Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

[redacted]
Chief Executive
St. George's Healthcare NHS Trust
Blackshaw Road
London SW17 0QT

H.M. Assistant Coroner Dr Sean Cummings
For the Coroner Area of West London
West London Coroner's Court
Bagleys Lane
Fulham
SW6 2QA

18 August 2020

Dear Dr Cummings

I am writing in response to the Regulation 28 Report that you issued to St. George's University Hospitals NHS Foundation Trust on 22 June 2020 following the Inquest into the death of baby Bethan Naomi Harris which took place on 18 and 19 November 2019.

I note your concerns as set out at paragraph 5 of the report. For ease of reference, I will address the concerns in the order raised in the report.

1 **The Inquest was held one year after Bethan's death. During the course of the oral evidence it emerged that several important learning issues had not been addressed.**

I am very sorry that the important learning issues and improvement actions related to each of the issues were not conveyed effectively during the oral evidence given by the midwives at the Inquest. The staff involved were, and still are, profoundly affected by this incident. The Midwives involved had not participated in an Inquest hearing before and found it incredibly stressful. I believe this impeded their ability to verbalise how deeply they were affected by the case and to describe their reflection and learning at various points in time in the year following Bethan's death. I am aware that this individual reflection and learning continued after the hearing with the support from the Professional Midwifery Advocate (PAM) team through verbal discussion, written reflection and a Professional Practice Action Group programme for one of the midwives.

The senior midwifery team has also assured me that all of the highlighted issues in the serious incident investigation report have been completed, and are monitored by the maternity governance team. In response to the serious incident action point 1 '*to ensure patients are adequately counselled regarding management options in the post-dates period*'

the maternity governance team undertakes a quarterly maternity notes audit. This involves auditing the notes of women attending for 40 and 41 weeks antenatal appointment and the information given regarding induction of labour. The last quarterly audit reported 67% of women had induction of labour discussed and offered at 40 weeks and 83% at 41 weeks gestation. Although this percentage is below the expected performance target of 95% at 40 weeks, the maternity governance team is working towards ensuring induction of labour information is discussed and given from 36 weeks gestation in preparation for more in-depth discussions on induction of labour at 40 weeks. This audit will be repeated in October 2020 and will review the notes of attendees at appointments between July to September 2020.

Action point 2 of the serious incident report required *'greater clarity of options around risks, benefits and alternatives to induction of labour*'. The induction of labour information leaflet has been reviewed and updated and is now available on the maternity page of the Trust website. As a Trust we recognise for many of our women English is a second language and we are in the process of having this leaflet translated into different languages which will be available from 1 September 2020.

The maternity governance team will continue to monitor this compliance with the provision of information, discussion and offer of induction of labour. The team is also responsible for continuing the quarterly audits of the antenatal care pathway, the results of which will be shared with all staff at various forums which include governance meetings and the governance newsletter.

2 There were issues relating to handover of patients to midwives and at the time of Inquest there had been no further specific training in relation to handover. Indeed it was stated that the process in place at the time of Bethan's delivery still pertained without alteration. This represented a risk to patients.

Following on from the Inquest the maternity governance team undertook an audit of the use of the clinical handover tool Situation Background Assessment Recommendation (SBAR) within the maternity unit. The result demonstrated poor compliance with the SBAR tool. The staff reported they were unclear on when and how to use the SBAR tool. This resulted in a review and update of how the SBAR tool is taught and used. The revised SBAR tool provides clarity on how, when and where the SBAR should be used; practical use of the tool has also been incorporated into the unit mandatory multi-disciplinary training which includes clinical scenarios. The updated version of the SBAR tool is included in the maternity unit Admission Guidelines. The updated version of the SBAR tool was re-launched in May 2020 through various forums including staff meetings, face to face teachings, newsletter and email.

The maternity governance team is responsible for undertaking quarterly audits of the SBAR tool and sharing the results both locally within the maternity unit as well as at the Trust monthly divisional and directorate meetings.

3 At the time of Inquest a team debrief, which you consider to be a source of learning to reduce the risk of serious incident in future, was still outstanding.

Although there had not been a formal team debrief, there had been numerous meetings with individual members of staff and groups of two or three staff on a number of occasions, long before the inquest, to discuss and reflect on the care provided to Ms [redacted] on 16 November

2018. Following the coroner's Inquest, a team debrief was facilitated by the Professional Midwifery Advocate (PMA) team and lead midwife for governance with attendance and support from the legal team. The midwives in this case have attended leadership and PROMPT (Practical Obstetric Multi-Professional Training). The Trust recognises the value of this training and registered all staff groups to attend PROMPT.

Prior to the Covid-19 pandemic more than 90% of staff within the maternity unit had attended PROMPT training. The pandemic resulted in a pause on training. However, following the easing of restrictions, the maternity practice support team is now working towards achieving the target of 100% staff trained. Compliance with mandatory training is monitored by the maternity governance team.

The arranged Human Factors training has, unfortunately, been suspended due to the Covid-19 pandemic but once it restarts, it will equip all midwives to develop better situational awareness. Due to the requirements of social distancing we are currently working with the training provider to explore alternative methods for the delivery of the training.

The value of team debriefs following any serious incident has been acknowledged by the midwifery governance team. The team agrees wholeheartedly that staff should be offered a team debrief immediately following any serious or adverse incidents and have facilitated team debriefs since January 2020.

4 There was little evidence from the oral evidence given that any effective reflection, reflective discussions or learning had taken place subsequent to Bethan's birth and then death. You consider it important that organisations seek to ensure individual and collective reflection to seek to avoid repetition. You felt that the evidence for this, one year on, was lacking.

Learning from Bethan's death has been shared throughout the maternity unit via PROMPT, as outlined above. The case, appropriately anonymised, was presented at the maternity unit meeting on 15 November 2019 and at the Clinical Governance study day on 19 December 2019. Individual reflection and learning has also taken place with the support of the PMA team through verbal discussion and written reflection.

The issues identified have been communicated to staff via the governance newsletter and at staff forums. There is also on-going learning through mandatory training as Bethan's case is used as a reference during the Fetal Monitoring and Skills and Drills study day. It is a requirement at the Trust that each member of staff attends a yearly training update with the practice development team facilitating monthly training sessions. As of February 2020 more than 90% of the midwives and doctors have attended this training.

I am aware from the senior midwifery team who have reported back to me that there has been, as reflected in the paragraphs above, many individual discussions with the midwives involved about the events of Bethan's birth and subsequent sad death in November 2019, but there was no recognised structure to support a formal team debrief involving all staff in the year following Bethan's death. The team, and the organisation as a whole, unequivocally accept that individual and collective reflection after such incidents is key to avoiding repetition, and it is truly regrettable that this was not taken forward in a clear and structured manner in Bethan's case. We hope you will accept that this has now been addressed and will always feature in the way such incidents are managed in future.

I hope this response provides assurance that the Trust is fully committed to learning from incidents and it is a matter of true regret for all involved that this was not demonstrated effectively in Bethan's case.

Please do not hesitate to contact me if you would like further information or assurance on any residual concerns you may have.

Yours sincerely

[redacted]

[redacted]
Chief Operating Officer

On behalf of

[redacted]
Chief Executive

C.C Ms [redacted]