Mid and South Essex
NHS Foundation Trust

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Tel No

03 November 2020

Mrs Caroline Beasley-Murray
HM Senior Coroner
Essex Coroner's Court
Seax House, Victoria Road South
Chelmsford
Essex, CM1 1LX

By email only to:

Dear Mrs Beasley-Murray

Response to Regulation 28: Report to Prevent Future Deaths (2)

Following the Inquest touching upon the death of baby Frederick Joseph Terry and your subsequent imposition to regulation 28: Report to Prevent Future Deaths (dated 9th September 2020), I write to advise you of the actions that Mid and South Essex NHS Foundation Trust's maternity services have made.

I am grateful that you have identified the main areas of concern, namely that the independent expert opinion has drawn attention to the following areas of concern:

1. Lack of risk assessment leading to the options available to mothers as to delivery.
2. Forceps delivery was attempted without recognising an occipito-posterior position. More training in this respect is required and the use of scans developed.
3. The injuries imply an excessive degree of force in the application of the forceps and the traction
4. Concerns about the engagement and induction of locum staff and management of staff levels on the maternity ward
5. The need for a bleep in the neonatal unit
6. Accuracy of record keeping
7. Training and procedures in respect of how communications should occur between all clinical personnel in the delivery theatre
8. Training and procedures in respect of how communications with the family should be carried out. This should cover the duty of candour.

9. Availability and suitability of resuscitation equipment and procedures on the maternity ward. The Trust's Neonatal Resuscitation Policy may need to be revisited
10. The Trust's Action Plan must be rigorously carried out
11. It would have been helpful for there to have been, during the course of the inquest, an exploration, in the course of evidence, of the treatment and care provided to baby Freddie and his parents at the time of delivery. Currently there is no legislation to cover the holding of a coroner's inquest into a stillbirth. In March 2019, HM Government issued a *Consultation on coronial investigations of stillbirths* It would be helpful for this important topic to be progressed, whatever the ultimate jurisdictional decisions.

Your Regulation 28 Report recommended that Mid Essex maternity services needed to take action to prevent future deaths occurring. I have set out below Mid and South Essex NHS Foundation Trust's maternity services responses to the issues highlighted above.

The guidelines have been updated to reflect the Royal College of Obstetricians and Gynaecologists recent guideline on Assisted Vaginal Birth (April, 2020)[1], this includes a risk assessment to assist with decision making for an assisted vaginal birth, an improved documentation pro forma following an assisted vaginal birth and reference to ensuring that the baby's head is checked immediately at birth for signs of trauma when obstetric instruments have been applied.

The patient's records Antenatal Care Record have been updated to include patient information leaflets in relation to Caesarean Section and Assisted Vaginal Birth and the 'assisted Vaginal Birth Record' has replaced the 'Operative Vaginal Delivery' page in the 'Operative Delivery and Theatre Care Record'.

Training in the use of ultrasound to define the fetal position as part of the risk assessment has been implemented with specific training by ,on the use and application of obstetric instruments. Situational awareness and communication forms part of the midwives, doctors and nurses mandatory training programme.

Processes have been strengthened with a specific Obstetrics and Gynaecology locum checklist in place, with one additional paid hour to complete and a self-assessment tool for obstetric technical skills has been added to the locum recruitment vetting process. The Trust has also employed a further Obstetric Consultant on a 1 year basis (whilst MSE reconfiguration in place). The Senior Nurse in the Neonatal unit now carries a 24 hour bleep and is summoned as required using the 'Code Blue' emergency call.

To endorse effective communication in theatres the 'Below Ten Thousand Feet' initiative has been driven with an aim on focussing on immediate safety concerns, this is used in conjunction with the SBAR communication tool.

To ensure effectiveness of the measures audits will be undertaken, such as an ongoing audit of unsuccessful vaginal births and a monthly audit of the maternity acuity tool to demonstrate high activity, safety mitigation strategies and escalation.

Learning from the incident has been shared across the Trust through a patient Safety Alert and the action plan has been scheduled for discussion at formal meeting within the division, the Trust and the Maternity Network region, this will continue until the actions have been completed.

Please find the evidence to address the concerns raised within the action plan with evidence of the corresponding actions.

I hope that this response helps to assure you of Mid and South Essex NHS Foundation Trust's maternity services commitment to continuous improvement. As specified within the Prevention of Future Deaths Order, the response has been sent within the 56 day duty period.

Yours sincerely

Chief Executive

Reference:

1. , on behalf of the Royal College of Obstetricians Gynaecologists. Assisted Vaginal Birth.