Homerton University Hospital NHS
NHS Foundation Trust

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Her Majesty's Coroner for Inner North London
HM Coroner's Court
Poplar
127 Poplar High Street
London
E14 0AE

9th February 2022

Dear Madam

Regulation 28: Prevention of Future Deaths Report Response
Deceased: Ziggy MITCHELL-STAGG (died 04.04.2021)

I am writing in response to your Prevention of Future Deaths Report issued to the Trust following the Conclusion of the inquest into the death of Ziggy Mitchell-Stagg.

You raised four concerns in your letter which I hope will be addressed below.

1. *There was not standardisation of the terminology used by the midwives and obstetricians to describe meconium found, and the information requested by the computer system to record this did not necessarily reflect the verbal descriptions. Sometimes grades I, II & III were used; sometimes significant and insignificant, thick or thin.*

   There was also inconsistency as to whether grade II was significant, and whether the term significant referred purely to the meconium noted, or to the meconium in the context of other features.

   The Trust accepts that during the course of the treatment of Ziggy's mother and the inquest, the terminology used to describe meconium was inconsistent. A few actions will be taking place to ensure more consistency in the maternity department:

   a) Our computer system upgrade was already in place before the inquest, and one of the upgrades included updating the meconium grading from Grade I, II & III to the new system of Significant and Insignificant. The Trust has approved this change. A text box will now flash up once significant/insignificant is selected that will allow the clinician to enter the reason why they made that selection and whether any onward action/escalation is needed. This change has been finalised and will be implemented by March 2022.

   b) As stated above, the Trust acknowledges that the grading of meconium is not up to date and is inconsistent. We therefore plan to hold a '*Meconium Awareness Month'* where the following will happen:-

      - policies that require upgrading (from Grade I, II & III to significant/insignificant) will be circulated, once updated and agreed;
      - the new upgrade mentioned in (a) above will be rolled out;
      - specific training will be delivered on identifying significant/insignificant meconium and ensuring staff are no longer using the old grading system for communication and note taking;

- daily safety huddles and handovers will ensure that staff are reminded of this change and will be encouraged to take time to review all the changes;
- the Practice Development Midwives (PDM's) will provide learning specifically from this case.

We are making plans for this awareness month will take place in March 2022.

2. *The obstetric registrar attending to Ziggy's mum did not make any notes in the medical records after 3.46am, even retrospectively.*

   The obstetric registrar has been spoken to by her relevant manager and it has been agreed that she will attend an external course on documentation. Our in-house legal team provide training to the midwifery team on a monthly basis on the importance of documentation and this training will now be delivered to the doctors on a quarterly basis as well. The legal team will be delivering their first session on the 25th February 2022 where all doctors that cared for Ziggy's mum will be in attendance and this case will be discussed.

3. *I was told that your trust does not have a local policy regarding the use of centralised CTG monitoring, and it seems such a policy merits consideration.*

   A Policy has been drafted and has been signed off and approved. This will be circulated via an email to all staff and will be part of the daily handovers.

4. *There is national guidance that there should be a fresh eyes review every hour for women in labour, but your trust policy indicates only every two hours. It seems that the trust policy merits reconsideration, either to amend it or to record why there is a departure from national guidance.*

   The trust realises that the hourly 'fresh eyes' review is embedded within national guidance and we want to strive to achieve this. The trust previously trialled this in 2019 however it was found that a true fresh eyes review was not achievable every hour.

   We agree that our Trust guidance needs revisiting and our first step in that process is to liaise with other neighbouring Trusts of similar acuity to learn from them and understand how they adhere to an hourly fresh eyes which not only assesses fetal well-being but provides a holistic view. We will then create our own action plan for implementation.

   We trust that this answers all of your concerns and we are grateful for these issues being highlighted to us so that we can improve patient safety.

Yours faithfully

[redacted]

Dr [redacted]
Medical Director