailed local, or indeed national, guidance, for obstetricians and midwives which addresses this issue or discusses important considerations such as whether infection can be controlled by antibiotics alone or whether swifter methods of foetal delivery, such as a caesarean section, should be considered, or indeed whether specific microbiology advice needs to be obtained as part of a multi-disciplinary team approach. Cases such as Rhian's may well be rare, however consideration could be given as to whether more detailed and specific guidance should be made available to assist clinicians when treating mothers in maternity units following feticide.	In relation to Infection risk, Chorioamnionistis is a rare, but significant complication of feticide. Feticide is not performed at WAHT; cases are carried out at our tertiary fetal medicine centre. Retention of a dead fetus also poses a significant risk of infection, therefore in combination Rhian was at high risk of infection and this does not appear to have been documented. There is no national guidance on delivery following feticide; as such there is no local guidance. Following this tragic incident we engaged with the regional Chief Midwife and learnt of a similar case which had occurred in a separate maternity unit. In light of this information, the obstetric lead at WHAT has been in contact with the regional Obstetric lead. If guidance is needed for management of delivery following feticide this would ideally come from a National body (eg RCOG) or from a tertiary unit where feticide is performed. We are happy to share our learning from this case and to contribute to national guidance on this matter. Local guidelines within WAHT highlight the importance of not attributing maternal temperature solely to the use of misoprostol and to swiftly enact the septic bundle where there is evidence of maternal infection. This change to local guideline has been made to reflect learning from this case. Induction of Labour guidance has recently been updated by NICE NG207 published 4th November 2021. In response to this WHAT are reviewing the fetal loss local guidance to reflect these changes and to highlight the additional risk of infection when feticide has been performed prior to delivery. The findings from the HSIB investigation have been shared with all staff in various ways including a local education session. See embedded document A follow up educational session is planned for the 29th April 2022, where the findings of the coroner's inquest and recommendations made will be shared wider.

Recommendation	Trust Lead for Recommendation	Actions to be taken by the Trust	By Whom	By When	How we will know if the action has been successful?(KPI's)	KPI monitored through (Trust Forum)
1. Informed consent and maternal choice regarding mode of delivery	[redacted] (Obstetric Lead Consultant) & [redacted] (Director of Midwifery)	Adopt 'I Decide Tool' to assist with decision making around mode of delivery (including documentation in Badgernet)	[redacted] (Obstetric Lead Consultant)	April 2022 (to be part of the pilot)	Use in practice	Maternity Quality Governance Meeting
		To include 'maternal perception of informed consent' within the MVP user feedback surveys.	[redacted] (Director of Midwifery)	June 2022 (as latest survey has just reported)	Inclusion in MVP user questionnaire	Maternity Quality Governance Meeting
		Introduction of Personalised Care Plan into BadgerNotes App	[redacted] (Badgernet Lead Midwife)	Jan 2022	Use in practice	Maternity Quality Governance Meeting
		Establish a robust process to manage 'in labour' requests for Caesarean Section.	[redacted] (LW Lead Consultant & Matron)	April 2022	Process to be in place and subsequently audited by Audit & Guidelines Midwife	Labour Ward Forum (then to Maternity Quality Governance Meeting)
		Appointment of Audit & Guidelines Midwife	[redacted] (Divisional Quality Governance Lead -Women	April 2022		Maternity Quality Governance Meeting

			& Children's)			
2. Infection risk of retained foetus following feticide	*There are no ongoing actions within the trust for this recommendation. Possible national or regional guidance would be adopted if available. We currently manage labour following feticide according to our 'Induction of Labour' guideline. Within the trust, amendments and improvements to induction guidelines have already been implemented and learning from this case has already been shared widely. We will fully engage with any regional or national guideline formation.*					