

OCKENDEN REPORT - FINAL

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES

at The Shrewsbury and
Telford Hospital NHS Trust

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Return to an Address of the
Honourable the House of Commons
dated 30 March 2022 for

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES

at The Shrewsbury and
Telford Hospital NHS Trust

Our Final Report

HC 1219

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

30 March 2022

Dear Secretary of State

I publish the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, at a time when the NHS continues to face significant challenges arising from the Covid-19 pandemic. In the 2 years of this pandemic since early 2020 the NHS and its staff have had to be ever more innovative in the ways services are delivered to ensure the provision of high quality care to patients.

NHS staff, including maternity teams who have worked throughout this pandemic, are exhausted. We have seen so many frontline NHS staff go above and beyond the call of duty to support and care for their patients in these truly extraordinary times. Our NHS is rightly held in high regard by so many for the lives it saves and the care it provides.

However, this final report of the Independent Maternity Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.

This review owes its origins to Kate Stanton Davies, and her parents Rhiannon Davies and Richard Stanton; and to Pippa Griffiths, and her parents Kayleigh and Colin Griffiths. Kate's and Pippa's parents have shown an unrelenting commitment to ensuring their daughters' short lives make a difference to the safety of maternity care. It was through their efforts that your predecessor, the former Secretary of State for Health Jeremy Hunt requested this independent review. When it commenced this review was of 23 families' cases, but it grew to include reviews of nearly 1,500 families, whose experiences occurred predominantly between 2000 and 2019.

This final report follows on from our first report which was published in December 2020. In the first report we outlined the Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. This second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed. For this second report my independent maternity review team have identified a number of new themes which we believe must now be shared across all maternity services in England as a matter of urgency to bring about positive and essential change. Our Local Actions for Learning for the Trust and Immediate and Essential Actions, must be implemented by The Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all Trusts across England in a timely manner.

Since the publication of our first report, the Government has introduced a range of measures¹ and invested very significantly in supporting maternity services across the country. This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers², as cited in the recent Select Committee report³ has estimated the cost of full expansion of the maternity services workforce to be £200m - £350m. We endorse and support this view.

In the last year since our first report was published we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing

1 <https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england>

2 <https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf>

3 <https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm>

attrition of maternity staff and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies and meet the Government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring soon or after birth by 2025⁴.

In our first report we wanted to ensure that families' voices were central, as for far too long women and families who accessed maternity care at the Trust were denied the opportunity to voice their concerns about the quality of care they had received. Many hundreds of families who received maternity care at the Trust have told us of experiencing life-changing tragedies which have caused untold pain and distress. In order to ensure families' voices are heard, listened to and acted upon within maternity services the NHS will need to continue progress on the role of the independent senior advocate role within maternity services that was an Immediate and Essential Action in our first report.

Secretary of State, through our work to date we have recognised a critical need for timely and independent reviews of serious maternity incidents to ensure lessons are learned and changes implemented effectively. We note and endorse the creation of a Special Health Authority⁵ to oversee maternity investigations, taking over the work of HSIB. We fully support your view that the provision of 'independent, standardised and family focussed investigations of maternity cases that provide families with answers' is essential. We further urge that there must be a timeliness to this work since delay in introducing change and learning leads to the risk of repeated incidents, as we saw at The Shrewsbury and Telford Hospital NHS Trust. We would expect that learning and service change from maternity incidents be introduced into clinical practice within six months of the incident occurring and that all investigations are independently chaired.

Finally and importantly Secretary of State we state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Thank you Secretary of State for your ongoing support,

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Donna Ockenden', with a horizontal line underneath the name.

Donna Ockenden

Chair of the Independent Maternity Review

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 <https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560>

Acknowledgements

The work contained in this final report and the first report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, came about from the exceptional efforts of parents Rhiannon Davies, Richard Stanton, and Kayleigh and Colin Griffiths, who daughters died as a result of the care they received at the Trust.

The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016 were both avoidable. Owing to their unshakeable commitment to ensure the precious lives of their babies were not lost in vain, this review has implementation of meaningful change, not only in maternity services at The Shrewsbury and Telford Hospital NHS Trust – but also across England. As we publish this final report, we want to acknowledge and pay tribute to Rhiannon, Richard, Kayleigh and Colin.

Very importantly, and as Chair of this review, I want to extend my heartfelt thanks to all of the families who have come forward to share their experiences. So many families have explained to me that for more than two decades they have tried to raise concerns but were brushed aside, ignored and not listened to. My review team and I have listened to families and heard their concerns and distress. This final report has come about following the careful consideration by my review team of 1,592 clinical incidents involving mothers and babies resulting from the maternity care of 1,486 families. Their contribution to this review and report has, in my view, been central to a review of maternity services which I hope and believe will now save lives and reduce harm in maternity services across England.

Thanks to the bravery and determination of all the families in sharing their experiences we have produced this report, which my review team colleagues and I believe will continue to shape the learning which will profoundly change maternity care now and in the years to come. Never again should families be left to grieve or suffer in isolation, with the additional pain of feeling their legitimate concerns are being ignored. Our intention is that this report will underpin the future journey of maternity services in England, so that maternity services will be safer, will hear families better and will be more accountable.

Why this Report is Important

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent.

The families who have bravely contributed to this review know all too well the devastation which follows such events, and have explained to my review team and me that they want this review to answer their questions. Families have also clearly explained that they want what happened to them to matter and to ensure that in future voices, such as their own, are listened to and heard and that meaningful and sustained changes will be made to try to ensure that what happened to them will not happen to others in future.

The accounts of families involved in events at maternity services at The Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service but also on other maternity services across England, as can be seen by recent reports of concerns in a number of other trusts. That is why this report aims to not only address specific concerns about The Shrewsbury and Telford Hospital NHS Trust but to provide Immediate and Essential Actions for all maternity services across England. Sometimes that spotlight can feel harsh to staff on the front line doing their very best in what are often extremely challenging circumstances. As a multi-professional clinical review team, largely made up of midwives and doctors currently working on a daily basis in NHS maternity services across England, we understand that.

Even now, early in 2022 there remains concern that NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that if the 'whole system' underpinning maternity services commits to implementation of all the Immediate and Essential Actions within this report with the necessary funding provided then this review could be said to have led to far reaching improvements for all families and all NHS staff working within maternity services.

The size and scale of this review is unprecedented in NHS history. After reviewing the experiences of so many families and listening carefully to both those families and to the past and present staff who came forward, we have been given a once in a generation opportunity to improve the safety and quality of maternity service provision for families across England, now and in the future.

Donna Ockenden

Chair

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Explanation of Terminology

In this report the review team has used words or medical terms which some readers may not be familiar with. While we have tried to keep the use of such words and terminology to a minimum, at times it is unavoidable. This is so we can accurately address specific clinical issues we found within our review as well as make recommendations to improve maternity care now and in the future at the Trust and across the NHS in England.

To try to aid readers' understanding where we think language has become technical, where the terms are used for the first time, we direct readers to a glossary (found at the end of the report) which will give further explanation of their meaning.

Executive summary

This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (“the Trust”) commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. It has previously been reported that this review was considering 1,862 family cases. However after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the Trust’s internal investigations where they occurred. In addition, the review team has considered external reports into the Trust’s maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner’s reports.

Throughout this process our priority has been to ensure that the families impacted by the maternity services at the Trust are heard. They wanted to understand what had happened to them, as well as ensure that finally lessons are learned so that no further families experience the same harm and distress that they did. Families were offered a variety of methods to engage with the review team and share accounts of their care and treatment. Throughout this report we have included vignettes of the care received by families either through our review of their maternity care considering the documentation that was received from the Trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard as well. In 2021 the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard. In the final weeks leading up to publication of the report, a number of staff withdrew their cooperation from the report and therefore their content (or “voice”) was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as ‘a staff member told the review team...’

Within this report we have included a timeline of events which led up to the commissioning of this independent review (see chapter 1). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies which took place during the period under review. It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion due to concerns around other clinical areas within the Trust and also due to the significant turnover at Executive and Board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua's mother was considered to have a low risk pregnancy, and even after she reported episodes of severe uterine tenderness and tightening at 31 weeks this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but on her admission the baby's heart rate was not monitored appropriately. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this a ventouse delivery was attempted before an emergency caesarean was conducted. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at six hours of age.

The review team found evidence of poor investigation into all three of these cases which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the Trust.

Unfortunately these three cases were not isolated incidents and throughout this review we have found repeated errors in care, which led to injury to either mothers or their babies. During our work we have considered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

In total 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and in three-quarters of cases the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not, recognise system and service-wide failings to follow appropriate procedures and guidance. As a result significant omissions in care were not identified and in some incidents women themselves were also held responsible for the outcomes.

As part of the review 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in maternity care which if managed appropriately might, or would have, resulted in a different outcome. Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns, however these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care provided which might or would have resulted in a different outcome.

The review team found that throughout the review period staff were overly-confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For

example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the Trust women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report, where there were delays in women being admitted to the labour ward during induction of labour, being assessed for emergency intervention during labour or reviewed by consultants in the postnatal environment. On occasion this resulted in families being discharged from hospital but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care the review team has identified a failing to follow national clinical guidelines whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst the Trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes.

Unfortunately these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care and in some cases even including explanations which laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians, in part these delays in care could be attributed to staffing and training gaps at the Trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce, which negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward coordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and on occasions unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient to staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore it failed to foster a positive environment to support and encourage service improvement at all levels. In addition the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity

service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the Trust went unknown until this review was undertaken.

Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/2019 considered as part of this review.

This meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies including local Clinical Commissioning Groups and the Care Quality Commission during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the Trust sooner.

Local Actions for Learning and Immediate and Essential Actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that following our first report in December 2020 there does seem to have been a recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed.

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.

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Section 1

History, methodology and families

- Introduction
- Chapter 1. Concerns that led to this review - a timeline
- A case study highlighting failure to investigate, inform and listen
- Chapter 2. How we approached our review
- Chapter 3. Supporting the families during our review

Introduction

Our first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*, was published in December 2020¹. The report, which was outside the terms of reference for this review, was prepared at the request of the then Minister of State for Patient Safety, Suicide Prevention and Mental Health Nadine Dorries MP. It observed important emerging themes which required urgent action following review of the maternity care experienced by 250 families. The aim was to focus on immediate improvements for the Trust through **Local Actions for Learning** (LAF_L) and the wider maternity system across England with **Immediate and Essential Actions** (IEAs).

This second publication reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care we have found. Of importance, and in accordance with the Terms of Reference, this report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

From its start, in the summer of 2017, we have seen the number of families included in this Secretary of State Independent Maternity Review increase substantially from the original 23 families. It is now recognised that this review is likely to include the largest ever number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

We reported in July 2020 that 1,862 individual families were included in this review. After further analysis and validation of data with the Trust, the total number of families included in this review is now established to be 1,486 resulting in 1,592 clinical reviews of care. The majority of cases are from the years 2000 to 2019. However, a number of families came forward in the early period of the review whose care preceded these years and it was agreed by NHS England that, where possible, their care would also be reviewed.

All care and treatment provided to families, the quality of any Trust-led incident investigations, Trust-led reviews, external reviews and the resultant recommendations, actions and learning have been considered with reference to the relevant guidance and standards of the day, by clinicians who were in clinical practice at the time.

Every clinical review undertaken has been led by expert clinicians and each case has been carefully considered using a consistent standardised methodology. The multidisciplinary review team has been expanded during the process to reflect the growing number of families. The majority of reviewers currently work in clinical posts at trusts across England, with the number of team members who have been a part of the review since its start exceeding 90.

Over the course of the review, the team has faced many challenges and these are explained in more detail within the report. These have been mainly related to systems and processes required in order to undertake a review of this size, as it became evident that the required protocols, procedures and structures were not immediately available to support it. The COVID-19 pandemic at times impeded progress as our clinicians quite rightly prioritised their NHS commitments.

We have always emphasised that the voices of the families are central to this review. Throughout, we have ensured that families have been updated on the review's progress and we have worked closely with support agencies to ensure that listening, counselling and psychological help is and has been available for those in need.

The voices of staff at the Trust have also been important to assist with our understanding of events. We launched our Staff Voices engagement strategy to reach out to both former and current staff at the Trust. They were offered the opportunity to engage with us through an initial questionnaire survey and further conversations to share their experiences of working at the Trust. Despite reaching out through social media and the local press including radio, TV and a local newspaper and joint messaging with the Trust, fewer staff and ex-staff contacted us than we had anticipated or hoped for.

¹ Ockenden, D. *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust* (2020) <https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust>

At the time of publication only just over 100 current and former staff had contributed to the review with a further number of staff withdrawing from the review in the weeks before publication. This led to a number of last minute changes to the report as we were unable to use staff contributions without their consent. Those staff withdrawing were apologetic but most were concerned about being identified in the report. Despite our assurances, they maintained that they did not want to be quoted in the final report and we respected their decision.

Since our first report, we are encouraged to hear of progress at the Trust through its improvement programme in response to both our **Local Actions for Learning and Immediate and Essential Actions**. Indeed, we heard through staff of the willingness of their colleagues and themselves to learn from the review, in order to continue to improve and work towards building and maintaining a safer local maternity service.

The review team was particularly encouraged by the overwhelming positive response to our first report from maternity colleagues across England and the wider NHS. We were equally encouraged to see that our call for action to ensure investigations, reviews and reports that lead to meaningful change was heard.

We acknowledge that the proposed funding of £95million towards workforce and training provided by NHS England and Improvement is a major stride in the right direction. However, we are equally conscious that this is only the start of the journey and state that what is required in order to continually improve safety in maternity services is a multi-year funding increase for workforce expansion and training, in forthcoming years.

Our **Immediate and Essential Actions** from this report, based on our findings from the clinical reviews and listening to the voices of both families and staff, identify that the wider system must invest further in staffing across the whole maternity team to ensure that there are sufficient numbers, and that the workforce is equipped with the right skills and is able to deliver care in the right place at the right time.

Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services.

Whilst the review has been heartened by the Trust's progress over the last year, NHS England and Improvement must continue to provide appropriate support and ongoing oversight of its continued progress. Regulators such as the Care Quality Commission together with the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child Health must continue to strengthen their collective efforts of collaborative working to hasten the implementation of these further **Local Actions for Learning and Immediate and Essential Actions** outlined in this final report.

We are aware that since the inception of this review, there are now at least two other independent maternity service reviews in progress. This may be indicative of some wider systemic issues. At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning.

Over and over, families have expressed their two key wishes for this review. They want answers so that they can understand what happened during the care they received and why. We hope that this report will go some way in identifying and explaining the factors that contributed to the systemic failures which led to the harm they experienced. Secondly, they want the system to learn. We note that as a result of our findings in our first report, through our **Local Actions for Learning and Immediate and Essential Actions** the Trust and the wider NHS are beginning to learn and improve. We anticipate that through this report the learning will be sustained. No more families should have to live with the consequences of poor governance systems and structures within the NHS.

We must ensure that for all the families who contributed to this review there continues to be visible, measurable and sustainable change at the Trust and across the wider maternity system in England. That change through the implementation of our **Local Actions for Learning and Immediate and Essential Actions** will be the legacy of these families and the terrible loss and harm they have experienced.

Chapter 1

Concerns that led to this review

- 1.1 The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. The following is a chronology of reports and reviews into the Trust's maternity services over this time.
- 1.2 This timeline shows the failure of the Trust's maternity services to listen to families and to learn from critical incidents spanning the entire period of the review. In 2001, a woman gave birth to a baby in very poor condition who subsequently died at 21 minutes of age. The cause was due to failure to recognise abnormalities in the fetal heart monitoring. The family felt that there was no attempt to be honest with them in subsequent correspondence from the Trust and they claimed that as well as clinical mistakes, there was obfuscation, and a cover-up. The family subsequently took legal action against the Trust in order to get answers that they had been unable to get from the Trust before litigation commenced.
- 1.3 In 2002 a baby girl named Olivia died following a traumatic ventouse and forceps delivery. The subsequent independent medical report prepared for this family found severe failings in obstetric care. The mother described how at that time she felt like a *'lone voice in the wind'* trying to raise concerns about the Trust's maternity unit. Olivia's mother made multiple attempts to publicise what had happened to her daughter including appearing on national television on the 'This Morning' programme in 2006.
- 1.4 Olivia's mother told the review chair in late 2018: *'I hope that by speaking out other women who've suffered in childbirth will come forward ...to expose the cover-ups that clearly happen...at the time, because I ended up on This Morning as well, talking about this, and the amount of women that day that phoned in, who'd gone through similar things, and it gave me a kind of peace because I knew that they were getting help in the right direction...'*

2007 Healthcare Commission

- 1.5 In 2004, two babies were born in poor condition which resulted in cerebral palsy. These cases were reported in the local press at the time and the solicitor who represented both families wrote to the then regulator of NHS trusts, the Healthcare Commission (HCC), and the Shropshire and Staffordshire Strategic Health Authority calling for an inquiry. The review team has not seen any evidence that an inquiry took place.
- 1.6 Three years after the experience of these families in April 2007 the Healthcare Commission wrote to the then CEO of the Royal Shrewsbury Hospital² regarding its concerns about the maternity service. The HCC said they had received concerns in March 2006 with regards to poor care resulting in birth injuries. The allegations raised with the HCC were that staff failed to recognise and act upon abnormal cardiotocograph³ (CTG) tracings, that there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines and there was a lack of, and inappropriate, staff training.
- 1.7 The HCC visited the maternity service and said it was satisfied that CTG training for staff and audit had been introduced and that the Trust then used NICE guidance. The HCC considered that the concerns raised with it did not meet its criteria for an investigation and therefore did not undertake one, but suggested areas for improvement with a plan to monitor the implementation of the recommendations until it was satisfied that sufficient progress had been made. The HCC noted the Trust's low caesarean section rate of 14 per cent in 2005 compared to the UK national average of 23.2 per cent. The HCC did not examine unplanned

2 Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007
<https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf>

3 See glossary

admissions to the Neonatal Intensive Care Unit (NICU), rates of hypoxic ischaemic encephalopathy (HIE) or relevant other near misses. This was a significant lost opportunity for learning at an already troubled Trust.

1.8 In the letter from the HCC to the Trust dated April 2007, the following recommendations were made:

RECOMMENDATIONS	
CTG	The Trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/inappropriate staff training	Skills drills training programmes should be evaluated and revised where necessary.
Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)	The Trust needs to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice	Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical Governance	The Trust should share its revised Clinical Governance structure with the Commission.
Clinical Risk Adviser	The Trust should consider the need for permanent additional resource for the Clinical Risk Adviser for the Children and Maternity Service.

2008 Baby Joshua, and baby Kate Stanton-Davies in 2009

1.9 In March 2009 baby Kate Stanton-Davies died following her birth at Ludlow birth centre. Richard Stanton and Rhiannon Davies, Kate’s parents have up to the present day voiced their concerns about the circumstances surrounding Kate’s death and about the safety of maternity services at the Trust. The Ockenden review team notes that another baby was born the year before, in May 2008, also at Ludlow Birth Centre. Baby Joshua died a few days after birth after also being born in a very poor condition. A review of this case by the review team has noted that there were significant concerns in the care provided to Joshua’s mother and that there was not an appropriate investigation. The coroner did not hold an inquest, following receiving information provided by the Trust, but the family explained to the review chair that they were not involved in these discussions between the Trust and the coroner.

1.10 In summary, the births of baby Joshua and Kate Stanton-Davies have similar features. Both mothers presented with antenatal clinical concerns and reduced fetal movements, there were concerns during the labours, there were resuscitation concerns for both babies and both babies required air ambulance transfer. Both families were dissatisfied with the internal investigations and failure to obtain answers to their questions.

- 1.11** A paediatric death review (an internal investigation by the Trust) occurred in September 2008 following the death of baby Joshua in May 2008. The minutes of the meeting state that all midwives were up to date with neonatal resuscitation and *'advised all midwives to call 999 at the first sign of mother or baby being compromised'*. This was also stated in the action plan which said: *'an ambulance should be called as soon as there are indications that transfer of mother or baby may be required due to the time lag in the ambulance arriving.'* When Kate Stanton-Davies was born 10 months after baby Joshua in the same birth centre an ambulance was not called for 90 minutes, despite signs that Kate was seriously unwell from birth.
- 1.12** One overarching theme from this review is that over the years there has been a failure within maternity services at the Trust to investigate and learn from serious clinical incidents. It is apparent that baby Joshua's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of Kate Stanton-Davies was investigated⁴ by Debbie Graham Ms Graham could not locate any definitive guidance for the operating of Ludlow MLU for 2009⁵. This was despite the fact that after the earlier death of baby Joshua these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.
- 1.13** Joshua's parents were scathing of the Trust and their lack of transparency and openness and their failure to learn. In a meeting with the review chair in early 2022 Joshua's mother told of *'phoning and phoning the [Royal] Shrewsbury Hospital for over a year, waiting and waiting for answers, they were always on leave, always in surgery, always not available. No one spoke to me.'* Joshua's father described the Trust as *'ducking and diving, avoiding telling the truth, they've been dodging and weaving all these years.'* Joshua's parents eventually commenced litigation in order to get the answers they wanted from the Trust.
- 1.14** The Ockenden review team has also searched within the vast amount of information provided by the Trust for relevant guidelines. The SaTH guideline *Resuscitation of the Neonate at a Midwife-Led Unit or a Home Birth by a Midwife and When to Summon Assistance* was first implemented in June 2010. It took just over 2 years after the death of baby Joshua and 15 months after the death of Kate Stanton-Davies to ensure this critically important clinical guideline was introduced.
- 1.15** In 2015 a woman had a delayed transfer from the midwifery-led unit and fetal monitoring was not undertaken during the transfer period. The baby was delivered in very poor condition and subsequently died. The family were critical of the ensuing investigation, and of correspondence with the Trust, and said during a meeting with the Ockenden review team that they had been *"put off, fobbed off and had obstacles put in our way"*.

2013 Clinical Commissioning Groups' (CCGs) review

- 1.16** In 2013, there was a review into the maternity services at the Trust by the two Clinical Commissioning Groups⁶. This review was commissioned following concerns over an increased incidence of serious clinical adverse events and the safety of the clinical model of maternity care in Shropshire.
- 1.17** The CCGs' review of risk management focussed on reported serious incidents and near misses in the period April 1, 2012 to March 31, 2013⁷. The review team has found evidence of significant underreporting and cases that should have been investigated not being investigated, so it is our view that the CCGs' review would have underestimated the scale and volume of the incidents at the time. The CCG review also looked at policies, clinical governance systems, care pathways, and training, and concluded that *'there was an openness and transparency in reporting and investigation culture, which has led to a higher*

4 Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015) <https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf>

5 Ibid n3 p25

6 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review The Shrewsbury and Telford Hospital NHS Trust (2013) <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D>

7 Ibid n5 p5

reporting of serious incidents than would have been reported elsewhere. The review stated further *‘there is a robust approach to risk management, clinical governance, and learning from incidents’*. The higher reported rate of unexpected admissions to the NICU compared to other local units was attributed in part to *‘diligent reporting’*⁸ and a thematic analysis was recommended to understand the reasons for this higher NICU admission rate.

- 1.18** Of note in this CCGs’ report is a recommendation for neonatal services that *‘measures to implement standards for ‘Local Neonatal Units’ are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care’*. There is evidence within this second Ockenden report that this recommendation was not implemented, (see more in neonatal chapter 12). Furthermore a recommendation concerning serious incidents said that the Trust must *‘ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework’*. There is no evidence in the documentation provided to the review team by the Trust that this recommendation was actioned, (see more in clinical governance chapter 4). There is also no evidence that the CCG held the Trust to account for meeting these very important recommendations.
- 1.19** The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups⁹. It should be noted that this survey took place when the labour ward was at the much older Royal Shrewsbury Hospital prior to a move in 2014 to a new purpose-built maternity unit at the Princess Royal Hospital, Telford, so any negative comments on the condition of the estate could be reasonably disregarded.

- 1.20** Within the 2013 report there were some very positive comments from women:

All of the staff involved in my care both during my pregnancy and in labour were excellent. The midwife who dealt with my labour was first rate.

The care we had was excellent - the midwives acted swiftly to save my daughter’s life, as did the neonatal ward in Shrewsbury.

However, there were also some very concerning negative comments:

I had a terrible experience and ended up being treated for post-traumatic stress following this birth, ahead of my second child. I felt frightened and not listened to during the birth and was ‘cared’ for by a rude uncaring doctor.

The whole experience of labour and the birth was horrific. The midwife was horrible, the on-call consultant was bad tempered.

I felt the midwives were unprofessional and rude. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren’t a bit, they just kept telling me how busy they were. I don’t want to have another baby at Shrewsbury.

I had an awful experience giving birth, the midwife was horrible to me, I felt I got no support. Afterwards in the ward I got no help with breastfeeding.

I felt that my concerns during labour were not addressed, that I was made to have a natural birth when an emergency c section was more appropriate just so they didn’t dent their precious natural birth rate target. I felt like I was on a butcher’s slab.

- 1.21** Although, as commented by the authors of the CCG report, 90 per cent of the patient feedback was favourable the 10 per cent negative feedback contains some very concerning family stories indicating poor maternity care. The sample size of 47 women was also very small. The report thanks *‘the young mums*

8 Ibid n5 p7

9 Ibid n5 p19

who provided valuable feedback¹⁰ It is of note that the families' concerns, which do not appear to have been followed up by the CCG, are very similar to many of those heard by the Ockenden review team.

- 1.22** The overall assessment from this CCG review was that this was a safe and good quality service. The report states: *'it is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust...'* The Trust Board reviewed this report¹¹ and in the minutes it noted *'[some] concern about some families' experiences but this was in the context of generally good services.'*

NHS Litigation Authority

- 1.23** In March 2014 the Trust was assessed by the NHS Litigation Authority¹². This assessed the maternity service for organisation, clinical care, high risk conditions, communication, and postnatal and newborn care. The Trust was awarded the Level 3 standard, this was the highest standard available to be awarded. It should be noted that the Clinical Negligence Scheme for Trusts (CNST) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.
- 1.24** In 2014 there was a Deanery (medical training) review¹³ into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:
- 1.25** *'The Trust must integrate Clinical Governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from Clinical Incidents and that any learning points are clearly disseminated to trainees appropriately.'* There is no evidence that has been seen by the review team that this was actioned by the Trust.

2015 Care Quality Commission

- 1.26** In 2015 there was a Care Quality Commission Quality Report on SaTH¹⁴ which followed on from a visit to the Trust in 2014. The overall rating for maternity services was "good". It is noticeable that in this CQC report other Trust services such as medical care, surgery and urgent and emergency services were rated as 'requires improvement'. The CQC did comment that staffing levels should be improved on the labour ward and also commented that: *'the Trust must ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised, so that service development and learning can take place'*. However, this comment was a Trust-wide action and not specific to the maternity service.

2015 Debbie Graham independent review

- 1.27** In 2015 there was an independent review by Debbie Graham¹⁵ which reviewed the high profile case of Kate Stanton-Davies and made some criticisms of the Trust's response to the family.
- 1.28** The independent review by Graham found that although clinical governance processes were in place in 2009, at the time of Kate's birth there was a disconnect between policy, and the systemic mechanisms in place, which prevented effective clinical governance activity from being embedded into the culture of the organisation. This lack of a safety culture within maternity services at the Trust prevented Kate's death being raised as a Serious Incident (SI). Instead of an SI investigation the death was investigated as a High Risk Case Review (HRCR), and secondly as an unconnected midwifery supervisory investigation, therefore no learning started to occur from Kate's death until the findings of the coroner's inquest in 2015, 6 years after Kate died.

10 Ibid n5 p3

11 2014 Trust Board papers supplied to the review team

12 NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

13 NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

14 Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015) <https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404>

15 Ibid n3

- 1.29** In its conclusions the Graham report stated that *‘...the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services...In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future’*.

2016 Baby Pippa Griffiths

- 1.30** Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa’s feeding, breathing and other symptoms a number of times overnight after her birth and before she died, but had been reassured. It was established at the coroner’s inquest that Pippa would have survived had post-delivery literature been given to Pippa’s parents, and had a complete systematic enquiry into her neonatal health taken place.
- 1.31** Kate’s and Pippa’s parents (Rhiannon Davies, Richard Stanton, Kayleigh and Colin Griffiths) wrote a joint letter to the Trust Board in April 2017 expressing concern about maternity services at the Trust, discussing their own losses and other cases and saying that nothing had been learned and nothing had changed with regards to maternity services since Kate’s death in 2009. At interview with the chair of this review in December 2017 Colin Griffiths, Pippa’s father, described the behaviour of the Trust at the time of her death and afterwards as feeling *‘like it was a sweep under the carpet, that’s what it felt like’*.
- 1.32** Kayleigh, Pippa’s mother, described to the Chair of the review in November 2017 the significant effort the family made to try to get the Trust to investigate her death in April 2016. She said: *‘so...I left it until late May, and then it went into June and we’d heard nothing at all from them so I phoned...and said what’s happening, surely there’s an investigation taking place? And [X¹⁶] said to me “oh, it’s just an internal thing, we’re looking into it, but if you’ve got any questions just send them to me and I’ll ask them to look at them...”* Kayleigh continued: *‘I...said “it’s not right, you don’t just have a sudden, unexplained death and then say there’s no investigation and the family’s not going to be involved”. So I went online straight away and got some NHS England guidance up about involving families and sent it...emailed it...And said there’s got to be more to it, and I sent...some questions... And, from there, I contacted...I was just thinking something’s not right and I’d seen a lot about Richard and Rhiannon Davies and I made contact with them...I contacted the Chief Exec at SaTH and said, you know, this has got to be investigated...’*

2017 Ovington Review (internal)

- 1.33** In 2017 the Quality and Safety Committee of SaTH commissioned an internal review into the maternity services following on from concerns raised by bereaved parents and the increased perinatal mortality rate, which had resulted in public attention. This report, Review of Maternity Services 2007-2017¹⁷ was authored by Colin Ovington, then working within the Trust, and published in 2017.
- 1.34** The Ovington report made recommendations that the maternity service should ensure that governance arrangements are more transparent and open, and should improve the learning from incidents and investigations. It recommended engaging peers from other trusts to assist in the investigation and learning from incidents, and that the Trust should use a standardised process for investigating stillbirths and neonatal deaths. It is unclear whether these recommendations were ever acted upon since the review team has not been provided with or seen any connected action plan or any evidence of completion of the actions following that report.

¹⁶ X – identifier removed by review team

¹⁷ Ovington, C. Report Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017)
<https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf>

2017 Royal College of Obstetricians and Gynaecologists Invited Review

1.35 In 2017 there was a Royal College of Obstetricians and Gynaecologists Invited Review and subsequent report into the maternity services based on a visit to maternity services at the Trust carried out from 12-14 July 2017¹⁸. This report noted the following:

- There were workforce issues, with insufficient numbers of consultants providing obstetric cover. It also noted that middle grade rotas were not always filled by the deanery meaning that the maternity service relied on overseas trainees and locums.
- Risk management and governance systems were inadequate with a lack of resources.
- Incident reporting was inadequate with little evidence of widespread learning from incidents.
- The assessors viewed the allocation of the workforce across the sites as a patient safety issue.
- Current morale among the midwifery workforce was very low.
- The midwifery manager on-call rota required managers to deal with clinical areas they had no experience with.
- The perinatal mortality rates had remained above average compared with rates in similar trusts. The assessors did not see evidence of action plans and resulting changes in practice to act on this concern.

The RCOG report was not presented to the Trust Board until July 2018, and when presented it was prefaced by a report addendum dated 27 April 2018 which reported on interim progress on the recommendations from the original report.

2020 NHS Improvement response

1.36 Concerns were raised by families as to the time taken for this report to be presented to the Trust Board. On 29 November 2019 a letter of complaint was sent to the National Medical Director by two families. The letter alleged that the RCOG report was withheld from the Trust Board for 12 months. Furthermore, it alleged that Trust management sought to 'water down' the RCOG report by requesting a further document (the addendum) to be produced by the RCOG acknowledging improvements that had apparently been made. This addendum document was then added to the original report before being presented to the Trust Board in July 2018.

1.37 In response to this letter, NHS Improvement's Investigation Team conducted a review into these allegations and published the document *Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust* in July 2020¹⁹.

1.38 This NHSI review noted that twelve months elapsed between the RCOG's site visit and the report being presented to the Trust's Board. It noted that when the draft report was received three months after RCOG's site visit, a number of Trust staff were unhappy with the findings feeling it was not an accurate representation of the service. The CEO, in part guided by maternity staff feedback, initially did not accept the RCOG draft report.

1.39 Following further discussions with RCOG, the Trust did then accept the report in early January 2018 but remained concerned about its tone and content, particularly in relation to the executive summary. The Trust made representations to RCOG to address this, and also proposed a follow-up exercise to evidence improvements the Trust felt it had made. The RCOG declined to make any further changes to the report,

¹⁸ Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

¹⁹ NHS Improvement. Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust (2020)
<https://www.england.nhs.uk/midlands/publications/review-of-the-handling-of-a-report-produced-by-the-royal-college-of-obstetricians-and-gynaecologists-on-maternity-services-at-shrewsbury-and-telford-nhs-trust/>

but did agree to this follow-up exercise, to be conducted as a ‘progress review meeting’ at the RCOG’s premises in London. The RCOG did not visit the Trust to assess the ‘improvements’ for themselves.

- 1.40 When the report was finally presented to the Trust Board the covering paper was overwhelmingly positive in tone, with its twelve-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was still significant further work to do.
- 1.41 The NHS Improvement report further found that governance arrangements at the maternity service and care group level were not operating effectively in relation to the report and associated action plan. Although a lot of work was initially done to implement actions and keep the action plan updated, there had been very limited ongoing scrutiny of the plan by local or corporate governance forums. This was concerning given the severity of some of the issues identified in the 2017 RCOG report.
- 1.42 The NHS Improvement report noted that the Trust was not obligated to commission the RCOG Invited Review but chose to do so and committed from the start to publish the results, knowing that this would open it up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary focus of maternity services and the Trust seemed to shift towards the perceived public reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the necessary improvement of patient services.
- 1.43 Following the publication of the RCOG report there was significant criticism in the media and from families that the body had not alerted the regulator (the CQC) with regard to its findings. Instead the RCOG had only released the report to the Trust. At the time²⁰ the RCOG sent reports arising from Invited Reviews to the service/Trust that had been reviewed, without always notifying regulators²¹. The 2015 policy was clear that the RCOG would ‘*encourage dialogue...with regulatory agencies and authorities*’ and ‘*encourages the sharing of the report with the CQC...*’ (RCOG 2015, p3). The RCOG policy was subsequently strengthened in 2020 with the policy stating that ‘*the RCOG will send a copy of the final report to the organisation’s healthcare regulatory bodies*’.²²

2018 Care Quality Commission

- 1.44 In 2018 there was a CQC report²³ which rated the maternity service inadequate under the safety domain. Of note there were concerns about cardiotocograph training and mandatory training. The report also commented: ‘*We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning*’.
- 1.45 The review team has been contacted by and interviewed a number of staff who have worked at the Trust over the period of this review. A number of Trust staff at Board level have also been contacted by the review team and interviewed, these have included some current and former Chief Executive Officers, Chairs of the Trust, Chief Nurses and Medical Directors.
- 1.46 A number of themes have come from these interviews and broadly this feedback forms a consistent picture of the culture in the Trust during the period of this review, with the documentary evidence also considered by the review team.

20 Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015)
<https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf>

21 Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020)
<https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/>

22 Royal College of Obstetricians and Gynaecologists. Invited Review Service: <https://www.rcog.org.uk/en/about-us/invited-review-policy/>

23 Care Quality Commission 2018 report Shrewsbury and Telford NHS Trusts
<https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust>

- 1.47** It was clear from a number of staff interviews that this was a Trust which had a number of problems. A Board member told the review team that: *‘there seemed to be a number of political issues making reform of services difficult’* and there were comments that the populations of Shrewsbury and Telford differed and that *‘everybody in Telford wanted all the services in Telford and everybody in Shrewsbury wanted all the services in Shrewsbury’*.
- 1.48** One staff member said to the review team *‘people just didn’t do anything... and there just wasn’t a culture of accountability for completion..’* and another commented: that *‘this wasn’t just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure’*. The review team has noted that for many years there have been concerns with regard to safety and performance across the whole of the Trust, including the emergency department.
- 1.49** One interviewee described the maternity service as the *‘Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn’t like having oversight by the corporate team’*. The same interviewee commented that *‘there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team’*.
- 1.50** Over a prolonged period, the Trust Board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member *‘women’s and children’s was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good’*. The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without Trust oversight.
- 1.51** The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust²⁴ showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) from 2000 to early 2020, of which 8 were in post between 2010 and the current day. This lack of continuity at Board and CEO level resulted in a loss of organisational memory and contributed to this “self-management” and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that despite significant evidence to the contrary, the maternity unit up until about 2017 was actually not considered to be a trust risk.
- 1.52** One staff member interviewed stated that following serious incident reports there would have been recommendations made and that often these reports and recommendations were good but what was missing was the follow-up of the actions from the recommendations. It was said that *‘there just wasn’t a culture of accountability for completion’*.

Concerns from local external bodies

- 1.53** In late 2021 the review team also spoke to some senior staff of the Clinical Commissioning Groups (CCG) in post between the years 2013 to 2020. We were told that the CCGs did have concerns about maternity services at the time and were aware of the local press reports and family concerns. The CCGs had concerns about the length of time that SIs took to be reported and we were told by a contributor that *‘reviews of serious incidents seemed to take a long, long, time to happen and there was an impression of evasiveness around how the learning from those reviews was shared’*. The same contributor told the review team that the CCG did have meetings with the maternity service representatives from the Trust but were assured that *‘things were improving’*, and were told that the CCGs were in any event *‘limited in their power to change things for the better’*. It should be recognised that the CCGs were also concerned about SI investigations and learning from other services across the whole Trust and not just maternity.

²⁴ Who’s Who at the Trust – internal document received by the review team on 9 September 2020

Missed opportunities

- 1.54** In summary this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk. The consistent message coming from both senior maternity staff and from Trust Board members was that external reports into the maternity service were generally favourable and that there were more pressing problems in other services at the Trust. The management of the maternity service was perceived to be competent and able and governance concerns seem to have been managed within the service and not escalated.
- 1.55** The review team believes that the Trust Board and the CCGs were ‘reassured’ rather than ‘assured’ with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns.

Case Study

Thematic review of three cases at the Trust sharing similar themes within a nine month period (2008-2009)

- 1a.1** Here we examine the case of Kate Stanton Davies and deaths of two other babies which occurred within a short time period at the Trust. Throughout this report we highlight repeated incidents where maternity services at the Trust failed to investigate, learn and make impactful changes to improve patient safety.
- 1a.2** Within nine months, between May 2008 and March 2009, there were three neonatal deaths of babies that should have led to a systematic review of governance processes, strong actions and learning as well as a coronial inquiry into safety at the Trust. In all three cases there are significant failings in the care and treatment provided, omissions in the subsequent investigation into care, and failure to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit.
- 1a.3** Most concerning is a lack of transparency and honesty in communication with the families concerned despite internal recognition at the Trust that the investigations were not robust.

Baby Joshua 2008:

- 1a.4** The maternity review team has found evidence of a case that occurred nine months earlier than that of Kate Stanton Davies. In May 2008 a baby boy called Joshua was born at Ludlow midwifery led unit (MLU) in poor condition. Joshua was transferred by air ambulance to the Royal Shrewsbury Hospital (RSH) Neonatal Unit and died there on day 6 after his care was withdrawn.
- 1a.5** Joshua's mother was considered low risk with a previous pregnancy and birth and it seems an assumption was made that she would deliver in the freestanding MLU at Ludlow. There was no analysis of risk to ensure normality and whether or not it was appropriate or not to deliver in Ludlow. However, from 31 weeks of pregnancy the maternal risk changed. Joshua's mother reported three episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to RSH and this review team believes that concealed abruption should have been considered by clinicians at the time.
- 1a.6** Joshua's mother reported decreased fetal movements the day prior to labour at 37+5 weeks gestation. No admission CTG was performed; she progressed quickly in labour, and an amniotomy²⁵ performed at 9cm revealed significant meconium. Seventeen minutes later her baby was delivered with no sign of life. No ambulance had been called in preparation for delivery and no attempt was made to perform a CTG once the meconium was identified.
- 1a.7** Two midwives at the unit attempted to resuscitate the baby but did not follow UK resuscitation guidance. A paediatrician doing a peripheral clinic took over the resuscitation. An ambulance road crew arrived to help. Joshua was transferred unsecured on a stretcher and ventilated by valve and mask in the air ambulance to RSH where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to Joshua's brain.
- 1a.8** The review team observes that timely intermittent auscultation was not performed in labour, and what monitoring did occur was not described in an accepted manner. The review team is concerned by alterations added to the notes in a different pen that appear to change the fetal heart rate recordings documented during labour.
- 1a.9** Placental histology confirmed a significant abruption with an attached and organised blood clot. The pathologist concluded that the abruption was silent and established. Despite this, the explanation given

²⁵ See glossary

to the parents at the bereavement consultation was that the abruption must have been acute in the final 15 minutes of labour, perhaps secondary to a tight umbilical cord causing an unpredicted, acute placental detachment. This is despite no evidence of fresh blood loss at birth or post-partum haemorrhage. The bereavement letter stated: *'nothing could have been done or predicted'* and lacked any apology or reassurance that lessons would be learned.

- 1a.10** The review team do not accept this opinion of the likely pathology. In addition, we observe from the maternity records supplied by the Trust that the meconium revealed prior to birth was thick and established, indicating that the release was likely to have been some time before, perhaps in the days leading to labour when decreased fetal movements were reported. The review team consider that concealed abruption most likely occurred in the third trimester, contrary to the opinion offered to the parents at the bereavement appointment.
- 1a.11** There are a number of documents provided to the review team by the Trust which show discrepancies between the factual events and what was actually discussed with the parents. There are also extracts that contain additional information which was not disclosed to the family. This information is found in incident reports filed by members of staff and communications between professionals, provided to the review team by the Trust.
- 1a.12** The review team conclude that the risk management review of this incident by the Trust failed to follow appropriate local investigation processes to identify the root cause. The Trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the Trust who decided to manage this incident internally.
- 1a.13** The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow. As well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.
- 1a.14** Documents shared with the review team by the Trust show that the lack of a portable resuscitator in Ludlow MLU had been on the maternity risk register since 2005. The Trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.
- 1a.15** A few weak action points from this case were circulated via a memorandum suggesting that change in practice was not mandatory and it was optional whether to use CTG monitoring if a woman presented with reduced fetal movements at the MLU. It also suggested it was optional to summon an ambulance when amniotomy was performed with evidence of meconium.
- 1a.16** A clinician who cared for the baby initially, stated in a letter to the Clinical Director in July 2008 that they had serious concerns regarding the quality of the case review. They pointed out a number of inaccuracies in the findings of the review and wrote: *'I really do wonder whether they have actually read these notes and wonder [about] the quality of the case review'*, and *'I am concerned that there is evidence the parents have not received an accurate explanation of the events leading up to the birth, during the birth and the resuscitation'*.

Baby Thomas 2009

- 1a.17** In January 2009, after the birth and death of Joshua but before Kate Stanton-Davies was born, a multiparous mother delivered in the consultant unit. Uterine rupture was diagnosed at caesarean section after a failed ventouse and prolonged labour with injudicious oxytocin use. The baby, named Thomas died at 34 minutes of age and was classified as an early neonatal death. The coroner agreed to the stated cause of death as: 1. Multiple organ failure; 2. Severe HIE; 3. Ruptured uterus and placental abruption. No post mortem was performed.
- 1a.18** The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic²⁶ baby. No gestational diabetes testing was performed in this second pregnancy. Numerous attendances in a long latent phase of labour were apparent and all clinical midwifery reviews highlighted a large for dates baby with poor engagement of the fetal head.
- 1a.19** The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. 19 hours later she was taken to the labour ward for amniotomy at 5cm. During the 11 hours following amniotomy there were repeated periods of abnormal CTG and high dose oxytocin infusion was administered for long periods of time leading to and after full dilatation. The contraction frequency was 5 in 10 minutes for long periods and poor medical input was noted. Vaginal examinations revealed classic signs of obstructed labour of a baby in the deflexed occipito-posterior position²⁷. An hour prior to eventual birth by caesarean section there were classic signs of uterine rupture including haematuria²⁸, breakthrough pain, hypotension, and diminished uterine activity, failure to establish between a clear fetal or maternal heart rate. The midwife sought assistance for possible uterine rupture²⁹. A ventouse delivery was initiated 35 minutes later and failed after 3 pulls. A caesarean was conducted 10 minutes later and uterine rupture with placental abruption³⁰ was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.
- 1a.20** ADATIX³¹ submission was generated following this event and the outcome of uterine rupture, early neonatal death and major obstetric haemorrhage (4.8 litres) was classified as low harm. It was stated that the case would be discussed in a case review meeting that same month but to date the review team has received no documents from the Trust pertaining to a risk review or outcomes.
- 1a.21** The review team has graded this incident as Grade 3 (the highest grade of harm) and has major concerns with the management of the incident and the apparent lack of scrutiny.
- 1a.22** In a bereavement letter, the Trust inaccurately informed the parents that the demise was acute and no one could be certain when the rupture occurred. No reference is made in the letter to the reasons why the mother's uterus was ruptured, or to the chronic hypoxia revealed by the cord ph. There is no reference in the letter to lessons being learned or actions that could prevent such tragedy in the future.

The Stanton Davies family and baby Kate 2009:

- 1a.23** Two months after the birth and death of baby Thomas and 9 months after the birth and death of baby Joshua, baby Kate died avoidably on 1 March 2009 after her birth at Ludlow MLU. Kate died at 6 hours of age following cardiopulmonary collapse at 90 minutes of life. She was severely anaemic and paediatric help should have been sought earlier.
- 1a.24** The case has been reviewed extensively: with a highly criticised supervisory investigation, multiple external opinion reports and finally in 2012 a coroner's inquest with jury, all of these occurring after constant pressure from Kate's grieving parents. The inquest concluded that Kate should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in Kate being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage³². The MLU staff failed to provide Kate and

26 See glossary

27 See glossary

28 See glossary

29 See glossary

30 See glossary

31 See glossary

32 See glossary

her mother Rhiannon with midwifery expertise. Intermittent auscultation in labour was not adequate and opportunities to manage a baby in difficulty during the first hours of life were missed. Kate died shortly after arrival by air ambulance at a tertiary neonatal unit.

- 1a.25** There have been numerous specialist opinions on this case over a long period of time. It is clear that the Trust failed to fulfil its responsibility to establish the facts and establish accountability. In particular, the Trust failed to investigate Kate's death appropriately, failed to hold staff to account and failed to address her parent's concerns, and particularly those pertaining to the inadequacy of the supervisory investigation. Further external opinions revealed that midwives did not consider her mother Rhiannon's antenatal care as a whole and did not consider the bigger picture, which would have indicated that Kate should not have been delivered in an MLU. The Trust's investigation into midwifery practice is described as ineffective and half-hearted and the consultant feedback is criticised as being badly considered.
- 1a.26** Consideration of these three cases of term babies, Joshua, Thomas and Kate who were born and died within 10 months of each other show that by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.
- 1a.27** The review team is particularly concerned by the lack of transparency internally within the Trust and the lack of honesty and transparency with families. This is all the more concerning, when it is clear that major issues in safety were apparent in both MLU and consultant settings during the period leading up to the birth and death of Kate Stanton-Davies, and before her the birth and death of baby Joshua and then baby Thomas.

Chapter 2

How we approached this review

- 2.1** This Independent Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SaTH or similar abbreviation) was commissioned in May 2017 by NHS Improvement (NHSI) at the request of the Right Honourable Jeremy Hunt MP, then Secretary of State for Health and Social Care. This was in response to concerns raised with Mr Hunt by Rhiannon and Richard Stanton Davies and Kayleigh and Colin Griffiths about the deaths of their daughters in 2009 and 2016 respectively and about 21 further families which experienced adverse outcomes at SaTH. These concerns were with regards to the maternity care received at the Trust and with the failure of the Trust to provide satisfactory answers to questions asked about the care it provided.
- 2.2** The first terms of reference in 2018 were written for the planned review of 23 families, but were amended in November 2019 to encompass a much larger number of families. Both the first and the current terms of reference are found in appendices 5 and 6.
- 2.3** This is the second report published by the Ockenden review team. The original plan was to publish one complete report when the reviews of all the cases had been completed. However in July 2020, following an increase in the number of families included in the review, the then Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP, requested a first report focussing on important early actions and learning to improve local and national maternity services. That first report, based on the first 250 clinical reviews, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Hospital Trust*³³ was published on 10 December 2020.
- 2.4** For this second report we have reviewed all reported cases of maternal and neonatal harm in the period 2000-2019. As stated in the terms of reference, these comprise cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other complications in mothers and newborn babies. A number of cases were reviewed outside of these years and the earliest case reviewed was in 1973 and the latest in 2020. In total this review has examined the maternity care of 1,486 families resulting in 1,592 clinical incidents involving mothers and babies.

The start of the review in 2017

- 2.5** When this review began in late 2017 a small team of six obstetricians, midwives, neonatologists and administrative staff were recruited by Donna Ockenden (chair of the review) to begin work as agreed with NHSI. During summer 2017 and early 2018 some original hospital records were transported securely from the Trust to the review's office in Chichester, West Sussex and reviews were undertaken by the clinical team using these records.
- 2.6** Although this review commenced with 23 families many more came into the review through a number of different channels up until July 2020. This was in response to Trust-led action, word of mouth, social media and press reports. As a consequence the review continued to change and grow throughout the period, as we describe below.
- 2.7** The period under review has been largely determined by the data the Trust provided to the review team and the terms of reference (TOR) formulated by the review team and NHSI. The year 2000 was identified as a starting point because the first case within the original 23 Secretary of State cohort occurred in 2000.

33 Ockenden, D. *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust* (2020) <https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust>

- 2.8** The terms of reference for the review were revised in November 2019 to take account of many further families’ cases coming to the review’s attention. Many of these additional clinical cases came from the Trust directly reporting families to the review. For instance, a large number of additional cases were reported to the review team by the Trust following a data collection exercise referred to as the ‘Open Book’, in which the Trust (supported by NHSI) undertook an internal investigation to identify cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. This started as an electronic review in autumn 2018 but further cases were added later in July 2020 (Extended Open Book) after analysis of paper records held by the Trust. The Open Book and Extended Open Book exercises resulted in more than 700 cases of poor outcomes across the four categories within the period 2000-2018 being referred to the review.
- 2.9** As requested by NHS Improvement, (NHSI) the Ockenden review team drafted an interim report based on early findings and progress which was sent to NHSI in January 2019. Prior to this in autumn 2018 NHSI had formed an oversight committee to scrutinise the work of the Ockenden review team, comprising NHSI, RCOG, RCM and CQC, to which it circulated the interim report. This committee was subsequently withdrawn after concerns were raised by families and in the media.
- 2.10** The interim report was leaked to the media by an unknown source in November 2019. In response, the number of families contacting the review rose rapidly. Over the course of the review further media coverage resulting from debates in Parliament and from police enquiries resulted in large numbers of families contacting the review.
- 2.11** In addition, further families were referred to the review by local solicitors representing families and there were additions to the review following contact with the local coroner.

The families within the review have been assigned to a number of different cohorts as shown in Table 1.

Table 1: Family cohorts and timing on entering the review

COHORT	DESCRIPTION	YEAR
Secretary of State (SOS)	The original 23 families at the foundation of the review	2017
Original Direct Contact	Families contacted the Chair having learnt of the review through contact with other families or via social media	2018-2019
Legacy (the Trust named this the ‘Legacy’ cohort)	Trust-led investigation of further cases identified by the review team following scrutiny of documents pertaining to the Secretary of State cohort of 23	2018
Original post-media coverage	In response to growing media interest	2018-2019
Open Book (Trust-named)	NHSI-led data gathering at the Trust (electronic records only)	May 2019
Post-November 2019 media coverage	In response to the interim status update to NHSI which was leaked to the media	November 2019
Post-parliamentary adjournment	In response to a parliamentary adjournment debate on the review	January 2020
Solicitor	Families approached a law firm in response to media coverage which then referred them to the review team	April 2020
Extended Open Book	Trust-led data gathering (to include all paper copies of medical records)	July 2020
Post-West Mercia Police announcement	In response to West Mercia Police statement regarding the launch of an investigation	July 2020
Coroner	Coronial referrals to the review	July 2020
Saves and Learning (Trust-named)	The Trust identified a number of cases to demonstrate learning within maternity services – a selection of these cases were then passed to the review team	October 2020

Changes to the organisation of the review

- 2.12** By the time of the first COVID-related national lockdown in March 2020 the review had received only a small number of medical records and associated governance documents from the Trust. There were significant delays in receiving medical records from the Trust throughout 2018 and 2019 with NHS Improvement needing to intervene to try to secure the release of records on an ongoing basis.
- 2.13** In consequence of the growth in the size of the review's investigation NHSE&I commissioned a company to provide the review with an Electronic Document Records Management System (EDRMS) so that the team could access securely Trust medical records which were scanned and uploaded remotely. This was expedited because owing to lockdown the review team's progress was temporarily halted as the team were unable to travel to the review office. The team commenced accessing the medical records via this secure platform from July 2020. All medical records that had been received from the Trust were securely returned to the Trust once the EDRMS system was up and running.
- 2.14** The review's internal governance structures were adjusted in response to the high volume of enquiries from families who contacted through emails, social media and telephone calls. All of the initial family contacts were recorded, with follow-up arranged, then an assessment and full clinical reviews were conducted where required. In April 2020 a press statement was released advising the public that the review would close to new families in July 2020.
- 2.15** The first Ockenden report published on 10 December 2020 was outside the original terms of reference but was requested by the Minister to ensure early learning was disseminated to the Trust and the wider NHS. That first report has occasioned some delay to the publication of the final report.

Closure to new families and progression to final report

- 2.16** When the review closed to new families in July 2020 it confirmed that 1,862 families came within the review. This was widely reported in the media.
- 2.17** It should be noted that well over this number of families contacted the review; however the events experienced by some of those families fell outside the review's terms of reference and the review team advised them of the alternative routes they could explore, including approaching the Trust through the email address it had set up for families if they had any concerns.
- 2.18** Once the screening process had been completed there were 1,815 families for whom the review requested medical records in order to conduct full medical reviews. The reduction of 47 cases arose from a number of duplicate cases, (where for example the Trust and the review team had two different names for a woman following marriage).
- 2.19** After excluding cases where there were missing hospital records or where consent for participation in the review was not given or could not be obtained the final number of families included was 1,486. Some mothers had more than one incident reviewed over the period of this review and in total 1,592 clinical incidents have been reviewed.

Clinical incident categories and data validation

- 2.20** Families have been assigned to clinical incident categories. The four clinical incident categories described above (maternal deaths, stillbirths, neonatal deaths, and HIE) were defined by NHSI and the Trust when undertaking the Open Book data collection exercise. The remaining categories (maternal morbidity, cerebral palsy, and the combined category) were defined by the review team to encompass other clinical incidents and issues the families experienced.

Table 2: Clinical incident categories

CLINICAL INCIDENT CATEGORIES
Maternal deaths
Stillbirths
Neonatal deaths
Hypoxic ischaemic encephalopathy
Maternal morbidity
Cerebral palsy
Combined category*

**Combined category: comprises medical termination of pregnancy, missed fetal abnormality, intraventricular haemorrhage, infant death, child death*

- 2.21** All of the families assigned to the maternal morbidity category self-referred to the review and were largely motivated to do this following reports about the review in the media, or through speaking to other families already within the review. The Trust was aware of a few of these cases, where the family had initially raised concerns through the Trust’s complaints process. However, the majority did not have any form of governance investigation, whether initiated through the Trust’s clinical incident investigation process at the time of the incident or through the complaints process. The overall conclusion by the review team is that the Trust appeared not to be aware of these families’ concerns.
- 2.22** The majority of the families in the cerebral palsy category also self-referred. Similarly, the majority of these families did not have a Trust investigation at the time of their maternity episode. Many of the families reported being concerned about their baby from the time immediately following their birth and spent a number of years trying to find out from health professionals, or through commencing litigation, why their child had been damaged. Whilst the review spans the years 2000 to 2019 it should be recognised that the review team were contacted by many families whose maternity episode at the Trust occurred before 2000 and the earliest case reviewed was in 1973.
- 2.23** A total of 170 families from before 2000 and 15 families from after 2019 are included in this review by agreement with NHSE&I as a variation to the original terms of reference. Reviews of these cases have been largely determined by the availability of medical records, with the team being unable to review family cases where there were no medical records. For all the cases under review the standards of care that would have been considered acceptable at the time the incident or concern occurred, and the policies and normal practice at that time, have been used as the benchmark.
- 2.24** Families included within the review after December 2018 are those who self-referred and a small cohort named by the Trust as ‘Saves and Learning’. The families within the Saves and Learning cohort were offered to the review team by the Trust as it wished to demonstrate learning and positive service change in its approach to categorising and investigating serious incidents. Some of these cases had been investigated by the Healthcare Safety Investigation Branch (HSIB). The review team felt that as these cases were offered as examples of change and progression, the governance processes for them should also be reviewed. More detailed commentary on this cohort is included within the clinical governance chapter.
- 2.25** Families who contacted the review with more recent concerns about their maternity experience were referred back to the Trust to be addressed through the Trust’s formal complaints process and timeline. The small number of families from 2019 who self-referred and who remained with the review were those who continued to be dissatisfied with the Trust’s response to their concerns. The review includes 15 families

from 2019-2020. Some families from 2021 and 2022 also came forward wishing to share HSIB reports and their experience. The review team advised these families to contact the Trust as we were unable to consider their case due to the review being closed.

- 2.26** The review received some enquiries and heard accounts from a small number of families with poor maternity experiences at other NHS Trusts across England. Following discussion with NHSE&I the review team advised those families to contact the trusts concerned.

Clinical review methodology

- 2.27** The core review team comprised obstetricians, midwives, obstetric anaesthetists and neonatologists, with professionals from other disciplines joining the team as and when their specialist expertise was required. Over the course of the review the number of clinical reviewers recruited increased to reflect the growing number of families to be considered. The majority of reviewers retained clinical posts at NHS trusts across England, from Leeds to Plymouth, and all review team members remain on their relevant professional registers.
- 2.28** As the family numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases has been reviewed, discussed and graded in accordance with the methodology agreed. The clinical care has been graded using a long-established grading of care³⁴ scoring system developed by the University of Leicester which was also used in the *Report of the Morecambe Bay Investigation*³⁵ (2015) by Dr Bill Kirkup.

Governance documentation

- 2.29** Much of this review centres on the quality of the governance processes in place within the Trust, the quality of clinical incident investigations and any subsequent learning following clinical incident investigations. In our first report, we mentioned that we had received a large volume of governance documentation from the Trust which we had yet to consider. We also reported that in the 250 cases considered to date there was evidence that some serious incidents were not investigated. Subsequently we have found that a number of these cases were investigated, but the governance documentation had not been sent to the review team.
- 2.30** In the summer of 2021 we were advised by the Trust that it had located many boxes of documents potentially relating to former patients and staff, which had been stored in an unused accommodation block. Subsequently it was confirmed that 171 of those boxes contained information relating to maternity cases. Initially the Trust advised the review team that the maternity governance records found were copies of information already sent to us. This was not correct.
- 2.31** The review had forecast completion of most of the clinical reviews by mid-August 2021 in order to commence writing the report, which was then planned for publication in December 2021. The Trust provided the review team with information relevant to the families we were aware of, undertaking the screening and sorting of this information themselves, the review team were not involved. Having received this new governance documentation concerning so many families in July 2021, concerns were escalated to NHSE&I as this meant that the reviews already undertaken would need to be reconsidered in light of the new information. Our ability to deliver a second report in December was now severely compromised. The Trust continued to send governance documentation until the end of September 2021, which we agreed as a cut-off date. At this late stage, we had received documentation concerning more than 500 families within the review meaning that each case needed to be reopened and the new documents needed to be reviewed in order to determine whether they changed the reviewer's findings and conclusions following the clinical review which had already been completed.

³⁴ <https://pubmed.ncbi.nlm.nih.gov/12390986/>

³⁵ Kirkup, B. The Report of the Morecambe Bay Investigation. (2015)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Family voices

- 2.32** Many families have been offered the opportunity to meet with the chair of the review. From December 2017 until the beginning of 2020 these meetings were through one-to-one meetings in Shrewsbury. These were supported by telephone and email conversations with senior midwives working as part of the review team. Following severe flooding in the Shrewsbury area, and as the COVID pandemic ensued, video-conferencing platforms were used. Conversations were recorded and transcribed, the families were offered copies of the transcript so that they could review and add to their conversation, and the recordings were deleted.
- 2.33** The review has contacted the families regularly with an all families update on the review's progress. As the review grew in size and the pandemic lengthened, making travel very difficult, it was clear that the review chair would not be able to offer all families a face-to-face meeting. Instead families were invited to submit their accounts and questions via email, phone call or in writing to the review team.
- 2.34** Families have been offered support through a collaboration with SANDS, Bereavement Training International, and Child Bereavement UK. There is also a psychological support service provided by Midlands Partnership NHS Foundation Trust which will be discussed in detail later on in this report.

Staff Voices

- 2.35** The Staff Voices engagement strategy, which will be discussed in detail later in the report, was also significantly delayed. This was firstly and understandably at the request of the Trust due to the enormous pressures that it was facing due to the impact of the COVID pandemic. The Trust then delayed the launch of the Staff Voices process which was scheduled for February 2021, until April and then 11th May 2021. There were several hurdles which the review team had to overcome owing to the way that the Trust launched the process within its organisation. This, alongside the late delivery of significant amounts of governance documentation contributed to further concerns about the ability to publish this report by December 2021.

Data platform

- 2.36** The review team spent many hours screening telephone conversations and emails in order to ensure that the families included within the review met the terms of reference. From November 2019 it became increasingly evident that maintaining records on a system originally intended for 23 families was no longer viable.
- 2.37** NHSE&I were unable to either provide us access to a fit purpose secure electronic platform or suggest any other review or public enquiry which could help with recommending a platform for holding the review data, as a review of this volume appeared to be unprecedented. In August 2020 the review commenced conversations with an external provider and were able to secure a contract for development of a bespoke data platform which could be accessed remotely. This data platform was able to securely hold family details and it enabled the review team to write up their clinical findings directly onto the platform.
- 2.38** The review team started using the platform in April 2021 and transferred over all data from previously completed reports, including the 250 cases reported on in the first report. This enabled the review team to work more responsively and flexibly as the majority of clinical reviewers were now working remotely.

Limitations with regard to data comparisons

- 2.39** There are limitations that should be acknowledged when interpreting the data presented in this review. For instance, we are unable to be certain whether all cases which meet the terms of reference between 2000 and 2019 have been identified and shared with the review. We anticipate that, using the approaches described above, most of the cases have been identified. However it remains the case, (especially with so much governance material found stored at the Trust in an inappropriate setting and provided to the review team so late in the review process) that there may have been cases that have not been provided to us.

- 2.40** Finally, we are also cognisant that the Trust has not provided us with information regarding families who experienced adverse outcomes more recently than December 2018, which is the cut-off date it applied in the Open Book and Extended Open Book exercises.

Working with the Shrewsbury and Telford NHS Hospital Trust

- 2.41** Throughout, the review has been keen to maintain good working relationships with the Trust. There have been several attempts to establish consistency and good communication by ensuring that the review team have a key point of contact at the Trust to assist with swift responses to requests. These contacts changed over time as staff joined and left the Trust.
- 2.42** The review team also received a very small number of emails from families who have received good care at the Trust. These were acknowledged and shared with the Trust.

Reporting progress to NHSE&I

- 2.43** The review team has been conscious of the time this review has taken. Following on from the publication of the first report in December 2020 the review team and NHSE&I both wished to follow this up with the final report in December 2021. As outlined earlier the delay in publication to March 2022 has been due to several factors: introducing new electronic data systems, delays in receiving information from the Trust and delays in engaging Trust staff for their views, the complexities of managing a review of this size, and the fact that most of the reviewers in the team held full-time NHS positions.
- 2.44** During the national COVID restrictions in January 2021, we became increasingly worried regarding the reduced availability of our clinical team owing to the pandemic pressures and the need for them to quite rightly prioritise their NHS commitments. We raised this concern with NHSE&I and with their assistance, and that of the Royal Colleges, we were able to welcome additional colleagues to the team between March and May 2021. This was essential as our projected plan between January and July 2021 was to complete in excess of 1,200 clinical reviews.

Request to delay publication

- 2.45** In August 2021, recognising that the December publication date was now compromised owing to the late delivery of the large amount of governance documentation from the Trust and the delay with the staff voices engagement strategy, the review team wrote to the Secretary of State for Health and Social Care raising concerns and suggesting an alternative publication date of March 2022. Following discussions this extension of time was agreed by the Parliamentary Under Secretary of State, Minister for Primary Care and Patient Safety, Maria Caulfield MP.

Family feedback

- 2.46** It is not possible or appropriate to publish clinical reviews of all individual families' experiences in the report. However it has always been intended that the review team would feedback to families in a way that will help them to understand what happened during their maternity care. In August 2021, the review team wrote to NHSE&I outlining the reasons why giving individualised feedback to families about what had happened in their care was so important and why the feedback should be given by the review team. This process of feedback has been agreed and will take place throughout April, May and June 2022.

Closedown of the review

- 2.47** The review team has used an independent legal team for advice throughout the review. In particular we have received advice on data protection aspects of the review, and will be closing down the review and archiving its records in accordance with all legislative requirements.

Cost of the review

- 2.48** From its inception, the review has always been mindful that it has been financed through public funding. The review chair has held senior positions within the NHS and is well aware that large budgets have to be managed accordingly with demonstrable accountability for expenditure. All costs have been clearly accounted for each month and ranged from day to day office costs, to the management of the various secure platforms.
- 2.49** Since 2017, it is publicly reported that the Trust (via NHS Resolution) has paid out at least £50million to families as compensation for babies who have suffered brain damage or have died. In 2018/19, across England, there were 188 successful maternity claims averaging £9.9million each, amounting to £1.86billion in total (NHS Resolution 2019)³⁶.
- 2.50** The additional hidden costs for patients of failures in clinical care include relationship breakdowns, mental health issues and ongoing family suffering, which invariably lead to an increase in demand for resources across health and social care. All of these consequences have been acknowledged, recognised and witnessed through the review team’s meetings with families in the course of the review.
- 2.51** Whilst the review team recognises that the costs for conducting this review are significant, they are a fraction of the cost of one successful cerebral palsy claim. It is intended that our **Local Actions for Learning** and the **Immediate and Essential Actions** are deemed strong enough to continue their positive influence of enhancing the safety culture within maternity services across England, in addition to clearly stating the essential sustainable improvements required within the maternity service at the Trust. They are intended to help with the ongoing repair and restoration of public confidence and trust in maternity services both locally in Shropshire and more widely across England.

Chapter 3

Supporting the families during our review

Three tiers of dedicated family support

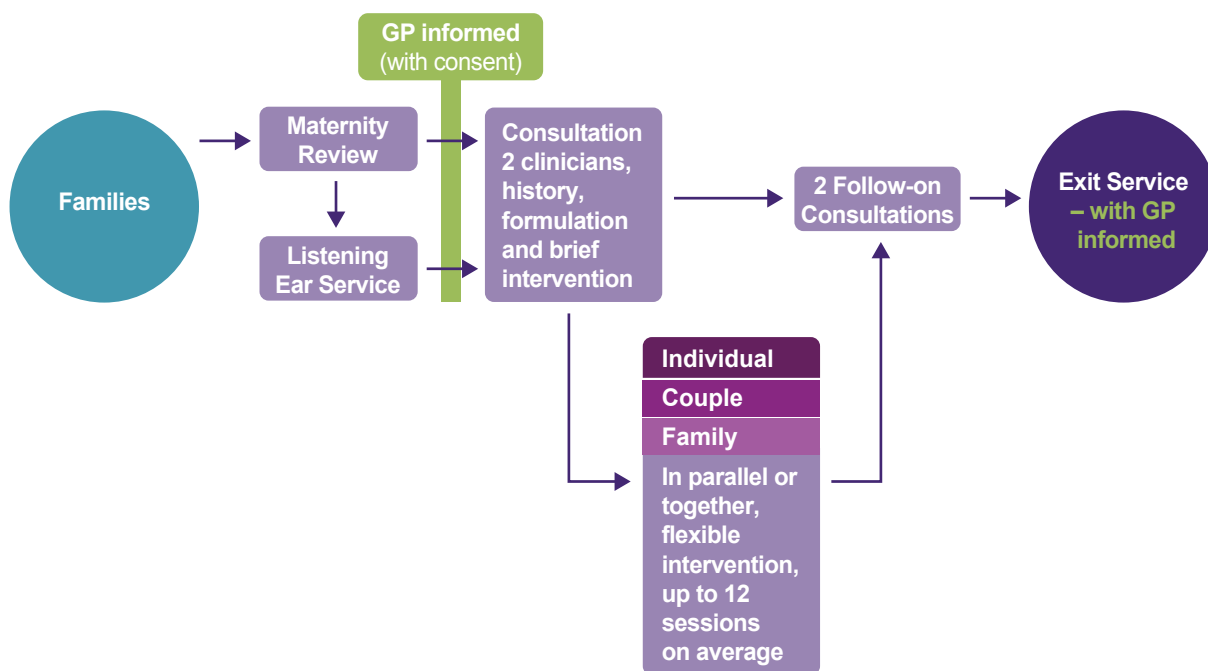
The Listening Ear service (Tiers 1 and 2)

- 3.1** The Listening Ear service, comprising three partner organisations: Bereavement Training International, Child Bereavement UK, and SANDS, was commissioned directly by the review team to be available for all families involved in this review. We recognised that the experience of families coming forward and their case being discussed and revisited with them would reignite difficult and painful feelings.
- 3.2** Key objectives of the Listening Ear service were as follows:
- To offer a support service, not a counselling service, providing in most cases a one-off listening ear session to families.
 - To act as a second tier sign-posting service, providing details of national and regional support services for ongoing or specialist support.
 - To provide onward referral to a dedicated team of psychologists offering specialist psychological support (Tier 3) where appropriate, or if requested by the family.

Specialist psychology service (Tier 3)

- 3.3** As the review team began meeting with families to review their adverse maternity experiences the Chair of the review identified that further support was needed for some families. There was recognition of a gap in service provision for those with complex grief, trauma and emotional distress. This service was beyond the scope of primary care services, but in most cases would not reach the criteria for secondary mental health services. Working in collaboration with the local clinical network and other system-wide stakeholders a specialist psychology service, hosted by Midlands Partnership NHS Foundation Trust (MPFT) and commissioned by NHS England and Improvement (NHSE&I) was established. This dedicated service was designed for families to benefit from an experienced clinician “front-loaded” model, differing from existing services which deliver a stepped model of care.
- 3.4** A consultant psychologist-led team was recruited to work on a flexible, and at points due to the COVID-19 pandemic remote, basis which also enabled access for those families now living out of the area. Face-to-face provision was also available to any families requesting this, where possible. The duration of support was planned for an 18 month to two year period, with key stakeholders and related care pathways across the local system involved in active, regular review of the emerging clinical data, in order to develop clear plans for transition into relevant care-pathways at the conclusion of this time-limited provision. Extension of the service beyond this timeframe for a period of 3-6 months, to the end of 2022 has recently been requested, in anticipation of the increase in demand following publication of the final report and as families begin to process its findings.
- 3.5** Access to the specialist psychology service has been via the maternity review team and the Listening Ear service. All families referred were offered a minimum of two consultations (an initial appointment, with the offer of 1-2 subsequent sessions as required) with two psychologists, providing them with an opportunity to feel that their experiences had been listened to and heard. Through embedding this model it was

anticipated that many families would be able to receive support and sufficient intervention at the point of consultation: promoting a positive, strengths-based model, acknowledging the resources families had drawn upon, often over many years, in their own lives to cope with what they had been through. The option of further intervention sessions with two clinicians provided the versatility of either two clinicians working with the whole family, or different parts of a family working in parallel with a different clinician. This model was designed specifically with the importance of continuity of care in mind, in order that families would not have to repeat their story. The diagram below provides an overview of the offer:



- 3.6 Where initial consultations indicated the need for further psychological interventions, families have been offered a range of NICE recommended treatments based on the individual formulation of their experiences. Treatments have included trauma-focussed Cognitive Behavioural Therapy³⁷ or CBT, Eye Movement Desensitization and Reprocessing or EMDR³⁸, couples therapy, and family or systemic interventions. The quality and effectiveness of these interventions has been routinely measured with the use of validated outcome measures, and bespoke client experience measures.
- 3.7 From the outset the specialist psychology service was developed with a clear exit strategy, remaining responsive to the needs of families, but with the flexibility to adapt the delivery and type of interventions as appropriate, given the time available. Communication with the families has been transparent to explain the scope, access and duration of the service, and with stakeholders preparing for the transition to relevant care pathways both within the NHS and wider local system at the close of this specialist provision.
- 3.8 Family feedback to the service has highlighted the importance to them of having a dedicated team of specialists with specific knowledge and expertise in the psychological impact of adverse maternity experiences. In particular families have valued the ease of access to the service, with an absence of waiting lists or restrictive referral criteria. Families have also reported how important to them it has been to have the experience of being listened to, understood, and believed, offering the opportunity for a restorative experience of compassionate care.

37 See glossary

38 See glossary

In conclusion

- 3.9** The provision of a comprehensive package of emotional and specialist psychological support available to all families involved in the review process has been central to helping them navigate the profoundly significant and potentially very painful process of their adverse maternity experiences being reviewed. Many families will have found their maternity experiences to have been life-changing, involving many layers of distress and trauma, with the ripple effects felt by whole families, the wider community, and across generations. The availability of dedicated expert support has meant that families have not had to manage this latest process alone, and have been empowered to have the opportunity to reflect on and understand what they have been through, with professionals committed to facilitating this with care and compassion.
- 3.10** It is strongly recommended that should any review or investigation be required in the future, this model of family support should be used to inform good practice, drawing on what has been learnt with regards to procedures, protocols and pathways. Above all, there must be recognition that any review of this nature will inevitably impact on those involved, and that the provision of emotional and psychological support should be integral to how the system responds to this need.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER OUR REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 3.11** Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.
- 3.12** There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

OCKENDEN REPORT - FINAL

Section 2

Internal oversight and external scrutiny

- Background information about the Trust
- Chapter 4. Clinical governance
- Chapter 5. Clinical leadership
- Chapter 6. Our findings following review of family cases

Background information about the Trust

Service overview

- 3a.1** The maternity service at the Trust is provided as a ‘hub and spoke’ model with a consultant-led maternity unit surrounded by various midwifery-led units within the Shropshire region.
- 3a.2** The consultant maternity unit was originally based at the Royal Shrewsbury Hospital site (RSH) until 2014 when consultant-led services were transferred to the Princess Royal Hospital (PRH) site at Telford. Throughout the years there have been a number of midwifery-led units, however some of these are temporarily or permanently closed for intrapartum care due to operational reasons. The current five midwifery-led units are based at Royal Shrewsbury Hospital, the Princess Royal Hospital Telford (the Wrekin unit), Bridgnorth, Oswestry and Ludlow. At the time of publication of this report, the only midwifery-led unit providing intrapartum care is the Wrekin unit co-located (or alongside unit) at the PRH in Telford. There are additional community bases at Whitchurch and Market Drayton.

Geographical area

- 3a.3** The geographical area covered by the service is approximately 2,500 square miles (including the local authority areas of Shropshire, Telford and Wrekin and parts of mid-Wales). A significant amount of the catchment area is rural; this is likely to be a contributing factor to the number of midwifery-led units within the region and the Trust’s ongoing community midwifery service provision.

Birth rate

- 3a.4** The birth rate figures below have been extracted from the Trust’s maternity dashboard and are based on financial years (April - March). The birth rate is gradually decreasing; whilst a proportion of this change is recognised as being in line with the national birth rate, some staff also shared concerns with the review team that women are choosing to give birth elsewhere within the region, rather than at the Trust. One staff member told the review:

‘We have a lot of women who come under the Trust’s locality but they are choosing to birth elsewhere because they do not want to go there.’

Table 1. Annual birth rate at the Trust 2008 – 2020

WARD	YEAR											
	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	5234	5250	5219	5240	5154	5012	4654	4859	4928	4655	4511	4422

Reference: Shrewsbury and Telford Hospital NHS Trust Maternity Dashboard

Demographic

- 3a.5** The term demographic refers to the structure of a population including (but not limited to) factors such as age, ethnicity, employment and education status. Data was available from a variety of sources including local data from the Trust, as well as large-scale reports such as the Indices of Deprivation³⁹. Now more than ever, it is recognised that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality⁴⁰. Therefore, the continual monitoring of the local demographic is vital in terms of ongoing planning and provision of maternity services⁴¹.
- 3a.5** The use of electronic maternity information systems (MIS) is now standard in most maternity units in England. However it is important to acknowledge that MIS data is at times incomplete, sometimes because of incomplete data capture as well as individual user input error. Missing data can also be attributed to the constraints and designs of data capture systems, however this is likely to improve with the ongoing development of electronic maternity information systems. It has been recommended that quality improvement indicators should incorporate metrics on data completeness⁴².

Ethnicity

- 3a.6** The majority of women receiving maternity care at the Trust were reported to identify as white British⁴³; whilst approximately 10 per cent of the maternity population identified as originating from a Black, Asian or Minority Ethnic background, (BAME) in comparison to a national average of 19-22 per cent⁴⁴.
- 3a.7** Unfortunately, there were 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years (Figure 1). The incomplete datasets are also recognised within the Trust's annual perinatal mortality reports between 2013 and 2018⁴⁵.
- 3a.8** Consequently, there are limitations with regard to the correlation of any trends or themes directly linked to ethnicity. However, due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, as previously stated, it is suggested that all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring. Research suggests this is achievable with the use of self-declaration within maternity booking systems⁴⁶.

39 Ministry of Housing, Communities and Local Government (2019) 2019 Indices of Deprivation – Telford and Wrekin. https://www.telford.gov.uk/download/download/15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

40 Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

41 NHS England and NHS Improvement. *Equity and equality. Guidance for local maternity systems*. (2021) <https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf>

42 *National Maternity and Perinatal Audit Clinical Report 2017* [https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report\(web\).pdf](https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf)

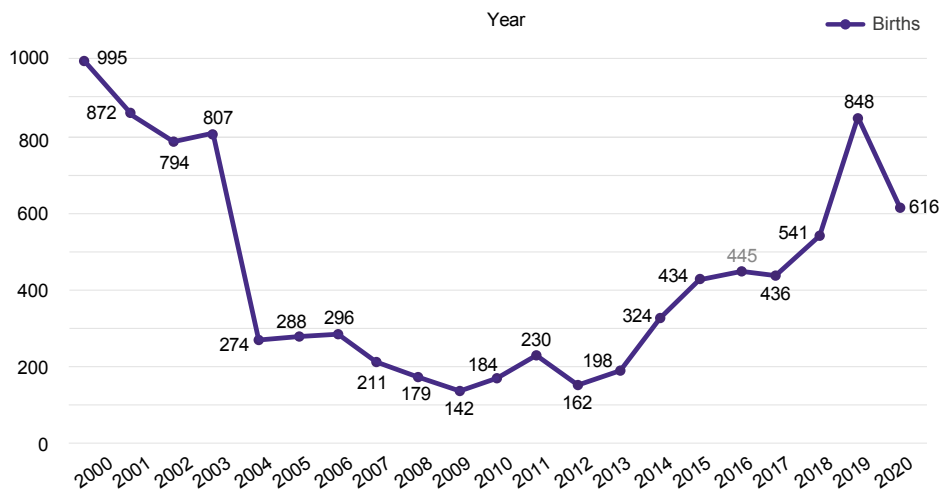
43 Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

44 MBRRACE-UK. *Perinatal mortality surveillance report for births* (2013-2018)

45 Ibid n7

46 Jardine, JE., Fremaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. *Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study* (2021) British Medical Journal Open, 11(8). doi: <https://doi.org/10.1136/bmjopen-2021-051977>

Figure 1. Number of records with incomplete ethnicity data at the Trust 2000 – 2020



Reference: Shrewsbury and Telford Hospital NHS Trust⁴⁷

Age

- 3a.9** The lower and upper ranges of maternal reproductive age are recognised as a risk factor for adverse outcomes in pregnancy. Although research is limited, evidence suggests younger mothers are at increased risk of various complications including preterm birth and are more likely to have a baby with a low birth weight⁴⁸. Mothers of advanced maternal age are recognised to be at greater risk of complications including pre-eclampsia, preterm birth, stillbirth and neonatal morbidity and mortality⁴⁹.
- 3a.10** Upon analysis of national data for younger mothers, it was observed that the age parameters for ‘teenage pregnancy’ vary. Whilst the Office for National Statistics (ONS) collates data on conception rates of women aged 15 to 17 years old, national reports into perinatal morbidity and mortality categorise ‘teenage’ pregnancies as mothers under 20 years old⁵⁰. It is therefore not possible to correlate national teenage pregnancies with perinatal morbidity and mortality.
- 3a.11** Data from the Trust was compared with data from the ONS to identify whether there was a greater incidence of teenage pregnancies, and pregnancies to women of advanced age, within this review than the national average.
- 3a.12** The review team noted the Trust predominantly covers two local authority areas, Shropshire as well as Telford and Wrekin. Although the local rates of conceptions to younger mothers have fallen in line with the national average, within Telford and Wrekin teenage conception rates were consistently higher than the national average throughout the timescale of the review (Figures 2 and 3). These findings are also recognised within the Trust’s annual perinatal mortality reports⁵¹.

47 Ibid n6

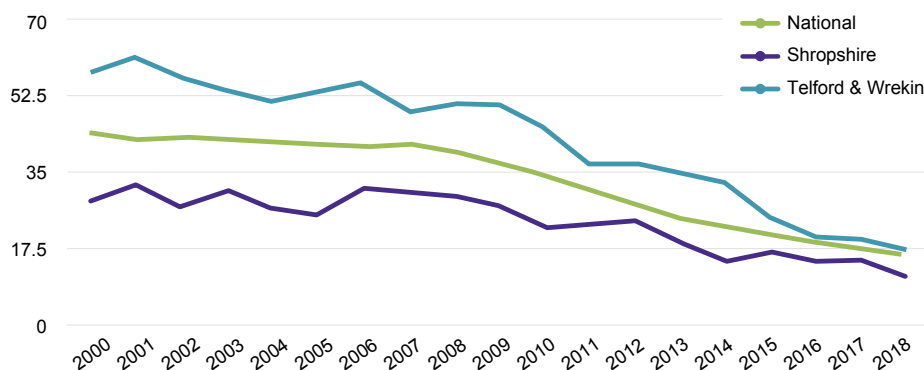
48 World Health Organisation. *Adolescent pregnancy*. (2020) <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>

49 Royal College of Obstetricians and Gynaecologists. *Induction of Labour at Term in Older Mothers*. (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdf

50 Ibid n3

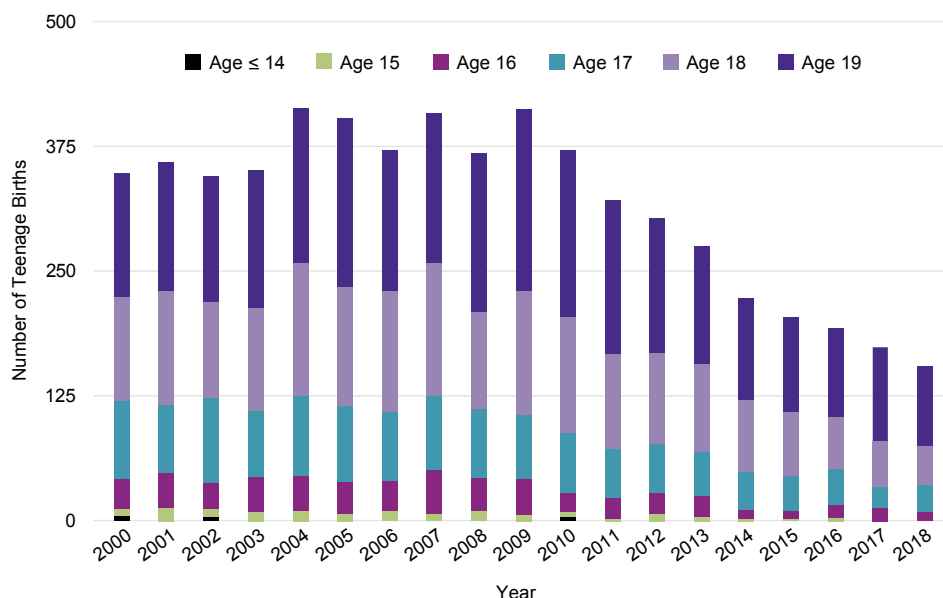
51 Ibid n7

Figure 2: Aged 15 – 17 years of age conception rates per 1000 women



Reference: ONS⁵²

Figure 3: Number of teenage births (mothers under 20) at the Trust



*Data from 2019 and 2020 are not reported due to the observed discordance of the annual birth rate reported within the maternity dashboard and birth rate stratified by maternal age provided by the Trust

Reference: Shrewsbury and Telford Hospital NHS Trust⁵³

3a.13 Despite there being a higher proportion of teenage pregnancies at the Trust than the national average, teenage pregnancy cases within the review population (i.e. with adverse outcomes) comprise only 6.4 per cent of cases, which is comparable to the overall proportion of teenage pregnancies at the Trust during the timescale of the review. Consequently, the review team concluded that the increased rate of adverse outcomes observed in the Trust against the national average is unlikely to be due to teenage pregnancies.

3a.14 The incidence of women with advanced maternal age was found to be less than or similar to the national average during the timescale of the review⁵⁴. The lower parameter of advanced maternal age is 35 years old, above which there is a statistically significant increase in the risk of stillbirth and other adverse outcomes

52 Office for National Statistics. *Conceptions in England and Wales: 2018*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence>

53 Ibid n6

54 Ibid n7

listed above. The proportion of women with advanced maternal age at the start of the review was 15 per cent in 2000 and gradually increased to 20 per cent in 2007, after which the proportion did not increase further. This was noted to be in line with national rates of maternities for women aged 35 years and over⁵⁵; therefore, it should not disproportionately affect morbidity and mortality rates at the Trust.

Deprivation

- 3a.15** Similarly to ethnicity, social deprivation is recognised to be a significant risk factor for morbidity and mortality. MBRACE-UK reports that women living in the most socially deprived areas⁵⁶ are three times more likely to die during or within the year that follows pregnancy than those living in the least deprived areas. Deprivation rates are monitored throughout the country by the assessment of factors such as income, employment, education, living environment, crime, health and barriers to housing.
- 3a.16** Throughout the time period of the review, a proportion of the geographical area covered by the Trust was regularly ranked within the top 10 per cent of the most deprived areas within the country⁵⁷. Despite this, due to other areas within the region being classified as the 'least deprived', annual perinatal mortality reports consistently highlight the levels of deprivation as similar to the national average⁵⁸, therefore morbidity and mortality rates should not be disproportionately affected.
- 3a.17** The overall conclusion of the review team was that the ethnicity data (though incomplete), the deprivation rates, and the maternal age distribution for the Trust should not have caused any disproportionate effect on morbidity and mortality rates at the Trust when compared with the national average.

55 Office for National Statistics. *Birth characteristics in England and Wales: 2019*. (2020)
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents>

56 Ibid n3

57 Ibid n2

58 Ibid n7

Chapter 4

Clinical governance

Introduction

- 4.1** In line with the terms of reference of the review, this chapter aims to explore whether the local governance within maternity services at the Trust met the standards that would be reasonably expected of it between 2000 and 2019. In doing this, the review team examined a broad range of governance documents supplied by the Trust including, but not limited to, risk management documentation, minutes of meetings, job descriptions, incident notifications, investigation reports, policies, guidelines, audits and complaint responses.
- 4.2** Whilst acknowledging that the review covers a considerable time frame, and taking account of the fact that governance requirements changed over time, the review team found that the working practices and prevailing attitudes within the maternity service and the maternity governance team at the Trust did not pay sufficient attention to the safety of mothers and babies.
- 4.3** The key themes identified requiring improvement within maternity services at the Trust were:
- The poor quality of incident investigations
 - Poor complaints handling
 - Local concerns with statutory supervision of midwifery investigations
 - Concerns with clinical guidelines and clinical audit

1. Quality of incident investigation

Background and historical context of incident investigation.

- 4.4** The definitions and processes for reporting and investigating incidents have changed throughout the time period of the review and therefore the review team has been careful to examine how the Trust reported and investigated incidents in relation to the expected standards at the time.
- 4.5** A patient safety incident is any unintended or unexpected event which can, or does, lead to harm for one or more patients receiving healthcare⁵⁹. In 2003 the National Reporting and Learning System (**NRLS**), which is a central database where trusts report incidents, was created and thereafter the culture of reporting incidents to improve safety in healthcare improved nationally. Serious Incidents (**SI**) are acts or omissions in care that results in unexpected or avoidable death or serious harm: 'where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified'⁶⁰ to prevent it from occurring again. However it was not until 2010 that a nationally consistent definition of what constituted a SI was published and the use of a specific methodology, Root Cause Analysis⁶¹ (**RCA**), was recommended for conducting these investigations⁶².

59 NHS England, *Report a patient safety incident* <https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/>

60 NHS England, *Serious Incident Framework*, (2015) <https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incident-framework.pdf>

61 See glossary

62 National Patient Safety Agency *National framework for reporting and learning from serious incidents requiring investigation*. (2010) <https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064>

- 4.6** In our first report, we identified some of the key issues from the 250 cases we reviewed, which included inconsistent multidisciplinary input to SI investigations which were often cursory and did not identify underlying systemic failings, and failed to learn lessons. In fact we found that some significant cases of concern were not investigated at all.
- 4.7** Having now considered the care of all families included in the review, in addition to the aforementioned cases for our first report, the review team has identified the following concerns regarding governance in maternity services at the Trust:
- a) Incidents that should have triggered a Serious Incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (**HRCR**), apparently to avoid external scrutiny.
 - b) When serious incident investigations were conducted many were of poor quality.
 - c) There was a lack of learning and missed opportunities to improve safety.
 - d) There was a lack of oversight of serious incidents by the Trust's commissioners.
 - e) There were repeated persistent failings in some incident investigations as late as 2018-2019.
- a. Incidents that should have triggered a serious incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (HRCR), apparently to avoid external scrutiny**
- 4.8** The review team has found a concerning and repeated culture at the Trust of not declaring adverse outcomes as an SI in line with the national framework. Instead, they were inappropriately downgraded and investigated by what the Trust termed a High Risk Case Review (HRCR). This method of investigating incidents, created by the Trust, was less robust, varied considerably in quality and lacked the rigour and transparency of an SI investigation. Notably, HRCRs were not reported to NHS England, the Clinical Commissioning Groups (**CCGs**) or the Trust Board, and therefore avoided external scrutiny.
- 4.9** In October 2021 during the 'staff voices' interviews the review team asked a member of staff for the circumstances in which the HRCR process started appearing within the Trust's local investigation process they responded:
- 4.10** *One year we were criticised for over-reporting too many Serious Incident investigations. This raised a red flag with the CCG, or the PCT or whatever it was at the time, and they said you've got an awful lot of SIs. We looked back at them and when they were reviewed again, it was decided was that some of them shouldn't have been reported as SIs, we were over-reporting. In our mind these are cases that needed significant review, so we designated them as a High-Risk Case Review, where we will spend quite considerable time looking at them and examining them and trying to learn from them because they are important, but they didn't hit the SI criteria.'*
- 4.11** The review team saw that frequently an early assessment was made by the maternity service that there was no act or omission in care, which meant that the investigation was downgraded to a HRCR. This meant that the true scale of serious incidents within maternity services at the Trust went unknown over a long period of time.
- 4.12** The earliest version of the maternity service's Risk Management Strategy available to the review team, version 5, June 2010, correctly defines a Serious Incident (or what was then termed a Serious Untoward Incident) in line with the national guidance⁶³ and, within section 8.7, includes a clear list of maternity-specific categories that must be investigated as an SI. This list included but was not limited to:
- Maternal death (booked at The Trust and who died up to 1 year following delivery)
 - Intrauterine death: over 37 weeks gestation and during an inpatient admission
 - Intrapartum death: specifically those that die during labour or during an inpatient admission

- Unexpected neonatal death: from 37 weeks gestation to 28 days post delivery
- Maternal unplanned admission to ITU
- Unexpected admission to NICU: where APGARS⁶⁴ are below 4 at 10 minutes and/or the baby has already required intubation.

- 4.13** Section 8.7.1 said: ‘Arrangements for ensuring that all Serious Untoward Incidents undergo a root cause analysis’, explains that within the maternity governance meeting ‘a decision is made to whether a high risk case review is needed’. Within the document, there is no definition of what an HRCR is. In Version 6.1 from March 2014, section 9.2.9 states that an HRCR will be conducted for those cases ‘where there is a poor outcome, patient experience or near miss not fitting the Serious Incident criteria. This additional scrutiny will be an opportunity for transparency, learning and service enhancement’.
- 4.14** The review team however, found many examples of families who met the criteria to have a full SI investigation, but had an internal HRCR conducted instead. For example, between 2011 and 2019 there were a number of maternal deaths, stillbirths, neonatal deaths and babies born with HIE where an HRCR was conducted. Where these cases correctly underwent a SI investigation, rather than an HRCR, the subsequent investigations were often found by the review team to be of poor quality. Examples of this are found throughout this chapter and other clinical chapters in this report.
- 4.15** This practice of conducting an internal HRCR when an SI was required is illustrated by a family in **2015**. This involved a baby born by instrumental delivery, which clearly fell outside national guidelines (this delivery occurring with 10 pulls of three sequential instruments). This baby suffered significant skull fractures, brain injury and has ongoing long-term disabilities as a result. Despite this meeting national SI criteria as an act or omission in care which resulted in serious harm⁶⁵, the decision was made to conduct an HRCR instead. The HRCR did follow an RCA approach but the quality of the investigation was poor. It did not involve the family, did not identify the root causes but instead concentrated on the incidental findings and the mitigations. Seemingly, the action plan did not offer any learning to the Trust so that similar incidents were prevented from happening again in the future.
- 4.16** In a typed transcript provided to the review team by the Trust, of a recording of the meeting at which the decision was made to undertake an HRCR instead of an SI for the case of this family, it is stated that an HRCR approach was utilised because ‘*A high risk case review has a very similar process, but it doesn’t get reported to our non-executive, Health England and Tom, Dick and Harry... an SI gets reported all over the patch as far as I can see...*’ This approach was taken despite the fact that following its 2014 visit the CQC highlighted its concern to the Trust about an under-reporting of SIs in maternity. There is also evidence from the same meeting that some individual members of staff present were not happy with how the investigation process was being run, with one attendee, (a staff member) insisting that the meeting was recorded. They said: ‘*My experience of the way that some of the investigations have been run have led me to believe that I should record this*’.
- 4.17** From the documentation supplied to us by the Trust the review team has been unable to identify when the Trust started using HRCRs or why they were implemented but the 2014 Maternity and Risk Management Strategy, version 6.1 stated that their aim was to ‘*establish a clear and complete chronology of what happened on the date of the incident and any preceding events that could have impacted on the outcome for the family*’. This is too narrowly focused and so, in many cases, an HRCR failed to identify why the incident occurred, meaning that many learning opportunities were missed. Confusingly, the HRCR investigations often used phrases such as ‘Root Cause Outcome’, ‘RCA meeting’ and ‘RCA discussion’, when in fact a root cause analysis was often not performed. Failing to do this properly meant that families were not given the answers they sought and deserved, the Trust did not identify the underlying issues that led to the incident occurring, and lessons were not learnt, so increasing the risk of further harm to families under the care of the Trust.

64 See glossary

65 Ibid n2

b. When Serious Incident Investigations were conducted many were of poor quality

- 4.18** When an SI was declared and a full RCA was conducted the quality of the reports was better than for the HRCRs, however many were still not of the standard that would have been expected. The review team has described the specific omissions with regards to serious incident investigation within the chapter on maternal deaths, however the review also found similar themes when assessing other serious adverse outcomes.
- 4.19** The Royal College of Obstetricians and Gynaecologists (**RCOG**) undertook an Invited Review of maternity services at Shrewsbury and Telford Hospital NHS Trust on 12–14 July 2017. This identified that the Trust's process of investigating SIs was complex and failed to adhere to recommended timescales; in one case reviewed by the RCOG team some 8 months after a stillbirth the report was still incomplete. The RCOG team also identified that the Trust's internal team conducting the investigations was not appropriately resourced or trained in RCA methodology. It also identified that there was no culture of shared learning, that the RCAs often focused on the wrong issues, lacked system wide actions and focused instead on non-specific actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans were completed and recommendations often focused on individuals, rather than recommendations for system changes.
- 4.20** The Ockenden review team has found similar failings to those identified by the RCOG team in 2017 including long waits for families to be given answers, investigations that focused on describing what happened rather than why, a focus on individual errors rather than systemic issues, and actions that were unlikely to prevent recurrence.
- 4.21** *A young mother in 2013 had what the RCA described as a 'prolonged pregnancy with intrauterine death' but failed to examine why this occurred and missed causative factors identified by the review team such as lack of fetal monitoring for 15 hours during the induction of labour process. The review team also identified terminology in the Trust report which could be seen as imparting blame on the mother, suggesting that 'patients liked to be left to sleep', putting the emphasis on the mother for not reporting fetal movement concerns, rather than assessing why there was a lack of fetal monitoring. The RCA recommended that fetal viability should be assessed at least once per shift and the Maternity Governance meeting (06.08.13) 'Confirmed with the... manager, [this recommendation was] now embedded in practice and agreed that manager to undertake audit'. The review team however has found no evidence that an audit was undertaken and even within the Trust's 2017 v5.5 Induction of Labour guideline, there is no evidence this practice has been embedded. (2013)*
- 4.22** *In 2015, a family did not receive an apology from the Trust, were not involved in the investigation, were not asked to submit questions and waited over 12 months to find out why they suffered an intrapartum stillbirth. The subsequent report focused on individual errors, for example "educational need for midwife – sticker regarding fetal movements absent" and missed the systemic issues contributing to the incident. (2015)*
- 4.23** *In 2015, a family waited more than 9 months for an SI to be declared after they suffered an early neonatal death, despite the Trust's 2014 Maternity Service's Risk Management Strategy Version 6.1 stating an SI should have been conducted from the outset. The RCA described the cause of death as a 'sub-acute cord compression leading to acute cord obstruction', but failed to identify why this happened. There was no mention of concerns identified by this review team such as a failure to upgrade intrapartum care to a high risk pathway, and staffing issues and shortages meaning that 1:1 care could not be provided. There was also a failure to monitor the fetal heart rate adequately. This lack of attention to the root cause of the incident meant the systemic issues related to why the incident occurred were not identified and the recommendations that were made did not address the systemic issues within the Trust's maternity services at the time. (2015)*
- 4.24** In later years there is evidence of improvement in the quality of some SI investigations. In **2017**, a family suffered a similar incident to earlier cases, namely an intrauterine death whilst awaiting an induction of

labour in hospital. The RCA identified multiple systemic and organisational issues resulting in a delay in transferring the mother to the labour ward. The recommendations focused on addressing the issues that created the delay, for example the closure of triage at 8pm putting additional pressure on the labour ward, and how these could be addressed. The report also highlighted that there was *‘a culture of normalising long waits for women undergoing induction of labour, who are ready to be transferred to the delivery suite [labour ward] when the delivery suite is busy’*. It should be acknowledged that this was highlighted and multiple recommendations were focused on making improvements. However the review team is of the opinion that the poor investigation of the earlier incident from 2013 represents a missed opportunity to improve and to potentially prevent future incidents, such as this incident in 2017.

c. Lack of learning and missed opportunities to improve safety

- 4.25** Once investigations were conducted the review team still found there were multiple missed opportunities for the Trust’s maternity service to learn, improve and prevent future harm occurring to other women and babies.
- 4.26** There have been some attempts to improve the safety culture and learn from incidents. In June 2017 the Trust conducted an internal review⁶⁶ of maternity services. It considered the history of maternity services between 2007 and 2017, focussed on issues of patient safety, learning, and engagement with bereaved parents. The report further stated that the service must ‘create a coordinated approach to the maternity safety improvement plan’ and that ‘safety in maternity is protected by the efforts of the staff and supported by leaders’. The review concluded that ‘all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service’. As of January 2022, the review team has not been provided with this action plan or seen any evidence of its existence in the information provided by the Trust and therefore we cannot comment on the efforts made and any impact of this plan in improving learning and safety at the Trust.
- 4.27** *In 2010 a woman developed chorioamnionitis⁶⁷ and the baby was born in a poor condition, requiring cardiac massage, and subsequently developed brain damage. At the time there was no incident report completed, no review of the care provided, no investigation performed and therefore no learning. In 2018, the Trust asked external experts to review the care provided to the family and they found that the CTG heart monitoring was abnormal for most of the duration of the labour and that there was a lack of obstetric reviews despite midwifery concerns. Oxytocin was started and increased inappropriately when the CTG was abnormal and was also increased despite hyperstimulation in the second stage. They also found that there was a long period of fetal bradycardia not acted upon, and despite performing an instrumental delivery with meconium present the neonatal team were not called to be present at the delivery. This was not one failing in care, but multiple failings. What is clear from the intrapartum section of this report is that issues with the inappropriate use of oxytocin, amongst other failings identified in this case, did continue after 2010.*
- 4.28** *The lack of investigation in 2010 for a family resulted in a missed opportunity to learn and, due to this it is likely to have resulted in similar situations occurring to other women. Also concerning is that the family were seen a week after the birth of their baby by an obstetric consultant who explained that ‘You made good progress in labour and had a very straightforward ventouse delivery for delay in the second stage of labour. Your baby’s condition was much unexpected... what is very confusing is that the continuous heart rate monitoring that was performed during labour did not show any signs of your baby becoming distressed and this is unusual’. This was either an unintentional misunderstanding of the clinical situation or a purposeful lack of transparency and honesty. Either way, this follow-up and review was not fit for purpose. The poor governance processes at the time meant that this family waited 8 years to find out there had been significant failings in care that led to their child suffering brain damage. (2010)*

66 Review of Maternity Services 2007 – 2017 by Colin Ovington, on behalf of the Quality and Safety Committee, dated 27th June 2017, provided to the review team by the Trust

67 See glossary

- 4.29** The review team also found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm. The following three examples over a 12-year period demonstrate exactly this:
- 4.30** *Firstly, in 2006 a child was born with brain damage (HIE) after the mother developed an infection (chorioamnionitis) due, in part, to multiple inappropriate vaginal examinations after her waters had broken before she was in labour. No investigation was done, no learning identified and therefore no actions were taken to prevent a recurrence. (2006)*
- 4.31** *Secondly, in 2011 a child developed multiple long term disabilities secondary to inappropriate care in a similar situation (waters breaking before labour). Despite the baby spending 23 days on the neonatal unit there was no investigation performed and again, a missed opportunity for learning. The Trust acknowledged at the time that the 2004 guideline followed at the time was inappropriate and 'very out of date'. Nevertheless, it was still not updated for another three years until 2014. (2011)*
- 4.32** *Thirdly, in 2015 a very similar incident occurred, with repeated unnecessary vaginal examinations despite the woman's waters having been broken for more than 48 hours before labour and this subsequently led to an infection (chorioamnionitis) and a poor outcome for the baby. This poor outcome could potentially have been prevented had investigations been conducted in previous years following competent and appropriate multi-professional governance processes by a team with a willingness to learn. (2015)*
- 4.33** *In 2016, the Trust had a second opportunity to review the care provided to a family but this opportunity was again missed. The mother initially made a complaint but after receiving an inadequate response from the Trust, contacted the Parliamentary and Health Service Ombudsman (PHSO⁶⁸), who conducted a review in 2018 and identified failings in care. It was only at this point, three years after this third incident, that the Trust created an action plan to reduce the likelihood of recurrence in the future. The review team however has been unable to find any clear evidence from the information supplied to us by the Trust that the change following the PHSO report has been implemented. (2016)*
- 4.34** Sadly, the review team encountered many further examples of repeated missed opportunities to learn:
- In 2009 a baby born at the Trust was admitted to the neonatal unit with severe hypoxia and suspected HIE. The baby subsequently died within 12 months of birth due to complications from severe cerebral palsy. There was no investigation performed after the baby was admitted to the neonatal unit with HIE and a missed opportunity for improvement. After the birth the parents met with two consultants who could not identify what went wrong and decided against asking for an external investigation. (2009)*
- 4.35** *In 2010, the Trust had a further opportunity to review this case after receiving a complaint letter from the family. However the family have explained to the review team that this response lacked sympathy and compassion and again did not identify any failings in care. The issue of a lack of learning is multi-professional and the neonatal team did not review the care they provided either. Subsequently a letter to the GP from the consultant obstetrician explained that the labour care was 'appropriate' and nothing could have been done differently.*
- 4.36** *It was only after a second complaint response in 2017, with a new Chief Executive at the Trust that an external investigation was conducted. In 2018, 9 years after the initial incident occurred, an investigation*

68 See references – various documents on PHSO consulted for this chapter inc:

1. Parliamentary and Health Service Ombudsman (PHSO). Learning from mistakes. 2016.
2. Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. 2015.
3. House of Commons Public Administration and Constitutional Affairs Committee. Will the NHS ever learn? 2017.
4. NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. 2017.

identified multiple failings, substandard care and that the delivery should have been sooner. Despite the long delay and the multiple failings, the review team could not find any evidence that this report was shared with the family.

- 4.37** In 2011 a woman was inappropriately discharged home with severe pre-eclampsia and subsequently had an eclamptic seizure within 24 hours. No incident form was completed, no investigation occurred (2011)
- 4.38** A mother at 36 weeks gestation with diabetes whose antenatal CTG was persistently abnormal for 3 days whilst in hospital, which should have prompted delivery, was discharged home without a plan in place and subsequently her baby died (2011)
- 4.39** In the second case above the review team found the care provided to the mother to be significantly suboptimal, however only a cursory internal review was conducted, (notably the CTGs had disappeared) and no clear recommendations for improvement were made.
- 4.40** The review team also identified that many governance documents between 2009 and 2019 included the following inappropriate images. These images were found on multiple SI reviews, HRCR reviews, minutes of maternity governance meetings, quarterly maternity safety reports, patient safety events, feedback of learning documents and an external letter to the ambulance service. The review team felt that having such images on governance documents was insensitive and demonstrated a lack of professionalism.



d. Lack of oversight of Serious Incidents by the Trust's commissioners

- 4.41** When an SI investigation is completed locally, it is reviewed by the local Clinical Commissioning Group (CCG) for approval and closure if the investigation and action plan are deemed appropriate. Previous national reports have highlighted concerns that despite closure of incidents, once external scrutiny is applied to the original investigations they are often found to be of poor quality, thereby questioning the oversight of commissioners in this process⁶⁹. The review team also identified extensive and repeated concerns with the quality of SIs undertaken by the Trust, which may indicate a lack of external scrutiny.
- 4.42** The Telford and Wrekin, and Shropshire, CCGs undertook a review of the Trust's maternity services which was published in 2013 and found the Trust was 'a safe and good quality service, which is delivered in a learning organisation'⁷⁰. The commissioners' review of risk management focused on reported SIs and near misses in the period 1 April 2012 to 31 March 2013, which was likely to have underestimated the scale and volume of incidents. It also looked at policies, clinical governance systems, care pathways, and training, and concluded that: 'There was an openness and transparency in reporting and investigation culture,

⁶⁹ Magro M. Learning from five years of cerebral palsy litigation claims. (2017) NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

⁷⁰ Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, *Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust* (2013) <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D>

which has led to a higher reporting of serious incidents than would have been reported elsewhere. The review stated further *‘There is a robust approach to risk management, clinical governance, and learning from incidents’*. The review team has identified failings in a lack of incident reporting, low levels of SIs being declared, poor quality RCAs and investigations where lessons are not learnt and further harm is caused at the same time. These failings beg the question as to whether the CCG review process was fit for purpose.

e. Persistent failings in incident investigations as late as 2018-2019

4.43 The Trust shared with the review team a selection of self-selected maternity incident investigations from 2019 which the Trust entitled ‘Saves and Learning.’ These maternity cases were submitted to the review team with the aim of demonstrating improvements in maternity investigation methodology during the latter years and as examples of good practice. There were 12 cases in total. The total number of maternity incidents occurring in the Trust during 2019 are unknown. Improvements in investigation processes have been developed since 2018 and there is now more focus on learning and feedback in different forums, however what is not clear from the evidence seen by the review team is whether these forums are open to all staff groups and whether staff are enabled and encouraged to attend. Extracts from the Maternity and Neonatal Collaboration Survey in 2018⁷¹ demonstrate that staff felt that feedback from incidents was still not disseminated as well as it could have been *‘Ensure feedback from any incidents is clearly communicated to staff to ensure continued staff learning and development’*.

4.44 The ‘Saves and Learning’ investigations demonstrated improvements in asking families to contribute to investigations, they were asked to forward their concerns and recollections or attend a meeting if preferred. There was also improved oversight of the recommendations and actions at governance meetings and when actions were delayed, the review team saw evidence that there was timely follow up with action leads. However, the review team identified from the small sample provided by the Trust that the local processes needed to be further improved, in particular:

- There was a lack of consistency in the seniority and staff groups that attended the rapid review meetings and the panels did not comprise of staff members senior enough to decide on the level of investigation.
- There was no oversight or accountability from the Director of Midwifery nor the Clinical Director for obstetrics or the consultant lead for risk.
- There was still a reluctance to declare an SI and in most cases a HRCR was still conducted, when an SI would be the appropriate investigation.
- Actions did not always correlate with the findings of the investigation.
- Action plans were monitored by the quality improvement midwife however there was no evidence in the cases reviewed that they were overseen by the senior leadership team. During the staff voices meetings in late 2021 a member from the senior Trust team raised concerns to the review on the suitability of staff who were responsible for quality improvement and safety. They explained that staff were promoted to roles without previous substantive clinical experience and without any means of formal support.
- Significant delays in completing all of the 12 Saves and Learning cases from 2019 that were shared with the review team by the Trust.
- Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution⁷² that

⁷¹ Maternity and Neonatal Collaboration survey 2018, provided by the Trust

⁷² Ibid n11

women and their families should be actively involved in investigations. Best practice from HSIB⁷³ shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations.

- In discussing the safety of the unit and the robustness of governance processes, during the time they worked there, some staff showed a willingness to bring in changes to improve safety in an unsupportive system. When asked if the unit was safe they responded: *'I don't ... I don't even know if I can answer that. I felt it was safe on a day-to-day business basis, based on day-to-day firefighting and operational exhaustion from people trying to do the right thing'*.

4.45 Despite the improvements the Trust believes it has made, anonymised extracts from the Maternity and Neonatal Collaboration Survey in 2018 demonstrate concerns by their own staff regarding an unsupportive culture and one of blame following SI investigations. One extract included *'I am concerned that midwives who have made errors are treated badly, one midwife was on the verge of suicide due to the way she was treated in her involvement in a SI. More support and care, counselling and help needed in these situations so that the practitioner is not pushed to breaking point or self-harm from intense pressure.'* Another contributor to the same 2018 survey said: *'senior management in care group or above not understanding real issues. Not learning from mistakes'*.

4.46 These findings by the review team differ from the publicly presented findings of two external reviews; firstly, the addendum to the RCOG Review of Maternity Services on 27 April 2018⁷⁴. The original report, which was more critical, had been completed in 2017, but was not presented to the Trust's Board until an addendum had been prepared which highlighted a much more positive situation with risk management than actually existed. This is discussed in more detail elsewhere in this report. The 2018 addendum to the 2017 RCOG report stated that: *'The Care Group has strengthened its risk management structure, risk management meetings are held regularly and rapid review meetings following incidents are executive led' and that 'RCA investigations follow the NHS Improvement SI Framework'*. Secondly, the 2019 CQC⁷⁵ report of maternity services at Princess Royal which felt that *'the service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service'*.

4.47 Patient safety relies on maternity services receiving appropriate and timely feedback from regulating bodies to ensure improvements can be made and in these examples above the external systems for review and monitoring of the Trust seem to have failed.

2. Poor complaints handling

4.48 Effective local complaints handling is a part of good clinical governance, enshrined in the NHS Constitution⁷⁶. Done well and in a timely manner, a complaint response can provide patients and families with the answers they deserve, allows areas of concern to be identified and can be used to analyse trends to improve services. In Wales⁷⁷ the NHS has published extensively on the benefits of complaints to a service. The review team identified that the Trust performed poorly in all of these areas and identified the following concerns:

- a) Lack of senior oversight and input into complaints handling and patient experience
- b) Lack of openness and transparency.

73 Healthcare Safety Investigation Branch *Annual Review 2020/21* (2021)
https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

74 Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services.
<https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf>

75 CQC report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

76 NHS Constitution; NHS Complaints Guide, (updated January 2021).
<https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service>
[Accessed on 28 October 2021]

77 NHS Wales Using the gift of complaints (2014) <http://www.wales.nhs.uk/usingthegiftofcomplaints>

a. Lack of senior oversight and input into complaints handling and patient experience

- 4.49** The review team identified that there was a lack of input from senior members of the leadership team in the writing, review, approval, quality control and trend analysis of complaints. There is no evidence available that the Head of Midwifery, Director of Midwifery and Clinical Director were ever advisory on complaint responses before they were sent to the Trust's Patient Experience Team for the then CEO's signoff. Neither is there any evidence, that complaint themes and trends were analysed and used proactively to improve the service. Even in the latter years of the review period it was unclear what structure was in place for answering complaints and where the accountability lies.
- 4.50** The review team identified that in 2009, the Trust created a Patient Experience Midwife post. This role was created to provide an effective and timely complaints and claims procedure framework. One of the main objectives of the role was to develop a patient involvement strategy to contribute to the clinical governance agenda and to maternity service development. This role and scope was innovative for the time, however there is no evidence shared with the review team that the objectives of the role were actually ever met. Despite the creation of this role many years earlier there has been no documentation provided of a patient experience strategy or any evidence seen that the Maternity Services Liaison Committee (**MSLC**) or (from 2017) that Maternity Voices Partnership (**MVP**) meetings were included within the terms of reference for clinical governance meetings.
- 4.51** Whilst the review team acknowledges that the role and job description was forward thinking, the patient experience midwife post lacked the required experience and authority to lead on patient experience, complaints and claims. This meant that from its introduction the post was undervalued. Additionally, it devolved responsibility and oversight from the divisional senior leadership team to members of staff who had no real influence in changing practice.
- 4.52** Between 2007 and 2013 it appears from information provided by the Trust that complaints were managed between two members of staff who worked part time, one of them a retired member of staff who returned to work one day a week.
- 4.53** One staff member described the process of responding to a complaint to the maternity review team as: *'[the second midwife] would look up some of the notes or [they] would get information, [they] would start to put a response together and then I would look at it, tidy it up or ask for more information when I came in. The actual complaint came in and we started to look at the notes, look at all the things that had been written down and then talked to the people that were involved in that case. Then from their comments and from what was written and from the patient's letter, we started to investigate what had happened and understand what had happened and then try to put a response together for the patient. Those all had to go, of course, to the Chief Executive office because they all go out in [their] name, not ours'*. There was no evidence that other members of the maternity department contributed, or that responses were reviewed before being sent to the CEO for approval.
- 4.54** With regards to trend analysis, the review team has seen evidence that complaint trends were identified at maternity governance meetings but there was no evidence that actions were taken to prevent similar incidents occurring. In 2009, the Clinical Director informed the members at the maternity governance meeting about the existence of a separate monthly meeting where complaint themes were discussed and that monitoring of actions would occur at the maternity governance meeting. The review team however has seen no evidence that this forum was ever formed and no evidence of action plans being presented to the governance meeting.

b. Lack of openness and transparency

- 4.55** There is evidence that complaint responses lacked transparency and honesty, especially with regards to clinical care. The review team has identified families where care was sub-optimal, where different management would likely have made a difference to the outcome, however the complaint responses

justified actions, delays and omissions in care. In addition, they often lacked compassion and in a number of responses it was implied that the woman herself was to blame.

- 4.56** There are examples of families whose complaint letters were dismissed, only for external investigations, sometimes many years later, to identify failings which should have been evident at the time, had a thorough complaints investigation been conducted.
- 4.57** *In one example from 2013 a baby was born in a midwifery-led unit and diagnosed with Hypoxic Ischemic Encephalopathy (HIE) secondary, due to a failure to monitor the fetal heart rate (FHR) appropriately in labour. The complaint response from the CEO stated that the fetal heart rate was normal, and that it was recorded at specified intervals of every 30 minutes in labour. The multi-professional review team did not agree that the heart rate was normal and thinks the response to the family is incorrect. (2013)*
- 4.58** On a number of occasions parents wrote to the Trust find out whether their case had been investigated, often in situations where an investigation should have been conducted and the family involved from the outset; cases range from intrapartum deaths to severe physical and developmental disabilities.
- 4.59** *After complaining in 2009 a mother reported to the review team that: ‘The response to my complaint made me so angry. It didn’t address any of my concerns...and was misspelt.’ (2009)*
- 4.60** *In 2009 another family wrote to the Trust pleading for them to open an investigation into the death of their baby, requesting to be involved in the investigation and asked whether if things were done differently the outcome would have been different. In the response received the Trust said: ‘The protocols for dealing with CTGs are clear and laid down for all staff. All staff, both midwives and doctors receive updates on the interpretation of CTG traces every 6 months. The loss of X was unexpected therefore difficult to prevent as [the] CTG trace was not indicative of an at-risk fetus that needed immediately delivery. If every dubious or worrying CTG resulted in an emergency caesarean section then 1/3 of all women would be delivered surgically’.*
- 4.61** The Trust continued: *‘Patients cannot demand a caesarean section. They can request one and discuss the issues with the consultant but if the attending medic does not agree that a caesarean is necessary they will not undertake one’.* (2009)
- 4.62** This is a tragic case of a neonatal death where an independent investigation undertaken in 2018 identified significant failings in care and also a failure of the Trust at the time to learn lessons and recognise that earlier delivery could have altered the outcome for this family.
- 4.63** *In 2018 an investigation was started without the woman being told an investigation was ongoing or being asked to contribute. This is despite Duty of Candour⁷⁸ being well embedded nationally and being a legal requirement. The family received a written complaint response that outlined actions the Trust had put in place and completed but at a subsequent complaint meeting the parents questioned the honesty and transparency of the written response as the actions had not started at the time of the meeting. The family said: ‘It’s the fact that, when all this first happened, we went through an awful lot...and to be told that you had spoken to Dr X. Dr X had completed some key learns and due to that, you thought nothing was wrong, so you closed the investigation...but since then, obviously, we’ve found out that none of that actually took place’.* (2018)

3. Local concerns with statutory supervision of midwifery investigations

- 4.64** The overarching responsibility of the Local Supervisory Authority (LSA) and Midwifery Supervision was to protect the public by monitoring midwives’ fitness to practice and instigate remedial actions where necessary.

⁷⁸ General Medical Council, The professional duty of candour <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour>

- 4.65** From 2001, the Nursing and Midwifery Council (**NMC**) gave powers to the midwifery body, composed of trained Supervisors of Midwives (**SoMs**), in the form of statutory supervision in accordance with the NMC's rules and standards to regulate midwives. Supervision was subsequently removed from statute in 2017 and replaced by a new model which was based on midwifery education and quality improvement. The review team has considered the role of midwifery supervision in-line with what was current practice from 2000 to 2017.
- 4.66** As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by SoMs at the Trust. From the governance documents the review team has received from the Trust there is minimal evidence that investigations were taking place, however there are some SoM updates within the maternity governance reports which indicate that investigations were taking place. We have received a small number of investigation reports which were of poor quality and which, from their dates, appear to have been conducted many years after the incident.
- 4.67** A significant number of SoM investigations provided by the Trust to the review team were all dated during one week in December 2016 and written by a single SoM. Some of these investigations related to incidents that occurred over 10 years prior. The review team were informed that this was due to a member of staff recognising that the original investigations lacked objectivity, with gaps in their quality.
- 4.68** This appears to be a conscious attempt to identify any significant practice issues, however it is unclear whether the midwives involved in the older clinical incidents received feedback - although this would have been out of date given the length of time since many of the incidents took place.

Findings from an RCA review and supervisory records:

- 4.69** A family experienced an unexpected admission of a term baby to the neonatal unit in **2015**, with the baby subsequently dying aged 5 months. A rapid response meeting was held to review the care and identify any immediate learning. At this meeting there were no identified SoMs present.
- 4.70** This initial review recommended that, due to the potential for long term harm, the RCA level should be undertaken as a serious incident. The supervision, (SoM) team was notified 2 weeks after the incident and a supervisory investigation was undertaken a month later. The investigation went ahead, however there was no chronology to benchmark the midwifery care against the standards of care at the time. From the initial 72 hour review there appeared to be a primary fixation on the lack of differentiation between the maternal and fetal heart rate, contributing to the difficulty in interpreting the fetal heart rate.
- 4.71** At this first meeting, it is unclear whether the maternity team considered the overall picture of this mother's labour. A further rapid review meeting was held 3 weeks later. The discussion at this stage still failed to demonstrate a detailed understanding of the 66 minute period when the fetal head was on the perineum, at a time when the umbilical cord will have been compressed. (2015)

How staff members described the SoM team:

- 4.72** Staff members described to the review team that the culture of the SoM team between 2010 and 2016 was discriminatory and non-inclusive. The review team heard from a midwife, in October 2021 who stated that they '*never felt [they] could fit in with the culture of the unit and were made to feel like an outsider by [their] colleagues*'. Though initially supported upon qualification to undertake the SoM Preparation Course [X] was not appointed into a SoM role because 'the existing SoM team did not want [X] appointed'.
- 4.73** Another member of staff raised concerns that SoM investigations were not transparent or fair and lacked rigour: '*I started to see gaps and I started to point them out and say, "Well actually, look, we've got the same people. The same people are involved in these reviews. The same people did the supervisory investigations, the same people marked them, the same people in the LSA marked them, we've got these patterns"*.' It is evident that staff raised concerns about the quality of the investigations at the time, and

some conscious attempts were made to establish some objectivity, the same staff member added: *'There were reviews from a supervisory perspective and we still just about had supervision then [2016] so we did do that and we did some deep dives into...so we did reviews, but if you like, we were still marking our own homework.'*

External reviews of the SoM function at the Trust

- 4.74** Information provided to the review team indicates that there have been two external independent reviews of a midwifery supervisory investigation previously undertaken by the Trust's SoMs. The Local Supervising Authority Midwifery Officer (LSAMO) – the senior person who was responsible for upholding the standards of midwifery supervision at a regional level - Annual Report April 2014 – March 2015 stated that a complaint was received regarding the LSA function during the 2014-2015 supervisory year. The complaint related to a family who requested a review of a supervisory investigation in relation to the birth of their daughter in 2009. The family were gravely concerned at the lack of quality and accuracy of the initial investigation.
- 4.75** The external review concluded that the quality of the supervisory investigation was poor. There were a number of inaccuracies in the timeline and events, the facts of the incident were not established and the principles of the midwifery supervisory investigation were not adhered to. In the period between the initial investigation and the external report in 2015, there was no local learning or safeguarding of the public during a 6 year hiatus. Following the external review, the investigating SoM was found to be unsuitable for the role and they were removed from their supervisory duties by the LSAMO.
- 4.76** The second independent review was of a case of maternal death and intrauterine death. It was commissioned by the regional Chief Nurse in 2016. From information provided to the review team we found that the original investigation is incomplete, and has focused on the methodology of the investigation rather than the actual investigation of the incident.
- 4.77** The external investigation identified that two of the nine midwives who cared for the family would benefit from more support and development and the remaining seven should reflect on the care they provided. The original Trust investigation had only reviewed the care of one midwife and found no further learning was required. It had concluded that there were not any serious concerns in relation to midwifery practice.
- 4.78** The review team considered the language used at times in the reports seem to be inappropriate for the tragic outcomes and impact on the whole family. When discussing a meeting with family members as part of the investigation, they used terms such as the family being 'brave'. The external reviewers thanked the family member for involvement in the second review and described their 'graciousness' for taking part in the investigation.
- 4.79** The review team's opinion is that the external (or second) investigation also failed to identify that with improved care the outcome for the woman could have been significantly different. The first investigation failed to identify any systemic issues around CTG interpretation and sepsis management, which were relevant, factors. It was also felt by the review team that the few recommendations for improvements made would not have prevented a similar situation occurring in the future. The second investigation relied on the presumed cause of death (amniotic fluid embolism) as 'unavoidable' and therefore did not address salient issues particularly around the identification and management of the critically ill mother, sound escalation plans and multidisciplinary team working.
- 4.80** Two years after the mother's tragic death, the external assessors acknowledged that some of the recommendations for improved care were still *'in progress'*. It is the review team's opinion that despite being a second investigation the LSA (external) investigation still missed significant points for learning, and improvement, specifically that had the sepsis been treated more promptly earlier, that the outcome might have been significantly different.

Causes of supervisory failings and failure to learn:

4.81 The review team identified the causes of supervisory failings as:

- The supervision function was not independent from the management team, therefore the same people scrutinised clinical incidents regardless of whether this was a supervisory review or not.
- The short staffing levels did not appear to provide supervisors with protected time to carry out supervisory activities.
- A lack of involvement of supervisors in risk management and incident reviews which prevented them from identifying the incidents that warranted supervisory review.
- A lack of integration between supervision and clinical governance.
- A lack of leadership within the maternity governance structure.

4. Concerns relating to clinical guidelines and audits

4.82 The writing, review and use of clinical guidelines to inform best practice and the conducting of clinical audits to monitor compliance with these guidelines is an integral part of ensuring a service is safe. The review team has identified the following concerns:

- a) A lack of multidisciplinary input into guideline management and audits
- b) A lack of a change in practice and monitoring of compliance in response to clinical incidents
- c) The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

a. A lack of multidisciplinary input into guideline management and audits

4.83 Before 2010, and following review of the guidelines supplied to the review team by the Trust, the approach to guideline and protocol management lacked a multidisciplinary approach at the Trust. Guidelines appeared to have been drafted by midwifery staff, with no input or oversight by the obstetric consultants.

4.84 From 2012 onwards the review team identified a named guidelines midwife in post, and identified that subsequent to this, there was a more consistent approach to how guidelines were written, reviewed and then referenced. The review team were unable to find evidence of a named obstetric lead, and obstetric input was not well defined, which meant that there was a lack of multidisciplinary input into guideline management. A member of staff stated *'practice wasn't evidence-based but there was nobody qualified, competent or capable to update guidelines or to even write guidelines. They didn't have very many and what they had weren't evidence-based...I know full well that their guidelines were woefully out of date'*.

4.85 With regard to audits, there is evidence supplied by the Trust of formal registration of women's and children's audits throughout the review period, forming part of the yearly corporate audit plan. This is in line with general practice in maternity units and the majority were conducted by an audit midwife with only a small number, in comparison, having obstetrician involvement. Anaesthetists were involved in audits in earlier years, then no longer featured at the audit meetings and their involvement in maternity audits was not seen in recent years.

4.86 Experience from the multidisciplinary members of the review team is that good practice for most maternity units would be for audit meetings to be multidisciplinary, where all clinicians learn together. The review team noted that the attendance record at audit meetings, especially prior to 2012, demonstrated that, in general, very few midwifery and nursing staff attended, with no midwives present at some. The meetings were often obstetrician-led, attended by the obstetric team and had obstetricians conducting the audits. This shows a culture of exclusion and disparity between the staff groups. After 2012 there was clearly a shift, as most audits were midwife-led, usually by the audit midwife with little involvement by other staff groups. Actions to try to improve obstetric attendance were noted at meetings as late as July 2017.

- 4.87** For example, in September 2018 the operative vaginal delivery audit was conducted by a midwife and demonstrated that no analgesia was used for ventouse deliveries. The review team felt this was unlikely to be correct, as it would be surprising if none of the women who had a ventouse had an epidural, which is known to increase the risk of instrumental delivery. However, a suggestion was made at audit meetings for this to be investigated and for consultants to supervise future audits with the aim that their presence would promote evidence-based practice and influence a change in practice. The lack of obstetric involvement in the initial audit would have made it difficult for the auditor to develop a robust plan to effect change as it is based on the individual's limited knowledge and experience on the subject.
- 4.88** Audits were also presented within the maternity governance meetings which to 2012 were mostly attended by midwifery staff. After this time, the review team has noted good attendance by consultant obstetricians and midwives but attendance by junior medical staff was often lacking. The updating of guidelines and leaflets was a regular item on the agenda, however this item was often cancelled when there were more pressing matters being discussed, at the expense of guideline updates.
- 4.89** Maternity audit action plans were also agreed at these meetings, but discussion when it occurred commonly appeared as perfunctory which was inappropriate as the forum did not have full representation and authority to make decisions. Many action plans merely stated the means of dissemination of findings, rather than addressing the discrepancies identified. Often there was no action plan to improve compliance and then to re-audit. The review team found therefore that management of maternity audits were a significant lost opportunity to improve the quality of maternity care at the Trust throughout the entire period of the maternity review.

b. A lack of a change in practice and monitoring of compliance in response to clinical incidents.

- 4.90** The review team has identified cases where similar and continuing errors in practice have occurred over the years, which suggests a failure to learn lessons and implement change in maternity practice. When an incident has been investigated and an action plan created, it is vital that these actions are implemented to prevent future harm occurring. The review team has found repeated instances where this has not been the case in maternity services at the Trust.
- 4.91** *In 2015 a woman with a previous baby on the 5.5th centile was not offered an obstetric review or growth scans. She subsequently suffered a stillbirth at 37 weeks. The baby had a birth weight less than the 3rd centile. The subsequent investigation into this stillbirth recommended that: 'Any previous birth weight between 5.0 and 5.5 centile will be rounded down to 5th centile for the purposes of ascertaining which patients will be offered routine scans at 32 and 36 weeks'. This recommendation however was not written into the Assessment (Antenatal) Guideline Version 11 (2015) nor any versions afterwards. Despite the 2013 RCOG Green Top Guideline⁷⁹ recommending use of the 10th centile to determine when ultrasound scans are required, this was not followed at the Trust until 2018. (2015)*
- 4.92** *In 2016 a woman, for whom English was not her first language, telephoned maternity triage with abdominal pain and was advised to remain at home and sadly attended with a concealed placental abruption and had a neonatal death. The recommendation from the investigation was to update the maternity triage operating procedures to include that women for whom English is not their first language should be invited in for assessment to avoid issues with communication. There is no evidence this occurred. (2016)*
- 4.93** *In 2018 a woman in early labour telephoned the maternity triage as she believed her 'waters had broken' but she was not invited in for assessment, and the outcome in this case was an early neonatal death. The Latent Phase of Labour and Intrapartum Care on an MLU guideline was updated following this incident and a compliance audit was recorded as being completed, however no evidence of this compliance audit has been supplied to the review team by the Trust. (2018)*
- 4.94** There is evidence of sharing audit findings at audit meetings. However, there is lack of consistent evidence

79 Royal College of Obstetrics and Gynaecology *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013)
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

that practice changed as a result of audits. Of particular note is that the majority of audits did not make reference to previous audit findings, hence the opportunity for comparison and therefore learning to improve the quality of maternity care was lost.

4.95 One example is that an electronic training package used by staff for CTG training was discussed at the maternity governance meeting held in February 2016 and it was said to be in routine use. However, in the July 2017 governance meeting, it is reported that staff were unfamiliar with the aforementioned training package. This is inconsistent with the assurances given at prior maternity governance meetings and to external bodies such as the Commission for Health Improvement as far back as 2007. Poor CTG interpretation leading to poor outcomes for babies was a recurring theme among many cases over the period of time considered by the review team.

c. The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

4.96 The Clinical Negligence Scheme for Trusts, better known as CNST, is an insurance scheme administered by NHS Resolution (previously known as the NHS Litigation Authority), whereby individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence. In the earlier years the CNST standards were met by auditing practice against prescribed standards and identifying evidence of improvement in practice informed by those audits. Successful achievement of Level 1, 2 or 3 resulted in a percentage reduction of trust payments to the NHSLA for indemnity insurance.

4.97 The review team saw evidence that guidelines were amended and updated based on the CNST assessment reviewer's comments and the maternity unit was successful at gaining Level 1. A member of staff stated in a meeting with the review team that as early as 2009 there were significant concerns amongst individuals about standards of maternity care and governance at the Trust.

4.98 In discussing CNST, a staff member told the review team *'...in 2009, there were signs then that governance was not as it should be and I fought a battle even then just with regard to CNST and I was told we're going to get CNST Level 2, and I said, "We're not", and I was told, "We are", and I said, "We're not", and that was the first time that I experienced having a battle with the...leadership at the time, and the Board...but you know what's right and you can't get beyond that barrier. So I considered that I won that battle, in that we did the right thing...we weren't going to get Level 2 unless we fudged it, so those are my words...but it was met with absolute disdain and I remember...being dragged into [X's] office and told, "Sit there with your laptop, we're going to do this action plan for CNST together..."'*

4.99 This was also confirmed by another member of staff stating: *'I don't think that anybody on the Board expected me to be finding us non-compliant, because obviously that had gone through the Board, so that was a really difficult time as well. ...It was a really difficult time, because we were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it, and then obviously we had to look at year one and then we owed a significant amount of money. I think that, you know, that's an example of where they didn't know how much information they should have.'*

4.100 The Trust subsequently gained level 2 in 2012. The review team saw some of the best conducted audits in 2013–2014, with the Transfer of Women Audit being noted as an example of good practice in its structure and findings.

4.101 During 2013/14 the Trust was preparing for Level 3 assessment. The Trust scored a remarkable 48/50 of the required criteria. NHS Resolution (NHSR) stated⁸⁰ *'the audit reports were in general of a high quality, with readily identifiable measurable standards'* and *'Particularly impressive was the spread of actions that had been implemented as a result of the audit findings...It was clear to the assessors that each deficit identified had been carefully considered and time and effort had been put into drilling down to the root causes and applying meaningful measures to rectify the issues'*. However, there is a distinct disparity

⁸⁰ NHS Resolution, NHS Litigation Authority. *NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust, Level 3, p23 (March 2014)*

between those observations of NHR and the findings of the review team as in subsequent years the audit reports did not lead to sustainable safety improvements in maternity services at the Trust.

- 4.102** In 2017 NHS Resolution changed the CNST assessment to become an incentive towards improving safety. Maternity services provided self-assessments which were signed off at Board level on 10 safety actions which it was thought, if achieved, would demonstrate that a Trust was providing safer maternity care⁸¹. By achieving all 10 safety actions Trusts would recover the elements of their contribution to the CNST maternity incentive fund and also receive a share of any unallocated funds.
- 4.103** The Trust received its rebate in 2018, but after a CQC inspection report in November 2018 rated the maternity services as inadequate⁸² the Trust was obliged to return the money it had received. The review team has heard from a member of staff that it was obvious the Trust would not achieve the CNST standard. This is evidenced by the fact that although the Trust declared in 2019 a 90% or more compliance with the multidisciplinary training target in 2018 and 2019 the maternity clinical governance meeting minutes on 25 February 2019 records that there was discussion of the risk that the Trust would not achieve this target.
- 4.104** In August 2019 the Training Figures document states that the *‘maternity incentive scheme training requirements were achieved’*. However the review team has heard evidence from a member of staff that actions were signed off as *‘actions met’* without appropriate evidence being either shared with, or requested by, the executive team and Board.
- 4.105** A member of staff said to the review team: *‘...I have thought a great deal since my interview and how things will not change unless we are prepared to push aside feelings of dismay, anxiety and fear and unless we are prepared to act by the very principles we are expecting from others.’* The staff member stated to the review team that *‘X advised me when I was undertaking a review of CNST year 2 submission to “be careful what you find” as it will cause “reputational damage” to the Trust’*.
- 4.106** The review team has identified multiple and repeated failings in maternity governance throughout the timeframe of this review, spanning poor quality incident investigations, poor complaints handling, concerns with how the Trust implemented statutory supervision of midwifery supervisors and concerns with implementation of the systems for guideline development and clinical audit. The review team feel that these serious failings led to unnecessary harm occurring to mothers and babies over a prolonged time period.

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 4.107** Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.
- 4.108** The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.
- 4.109** All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.
- 4.110** The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

81 NHS Resolution. The maternity incentive scheme year 2 results. Published 13th February 2020. <https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%20of%20any%20unallocated%20monies>.

82 Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018) <https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust>

- 4.111** Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.
- 4.112** All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.
- 4.113** All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months
- 4.114** The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.
- 4.115** Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 4.116** The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.
- 4.117** All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.
- 4.118** The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 4.119** There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.
- 4.120** The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 4.121** Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

4.123 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.124 There must be midwifery and obstetric co-leads for audits.

4.125 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

4.128 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.129 There must be midwifery and obstetric co-leads for developing guidelines.

4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.131 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

4.132 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment⁸³ Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

4.133 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

The NHS Patient Safety Incident Response Framework (PSIRF)

4.134 As has been clearly explained within this chapter, there have been many failings in how maternity incidents were investigated in-line with the national frameworks at the time, namely the 2010 National Framework for reporting and learning from serious incidents requiring investigation⁸⁴ and the 2013 and 2015 Serious Incident Frameworks⁸⁵. It is also widely accepted that prior to this review, multiple reports, including maternity specific reports, have already highlighted significant shortcomings in the way patient safety incidents are investigated and learned from⁸⁶.

4.135 To improve this situation, NHS England published the 2019 NHS Patient Safety Strategy⁸⁷ and will be implementing the Patient Safety Incident Response Framework (PSIRF)⁸⁸ which is due for gradual implementation across all organisations from spring 2022. Taking into account that at the time of publishing this report there will be more than 20 organisations working within the PSIRF framework⁸⁹ who will continue their work after this report is published, the review team has discussed the PSIRF methodology with NHS England. These discussions have helped ensure that the approaches and principles within the PSIRF are aligned with those of this maternity review.

4.136 The PSIRF differs from the current SI framework, which it will replace, in a number of ways and the review team support the fact that it will have a broader scope, moving away from ‘hard-to-define thresholds for serious incident investigations’ and that it is committed to engaging and supporting patients, families, carers and staff in accordance with a just culture. The PSIRF Introductory framework, published in March 2020, identifies the process currently being used by early adopter sites and has been published ‘so that all parts of the NHS, patients, families and other stakeholders can engage with the proposals and help [NHSE] learn how we best ensure our aim is met’.

4.137 The review team has engaged in dialogue with NHS England based on the findings of this review to receive assurances that the PSIRF works effectively for maternity services. The following issues are of key importance:

PSIRF- Resources and expertise:

4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams:

- Maternity governance lead (who is a midwife registered with the NMC)
- Consultant obstetrician governance lead (Minimum 2 PAs⁹⁰)
- Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills).
- Maternity clinical incident leads
- Audit midwife - a lead midwife for audit and effectiveness

84 Ibid n4

85 Ibid n2

86 Royal College of Obstetrics and Gynaecologists. Each Baby Counts: key messages from 2015 (2016) <https://www.rcog.org.uk/globalassets/documents/guidelines/research-audit/rcog-each-baby-counts-report.pdf>

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016) <https://www.ombudsman.org.uk/publications/learning-mistakes-0>

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015) <https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has>

House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS ever learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England.* (2017) <https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf>

87 NHS England website. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

88 NHS England. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

89 NHS England. Introductory Patient Safety Incident Response Framework. (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

90 A PA or ‘programmed activity’ is the unit of currency in a consultant contract, each PA broadly equalling 4 hours – see https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

- Practice development midwife
- Clinical educators, to include leading preceptorship programme
- Appropriate governance facilitator and administrative support within the maternity department.

4.139 The review team is assured that these are key team members who will need to understand PSIRF principles and should be involved in planning preparations locally for implementation of PSIRF.

PSIRF and Training:

4.140 The review team is assured that appropriate training in patient safety incident investigations, and safety science more widely, will be a core feature of the PSIRF and that NHSE&I will set minimum levels of training required for investigation leads.

4.141 The review team strongly supports the notion that training must be available prior to PSIRF implementation and are assured that this will be set out within an investigation training framework which will include a straightforward mechanism for providers to commission the training that their staff need.

4.142 The review team is assured that all relevant tools and templates will be available prior to rollout and should further investigation skills training become necessary over time, the minimum training standards requirement will be adapted as appropriate.

PSIRF- What to investigate and ensuring effective oversight

4.143 Maternity and neonatal incidents which meet the Each Baby Counts and maternal deaths criteria will be referred to HSIB for a HSIB-led PSII (or new statutory body). Organisations will also be required to continue to report to NHSR Early Notification Scheme, RCOG EBC project and MBRRACE-UK as well as the PMRT being used for all stillbirths and neonatal deaths. The review team supports this approach of maintaining set criteria for what must be investigated externally.

4.144 The review team also supports the move away from subjective and hard to define thresholds for SI investigations and towards a proactive approach to safety and learning investigations, which can be based on findings from more than one similar completed incident investigation.

4.145 The review team raised concerns that the PSIRF focuses on trusts determining locally what to investigate and although well intentioned to promote a culture of learning, felt this could lead to similar problems as found at Shrewsbury and Telford Hospital NHS Trust, where incidents were downgraded and not appropriately investigated. The review team has been assured that there will be appropriate oversight built into the PSIRF framework with organisations expected to conduct a gap analysis to assess this, whilst also being assured that a training specification for oversight training will be in place before roll out begins. It is the expectation of NHSE&I that the relevant individuals in oversight roles will have received the appropriate training prior to organisations transitioning to PSIRF.

PSIRF and linking complaints to investigations to aid learning

4.146 The review team has been informed that although this is not part of the PSIRF, providers will be encouraged to bring patient safety and complaints teams together as part of the PSIRF implementation and encourage a collaborative and coordinated process. As stated in the IEAs underpinning this final report all trusts must ensure the maternity complaints process is incorporated within the maternity governance team structure responsible for incident investigations to ensure that complaints are not completed and responded to in isolation. The review team states that **NHSE&I must undertake work to provide those dealing with complaints appropriate training in effective complaints handling.**

PSIRF and reducing variation in investigations

4.147 The review team support the notion of a standardised investigation template and are assured that the patient safety incident investigation (PSII) template has been built on the principles developed by HSIB and that the template will be available prior to PSIRF implementation.

Patient and family involvement in investigations

4.148 The review team has been assured that the active involvement of women and families in investigations is fundamental to the PSIRF and that NHSE&I are currently working with HSIB and a group of independent stakeholders (including academics, patients and patient advocates) to develop an involvement guide that will ensure these requirements are covered in detail.

Chapter 5

Clinical leadership

Introduction

- 5.1** Safe, high-quality maternity care across England is not an ambitious or unrealistic goal and should be the minimum expectation for all women, their families and their babies. Effective clinical engagement and leadership is critical to improving quality, safety and patient outcomes within the NHS⁹¹. Frontline teams do not operate⁹² in a vacuum; leadership is the key determinant of the organisational culture in which frontline teams operate. ‘When things go well, it is down to good leadership and when they don’t, who takes responsibility? Does it rest with the ‘senior’ midwife, the trust’s chief executive, the board or the midwife delivering the care?’⁹³
- 5.2** Historically, strategic and operational leadership roles within maternity services were held by the obstetric clinical lead, the clinical director and the director of midwifery⁹⁴. These roles have overarching responsibility for the daily operational delivery and strategic management of maternity services locally and are accountable to the trust board for quality, performance, governance and professional leadership. This responsibility includes making positive changes in the workplace where necessary to shape a fair and positive environment, and encouraging a culture which supports improved clinical outcomes for women and their families. The review team has identified that these responsibilities were not always met within maternity services at Shrewsbury and Telford Hospital (SaTH) NHS Trust.
- 5.3** During a ‘Staff Voices’ interview with the review team in late 2021 a member of staff reported how the Trust’s board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services.
- 5.4** The staff member told the review team: *‘I don’t think that actually the Board knew what was needed in maternity services. I was giving them information that they’d never had before’*.
- 5.5** The primary influence of clinical leadership is through the expression of clinical expertise, with direct involvement in patient care. A recent RCOG publication⁹⁵ (2021) reiterated how the role of the consultant obstetrician is that of the clinical expert, one who influences both clinical decision-making and standards of clinical practice thereby reducing variation in patient care and optimising clinical outcomes in maternity settings by being physically present and visible⁹⁶. The absence of such clinical leadership has been identified by the review team as a contributory factor in the failure of maternity services at the Trust to provide high quality and safe maternity care to women and their families, and is an overarching theme in this report. This has been widely reported in many national maternity reports over many years⁹⁷. These national maternity reports include those by the Department of Health, Royal Colleges and CEMACH.

91 Joseph & Huber 2015, <https://pubmed.ncbi.nlm.nih.gov/29355179/> 2015

92 NHS England: *National Maternity Review: Better Births: Improving Outcomes of maternity services in England* (2016) p72: <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

93 Royal College of Midwives (RCM) (2012). Leadership - what’s that got to do with me? Midwives Magazine Issue 2 2012 [online]. Available at: <https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/> [Accessed 24th November 2021].

94 Royal College of Obstetricians and Gynaecologists (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. Available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf> [Accessed 01 December 2021].

95 Royal College of Obstetricians and Gynaecologists (2021) *Workplace Behaviour Toolkit*. Available at: <https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/> [Accessed 01 December 2021].

96 Ibid n4 RCOG (2007 and 2021)

97 Department of Health *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996*. (1998). RCOG, 2004, CEMACH, 2007, Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]. Knight et al, 2016 and NHS, 2019.

Review of independent reports

- 5.6** It is acknowledged that the assessment of maternity services has continually evolved over the 20-year span of this independent review, and that different standards and priorities have been expected of maternity services at different times. Key national reports continued to highlight poor leadership as the reason that maternity services were failing women and hampering continued development of the professions⁹⁸. In assessing the quality of leadership within maternity services at the Trust, the review team has considered the most recent external reports reviewing maternity services at the Trust and whether the leadership team were responsive in making effective changes following the recommendations made in those reports.
- 5.7** A review of maternity services at the Trust was undertaken by the two local clinical commissioning groups⁹⁹ (CCG's) in 2013. This was in response to concerns regarding the increased number of serious incidents (SIs) at the Trust, and the safety of the 'hub and spoke' model¹⁰⁰ of maternity care. The findings from the CCG's were favourable, with the overall assessment noting that maternity services provision at SaTH was a safe and good quality service. The Trust board reviewed this report noting: *'There had been concern about some families' experiences but this was in the context of generally good services'*.¹⁰¹
- 5.8** In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, the highest standard under the Clinical Negligence Scheme for Trusts (CNST). The Trust was benchmarked against the requirement to demonstrate good leadership, with an open and supportive culture, providing a service that can fulfil the needs and expectations of women and their families. A maximum score of 10 out of 10 was awarded in 2014, suggesting there were no concerns regarding leadership and management at that time.
- 5.9** Following the successful submission of CNST data, a staff member explained to the review team that they had voiced concerns regarding the accuracy of the data submitted, suggesting there was no evidence to support that the service was ever compliant in meeting the criteria. The staff member told the review team:
- 5.10** *'We were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it.'*
- 5.11** In 2014, a Deanery review of medical training was undertaken. Clinical governance was identified as an area for improvement. The Deanery report stated:
- 5.12** *'The Trust must integrate clinical governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from clinical incidents and that any learning points are clearly disseminated to trainees appropriately.'*
- 5.13** An independent review in 2015 by Debbie Graham which considered the case of a family who had suffered the death of their baby daughter criticised the Trust's response to the family. However the report concluded *'...the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services and the strengthening of the Trust's clinical governance and complaints processes. In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'*. Graham (2015) does not state the basis upon which this conclusion was reached. When considering a number of cases after 2015 and through until 2019 the review team has not seen evidence that this belief came to fruition.
- 5.14** For instance, in 2018 a family in conversation with the review's Chair described the approach of the Trust at listening to families following critical incidents as *'tinkering at the edges'*. In reviewing the SI report into the

98 RCM 2012

99 See glossary

100 See glossary

101 2014 Trust Board papers supplied to the review team

death of their baby the family (who had significant professional experience in risk management and root cause analysis) said of the Trust's SI report: *'It's not getting down [to the detail]...it says here root cause analysis, they're fine words but the words don't mean anything because they don't understand...and, again with all due respect to them, as I say, from my world I live, eat, sleep and breathe root cause analysis...'*

- 5.15** The 2017 Ovington report compiled internally within the Trust stated how *'safety in maternity is protected by the efforts of the staff and supported by leaders'*. It concluded that governance arrangements should be more transparent and open. It also highlighted how learning from incidents and investigations should be improved. No action plan to meet these recommendations in Ovington (2017) has been provided to the review team at the time of writing this report in spring 2022.
- 5.16** In 2017, there was an invited review of the maternity services by the RCOG. This review found that while there was evidence of strong leadership and good working relationships between the various staff groups, concerns relating to workforce numbers and insufficient numbers of consultants providing obstetric cover were identified. There was evidence of middle grade rotas not always filled by the Deanery, resulting in maternity services relying on overseas trainees and locums. In accordance with other previous reviews, the RCOG report identified a lack of resources and inadequate incident reporting, risk management and governance systems. This report was subsequently not presented to the Trust Board until May 2018. The Trust's 2018 Care Quality Commission report concluded within the 'Well Led' domain that leadership required improvement and also raised governance concerns stating:
- 5.17** *'Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.'*
- 5.18** *'We found areas of concern that were raised in our last inspection in December 2016, for example service-wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning.'*

Obstetric services, workforce and clinical leadership

- 5.19** It is clear from the evidence provided by the Trust to the review team that prior to 2012 the obstetric medical staffing at both consultant and junior doctor level at the Trust was inadequate for the size of the unit at around 5,000 births per year. The number of consultants, and the number of women that they were responsible for meant that timely reviews of women on the labour ward, or in other inpatient areas would have been very difficult, if not impossible, to provide at times. Therefore, midwives wishing to escalate clinical concerns would have been regularly working in an environment in which it would have been difficult to obtain a timely senior obstetric review.
- 5.20** The poor provision of medical staffing resulted or certainly contributed to delays in the instigation of appropriate medical management. This created an environment in which it was accepted within maternity services at the Trust that it was normal practice to wait for an obstetric review, thus leading to clinical risks, which ultimately contributed to poor maternity outcomes. The review team has heard from one member of the medical staff who confirmed that for many years the registrar had to cover both gynaecology and obstetrics clinical areas.
- 5.21** This staff contributor told the review team:
- 'One of the problems...in this sort of context that I've been describing, was a very, very overburdened and thinly stretched middle tier in the obstetric team. I was, frankly, flabbergasted at what I was being told, you know, doctors were being asked to cover services that, it was manifestly clear, you couldn't possibly do that on your own.'*

5.22 There is evidence within business plans to the Board (provided by the Trust to the review team) that the Trust was working to increase the number of doctors at both middle grade and consultant level. The number of hours of consultant presence on the labour ward subsequently increased from 40 hours in 2011 to 76 hours in 2013. These plans included evidence that solutions were being sought to support this, including better provision of elective caesarean section lists, for example. In spite of these efforts, in 2016 the Trust had difficulty in being able to appoint the required number of middle grade doctors, resulting in the staffing levels being below the recommended standard for both consultant and middle grade staff. At the time of writing this report in early 2022 there has been further consultant expansion at the Trust supporting an increase in resident consultant hours on the labour ward.

Neonatal services, workforce and leadership

5.23 It is clear from the majority of medical records reviewed that involvement of the consultant neonatologists in clinical decision-making, in the provision of neonatal care and in communication with parents and other family members was of a high quality. The medical records suggest that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They often wrote discharge summaries themselves and were also usually involved in the long-term follow-up of their patients, providing continuity of care for their parents. For some of the clinical cases reviewed, the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This may compromise the availability of skilled care, and, given the size of the neonatal service at the Trust, it would be important to have separate consultant cover for the neonatal and general paediatrics services. This has now been achieved.

5.24 Advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick infants on the NNU and of babies on the postnatal ward. As far as can be judged it appeared that their practice was appropriate and likely to have made an important contribution to neonatal practice within the Trust. For some of the cases reviewed it was clear that, out-of-hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care in both units. The employment of ANNPs has undoubtedly provided some mitigation of this but it was not clear whether the service was adequately covered to this level at all times.

5.25 The review found some evidence of senior neonatal leadership within maternity and perinatal governance processes, and on occasions in raising concerns about individual cases in the perinatal service. We heard evidence of attendance by a neonatologist at Perinatal Mortality and Morbidity (M&M) meetings. In interviews with the review team, we were told of neonatologists attending joint mortality meetings from the early 2000's. Neonatologists contributed data to the national neonatal audit project, which collects important neonatal outcomes. Neonatologists and obstetricians told the review team that they usually met bereaved parents independently, but the review team found some evidence of correspondence between them, including selected cases where a neonatologist wrote to the consultant obstetrician requesting a case review after an adverse outcome.

5.26 Some of the neonatologists told the review team that they raised concerns in the early 2000s about a perceived higher than expected incidence of hypoxic ischaemic encephalopathy (HIE). They also raised concerns about lack of recognition of IUGR and of trauma secondary to instrumental delivery. At interview members of the neonatal team told the review team that these concerns were raised with clinical colleagues and the divisional management team, however the outcome remains unclear.

5.27 A staff member told the review team: *'We have been always very closely involved because we have regular monthly perinatal mortality reviews, meetings every third Wednesday, third Friday of every month and we would actually attend all the late fetal losses, stillbirths, everything, it's not just neonates...so we would robustly challenge them...and those were very well attended meetings, including midwives, obstetric, neonatal teams, perinatal pathologist and geneticist etc.'*

5.29 They continued:

'I think the consistent feature from the neonatal side for us for many stillbirths etc. was the lack of recognition for fetal growth restriction and I think that's another part we repeatedly brought out. I think that led to the introduction of the customised growth centiles as well as the GROW programme.'

Midwifery roles, workforce and leadership

5.30 Frontline midwifery leadership incorporates a myriad of midwifery roles across maternity services including midwives¹⁰², matrons, senior midwifery managers, labour ward coordinators, community clinical leads and specialist midwives. It is notable that, in spite of the RCOG safety recommendations from 2007 on standardising an approach to clinical leadership roles, the Trust did not have any consultant midwife posts for all of the time period considered for this review. The Trust has informed the review team that their first consultant midwife is due to take up employment in early 2022. The national recommendation remains that midwifery-led units (MLU) have one full-time consultant midwife post and obstetric-led units have one additional full-time consultant midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care¹⁰³.

5.31 The review found no evidence that there was a consideration of developing the role of the consultant midwife, during the time period under consideration. In conjunction with the consultant obstetrician, the consultant midwife could have provided the balance of professional and effective clinical leadership to ensure the improvement of both quality and safety across maternity services.

The labour ward co-ordinator

5.32 The role of the labour ward coordinator is multi-faceted and central to ensuring the safety of pregnant and labouring women and babies. It encompasses the role of midwifery clinical expert; to inform and challenge practice, and to escalate clinical concerns whilst prioritising and managing the complex demands of contemporary midwifery and maternity care in the high-risk clinical setting of the labour ward.

5.33 Maintaining oversight and knowledge of the management of all clinical cases, the coordinator acts as a source of clinical support for junior midwifery and obstetric staff and a professional conduit across multidisciplinary teams thereby ensuring appropriate use of resources to enable the effective and safe provision of care. While there were some examples of good midwifery leadership seen, staff within maternity services at the Trust shared with the review team their own lived experiences of when this was not always the case.

5.34 A staff member told the review team:

'I was, I think, three months into my labour ward rotation and I kept pressing the call bell saying she's bleeding a lot quicker than I'd like, you know, I think we're up to 500mls now, and the coordinator kept coming in saying I'm on [the] ward round, it'll have to wait...I felt like I'd let that woman down because my skills weren't good enough, that's how I was made to feel when, actually, that was a situation I should have had help in...if she was bleeding that much I should have had help.'

5.35 Each labour ward must have a team of experienced senior midwives rostered as labour ward coordinators, who have supernumerary status; this is defined as having no caseload of their own during a shift and is fundamental to the effective running of the labour ward, which is a high risk clinical area. This is also a recognised requirement in the CNST safety standards¹⁰⁴.

102 Ibid n4 RCOG (2007) & Kings Fund, 2008 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

103 Ibid n4 RCOG (2007) RCM, RCA, RCPCH, 2007 and Kings Fund, 2008

104 NHSR, 2020

- 5.36** The review team found that the Trust allocated one band 7 labour ward coordinator per shift who had overall responsibility for coordinating the care throughout a clinical shift, and for the allocation of staff (Labour Ward Staffing v2, 2015). Out-of-hours in the absence of the management team, the coordinator was also responsible for overseeing the clinical activity across the whole of maternity services, including the distant MLUs, and community activity across Shropshire, with escalation to the on-call manager at home, according to the Future Model of Care, 2016 document, shared with the review team by the Trust.
- 5.37** Reports by the CCG in 2013 and the RCOG in 2018 found that due to midwifery staffing shortfalls, the coordinator was supernumerary for only 50% of the time (RCOG, 2018). This mirrored the findings of the review team who identified that, in many instances, the coordinator had their own women for whom they were responsible for providing clinical care and were therefore not able to fulfil their required role, in particular the provision of support for junior midwives and doctors. Nor were they able in these circumstances to achieve and maintain the necessary 'birds eye' view of the labour ward.
- 5.38** A staff member told the review team:
- 5.39** *'The shift leader was constantly having a patient and from the time that I was working on their labour ward, ...you sometimes couldn't get hold of the shift leader because she was in looking after a woman.'*
- 5.40** Another staff member told us:
- 5.41** *'I was frightened about putting in...being put into an area that I just, just wasn't my area of expertise and not having support. But it wasn't just lack of support, it was actually, I was just frightened of going past a labour ward; I didn't want to do it, it wasn't my area of expertise and at the time if you voiced those concerns that was probably going to mean you were going to go there full time...'*

Midwifery matron

- 5.42** The role of the midwifery matron is deemed to be the cornerstone for improving the quality of clinical care through visible, compassionate and inclusive leadership and management. The role has evolved considerably since the publication of The Matron's 10 Key Responsibilities in 2003, and the Matron's Charter in 2004. However, the fundamental aspects remain the same: this includes promoting professionalism in the workplace, ensuring good patient safety and service-user experience, control of infection responsibilities, and monitoring the cleanliness of the clinical environment. It is widely acknowledged that midwifery matron roles also encompass workforce management, budgetary responsibilities and effective resourcing of equipment and maintenance of estates. The recommended minimum requirement for presence is one full-time equivalent, with additional on call and out-of-hours cover, ensuring 24-hour managerial cover¹⁰⁵.
- 5.43** The review has identified that as late as 2015 the Trust did not meet these recommendations, as the labour ward manager was found to be a hybrid of roles consisting of two shifts working as a labour ward coordinator and three shifts as a matron according to Labour Ward Staffing v2, 2015. In addition, the lead midwife/clinical risk co-ordinator role for consultant inpatient service also had responsibility for leading midwifery care and management on the labour ward. This combination of roles would have resulted in a workload that was not manageable and would have led to key issues being overlooked.

Statutory supervision of midwifery

- 5.44** Prior to its removal as a statutory function in March 2017, the West Midlands Local Supervisory Authority (WMLSA) had overarching responsibility for statutory supervision of midwifery at the Trust. While there were many professional principles for midwifery supervision, in terms of clinical leadership its purpose was to maintain and improve quality, and to protect women and babies by actively promoting a safe standard of

¹⁰⁵ bid n4 RCOG (2007) and RCM, RCA, RCPCH, 2007

midwifery practice, which contributed to the protection of the public. The role of a supervisor of midwives (SoM), who was appointed by the WMLSA was intended to play an important part in providing expert, professional leadership for midwifery at both local and regional level¹⁰⁶.

- 5.45** A SoM timeline produced by the review team consisting of information extracted from documentation provided to the review including WMLSA audit reports, identified a high level of confidence in the supervisors of midwives at both Trust executive and clinical levels. The supervisors were said to be ‘cohesive’, had a ‘very good team dynamic’, and were said to be actively involved in staff training, which included participating and leading in obstetric emergency drills.
- 5.46** In 2012, a WMLSA visit reviewed the Trust’s SoMs’ investigation process, which concluded that the team would benefit from further support and guidance around report writing. This training was said to be provided in a supplementary visit to the Trust, however there is no evidence in the documentation provided to the review team that the WMLSA ever returned to the Trust to ensure improvement had occurred.
- 5.47** Until 2017, the caseload numbers of SoMs at the Trust were repeatedly identified as being above the then recommended ratio of one SoM to 15 midwives. To address these concerns, four of the current supervisors held a double caseload (i.e. 30 midwives) and received double financial remuneration and 15 hours of time in which to manage the additional workload. Similarly, appropriately qualified staff who had retired or previously left the Trust were recruited on a bank basis to provide further support to the supervisory team. There is also evidence which suggests the SoMs were supporting the CNST team; while the context of this is unclear, this may have given rise to a perceived conflict of interest as documented in the Midwifery Regulation in the United Kingdom report (Kings Fund 2015).¹⁰⁷
- 5.48** In response to a complaint from a family, an external review was commissioned by the Trust to review an original investigation, which had been conducted by the Trust and signed off by the Local Supervisory Authority Midwifery Officer (or LSAMO) in 2009. The external review concluded that the quality of the supervisory investigation was poor, noting that the principles of root cause analysis were not applied, resulting in key events not being investigated. A repeat investigation by two midwives independent of the Trust made a number of recommendations relating to midwives involved in the clinical care; these included consideration of supervised practice, development support and referral to the Nursing and Midwifery Council (NMC). Furthermore, a significant number of systems issues were identified, that had not been identified in the original investigation including the escalation of staffing issues during times of increased activity/emergency. The absence of a systematic root cause analysis and the lack of support available to the investigating SoM, in particular when interviewing midwives, was also highlighted.
- 5.49** An independent review was instigated of WMLSA governance and assurance arrangements to determine whether the management and oversight of midwifery supervision was adequate. The review, which was carried out by NICHE patient safety¹⁰⁸ identified a lack of rigour around oversight of the investigative process, best practice was not followed and the quality of reports was not sufficient to prevent reoccurrences. With the purpose of statutory supervision of midwifery being to maintain and improve quality, and to protect women and babies by promoting a safe standard of midwifery practice, these were lost opportunities to achieve these objectives over a long period of time.
- 5.50** In late 2016, the WMLSA instructed the Trust to review a number of its cases internally. These appear to be some of the cases of the original 23 families, from 2000 onwards which make up the cohort that was highlighted to the Secretary of State and began the process of this review. This task appears to have been undertaken by one SoM at the Trust. The Trust found that none of the nine case investigations, which have been made available to the review required further investigation, thereby missing valuable opportunities for wider organisational learning and further improvement to processes. None of the families were contacted to be involved. Despite the complexity of some of the cases, this was a single professional review, failing

¹⁰⁶ NMC, 2015

¹⁰⁷ <https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom>

¹⁰⁸ NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

to involve other key colleagues who could have potentially provided significant assistance; for example obstetric, neonatal or anaesthesia colleagues. The review team believes that the WMLSA's instruction to undertake a further internal supervisory review of the investigations is questionable as we have not been able to evidence that assurance had been sought arising from the LSA's initial concerns regarding the quality of supervisory investigations, originally identified several years before.

Concerns regarding governance and concerns from families

- 5.51** Independent reports into maternity services at the Trust, including Graham (2015), identified governance issues, concerns from families and failure to learn from incidents and investigations. There is often a clear disconnect between the issues raised by the families and the findings in the subsequent investigations report. It is also clear that the maternity department, the Trust and the CCG were aware of these issues raised by families. The governance chapter of this report reviews this in more detail, but the evidence available and seen by the review team is that whilst the various reports made recommendations these did not translate into consistent improvements. As indicated in the first Ockenden Report (page 15) there were examples in 2016 and 2017 of families' dissatisfaction with investigation reports. Further examples were found in multiple interviews with families by the review chair throughout 2018 and 2019.
- 5.52** The RCOG undertook an invited review of maternity services at the Trust during July 2017, which was commissioned by the Trust's Medical Director to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services.
- 5.53** The review team was provided with documentation updating on the progress of actions against the recommendations of the RCOG review; including an addendum to the report received during June 2018. This addendum had been prepared following a visit to the RCOG in London by a Trust team. The RCOG had not returned to the Trust to assess the accuracy of the evidence submitted. Quotes from the 'addendum' include the following: *'Review had been undertaken of the manager on-call rota and the rota is now "working better". The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.'*

Team working, culture and civility

- 5.54** The complexities and challenges of team working are not exclusive to healthcare settings, however unlike in some specialities, the effect of poor relationships and collaboration can have catastrophic long-term consequences for individuals, teams and organisations¹⁰⁹.
- 5.55** National reports into failing maternity services over a number of years have highlighted conflicting agendas and poor teamwork as significant contributory factors towards adverse maternal and neonatal outcomes¹¹⁰. Whilst there was some evidence of multidisciplinary team working at the Trust, there was often a notable lack of leadership, accountability and situational awareness.
- 5.56** *'In 2015 a woman in labour with a twin pregnancy at 36 weeks gestation did not receive an obstetric review on arrival to the labour ward. The neonatal unit were not informed of the admission. No progress in cervical dilatation was escalated to the labour ward coordinator, however there was no change to the management plan or escalation for obstetric review.'*
- 5.57** *'At full dilatation, an obstetrician attempted to perform a ventouse delivery of twin two. The ventouse cup came off after four pulls. Keilland's forceps were subsequently applied and five pulls were attempted. Neville Barnes forceps were then applied and the baby was delivered in poor condition with one further pull (ten with an instrument in total). The baby had moderate to severe hypoxic ischaemic encephalopathy.'* (2015)

109 Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021) Available at: <https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf> [Accessed 01 December 2021].

110 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021].

5.58 Due to the requirement for 24/7 cover of a significant proportion of service provision, teams within maternity units increasingly involve various practitioners of different clinical expertise¹¹¹. Teams are also rarely constant, resulting in a number of individuals practising their specific roles within interchangeable groups. As such, training should enable maternity practitioners to function effectively in whichever team or environment they find themselves working in.

5.59 Furthermore, the labour ward can be a particularly challenging environment for even the most cohesive teams or groups due to its acute, unpredictable and specialist nature.

5.60 A staff contributor told the review team in late 2021:

'The fear was being pulled to somewhere else in the middle of a nightshift or being on-call for homebirths or midwife-led units. Being on-call perhaps having worked the day before, working the next day and then being called in to the labour ward to work a whole night shift because it was lacking in staff and that was very fearful...'

5.61 *'Yes, I certainly wasn't equipped because I was a community midwife...those were my areas of expertise, and I was expected to go in and act as a manager on labour ward and I was terrified. I was terrified and much stressed, and very emotional all the time about it.'*

5.62 Throughout the years, there have been multiple reports and research detailing the intricacies of team working and its direct relationship with safety outcomes and patient experience¹¹². Additionally, there have been recommendations from leading organisations over a long period of time with the aim to improve safety through the standardisation of minimum multidisciplinary staffing requirements¹¹³. Despite this, the overall team working at the Trust remained suboptimal, which contributed towards many preventable incidents and adverse outcomes.

5.63 A staff contributor told the review team in autumn 2021:

'Culture is a big thing because I feel there's a reluctance to change there. Yes, they do need to change because this has resulted in lots of families having a terrible event happen in their lives that shouldn't have happened and I'm a midwife, and I know that things don't always go to plan. I don't believe that anybody has set out to go to work to cause harm or anything like that, but I think that probably some processes, some attitudes have definitely been a reason as to why things have not gone to plan.'

5.64 Another staff member said the following to the review team in early 2022:

'If I could say anything to the families it would be that there were people who tried to make changes, we tried to escalate our concerns and be heard but every process we used was set up not to acknowledge our voices or the problems we were highlighting. We were ignored and made out to be the problem but ultimately we failed to make ourselves heard...'

5.65 Many different factors affect the dynamics of team working which are well illustrated within various national programmes including Each Baby Counts. The following feature as contributory factors in adverse incidents:

- Individual human factors (present within 58 per cent of cases)
- Team communication issues (present within 53 per cent of cases)
- Lack of team leadership (present within 24 per cent of cases)
- Poor intra- or inter-professional communication (present within 43 per cent of cases).¹¹⁴

111 Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

112 Ibid n20 and Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. (2019) *How to be a very safe maternity unit: An ethnographic study*. Available at: <https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/> (Accessed 01 December 2021).

113 National Institute for Health and Care Excellence *Safe midwifery staffing for maternity settings*. (2015) Available at: <https://www.nice.org.uk/guidance/ng4> [Accessed 01 December 2021] and Ibid n4

114 Royal College of Obstetricians and Gynaecologists (2020) Each Baby Counts. 2020 Final Progress Report.

5.66 Similarly, Civility Saves Lives (2017)¹¹⁵ articulates how negative behaviour such as rudeness or bullying results in a significant decrease in a clinician's performance and/or cognitive ability. Furthermore, incivility is recognised to not only affect an individual recipient, but also bystanders, patients/relatives and the wider team within healthcare settings¹¹⁶.

5.67 A staff member told the review team that:

'There is culture of bullying on labour ward 24. Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it. I was told that I was a band 6 midwife so I should have no problems. I also got told by one shift co-ordinator that I was qualified longer than her and why was I asking her to support me with what was a difficult delivery?'

5.68 Whilst the identification of human factors will always remain integral to patient safety, there is more recent emphasis on addressing and preventing such issues from occurring in the first instance. Consequently, there is an increasing recognition of the importance and value of workplace culture and civility.

5.69 Workplace culture can be defined as 'shared ways of thinking, feeling and behaving within an organisation'¹¹⁷. The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).

5.70 It is imperative to ensure the 'culture' within all healthcare settings is one that promotes openness, transparency and the psychological safety to escalate concerns. Yet the review team found evidence of disempowerment, with staff encouraged not to complain or raise awareness of poor practice within both personal and professional capacities.

5.71 A staff contributor told the review team that:

'You feel like you're penalised constantly in this organisation. I'm keeping my head down now. I have raised it before, I went to HR and it was almost as though I was causing trouble.'

5.72 Another staff member told the review team:

'Whilst reviewing the governance and assurance processes, I was approached by a consultant [obstetrician] who said be careful what you find.'

5.73 Reflecting on the harm caused to families a current staff member told the review team in early 2022:

'I am sorry and I know that sorry is not enough but by engaging with this review we hope that our voices will finally be acknowledged and that change will happen so that there are robust and independent places for clinicians to speak out that acknowledge what we are saying, what needs changing and act on this without fearing reprisals..'

5.74 Positive behaviour strategies have been designed to address negative cultures within healthcare, to improve the working environment for staff and so promote the delivery of safe and compassionate care for patients. Some of these strategies include the implementation of a Workplace Behaviour Toolkit (RCOG, 2021), Civility Toolkit (HEE, 2021) and the creation of national patient safety movements such as Civility Saves Lives (2017) and Learning from Excellence (2014).

5.75 Whilst it is of equal importance for all staff within maternity settings to demonstrate positive behaviours in their everyday practice, it is vital that leaders, such as the labour ward coordinator and senior obstetricians,

Available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf> [Accessed 01 December 2021].

115 Civility Saves Lives (2017) Civility Saves Lives. Available at: <https://www.civilitysaveslives.com/> [Accessed 01 December 2021].

116 Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

117 Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907.

are acutely aware of their own behaviour and how this influences other members of the wider team. Where negative workplace practices or behaviours are identified, leaders should ensure they take proactive steps to support individuals, address concerns and prevent the creation of a systemic negative culture similar to that described by staff at the Trust.

5.76 During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.

5.77 A staff member told the review team:

'At a study day in 2016/2017, following the Kirkup report, a senior manager made the comment "we (SaTH) are not a Morecambe Bay". I made the comment that we absolutely were a Morecambe Bay - a trust full of unhappy staff with ineffective poor leadership, looking to hide or ignore poor care and poor management. I have worked for [another NHS Trust] which learned from its mistakes and supported its staff for the past [number of] years.'

5.78 *'I didn't realise how bad things were in SaTH until I left. The bullying culture from top down breeds bullying. I used to be proud to work there, but that changed from 2006.'*

5.79 Another member of staff told the review team of events within maternity services in 2019:

5.80 *'SaTH was managed with a big...stick from behind, there was no forward thinking leadership. We had changes in policy imposed on us, we did not contribute to changes. We were bullied, everything was done under the guise of 'clinical need' or 'your contract says.' We had issues with pay being withheld, managers not happy to reconcile hours/wages. The on-call rotas and change lists were both used as bullying tools. [An] entire team of five experienced midwives left the Trust in less than 18 months...I tried to raise a concern and instead of being listened to I was referred straight to occupational health. It seemed that as I dared raise a concern I must obviously be mentally unwell (this was in 2019)...this whole conversation was held in public unbeknown to me. Other midwives sitting in the office were listening to the way the manager spoke to me. I was and am still absolutely appalled by that action. I resigned...There are a lot of, I would say, home grown midwives, there are cliques there and, you know, they are Band 6s, Band 7s, Band 8s and they are a little gang, and, yes, they will make your life hell.'*

5.81 They continued: *'It's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle ... you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work...'*

5.82 The staff interviews with the review team also highlighted that there was a lack of respect and role appreciation between the consultant unit staff and the community teams.

5.83 A staff member told the review team that *'There was a...bit of a feeling that because they were the consultant unit, they knew better than you, but actually, we're in the outlying units because we're experienced and we know what we're doing, but...we didn't feel like that respect was always there. Often our decisions were questioned as to, "Well, try this, try that", "Well no, actually, I'm sending her... [the mother in]" '*

5.84 They continued:

5.85 *'Actually, they need to know our role; they need to know what it's like half an hour, 45 minutes. ...Nearly an hour away from the consultant unit, and they forget that you have to think that far ahead because of what might happen. We don't have an emergency buzzer to have the whole team in, so we have to think ahead and I think they forget that.'*

Conclusion

- 5.86** External reviews of the maternity services at the Trust between 2013 and 2017 gave the overall message that this was a safe maternity service. This review is concerned that some of those messages gave false reassurance and as a consequence opportunities were lost to have improved maternity services at the Trust sooner. For example, there were a number of concerns arising from these reports regarding governance issues and concerns raised by families, however these issues did not appear to have been prioritised.
- 5.87** The workforce is a cause for concern, and there were missed opportunities to address the shortfalls in staffing. It is clear that there were insufficient numbers of consultant obstetricians and junior obstetric staff and that there was inadequate anaesthetic support to the maternity unit. It is clear that the midwifery staffing across the service was poor and resulted in the service constantly working in escalation. This impacted on staff confidence and morale, creating a culture of fear and anxiety. There is also evidence of a lack of role appreciation across the service, particularly with those providing maternity services in the community.
- 5.88** The review team found evidence from documents provided by the Trust (2013-2016) that the local leadership had identified and escalated workforce issues and business plans had been drawn up to increase consultant and middle grade staffing. In recent times there has been a significant expansion in consultant obstetrician staffing.
- 5.89** Overall, there is a picture of external, independent and internal reports not being critical of clinical leadership at the Trust. However, the review team is concerned that even where recommendations were made, there is no evidence of who was accountable for their implementation or who, within the context of leadership, was responsible for maintaining oversight of these. Because of this, there was no effective strategy for meaningful change within maternity services at the Trust which further perpetuated the cycle of harm to women and families accessing maternity services at the Trust over an extended period of time. Staff who are currently employed in maternity services at the Trust and who engaged with the maternity review team as recently as early 2022 told us of a fear of speaking out in maternity services that persist to the current time. This is of very significant concern to the review team and has been shared with the Trust in advance of publication of this report.

Chapter 6

Our findings following the review of family cases

- 6.1 A total of 1,862 cases were either reported by the Trust or self-referred to the review. After the closure date for referrals the database was reviewed and 47 duplications were identified and removed leaving 1,815 cases.
- 6.2 The review was intended to span the years 2000-2019. However, as discussed in previous chapters, some earlier and later cases were reviewed in line with the updated terms of reference. The earliest case reviewed occurred in 1973 and the latest in 2020.
- 6.3 After excluding cases for which hospital records were missing, or where consent for participation in the review was not given or could not be obtained, the **final number of families whose cases were reviewed was 1,486**. It is important to note that some families had more than one clinical incident reviewed, as some mothers had more than one pregnancy during the review period. **In total 1,592 clinical incidents were reviewed**. Table 1 outlines the number of families and clinical incidents throughout the review period.

Table 1: Time period of family cases included in this review

YEARS	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	1,486*	1,592

* Four families had clinical incidents that fell both within the 2000-2019 years and outside these years. Therefore there are 1,486 unique families in total.

- 6.4 In line with the terms of reference underpinning this review we reviewed all 1,592 clinical incidents and analysed two aspects. Firstly, we graded the care provided by the Trust as set out overleaf. Secondly, we reviewed all the maternity governance documentation provided to the review team and graded the quality and appropriateness of the incident investigation in line with national frameworks at the time.

Grading of care

- 6.5 All the clinical incidents were reviewed by members of the review team which comprised obstetricians, midwives, neonatologists, and other specialists where appropriate. The clinical care was graded using an established grading of care scoring system (Table 2) developed by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), which was similarly used in the Morecambe Bay investigation report by Dr Bill Kirkup, OBE. Further details on the findings and the Immediate and Essential Actions recommended by this review are described in the accompanying chapters.

Table 2: Grading of maternal and newborn care provided

GRADE	SUMMARY DESCRIPTION OF CARE	DETAILED DESCRIPTION OF CARE
0	Appropriate	Appropriate care in line with best practice at the time
1	Minor concerns	Care could have been improved, but different management would have made no difference to the outcome
2	Significant concerns	Suboptimal care in which different management might have made a difference to the outcome
3	Major concerns	Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome

6.6 Table 3 shows the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy / brain damage the investigation into mother and baby is considered as one family. **It is important to note that a mother or baby can be in more than one category and this includes the maternal morbidity category and the combined category.**

Table 3: Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

*Some mothers had more than one pregnancy where a clinical incident occurred during the period of the review (for example a stillbirth in one pregnancy followed by another incident in a subsequent category).

**Review of the care provided to the mother

***Review of the neonatal care provided to the baby after birth

Maternal deaths

6.7 There were 12 maternal deaths reviewed and in nine of the 12 cases (75 per cent) the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in chapter 10.

Stillbirth

- 6.8** 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in care which if managed appropriately might, or would have, resulted in a different outcome.

Hypoxic Ischaemic Encephalopathy (HIE)

- 6.9** HIE is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns however these were unlikely to influence the outcome observed.

Neonatal death

- 6.10** Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care which might or would have resulted in a different outcome.

Cerebral palsy

- 6.11** All of the families in this group self-reported to the review. The diagnosis of cerebral palsy was often made some years following their maternity episode. On reviewing the medical records, where it was found that the neonatologists at the Trust had recorded a diagnosis of HIE in the early neonatal period, a small proportion of families were subsequently transferred to the HIE incident category. From the remaining cases of cerebral palsy, more than 40 per cent were identified to have significant or major concerns in maternity care which might have resulted in a different outcome. The grading of neonatal care in most of the cases was either appropriate or with only minor concerns.

Maternal morbidity

- 6.12** Within this group were families who did not meet the incident categories identified in the NHS England and Improvement (NHSE&I) and Trust-led Open Book exercise conducted in the autumn of 2018 (maternal death, stillbirth, neonatal death and HIE). There were 614 women in this group, and they included women who experienced morbidity such as admission to intensive care, women who had had a caesarean hysterectomy, women who had severe sepsis or major haemorrhage or reported having experienced rare adverse outcomes such as eclampsia, amniotic fluid embolus or a cardiac arrest. Our reviewers identified significant and major concerns in the care provided to one in four women in this group. The care provided to the baby was considered appropriate in more than 90 per cent of records reviewed.

Combined category

- 6.13** This group included families who were outside the other categories. Some of these families self-reported. This category included medical termination of pregnancy, missed fetal abnormality, neonatal intraventricular haemorrhage, infant death and child death. There were 58 cases reviewed in this group. Most of these cases were graded as receiving appropriate care or care with only minor concerns.

Quality of investigation

- 6.14** We graded the quality and appropriateness of clinical incident investigations undertaken at the Trust throughout the time period of the review. Nationally, investigative processes have improved over time and this is described further in Chapter 4. Table 4 outlines the grading system used for the clinical incidents from 2011 onwards.

Table 4: Grading of investigations from 2011 onwards

GRADE	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with family at time of incident. Feedback to family once investigation concluded.
Poor	Any of the above missing (state which).	Very little family involvement, or feedback to family lacking after investigation.
None	Incident not investigated.	No family involvement.

6.15 The tables below show the results for stillbirths and neonatal deaths for the period 2011-2019. The maternal death investigations are discussed more fully in Chapter 10. Where there was no Trust investigation this is shown. In some cases the review team reported “unable to grade” which was usually due to incomplete documentation. Only where there was sufficient documentation for a review was a grading of appropriate or poor given.

Table 5: Stillbirths (2011-2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%	85	32.9%	40.0%	27.1%

6.16 In the period 2011-2019, 68 (40 per cent) of the 168 stillbirths reviewed did not have an investigation. Of those where an investigation occurred 36 per cent were found to be appropriate. Family involvement was graded as appropriate in 33 per cent of cases.

Table 6 Neonatal Deaths (2011 – 2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
77	44	54.5%	34.1%	11.4%	41	41.5%	31.7%	26.8%

- 6.17** In the period 2011-2019, 33 (43 per cent) of the 77 neonatal deaths reviewed did not have an investigation. Of those where an investigation occurred 55 per cent were considered to have been appropriately investigated. Family involvement was graded as appropriate in 42 per cent of cases.
- 6.18** In the hypoxic ischaemic encephalopathy group there were 12 cases reviewed for the period 2011-2019 and of these eight were investigated by the Trust. This group was considered too small to draw conclusions on the quality of the investigation.

OCKENDEN REPORT - FINAL

Section 3

Our findings of what happened to the families

- Chapter 7. Antenatal care
- Chapter 8. Intrapartum care
- Chapter 9. Postnatal care
- Chapter 10. Maternal deaths
- Chapter 11. Obstetric anaesthesia
- Chapter 12. Neonatal care

Chapter 7

Antenatal care

- 7.1** Safe and individualised antenatal care must be the foundation underpinning a woman's pregnancy and birth journey. From the point at which a woman notifies her pregnancy, often to her GP, and then attends a booking appointment with a midwife, a detailed and thorough risk assessment must be undertaken. Comprehensive, individual and woman and family-focussed questioning permits an accurate risk assessment so that care can be personalised and women can be signposted to the most appropriate antenatal care pathway.
- 7.2** For many women antenatal care is provided by a wide group of professionals including midwives, doctors and sonographers, as well as individuals from external agencies such as social care. This relies upon the sharing of accurate information between primary care and hospital maternity services and on occasion other medical specialities. Throughout antenatal care provision there is a necessity for close interdisciplinary working between these groups to ensure optimal and safe antenatal care is delivered. This chapter focuses on aspects of antenatal care that were not previously addressed in the first report and aims to highlight areas within the maternity service provided by the Trust which the review team felt warranted further attention.

Good practice in antenatal care and missed opportunities for learning

- 7.3** Throughout the time period of the review our multi-professional review team found a number of examples of good practice, of compassionate and safe antenatal care. However, also throughout the entire period of the review our team found poor standards of antenatal care, showing a lack of consistency and significant opportunity for improvement. Unfortunately there were significant numbers of poor standards of investigation when things went wrong or investigations that should have taken place which did not. Overall, the Trust continued to miss significant opportunities for significant learning throughout the entire time period of the review.

Care of vulnerable women

- 7.4** Pregnancy is a well-documented catalyst that may increase maternal vulnerability and inequalities already present in the lives of some women¹¹⁸. Vulnerability can be seen in women that have previously or are currently experiencing poverty, homelessness, domestic abuse, learning difficulties, seeking asylum, substance misuse, poor mental health, complex co-morbidities and teenage pregnancy. It is widely recognised that pregnancy carries a great deal of uncertainty. Women who are vulnerable in pregnancy are more likely to be exposed to additional harm, stress and anxiety.
- 7.5** The review team found evidence of missed opportunities to further investigate women from vulnerable groups. There was a lack of professional concern and in some cases a lack of appropriate referral in cases where further exploration was warranted. It is recognised that vulnerable women who receive appropriate support and intervention have improved outcomes¹¹⁹.
- 7.6** *In 2009 a young woman in her first pregnancy was booked for consultant-led care due to her age and was diagnosed as having a baby with fetal gastroschisis¹²⁰. She was not referred for additional support from the teenage pregnancy midwives but instead was seen by multiple midwives. As a result there were missed opportunities to explore her possible complex social needs as her care continued to be focused largely on the fetal gastroschisis (2009).*

118 NHS England. Better Births (2016) <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

119 Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010) <https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf>

120 See glossary

- 7.7** *A very young woman was booked for her first pregnancy in 2013. There was no referral to the teenage pregnancy service nor any further exploration relating to her social circumstances, particularly as her partner was significantly older than her. She was not offered appropriate additional support and care. (2013)*
- 7.8** *In 2013, a young teenage woman presented with a history of three previous pregnancies, all of these ending in miscarriage. Whilst she was appropriately referred to the teenage pregnancy midwife there was a lack of professional exploration or questioning around her social background, support networks and mental health. Appropriate signposting and referrals were not made in the pregnancy, and she did not receive the necessary additional offers of care and support. (2013)*
- 7.9** National guidance for women with complex social factors was updated in 2010¹²¹ and emphasised the need to improve support for women with additional needs. The Trust has guidance available with care pathways and referral processes for specialist practitioners such as the safeguarding team and teenage pregnancy midwife. The review team considered many cases where guidance was followed and referrals had been appropriately made
- 7.10** *In 2018, the review team had concerns around a lack of appropriate safeguarding and domestic violence screening- not completed at the booking visit. There were a number of missed opportunities to follow up the questions about domestic violence. It is appreciated there is always a possibility that an individual may not disclose any concerns. Following what was thought to be a domestic violence incident there was significant maternal morbidity and stillbirth. The review team subsequently saw evidence of learning from the Trust and changes to practice following this case. (2018)*

Good practice

- 7.11** *In 2008 a young teenage woman in her first pregnancy received appropriate input and referrals from the teenage pregnancy midwives and additional input and investigation from the fetal medicine consultant. Bilateral talipes¹²² were identified on an ultrasound scan. The baby was born at term and had an extended stay on the neonatal unit for nearly 1 month due to its inability to feed and the need for nasogastric feeding. There were extensive investigations for a possible neuro-muscular disorder and the family were counselled and supported by a geneticist about this. (2008)*
- 7.12** *A young woman in her first pregnancy in 2016 was appropriately referred to the teenage pregnancy team. The review team observed use of interpreters and the offer of a comprehensive assessment which would have resulted in an holistic consideration of the family strengths and needs. This was declined by the mother and the family (2016).*
- 7.13** Whilst highlighting these examples of good practice, the review team found that overall there was a lack of consistency, potentially exposing women and their babies to increased risk and potentially unnecessary harm.

Fetal growth assessment and management

- 7.14** Monitoring fetal growth is an integral component of safe and effective antenatal care. Over the last 20 years there has been increasing evidence that fetal growth restriction (FGR) is associated with stillbirth, neonatal death and increased perinatal morbidity. The Perinatal MBBRACE report in 2015¹²³ on term antepartum stillbirths found that ‘about one in three term, normally formed, antepartum stillbirths are related to abnormalities of fetal growth’.

121 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010) <https://www.nice.org.uk/guidance/cg110>

122 See glossary

123 MBBRACE-UK. Perinatal Confidential Enquiry. *Term, singleton, normally-formed, antepartum stillbirth* (2015) <https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf>

- 7.15** In November 2015, the Department of Health¹²⁴ announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The National Maternity Review, Better Births¹²⁵ (2016) highlighted a range of measures which can enhance the safety of care for women and babies, and identified a ‘care bundle’ as good practice in reducing stillbirths.
- 7.16** NICE (2003, 2008)¹²⁶ and RCOG (2013)¹²⁷ guidance advocates the use of symphysis fundal height (SFH) measurement and plotting these on a growth chart in the maternity handheld notes as essential to the care of low risk women. A referral for an ultrasound growth assessment is indicated where thresholds are reached or for women who are deemed to be high risk.
- 7.17** In 2016 NHS England produced the Saving Babies Lives Care Bundle Toolkit for maternity units to reduce the risk of stillbirth. The ‘toolkit’ was a range of measures that could be deployed to improve safety for mothers and their babies. One element of this has been the detection and surveillance of fetal growth restriction (FGR); (version 2 published 2019)¹²⁸. However, it must be acknowledged that historically, national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice.
- 7.18** In 2007-2008 the Trust introduced customised growth charts as part of the national Growth Assessment Protocol (GAP)¹²⁹ and Gestation Related Optimal weight (GROW)¹³⁰ programme with the West Midlands being one of the first regions to introduce the programme. Prior to this time the non-customised SFH and ultrasound growth charts were in use within the Trust’s handheld antenatal notes.
- 7.19** The review team found many instances where fetal growth restriction occurred but was not identified. Whilst it is recognised that despite following guidance it is not always possible to detect FGR (given the limitations of available methods including ultrasound) there were definite themes that emerged from review of these cases:
- The SFH measurement was not always completed and documented at each antenatal visit from 24 weeks.
 - The SFH measurements taken were both inconsistently and inaccurately plotted onto the growth chart.
 - A lack of appropriate referral when SFH measurements would have triggered an ultrasound scan.
 - Failure to monitor growth by ultrasound in babies at high risk of FGR (e.g. women with underlying hypertension).
 - Lack of recognition, action and wider learning by the Trust when babies were born growth restricted, including those who died.
- 7.20** *In 2017 a nulliparous¹³¹ woman was assessed at her antenatal visit at 27 weeks and it was noted that the symphysis fundal height (SFH) plotted above 90th centile when plotted on the customised growth chart. Following this fetal growth appeared to be reducing in trajectory. According to local guidance a fetal growth scan should have taken place. This did not occur. At 35 weeks gestation a stillbirth occurred of a grossly fetal growth restricted baby (birthweight at delivery on the 1st centile). The Trust recognised that*

124 <https://www.england.nhs.uk/mat-transformation/saving-babies/>

125 Ibid n1

126 National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003) <https://www.nice.org.uk/guidance/cg6> and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) <https://www.nice.org.uk/guidance/cg62>

127 Royal College of Obstetrics and Gynaecologists *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

128 NHS England. Saving Babies’ Lives Version 2: a care bundle for perinatal mortality (2019) <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

129 Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., *The Growth Assessment Protocol: a national programme to improve patient safety in maternity care.* (2013) https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

130 Gestation Network. Growth Charts GROW <https://www.gestation.net/growthcharts.htm>

131 See glossary

there were missed opportunities to detect IUGR and refer appropriately. There was confusion from staff about guidance and when a woman should be referred for a scan. Had this severe IUGR been detected earlier delivery may have been expedited prior to stillbirth occurring. (2017)

Staff voices on fetal growth:

7.21 A staff contributor told the review that that they had encountered problems with women being referred for growth scans and had found that some clinical colleagues were uncertain of SFH measurement technique:

‘When I was doing some of the clinics, I would be seeing antenatal women who should have had a scan... and in one clinic session, there were three women who should really have been referred for a growth scan and obviously, I did refer them, but I mean even the one partner had plotted the growth on the chart because they said the midwife hadn’t plotted it...’

7.22 *The staff member continued: ‘I was even asked the one time, “How do you measure fundal height?” by a midwife? I don’t know, having a joke or something, I says, “How do you mean?” and [midwife] said, “Well...” literally [they] described how they measure the fundal height, I said, “Well, it’s clear on the growth chart how to measure it you know, this is how you do it; it’s on the growth chart itself how to measure it,” and [they] says: “I do it the opposite way”, which wouldn’t give you the correct measurement’.*

7.23 Incorrect assessment of fetal growth was repeatedly observed by the review team. Some examples of this include:

In 2011 a woman had continuity of care with the same midwife during her antenatal care, however the SFH measurements were incorrectly documented at some visits (not written in centimetres), and were incorrectly plotted in their position and mark used on the growth chart. The plots, if correct should have alerted referral for an ultrasound scan to assess growth. The pregnancy ended in a stillbirth of a baby with growth restriction. (2011)

7.24 The Trust’s initial investigation in June 2011 did not recognise that there had been missed growth restriction. The governance documentation reviewed was poorly completed and there was no indication that any of the actions had been achieved. Following a complaint from the family in October 2011 a further investigation took place and it was acknowledged that the growth measurement and plotting did not identify growth restriction. An action plan was made and evidence subsequently supplied to the family that the actions had been completed. However the learning only took place after a family complaint and not before. Families consistently told the review team of investigation only commencing after receipt of a complaint or commencement of litigation. The review team has seen this was a regular feature during the whole time period of this review. (2011)

7.25 *At 36 weeks’ gestation in 2013 a woman experienced an intrauterine death. Following birth it was found the baby was significantly growth restricted. On case review it was established the SFH was not plotted on the GROW chart. The SFH was persistently measured as >90th centile (when retrospectively plotted) but the baby was profoundly growth restricted, and weighed 1.53kg at birth (1st centile). This case highlights poor SFH measurement techniques by several different antenatal care providers. (2013)*

7.26 Governance documents supplied by the Trust to the review team for the above case recognised that growth was not plotted appropriately and there had been missed FGR. Actions stated by the Trust were to ensure GROW training was being accessed by all, including GPs. GAP training was due to start in 2014. A further meeting in 2015 found that the CCGs had not progressed these actions and the GPs had not accessed the GAP training. Following this meeting the action was for the patient safety manager to highlight the need for the GAP training with the CCGs in conjunction with the recent MBRRACE report. The target date was February 2016, 3 years after the case. The review team has not been provided with evidence by the Trust to demonstrate this actually happened despite the significant passage of time.

- 7.27** *In 2015, a woman became pregnant who had previously had a small baby with a birth weight just above the threshold in the local guideline to merit referral for an ultrasound scan. She was a current smoker and in this current pregnancy missed antenatal appointments due to issues with scheduling and non-attendance. Despite these risk factors, in the pregnancy in 2015 the complete clinical picture was not considered and she was not appropriately referred for an obstetric review or serial growth scans. (2015)*
- 7.28** *Her baby was stillborn at 37 weeks, with a birth weight less than the 3rd centile. The investigation by the Trust recommended a change to guidelines, to clarify exactly which centiles must be included in the risk assessment guidance for referral for scans in a subsequent pregnancy. The following two versions of the guidance did not change and the antenatal risk assessment was not updated until 2018, a gap of 3 years following the incident.*
- 7.29** *A woman who was known to have large uterine fibroids had midwifery-led care throughout her pregnancy in 2016. There were errors in the interpretation of the baby's growth, fetal and growth restriction was not detected and an obstetric opinion on the ultrasound scan was not obtained. The baby was born at 31 weeks and was severely growth restricted with a birthweight less than the 1st centile. The baby died the same day from a severe hypoxic birth injury. Local investigation recognised there was a missed opportunity for earlier specialist ultrasound scanning. (2016)*
- 7.30** *Staff interviews undertaken during late 2021, as part of the Staff Voices initiative, supported the view that the Trust remained slow in implementing recommended changes. A staff member told the review team: 'so we're going to put that into our protocols and policies and before it was just 'mañana', we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.*

Specialist antenatal care

- 7.31** *Some aspects of antenatal care require the input of specialised services. The review team identified the following areas of concern with specialist services that were being delivered at the Trust.*

Fetal medicine care

- 7.32** *A number of cases were considered where fetal medicine care was provided at the Trust. The review team identified incidences where a baby was born with an abnormality which was not detected until after birth or where a fetal abnormality was detected during the pregnancy and the review team had concerns about the care provided. From review of clinical records, in most cases the quality of fetal medicine care at the Trust appears to have been appropriate or good for the year that the pregnancy occurred. Some fetal abnormalities would not necessarily have been expected to be diagnosed antenatally and for those diagnosed it was evident that appropriate, kind and compassionate care had been provided both during the pregnancy and following a pregnancy loss.*

Good care

- 7.33** *In 2007 a woman had a pregnancy complicated by multiple abnormalities found on the anomaly scan. She was seen by the fetal medicine consultant at the Trust and counselled regarding the increased chance of a chromosomal abnormality and she had an amniocentesis. The baby was confirmed to have a chromosomal abnormality and a referral to the genetics team was made. The parents decided to terminate the pregnancy. There was documented evidence of good communication with the parents and GP antenatally and postnatally and evidence of compassionate antenatal and bereavement care. (2007)*
- 7.34** *In 2012, a baby was diagnosed with a significant brain abnormality at the anomaly scan. There was referral to the tertiary centre and the parents were counselled by the geneticists and paediatric neurologists at the tertiary centre and the neonatal and fetal medicine team at the Trust. The woman had regular scans and thorough investigations during the pregnancy with good multidisciplinary antenatal care and*

communication noted. The baby was delivered at 37 weeks and the baby died at a few hours of age. There was appropriate follow-up with the neonatal and genetic teams. (2012)

- 7.35** *A woman had a pregnancy in 2016 complicated by multiple fetal abnormalities identified at the anomaly scan at 19 weeks. She was seen by a fetal medicine consultant and offered an amniocentesis (invasive testing) and possible termination of pregnancy which she declined and had a stillbirth at 36 weeks. She was seen regularly by the midwives and obstetricians throughout the pregnancy and offered bereavement support. (2016)*
- 7.36** These cases demonstrate that there was often appropriate multidisciplinary care, support, counselling and bereavement care for the parents, including care at the tertiary centre where appropriate, following the diagnosis of a significant fetal abnormality.

Poor care

- 7.37** However, the review team found a number of cases where care was substandard. For fetal abnormalities such as cardiac abnormalities, babies that require surgery immediately post birth, babies with multiple abnormalities suggestive of a genetic syndrome or babies with severe early onset FGR, then referral to a tertiary fetal medicine centre during the antenatal period is the appropriate care pathway expected. This would ensure multidisciplinary counselling and expert care and for many babies birth in a unit with a Level 3 neonatal unit would be appropriate. There appeared to be a reluctance by some clinicians to refer some women for tertiary centre fetal medicine care for advice and counselling, or to transfer care to a Level 3 centre as a more appropriate place for birth. In cases where a fetal abnormality was detected postnatally or a baby died with abnormalities there was often no Trust investigation of the screening process or care. Thus opportunities for learning were lost.
- 7.38** When interviewed by the review team a member of staff at the Trust agreed that there was sometimes a reluctance to refer fetal medicine cases for an external review.
- 7.39** The contributor told the review: *'I think I'd probably, in retrospect, agree...to some extent. I think there was a degree of fetal medicine clinical overconfidence...but there are other things that you thought perhaps ought to have been referred elsewhere earlier on, yes?'*
- 7.39** *A woman booked in her third pregnancy in 2015; although the 20/40 week anomaly scan was normal, significant fetal abnormalities were diagnosed at a later scan, which were likely to be associated with a poor outcome for the baby. She was counselled by a Trust fetal medicine consultant; although documentation of the discussion and possible outcomes were poor. The plan was made for the baby to be delivered at the Trust and for the neonatal team to be at the birth. The baby was delivered at 36 weeks and died within the first 24 hours of life. (2015)*
- 7.40** This case highlights the importance of appropriate antenatal communication and consideration for best place for birth. Although in cases, such as this, where the outcome is likely to be poor and the pregnancy is continuing, the outcome may be unchanged by referral to a tertiary centre, appropriate practice would be offering referral to a tertiary fetal medicine unit to ensure the provision of detailed counselling regarding the prognosis, including counselling from the wider multidisciplinary specialists. The specialist team would comprise geneticists, neonatal surgeons and speciality paediatricians to plan appropriate antenatal surveillance and postnatal care and ensure informed decision making by the parents.
- 7.41** Ongoing antenatal care following referral can be shared between the local and tertiary centre but at least one visit to the tertiary centre will ensure that key expertise is sought. Consideration must also be given to birth in the tertiary centre in complex cases, where the abnormality is likely to require early surgery and where level 3 neonatal care may be required to ensure optimisation of care at birth. With all of this information provided to the woman and her family they are then able to make an informed choice.

- 7.42** *In 2008 a women in her sixth pregnancy was identified as having a baby with a significant congenital abnormality at the anomaly scan. She was counselled by a Trust obstetric consultant, the neonatal team and neonatal surgeons at the tertiary centre. She decided to continue her pregnancy and delivered her baby at the Trust. The baby was transferred to the tertiary centre postnatally and died aged four days. Following review of this case it was agreed that referral to tertiary fetal medicine service should have been made and consideration given to the appropriate place of birth. (2008)*
- 7.43** *In 2019, a woman had a pregnancy affected by severe early onset fetal growth restriction. There was no referral to a tertiary centre for specialist review, counselling or advice, particularly when the woman was reluctant to consider local advice regarding birth. The review team found there was limited evidence, pointing to inadequate counselling, and fetal medicine management was not in keeping with best practice. (2019)*
- 7.44** In the chapter focussing on neonatal care the review team discuss the change in designation of the neonatal unit in 2006 from level 3, (neonatal intensive care unit or NICU) to level 2, or a 'local' neonatal unit. Staff interviews supported the culture of reluctance to transfer women in utero or neonates to a Level 3 tertiary unit following the Royal Shrewsbury Hospital being designated a Level 2 or local neonatal unit, (LNU) in 2006. Staff described a gap of circa 8 years before the changes introduced in 2006 were actually implemented, but some were reluctant to be quoted within the report. Some staff members from the Trust stated that there was a lack of capacity at the designated level 3 units in the surrounding area, leading to the Royal Shrewsbury Hospital continuing to care for babies outside its designation. However this was disputed by the neonatal network.
- 7.45** One staff contributor told the review: *'Part of the sense of futility is that we have raised concerns, you know, sometimes we've actually had quite heated debates about...if on the obstetric side they feel that they don't want to send to Stoke or Birmingham, and...want...to keep the patient, and you're made to feel that you're letting the side down by not agreeing to proceed...I think for some of them there is a reluctance, and I don't know if that is a cultural thing because I think for a long time, particularly while based at RSH, there was a feeling that it was a very standalone unit and it did its own thing. So I think culturally there's been that feeling...'*

Multiple pregnancies

- 7.46** About 1 in 60 pregnancies is a twin or triplet pregnancy (NICE 2015). A unit with approximately 5,000 births a year such as the Trust would expect on average 65-75 pregnancies resulting in multiple births a year. Multiple pregnancies are known to be at greater risk of adverse obstetric outcomes and so additional antenatal care is required.
- 7.47** NICE guidelines on twins and triplet pregnancy were first published in 2011 and have since been updated in 2019¹³². Guidance has emphasised the importance of detailed antenatal counselling for women with twins or triplets especially with regards to intrapartum management. This is best facilitated through a specialist clinic. The review found multiple cases where limited or no counselling was evident with regards to management of twin pregnancies.
- 7.48** *In 2013, a multiparous¹³³ woman booked with a DCDA¹³⁴, twin pregnancy. At 31 weeks she was seen by a registrar and requested birth by caesarean section. She was told this was not necessary but there was no documented discussion regarding the risks associated with vaginal birth for the second twin. Twin 2 experienced a complicated birth and suffered HIE Grade 3. The child is now profoundly disabled and the mother suffered post-traumatic stress disorder. (2013)*

132 National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019) <https://www.nice.org.uk/guidance/ng137>

133 See glossary

134 See glossary

- 7.49** In 2014, a 41-year-old first time mother who conceived through assisted conception was advised an induction of labour at 36+ weeks as her twins were small. There was no evidence of any antenatal counselling. Labour was induced and she required an assisted vaginal birth for both twins in theatre. The second twin had a very complicated birth and as a consequence suffered HIE. (2014)
- 7.50** In 2017, a primiparous¹³⁵ woman was induced at 37 weeks and 5 days as she had a DCDA¹³⁶ twin pregnancy, this was in accordance with local guidance. There was inadequate documented antenatal discussion with regards to the process of induction of labour, consideration of epidural analgesia and the potential risk of caesarean section for twin 2. Furthermore, at the time of induction prostaglandin (medication given to start the labour) was given without an obstetric review or an ultrasound scan to confirm presentation of the twins. An emergency caesarean section was undertaken for a fetal heart rate abnormality. There was a postpartum haemorrhage of 2500mls which was appropriately managed. (2017)
- 7.51** Further cases of concern regarding the management of multiple pregnancies were seen by the review team. In conclusion, the review team found that multiple pregnancy management at the Trust gave cause for concern across the entire review period.

Diabetic Care

- 7.52** The care of women with diabetes encompasses women with both pre-existing diabetes and women who develop diabetes during pregnancy, known as gestational diabetes mellitus (GDM). UK rates of GDM have steadily increased over the last decade with Diabetes UK estimating that about 1 in 16 women will develop GDM. Women with pre-existing diabetes make up a smaller proportion of the women requiring diabetes care, but pregnancy complications are greater in this group.
- 7.53** UK guidance for the management of diabetes in pregnancy was first published by NICE in 2008 (revised in 2015 and updated 2020)¹³⁷. Prior to NICE guidance CEMACH¹³⁸ published a landmark report in 2007 that highlighted women with pre-existing diabetes had a fivefold increased risk of stillbirth and a threefold increased risk of perinatal mortality. All these reports emphasise the importance of multidisciplinary care for women with diabetes and that women must have ready access to specialists with expertise in the care of diabetes in pregnancy.
- 7.54** Diabetes care at the Trust must be led by a named consultant obstetrician who acts as a lead for the service. This lead consultant must have sufficient time in their job plan to lead the diabetes service effectively. This can be benchmarked against other similar sized trusts. The lead consultant must work in conjunction with a consultant diabetologist, specialist nurses, midwives and also a diabetes dietician. It is imperative that these individuals work together in a collaborative manner. The diabetes service at the Trust was created in 1999 and has increased in size over the last 20 years. The number of women presenting with diabetes has been increasing significantly.

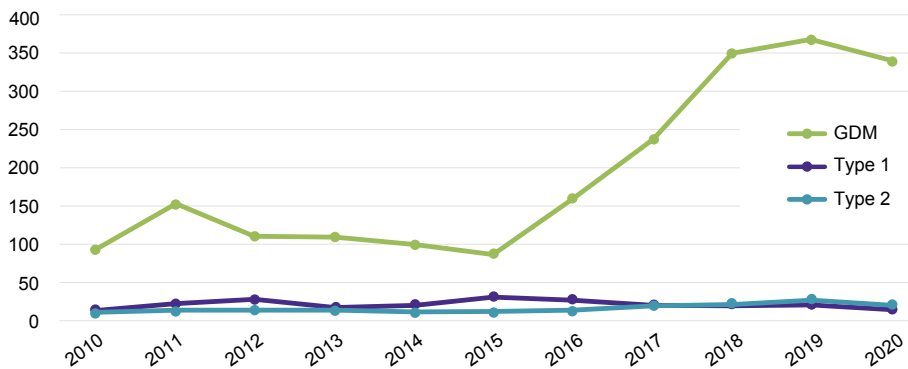
¹³⁵ See glossary

¹³⁶ See glossary

¹³⁷ National Institute for Health and Care Excellence. *Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3* (2020) <https://www.nice.org.uk/guidance/ng3>

¹³⁸ Confidential Enquiry into Maternal and Child Health. *Diabetes in pregnancy: are we providing the best care?* (2007) <https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care>

Diabetes yearly breakdown



Source: Shrewsbury and Telford Hospital NHS Trust

7.55 In 2016, a woman had appropriate multidisciplinary team antenatal care that involved senior obstetric, diabetic specialists and midwifery input. However there was failure not to act or further investigate increasing ketonuria¹³⁹ and fetal macrosomia¹⁴⁰ in a diabetic smoker all of which are individual risk factors for intrauterine fetal death. An antepartum stillbirth occurred at 34 weeks and 6 days. There was no evidence provided to the review team that this case was discussed at a governance meeting or that any learning was identified. (2016)

7.56 In 2016 a women with Type 1 diabetes who had poor control prior to pregnancy, suffered a stillbirth at 34 weeks' gestation. There were multiple missed opportunities to improve diabetic control and care sometimes seemed fragmented. The risks of the pregnancy were not shared with the patient. The patient had a pregnancy the following year where the care was much improved with evidence of better multidisciplinary team working. (2016)

Staffing of the maternity diabetic service at the Trust

7.57 The Trust has advised the review team that the present diabetic service consists of two consultant obstetricians, and two endocrinologists. There is one Band 7 midwife and two band 6 midwives who both provide less than 0.5 full time equivalent cover. The service also has access to diabetes nurse specialists. The review noted current problems with staffing and capacity within the diabetic service, especially given the increasing workload. Firstly, there is no current provision for consultant cover during periods of annual leave, study leave and other absences, meaning women have limited access to the correct specialist during their antenatal care.

7.57 Furthermore, from the documentation provided to the review team there appears to be only one fortnightly clinic run for women with GDM. This is inadequate for the number of women managed with GDM in the service, which is on average 29 women a week (based on the Trust's data for the last 3 years). Having such limited appointments available for complex pregnancies means that an appropriately detailed assessment is unlikely to be made, which increases the likelihood that omissions will occur and errors will be made.

Good practice

7.59 Whilst the review had concerns regarding the maternity department's ability to support the diabetes service it saw good practice, in that the department had invested to develop a midwifery non-medical prescriber. This model of care means a specialist midwife has a greater depth and understanding of diabetes and also continues to manage women with gestational diabetes when medical therapy is required.

139 See glossary

140 See glossary

Preconception care and diabetes

- 7.60** An important facet of diabetes management is access to preconception care for women with pre-existing diabetes. Women with very poor diabetic control must be advised against becoming pregnant until better diabetic control is established and must have access to appropriate advice on contraception and medications to avoid when embarking upon pregnancy. The review found evidence of numerous cases of women with pre-existing diabetes who had not had access to preconception care. This includes the case below, which is relatively recent.
- 7.61** *In 2019 a woman with underlying type 2 diabetes and an elevated BMI booked with an average blood glucose level of 117 prior to pregnancy (desired upper level for pregnancy is 48). Whilst she was first seen prior to 10 weeks of gestation, she unfortunately suffered an intrauterine death at 16 weeks, which may have been related to her pre-pregnancy diabetic control. (2019)*
- 7.62** Cases such as this evidence the disconnect between diabetes care, general practice and maternity services and the need for greater emphasis on preconception care. With better access to preconception care and provision of appropriate contraception services, this will help reduce or minimise cases of pregnancy loss associated with a woman's diabetic status.
- 7.63** As pregnancies in women with underlying diabetes are at elevated risk of poor fetal outcome it is imperative that women undergo thorough clinical and risk assessment at all antenatal visits. This includes assessment of blood pressure, urine and measuring and plotting the SFH.
- 7.64** A further important component of antenatal care for women with diabetes is that of birth planning. Women with diabetes are far more likely to require induction of labour or birth by planned caesarean section, particularly in the presence of fetal macrosomia or fetal growth restriction. There was evidence that this failed to occur in several cases leading to poor fetal outcome at the Trust.
- 7.65** *In 2014 a woman with type 1 diabetes was seen at 35 weeks and a plan was made for induction of labour at 38 weeks. There was no assessment of fetal growth beyond 35 weeks, but it was noted the abdominal circumference plotted above the 95th centile. At the time of induction, it was noted that the SFH measured 46cm and yet this was not acted upon. The patient underwent induction of labour which culminated in a vaginal birth complicated by a shoulder dystocia and abnormal fetal blood gases. Unfortunately, an early neonatal death occurred which was related to fetal hypoxemia at birth. (2014)*
- 7.66** When planning the place and mode of birth, maternity team members must provide women with evidence-based advice and recommendations. This will enable women to make an informed choice about their pregnancy and birth. This discussion must be fully documented in the maternity notes.

Good practice

- 7.67** There is evidence within the diabetes service that the Trust has made efforts to enhance antenatal care for diabetic women. The Trust has invested in the use of smartphone technology to allow remote reviews and telephone consultations for women with gestational diabetes. Additionally, NHS England recently mandated funding for all women with type 1 diabetes to have access to continuous glucose monitoring (CGM) in pregnancy. This funding stream has commenced after the period of the review but it is nevertheless important that the Trust ensures women have equity of access to CGM early in pregnancy.

Hypertension management

- 7.68** Gestational hypertension (also referred to as pregnancy induced hypertension) is a common disorder and may affect up to 1 in 10 pregnancies. It describes new onset hypertension in pregnancy occurring after 20 weeks gestation where maternal blood pressure is greater than 140/90 on two separate readings more than 4 hours apart. Hypertension identified prior to this point is known as chronic hypertension and affects about 1-2% of women. Gestational hypertension as well as chronic hypertension are known to be

risk factors for the development of complications in pregnancy and so women must undergo assessment of blood pressure at every antenatal visit. Furthermore, women who develop hypertension may require antihypertensive treatment during pregnancy to reduce the risk of developing severe hypertension.

- 7.69** National guidance for hypertension management was first published by NICE 2010 with collaboration from the RCOG and the RCM. It has since undergone revision in 2019¹⁴¹. Prior to 2010, the UK confidential enquiry in maternal deaths (CEMACH)¹⁴² emphasised the importance of treating severe hypertension which may have contributed to cases of maternal death. Given how common hypertension is, all healthcare professionals working in maternity services must be aware of the need for monitoring and onward referral of woman with hypertension for obstetric review.
- 7.70** The Trust shared with the review team its first guidance for hypertension in pregnancy. This appears to have been created in 2006. The document is entitled Hypertension Severe (it has no implementation date but was due for review in 2008). It is noteworthy that the guidance stated that the initiation of antihypertensive medication for high blood pressure was only required if the systolic was 170 or greater, and they acknowledge that the Confidential Enquiry recommendation (published 2007) stated a lower blood pressure of 160 systolic required treatment. This potentially indicates a reluctance within the Trust's maternity service to treat severe hypertension according to national guidance. It must be noted these thresholds are much higher than the current guidance set out from NICE where blood pressure requires treatment when it is 150/100 or greater.
- 7.71** This review covers an extended period over 20 years and underpinning the review is a methodology acknowledging that assessment of cases must utilise the national guidance in use at the time. When reviewing the management of hypertension, the review team has focused on cases from 2009 onwards so that maximum learning could be established for the Trust as regards current service provision from the cases reviewed. Nevertheless, it must be acknowledged that there were many significant cases that were encountered where there was suboptimal management of hypertension prior to 2009. One example is:
- 7.72** *In 2001, a woman developed severe hypertension with a blood pressure 165/100 and proteinuria at 36 weeks' gestation. A 24 hour urine collection was raised at 0.5g/l. No treatment was started, instead her elevated blood pressure was attributed to anxiety, despite clinical signs of severe hypertension. Over a week later induction of labour was finally decided upon when she developed epigastric pain and felt very unwell. There was no long term harm to mother or baby in this case. (2001)*
- 7.73** Following publication of the 2010 NICE guidance the review team found continued deviation from NICE guidance in the treatment of women with hypertension at the Trust.
- 7.74** *In 2011 a woman developed hypertension at 38 weeks' gestation in her first pregnancy, despite multiple elevated blood pressure readings that would have justified treatment, no treatment was started. She suffered an intrapartum stillbirth during the induction of labour, (IOL) process. The review team felt this was a high risk case, and a scan should have been carried out prior to IOL. In addition, assessment should have been made by an experienced midwife, not a student. If the CTG had been normal at the beginning of induction, then it is more likely than not that with adequate and ongoing observation and assessment, the outcome would have been different. (2011)*
- 7.75** *A woman developed hypertension and proteinuria at 33 weeks gestation in 2011. She was admitted to the antenatal ward and started on treatment and given intramuscular steroids in anticipation of early birth. She had persistent vomiting and an ongoing headache. A consultant review occurred and it was decided she could have outpatient management. The woman was discharged but had an eclamptic seizure at home and was transferred and delivered by emergency caesarean at another hospital. The review team have not been provided with any documentation by the Trust that indicated any investigation or subsequent learning occurred as a result of this case. (2011)*

141 National Institute for Health and Care Excellence. Hypertension in pregnancy: *diagnosis and management NICE guideline NG133* (2019) <https://www.nice.org.uk/guidance/ng133>

142 Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives 2003-2005* (2007) <https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005>

7.76 *In a 2013 pregnancy a woman with type 1 diabetes was reviewed as an inpatient at 37 weeks as she had developed hypertension and proteinuria. Her blood pressure was elevated at 162/98mmhg. Her case was escalated to a consultant who despite clinical signs of hypertension and proteinurea indicated that no treatment was required. The review team found had concerns that such a high risk case had induction of labour started on the antenatal ward. There was poor management of her pre-eclampsia; earlier medication/treatment for pre-eclampsia would be recommended in this case. The review team notes with concern the management of a high risk IOL on the antenatal ward. Due to the complexity of this case, IOL should have been managed on the labour ward. There were also concerns regarding the management of this woman's diabetes with a delay in starting an insulin 'sliding scale'. (2013)*

Chronic hypertension

7.77 Another key element to managing hypertension in pregnancy is the recognition of women who have chronic hypertension. This cohort of women are at greater risk of developing severe hypertension in pregnancy as well as pre-eclampsia, having a preterm birth or a baby born small for gestational age. Women identified with chronic hypertension must be cared for throughout their antenatal period on a consultant-led care pathway. Current evidence suggests women should be advised to take aspirin from 12 weeks' gestation¹⁴³. Additionally, women may require additional fetal growth scans to assess for growth restriction, which is more common in this cohort of women.

7.78 *A 42-year-old woman with a history of previous pregnancy affected by pre-eclampsia had a booking blood pressure of 140/80 with dipstick proteinuria in 2015. She was appropriately referred to see a consultant at 11 weeks. However, there was no consideration that this might be chronic hypertension with an underlying renal disease. Unfortunately, the woman developed superimposed pre-eclampsia and experienced a stillbirth at 27 weeks' gestation. (2015)*

Inpatient antenatal care

7.79 It is estimated that about 12 per cent of all pregnant women are admitted to the antenatal ward during their pregnancy¹⁴⁴. Women admitted for hospital care antenatally are more likely to need extra surveillance for an existing or new condition during their pregnancy. As a review team we acknowledge that there is an absence of national guidance that sets thresholds for when a woman must be admitted. Nevertheless, when women are admitted to the antenatal ward a clear consultant obstetrician-led plan of care is required as a standard.

Obstetric ward rounds

7.80 The Trust's Maternity Clinical Operation Policy (2015) describes the cover and support for the wards (wards described as labour ward; antenatal ward; postnatal ward and other pregnant women in hospital such as ITU) with a consultant on site from 08.30 to 20.30 from Monday to Friday and 08.00 to 16.00 on weekends and bank holidays. However, there is no clear description of what this 'support' entails. There is no mention of dedicated ward rounds on the antenatal ward. The RCOG Roles and Responsibility of a Consultant¹⁴⁵ (published 2009 and updated 2021) has identified that obstetric ward rounds enable staff to monitor, anticipate and respond in a timely way to emerging problems. They permit women to voice their concerns and enable them to ask questions and receive answers with regard to their care.

143 Ibid n25

144 Tracy, K. et al. *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO*. A randomised controlled trial. (2013) *Lancet*. Vol 382, Issue 9906 p1,723-32

145 Royal College of Obstetrics and Gynaecologists. *Roles and Responsibilities of a Consultant – Workforce Report (2021)*
<https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/>

- 7.81** Handovers must also include high risk women in the antenatal ward, enabling the out of hours team to be aware of concerns and possible reviews needed during their shifts (RCOG 2010¹⁴⁶, NHS1 2019¹⁴⁷).
- 7.82** The review team found many incidents of high-risk women admitted to hospital not being reviewed by consultants. There was a lack of consultant presence on the antenatal ward and no evidence seen of a structured antenatal ward round. Medical assessments of antenatal inpatient women seemed to happen when a midwife asked for a clinical review rather than being part of the daily routine in maternity services.
- 7.83** When a plan for treatment or intervention was decided, documentation of detailed discussions with the women and their partners was rarely found within the records supplied to the review by the Trust.
- 7.84** *In 2005, a woman with a complex pregnancy had an amniotic fluid drainage (removal of excess amniotic fluid around the baby) on the ward. There was no mention of a discussion of the procedure with the woman or any record of the procedure itself. The only documentation in the medical records provided to the review team by the Trust is the amniotic fluid biochemistry. (2005)*
- 7.85** During the staff voices interviews in autumn 2021, staff were asked about inpatient care and if registrars couldn't get hold of consultants to see high-risk antenatal patients, whether they would make it known that it was a concern. A staff member replied: 'No, they wouldn't, they would just act on whatever... they would just do whatever they can'.
- 7.86** *In 2017 a woman was booked in for low risk midwifery care, but placed on aspirin as there was a family history of pre-eclampsia. The woman presented as large for her dates, had oedema and reduced fetal movements on presentation at 39 weeks and 6 days gestation. She was booked for an induction of labour. Following Propess¹⁴⁸ times 1 and Prostin¹⁴⁹ times 3, when ready for artificial rupture of membranes (ARM) the labour ward was too busy to accept her transfer, so the mother remained on the antenatal ward. Approximately 12 hours later, she was transferred to the labour ward. However, on attempting to auscultate the fetal heart, intrauterine death was identified and confirmed on ultrasound scan. (2017)*
- 7.87** Additionally, the review team encountered multiple instances where women who were admitted for induction of labour did not have a clinical review at all prior to commencing the induction process.
- 7.88** *A woman was admitted for induction of labour at 40+1 weeks in 2013. Through the documentation provided by the Trust to the review team the indication for induction was not clear. Prostaglandins were given as the cervix was unfavourable. No obstetric review is documented in the notes until 48 hours after admission. Baby was born delivered by emergency caesarean section. Parents report their experience around induction, labour and the immediate postnatal experience being 'horrific.' (2013)*

Escalation of concerns

- 7.89** The RCOG Each Baby Counts (2020)¹⁵⁰ documented that 'failure to escalate/act upon risk/transfer appropriately' occurred in 36 per cent of reviewed reports. Factors affecting escalation nationally included site-based or professional team alliances, and skill gaps within specialisms and wider teams.
- 7.90** The review team identified many cases where midwifery staff appeared reluctant to escalate their concerns regarding care and treatment to obstetric and neonatal colleagues. High risk and complex cases were not escalated to the right person in a timely manner. Sometimes, there was recognition by the midwifery team of the need to escalate but as the junior doctor was often busy, they just waited despite their concerns.

146 Royal College of Obstetrics and Gynaecologists. Improving patient handover: Good practice no. 12 (2010)
<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/>

147 NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019)
<https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/>

148 <https://www.medicines.org.uk/emc/files/pil.135.pdf>

149 <https://bnf.nice.org.uk/drug/dinoprostone.html>

150 Royal College of Obstetrics and Gynaecologists. *Each Baby Counts: 2019 progress report* (2020)
<https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/>

In other cases, they did not recognise a sick or deteriorating women and failed to escalate. The cases below are examples from across the timespan of the review. In addition, frequently women with confirmed preterm pre-labour ruptured membranes were not given antibiotics in keeping with national guidelines.

- 7.91** *In 2002 a woman was admitted with repeated episodes of antenatal bleeding. Her waters then broke at 25 weeks' gestation. She reported tightenings but was asked to go for a walk and given some analgesia. It was eventually realised that the so called tightenings were labour and she experienced a vaginal breech birth just 75 minutes later. (2002)*
- 7.92** *A woman with a history of ruptured membranes for 3 days in 2011 was admitted feeling unwell and had a raised pulse. Despite raised inflammatory markers on her admission bloods, there was a delay in recognising how unwell the woman was and she was transferred to labour ward with overwhelming sepsis 14 hours later. (2011)*
- 7.93** *In 2016, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation. Antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously even though the baby was breech. She experienced an intrapartum stillbirth with evidence of E.coli sepsis. (2016)*
- 7.94** The review team also saw multiple cases where women who were considered high risk were admitted to the antenatal ward to commence an induction of labour when induction should have occurred (or it should at least have been considered) on the labour ward. Lack of senior review or awareness meant that care provision happened in the wrong place and often without full consideration of the clinical risks involved in the care provided.
- 7.95** *In 2010 a woman was transferred from the midwife-led unit, (MLU) by ambulance to the consultant-led unit. There was high clinical activity at the time and yet there was no escalation to the labour ward consultant. The registrar was unable to make a full assessment because they were conducting a twin delivery with another patient at the time. This case sadly resulted in the baby needing to be cooled and developing HIE. (2010)*
- 7.96** *In 2012, a 25-year-old mother with a history of previous caesarean section for breech decided to attempt vaginal birth after her membranes ruptured at 36 weeks. Prostaglandin was given on the antenatal ward. There was no documentation in the records provided by the Trust with regard to information given on the increased risk to the mother or her baby. The mother suffered a uterine rupture and the baby was born in poor condition. The baby died at 7 days of age. (2012)*
- 7.97** *In 2014, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation however antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously, even though the baby was breech. Her baby was born showing no signs of life. Resuscitation was initiated, but neonatal death was confirmed at 27 minutes of age. (2014)*
- 7.98** *A woman who was 25 weeks' gestation in 2016, was admitted to the antenatal ward with preterm pre-labour ruptured membranes, she developed a MEOWS score of 7 indicating that she was severely unwell. The midwife contacted the registrar who was busy, but there was no escalation to another clinician until almost an hour later. At this point the woman was severely unwell and a decision was then made for an emergency caesarean section. (2016)*
- 7.99** *In 2019, a 35-year-old woman in her third pregnancy was induced as her baby was severely growth restricted, with absent end diastolic flow¹⁵¹. She also had gestational hypertension. A decision was made to commence the induction on the antenatal ward. The CTG was deemed suspicious on admission and she was transferred to the labour ward. The consultant review was at first to prescribe prostaglandin, but*

151 See glossary

fetal monitoring remained suspicious and a category 2 caesarean section was performed. The review team is of the view that induction should have been started on the labour ward in the first instance due to consideration of the mother's known hypertension and a severely growth restricted fetus (placental pathology). This baby therefore needed frequent monitoring. (2019)

Delay in transfer of women to the labour ward

- 7.100** The review team found many incidences where there was a delay in transfer of women in established labour to the labour ward. Women were frequently not monitored appropriately despite being identified as high risk. There were also several cases of women experiencing induction of labour where following delays in transferring to labour ward an intrauterine death occurred. In other cases, the delay subsequently led to a category 1 caesarean section.
- 7.101** *In 2003, a 28-year-old woman was admitted to the antenatal ward at 29 weeks with abdominal pain. On the ward she collapsed with a tender abdomen. It took nearly 50 minutes to transfer her to the labour ward and conduct an emergency caesarean where a placental abruption was confirmed along with the death of her baby. (2003)*
- 7.102** *In 2013, a woman undergoing induction of labour on the antenatal ward was delayed in transfer to the labour ward. When the family requested for the fetal heart to be monitored as it had not been for an hour, the fetal heart could not be located. The midwife asked the woman to go for a walk and have a drink as it was handover. An intrauterine death was diagnosed on her return an hour later. (2013)*
- 7.103** *A type 1 diabetic mother had a high risk pregnancy in 2013 and was admitted having evidence of pre-eclampsia. There was delay in planning induction of labour (IOL). When IOL commenced it was conducted on the antenatal ward and transfer to labour ward was not arranged until the mother had reached 4cm cervical dilatation. The baby was born by emergency caesarean section and initially responded well to resuscitation, but required transfer to the neonatal unit at seven hours of age. The baby remained an inpatient for three weeks, and is now doing well. However, as well as a delay in transfer to the labour ward the review team also has concerns regarding the care provided in labour once transfer occurred. (2013)*
- 7.104** *In 2015 a woman who experienced an antepartum haemorrhage in late pregnancy was inappropriately advised by the consultant obstetrician that her plans to birth in a midwifery led unit (MLU) did not need to be reconsidered or changed. When problems were identified in labour there was a delay in transfer to the labour ward, and fetal wellbeing was not adequately monitored during the transfer period. The baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation and correspondence with the Trust. (2015)*
- 7.105** *In 2017, a woman whose transfer to labour ward was delayed during the induction process as the unit was very busy experienced an antepartum stillbirth whilst on the antenatal ward. During their investigation into what happened, the Trust through their Root Cause Analysis (RCA) recognised there were delays in transfer primarily due to maternity unit activity. In the RCA analysis section of the report the causes were identified as a lack of capacity on the labour ward, increased activity and emergency caesarean sections being undertaken. It also found that there was a 'culture of normalising long waits for women undergoing induction of labour when labour ward is busy'. (2017)*
- 7.106** Various versions of the Trust's Escalation of Maternity Services policy have been provided to the review team by the Trust since version 1 from June 2010 to version 5 in 2018. The policy repeatedly states that if the labour ward is busy, this must be escalated to the highest level and if women are waiting more than eight hours to be transferred to continue induction of labour then a senior obstetric review must occur. The review team found numerous cases where the trust did not follow its own escalation policy.

Misinterpretation of the antenatal cardiotocograph (CTG)

- 7.107** Fetal well-being assessments are a significant component of antenatal inpatient care and this will frequently be through CTG monitoring. Typically, women admitted to the antenatal ward may need enhanced fetal monitoring so it is imperative that CTG monitoring is undertaken appropriately and interpreted correctly. Delaying action or misinterpreting an antenatal CTG may lead to a poor fetal outcome. This is especially true in high risk women, such as those with pre-eclampsia, diabetes or severe fetal growth restriction.
- 7.108** The RCOG ‘Green Top’ guidelines Reduced Fetal Movements¹⁵² advises that all women have an antenatal CTG from 28 weeks (pre-computerised CTG) if they are not in labour. CTG monitoring for at least 20 minutes provides an easy and accessible means of detecting fetal compromise. The presence of a normal fetal heart indicates a healthy fetus with a functioning autonomic nervous system. Interpretation of the CTG must be according to the NICE classification of fetal heart patterns.
- 7.109** The review team found there were many cases where an antenatal CTG was incorrectly classified, or there was a delay in acting upon a clearly abnormal CTG leading to poor fetal outcome.
- 7.110** *In 2003, at 37+4 weeks gestation, a woman reported to the maternity triage unit with reduced fetal movements. The CTG was reported as having a baseline rate of 90 beats per minute (grossly abnormal) but there was no escalation made to an obstetrician, an intrauterine death was confirmed 30 minutes later. (2003)*
- 7.111** *In 2011, a woman at 34 weeks’ gestation attended the day assessment unit with reduced fetal movements and symptoms of pre-eclampsia. She was sent home and informed to return at a later time. When she was eventually seen by a locum registrar four hours later the CTG was interpreted as being abnormal but was not correctly classified and immediate escalation did not occur. Even when the case was reviewed by the consultant there was a delay in expediting birth to a category one caesarean section, instead, opting to perform an obstetric ultrasound scan. The baby was born requiring admission to the neonatal unit and was later diagnosed with hypoxic ischaemic encephalopathy grade 3. (2011)*
- 7.112** *In 2010, a woman with a complex social history was admitted to the antenatal ward with preterm pre-labour ruptured membranes, (PPROM) at 29 weeks gestation. The review team found a failure to obtain adequate CTG’s and a failure to perform additional fetal wellbeing tests such as a fetal biophysical profile whilst the woman was an inpatient. The review team also found no use of prophylactic use of antibiotics once there was confirmed PPRM, which may have reduced the risk of maternal infection and its complications. There was a lack of communication to the woman and her family and a lack of a clear obstetric plan. An intrauterine fetal death occurred 4 days after ruptured membranes occurred. Examination of the placenta showed there was histological evidence of acute chorioamnionitis¹⁵³ and funisitis¹⁵⁴. There was a complaint made by the family regarding treatment and plans were made with lessons to be learned but there is no evidence from the documentation shared with the review team by the Trust of these actions having been put in place. (2010)*

152 Royal College of Obstetrics and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011)
<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/>

153 See glossary

154 See glossary

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.113** The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.114** The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.
- 7.115** Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.116** The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.
- 7.117** Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.118** The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.119** Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.120** All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.
- 7.121** All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.
- 7.122** The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 7.123** The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.
- 7.124** The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.
- 7.125** The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Chapter 8

Intrapartum care

Multidisciplinary working

Failure to escalate and lack of senior obstetric input

- 8.1** Effective communication between healthcare professionals and women is an integral component of safe maternity care, this is absolutely vital during intrapartum care. Maternity services should foster a team approach based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication¹⁵⁵.
- 8.2** In our first report¹⁵⁶, which was a review of 250 cases across the timespan of the review, evidence was provided that concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women. In this second report the review team has selected vignettes from more recent years to highlight both a failure to learn and a lack of progression at the Trust in terms of governance and learning.
- 8.3** All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant. The consultant should be responsive and attend in person in complex situations such as the cases outlined in the vignettes below¹⁵⁷.
- 8.4** *In 2014, a pathological CTG in the second stage of labour failed to attract the attention of the obstetric team for too long. The trainee was busy but even during the daytime, there was no apparent attempt to call the consultant obstetrician despite a complicated operative delivery of a baby in the operating theatre. This baby now suffers cerebral palsy and no governance review was conducted. (2014)*
- 8.5** *In 2016 a woman was taken to the operating theatre for an attempted forceps delivery. The baby's head was in the posterior position and the delivery was undertaken by a junior registrar. No attempt was made to rotate the baby's head to the correct position and during the forceps delivery the woman sustained a 4th degree tear. There was no evidence of duty of candour being performed and the issue does not appear to have been raised with the junior doctor as a training issue. (2016)*

Consultant presence on labour ward

- 8.6** The requirement for consultant obstetricians to be directly involved and lead in the management of all complex pregnancies, labour and delivery, with planned twice daily consultant-led ward rounds was identified as a local action for learning for the Trust within our first report. As the review team has continued to review all of the cases for this report we have found little evidence of planned consultant level reviews throughout the time period of this review. There were many cases which demonstrated that the supervision of trainee doctors during day and night time did not meet the required standards. Many high risk women received minimal obstetric care during the induction of labour and intrapartum period, until a point of midwifery request for review.

155 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)* <https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf>

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) <https://www.nice.org.uk/guidance/ng4>

156 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

157 Royal College of Obstetricians and Gynaecologists Safe Staffing (2021) <https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/>

- 8.7** *In 2007, in the death of a woman who was a practicing Jehovah's Witness and who laboured and gave birth to twins, no middle grade or more senior review was received until the final stages of her second stage of labour. Consultant input into her care was only sought when an extensive perineal haematoma was discovered many hours after the birth. (2007)*
- 8.8** *In 2012 a woman who did not initially want a vaginal birth after a previous caesarean section birth was advised to undergo an induction of labour after pre-labour preterm rupture of membranes with signs of infection. The registrar advised oxytocin to be administered after 2 hours of pushing and the woman pushed in the second stage of labour as the oxytocin continued to be increased for over 4 hours until she suffered a uterine rupture and her baby died. No consultant input was evident within this birth or during the immediate postpartum period. Oxytocin was prescribed by the registrar during advanced labour when there were signs of obstructed labour without first performing a medical review. No apology was given for the mismanagement of this case and the conclusions of the subsequent Trust risk review were not appropriate or relevant to the real issues at the time. (2012)*
- 8.9** One midwife spoke to the review team in autumn 2021, describing that in a previous trust they had been familiar with a system in which a senior trainee, anaesthetist and obstetric consultant would lead a ward round after handover twice a day. The midwife was concerned that there were no ward rounds at the Trust however when questioning this, the response they received was: 'No, no, no, you are the Band 7 coordinator, you should know when the doctor needs to see the patient'. The midwife described to the review team how she was laughed at and ridiculed for suggesting that multi professional ward rounds were necessary.
- 8.10** Evidence was found by the review team that when care was escalated at the Trust there was a failure of the senior clinical team to respond appropriately:
- In 2016, a woman was admitted to the labour ward with evidence of excessive uterine contractions with a reassuring CTG and severe hypertension. This was escalated to the registrar who decided upon no further intervention. The midwife's written statement indicated unhappiness with this response however these concerns were not escalated further. The CTG was pathological for one hour before delivery of a large for dates baby with significant shoulder dystocia and postpartum haemorrhage (PPH). The baby was later diagnosed with grade 3 hypoxic ischemic encephalopathy (HIE). Escalation and obstetric involvement in this case was poor throughout. (2016)*
- 8.11** *In 2016, a woman spent approximately 8 hours on the labour ward, where she received minimal medical input despite midwifery requests for a medical review of her raised blood pressure (BP). At numerous times during the late first and second stages of labour the woman's BP was recorded as 160/105 mmHg or higher which is a medical emergency. Repeated attempts to have the woman reviewed due to her high BP were unsuccessful and when the consultant was informed, nothing was written in the notes and the consultant did not review the woman, instead prescribing an anti-hypertensive which had little effect. During a subsequent major postpartum haemorrhage this same consultant attended, advised on drug use and again documented nothing. The governance review failed to address these issues of lack of consultant review and action. (2016)*

Midwifery leadership and culture on the labour ward

- 8.12** A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case. Although the role of the coordinator is challenging, with contemporaneous documentation sometimes difficult when dealing with emergency situations, many cases reviewed have failed to demonstrate even any good quality retrospective documentation. The verbal and written communication between the coordinator and obstetrician is paramount and there is evidence that it failed in numerous cases.
- 8.13** *In 2015, a woman with a raised BP had her labour augmented with oxytocin for 12 hours without an obstetric review. The labour ward was so busy that the labour ward coordinator was caring for another*

labouring woman and did not perform a 'fresh eyes' assessment on a CTG when asked. The midwife had previously attempted to escalate clinical findings of raised maternal BP, significant proteinuria and an abnormal CTG with no documented evidence that she was supported by senior obstetric or midwifery staff even when the emergency buzzer was pulled due to fetal bradycardia. Eventually a decision was made to expedite the delivery using forceps and the baby required admission to the neonatal unit for suspected infection. (2015)

- 8.14** It is not ideal for the coordinator to be caring for a woman in labour, although the review team appreciates this can happen occasionally in an emergency situation. This role must be supernumerary so that the labour ward remains safe and there is senior presence available to assist midwives and to facilitate escalation to the obstetric team¹⁵⁸. Midwives also have a duty to escalate care and challenge decisions when there is a concern about safety¹⁵⁹.
- 8.15** *In 2016, a woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*
- 8.16** There is evidence that over a long period of time midwives may have been reluctant to ask for help when working on the Trust's labour ward. One midwife explained to the review team in late 2021 how *'you just tried to keep your head down...asking for help was seen as a bad thing. People were derided for asking for help. Even something simple like a junior midwife asking for support suturing, they were like ... [ridiculed]...'*
- 8.17** Midwives providing intrapartum care outside the labour ward described facing reproach from labour ward colleagues when they telephoned regarding a possible need to transfer the woman to labour ward. One midwife outlined the challenges midwives faced when transferring women into labour ward or planning ahead when the clinical picture of the woman they were caring for started to change stating that there was *'a bullying culture'* on the labour ward.
- 8.18** The same midwife explained to the review team how the general culture on the labour ward was to joke that the transferring midwife did not know how to look after a woman in labour, for example, *'Do you not know how to look after a woman in labour? So that was the culture. It started off as being a little bit more of a jokey sort of thing, then it became really quite insidious so that I used to dread it, I would dread ringing. In the end I would say...this is the situation I am bringing the lady up, expect me in an ambulance in forty five minutes, and then I would always get, well if you bring her up, you would have to look after her yourself'*.
- 8.19** Another midwife told the review team in autumn 2021 of a culture of bullying on labour ward. *'Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it.'*
- 8.20** A further example was provided by a midwife who described being belittled when asking for support on the midwifery-led unit due to an excessive and complex workload. *'I said: "I can't accept somebody in labour because there are nine women, nine babies, a midwife who's not familiar that needs my support as well and I don't feel it's safe..." [A manager] came storming down and said, "You've got no authority to close this MLU", and I was like, "I'm not closing the MLU, I'm saying that we need further support to be able to safely do this." [The manager] belittled me in front of a group of staff there and told me, "You're taking this woman".'*
- 8.21** The same midwife also commented on how midwives were belittled when transferring women to the labour ward: *'You'll hand over care to somebody on the consultant-led unit and the comments that they make*

158 Ibid n1 and Royal College of Midwives. *RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings* (2016) <https://www.rcm.org.uk/publications/publications/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings/>

159 Nursing Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. (2015, updated 2018) <https://www.nmc.org.uk/standards/code/>

in front of the woman, can be very belittling and degrading to your face in front of a family and that's not cohesive. That's not putting the woman first'.

- 8.22** It is evident from considering numerous reviews and hearing staff voices throughout the autumn and winter of 2021 that there continues to be some major issues relating to the culture of intrapartum care at the Trust. Influencing factors include human factors, leadership from senior clinicians, lack of escalation, locum doctors working for many years with little supervision, lack of robust governance processes and a lack of multi-professional working.
- 8.23** The culture of intrapartum care at the Trust may have resulted in harm to mothers and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance (for example unsafe operative delivery and, in particular, a number of inappropriate breech deliveries). These examples continue throughout the period of the review to the very end. Examples of these are detailed throughout this report.
- 8.24** The direct links between incivility and patient safety have been well documented. Civility Saves Lives¹⁶⁰ sets out the detrimental impact uncivil behaviours have on team functioning, decision-making, performance and safety. The consultant obstetrician and labour ward coordinators have an integral role to play in role-modelling the professional behaviours and personal values that are consistent with positive team working, including the demonstration of respect for colleagues and women¹⁶¹.

Use of medical locums at obstetric middle grade

- 8.25** The review team found that there appeared to be a high reliance on the locum medical workforce working at middle grade at the Trust without evidence of documented supervision and governance.
- 8.26** *During the birth of twins in 2015, a family told the review team the doctor was 'so aggressive, he was shouting. The midwives didn't like him; that was obvious'. The doctor conducted a poorly managed twin delivery and walked out of the room (not to return) during a postpartum haemorrhage and episode of extreme hypotension. The Trust has not shared any evidence of learning or the development of actions following this case with the review team. (2015)*
- 8.27** *In 2016 a locum doctor failed to recognise or intervene during a 40 minute terminal bradycardia resulting from acute intrapartum hypoxia. After alienating both the midwife and woman, he was told to leave the room and did so without any further delivery of care. The baby was born with HIE and severely acidotic cord blood results. The Trust risk review process was not robust and there was no evidence of internal reflection. The RCA report failed to investigate and recognise that this incident occurred due to gross lack of team working, failure in escalation, failure to monitor the actions of locum staff, failure to recognise acute bradycardia in labour and failure to document to an expected standard. The report concluded that, 'it is difficult to understand the team dynamics'. (2016)*
- 8.28** The review team found several examples where locum doctors acted unsupervised, leading to poor outcomes for mothers and babies. Equally it appears that there were not clear escalation plans to the consultant or midwife in charge. In cases of adverse outcomes there is evidence that these were not investigated in line with the incident framework utilised at the time and individuals were not held to account.
- 8.29** Consultants must be visible, approachable and demonstrate effective leadership skills, enabling other team members to speak up when something is wrong, ensuring good information flow and clinical prioritisation¹⁶².
- 8.30** The widespread shortage of suitably qualified obstetricians who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident has been well documented. The RCOG has highlighted the need for adequate support and supervision of locums

¹⁶⁰ Civility Saves Lives. Civility Saves Lives (2017) <https://www.civilitysaveslives.com>

¹⁶¹ Ibid n3

¹⁶² Ibid n3

who enter the workplace and has recently released guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales¹⁶³.

- 8.31** Locum doctors are employed to cover staffing shortfalls and trusts should have appropriately robust recruitment processes in place including assessment of their skills and knowledge, with structured feedback and support before they are released to work independently.

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 8.32** The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.
- 8.33** The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.
- 8.34** There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.
- 8.35** Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.
- 8.36** All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.

Fetal Assessment and Monitoring

- 8.37** National intrapartum guidelines¹⁶⁴ recommend intermittent auscultation (IA) of the fetal heart rate (FHR) in low-risk pregnancies and continuous FHR monitoring if there are abnormalities such as tachycardia or decelerations, meconium, bleeding, or interventions such as epidural analgesia or oxytocin administration.
- 8.38** Intrapartum monitoring of the baseline FHR, presence of decelerations, and visually determined FHR variability are used to assess the risk of fetal acidaemia¹⁶⁵ via a set of clinical guidelines. However, FHR abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia.
- 8.39** On the one hand this mismatch results in increased operative delivery of non-acidotic babies; whilst clinicians on the other hand may miss fetal compromise because current guidelines remain silent on the adverse role played by intrapartum factors, which impair fetal adaptation to the challenges of labour such as fever, chorioamnionitis, meconium, abnormal fetal behavioural states, and excessive head moulding. National perinatal audits and quality improvement programmes such as the Confidential Enquiries into

¹⁶³ Royal College of Obstetricians and Gynaecologists *Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales*. (2021) <https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf>

¹⁶⁴ National Institute for Health and Care Excellence *Intrapartum care for healthy women and babies* (2017) <https://www.nice.org.uk/guidance/cg190>

¹⁶⁵ See glossary

Stillbirths and Deaths in Infancy (CESDI) and Each Baby Counts (EBC) have highlighted the significant contributions of these conditions to adverse perinatal outcomes.

- 8.40** In our first report we found significant problems with the conduct of intermittent auscultation and the interpretation of CTG traces. The review team found problems with intermittent auscultation of labour throughout the entirety of the review period right up to the very end of the review timeline. Vignettes from the cases considered by the review team are presented below which continue to illustrate significant knowledge gaps and examples where the care of complex cases was left in the hands of inexperienced staff.

Failure to recognise and/or escalate the abnormal CTG in early labour

- 8.41** *In 2012, a woman presented to the MLU in labour. A CTG was performed on admission, which was reassuring, and early labour was diagnosed. The woman described her pain as constant, but the midwife did not perform an abdominal examination. Intermittent auscultation (IA) showed a significant drop in the baseline fetal heart rate (FHR) although remaining within normal parameters. The FHR was not auscultated for 1 full minute following a contraction. The FHR was auscultated prior to the lady entering the pool and found to be 90bpm. There was a delay in escalation. The baby was born in very poor condition and was later diagnosed with cerebral palsy. The family had concerns that the FHR was not listened to enough. The Chief Executive's letter to the family incorrectly stated that the FHR would be auscultated every 30 minutes during labour. (2012)*
- 8.42** Fetal bradycardia should be reviewed urgently by an experienced obstetrician to exclude irreversible obstetric emergencies (abruption, cord prolapse and uterine rupture) and to correct reversible causes such as supine or epidural hypotension and uterine hyperstimulation due to excessive oxytocin use. Urgent delivery should be undertaken where indicated if the bradycardia does not improve.
- 8.43** *In 2012, a multiparous woman with an uneventful pregnancy had a membrane sweep at 41⁺² and at 41⁺⁴ weeks and later admitted to the MLU contracting regularly. The woman presented with a temperature of 37.7°C, maternal heart rate (MHR) 120bpm, and cervix 3cm dilated. Following concerns the woman was transferred and arrived on the labour ward 2 hours later. A female baby was delivered in poor condition by ventouse with an Apgar score of 1¹⁶⁶ at 1 minute and 1 at 5 minutes. Despite intensive resuscitation the baby died after 40 minutes. Post-mortem findings were consistent with infection as a cause of the death. (2012)*
- 8.44** Clinicians should always consider factors which can influence the fetus. Antenatal factors such as placental insufficiency, intrauterine infection, meconium aspiration, hypoglycaemia, recreational substance abuse or fetal brain injury can all influence fetal heart rate patterns. Where suspected, these cases should all be escalated urgently to make an appropriate plan for delivery.
- 8.45** *In 2018, a woman in labour had meconium stained liquor and fetal tachycardia. The family were given the option to 'carry on' with the labour or opt for immediate caesarean. There is no evidence of discussion with the consultant regarding an appropriate plan of care. The CTG was not considered pathological by the maternity review team and therefore to give the woman 'an option' to have a category 1 caesarean is not the standard practice. There is also no evidence that a further vaginal examination was performed prior to the caesarean to exclude or confirm full dilatation, in which case an emergency caesarean may not have been necessary. (2018)*
- 8.46** Fetal heart rate tachycardia associated with meconium staining of the amniotic fluid raises the likelihood of fetal infection significantly. The team should involve a consultant in the management as soon as possible to set out a plan of care, and the family should be involved in a Montgomery¹⁶⁷ compliant manner.

¹⁶⁶ See glossary

¹⁶⁷ <https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf>

Augmentation

8.47 Augmentation of labour is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour. This can be achieved either by intravenous oxytocin infusion and/or artificial rupture of membranes.

Use of oxytocin

8.48 Oxytocin can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and to facilitate cervical dilatation and vaginal birth.

8.49 Many examples of the injudicious use of oxytocin were highlighted in our first report. The review team has found further examples of inappropriate oxytocin use which impacted upon fetal wellbeing and neonatal outcomes suggesting that sufficient learning from previous cases had not occurred. A common theme identified by the review team was the inappropriate commencement and continuation of oxytocin despite evidence of deterioration of the baby's condition.

8.50 Oxytocin should only be used when there is a valid indication and potential benefit for its use and appropriate guidelines and equipment available to support its safe administration. One-to-one midwifery care must be provided and the FHR rate and maternal contractions must be closely monitored. The identification and escalation of any concerning features relating to CTG changes should occur promptly and oxytocin reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns.

8.51 Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour. Decision-making regarding the plan of care and mode of birth should consider any additional risk or intrapartum factors which impair fetal adaptation to the challenges of labour and the stage of labour that has been reached.

8.52 *In 2012 a woman presented in spontaneous labour at 30 weeks' gestation. After an hour of pushing in the second stage, the fetus remained high in the pelvis with a pathological CTG. An oxytocin infusion was commenced. After a further hour of pushing, the woman consented to a trial of instrumental delivery in theatre. A manual rotation was undertaken followed by the application of Wrigley's forceps with a presenting part level with the ischial spines. No descent was noted after one pull. An emergency caesarean section was undertaken, and the infant was delivered in poor condition. The infant was resuscitated, but later died due to complications of severe hypoxic ischaemic injury and massive hypoxic damage to multiple organs. (2012)*

8.53 *In 2014, a woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken by the Trust but it failed to identify or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change future clinical practice. (2014)*

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.54 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

8.55 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

- 8.56** Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors

Midwifery-led units

- 8.57** There are five Midwifery-led-units (MLUs) that have provided antenatal, intrapartum and postnatal care in addition to the consultant maternity unit at the Trust, during most of the time period of this review. The Royal Shrewsbury Hospital, (RSH) in Shrewsbury, provided consultant-led care until 2014. Consultant obstetric services were relocated to the Princess Royal Hospital (PRH) in Telford in 2014. An overview of births by each MLU is provided in table 1 below. The review team is advised that Wrekin MLU has recently moved to a new location adjacent to the Shropshire Women and Children’s Centre at the PRH.

Table 1: Births by MLU Overview (Source: SaTH Clinical Dashboards)

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

- 8.58** Issues relating to MLU closures and staffing availability have been highlighted within the local press and Telford and Wrekin CCG’s Quality and Safety Report in 2013. Staff shortages within maternity are also raised as an issue within the Trust’s 2021 CQC report¹⁶⁸ and remain an urgent wider issue for maternity care on a national basis.
- 8.59** Evidence from staff who have contacted the review team suggest that there was an expectation for midwives working on the MLU to manage with reduced staffing. A midwife who had worked at the Trust until 2021 commented that: *‘historically, whilst working in the MLU, there was an expectation to stretch the boundaries of what was considered normal...MLU staff are seen as less important, less valuable, and less skilled. There can be poor conversations between teams frequently but teams working together stick together and support one another. This remains to this day. There is a very toxic culture within the place and it seems impossible to break despite some individuals trying to raise as an issue - myself included and part of the reason I have now left’.*
- 8.60** Another long term community midwife reflected on the impact this had on safe care provision on the MLU where there were *‘...incidents where we are caring for a woman and the second midwife has been told to leave the unit to move to another area. This is unsafe practice as there should be two midwives on the unit when a woman is birthing at all times’.*

168 Care Quality Commission Inspection (2021) <https://www.cqc.org.uk/provider/RXW?referer=widget3>

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 8.61** Midwifery-led units must complete yearly operational risk assessments.
- 8.62** Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.
- 8.63** It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

Delay in escalation and taking appropriate action

- 8.64** The review team found evidence of failure to appropriately document the FHR and undertake continuous electronic fetal monitoring (CEFM) using a CTG when abnormal FHR changes were detected on the MLU. Evidence of this has also been presented above. Information gained from any investigations performed after a birth were not always shared with women and families, and evidence of appropriate governance and shared learning from such incidents is frequently unavailable.
- 8.65** *In 2006, a multiparous woman was noted to have an abnormal FHR whilst in labour on the MLU. This was not acted upon, a CTG was not performed nor was the case escalated. The woman suffered a stillbirth. In the bereavement follow-up appointment the consultant gave incorrect information and initially withheld information from the parents about the possible cause for their baby's death. (2006)*
- 8.66** *In 2010, a primiparous¹⁶⁹ woman attended the MLU in labour. Intermittent auscultation (IA) was started, however there was a delay in starting CEFM when this became abnormal. Eventually the CTG was started and a further examination was undertaken which revealed a cord prolapse. Emergency transfer was arranged and delivery by caesarean section. The baby was born in poor condition and required cooling. There were missed opportunities for earlier transfer. (2010)*
- 8.67** *In 2010 there was a failure to appropriately document intermittent auscultation (IA) of the fetal heart and commence CTG monitoring for a woman labouring in the pool with meconium. There was a significant delay from the time of decision to transfer to the Royal Shrewsbury Hospital (RSH) to calling the ambulance for transfer. The midwife failed to ascertain the fetal wellbeing during transfer. Following admission to labour ward a CTG was commenced and was abnormal. The midwife escalated her concerns to the registrar and prepared the woman for an emergency caesarean section. Due to the workload of the labour ward the registrar was called away to attend a twin birth and there should have been escalation to the on-call consultant, who should have attended. The baby was born in poor condition, intubated and received cardiac compressions before receiving hypothermic cooling. (2010)*
- 8.68** A number of the MLU cases reviewed by our team reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon. Evidence of poor teamwork and communication during transfer has also been presented elsewhere in this and other chapters of this report.

169 See glossary

- 8.69** *In 2010 a mother self-referred to Wrekin MLU with absent fetal movements and abdominal pain. There was a failure of the two midwives working there to recognise the evident clinical signs of placental abruption: an obstetric emergency. There was no attempt to cannulate the mother and it took 80 minutes to assess her and order a “blue light” ambulance transfer from Telford to Shrewsbury. No paramedic crew were requested. Arrival time at the consultant-unit from initial admission was 1 hours 45 minutes. Following arrival there was appropriate assessment and whilst the baby’s death appeared unpreventable there are many care delivery issues that suggest that learning from this event was required. Postnatal care was not appropriate and there was no obstetric documentation in the notes until 09.45 the next day. There is no evidence of a governance review or learning from this case by the Trust. (2010)*
- 8.70** *In 2013 a woman with a history of multiple miscarriages attended the MLU for a post-term membrane sweep at 40+5 weeks gestation. A fetal bradycardia was noted prior to the procedure and the woman walked over to the consultant-unit and was in theatre within 20 minutes for a category 1 caesarean section. There followed a delay of 17 minutes after the consultant arrived in theatre where he discussed the possibility of not performing a caesarean section. The parents opted to proceed and the baby was born in poor condition and developed severe cerebral palsy. Neonatal care at all points within this case was excellent. The SI investigating team was solely made up of midwifery staff with no evidence of inclusion of an obstetrician, neonatologist or Trust executive all of whom would be expected to have involvement in this level of investigation. (2013)*
- 8.71** *In 2016 a primigravid¹⁷⁰ woman called Wrekin MLU at 09:18 stating that she did not think things were right as her baby was not moving as much and the pattern of movements had changed. She was advised to lie on her side, have a cold drink, and focus on the baby’s movements over the next two hours. The woman responded that she had done all of that already and still had reduced fetal movements. The MLU staff member responded that they had a lot on that morning so to wait until lunchtime before coming in. On arrival there was difficulty ascertaining the FHR, an ultrasound scan (USS) performed and urgent transfer to the consultant-unit was arranged where a category 1 caesarean section was performed. The baby was born in poor condition and died the following day. The parent’s comments suggest that they were put off attending the MLU earlier that day when they phoned with concerns because the unit was busy. The parents expressed many concerns about the bereavement care, the lack of information and their belief that the emphasis was on damage limitation for the hospital. (2016)*
- 8.72** A midwife employed at SaTH for many years who left in recent years¹⁷¹ told the review team that: ‘The MLU’s practice needed to be standardised and updated as practice was not evidence-based. There was nobody competent to update guidelines, what guidelines they had were not evidence-based’. In relation to learning from incidents the midwife emphasised that there was a reluctance to rotate staff to different clinical areas for updating for fear of upsetting people and ‘When an incident happened, once the cause had been identified and the actions agreed it took too long to implement change’. The review team notes that many guidelines have since been reviewed and updated.
- 8.73** Recent findings from national perinatal surveillance data which focussed on intrapartum stillbirths and intrapartum-related neonatal deaths in planned births at freestanding MLUs and those alongside consultant-led units found that in 75 per cent of deaths improvements in care were identified that might have made a difference to the outcome for the baby¹⁷². The authors conclude that these findings do not address the overall safety of midwifery-led settings for healthy women with straightforward pregnancies, but suggest areas where the safety of care can be improved. Issues with care were identified around risk assessment and decisions about planning place of birth, intermittent auscultation, transfer during labour, resuscitation and neonatal transfer, follow-up and local review.

170 See glossary

171 Date of leaving provided to review team but not stated to maintain confidentiality of staff member

172 Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. *Intrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMIE confidential enquiry.* (2020) BJOG 127

- 8.74** Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance¹⁷³. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality¹⁷⁴.
- 8.75** *In 2018 a woman made numerous contacts with Wrekin MLU triage throughout her pregnancy and early labour due to concerns about reduced fetal movements, bleeding and spontaneous rupture of membranes (SROM). Based upon national guidance it would have been appropriate for the woman to have been transferred to the consultant unit. Local Trust guidance did not align with national guidance. The baby was born in poor condition on the MLU and despite extensive resuscitation and neonatal support a decision was made to withdraw care and the baby subsequently died. (2018)*
- 8.76** National guidance recommends that when there are maternal concerns about fetal movements, the woman and the baby should be assessed (NICE, 2021). It is important that this assessment takes into consideration the full clinical picture and previous history of reduced fetal movements.
- 8.77** The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway was presented as an essential action in report 1. The review team continued to find evidence that this did not always happen. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Vaginal breech birth

- 8.78** Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women's wishes in relation to mode of birth were evident within the vaginal breech cases reviewed across the timespan of the review. Women reported to the review team that they were persuaded to have a vaginal breech birth without the associated risks being explained or there was a failure to make decisions regarding mode of birth in a timely way. There is a lack of evidence that governance processes were fully implemented which may have provided the Trust the opportunity to refine its decision-making processes, define the personnel needed for a safe breech vaginal delivery and refine the escalation pathways on the labour ward.
- 8.79** *Request for consultant advice or attendance was never made for the vaginal breech birth of a woman at 36/40 weeks gestation in 2003. There was a lack of formal documentation regarding the mother's birth wishes and advantages and disadvantages of mode of birth. The middle grade doctor was asked by the midwife to examine for footling breech but declined to do so. It was inappropriate for the most inexperienced member of the medical team (SHO) to be conducting a footling breech delivery alone in the labour room without registrar or consultant attendance. During the birth an emergency caesarean section was arranged. There is no documentation of involving the consultant in any way and when the consultant attends in theatre [they] appear surprised in [their] notes at the impending situation. The baby was born with no signs of life and after extensive resuscitation died at approximately 3 hours of age. (2003)*
- 8.80** *There was a failure to appropriately plan and escalate care for a woman at 31 weeks' gestation in labour with prolonged premature rupture of membranes in 2011. On the day of delivery, there was a failure to escalate for consultant decision-making, failure to make definitive decisions regarding the mode of delivery, failure to have adequate and highly trained individuals at the delivery, and failure to understand that a footling breech delivery at 31/40 weeks is relatively contraindicated by local and national guidelines. There was also no internal investigation of this case and so no evidence of lessons learned. (2011)*

173 Glenister C, Burns E, Rowe R. *Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS)*. (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

174 Rowe RE. *Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality*. (2010) Quality and Safety in Health Care 19 (2):90-4.

Management of twin pregnancies and births

- 8.81** Some of the issues within this section reflect the findings presented previously in this chapter, namely unsafe operative delivery, inappropriate use of oxytocin and a failure to escalate care with the added complication of a twin delivery to consider. The review team found significant concerns with the management of twin labour and births throughout the whole of the review period right to the very end of the review.
- 8.82** *In 2013, a primiparous woman with an IVF conceived twin pregnancy was induced at 36+5 weeks gestation as the second twin was found to be small. After one hour of pushing a decision was made for trial of instrumental delivery in theatre under spinal anaesthetic by a consultant and registrar. The first twin was born in good condition following a Keilland's forceps rotation. The second twin was born 37 minutes later by Neville Barnes forceps, after a total of 9 attempts at delivery by ventouse and Keilland's forceps. The baby was born in very poor condition and required resuscitation and transfer to the NNU where he underwent cooling and had multiple blood transfusions. He was subsequently diagnosed with moderate to severe HIE, subgaleal and subdural haemorrhage with depressed bilateral skull fractures. The administration of second stage oxytocin did not follow any guideline or regime. There was no concluded Trust investigation provided to the review team. (2013)*
- 8.83** *Inappropriate use of oxytocin and poor CTG management was noted with no escalation during the labour of a woman with a twin pregnancy at 35+4 weeks gestation in 2013. The second twin's birth was not expedited when it should have been and the baby was diagnosed with HIE 2. There was no obstetrician or neonatologist in the room for the birth of twin 1 despite twin 2 being breech, they were called to assist with twin 2 following a placental abruption and the baby required a vaginal breech extraction. (2013)*
- 8.84** *A woman was admitted to hospital in 2014 at 34+6/40 weeks gestation with a suspected urinary infection with uterine tightenings. It was found that that both twins had died in utero. Placental abruption was noted at birth, with partial dehiscence of the uterine scar. Brown liquor was also noted which was mildly offensive. (2014)*
- 8.85** *The antenatal care was complex as the woman had numerous admissions to hospital for abdominal pain and tightenings, urinary symptoms and back ache. It was noted that the CTGs during admissions often had loss of contact or poor quality interpretation that was not escalated. The woman's voice was not heard as it was documented that there were reduced fetal movements but no action was taken. The woman met with the Trust who made promises around improving bereavement support, but the mother told this review that it felt that this was not actioned. (2014 until 2020)*
- 8.86** *In 2016 a woman who had a twin pregnancy, complicated by twin to twin transfusion syndrome, developed pre-eclampsia and was allowed to go home despite signs of evolving pre-eclampsia. Subsequently one twin died and the governance review documentation leans towards blaming the woman for the outcome, as she decided to go home rather than accept the 'offer' to remain in the unit as an inpatient. (2016)*

Management of high-risk and complex mothers

- 8.87** In a significant number of cases the review team found evidence that the poor outcomes in mothers and babies were caused mainly because clinicians failed to recognise women at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications such as severe hypertension and significant antepartum haemorrhage. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.
- 8.88** *A woman presented on multiple occasions around term with hypertension and proteinuria in 2009. There were missed opportunities to manage hypertension appropriately with the woman returning at least four times for assessment of blood pressure, when there could have been consideration for delivery. During this time she saw a relatively junior member of medical staff and there was a failure to consider the worsening*

picture of pre-eclampsia and no involvement of the labour ward coordinator. There appeared to be no urgency to treat the severe hypertension and there was little thought as to whether to give magnesium when this was appropriate. The baby was born in poor condition with Apgar scores 1 at 1 minute and 6 at 5 minutes. (2009)

- 8.89** *In 2017 a primigravid woman in spontaneous labour developed mild intrapartum hypertension. She required emergency caesarean delivery and received ergometrine intraoperatively. Subsequently, she developed significant postnatal hypertension and required treatment. Her medical records and subsequent correspondence indicate significant friction between the midwives and the registrar over the administration of ergometrine and its subsequent effect. The parents' concerns and communication about investigation of the drug error were poorly handled, leading to a formal complaint. (2017)*

Psychological birth trauma

- 8.90** The degree of life-long psychological trauma revealed by families in this report is harrowing and profound. Women and families have given graphic written and verbal accounts describing their recollection of events that have led to long-term depression, anxiety, distressing memories and post-traumatic stress disorder (PTSD). Some have sought psychological treatment, whilst others have remained silent until now.
- 8.91** Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.
- 8.92** *A woman who gave birth in 2009 told the review team: 'I was lying on the table and was prepared for surgery but they couldn't find the anaesthetist. The senior midwife said to the assistant who was there "If this baby dies it's on his head". I reminded her I was still awake and she said "sorry no it will all be fine...". After the anaesthetist was found I was put under. My husband who was waiting outside was told 'go and walk round the car park for 45 minutes. But I have to prepare you don't hold out much hope for the baby' I had counselling after the experience but still felt I needed to complain as I knew how lucky we had been that our daughter was not only alive but well. I wrote my concerns down and the response I had just made me so angry. It didn't address any of my concerns...it was so bad that to be honest I gave up and just tried not to think about it.' (2009)*
- 8.93** There were many cases reviewed in which the care provided aligns with national standards and where there is evidence of the maternity team at the Trust going above and beyond the usual expectations in an attempt to support women. It is evident that for many women, any deviation from the expected progress of events, such as passage of meconium, bleeding of any degree or suspicious features on CTG is recalled by them years later as a failure of appropriate care.
- 8.94** Sometimes, despite documented good quality care and reassurances, the woman's recollection is terror, guilt, suspicion and feelings of Trust cover up. In addition, many women perceived any deviation from normality to be an indicator that a caesarean section was needed and that this was subsequently denied to them by the Trust. Despite this, the review team has seen many cases of meconium stained liquor, marginal placental abruption and mild infection that were managed appropriately with a trial of labour and outcomes that have been satisfactory.
- 8.95** *In 2017, a woman whose baby presented in the occipito-posterior position laboured for 15 hours having experienced a small antepartum haemorrhage. The woman received very good care during labour with ongoing and appropriate efforts to address her anxiety and analgesia requirements. A caesarean section was performed within a standard timeframe and both mother and baby were well following this. Despite good care, the woman's recollection of labour has developed into ongoing treatment for PTSD. (2017)*
- 8.96** Formal diagnosis of PTSD is a common finding in the review and despite the evidence of some good care as detailed above, there were also many cases reviewed that demonstrate poor management in labour that resulted in ongoing physical and psychological harm for women as detailed in the following vignettes.

- 8.97** *In 2011, a woman suffered psychological harm after being accused of ‘being lazy in labour’. Also, as an employee of the Trust, she was advised against making a complaint. (2011)*
- 8.98** The review team has heard recollections from women relating to feelings of loss of control and power, (2016), excessive and painful vaginal examinations (2003), not being listened to (2002; 2004; 2015; and 2016) which resulted in psychological trauma for themselves and on occasion their birth partners.
- 8.99** *In the case of a forceps delivery and a missed recto vaginal fistula in 2009, a woman told the review team: ‘Following my daughter’s birth by forceps, I was passing wind through my vagina. My wound was never checked whilst I was a patient in the hospital. It was only when I got home that a midwife asked me how I was and I said I felt something wasn’t right. She did then check me at home but found no problem. A couple of weeks later I went to see my GP about it and I was referred back to the hospital.*
- 8.100** *I saw a consultant obstetrician. After examining me the doctor informed me that I’d had a large baby and that had caused in her words “a baggy fanny”. To say I was upset is an understatement and despite telling her that I could tell the wind was coming from my back passage and passing through to the front, she said no further investigation was required. My issues got worse and the anxiety of going outside and embarrassing myself by having no control of passing wind meant I became nervous, anxious and depressed which seemed to exacerbate the situation. All of which resulted in upset stomachs and loose stools which resulted in my passing faeces through my vagina. Feeling that I should have pushed this matter further in the hospital made me feel inadequate as a mother. With the fistula causing personal care issues for me, the depression got worse. It wasn’t diagnosed for quite some time. The emotional effects of all this still affect me 10 years on.’ (2009 -2019)*
- 8.101** *A consultant said to a woman with physical disabilities in 2008: ‘How do people like me get pregnant, who would do that [have sexual intercourse] to me, and did I know what I was doing?’. (2008)*
- 8.102** *Many women describe how they moved to different units for subsequent births or even to other countries. One woman in 2013 described to the review team how she could never contemplate giving birth in the UK again and found her experiences in the USA far more acceptable. (2013)*
- 8.103** *After not feeling listened to in 2016 another woman described: ‘not having the courage to stand up and advocate for herself’. (2016)*
- 8.104** The few cases of maternal ICU admission for life-threatening illness are strongly associated with ongoing psychological morbidity and PTSD and women have expressed their strong desire for professional psychology services to be available to them.
- 8.105** *In a case of chorioamnionitis and failure to act on a pathological CTG in 2012 a woman told the review team: ‘They spent half an hour trying to resuscitate my daughter in the corner of the room, didn’t say anything to us until it was: “I’m sorry, but we couldn’t save her”. [I said] “But you were telling us everything was fine”. On top of that, the aftercare was absolutely appalling as well. They left us in the [delivery] room for I don’t know how long and then they put me in a wheelchair, gave my daughter to me, put us in a room and left us there basically. What was even worse, they put us on the maternity ward so we could hear babies crying. We could hear people being congratulated’. (2012)*
- 8.106** *Following a cardiac arrest in 2014, a woman still finds it difficult to come to terms with her condition and feelings she could still die. She described to the review team unhelpful comments from an unknown doctor saying, ‘ “Hi, I was the guy that restarted your heart”. I couldn’t cope with that. I was really struggling with the gratitude I felt for the people that had saved my life but also needed some counselling.’ (2014)*
- 8.107** *There were failings within the MDT in 2014 to manage a woman’s history and experience of childhood sexual violence. There was evidence of a disconnect between the midwifery notes and the woman’s recollection of events. Following her birth experience, the mother contacted the review team to help her to determine if her PTSD, and a birth injury which took years to heal, and left her unable to work is ‘normal and acceptable’. The woman explained to the review team that she had been unable to leave the house between 2014 and 2018.*

- 8.108** Evidence that staff at the Trust often try to settle fears and anxieties is present in many case reviews yet long term psychological harm has still occurred. Postnatal discussion meetings have routinely been offered to women at the Trust over many years but a debrief with a midwife is often not enough for women who have harboured deep seated anxieties and memories and have complex clinical questions that require answers. Most midwives in the UK are not trained to provide professional counselling and may not have the clinical knowledge to adequately explain clinical scenarios that require the input of an obstetrician, neonatologist or anaesthetist.
- 8.109** It would seem that women receiving their maternity care at the Trust may require the opportunity to review their birth experience more often and in a different way than is currently provided, even if the care was perceived as good. In cases where clinical care was below optimal or complications occurred, ongoing psychological support for women is necessary.
- 8.110** The NHS Long Term Plan¹⁷⁵ renewed the commitment for the NHS to improve specialist perinatal mental health services. The Perinatal Mental Health Programme and the Maternity Transformation Programme are working together to fulfil this ambition to enable maternal mental health services to be improved by establishing nationwide Maternity Outreach Clinics by 2023/24. This service will help provide support for women with moderate to severe complex mental health problems resulting from their maternity experience and is expected to address issues such as PTSD, perinatal loss and tocophobia (fear of childbirth).
- 8.111** In July 2020, NHS England and NHS Improvement invited proposals for pilot areas for the testing and development of a maternal mental health service. Shropshire Telford and Wrekin were selected as an early implementer and have revised and updated their Maternity Mental Health guidance. There is evidence that the Trust is working towards improving access to perinatal mental health services.

Conclusion

- 8.112** This second report builds upon our first report¹⁷⁶ published in December 2020. In that first report, evidence was provided that concerns were not appropriately escalated, leading to a direct impact on the safety and quality of care provided to women and their babies. In this second report which concludes our review of family cases the review team has highlighted both a failure to learn and a lack of progression at the Trust in terms of governance and learning across the timespan of the review.
- 8.113** In this chapter the review team has highlighted the essential need for effective communication between all healthcare professionals providing maternity care and the women they provide that care for. We have highlighted numerous examples where communication was not at the standard expected or required. As with other chapters in the report there is an ongoing concern from maternity staff at the Trust feeling unable to speak out and raise concerns about care at the Trust. This is an issue that requires urgent action and resolution at the time of publishing this report.

175 NHS England. *The NHS Long Term Plan* (2019) <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

176 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. (2020); https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9

Postnatal care

- 9.1** There is a need for continuing midwifery and multi-professional observation of the mother and her baby during the postnatal period since serious events or deterioration of already known conditions can occur in this time. The time after the birth of a baby is often when new mothers report they feel most vulnerable, with vulnerability increased where a woman already experiences social disadvantage or pre-existing medical co-morbidities. It is essential, therefore that postnatal care is safe, supportive and compassionate.
- 9.2** The importance of senior (consultant) involvement in acute care, including postnatal care, was emphasised by the RCOG 2021¹⁷⁷ when it noted that ‘consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission’ and that ‘this standard also applies to postnatal admissions’. This is not new advice, and reiterates Keogh¹⁷⁸ standard 2 first published in 2015 and emphasised by MBRRACE UK 2019¹⁷⁹. MBRRACE advised a ‘review of guidance [was] needed to ensure that deviation from the usual clinical pathway, with unexpected, or unexplained, symptoms [then] triggers a consultant review’. MBRRACE also noted ‘These enquiries have emphasised repeatedly the importance of senior review in relation to abnormal postnatal symptoms’.
- 9.3** Overall improvements in postnatal care across the wider maternity system require significant investment in both workforce, and technology, especially the improved availability of information technology on postnatal wards and across the community too. Midwifery and support staffing on postnatal wards is often poor, and across England maternity teams will recognise that staff are moved from postnatal wards and the community when there are staff shortages in those areas considered to be more acute, such as the labour ward. Across postnatal care the staff at the Trust have described to the review team how they are stretched beyond capacity. This can then lead to poor physical, social and emotional care provision for mothers and their babies.
- 9.4** Early postnatal discharge from hospital to home is not always appropriate, despite pressure (which can be from families or the maternity service) for women to leave hospital soon after birth. It must therefore only occur if clinically appropriate, and there must be appropriate support in the community after discharge. Across England, improved midwifery and support staffing levels in postnatal care will improve the safety of that care and lead to an increase in family satisfaction. Consultant job planning must also be considered to ensure that postnatal reviews are a timetabled activity.

Lack of consultant involvement in the management of complex postnatal cases at the Trust

- 9.5** The review team noted many cases where there was no consultant review, or inadequate consultant involvement, in the management of complex postnatal problems in maternity services at the Trust. For example:
- 9.6** *In 2002 a woman spent 17 postnatal days in critical care, and sadly died. During that time she was only reviewed on four occasions by an obstetric consultant. There should have been greater consultant obstetrician input into her ongoing care. (2002)*
- 9.7** *In 2006 a woman with known cardiac problems was discharged home soon after birth without consultant review, despite having been fluid overloaded in labour requiring treatment with diuretics and oxygen. She was admitted some three weeks later in significant heart failure and died. (2006)*

177 Royal College of Obstetricians and Gynaecologists, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021) <https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf>

178 Keogh B, *Seven Days a Week*, NHS England (2015) <https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/>

179 Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17*. Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019). <https://www.npeu.ox.ac.uk/assets/downloads/mbrance-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf>

- 9.8** *In 2007 there was no postnatal consultant review after a difficult caesarean section, even though the registrar who performed the surgery informed a consultant that they were concerned that there might have been bladder damage during the operation. The consultant simply advised an indwelling catheter for 14 days, however, after the woman was discharged home on day five she was readmitted on day 12 but was not reviewed by a consultant until day 15 when she was finally diagnosed with a ureteric injury which occurred during her caesarean section. (2007)*
- 9.9** *In 2011 a woman with known pregnancy induced hypertension, who required a prolonged postnatal stay in hospital because of labile blood pressure, had no postnatal consultant review. Earlier consultant review could have identified seriously deteriorating HELLP¹⁸⁰, from which the mother subsequently died. (2011)*
- 9.10** *In 2018 a woman who underwent a caesarean hysterectomy because of a placenta accreta¹⁸¹ had her surgery performed by a consultant, who also reviewed her the day after surgery, but there was no further consultant involvement in her care after this. (2018)*

Complex postnatal care requiring readmissions

- 9.11** Postnatal readmissions, for maternal complications, are uncommon, and are by definition complex. Management should therefore include review by a consultant. However, there were several cases where timely consultant review did not occur:
- 9.12** *In 2006 a woman was admitted with postnatal faecal incontinence, but was not seen by a consultant until 4 days after admission. (2006)*
- 9.13** *In 2009 a woman remained on the postnatal ward for 15 days after a caesarean hysterectomy for placenta accreta. In the first week she had regular obstetric review, including consultant reviews on days 1, 3 and 8. In the second week recording of maternal observations was very ad hoc and all the reviews were by very junior doctors. This woman was discharged home on day 15 by a junior doctor but was readmitted later the same day with severe sepsis, requiring ITU admission. Adequate observations, and thorough review before discharge, should have alerted clinicians to the developing sepsis, and would have allowed more timely management, possibly avoiding the need for ITU care. (2009)*
- 9.14** *In 2018 a woman was admitted with postnatal endometritis¹⁸², but did not have any consultant reviews. In this case the management was not timely, as it was not recognised that she had retained placental tissue requiring removal under anaesthetic until 3 days after admission. (2018)*

Observations and appropriate responses

- 9.15** Observation of vital signs, and appropriate response if they are not normal, underpins the provision of safe maternity care. This should occur at all stages of pregnancy, including the postnatal period. The review has noted many cases where this did not occur across the timespan of the review.
- 9.16** *In 2000 there were very limited postnatal observations recorded of a woman who had experienced a stillbirth, with abruption, and a 3 litre blood loss, which required a blood transfusion. (2000)*
- 9.17** *In 2008 there had been abnormal observations recorded but the midwife simply discontinued observations without explanation. This resulted in a delay arranging the blood transfusion this woman required. (2008)*
- 9.18** The review team has also noted a number of cases where women with known pregnancy-induced hypertension either had few postnatal observations recorded, or had hypertension recorded but there was no response to the abnormal readings (both on the postnatal ward and in the community). These cases include examples seen in **2008** and in **2011**.

¹⁸⁰ See Glossary

¹⁸¹ See Glossary

¹⁸² See glossary

- 9.19** *In 2008 when a woman reported severe rectal pain after a forceps delivery there was little consideration that she may have a serious complication. She was given analgesia, but very few observations of her vital signs were made, even when it was noted that she had only passed small volumes of concentrated urine. It was eventually realised, when it was noted that her heart rate was 140–160 bpm that an internal haemorrhage was likely, and her management was discussed with the on-call consultant who advised examination under anaesthetic (EUA) in theatre. Initially no plans were made for the consultant to attend theatre, but as the woman had still not gone to theatre 90 minutes after the decision for EUA, the consultant did attend. The woman went on to have a laparotomy¹⁸³, and drainage of a large retropubic haematoma¹⁸⁴. She also required a 6 unit blood transfusion. Earlier recognition of her blood loss should have led to more timely management. (2008)*
- 9.20** Shock in the postnatal period should be recognised by all members of the multidisciplinary maternity team. The team must be aware that as most pregnant women are fit and healthy they can compensate for blood loss, and therefore may not show all the classic signs of hypovolaemia¹⁸⁵, which are an increasing heart rate with a fall in blood pressure, usually secondary to blood loss. The review team noted a number of cases where there was a significant delay in either recognising postnatal shock, or a slow response to the situation by clinicians. These are discussed below:
- 9.21** *In 2006 a woman was admitted with a significant secondary postpartum haemorrhage (PPH). Fluid resuscitation was slow, as was the decision for an examination under anaesthetic (EUA) during which the mother required a hysterectomy. (2006)*
- 9.22** *In 2006 the midwife noted excessive blood in the drains after an emergency caesarean section with an associated tachycardia and fall in oxygen saturation. The midwife did inform both the registrar and consultant of her concerns. A litre of colloid fluid did not improve the mother's tachycardia, and her oxygen saturation deteriorated, but the obstetric team did not appear concerned as the blood pressure remained normal. It was not until approximately 2.5 hours after leaving theatre that a bedside blood test was performed which revealed a life threateningly low haemoglobin level of 3.3g/dL. She was then rapidly transfused and returned to theatre where she underwent repair of a bleeding left uterine artery. (2006)*
- 9.23** *In 2008 a woman with known severe pre-eclampsia developed pulmonary oedema some 36 hours after an emergency caesarean section. This is a recognised potential complication, which is why her postnatal care should have been multidisciplinary (obstetrics and anaesthetics) and should have included a clearly documented postnatal MDT¹⁸⁶ management plan of fluid restriction, careful monitoring of fluid balance and regular MDT clinical review including chest auscultation¹⁸⁷. In this case the care was not multidisciplinary, and did not involve appropriate fluid management. Had this occurred she would certainly have been better managed, and the pulmonary oedema possibly avoided, or managed earlier, so that admission to the medical HDU where her pulmonary oedema was well managed might have been avoided. (2008)*
- 9.24** *In 2016 a consultant obstetrician ignored clinical signs suggesting an ongoing problem. After a normal birth a woman had a high uterus and ongoing bleeding, this was managed with an oxytocin infusion but the heavy trickle of blood continued. She developed symptoms of light headedness, as well as a fast heart rate, and low blood pressure. Her blood loss was recognised, and managed with one unit blood transfusion. As her bleeding was still ongoing 7 hours after birth the registrar planned for her to have an examination under anaesthetic (EUA) to check for any retained placental tissues, or unrecognised tears. When she was reviewed by a consultant, some 9 hours after the birth, the consultant decided that EUA was not needed. The woman was transferred to the postnatal ward, where she had a further 3 unit blood transfusion the*

183 See glossary

184 See glossary

185 See glossary

186 See glossary

187 See glossary

next day, and was discharged home on day 3. She was readmitted 20 days later with heavy bleeding, and when she did undergo the EUA a large (9 x 5 x 3cm) piece of placental tissue was removed. Clearly the initial management controlled the immediate symptoms, but did not treat the underlying cause of retained placental tissue. Had the EUA occurred 7–8 hours after the birth, as planned by the registrar, then this woman would not have been exposed to the increased risk of infection and secondary haemorrhage. (2016)

Escalation

- 9.25** The review team has noted many cases where abnormal findings by midwives have then not been escalated to the midwife in charge of the ward/unit or to appropriately senior medical staff.
- 9.26** *In 2008 a postnatal woman, with known pre-eclampsia, had her blood pressure taken 5 times over a 20 minute period with all readings showing significant hypertension with no further escalation. A junior doctor came to review, but on attending found the woman asleep so the review did not occur until she woke up very confused, and with a headache about 2.5 hours after the hypertension was first noted. She was subsequently managed with a magnesium infusion and antihypertensive medication. (2008)*
- 9.27** In some cases midwives appropriately escalated concerns to medical staff, but the response to the escalation was poor.
- 9.28** *In 2019 a midwife escalated concerns about a woman's one-sided weakness the day after a manual removal of placenta was performed under spinal anaesthetic. The midwife's concerns were raised after the woman had been reviewed by an anaesthetist on a routine ward round, when no issues had been identified. The anaesthetist had not documented their clinical review in the medical records. The midwife's concerns led to a further review by an anaesthetic registrar who concluded that the woman's weakness could be explained as "prolonged effects from spinal". This was incorrect as spinal anaesthetic does not cause one-sided weakness. The midwife again raised her concerns, and the woman was then reviewed by a consultant anaesthetist who arranged a head CT scan which diagnosed a subarachnoid haemorrhage. In this case there was a delayed diagnosis of a serious condition. (2019)*

What Trust staff have told the review team

- 9.29** In late 2021 a number of maternity staff from the Trust, including current and past employees, spoke to the review team:
- 9.30** One contributor told the review team that *'There wasn't really much working together at all, it was very much we're midwives, they're obstetricians...if you knew certain obstetricians were on [duty] you would be fearful of calling them...because of their way with women...not very nice to the women'*. Another contributor, also noted *'A midwife couldn't ring the consultant on-call...afraid to ring with any concerns'*. A further staff member told the review team: *'It seems to be [with] processes, protocols, guidelines, some are using it, and some are not...policies and guidelines are all there...but not being followed'*.
- 9.31** A staff member described *'a very, very overburdened and thinly stretched middle tier in the obstetric team... doctors were being asked to cover services that you couldn't possibly do on your own'*.
- 9.32** Another staff contributor described: *'There were one or two, or even three, consultants that would intimidate the midwives and junior doctors, and make sure they were not approachable...many registrars have been intimidated not to contact the consultant during the night, and if they contact they get told off'*. The same contributor also commented on the relationship between consultants and midwives: *'They don't get on well...there is a barrier'*. Another contributor, commented on the relationship between consultants and midwives and said: *'Some you were seriously on your guard with... [would] bite your head off...I wouldn't have phoned a consultant lightly... [They] weren't particularly approachable'*.

- 9.33** Some staff also shared with the review team the lack of a supportive culture for junior or inexperienced staff that they had experienced very recently but declined to have their words used directly. It was explained to the review team that asking for help was seen as a bad thing and that junior staff at the start of their careers were often too frightened to ask for support when needed.
- 9.34** Overall staff feedback to the review team in late 2021 describes poor team working, failure to follow guidelines and an overstretched middle tier of obstetricians. This undoubtedly influenced the ability of postnatal ward midwives and junior doctors to be able to escalate potential clinical complications appropriately. These issues with lack of escalation were found within our first report and feedback directly to the review team from current maternity staff supports the findings in report 1.
- 9.35** There were however some encouraging reports from staff that the culture has started to change within maternity services at the Trust over recent years. A member of staff, interviewed in October 2021, who had only been with the Trust for a short period reported: *‘Overall I think the culture is good...on the postnatal ward’*. The same contributor reported: *‘Two new consultants [are]...trying to update the MEWS (modified early warning system) charts’* in reference to escalation from the postnatal ward, a recommendation from our first report.
- 9.36** Another staff contributor, referring to previously poor escalation at night commented *‘Doesn’t happen now...consultant now covering labour ward at night’*. The same contributor also commented that the relationship between doctors and midwives was *‘improved now’*. Another member of staff, commented on the appointment of an individual consultant in 2018 who changed the culture *‘in terms of consultant engagement...is engaged, approachable, woman-centred...and was the start of potentially the tide turning with what was quite an old and staid consultant body...it’s much better now...24/7 consultant cover on labour ward’*. The same contributor said *‘that is a good thing to come out of all this scrutiny’*.

Clinical follow-up in the postnatal period:

- 9.37** Clinical follow-up is comprised of two main aspects: firstly, follow up of results of investigations with potential amendments to already existing plans of care. Secondly, follow-up discussion and debriefing of care especially for families who have experienced perinatal loss, or a serious adverse event. This is essential to help women and their families understand, and begin to come to terms with, what has happened to them.
- 9.38** Follow-up discussions should address ongoing care needs, and discussion about any implications that events within the current/most recent pregnancy may have for care in a future pregnancy. In some cases it may be appropriate for this discussion/debrief to occur before discharge from the postnatal ward, but in others a formal follow-up appointment is required.
- 9.39** Such discussions require effective and timely communication with both the mother and her GP. It is therefore vital that the appointment occurs in an appropriate setting, within a reasonable timescale and is accurately documented and that the appointment is with a senior doctor who gives the family time for adequate discussion. The doctor also needs to listen to the family, who may hope that any investigation of their case could lead to learning and changes that might avoid another family experiencing a similar event. When a stillbirth occurs MBRACE-UK 2017¹⁸⁸ advised that *‘All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby’s stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy’*. The same report also advised that *‘A summary of their follow-up appointment, written in plain English, should be sent to the parents, and their GP’*. The review team found many examples where this did not happen:
- 9.40** *Failure to address the mother’s ongoing care needs were noted by the review team when in 2007 a woman was discharged from maternity care still on antihypertensive medication, which had been started during the pregnancy, but with no instructions to either the GP or the woman, about ongoing blood pressure management. (2007)*

- 9.41** *In 2014 a mother's membranes ruptured well before 24 weeks, and she went on to have a very pre-term birth and neonatal death after a few hours. In her pregnancy she had been informed of a positive test result, and advised to collect a prescription for treatment, which she did not do. This test result was noted when she was admitted, and appropriate treatment prescribed, but it was never given. This information was not relayed to the GP, nor was it addressed when the mother saw the consultant for follow-up. (2014)*
- 9.42** Similarly there are cases of women who experienced serious physical trauma at birth with potential implications for future births, where they and their GP do not appear to have been advised about these implications. One example is the following:
- 9.43** *There was a lack of information given to a mother in 2018 when a woman had an 'inverted T incision' on the uterus at caesarean section for the birth of the second very pre-term twin (25 weeks gestation). Sadly both twins died in the neonatal period. In the records provided by the Trust there was no evidence that the parents were made aware of the unusual incision on the uterus which does have implications for a future pregnancy: if this woman were to labour in the future there is a high risk of uterine rupture, which can be catastrophic for both mother and baby. The discharge summary to the GP did not include any information about the 'inverted T' incision. (2018)*
- 9.44** The review noted many perinatal loss cases where there was no evidence in the medical notes that the family had been offered a follow-up appointment; this was noted across the years of the review (2000–2019). For most of the last 20 years the majority of maternity units have arranged that these follow-up appointments take place away from any clinic associated with maternity care, but the Trust was still seeing these families in the gynaecology clinic as late as 2014.
- 9.45** These appointments are often distressing for the families, and must therefore be conducted sensitively. The written summary of the discussion must also be both sensitive, accurate and easily understood by the family. This was often not the case for the families considered by the review team.
- 9.46** *A family told the review that they felt that the consultant was 'unprofessional' during their post-stillbirth appointment in 2006, as he was ill-prepared, had not read the post-mortem report, and sent a letter with multiple factual errors after the appointment. The family explained to the review team that the consultant exacerbated their distress in an already extremely difficult situation, and they then had to write back to the consultant to get the factual errors in the letter corrected. (2006)*
- 9.47** *A family described their post-stillbirth consultant appointment in 2011 as 'very brief in and out in less than five minutes, and 'did not give [them] any answers'. The consultant was described to the review team as 'inattentive' and he is said to have 'sat on the table swinging his legs'. (2011)*
- 9.48** *A family who suffered a neonatal death in 2013, after a traumatic birth, reported that at the follow-up appointment the consultant 'showed no compassion or understanding of the trauma experienced'. (2013)*
- 9.49** In some cases the letter sent to the family after the follow-up appointment did not offer condolences, or was written using a lot of unfamiliar medical terminology. The review team has seen examples of this in both **2016** and **2018**. In other cases the letter used inaccurate wording that the family found upsetting for example in **2018** the consultant's letter after a stillbirth noted that the mother had 'gone through labour and delivered a very healthy girl' which is inappropriate given that the baby was stillborn. (2018)
- 9.50** It is expected that families are given complete and honest information both before discharge from the hospital and at the follow-up appointment. The review team found a number of instances where the information given was either incomplete, or misleading:
- 9.51** *In 2002 after an intrapartum stillbirth, the consultant's postnatal letter stated 'all the findings would probably suggest there was a little bit of growth restriction at the end, and that labour on top of a compromised baby caused the ultimate demise'. However, the letter failed to mention that the CTG was grossly abnormal for nearly 90 minutes before the stillbirth, that there was thick meconium, and that earlier birth by caesarean section would probably have resulted in a live birth. (2002)*

- 9.52** *In 2005 after a stillbirth there was appropriate discussion of the family's concerns, but no discussion about the growth restriction noted at post-mortem (not detected in the antenatal period) as a cause of the stillbirth, as well as an infection after probable pre-labour rupture of membranes. (2005)*
- 9.53** *In 2006 a family whose baby died at 3 days of age with severe HIE¹⁸⁹ and bleeding into an arachnoid cyst, noted that at post-mortem they were given the impression that 'haemorrhage into the cyst had caused the HIE' rather than hypoxia during labour. The multi-professional review team concluded there was clear evidence of a pathological CTG prior to birth and that the resulting features of HIE would be consistent with an intrapartum hypoxic insult which was likely to be due to cord compression worsened by injudicious use of oxytocin. (2006)*
- 9.54** *In 2008 a woman who experienced an abdominal wound dehiscence 5 days after caesarean section was told that 'the suture had snapped, and this was an equipment failure, not a medical issue'. (2008)*
- 9.55** *In 2013 after an intrauterine death that occurred in hospital during induction of labour, the family and GP were told that the cause of death was that the labour ward was too busy for her to be transferred for artificial rupture of the membranes (ARM). The Trust RCA did not consider that failure to monitor the fetal heart for 15 hours, (which contravened Trust policy), was the true cause. (2013)*
- 9.56** *In 2014 following IUD of 28 week twins, the consultant told the family that the scan a week before fetal demise showed that 'Doppler assessments of flow in the cord and brain were normal'. However, there was no evidence in the medical records that they measured Doppler flow in the brain when performing this scan. (2014)*
- 9.57** *In 2015 after a traumatic operative vaginal birth of the second twin, using 3 sequential instruments, a consultant discussed issues around the birth with the mother, on the postnatal ward, and explained that the baby was 'short of oxygen' during the birth, but did not mention the skull fractures that the baby had sustained. (2015)*
- 9.58** *Similarly in 2018 a family were told that there was no evidence of pre-eclampsia before a mother was admitted with an abruption and intrauterine death. However the review team noted that in the 2 weeks prior to the abruption the mother was being managed as an outpatient with proteinuria (measured by urinary PCR) and blood pressure that was increased from that recorded at booking. This does indicate that this mother did have known pre-eclampsia, which was a risk factor for abruption. Abruption cannot be predicted, or prevented, but if this woman had been managed as an inpatient, then urgent delivery as soon as the abruption was recognised might have achieved a different outcome. (2018)*
- 9.59** *In a number of cases families felt that the Trust was reluctant to undertake investigations, or to change practice.*
- 9.60** *After experiencing a neonatal death in 2005 a family told the review team: 'We just wanted to understand and maybe work with the hospital to try to change practice to avoid any parents having to go through the same painful ordeal. However, this certainly wasn't an option. It was like the door had been slammed in my face'. (2005)*
- 9.61** *In 2012 a family were told that there was a Trust investigation after the mother had to return to theatre because of intra-abdominal bleeding after an elective caesarean section, and that nothing different could have been done. However, the Trust has not given the review team any evidence of an internal investigation. The review team is critical of the care this woman received after her elective surgery. (2012)*
- 9.62** *In 2014 a meeting with the family to discuss the findings of the Trust investigation did not occur until more than 2 years after the birth, and the baby's neonatal admission, from an MLU with severe sepsis. After this meeting the Medical Director did send the family a letter outlining the results of the investigation, but also indicated that the letter had been composed from the Head of Midwifery's notes and transcription (it was obviously 'cut and pasted'). The letter concludes that there were still questions to be answered and confirmation was still required as to whether actions from the investigation had been undertaken.*

This was 2 years after the case occurred. The review concluded that this letter was unprofessional and reinforced the apathy shown towards the case. The review team considers there appeared to have been little involvement with or support shown to the family. (2014)

Compassion and kindness

- 9.63** Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.
- 9.64** *In 2002 a woman with pre-eclampsia discharged herself 36 hours after delivering 25 week stillborn twins as she felt her care ‘was appalling’. (2002)*
- 9.65** *In 2008 a woman reported her distress about the care she received on the postnatal ward after undergoing a postnatal laparotomy for a retroperitoneal haematoma. She felt that on the ward ‘There was no communication at all. I was shouted at, ordered about and forgotten...I was made to feel like an inadequate mother and made to feel like I was making up how poorly I was and I like I shouldn’t have rung the bell or asked for help’. (2008)*
- 9.66** *In 2011 two families commented that ‘midwives didn’t care’, ‘showed no kindness [and] support’ and ‘there was no caring involved’. One mother told the review that she felt unsupported after suffering a cardiac arrest and was not offered any psychological support. She told the review that she was made to feel ‘I was in the way and they wanted rid of me, they were in no way subtle about it once they decided that I had spent enough time in the unit’. (2011)*
- 9.67** *Another woman in 2015 told the review that she felt she had received poor care that also lacked empathy. (2015)*
- 9.68** The review team heard from families who felt unsupported and uncared for when their babies were unwell:
In 2010 a baby was readmitted with significant jaundice. The family felt that their baby was ‘starving to death’ and complained about lack of feeding support. A review of the medical records indicated that inconsistent advice had been given to the parents. (2010)
- 9.69** *In 2012 a mother felt ridiculed for having followed another staff member’s advice on how to put on her daughter’s nappy. (2012)*
- 9.70** *In 2014 a mother reported, whose baby was on the neonatal unit, that she was ‘told off’ for ‘worrying about her pain too much’. The woman reported to the review team that she was told by staff ‘what we tend to find is that those women who have babies next to them have more important things to think about. People like you who do not, are only concerned with themselves’. (2014)*
- 9.71** *In 2015 two families described the postnatal care as being ‘truly awful’ and that they ‘felt like a burden’ and ‘not listened to’. One of these families also described a midwife calling the mother ‘a princess’ for asking for formulafeed for her baby. (2015)*
- 9.72** *In 2016 a mother reported being left alone in the birth room, with the call bell out of reach, just 40 minutes after giving birth. (2016)*
- 9.73** Concerning attitude issues towards families were also reported by some staff. One contributor to the staff voices process, reported to the review team that ‘some staff [on the wards] ignored buzzers unless it was “their buzzers”.’ This meant that some women asking for help could not access any support if their own midwife was busy, off the ward, or on a break. This contributed to some families feeling that ‘midwives didn’t care’. The same contributor also commented that postnatal ward staff were probably quite unhappy and described ‘not much understanding between labour ward and the postnatal ward’. The same member of staff also stated: ‘I wouldn’t have wanted to go there as a patient’.
- 9.74** Staff members told the review team that asking for help was seen negatively but were unwilling to be quoted directly as having said this, despite assurances of anonymity. This was not an attitude likely to foster a good working environment for staff, nor likely to lead to good care for families. Another member

of staff, stated that the Trust was ‘a dreadful place to work...practice wasn’t evidence based ...guidelines woefully out of date...I tried to raise concerns unsuccessfully’.

- 9.75** Whilst the review team noted that the Trust had a perineal follow-up clinic for women who had experienced 3rd and 4th degree tears, or other perineal problems, they also noted issues with some staff communication in this clinic.
- 9.76** *In 2009 a woman was referred to this clinic because of persistent perineal symptoms, despite no known history of significant perineal trauma at birth. In the clinic the consultant who saw her dismissed her symptoms, and said that no further investigation was required, without even examining the woman. This woman was subsequently seen in another hospital where a rectovaginal fistula was diagnosed, which must have occurred because of significant trauma at birth, probably a missed 3rd or 4th degree tear. (2009)*
- 9.77** *In 2014 when a woman was reviewed in this clinic after a 3rd degree tear the doctor wrote in the notes: ‘Well, but fat and very anxious. Can try for a vaginal birth – risk of re-occurrence low’. (2014)*

Receiving postnatal care in the correct location

- 9.78** Care in the postnatal period for mother and babies must take place in an appropriate setting, according to clinical need.
- 9.79** *In 2012 there was inappropriate transfer to midwifery-led care in the postnatal period which led to poor management. The transfer of care, to a distant MLU, occurred 3 days after birth despite a complex caesarean section, massive obstetric haemorrhage, anaemia, postpartum pyrexia, persistent tachycardia and persistent pain. The mother was eventually transferred back, very unwell, to the consultant-led unit (inappropriately by car) on day 8 with severe sepsis, with both a pelvic abscess and a lung empyema¹⁹⁰. (2012)*
- 9.80** *In 2017 a woman with known pre-eclampsia was transferred to a distant MLU for ongoing postnatal care on day 3, despite her blood pressure remaining elevated. (2017)*
- 9.81** *In 2017 a mother and baby who had been transferred to a standalone midwifery-led unit (MLU) for postnatal care after birth was advised by a midwife: ‘Don’t tell them the baby is ‘grunty’ or they will send you back to the consultant unit’. A family member subsequently highlighted their concerns and the mother and baby were transferred back to the consultant-led unit (2017)*
- 9.82** *In 2018 a mother and baby were discharged home 4 hours after vaginal birth but the baby’s temperature was 36.1°C with no evidence of repeat measurement, the review team felt this was inappropriate. (2018)*
- 9.83** Follow-up appointments by community midwives after postnatal discharge from hospital should aim to both support the mother, and to detect and appropriately refer any maternal, or baby problems identified. In some cases this did not occur.
- 9.84** *In 2011 when a woman reported ‘very little bowel control’ on day 10, the midwife advised her to report this to her GP, rather than referring her to the obstetric team for review and management, or continuing to review the situation herself. (2011)*
- 9.85** In other cases women who had experienced pregnancy loss were advised to see their GP to get a prescription for therapeutic lactation suppression. It is normal practice to offer women lactation suppression after perinatal loss. The review noted evidence that lactation suppression was discussed with parents, but from the records of a **2016** early neonatal death it appears that Cabergoline was not stocked on the labour ward. This suggests that the management for families experiencing loss was not holistic.

190 See glossary

Staffing

- 9.86** Poor staffing levels, both midwifery and obstetric, will affect both the quality of patient postnatal care, and staff morale. It would appear that staffing levels and staff morale were an issue for some time at the Trust.
- 9.87** When contributing to the Staff Voices initiative in late 2021 one contributor graphically described the stress staff felt because of poor staffing levels, with postnatal ward midwives regularly being *'pulled to labour ward'* and described the way this affected care as: *'you ... try and just do the work as quickly as possible, and there wouldn't be any quality of care'*. The same contributor also described that this prioritisation of the labour ward, leaving the postnatal ward understaffed *'really increased our stress levels because obviously, it's upsetting when you can't give the care that you want to give...especially on a postnatal ward where it led to healthcare assistants or the women's services assistants doing most of the clinical care with midwives just running in with some painkillers or IV antibiotics, or doing a quick check'*.
- 9.88** The response from the staff member, when asked about escalation of concerns regarding staffing levels on the postnatal ward, was *'you know, you can escalate, but you know if there's nowhere to pull, there's nowhere to pull. You're just left and you just have to get on with it'*. The contributor also reported pressure for early discharge *'they [postnatal women] can't even stay in for breastfeeding support'*.
- 9.89** Many staff contributors also reported significant staffing issues. They described: [a] *'shortage of midwives... needing to pull in staff (from wards and community)...robbing Peter to pay Paul,'* and *'[being] concerned about safety and staffing'*.

Bereavement

- 9.90** It is sadly inevitable that many of the families included in this review have experienced the loss of a baby, which can have a huge impact on their long-term wellbeing. As noted by SANDS (2021) *'Good care cannot remove the pain and devastation that bereaved parents experience, but poor or insensitive care makes things worse, both immediately and in the months and years that follow'*.
- 9.91** Compassionate bereavement care must begin when a family are told that their baby has died (or before death if the baby is known to have an abnormality incompatible with survival), it is therefore vital that all staff communicate compassionately with families at this very difficult time. Below are some cases from across the timespan of the review identified by the review team where families felt this did not happen:
- 9.92** *In 2002 a family complained about the way that a midwife sonographer informed them that one of the twins had died when the mother presented with ruptured membranes at 37 weeks gestation. (2002)*
- 9.93** *Similarly in 2009 a family complained about the manner of the doctor who diagnosed the absence of fetal heart activity, which they felt was insensitive. (2009)*
- 9.94** *In 2018 the review team noted that a family wished to continue a pregnancy with known abnormalities incompatible with survival and they were seen by the bereavement midwife and consultant neonatologist together during the pregnancy to plan care at the time of birth. After these meetings a letter outlining the plans for care was sent to the family. However, this information was inadequately conveyed to the labour ward staff, who were unaware of the agreed plans. This led to the inappropriate repeated discussion of the issues when the mother was in labour, and after the baby was born. It was also noted that some of the agreed plans were not followed, such as the family spending as much time with the baby as possible before discharge from the hospital. It is clear from the documentation that at the time of birth there was little, or no, discussion with the family with regards to meeting their individual requirements, nor to fulfil their required cultural and religious practices despite these having been agreed at the pre-birth meetings. (2018)*
- 9.95** In most maternity units it is routine practice to suggest that women go home after being given oral mifepristone following the diagnosis of an intrauterine death, to return after 36-48hrs for further management to induce labour. It is however very important that staff ensure that parents are given the option of staying in the hospital if they prefer, or that they are clearly informed that they can return to the hospital at any time if they wish.

- 9.96** *A mother described how she felt in 2010 ‘When I left the hospital on the day I found out that my baby had died [at a scan]. I was told that they wouldn’t expect me to return for 48 hours, from when the tablet was taken’. This family reported that they felt unsupported. (2010)*
- 9.97** *Similarly a mother raised concerns regarding staff attitudes after the very early neonatal death of a very premature baby in 2014, who was born at 21+ week’s gestation. She explained that she had to ‘wait for the corridors to be empty before carrying her son back to the birth suite’. In her notes there was minimal documentation regarding postnatal bereavement care. (2014)*
- 9.98** Women who experience perinatal loss need to be cared for in a clinically appropriate area, so that both their physical and emotional needs can be addressed.
- 9.99** *In 2012 a family reported that their care after an intrapartum stillbirth was upsetting. Firstly the family were ‘left in the room for I don’t know how long...then put me in a wheelchair, gave baby to me (to hold), put us in a room and left us there’. This family also reported ‘what was worse they put us in the maternity ward so we could hear babies crying’. Families have clearly explained to the review team how both compassion and an appropriate place of care can help make the unbearable more bearable. (2012)*

Consent to post-mortem examination

- 9.100** Post-mortem is the most useful investigation in supporting the determination of cause of death and its value is frequently underestimated by health professionals¹⁹¹. Deciding on whether to have a post-mortem investigation conducted can be one of the most difficult decisions bereaved parents face in the period immediately after their baby dies. It is essential that this is dealt with in a sensitive way by a professional trained to take post-mortem consent. The review team noted cases where discussion with families about having a post-mortem examination was insensitive or unhelpful. Below are two examples:
- 9.101** *A family in 2009 told the review team that: ‘The doctor who went through the consent process for the post-mortem examination was observed by the midwife who documented “Noted that he went through documents very quickly and with little empathy. Family distressed by this and told me they were not happy with this when he left. Apologies given”.’ (2009)*
- 9.102** *Also in 2009, a family reported that following the stillbirth of their daughter ‘there wasn’t time or space to make the important and difficult decision about consenting to, or declining, a post-mortem examination’. In this case the post-mortem consent was discussed only 6 hours after an unexpected stillbirth, and the family felt that the consultant obstetrician counselled them against having a post-mortem, and this was their ‘largest concern about the care’ the family received. (2009)*

Ongoing care after bereavement

- 9.103** Not surprisingly parents are very fragile at this difficult time, something all maternity staff should be aware of. Some families reported experiencing a lack of sensitivity to the review team. A family told the review team that in 2009 they found a consultant’s attitude to be ‘*rude and completely dismissive of [their] concerns*’. (2009)
- 9.104** A family in 2011 felt deeply about ‘*the lack of compassion and empathy exhibited by the midwife*’. Also from 2011 the review team noted poor bereavement care and support and that there was evidence of a breach of confidentiality as there had been disclosure of the death of the baby to the woman’s father without her consent. This had caused a strain in their relationship ever since. (2011)
- 9.105** It is reasonable to expect that maternity staff are careful to obtain accurate information when caring for bereaved families, or those with sick babies on the neonatal unit.
- 9.106** *A mother complained about the postnatal care she received in 2009 following a bereavement saying that the staff appeared unaware of the issues and she had to keep explaining distressing details at every shift change. (2009)*

9.107 *In another instance in 2014 a bereaved family reported seeing a different community midwife at each postnatal visit. (2014)*

Specialist bereavement care

9.108 Families who have experienced baby loss must have ongoing support, either from their own community midwife, or from a bereavement midwife. The review team noted a lack of support for bereaved families in many cases, over a long period of time.

9.109 *From a case in 2003 the review team noted that one woman said she was happy with the antenatal and intrapartum care she received but when she needed support following her term stillbirth this was ‘sadly lacking’. In this case there was no information in the medical records about bereavement care apart from a checklist and mention of counselling in the bereavement follow-up letter. It is unclear whether this was ever arranged. (2003)*

9.110 *Following the loss of her baby in 2010 the clinical records indicated that the mother was discharged from maternity care on day 8 and advised to ‘call if further support needed’. (2010)*

9.111 *In 2011 the review team noted an apparent lack of bereavement support after a stillbirth. The only evidence of involvement from the Trust was a single telephone call some four weeks after the birth. The notes from this call, provided by the Trust, indicate that the mother was advised to contact other healthcare professionals for support if she wished. (2011)*

9.112 *In 2012 one family reported that the bereavement care they received was ‘appalling’ and another family felt that the bereavement support was ‘very tick box’ and that they found the maternity bereavement service ‘of no help’. (2012)*

9.113 *In 2016 the review team heard from parents of a lack of care and compassion in bereavement care following the neonatal death of their baby shortly after birth. (2016)*

9.114 Another important aspect of care at this difficult time is ensuring that parents receive all the information they require, or request, and that all appropriate services are informed of the bereavement.

9.115 *A family reported that in 2010 when they requested that the community midwife follow up the missing photographs of their stillborn baby that this did not occur. As the photographs had still not been sent to her months later the woman had to phone the ward herself to obtain them. (2010)*

9.116 *A family reported that in 2011 there was a delay in them being told that their baby had been returned following the post-mortem, which led to a significant delay in arranging the funeral. (2011)*

9.117 *In 2016 a health visitor was unaware of the neonatal death and provided congratulations and Bounty literature continued to be sent to the family, which they found distressing. (2016)*

Good bereavement care

9.118 In some cases, there was evidence of kind and compassionate support given to families after bereavement. The following are examples of that kind and compassionate care.

9.119 *In 2006 the community midwife was praised by the family for her care and compassion and they specifically asked for her in subsequent pregnancies. (2006)*

9.120 *In one case in 2011 the obstetric registrar offered condolences and gave a detailed discussion about post-mortem and the parents opted for a limited one with the knowledge that there was a limit to the information they would receive. (2011)*

9.121 *There was evidence in some cases that the maternity staff tried to help families with stillbirth registration. In 2014 a couple with English as a second language were escorted to the registry office to register their stillborn twins. It was also arranged for an interpreter to be present when the couple came to see their consultant for a follow-up appointment. (2014)*

9.122 *In 2012 the family reported that through bereavement support it was ensured that the family's concerns and questions were addressed in the Trust investigation.*

9.123 *In 2017 the parents reported effective information sharing, good levels of care including continuity of care after bereavement. (2017)*

Good postnatal care

9.124 Whilst the review has identified poor postnatal care it should be acknowledged that in the cases the maternity review team considered we also found examples of women receiving good, safe and supportive postnatal care.

9.125 *In 2011 there was evidence of effective team work with appropriate referral and involvement of social services, GP and health visitors. (2011)*

9.126 *In 2014 the review team also noted that 'the immediate midwifery care provided during the postnatal period was of good standard and aligned with local and national guidelines'. (2014)*

9.127 *In 2014 evidence was noted of extra postnatal community visits to provide more emotional support to a new mother. (2014)*

Good record keeping and good care planning

9.128 Good record keeping is fundamental to safe and high quality maternity care, and remains so in the postnatal period. Whilst the review has criticised poor record keeping, examples demonstrating appropriate and good quality postnatal record keeping were identified in **2010** and **2013**. The review team also identified sensitive documentation in the care of a family in **2008** and in another case involving a family in 2016 documentation was described as having a '*detailed midwifery record*' by the review team.

9.129 The review team also identified examples where problems likely to lead to a difficult outcome were identified during the pregnancy with evidence of good care planning in 2008. In cases from **2011** and **2015** the review team also noted evidence of family involvement in the planning of care.

9.130 Some cases of good clinical care were also noted. In **2011** timely multidisciplinary management was noted when a woman was readmitted with a severe wound infection after a caesarean section. The infection was promptly recognised as the severe life threatening condition of necrotising fasciitis, which was managed well.

9.131 In **2013** when a woman informed her community midwife that she felt 'unwell' at a routine visit, the community midwife recognised the severity of her condition and arranged prompt referral directly to the labour ward. When this woman arrived on the labour ward the midwives ensured that she was seen promptly by the obstetric registrar, who rapidly diagnosed sepsis and appropriately administered intravenous fluids and antibiotics within 30 minutes of her arrival in the maternity unit. She then went on to have good multidisciplinary management, including a short spell in ITU, and made an excellent, and fairly rapid, recovery. (2013)

LOCAL ACTIONS FOR LEARNING: POSTNATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 9.132** The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.
- 9.133** The Trust must ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

Chapter 10

Maternal deaths

The impact on families when a mother dies

- 10.1** Families have explained to the review team that the impact of a maternal death and thus losing a mother, wife, daughter, sister, or grandchild is far reaching across a whole extended family and the effect of this remains with them forever. Here are some of the ways families who have spoken to the review team about maternal death have described this to us:
- 10.2** ‘It never goes away...you just kind of...and it’s a natural thing, you just kind of withdraw within yourself a little bit. Usually, for me, that’s like a month, six weeks, two months.’ (2002)
- 10.3** ‘It’s just sad, I ache for her every day, every day.’ (2007)
- 10.4** ‘I think her Mum and Dad, they’re still grieving now...Even now like, I mean you go round the house and there’s always a candle lit, you know, they’ve got our wedding photos still up, you know, it’s just a constant reminder when you go round to their house.’ (Husband talking about his wife who died in 2011)
- 10.5** ‘...she was having some problems and eventually she said to her step mum that she felt bad that her Mummy had died because she’d wanted to have a brother or sister.’ This example is from a bereaved husband, talking about his first-born daughter whose mother died during a later pregnancy. His daughter believed that her wanting a sibling was the reason her mother had died in 2016.
- 10.6** The review team noted that several families felt their questions surrounding the maternal death had not been addressed by the Trust. Bereavement support after the event was also described by families as inconsistent:
- 10.7** When asked as to whether an investigation into the death had been performed a husband whose wife had died in 2002 responded: ‘There was no...it was just the...it was pulmonary oedema and obviously pre-eclampsia was like mentioned, or part of it. Yes, fluid on the lungs. No, they never gave an explanation for that, for why’.
- 10.8** Another family member said to the review chair: ‘It’s what makes me angry, because I feel like the Trust got off lightly at the time with me, because I feel that they recognised, in that meeting, how desperately distraught I was and they just decided...like everything was done, you know...We can’t find any reason for, but if you want to take a complaint elsewhere that’s up to you...but as far as we’re concerned there’s no case to answer...is what they basically said. And I came out flabbergasted because I think I’d expected them to offer me a big apology, you know, and say oh yes, we’ve made loads of failings here, and all this, that and the other...And of course they didn’t and when they didn’t do it I just thought I can’t do any more, like I haven’t got the energy to do any more. So I think they got off lightly really, and it makes me feel bad that I didn’t have the energy to do it, but it would have been too much for me to go through...because I want to go through this process [the Ockenden review] to get some answers for my own peace of mind as to what happened, because I laid a lot of blame on myself afterwards...’
- 10.9** The family member further recalled: ‘one doctor that wasn’t so pleasant or helpful...when I rang him to ask some of the questions, his exact words to me were “if you keep digging into this you’ll just find things you don’t want to find”. That’s what he said to me, and then he put the phone down’. (This feedback is from the partner of a mother who died in 2002)
- 10.10** A partner of a woman who died in 2014 told the review chair: ‘I was actually told that I would get to see [the investigations], they did an independent review on their midwives and then they did another one, I saw another lot...so the ones above them also went back on her case and went through all that, I was also told I would get them...[investigation reports] and we’ve never had them’.

Number of maternal deaths reviewed

- 10.11** At the time of concluding this review, in total 19 maternal deaths were noted by the review team. Three of these occurred prior to the core review period (before 2000) and one death in **2015** occurred after the mother was transferred in labour to another trust. This woman's pregnancy care was reviewed by the team as the majority of the pregnancy care occurred at the Shrewsbury and Telford Trust's maternity services, but her death was not.
- 10.12** Of the 16 cases that occurred within the core review period, there were eight direct¹⁹², and seven indirect maternal deaths¹⁹³, plus one accidental death resulting from a road accident, which was not investigated further by the review team.
- 10.13** One death which occurred at the Trust during pregnancy in **2019** was comprehensively investigated by the regional Healthcare Safety Investigation Branch¹⁹⁴ (HSIB) as per NHS policy. This case was not reviewed further by our team.
- 10.14** One mother who delivered at the Trust died in another hospital in **2019** and the family declined the HSIB review. It was not possible to obtain permission from the family regarding inclusion into our review. In cases such as this, there is ultimately learning for the whole maternity system and trusts involved must learn together through digital or remote means if necessary. The review team is not aware of any such joint learning in this case.
- 10.15** Clinical notes were unavailable for one woman who died in **2001**, despite recommendations that all maternity records should remain available for 25 years after the birth of the last child¹⁹⁵. An external governance review was arranged after the family complained to the Trust and provided to the review team by the Trust. The review team was therefore able to review the quality of the Trust's internal investigation after the death, but not the clinical care.

Analysis of the maternal deaths

- 10.16** The remaining 12 maternal deaths were each reviewed by a multi-professional team of midwives, consultant obstetricians, a consultant obstetric physician and a consultant anaesthetist, with special interest in obstetric and cardiothoracic anaesthesia. Further experts (including experts in intensive care, cardiology, neurology and others) joined the team to give expert opinion or answer specific clinical questions where required.
- 10.17** As with all other reviews, for each maternal death review the team adopted a holistic and multi-professional approach, including access to all available governance documentation provided by the Trust and communication with the family of the deceased mother.
- 10.18** Although statistical analysis of the maternal deaths is limited due to the small numbers, the review team noted the relatively high number of direct maternal deaths at the Trust. This is in contrast to the overall national trend, where direct deaths have been declining since 2004¹⁹⁶. This may be an indication that the care for pregnancy related conditions such as pre-eclampsia (PET), sepsis and major obstetric haemorrhage needs to be further improved locally.
- 10.19** The review team noted that all but one woman who died were of white ethnicity, a patient group which usually has a lower risk for mortality in pregnancy. Seven of the women who died were classified as obese at booking for maternity care (BMI > 30 kg/m²) and therefore were of higher risk for pregnancy related complications.

¹⁹² See glossary

¹⁹³ See glossary

¹⁹⁴ See glossary

¹⁹⁵ Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

¹⁹⁶ MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

10.20 Two maternal deaths did not have a coroner’s inquest. In three cases where there was a coroner’s inquest the review team commented further on the cause of death as stated by the coroner:

In 2002 a woman with pre-existing lung disease developed pre-eclampsia and had inappropriate fluid management with significant fluid overload, over many days. She later died from acute respiratory distress syndrome (ARDS). The pathologist at the inquest speculated that very high oxygen levels during ventilation on the intensive care unit led to the ARDS. The underlying respiratory condition and inappropriate fluid management were not identified at the inquest. The review team is of the opinion that this was a missed opportunity for learning from the death of this woman.

10.21 *In 2014 a woman with poorly managed sepsis and prolonged resuscitation efforts was found to have squamous epithelial cells in the pulmonary vessels at the post-mortem investigation and the cause of death was determined as amniotic fluid embolism (AFE). The review team is of the opinion that fetal squamous cells in the systemic or pulmonary circulation of the deceased is not necessarily proof that she died of AFE and that sepsis was a significant contributing factor. The review team is also of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.22 *The post-mortem investigation in a woman who died of major obstetric haemorrhage in 2017 found evidence for an undiagnosed cardiac condition, which was classified as contributory to the death. The review team is of the opinion that there is no evidence that the woman was affected by the cardiac condition in any way and that this did not contribute to her death.*

10.23 The clinical care and quality of the subsequent investigation were rated by agreement between the review team members as per below:

GRADING OF CARE	DEFINITION
0 Appropriate	Appropriate care in line with best practice at the time.
1 Minor Concerns	Care could have been improved, but different management would have made no difference to the outcome.
2 Significant Concerns	Sub-optimal care in which different management might have made a difference to the outcome.
3 Major Concerns	Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome.

10.24 The quality of the incident investigation root cause analysis or RCA at the Trust was rated differently depending on the year the incident occurred, to reflect the national developments in incident reporting and investigation.

For cases up to and including 2010:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

For cases from 2011:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified. Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with them at the time of incident. Feedback to the family once investigation concluded.
Poor	Any of the above missing.	Very little family involvement or feedback after the investigation.
None	Incident not investigated.	No family involvement.

Grading of care

10.25 The review team reviewed the maternal death cases individually prior to agreeing the grading at multidisciplinary team discussions. With hindsight, one will often judge a past decision by its outcome instead of based on the quality of the decision at the time it was made, given what was known at that time. The review team is conscious of the fact that there is a danger of judging past care decisions by the outcome, instead of based on the quality of the decision made at the time, which can lead to outcome bias when applying any grading of care. It is important to note that all cases were reviewed in accordance with best clinical practice and guidelines available at the time of the incident, to avoid outcome bias as much as possible.

10.26 The reviewers found none of the maternal death cases had received care in line with best practice at the time (grade 0). Three cases were found as requiring improvement in care, however, the eventual outcome would not have changed (grade 1). In six cases the care was rated as 2, meaning the reviewers found suboptimal care of the women and different management might have changed the eventual outcome. Three cases were graded as 3, where the eventual outcome could have reasonably been expected to be avoidable, had the care been different.

Grading and analysis of internal investigations

10.27 In line with the Terms of Reference of the review, all available governance documentation and family communication were reviewed in the context of best practice at the relevant time. A total of 11 incident investigations were considered. However, in some cases no comprehensive serious incident (SI) report was available (as would have been the expectation), but rather an abbreviated High Risk Case Review (HRCR), in the form of a spreadsheet. This appears to have been an internal Trust review process that has not been seen outside the Trust by review team members. It was not always clear to the review team whether, and if so how, these were shared with the families of the deceased women.

10.28 One maternal death in **2017** was investigated by an external provider. The review team agreed that the standard of the investigation was appropriate.

10.29 A maternal death that occurred in **2002** was not investigated by the Trust as the care was rated by them as appropriate, a finding with which the review team fundamentally disagree. The Trust maternity governance team noted *'This case was reported as a serious untoward incident and also a full report sent to CEMD (Confidential Enquiry into Maternal Death). It was also discussed at the mortality meeting, but it was felt*

that there were no lessons to be learned. This was a high risk pregnancy and Mrs X was aware of the potential effect this could have on her future. The staff were extremely saddened by her death’.

- 10.30** The review team acknowledges that the pregnancy in this case from **2002** was high risk, however there were multiple missed opportunities and a lack of understanding in regard to the mother’s underlying condition and poor management of developing complications. The family in conversation with the chair of the review has explained how they felt the Trust ‘blamed’ the mother and her husband for her death, because had the mother not got pregnant she would not have died.
- 10.31** In another case in **2001** the family made three requests via the NHS complaints procedure for an external review into the death of the mother. It was finally arranged by the Trust’s lay chairman and complaints convenor two years after the death in 2003 and identified significant issues in the care. In their letter to the family it is stated *‘The lay chairman and I agree that there has been a long period of local resolution, including a meeting with the consultant in charge...and several letters from the chief executive. In fact, this is the third request for an independent review. The independent clinical advice supports your view that there are still significant issues which need to be addressed concerning the standard of care provided...’* From the available documentation the review team can conclude that the initial investigation into the death by the Trust was poor.
- 10.32** The review team rated all available Trust investigations into these maternal deaths as poor. We found repeatedly that significant omissions in care were not identified by the Trust investigators, leading to missed opportunities for learning that could affect the outcome for other women and babies in the future.

Findings

- 10.33** Many RCAs did not involve a multidisciplinary team, even if there were multiple professions involved in the care of the woman (for example there was usually an absence of specialities such as obstetric anaesthesia, intensive care, infectious diseases, cardiology and/or haematology). Frequently only a few internal maternity staff performed the investigations and even at mortality and morbidity review meetings a truly multidisciplinary discussion did not happen.
- 10.34** It appears that all these cases of maternal deaths were investigated purely internally, with no external expert opinion sought, except in the one case mentioned above.
- 10.35** If and when post-mortem results became available during the investigation that seemingly pointed to a direction of an ‘inevitable outcome’, the direction of the investigation changed in such a way that detailed scrutiny and holistic review of the entire care did not happen.
- 10.36** Issues in care that were identified were frequently treated as individual failings and actioned by ‘internal reflection’ of involved staff. The investigations did not follow the appropriate systems-based approach as outlined in the relevant NHS incident frameworks and significant learning opportunities for the Trust and the wider maternity teams were lost. These frameworks are discussed further in the report chapter focussing on clinical governance.
- 10.37** The review team noted that frequently the women themselves were blamed or held responsible for the adverse outcomes, without identifying underlying and obvious failings in care. A husband recalled how in **2011** his deceased wife was blamed when he was told: *‘[it was] difficult for the midwives to listen to baby’s heart beat due to her size’*. This was also recorded in the maternity records. Trust documentation pertaining to a maternal death in **2002** stated *‘...she knew of the risks [related to pregnancy] and accepted these’*. In another case in 2002 the following was said *‘...she must have been responsible for some of that because she clearly did not complain very much and tended to ignore many of her symptoms...’*
- 10.38** In one case in 2014 there was a significant discordance between what was discussed with the relevant clinicians involved in the incident by email and the stated outcome of the internal incident investigation. The Trust investigation concluded *‘no deviation in care and management identified relating to root cause’*. However, in emails that were sent by one of the lead investigators to individual staff involved in the care

of the mother, it is clear that significant omissions in care were identified: *'...none felt that discharge to the antenatal ward at that point was the correct action'*. This case highlights significant cultural problems in the Trust at the time. There appeared to be a lack of ability to come together and examine why this happened. There was no insight into the problem resulting in a poor investigation, which later informed the coroner's inquest. This affirms the overall findings of the review team that significant contributory factors and/or the root causes for poor outcomes were not identified, or to the extent they were identified, were not addressed with a robust action plan; demonstrating a lack of rigour and transparency in the RCA investigations.

10.39 There is also evidence from the available governance documentation and conversations with families that in some cases failings in care were not communicated in an open and transparent way, once the investigations were completed.

10.40 *In 2006 a woman with an underlying cardiac condition, developed significant tachycardia and low blood pressure after the delivery. In a meeting with the family after the investigation they were told that 'The ECG of a pregnant woman can be misleading to a junior doctor with general medical experience; as it can appear to suggest the heart is not coping; which is incorrect and a normal rhythm in pregnancy.'* At no point was it discussed with the family as to whether this complication should have been escalated to a more senior doctor or cardiologist. There was also a missed opportunity to manage and treat the underlying causes of the tachycardia.

10.41 *In 2014 another family who questioned the appropriateness of treatment for maternal sepsis were told in a debriefing meeting that 'she did not have signs of profound infection' which is not corroborated by the clinical notes. The internal discussion at the Trust regarding the serious incident found that the sepsis treatment had been not well coordinated, but this was not disclosed to the family.*

Learning from maternal deaths

Local Actions for Learning and Immediate and Essential Actions from report 1:

10.42 The review team re-emphasises the importance of the previous Local Actions for Learning for the Trust and Immediate and Essential Actions for the wider maternity system from their first report regarding the learning from the maternal deaths at the Trust. They can be found in Appendix 2 and form a vital part of the ongoing learning for the Trust and wider maternity system. In particular continued focus must be around timely escalation to an appropriately senior level and multidisciplinary team working. MDT training involving maternity teams working with ITU, anaesthetic and other colleagues in management of the deteriorating pregnant woman is needed. This will ensure the right team are always available with the skills to manage complexity.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

10.43 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

Chapter 11

Obstetric anaesthesia

11.1 Expert advice was sought from anaesthetist colleagues within the Maternity Review Team for a number of cases. Criteria for anaesthetic review for this report were the presence of severe pre-eclampsia or HELLP; eclampsia; postpartum haemorrhage of 3000ml or more; significant pre-existing maternal medical disease; and concerns regarding the management of obstetric anaesthesia. As a consequence, 68 cases were referred to anaesthetists within the Review Team. This is a small percentage of the overall number of cases reviewed in this report and an even smaller proportion of the overall number of maternities taking place at the Trust during the past two decades. Consequently, there is a limit as to how representative of anaesthetic provision at the Trust these cases can be considered to be. However, there were a number of recurring themes that are worthy of comment to facilitate further learning.

Anaesthetists and the multidisciplinary team

11.2 The role of the anaesthetist on duty for obstetric anaesthesia is much broader than being merely a technician for provision of pain relief and anaesthesia. They must also work as part of the multidisciplinary team in the management of women experiencing pregnancies or childbirth, complicated by certain obstetric issues or pre-existing medical disease. As described in the first report, the review team again found evidence that anaesthetic input on the labour ward was often task-focussed and lacking consideration of the wider clinical picture of the women in their care.

11.3 *In 2012, ten days after emergency caesarean a woman was displaying florid signs of sepsis and a decision was made to reopen her wound. The specialty doctor anaesthetist gave appropriate intraoperative care at laparotomy which revealed pus in the caesarean wound and pus within the peritoneum¹⁹⁷. However, there was no evidence of discussion regarding where the patient would be best managed postoperatively and no postoperative instructions were documented by the anaesthetist. She was discharged back to the labour ward overnight and stepped down to the postnatal ward the following day despite the patient's concerns about her breathing. A respiratory examination was not undertaken until the second postoperative day when the patient was experiencing chest pain and had a significant oxygen requirement. She was later found to have a loculated empyema¹⁹⁸ for which she was admitted to the high dependency unit and later transferred to another hospital for surgical management. There was no anaesthetic input into the subsequent high risk case review. (2012)*

11.4 *In 2019, a woman developed severe intraoperative hypertension under spinal anaesthesia. Early the following morning the midwife noted unilateral arm and leg weakness and requested an assessment by the anaesthetist who suggested that this was a residual effect of the spinal anaesthetic, but did not document their review. Later in the day, after no improvement, a further review was requested and documented and the anaesthetist escalated their concerns to the consultant anaesthetist and medical team. A CT scan ten hours after initial concerns were raised revealed a subarachnoid haemorrhage¹⁹⁹ an internal Trust review of the case by a consultant anaesthetist found no problems with the anaesthetic care. (2019)*

11.5 As well as occasions where anaesthetists failed to involve themselves in the care of critically ill women, there were cases where the obstetric and midwifery teams failed to involve or inform the anaesthetist on duty about women with significant morbidity. Often the anaesthetist was only called to review a patient once a decision had been made to take them to theatre, sometimes for very urgent surgery, thus denying the anaesthetist the opportunity to make a considered assessment of the patient and to take steps to optimise the patient's condition prior to anaesthesia.

¹⁹⁷ See glossary

¹⁹⁸ See glossary

¹⁹⁹ See glossary

- 11.6** *In 2004, at 0520h, 50 minutes after a vaginal delivery, a woman had bled in excess of 1000ml. The midwife did not escalate this to the obstetric team until 0550h who, in turn, did not alert the anaesthetist until 0730h, just prior to transferring the patient to theatre for an examination under anaesthetic. Local guidelines regarding key personnel to be notified in the event of post-partum haemorrhage were therefore not followed. The woman raised concerns about her care when she subsequently attended an obstetric outpatient appointment. There is no evidence that her case was reviewed by the maternity governance team even though the consultant obstetrician stated in his letter from that appointment that it should be. The consultant mentioned that she would have a midwifery debrief appointment in order to address 'her various anxieties'. (2004)*
- 11.7** *In 2006, ten days after an emergency caesarean section a woman was readmitted with collapse and blood loss in excess of a litre. Despite a decision within 20 minutes of admission by the consultant obstetrician that the patient would need an examination under anaesthesia, there is no evidence that the anaesthetist was notified for more than 4 hours (contrary to the Trust's postpartum haemorrhage guidance at the time). The anaesthetist assessed the patient 9 minutes before she was transferred to theatre. She was so unstable that she required a general anaesthetic, hysterectomy, and a blood transfusion of 11 units. An incident report was submitted but a consultant obstetrician decided that a high risk case review was not required. The consultant wrote to the obstetrician who performed the caesarean section stating that 'care throughout [the readmission with postpartum haemorrhage] seems to have been appropriate and decision making made at the appropriate level' but queried the possibility of injury to the uterus at caesarean section. (2006)*
- 11.8** *In 2008, a multiparous woman was admitted with raised inflammatory markers²⁰⁰ after premature rupture of membranes at 33 weeks of pregnancy. A scan the day after admission showed the baby was in a footling breech position. Despite a recognised high probability of the need for early delivery, the anaesthetist was not called to review the patient until a decision was made for a category 1 caesarean section when the patient had reached 7cm cervical dilatation 6 days later. There is no evidence of learning arising from this case. (2008)*
- 11.9** *In 2018, despite repeated previous admissions with antepartum haemorrhage in a woman with known low anterior placenta accreta²⁰¹, the duty anaesthetist was not alerted to the presence of the woman in the hospital until the decision was made that she required a category 2 caesarean section, almost 36 hours after her admission with a further antepartum haemorrhage. Escalation by the duty anaesthetist to senior anaesthetic staff and involvement of additional theatre staff was then swift and her overall anaesthetic care good and safe. There is no governance documentation relating to this case. (2018)*
- 11.10** Failure of anaesthetic and obstetric resident on-call teams to escalate promptly to senior staff during times of high workload or when managing deteriorating or very ill women was noted in this review's first report and seen again in further cases reviewed for this current report. In response to a Local Action for Learning point from the first report, the Trust now has a specific guideline advising when the on-call consultant anaesthetist must be contacted by the resident anaesthetist. However, as with all guidelines advising on escalation to specific personnel (including the ones that were not followed in the vignettes below), this will only result in service improvement if its advice is adhered to, and if the consultant on-call is free to attend. Anaesthetic staffing at the Trust remains a concern which is discussed later in this chapter.
- 11.11** *In 2004, the resident anaesthetist was called at 0530h to see a woman in labour following an intrauterine death thought to be due to placental abruption. He was unable to attend for an hour and a half due to workload, by which time the patient had bled 1400ml and was tachycardic²⁰². There is no evidence that this incident was reported or that any investigation or learning occurred.(2004)*
- 11.12** *In 2013, a woman had labour induced due to pre-eclampsia. She had significant oedema, headache and visual disturbance. Her blood pressure was 166/115mmHg and she was struggling to cope with the impact*

200 See glossary

201 See glossary

202 See glossary

of an oxytocin infusion on her labour pains. 2h 25min elapsed between the duty anaesthetist being called and their attendance to site the epidural as they were busy in theatre. During this time the oxytocin infusion had to be switched off due to the woman's distress. Once the epidural was sited, the anaesthetist left the midwife to administer the initial doses, contrary to Trust guidance, as they were called for a category 1 caesarean section for another patient. There is no evidence that efforts were made to contact another resident anaesthetist or the consultant on-call to assist with the workload. An incident report was submitted about an unrelated aspect of her peripartum care, but no action plan or investigation was documented or made available to the review team. (2013)

Anaesthetic services, workforce and leadership

- 11.13** The first report raised concerns about anaesthetic staffing at the Trust, in particular at consultant level. The 2017 RCOG report²⁰³ commented that anaesthetic consultant staffing was non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) Guidelines for Obstetric Anaesthesia Services²⁰⁴ which recommended 12 consultant anaesthetist sessions per week to cover just the emergency work of the labour ward, with additional sessions required for management of clinics and elective caesarean list workload.
- 11.14** The Trust has a document reflecting its anaesthetic staffing and plans: Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants. Its first iteration was in 2010 and it has been amended over the years in response to service changes, audits, and a Clinical Negligence Scheme for Trusts (CNST) report, with a full review and update in 2015. At that point, the Trust self-evaluated that it required 14 sessions of anaesthetic consultant cover in order to comply with the OAA/AAGBI guidance but that it had a shortfall of three consultant sessions. Prospective cover for leave involved cover by another consultant or a specialty doctor.
- 11.15** By 2018 the self-evaluated number of sessions that required cover had risen to 16 but actual staffing remained static at coverage of 11 sessions only, a deficit of 5 sessions. Since the publication of the first report, the Trust has advised the review team that elective lists and clinics are almost always staffed by a consultant grade anaesthetist but that the labour ward only has dedicated consultant cover 50% of normal daytime hours. This falls short of current guidance from the Royal College of Anaesthetists (RCoA) as detailed in the Guidelines for the Provision of Anaesthetic Services (GPAS)²⁰⁵.
- 11.16** The review team has been advised by the Trust that, out-of-hours, the anaesthetic consultant on-call at The Princess Royal Hospital, Telford, has responsibility for general theatres, intensive care, paediatrics, and the head and neck surgical service as well as obstetrics. This results in situations where, understandably, they are unable to be in more than one place at a time. The review team has been advised by staff that attempts to recruit new consultant anaesthetists in order to provide a separate rota to cover intensive care have so far been unsuccessful. The required training and skillset of the obstetric anaesthetists and also that required for the non-obstetric anaesthetists who cover the maternity service out-of-hours is not specified in RCoA's guidelines. The Trust's Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants document states that '*Staff are made aware of the availability and access to all guidelines, protocols and policies during their induction*' but does not give any more detail on any measures taken to assure staff training and updates. A list of consultants who provide input to the on-call service has been provided by the Trust and it is notable that a significant proportion are locums. There is a nominated lead obstetric anaesthetist who has an active role in leading and managing the service, and this is reflected in their job plan.
- 11.17** A team of specialty doctors provide the out-of-hours and much of the within hours resident cover to the maternity service. They are described by the lead obstetric anaesthetist as a 'senior stable workforce'.

203 The RCOG report -Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

204 OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

205 Guidelines for Provision of Anaesthesia Services (Chapter 9 Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020). RCoA. (<https://rcoa.ac.uk/gpas/chapter-9>)

Doctors in training spend daytime hours on obstetrics but have not contributed to out-of-hours provision since 2011. The Trust has provided no detail to describe the training and ongoing development of the specialty doctor group of anaesthetists upon which the service relies so very heavily. Access to learning and development opportunities can be limited for staff grade, associate specialist and specialty doctors (SAS) generally within the NHS, specifically in comparison to consultant colleagues or doctors in formal training programmes. This may be due to the role of SAS doctors in managing service pressures and their lower supporting professional activity (SPA) allowance compared to consultant staff.

- 11.18** A member of staff talking to the review team in the autumn of 2021 told us; *'We're just about functioning but we are having to use locums and every week you look at the system and it's just a mess of extra people doing different lists, slotting in. So we're getting by, you know, week to week. It's quite a challenge...you raise your concerns and everybody says yes, yes, this is a big concern but nothing really happens'*.

Management of common obstetric conditions

- 11.19** In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines. There is evidence of women receiving excessive volumes of intravenous fluid prescribed by both anaesthetists and obstetricians. This took place in the presence of severe pre-eclampsia, contrary to local and national guidance regarding fluid restriction in such circumstances, and also after post-partum haemorrhage. In some cases, the women were displaying clear signs and symptoms of fluid overload over a protracted period before it was noted by medical staff.
- 11.20** *In 2004, after discharge to recovery following examination under anaesthesia for post-partum haemorrhage, the patient continued with 100-150ml intravenous fluids per hour despite plentiful oral intake. Some 3.5 hours later she was noted to be desaturating and an hour after that she complained that her hands felt 'tight' and they were documented as oedematous. Her urine output overnight peaked at 320ml/h. An obstetric SHO prescribed a further two units of blood as there was a decrease in the woman's haemoglobin. The following morning, with oxygen saturations of 88% on air, she was finally diagnosed as being fluid overloaded. She passed 1600ml of urine in the hour after she was given intravenous furosemide²⁰⁶ and shortly afterwards was able to stop oxygen therapy. (2004)*
- 11.21** *A woman who had symptoms and signs of severe pre-eclampsia in 2008 had her baby delivered by caesarean section after failed induction of labour. She was diagnosed with left ventricular failure²⁰⁷ and pulmonary oedema²⁰⁸ in the postoperative period when she had a positive fluid balance in excess of 2000mls. Fluid administration was consistently in excess of the nationally advised limit of 80ml/h with 1500ml being given in theatre alone. A handwritten note in the patient's hospital records stated that her case had been discussed at a governance meeting, but no documents reflecting this were supplied to the review team by the Trust. (2008)*
- 11.22** Obstetric haemorrhage is a common condition that all staff involved in the care of obstetric patients must be confident in recognising and managing. However, there were a number of instances where the obstetric and anaesthetic teams seemed slow to diagnose bleeding as the underlying cause of a woman's deterioration. For example:
- 11.23** *In the early hours of the morning after an elective caesarean section in 2012, a woman became progressively tachycardic and hypotensive²⁰⁹ feeling hot, clammy and dizzy, with a sense of ringing in her ears, vomiting, and loss of consciousness with a brief seizure. Despite a 30g/l drop in haemoglobin on blood gas sample analysis, raised lactate, and uterine tenderness, the staff grade anaesthetist who was called to see her (and the obstetric on-call team) did not recognise that the patient was bleeding as there was 'no excessive*

²⁰⁶ See glossary

²⁰⁷ See glossary

²⁰⁸ See glossary

²⁰⁹ See glossary

blood loss seen'. The medical registrar was called to comment on the seizure and suggested bleeding as an underlying cause. She was finally diagnosed as such once the obstetric consultant was contacted. An incident report was submitted, but there are no other documents available related to the case. (2012)

11.24 *Following a vaginal delivery in 2016 a woman suffered a postpartum haemorrhage which resulted in tachycardia, hypotension, and the administration of 3.5 litres of crystalloid²¹⁰ by the obstetric team. The haemoglobin pre-delivery was 123g/l and at its lowest was 60g/l. The obstetric registrar estimated blood loss as 1000ml and wanted to take the patient to theatre for an examination under anaesthetic. The consultant anaesthetist estimated blood loss as 2000-3000ml. The consultant obstetrician estimated blood loss as 1200ml and overruled the plan for examination under anaesthesia. After a unit of blood that day and three the following day, the haemoglobin improved to 89g/l. A blood loss of just 800ml was later documented on the woman's discharge summary. When the woman was readmitted a month later she had a large remnant of placenta removed under anaesthesia and required a further blood transfusion. There was no incident reporting concerning these events. (2016)*

11.25 Local Actions for Learning from our first report highlighted the need for development of evidence-based guidelines and multidisciplinary training for developing and maintaining staff skills in the diagnosis and management of obstetric conditions. The Trust's anaesthetists have worked to create a full range of obstetric anaesthesia guidelines in response to the first report, and now acknowledge the challenge in embedding them into clinical practice and monitoring adherence to them. It is reassuring to hear from staff interviews that obstetric skills and drills are now undertaken regularly on the labour ward and involve the multidisciplinary team, including the anaesthetists.

Postnatal follow-up

11.26 In the process of undertaking reviews of clinical records for the purposes of this report, it is apparent that many women who experienced complications did not have the opportunity to have a proper discussion with clinicians about their peripartum care. On occasion there has been poor practice and care on the part of the Trust that has not been adequately discussed, and on other occasions women have had a complicated and difficult childbirth. From the communications between women, their families and the review team it is clear that a sense of not being listened to, as well as a lack of understanding about peripartum events, has persisted for some women and families for many years, impacting negatively on their psychological state, even now.

11.27 With the power of retrospection, it is clear that many women would benefit from postnatal discussion with clinicians who can actually give individualised answers about their care. Such discussion can occur at the time of events taking place but must be reinforced after discharge, when women are more able to gather their thoughts and questions in advance of a meeting, be supported by the presence of a friend, relative or advocate if they so choose, and take notes of answers.

11.28 Outpatient postnatal follow-up by an anaesthetist must be offered for women for whom significant issues have occurred, especially where they may impact on anaesthesia management or anxiety during future childbirth. Such issues include inherent anaesthetic complications such as intraoperative pain, including where conversion to general anaesthesia became necessary, suboptimal epidural pain control with significant consequent distress, and postdural puncture headache. More serious complications such as awareness under general anaesthetic and neurological complications related to anaesthesia must also be followed-up in an outpatient setting. Clinicians must also recognise situations where women would benefit from a conversation and explanations regarding their anaesthetic care even when nothing has actually gone wrong. Provision of such appointments must be seen as part of a culture of openness and willingness to maximise improvement of patient care, rather than as an admission of failure on the part of the Trust.

210 See glossary

- 11.29** *A woman made contact with the Review Team regarding her ‘horrendous’ experience of pain during caesarean section under epidural top-up with intraoperative conversion to general anaesthesia in 1999. Despite the passage of time, the experience still causes the woman distress to this day. On review of the medical records it is clear that the epidural never offered adequate pain relief in labour and there is no evidence that the top-up for surgery was checked for adequacy. Twenty minutes after arriving in theatre the patient was given a general anaesthetic with a note documenting ‘switch to GA after initial incision for surgical reasons’. After a midwifery debrief, the patient’s notes were passed to a consultant anaesthetist who wrote a note saying that ‘bar reassurance, probably there is no specific reason to see her’. Although this case occurred before the main period of the review, it is included here as a reminder to all clinicians involved in maternity care how psychological injuries may persist for years afterwards. Efforts must be made to minimise such occurrences and to provide adequate help to manage the consequences of such events when they do occur.*
- 11.30** *Two days after an emergency caesarean in 2017, a woman was admitted to HDU with acute lung injury. A confusing and conflicting range of underlying diagnoses were reflected in the notes and discussed with the patient by the obstetric, anaesthetic and respiratory teams. At discharge, the patient asked about the possibility of a debrief with an obstetrician. She later had a debrief with a midwife only, where no further insights on the woman’s underlying medical diagnoses were discussed and she remained unclear as to what had caused her significant illness. Over a year later she was still requiring psychological support. In this case a multi-professional meeting with clinicians who had been involved in her care would have been more appropriate than a midwife-only debrief. (2017)*

Documentation

- 11.31** On performing reviews of medical records for this report, midwifery documentation has tended to offer the most consistent evidence for understanding the development and timing of events. Brief reviews by both obstetric and anaesthetic doctors are often not documented by the doctors themselves despite being of clinical significance, and anaesthetic documentation is commonly restricted to an anaesthetic chart only. Documentation on the anaesthetic charts was frequently patchy, lacking detail of block adequacy achieved before surgery, or medication administered.
- 11.32** *Despite attending a patient with massive antepartum haemorrhage, the duty anaesthetist in 2004 did not document their actions or plan. The patient was reviewed a number of times over the course of the subsequent day by a consultant anaesthetist who again did not document anything. Their reviews, actions and advice were documented by the midwife only. (2004)*
- 11.33** *Following a category 1 caesarean section for antepartum haemorrhage complicated by massive obstetric haemorrhage in 2015 the patient remained cardiovascularly compromised for a time period in recovery, as evidenced by low blood pressure and high heart rate on her observation chart. The healthcare worker who completed the observation chart also documented the presence of the consultant anaesthetist for the full 45 minutes of that instability, although the anaesthetist made no entry in the notes. (2015)*

Learning from adverse outcomes

- 11.34** An important part of the purpose of reporting adverse events is in order to inform staff about the possibility of risks, to learn from the adverse outcomes of the practice of others, as well as oneself, and to take steps, where possible, to minimise similar occurrences in future. Failure to learn from such occurrences and share reflections with colleagues, risks a failure of ‘institutional memory’ and may result in repeated and needless patient harm. Staff of all grades and specialties benefit from continual peer and self-review of their practice in the form of morbidity and mortality meetings. Just 39 incident reports concerning obstetric anaesthesia were submitted in the Trust during the time period 2008-2021. The Trust must consider whether such a low reporting rate indicates staff acceptance of poor practice and complications, or a lack of faith that reporting can effect change.

- 11.35** *A spinal anaesthetic was sited for a forceps delivery in 2010. Documentation on the anaesthetic chart stated 'no pain on insertion/injection'. The woman developed foot and leg pain the following day but the anaesthetist declined to review the patient as they 'thought it unlikely to be related to spinal anaesthesia'. An MRI requested by the orthopaedic team showed oedema²¹¹ of a low-lying and tethered conus²¹². Documentation of subsequent discussion between the anaesthetist and the woman reflects that she had actually experienced 'electric shock' pains on initial spinal insertion but the anaesthetist wrote that they had withdrawn the spinal needle when this had occurred. There was no explanation as to why there was a discrepancy between the documentation on the anaesthetic chart and the subsequent conversation. The patient needed ongoing management for neuropathic pain and foot drop after discharge. The chief executive's response to a complaint letter included the statement: 'Training is not an issue as [the anaesthetist's] main activity is undertaking epidural and spinal anaesthetics in the maternity department'. (2010)*
- 11.36** *In 2012, a woman experienced non-postural headache and focal neurological symptoms after an epidural for labour by a staff grade anaesthetist (which took a number of attempts to insert, worked sub-optimally, and was sited more than five hours after it was requested due to labour ward workload). It was only on her fourth readmission with symptoms that brain imaging was undertaken and bilateral subdural haemorrhage diagnosed. In the Trust's response to her complaint letter, it stated that the anaesthetist had said that the subdural haemorrhage could not have related to an accidental dural puncture as none was noted at the time of epidural insertion, thus failing to acknowledge that unrecognised dural puncture may take place. Possible causes suggested in the letter were high blood pressure in labour, the stress of her baby being admitted to the neonatal unit, and a pre-existing neurological susceptibility. (2012)*
- 11.37** *In 2018, a root cause analysis into the management of a woman with what was considered to be an atypical presentation of pre-eclampsia (drowsiness, reduced level of consciousness in conjunction with elevated blood pressure, headache, vomiting and epigastric pain) looked at statements from three midwives and an obstetric middle grade. It did not involve the consultant anaesthetist or consultant obstetrician involved in the patient's care at the time culminating in her emergency caesarean section and seizure. Nor did it address the failure of the obstetric and midwifery teams to check on blood results taken in triage the night before, when the woman was assessed and discharged home, which would have shown her to be severely hypercalcaemic²¹³. Nor did it investigate how an incorrect (elevated) value of INR²¹⁴ was verbally reported to the team caring for her, resulting in unnecessary administration of blood products, a decision not to perform a planned lumbar puncture, and a decision not to manage a fibroid at the time of caesarean section. (2018)*
- 11.38** Anaesthetists should be included in and engage fully with the multidisciplinary team, both clinically, and in maternity governance activity. The Trust's Women's and Children's Root Cause Analysis planning proforma in use in 2018 has a list of job roles with the option of indicating who should be present. None of the 17 job roles listed is that of consultant anaesthetist.
- 11.39** Involvement of the anaesthetic team in governance activity requires a change in culture and attitude but also requires time and planning. Departmental leads and the executive team must address the resource requirements necessary for anaesthetists to take an active role in obstetric governance and ensure time away from clinical commitments is allowed for this purpose in anaesthetic staff job plans. This will necessarily have cost and recruitment implications. Conflicts of demands on the time of consultant anaesthetists must be addressed at executive level and not left solely to individual anaesthetists to resolve.
- 11.40** The terms of reference for the Trust's maternity governance meetings from January 2018 state that an anaesthetist is required to attend every three months – minutes of attendance suggest that even this low benchmark is not being achieved. It is important that, even in times of high clinical workload, anaesthetic presence at governance meetings must be maintained to ensure the safety and the integrity of the service in the longer term. This is certainly challenging if, as Trust staff advised the review team, there are still considerable issues with consultant anaesthetic staffing.

211 See glossary

212 See glossary

213 See glossary

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Local Actions for Learning

- 11.41** The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.
- 11.42** The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA ‘Guidelines for Provision of Anaesthetic Services’ (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust’s executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 11.43** The Trust’s executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.
- 11.44** The Trust’s executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust’s services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.
- 11.45** The Trust’s executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by GPAS in 2020.
- 11.46** The Trust’s anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.
- 11.47** The Trust’s department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

Chapter 12

Neonatal care

Introduction

- 12.1** In this chapter we focus primarily on the clinical care provided by the neonatal team to babies delivered at the Trust. The majority of the care reviewed took place on the neonatal unit (NNU), but the neonatal team were involved in resuscitation of babies on the labour ward as well as managing some babies on the postnatal wards.
- 12.2** It is important to emphasise that in line with the terms of reference the cases reviewed only represent less than two per cent of the total births at the Trust and a small minority of neonatal admissions over the review period. Cases were ascertained due to either parental concerns about the quality of maternity care or due to poor outcomes - specifically neonatal death or brain injury. In addition, some cases came to light in the Open Book exercise arranged by the Trust which considered HIE and neonatal death as factors for referral to the review.
- 12.3** As well as identifying areas for improvement and learning, the review team also noted many examples of good neonatal practice and often excellent communication. The number of complaints by families about the care they received in the neonatal unit was quite low.

Organisation of neonatal services in the UK (2000-2019)

- 12.4** In 2001 the British Association of Perinatal Medicine (BAPM) updated its 1996 standards for hospitals providing neonatal intensive care. There was a recommendation that hospitals work together in networks and care of the smallest and sickest infants be centralised into larger centres, neonatal intensive care units (or NICU), known as level 3 units. This led to the development of managed neonatal networks and was incorporated into the Maternity Services National Service Framework in 2004. It was also recognised that clinical skills needed to be maintained in the local neonatal units (LNU), known as level 2 units, to provide short term intensive care (usually up to 48 hrs) for more mature babies in close liaison with their designated level 3 NICU.
- 12.5** In 2009 a Department of Health taskforce of neonatal professionals and parent representatives published a Toolkit for High Quality Neonatal Services²¹⁵ with service specifications to standardise special care, high dependency care and intensive care. In 2010 the National Institute for Health and Care Excellence (NICE)²¹⁶ published quality standards for neonatal specialist care. In most trusts compliance with these standards is reviewed through clinical governance processes.
- 12.6** NHS England commissions all levels of neonatal critical care. The commissioning of care is usually agreed with the neonatal network but ultimately is a formal agreement between the commissioners and the provider unit trusts.

Neonatal transport

- 12.7** Babies should ideally be delivered in the most appropriate setting for their predicted care needs. In utero (before delivery) transfer is preferable to postnatal transfer and has been shown to improve outcomes. However babies do sometimes need to be transferred after birth for escalation of care, or to access

²¹⁵ Department of Health. Toolkit for High-Quality Neonatal Services (2009)
https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

²¹⁶ National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

specialist care (e.g. for neonatal surgery). Over the period of this review, neonatal transport services, which were traditionally provided and staffed by the larger NICUs, were centralised in all networks so that a dedicated transport team is responsible for moving babies between units, and since 2015 most services have had a centralised telephone triage system. In the West Midlands, a centralised team has provided transport services 24/7 since 2008. Teleconferenced triage has become available in very recent years.

Organisation of neonatal services at the Trust (2000-2019)

- 12.8** Following the establishment of neonatal networks in England in 2004, the Trust's neonatal services initially formed part of the Staffordshire, Shropshire and Black Country Neonatal Network (SSBCNN) becoming an operational delivery network in 2013 (SSBCODN). The NNU and the obstetric services at the Trust are located within the Shropshire Women and Children's Centre, based at the Princess Royal Hospital (PRH) in Telford, having moved there from the Royal Shrewsbury Hospital (RSH) in late 2014.
- 12.9** Prior to 2006 the neonatal service at the Trust provided intensive care. Since 2006, when unit categories were first defined, it has been designated as a Local Neonatal Unit (LNU) of level 2. This means that it is commissioned to provide special care and high dependency care for newborn babies, as well as intensive care for periods of up to about 48 hours. Babies requiring longer-term intensive care and singletons born at less than 27 weeks gestation, if not transferred in utero, should be discussed with and transferred to a level 3 unit (NICU).
- 12.10** The neonatal unit at the PRH in Telford has 22 cots and is busy compared to other LNUs with above average numbers of preterm babies admitted. In 2018-19 it provided 7,425 care episodes, which was in the top quartile of critical care activity for neonatal units providing critical care in England.
- 12.11** The review team heard that the neonatal service at the Trust disputed its revised designation and did not work in line with the new scope of its responsibilities. There is debate why this was. Some at the Trust felt that due to the unit's size, expertise and geographical location (including receiving babies from Wales) it should have been designated as a level 3 unit. Others at the Trust have stated that there were insufficient cots and expertise elsewhere throughout the region, although this is disputed by the neonatal network²¹⁷. The West Midlands Neonatal Operational Delivery Network confirmed in correspondence with the Chair of this review that *'capacity in both University Hospital North Midlands (which is the care pathway for SaTH and Royal Wolverhampton Hospital NHS Trust) has rarely been so that they would not take a baby that required NICU care'*. Despite this, the review team found evidence of non-compliance by the Trust with its 2006 level 2 designation until at least 2015.
- 12.12** The review team noted that for a period of nine years after the designation to a level 2 unit, transfer of babies from the Trust that required intensive care did not consistently occur in line with the national and network guidelines. According to the neonatal network capacity issues were not causative. The review team is of the clear opinion that NICU care relies on a properly resourced multidisciplinary team and that the designation as a level 2 unit after 2006 should have been respected and adhered to.
- 12.13** Following the contested designation as a level 2 unit in 2006, the review team has been advised that network leadership and the commissioners met with the Trust on several occasions, especially after the publication of a network care pathway document in 2011 to try to ensure that neonatal care within the Trust followed the guidance.
- 12.14** The Royal College of Paediatrics and Child Health (RCPCH)²¹⁸ carried out an invited review in 2013. They noted that *'given the availability of experienced and dedicated neonatologists, at the time of the visit the unit cared for a number of babies under 27 weeks and provided an enhanced range of intensive care services'*. They noted that this intensive care activity was not supported by the neonatal network and that the unit would in future work as a standard level 2 local neonatal unit. The Trust continued to deliver some aspects of intensive care outside the agreed care pathway until the unit moved to the Telford site in 2014.

²¹⁷ Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

²¹⁸ Report provided to the review team by the Trust

Cases considered by the review team also demonstrated that this progressive change in neonatal care took many years to be embedded into clinical practice:

- 12.15** *In 2011 a baby was delivered at 26 weeks gestation after threatened preterm delivery from 23 weeks with no record of consideration of in utero transfer. Senior staff were closely involved in care at the Trust with a good relationship with the family and evidence of compassionate care was seen after the poor outcome. (2011)*
- 12.16** In the next revision of the network care pathway in 2015, it was made more explicit that advanced therapies should not be delivered at the Trust, unless in exceptional circumstances and after discussion with a neonatologist at the Royal Stoke Hospital (now University Hospitals of North Midlands) NICU. Sometime after the move to the new unit in Telford the neonatal unit started operating at the designated level 2.

Perinatal and neonatal mortality

- 12.17** The perinatal mortality rate (PMR) and the neonatal mortality rate (NMR) are measures which are used as benchmarks of the quality of obstetric and neonatal care, although other factors such as socioeconomic circumstances and maternal age also have an important influence on these measures.
- 12.18** The MBRRACE-UK perinatal surveillance annual reports have been available since 2013, and they have provided PMR and NMR data, 'adjusted and stabilised' with regard to key contributory factors, for individual trusts from 2014²¹⁹. The neonatal mortality rate (NMR) for the Trust was above the average for similar providers (similar numbers of births LNUs) for the years 2014–2016, but in 2017 it dropped to below the average. In 2018 and 2019 it was 'red' (more than 5 per cent above the group average). It should be noted that in all these years the NMR and PMR were comparable to many similar units and were not statistical outliers. Mortality rates for preterm babies born between 2015–2018 were also high for babies born within the SSBCODN network and for two of its neighbouring networks.
- 12.19** In 2009 the neonatal service at the Trust described itself in the National Neonatal Audit Programme (NNAP) report as a NICU, despite having been designated as a level 2 NNU in 2006. This review has also been provided with documentation of a presentation to the CCG in 2018 where a Trust representative outlined that one of the reasons that the Trust felt its neonatal unit had higher perinatal mortality than its peers was because it was being compared with level 2 units (LNUs) when it had in fact been operating as a level 3 unit (and therefore accepting and continuing to care for more complex cases) until 2016. In this presentation the Trust representative made the case that therefore the figures were not representative. They stated the reason for operating at level 3 was due to capacity issues elsewhere in the network. There has been no evidence seen by the review team that capacity in other units was an issue and this has been confirmed by the neonatal network. The review team note that the data is difficult to interpret as the Trust had consistently not worked at the level it had been allocated and that it should not have taken in excess of eight years for the Trust to have worked at the level it had been designated.

National Neonatal Audit Programme

- 12.20** The National Neonatal Audit Programme (NNAP) has measured the quality of care delivered by neonatal units since 2006. NNAP reports available online (2014–2019) indicate that, for the limited number of quality indicators, the NNU at the Trust was performing at above the average for LNUs in the UK. In particular, the Trust NNU achieved one of the best scores compared with other LNUs for communication (the proportion of parents who meet with a senior member of the neonatal staff within the first 24 hours of admission). Temperature control of babies was also above average and eye-screening was excellent for this period.
- 12.21** The length of stay on the NNU at the Trust for late preterm babies and more mature babies was reported to be longer than in other NNUs - this may reflect a need to improve transitional care facilities at the Trust. In 2018 and 2019 the proportion of neonatal nurses working in the NNU at PRH who had a specific

219 MBRRACE Perinatal mortality surveillance reports 2013–2016 <https://www.npeu.ox.ac.uk/mbrance-uk/reports/perinatal-mortality-surveillance>
MBRRACE Perinatal mortality surveillance report 2017 <https://www.npeu.ox.ac.uk/mbrance-uk/reports>

qualification in the care of sick newborn infants was lower than the average for LNUs in the UK and appears to be falling.

Review of neonatal clinical care at the Trust

- 12.22** During our reviews we identified a number of cases where individual errors were made or there was poor practice. However, these were very much the exception and we have found no evidence of systemic poor neonatal practice or lack of care or compassion in the neonatal service. The review found evidence that identified failings in care were addressed by the Trust with the development of appropriate guidelines, but the review team does not know if the development of these guidelines then led to improvements in care. However, some incidents occurred with sufficient frequency, or were sufficiently important, that we feel there is scope for wider learning on a national level.
- 12.23** It appears from the majority of the medical records reviewed that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. There were frequent examples of the consultants being called to assist with resuscitations of newborn babies on the labour ward and in many cases their interventions led to an improvement in the short-term outcome.
- 12.24** Review of the medical records shows that the Trust was an early adopter of the Advanced Neonatal Nurse Practitioner (ANNP) model and that ANNPs played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. We noted their practice to be appropriate and that the ANNPs formed an important part of the neonatal staffing model. The quality of their entries in the medical records was generally noted to be of a very high standard. During the reviews we did not identify any systematic concerns about nursing care.

Transfers, referrals and escalation of care

- 12.25** Neonatal care is most effective when delivered in close partnership with other services as discussed above. When reviewing individual cases we found evidence of effective joint working:
- 12.26** *In 2005, after an uncomplicated term delivery a baby became progressively seriously ill with breathing and neurological problems. On the first day of illness the problem had been recognised as a very severe metabolic disorder and advice on care was obtained from regional and national specialist services. Despite transport to the national centre being arranged sadly it was not possible for the baby to survive. Successful genetic diagnosis allowed counselling about future risk to be provided to the family. (2005)*
- 12.27** *In 2010 antenatal scans had suggested the possibility that a baby might have problems and a plan was in place for assessment and care at birth. After delivery it became clear that the baby could not manage to breathe strongly enough on their own and needed support from a ventilator. Specialist reviews were arranged in Shrewsbury and the required investigations quickly carried out with close involvement of regional and national services. A definitive diagnosis of a neuromuscular disorder was very quickly established and palliative care agreed with the family. We found good evidence of highly effective and compassionate care with input from multiple specialists. (2010)*
- 12.28** We found evidence of appropriate communication with tertiary specialists when babies required escalation for specialist care, including surgical or cardiac care and good liaison with Alder Hey and Birmingham specialists regarding MRI scans and post-mortem reports. However, in some other cases we found planned deliveries being arranged at the Trust which had not had the involvement of specialist services as would have been expected.
- 12.29** *In 2008, a baby was diagnosed with significant spina bifida²²⁰ (lumbar myelomeningocele) with severe hydrocephalus in the antenatal period. There was no evidence of tertiary fetal medicine or neurosurgical*

discussion regarding appropriate tertiary referral. The baby delivered at the Trust. There were challenges delivering respiratory support in head box oxygen²²¹ and baby needed support with a ventilator when the transport team arrived at 30 hours of age, before they could be moved to Birmingham Children's Hospital, (BCH). Despite continuing intensive care in the regional unit the baby developed worsening respiratory distress at BCH as well as a coagulopathy²²² and remained too ill for surgery and died. (2008)

12.30 During the period when the neonatal service continued to operate as a NICU, despite its designation as a neonatal unit, some babies were delivered with major congenital anomalies requiring high level intensive care.

12.31 *In 2008, there was an antenatal diagnosis of diaphragmatic hernia²²³. The parents were seen by a neonatologist and plans for delivery in Shrewsbury were discussed. An antenatal appointment was offered at Alder Hey. Parents declined this as they felt they had too many appointments to attend. The surgical service were aware of the plan to deliver locally and to transfer the baby after stabilisation. No major difficulties were encountered with the baby's initial care at Shrewsbury and baby was transferred but at the tertiary unit the baby progressively deteriorated and did not survive. (2008)*

12.32 In the same year another baby with the same major anomaly was delivered in Shrewsbury:

The baby was diagnosed in the antenatal period in 2008 with a diaphragmatic hernia. The neonatologist wrote a letter to the parents and another to the paediatric surgeons in the local surgical centre at Birmingham Children's Hospital (BCH). This states 'baby has diaphragmatic hernia, booked to deliver at RSH and as a unit that is able to perform all levels of intensive care we feel that we are in a position to offer neonatal resuscitation and stabilisation pre-surgery at Shrewsbury. One of the neonatologists will personally be on call for the lady's delivery'. (2008)

12.33 *The regional surgical service were aware of the planned delivery with no evidence seen by the review team that they suggested any alternative plan. The baby died after three hours after challenges in delivering aspects of intensive care. Whilst the outcome might not have been different it was not clear that the parents had been offered the opportunity to discuss options with the specialist surgeons in Birmingham prior to delivery.*

12.34 Babies found to have diaphragmatic hernia during antenatal scans are now transferred for delivery in Birmingham Women's Hospital or Liverpool Women's Hospital. In our review of the medical records it was not always apparent that early consultation with a tertiary centre, to consider planning of transfer of care where appropriate, had taken place. It is possible that such consultations did take place but were not documented in the medical records to which we had access.

12.35 *In 2011 a woman presented at 25 weeks, with a twin pregnancy complicated by twin to twin transfusion syndrome²²⁴. There was antenatal discussion with Birmingham but the babies were born at RSH. The first twin needed prolonged resuscitation at birth. Later in the first week he required exceptionally extensive intensive care after a large brain bleed. There was no recorded discussion with a NICU and missed opportunities to transfer out in the first 2 days before baby became critically unstable. Sadly, the baby died. The other twin died at 5 months of age in a specialist centre, with airway problems. (2011)*

Management of babies with Hypoxic-Ischaemic Encephalopathy

12.36 Hypoxic-Ischaemic Encephalopathy (HIE) is due to impaired delivery of oxygen to the brain. Until around 2010 treatment was largely supportive, although clinical trials of brain or body hypothermia were undertaken in the early 2000s and published in 2005-2009 and cooling therapy was initially offered in a limited number

221 See glossary

222 See glossary

223 See glossary

224 See glossary

of centres participating in these trials. By 2009 it was established that therapeutic hypothermia significantly reduced the incidence of death or disability from HIE and the BAPM issued a position statement on its use. At this time therapeutic hypothermia (cooling) was normally delivered in NICUs although some larger LNUs in the UK still undertook this therapy on a transitional arrangement if agreed by the network.

- 12.37** To be most effective, cooling should be commenced (either passively or actively) by 6 hours of age. It is important that cooling therapy follows evidence-based pathways wherever possible. We found some examples of cooling outside this pathway.
- 12.38** *In 2010, a baby born after cord prolapse with an umbilical cord pH 6.8 was cooled quickly and effectively, required full intensive care including inotropes to support blood pressure and mechanical ventilation to support breathing. The baby was not discussed with or transferred to a NICU. (2010)*
- 12.39** The review found that the clinical management of HIE in many cases was of a good quality but found that the cooling therapy delivered at the Trust was outside the agreed network pathway for this provider which stated: *'Newly born infants who require cooling for treatment of perinatal asphyxia will have active cooling initiated at RSH prior to being transferred with continued active cooling to UHNS or New Cross Hospital the Network Lead Centres or an appropriate neonatal intensive care unit'*.
- 12.40** *In 2011 a baby was cooled because of HIE. The seizures were very difficult to control despite anticonvulsants and so there was a documented discussion with a NICU outside the network but with a strong research reputation for cooling, who suggested it could be extended by 24 hours. The cooling in fact continued for a total of 6 days. Whilst there was no evidence of direct harm from this, it was unusual practice and outside the advised practice. The child continued to have epilepsy through early childhood. (2011)*
- 12.41** We did however find evidence of good practice in that the Trust diligently reported babies receiving therapeutic hypothermia for HIE to the 'cooling registry' which gathered data after the TOBY²²⁵ study on hypothermia was published.

Resuscitation and stabilisation at birth

- 12.42** The review found a number of cases where the Newborn Life Support algorithm was not followed in the correct order. In particular, where cardiac compressions were started before lung inflation had been achieved. It is vital that an airway is established and effective lung inflation achieved before moving on to cardiac compressions as they otherwise will not be effective.
- 12.43** Intubation of small babies is a difficult skill, and one that is increasingly hard to gain competence in as intubation opportunities have become less frequent with greater use of non-invasive ventilation. We found in general that babies were intubated on the labour ward appropriately. The Trust appeared to be relatively late adopters of CO₂ detectors (which can help confirm the endotracheal tube is correctly placed). In some cases babies had multiple extubations and intubations in the first minutes of life, either due to uncertainty about their position or due to accidental extubation.
- 12.44** *In 2007, an extremely preterm baby weighing just over 500g was in poor condition at birth, and had five intubation attempts including the use of a bougie. When successfully inserted, the ET tube was inserted too far. (2007)*
- 12.45** *In 2008 a baby at 23 weeks born in the Trust had two accidental extubations within the first hours of life, so required three intubations in four hours. The baby deteriorated on day 10 for which they were given a third dose of surfactant (unusually late). Deterioration was found to be secondary to intestinal perforation and they were then transferred to a surgical NICU. (2008)*

225 TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/>

Communication during neonatal resuscitation

12.46 In the cases considered by this review we sometimes found that a structured approach to communication to a senior doctor in a crisis situation did not always happen. Our view is that there should be a shift in expectations such that, when it is known that senior help cannot attend immediately, a formal two-way telephone dialogue, based on the SBAR (Situation, Background, Assessment, and Recommendation) structure, should take place at the time of calling for the senior help. This two way conversation directly with the resuscitation team should involve a review of the interventions which have been tried and advice from the senior help concerning the actions to be taken pending their arrival. This situation is not unique to this Trust.

Management of hypoglycaemia (low sugar levels)

12.47 The review identified a number of cases where there was prolonged hypoglycaemia without effective or timely intervention. In some instances this was due to the need to transfer from the midwife-led unit (MLU) to the neonatal unit.

12.48 *In 2018, a term baby was born at the MLU in Princess Royal Hospital, Telford, at 03:44 with a very slow heart rate. After the neonatal team arrived and baby was intubated the heart rate improved. On arrival at the NNU at 04:55 the baby was hypotensive, hypothermic (planned) and had an apparently unrecordable blood glucose at 05:26 and 05:43. There is no evidence of it having been measured prior to this. An emergency blood transfusion was given for low haemoglobin, but the glucose was not addressed (even having been measured) until a bolus and infusion of dextrose were given at 07:05. This is 3 hours and 20 minutes after a major resuscitation (known to deplete glucose stores) and 1.5 hours after the glucose was first noted to be unrecordable. This may have contributed to the failure of the heart to respond to inotropes, fluids and other resuscitation measures. The first dose of antibiotics was not administered until 3 hours after admission to NNU and 2 hours after it was prescribed, despite IV access being in place. This is an unacceptable delay. Sadly, the baby died. (2018)*

12.49 *In 2007, a growth restricted term baby had very low cord pH at birth (but the baby quickly recovered with Apgar²²⁶ scores of 8 and 10), and required only facial oxygen. A paediatrician appropriately requested to keep baby warm and establish feeds. On review at 30 minutes, they noted profound hypoglycaemia. The paediatrician instructed “commence feeds as soon as mum ready and if concerned to inform NNU”. A doctor was called to review the baby when it was noted to be dusky aged 1 hour. The requested senior review said baby did not need admission. No further glucose levels documented until admitted at 13 hours, when they were normal. This baby was later diagnosed with HIE. (2007)*

Management of sepsis

12.50 In general the management of babies with suspected sepsis was in line with national recommendations and common practice. However, in the majority of cases reviewed where infection or suspected infection were part of the clinical picture, it did not seem that the use of infection markers such as C-reactive protein²²⁷ (CRP) for ‘tracking’ of the progress of the infection was standard practice. This was an active decision on the part of the neonatal consultants. We have not been able to identify a situation where the absence of these measurements was likely to have had a significant influence on the clinical outcome. However, infection markers can be useful in both the identification of infection and in guiding treatment and are widely used in neonatal practice. In more recent years the Trust has adopted the use of CRP.

²²⁶ See glossary

²²⁷ See glossary

Communication with families and documentation

12.51 Case reviews almost invariably showed evidence of good communication with the parents, especially by the ANNPs and consultants. There was evidence of compassionate care for the babies and their families, especially at the end of life or when considering reorientation of care towards comfort-orientated care.

12.52 *In 2002 a baby was born at full term and unexpectedly found to have severe respiratory problems from birth. The baby was diagnosed on the neonatal unit at Shrewsbury with severe pulmonary hypoplasia, (under-development of the lungs) and sadly this was untreatable and the baby died on the first day of life. There was extensive consultant involvement in the baby's short life, including the involvement of a second consultant in reviewing an unexpectedly serious case, a consultant doing the summary letter and, most importantly, sometime after the sad death, when all results were back, the consultant visited the family at home to go through the results of the baby's post-mortem examination and other specialised tests. The review observed this as an example of exceptionally good practice. (2002)*

12.53 We also found evidence that some parents had confidence in the quality of the consultant-led neonatal follow up:

In 2001, a baby was delivered by forceps after an eight hour 2nd stage of labour and developed HIE. The baby was discharged home well on day 9. The parents moved to Leicestershire but declined transfer of care to a local consultant and chose to come back to Shrewsbury for each neonatal follow-up visit to maintain continuity of care. (2001)

12.54 We found some examples where neonatologists requested that obstetricians at the Trust review a baby's care when they perceived there were unexpectedly poor outcomes.

12.55 *In 2009, a baby was born at 42 weeks, 50 hours after rupture of membranes with the cord tightly round its neck and thick meconium, and with a low cord pH of 6.5. Fortuitously the baby had a normal MRI brain scan and was said to be developing normally at 2 years of age. After seeing the family at an outpatient appointment the neonatologist wrote first to the risk manager in August suggesting the case was reviewed. The neonatologist also wrote to the obstetrician requesting a parental meeting and wrote again in November chasing this up as the family had still not heard anything. The long term outcome of this case is not known. (2009)*

12.56 In another case the neonatologist had concerns about the care of a baby after transfer between other NICUs:

12.57 *In 2008, a baby was born at 23+1 weeks in RSH after in utero transfer and received 11 days intensive care before being transferred to a surgical NICU due to intestinal perforation. Having received surgery the baby was repatriated to a third neonatal unit and apparently arrived in a 'shocked' condition, hypotensive and hypothermic and died 1 week later. The neonatal consultant at RSH wrote to the neonatologist at the receiving hospital suggesting they raise this with the referring surgical centre as this was 'unacceptable'. This represents evidence of concern for governance and ensuring quality of care. These examples were infrequent, but evidence a desire to ensure good quality of care for patients and their families. (2008)*

Combined medical and nursing notes

12.58 The clinical records that were reviewed had separate medical and nursing entries. This has the potential for important information not being accessed by key members of staff involved in the care of individual babies. The standard of medical and ANNP note-keeping was generally good and the admission clerking in particular was generally very comprehensive. However, there was no obvious systematic approach for daily ward round reviews, which meant that continuity of potentially important information was sometimes lacking.

12.59 Although by no means universal, prior to the introduction of electronic clinical records many NNUs had moved to having combined medical and nursing notes. The Trust now uses joint neonatal and medical notes and are moving to an electronic patient record.

Middle grade or Trust Tier 2 neonatal staffing

12.60 For some of the cases reviewed it was clear that, out of hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care to both units. It is for this reason that it is a service specification for level 3 NICUs that there is separate middle-grade cover for neonatal and paediatric units and why level 2 LNUs should not undertake prolonged intensive care.

12.61 The review found evidence that in some cases this led to a delay in middle-grade attendance at deliveries and in reviewing sick babies on the neonatal unit. As already discussed the Trust were early adopters of the ANNP model and this undoubtedly provided some mitigation but it was not clear whether the neonatal unit was adequately covered at middle-grade level at all times.

Consultant neonatologist staffing

12.62 It is clear from the majority of case notes reviewed that involvement of the consultant neonatologists in clinical decision making, in the provision of neonatal care and in communication with parents and other family members was of a very high quality. The case notes usually record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They were usually involved in the long-term clinic follow-up of their individual patients, providing continuity of care. Information sharing was aided by the neonatal discharge summaries often being written by a consultant. Having met with staff it is apparent to the review team that this high level of direct consultant input may have been at some personal cost and may have been offered in part due to a desire to continue as a NICU after designation as a LNU in 2006.

12.63 For some of the cases reviewed the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This can also compromise the availability of skilled care. Given the size of the maternity and neonatal service at the Trust, if it was aiming to provide ongoing neonatal intensive care at the time, it would be essential to have designated neonatal consultants on call 24/7. This was highlighted by the RCPCH invited review in 2013:

12.64 *'The neonatal rota is not compliant with BAPM staffing arrangements given the level of intensity of services provided at the RSH site. There is an enthusiastic staff team keen to develop their skills and care for babies locally, and a consultant group that provides prospective cover out-of-hours, coming in to support juniors and general paediatric consultants even when not on call. This is not sustainable and must be addressed when the service moves. The current enhanced status is not supported by the network following a CCG-commissioned review of maternity services and will in future operate as a standard level 2.'*

12.65 It is the review team's understanding that separation of the neonatal and paediatric consultant on call rotas has now been achieved, and we found evidence that the neonatal service has, since the move to Telford and publication of the updated care pathway by the neonatal network in 2015, largely been operating appropriately as a level 2 Local Neonatal Unit.

LOCAL ACTIONS FOR LEARNING: NEONATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 12.66** The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.
- 12.67** As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.
- 12.68** The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.
- 12.69** The number of neonatal nurses at the Trust who are 'qualified-in-specialty' must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

OCKENDEN REPORT - FINAL

Section 4

Our call for essential action following completion of this review

- Chapter 13. What happened in maternity services after our first report
- Chapter 14. Local Actions for Learning (LAfL) - the Trust
- Chapter 15. Immediate and Essential Actions to improve care
and safety in maternity services (IEA) across England

Chapter 13

What happened in maternity services across England after our first report

- 13.1** Our first report Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was based on a review of 250 family cases and was published on 10 December 2020. The report outlined seven Immediate and Essential Actions, (IEAs) for maternity systems across England and 27 Local Actions for Learning, (LAfL) for the Trust.
- 13.2** Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.
- 13.3** All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Additional funding for maternity services

- 13.4** Our first report highlighted that the amount of improvement required must be backed by real investment in maternity services.
- 13.5** In March 2021²²⁸ the Government made available £95.6million of investment for maternity services across England for:
- 1,200 additional midwifery roles
 - 100 whole-time equivalent consultant obstetricians
 - Backfill to allow for multidisciplinary team training
 - An additional midwife in every unit to support newly qualified midwives as they begin their careers.
- 13.6** Alongside this, in July 2021 the Government announced £2.45m²²⁹ to be invested into maternity services. These funds were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress.
- 13.7** For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding (SDF)²³⁰. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

228 NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update <https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf>

229 Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021) <https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care>

230 NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021) <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf>

- 13.8** With a shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for midwives, increasing the number to 800 in England. To support retention of midwives, NHSE&I has also funded a pastoral care midwife²³¹ role in every maternity unit during 2021/22.
- 13.9** With midwifery and obstetric staffing numbers continuing to cause significant concern and attrition from the midwifery profession, midwives and doctors remaining on the frontline are working tirelessly to support mothers and their babies in achieving a safe outcome.

Our call to action

Funding

- 13.10** Whilst the funding announcements we have seen have already made significant strides in the right direction in improving maternity services for all, much more still needs to be done. The Health and Social Care Committee report²³² on maternity safety in England, published in June 2021, stated that NHS maternity units in England needed an investment of £200-£350m to prevent women and babies dying or sustaining avoidable harm. This view was supported by the NHS Confederation²³³ and we state this level of investment must be forthcoming.

Continuity of carer (CoC)

- 13.11** We recognise the original aim of CoC which seeks to ensure a mother receives safe and personalised care from the same midwifery team with a named midwife who coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met through all stages of maternity care. The CoC model was introduced with little recognition of its potential impact on an already pressured maternity system across England.
- 13.12** Recent guidance²³⁴ has aimed to address the concerns expressed that CoC will lead to unsafe and inconsistent staffing and provides guidance for local planning and implementation of CoC. At a time of unprecedented stress on NHS resources we continue to hear concerns relating to attempts to support this model, which can lead to inequities in care provision. The CoC model must be reviewed and suspended until all Trusts demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that CoC models of care place on maternity services already under significant strain. The reinstatement of CoC should be withheld until robust evidence is available to support its reintroduction
- 13.13** As a multi-professional clinical review team comprising midwives, obstetricians, neonatologists and other specialist colleagues who work within (and closely with) maternity services in trusts across England, we strive to ensure that all women receive high-quality, safe care throughout their pregnancy pathway which is tailored to their individual needs. We all recognise the challenges faced by maternity services across England as they work to ensure that the maternity care provided leads to the best possible outcomes for mothers and their babies.
- 13.14** In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time. This is a Trust that was also failed by the wider maternity system which did not act, and this must not happen again.

231 Ibid n1

232 Ibid n2

233 NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021)
<https://committees.parliament.uk/publications/6290/documents/69337/default/>

234 NHS England/ I (2021) *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22*
Available: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

- 13.15** We urge maternity services across England to continue their work in implementing the IEAs from our first report. We have seen so much excellent practice and a real desire to improve. Now, the NHS across England and the Shrewsbury and Telford Hospital NHS Trust must make ambitious plans to ensure timely implementation of the additional Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEA) from our final report.
- 13.16** As difficult decisions loom about NHS funding post the COVID-pandemic, maternity services in England **must not slip down the priority list**. The scale of this review is unprecedented in NHS history and after listening to so many families, we have been given an unrivalled opportunity to change and improve maternity service provision for all parents and their families now and in the future. Together the changes we have outlined, and the demand for better funding will ensure safer outcomes for more women and families, reducing the risk of unnecessary loss of life, injury and resultant heartbreak.

Chapter 14

Local Actions for Learning (LAfL) - the Trust

Clinical governance

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.1** Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.
- 14.2** The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.
- 14.3** All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.
- 14.4** The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.
- 14.5** Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.
- 14.6** All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.
- 14.7** All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months
- 14.8** The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.
- 14.9** Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.10** The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.
- 14.11** All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.
- 14.12** The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.13** There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.
- 14.14** The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.15** Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.
- 14.16** Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.
- 14.17** All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.18** There must be midwifery and obstetric co-leads for audits.
- 14.19** Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.
- 14.20** Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.
- 14.21** Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.
- 14.21** Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.22** There must be midwifery and obstetric co-leads for developing guidelines.
- 14.23** A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.24** The Trust Board must review the progress of the maternity improvement and transformation plan every month.
- 14.25** The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment²³⁵ Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.
- 14.26** The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

235 NHS England. *Maternity self-assessment tool* (2021) <https://www.england.nhs.uk/publication/maternity-self-assessment-tool/>

Antenatal care

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.27** The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.28** The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.
- 14.29** Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019)²³⁶.

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.30** The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.
- 14.31** Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.32** The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

²³⁶ Ibid n11

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.33** Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD ROUNDS AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.34** All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017²³⁷). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.
- 14.35** All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021²³⁸.
- 14.36** The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR²³⁹ to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.37** The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.
- 14.38** The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

237 NHS England. *Seven day services clinical standards* (2017) <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

238 National Institute for Health and Care Excellence. *Inducing labour NICE Guideline 207* (2021) <https://www.nice.org.uk/guidance/ng207>

239 See glossary

- 14.39** The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts²⁴⁰ and Saving Babies Lives²⁴¹. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Intrapartum care

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.40** The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.
- 14.41** The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.
- 14.42** There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.
- 14.43** Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.
- 14.44** All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.45** Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.
- 14.46** The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.
- 14.46** Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.

²⁴⁰ Ibid n32

²⁴¹ Ibid n11

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.47** Midwifery-led units must complete yearly operational risk assessments.
- 14.48** Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.
- 14.49** It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.50** In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

- 14.51** The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

- 14.52** The Trust’s executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust’s services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.
- 14.53** The Trust’s executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.
- 14.54** The Trust’s anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice²⁴².
- 14.55** The Trust’s department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

LOCAL ACTIONS FOR LEARNING: NEONATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.56** The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.
- 14.57** As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.
- 14.58** The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.
- 14.59** The number of neonatal nurses at the Trust who are “qualified-in-specialty” must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

LOCAL ACTIONS FOR LEARNING: POSTNATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.60** The Trust must ensure that a woman’s GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

- 14.61** The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

LOCAL ACTIONS FOR LEARNING: STAFF VOICES

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.62** The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER THIS REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 14.63** Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.
- 14.64** There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Chapter 15

Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

- 15.1** We include these **Immediate and Essential Actions, (IEAs)** to improve safety in maternity services across England. These IEAs complement and expand upon the **Immediate and Essential Actions** issued in our first report. We note that NHS England and Improvement (NHSE&I) has supported the implementation of these actions in trusts across England since our first report was published.
- 15.2** These further **Immediate and Essential Actions** arise from findings from this large review into maternity services at Shrewsbury and Telford Hospitals NHS Trust. However, we are aware that similar problems may occur in other trusts across England and therefore these actions must be implemented widely in all maternity services.
- 15.3** This review is supporting and endorsing the latest Health and Social Care Committee Report “The Safety of Maternity Services in England”²⁴³. We agree with the select committee that the budget for maternity services be increased by £200-350million per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.
- 15.4** We further agree that the Department of Health and Social care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists, (RCOG) and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts, to enable trusts to deliver safe obstetric staffing over the years to come. This work must also consider the anaesthetic and neonatal workforce and be advised by the Royal College of Anaesthetists (RCOA), Obstetric Anaesthetists’ Association (OAA), Royal College of Paediatrics and Child Health (RCPCH) and British Association of Perinatal Medicine (BAPM). In this regard, the review team is also aware of and endorses the initiatives on workforce planning by the RCOA and the current national review of the obstetric anaesthesia workforce by the OAA in response to the first report.
- 15.5** We endorse the Health Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual Financial and Quality Accounts.
- 15.6** We endorse the Health Select Committee recommendation that the Maternity Transformation Programme Board should establish what proportion of maternity budgets should be ring-fenced for training but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.
- 15.7** We endorse the recommendation that a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board, working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).
- 15.8** We endorse the recommendation that training targets should be enforced by NHSE&I’s Maternity Transformation Programme, the Royal College of Midwives (RCM), the RCOG and the CQC through a regular collaborative inspection programme.
- 15.9** Along with staffing and training the Health Select Committee clearly articulated the need to learn from patient safety incidents. This issue has taken up a large part of both this second report and our first report and we endorse the committee’s findings that families must be involved in the investigative process and that lessons must be learned and implemented in a timely way to prevent further tragedies.

- 15.10** We also note the committee recognised that maternity units appear to have been penalised for high caesarean section rates and recommended that there should be an end to the use of total caesarean section percentages as a metric for maternity services. We note the progress on this with the recent advice from NHS England and NHS Improvement to Trusts²⁴⁴ to stop monitoring caesarean section rates. The recognition that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this) was identified in our first report. We noted that some mothers and babies had been harmed by this approach and we welcome the committee’s findings and the progress on this.
- 15.11** This review also supports the NHS Maternity Digital Programme. We recognise this as a key enabler to improve quality and safety. The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife. Enhancing and improving the digital programme will improve communication, and ultimately contribute to making maternity care safer.
- 15.12** The Parliamentary Health and Social Care Committee Report recommendations on staffing, training and learning from patient safety incidents echoes much of the work of our first and now this final report. We believe there is still so much more to do in order to make the maternity service in England the safest it can be. It is our intention that implementation of these further Immediate and Essential Actions will make a significant contribution to the delivery of safe maternity care.
- 15.13** Importantly: We state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

1: WORKFORCE PLANNING AND SUSTAINABILITY

<p>Essential action – financing a safe maternity workforce</p> <p>The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.</p>	<ul style="list-style-type: none"> • The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years’ data, for all absences including sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.
<p>Essential action – training</p> <p>We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.</p>	<ul style="list-style-type: none"> • All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this. • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

1. WORKFORCE PLANNING AND SUSTAINABILITY (CONTINUED)

- All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.
- All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.
- All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.
- All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.
- The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.

2: SAFE STAFFING

Essential action

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

- When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.
- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.
- All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.
- All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.
- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction
- The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.
- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.
- Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

2: SAFE STAFFING (CONTINUED)	
	<ul style="list-style-type: none"> All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.

3: ESCALATION AND ACCOUNTABILITY	
<p>Essential action</p> <p>Staff must be able to escalate concerns if necessary</p> <p>There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.</p> <p>If not resident there must be clear guidelines for when a consultant obstetrician should attend.</p>	<ul style="list-style-type: none"> All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. Trusts should aim to increase resident consultant obstetrician presence where this is achievable. There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit. There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.

4: CLINICAL GOVERNANCE-LEADERSHIP

Essential action

Trust boards must have oversight of the quality and performance of their maternity services.

In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

- Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.
- All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.
- Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.
- All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.
- All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.
- All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.
- All maternity services must ensure they have midwifery and obstetric co-leads for audits.

5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	
<p>Essential action</p> <p>Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.</p>	<ul style="list-style-type: none"> • All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms. • Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. • Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred. • Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. • All trusts must ensure that complaints which meet SI threshold must be investigated as such. • All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent. • Complaints themes and trends must be monitored by the maternity governance team.

6: LEARNING FROM MATERNAL DEATHS	
<p>Essential action</p> <p>Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.</p> <p>In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.</p>	<ul style="list-style-type: none"> • NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death. • This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required. • Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.

7: MULTIDISCIPLINARY TRAINING

Essential action

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

- All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.
- Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.
- All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.
- There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.
- There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
- Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.
- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.

8: COMPLEX ANTENATAL CARE

Essential action

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.

Trusts must provide services for women with multiple pregnancy in line with national guidance

Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.
- Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.
- NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.
- When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.
- Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

9: PRETERM BIRTH

Essential action

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.

Trusts must implement NHS Saving Babies Lives Version 2 (2019)

- Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.
- Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.
- Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.
- There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.

10: LABOUR AND BIRTH

Essential action

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.

Centralised CTG monitoring systems should be mandatory in obstetric units

- All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made
- Midwifery-led units must complete yearly operational risk assessments.
- Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.
- It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.
- Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.
- Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

11: OBSTETRIC ANAESTHESIA

Essential action

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.

Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.

Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

- Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.
- Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.
- All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC
- Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.

Obstetric anaesthesia staffing guidance to include:

- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.
- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.

12: POSTNATAL CARE

Essential action

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.

Postnatal wards must be adequately staffed at all times

- All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.
- Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.
- Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.
- Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.

13. BEREAVEMENT CARE

Essential action

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

- Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.
- All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.
- All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.
- Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.

14: NEONATAL CARE

Essential action

There must be clear pathways of care for provision of neonatal care.

This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

- Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.
- Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.
- Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.
- Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.
- Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.
- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

14: NEONATAL CARE (CONTINUED)	
	<ul style="list-style-type: none"> • Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

15: SUPPORTING FAMILIES	
<p>Essential action</p> <p>Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision</p> <p>Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care</p>	<ul style="list-style-type: none"> • There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.



OCKENDEN REPORT - FINAL

Appendices

- Appendix 1: Hearing the voices of staff
- Appendix 2: Immediate and Essential Actions (IEAs) from our first report
- Appendix 3: Glossary of terms
- Appendix 4: References
- Appendix 5: Terms of reference (TOR) - May 2018
- Appendix 6: Revised terms of reference (TOR) - Nov 2019
- Appendix 7: Review team members and who we worked with

Appendix 1: Hearing the voices of staff

Staff voices engagement strategy

- 1.1** In engaging with and listening to current and former staff at the Trust, we intended to highlight where they saw and see scope for improvement, but also to report on good practice in maternity services over the years. Staff were offered the opportunity to share any information with us that they felt would support them in having their views and voices heard. The culture within the Trust and specifically maternity services and whether it has changed over time is an important factor in order to understand the potential cause of any systemic problems.
- 1.2** Prior to conducting the staff survey for this review we reviewed the results from annual NHS staff surveys at the Trust over the previous 10 years. Staff across NHS organisations are encouraged to complete this survey each year and data are used to improve staff experiences locally and throughout the NHS, ultimately benefitting patient care. We also reviewed the Trust results from the Maternity and Neonatal Health Safety Collaborative (MatNeo) Culture Survey in 2018, which was part of the national Maternity and Neonatal Improvement Programme.
- 1.3** The NHS annual staff survey has undergone several iterations over the years and the Trust has restructured its service centres/ clinical divisions on a number of occasions. It therefore proved difficult to attribute the available data specifically to staff who worked directly within maternity services. The MatNeo Survey²⁴⁵, although identifying themes particular to the service, had limits in covering historical aspects of the culture at the Trust.
- 1.4** The review team worked directly with the Trust to ensure that past and present staff were offered the opportunity to contribute to this review. Reassurances were given with regards to anonymity and confidentiality and that responses would not be shared with the Trust. We developed a staff voices engagement strategy - known as 'Staff Voices', using a bespoke questionnaire survey followed by conversations with staff. The chair of the review also conveyed messaging regarding the Staff Voices strategy through local radio stations and via social media with the aim to reach out to as many former and current staff as possible.
- 1.5** Despite the assurances around confidentiality and not sharing findings with the Trust there is evidence from multiple conversations and contacts from staff themselves that they remained reluctant to participate. There appeared to be two main concerns from the staff who contacted the review who were uncertain about whether to participate or not - firstly they described being dissuaded from participating by their managers at the Trust. Secondly they expressed concerns about the ongoing police investigation at the Trust, Operation Lincoln, and whether the review team intended to pass information from staff to the police as a matter of routine. Whilst this was not the intention of the review team, the police have requested that we retain any relevant material and we may be required to disclose information to the police in due course.
- 1.6** In total only 109 staff came forward and participated in the review, some completed the survey only, some both completed the survey and spoke to us and some only spoke to us, declining to fill in the survey. We are sorry that so few staff members felt able to participate. In the last few weeks immediately prior to publication, 11 of the 109 staff who had come forward either fully or partially withdrew their cooperation or did not respond to multiple requests to use their content. This means that overall we have been able to use the staff voices of only 98 current or former staff at the Trust.

245 Provided to the review team by the Trust

The launch of Staff Voices

1.7 The staff voices survey was conducted from 12 May until 30 June 2021, with follow up conversations with staff occurring until January 2022.

1.8 Some staff employed by the Trust contacted the review team directly using the designated staff voices email address and asking for the link to the survey rather than accessing the link provided through the Trust. Many of these messages sought reassurance that the Trust would not know they had completed the survey. Some staff messaged the review chair directly, seeking assurance of confidentiality.

'...[I am] working for the trust and would like to take part in this survey but only if 100% confidential'. (Staff member, email to the review team)

'[working]...within SaTH [the Trust] as long as my name won't be mentioned and whatever I say is kept confidential I'm willing to take part in the survey'. (Staff member, email to the review team)

'Some staff were told be careful about how they answered this survey and were told to remember any comments made could be considered as part of the police investigation. This is the kind of passive aggressive approach of threat that NHS organisations use to deter staff from speaking up. It is so historically ingrained in the culture and possibly will have put staff off participating in the survey'. (Staff member, email to the review team)

1.9 These concerns were further confirmed during conversations held with current staff. One member of staff said: :

'.....and I know a lot of my colleagues didn't want to get involved because they were frightened, they were intimidated by the process'.

1.10 Another member of staff told the review team:

'I said, "Have you written out your questionnaire yet?" "No, we have been told not to".....but people won't because they have to put their name against the allegations and that sort of thing, and these people they've, as I have said before, they've got their friends and they just will not speak up, they daren't, they daren't speak up, you know.'

'So I know multiple people that have not approached you to speak because of fear, because of how it was put in that briefing [from the Trust to staff] there were people that had every intention of completing their survey and then after that, no way. I was like but this is your chance to speak. How can you make any changes? How can you do anything about it when we're given this opportunity but they're still working there? I think they were perhaps fearful of their jobs, I don't know'.

Another member of staff describing how fearful they felt about speaking up in the maternity service in early 2022 told the review:

'We used freedom to speak up and because of the reporting process they have to follow those concerns ended up going back to those we had concerns about...'

1.11 Overall, when taking into consideration the number of staff who are currently employed within the service and the number of former staff employed throughout the twenty years of the review's timeframe, we are disappointed that just 84 staff completed the survey. By comparison, in 2018, 192 (58%) staff who were working within the maternity and neonatal services at the Trust completed the MatNeo culture survey. Therefore we appreciate that our findings and conclusions are of limited value. However, having put considerable effort into hearing the voices of staff and having been told by the staff who participated how important it was to them to be heard, we believe this content is important despite the low number of participants.

Staff Conversations

- 1.12** Staff were asked within the questionnaire survey whether they agreed to a confidential face-to-face video interview with members of the review team and 76% of those completing the survey responded with 'yes'. Some staff contacted the review team via email requesting to speak with us, but did not want to complete the questionnaire survey.
- 1.13** The review team was also keen to speak with staff who held leadership positions within the Trust, maternity services and Clinical Commissioning Groups (CCG) to gain insight into the culture and changes over the years. The Trust and CCG contacted those staff who were of potential interest to the review to advise them of the request and to gain their consent for sharing their contact details. Other Trust and CCG staff were also able to contact us directly if they wished.
- 1.14** All interviews were conducted via a videoconferencing platform. Participants were advised they would receive a copy of the transcript of the conversation which they could annotate as they wished and that they could send additional information to the review team.

Staff Voices Results

- 1.15** In total, we received 84 staff survey questionnaires and conducted 60 staff interviews. Each staff member was allocated a confidential staff number. Of the survey respondents, 49% had been employed by the Trust for less than 10 years, 39% for between 10 and 20 years and 12% for more than 20 years. The majority of staff who engaged with the review were still employed by the Trust. The majority of staff were either employed or had been employed in clinical roles.

	Question	Yes	Sometimes	No	Total	Percentage 'Yes'
Professional and / or clinical concerns	Have you ever raised any professional or clinical concerns?	48	-	36	84	57.1%
	Have you ever been concerned about patient safety?	52	-	32	84	61.9%
Bullying	Have you personally witnessed or experienced bullying in the workplace at SaTH?	55	-	29	84	65.5%
Mandatory training	Do / did you have managerial support to attend mandatory training days?	55	20	9	84	65.5%
Teamwork	Did / do you think your multidisciplinary team works well together?	37	36	11	84	44.0%
Staffing Levels	Have you ever escalated concerns about staffing levels during your shift?	51	-	22	84	60.7%
Improvements	Did / do you feel there were / are any barriers to attempts to make improvements to the maternity service?	42	21	21	84	50.0%
Family and Friends Test	Would you recommend SaTH to family and friends for maternity care?	38	27	19	84	45.2%

Category	Question	Never	Rarely	Sometimes	Often	Always	Total
Culture	Whilst at SaTH did / do you enjoy coming to work?	2	16	34	27	5	84
	How often did / do you take part in multidisciplinary training) (e.g. obstetricians, midwives, neonatologists, support staff training together)	15	16	30	12	11	84

- 1.16** Many staff who spoke to us appeared very committed to the Trust, spoke of pride in the service and demonstrated loyalty and support towards their colleagues. Staff members told us: *‘...So I wanted to make clear that was what I’d seen. These people I’ve worked with have been trying really hard’*...Another member of staff said: *‘I do actually enjoy it and the team that I work with are a fantastic team...’*
- 1.17** From the questionnaires and interviews we identified key themes that had an impact on staff working in the Trust over the years and can give (albeit limited due to the small numbers) some insight into the culture throughout the years.

Merger of two trusts to form one trust

- 1.18** Staff described the difficulties they felt they experienced caused by the merging of the two sites to form one Trust and subsequently the move of consultant maternity services to Telford in 2014. One staff member said:

‘...I think it’s really tough for the management board. I think there was a disconnect in previous Trust boards, I think it was really hard. We did have quite an aggressive management structure when it was all about reconfiguration. It clearly felt like a new Chief Exec had come, Department of Health driving through, reconfiguration and relocating to Telford. We felt pretty coerced into agreeing to relocate to Telford, which clearly is wrong, and now, there’s talk about it was the wrong decision, the services are in the wrong place, but the majority of us thought that in the first place’.

- 1.19** Another staff member said:

‘As far as I could tell, you know, the Trust had been stuck, basically, for about twenty years, unable to make any progress, the two local authorities, the two populations at daggers drawn, you know, resisting every single change.trying to find a way through that log jam and come out the other side of it with a set of proposals that would make services less unsustainable.’

- 1.20** Another staff member told the review:

‘.....we hadn’t merged yet, and one of the great things that made me take the job in Telford was because the management team were based in Telford, because it was just one hospital, and they were incredibly responsive. You would bump into the Chief Exec on the corridor, the Medical Director, you could raise a concern or make a suggestion,.... oh, I wonder if this could actually improve patient care or this would be a good thing for safety, and it was really easy to get thingschanged because there was that responsiveness. With the merger.....the management structure was almost entirely based at RSH. They don’t come over, they’re not based at Telford, so you get none of the corridor conversations, which shouldn’t really be the way we communicate but actually is often the way communication happens, so we don’t have that access.’

Trust leadership

- 1.21** In our first report we discussed the high turnover of Chief Executives (CEOs), executives, non executives and other leadership roles at the Trust. Such a high turnover will inevitably impact on the performance of an organisation. One staff member told the review team:

‘.....I think that’s part of the problem.... they haven’t got a consistent leadership.....and it was a mess, you know, you can’t describe it any other way, there’d been no leadership whatsoever’.

- 1.22** Another staff member said:

‘One of the historical factors for the Trust is that there have been several management restructures, many different chief execs, and a real churn at the Trust board level as well..... I went through three management restructures, reappointed each time to a slightly different role..... Each of those management restructures sometimes took up to about eighteen months from the first letter of people being put at risk to people being

in place..... each time you lose good people, because there's only so many management restructures..... So, no sooner had you made a working relationship with an executive, than the next one was on their way. And also, with each of those structures came, obviously, slightly new ways of doing things, new policies, new training, some of the previous ways were not required, and there was a new focus'.

1.23 Another staff member said:

'...I guess that takes time, developing that trust in leadership does take time, and certainly one of the things that SaTH has not benefited from is longevity of leadership.'

1.24 Three other staff members told the review:

'So, there's been little in the way of corporate memory and additionally, the new incumbents would have to establish their relationships with the existing management structure'.

'We'd just had another Chief Executive who wanted to do yet another reorganisation and we were all supposed to apply for our posts and do maths tests and English and chemistry and I just thought, "I can't....."'

'...it's really bizarre, we've had ... we're on our third Medical Director since I've been in this role and we're on our third Director of Nursing. The current establishment, it seems to have much more traction and we seem to see much more evidence of things happening. The previous people that were in post, similarly, were saying all of the right things but it just wasn't translating it, the action wasn't happening. It was like there was a disconnect. The executives knew of the problem, they didn't understand the core cause of the problem'.

Culture

1.25 A priority when reaching out to staff at the Trust was to understand the culture within the maternity service and possibly the wider Trust. Through the survey, staff were asked 'Have you personally witnessed or experienced bullying in the workplace at the Trust? 65% of respondents replied with 'yes'. Of those 65%, 38% felt able to report it and of these, 33% felt it was adequately dealt with.

1.26 One staff member told the review team:

'Culture is a big thing because I feel there's a reluctance to change there.'

1.27 Another staff member told us:

'I feel that there are historical organisational/cultural issues that are very complex in how this situation has developed. I really believe that there are wider system errors that have let down women and their families but also staff. There are some really good people who care immensely about what they do but operating in a system that is in crisis management continually, can have significant impact on the ability to maintain passion and compassion.'

1.28 A further contributor stated: *'... the fear of speaking out is all-pervasive in SaTH and it's a very difficult thing to get rid of if that has been the culture for not just ten years, but twenty years, thirty years, it's inbred within the culture at SaTH that if you speak out, something is going to happen to you.....you'll be bullied or you'll be moved or you'll be ... you know, something will happen, something will be ... make it difficult for you.'*

1.29 One staff member described their own experience: *'X .was so strident that you tended not to argue with her, she was a bully, 100%'*.

1.30 Another contributor said: '

....when I joined. We just had the conversation about the need to change the culture, in terms of safety culture, that was very clear, and the organisation went with that process, including Listening into Action, which was another initiative that was brought in..... which is important, because I think staff hadn't felt previously that they'd got a voice to be heard. So, I think that Listening into Action was very important at that stage in terms of changing that culture within the organisation'.

1.31 Three different staff members told the review team:

'...previously, these groups have been split up in clinical areas but they go elsewhere and still behave in the same way. They are...big voices, they're dominating, they're intimidating...'

And: *'There are cliques there and, you know..... they are a little gang, and, yes, they will make your life hell..... I am speaking to colleagues now and they won't speak out... you couldn't speak to senior management, if you tried you got shot down.'*

And: *'And the safety huddles that we used to go to, I mean some of them were.... would speak to some of the managers like absolute ... it was just you'd stand back and think, "This is bullying".'*

1.32 Other staff members described a 'clique' on the labour ward at the Trust with a culture of undermining and bullying. Some staff members described that this had negatively and seriously affected their mental health. Other staff members described that the behaviour experienced on the labour ward was so bad that they had difficulty finishing their shifts and cried secretly whilst in work. These staff declined for their direct quotes to be used, because they were fearful of being identified.**1.33** Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.**1.34** One staff member said: *'...it's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle ... you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work, not sure how people are going to be with you, not being invited out onto nights out. Simple things like that, not being included in coffee mornings, and things like that..... it's very difficult to speak out, I've been there myself and I ended up going off ill with it.'***1.35** A current staff member in maternity services at the Trust spoke to the review team in early 2022 but described themselves as fearful to do so. The staff member said *'I really had to think very carefully about approaching the staff voices....when we were told not to speak out, but I will do it and take the consequences because it is the right thing to do...I am clear that there is no support for those that speak up...'***1.36** Periodic rotation through the clinical areas within a maternity service is a system evident in most maternity services. Its aim is to ensure that staff remain competent to deliver care in the main clinical environments and gain wider experience, and it also enhances professional development. It is also believed to improve communication as there is an understanding and awareness of what happens in other clinical areas. Some staff commented on the process within maternity services at the Trust, with some saying that poor behaviours still remain at the Trust.

'...they would have almost three or four months of these rumours going around, "There's going to be a change list; there's going to be a change list", and then finally, when the change list came out, there was a lot of anxiety from quite a few midwives.'

'The communication of the change list over the years has been very poor and has caused a massive amount of stress for all of us because you just find out that you're on the change list and off you go.'

'There was a lot of cliques there, a lot of managers were cliquey, there was the change list that was used as a... you had the impression that if you were a pain you would get moved, you know and nobody wanted that and, you know, it still goes on today..... I think that the managers, I think they are aware of the clique and I think they have tried to separate them but they're so deeply ingrained into the system... the management's almost scared to get rid of them because they almost form the core of the delivery suite expertise.'

'...they just didn't want students at all, they were not happy to have students...'

Governance

- 1.37** We routinely questioned staff regarding the governance systems across the wider Trust. Two staff contributors said:

‘.....one of my concerns at the time was really that..., I don’t think the Trust had a robust governance framework, to be honest.’ ‘...and we ended up having to just work within our department, because when we asked within the Trust there just wasn’t that resource... the Trust wasn’t as advanced as that, they just didn’t understand what we needed, so we ended up doing that’.

‘certainly my experience is it’s not about the people on the floor doing the work, it’s the whole system behind it that isn’t always as helpful as it could be and that affects those people that are trying their best ...’

- 1.38** Another contributor told the review: *‘.....yes, it did feel as though we weren’t perhaps hearing all that we should have been hearing..... We struggled consistently to get information from SaTH in those meetings from 2009 -2012. Reviews of serious incidents seemed to take a long, long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared. Reading the last Ockenden Report it was clear to me that whatever learning was taken from the incidents that are described wasn’t actually shared and taken forward, so the same things were happening over and over and over again, and in the context of an organisation who may describe themselves as a learning organisation I never felt that it really was’.*

- 1.39** A number of other staff members told the review team of their experiences:

‘It was a system wide failure to be able to escalate these priority pieces of work and to push it through, there didn’t seem to be the guidance, there didn’t seem to be the governance, there didn’t seem to be the process of challenge...’

- 1.40** Another staff contributor said:

‘This has just started recently, by recently I would say in the past four or five years, but before then we didn’t have this system, you see. We didn’t have clinical governance, it was just on the go, word of mouth, that if there was an issue you would get it discussed between you and the consultant, for example, or whoever was involved, but we didn’t have this learning procedure or learning process as is currently being done.’

- 1.41** Another staff member said

‘....things started to become visible when the CQC went in and we were given [an] inadequate rating..... but prior to that, it would be that things were kind of filtered down really by word. To be honest, there was a lack of process, a real lack of processes.’

Staff voices on statutory supervision of midwifery

- 1.42** Commenting on the ineffective nature of the process of statutory supervision of midwifery at the Trust one contributor said: *‘My recommendation was that there was a supervisory investigation. At the time it was dismissed because it was such a tight, tight group of supervisors, it was impenetrable and if you’re in, you’re in, and X was in. So, they were not keen to conduct that..... If they decided that this particular practitioner did not need a supervisory investigation then it was up to them. So, if your face fits, then you were okay.’*

- 1.43** Other contributors told the review team that the same people were involved in supervision investigations as in internal maternity governance investigations and that statutory supervision was only a process of internally ‘marking their own homework’.

Improvements in maternity governance from the perspective of staff

- 1.44** Some staff reported that in more recent years, the governance processes within maternity services at the Trust have improved.

'It has improved, there is no doubt that it has improved in comparison to the past, whether this is enough I don't know now. Obviously time will tell, but definitely there is now clinical governance, there are high-risk case discussions, meetings, and these issues that we've never had in the first ten, twelve years of my work here in this hospital.'

'.....there were lots and lots of changes that were really, really for the better, and the MDT really came together. I think also there was organisational developments as well, because the anaesthetist started doing some scenario-based training that we would all be invited to.'

'.....there is a much better process now of incidences being shared. Certainly in the last five years, maybe even less than that..... Some line managers are very good at sharing all memos and other managers not so'.

- 1.45** Other staff cautioned that the improvements seen within maternity services at the Trust remain very fragile and that the Trust needs further observation, scrutiny and support as of spring 2022. A staff member said: *'Ladies are being cancelled, rebooked and cancelled due to staffing issues and I have considered leaving as I worry about the impact this is having...'. The staff member added: 'I have been really worried...it is important people are aware of the situation...'*

Oversight of safety and performance within maternity services

- 1.46** A number of contributors reported to us that, for a long time, executives and board members viewed the maternity service as performing well and as a result did not apply a high level of scrutiny to the service. Equally external scrutiny did not raise sufficient concerns at board level. The following remarks illustrate this:

'....whilst they were confident and very strong individuals, very clear about their ability to manage their teams and manage the business, I didn't have any reason to question that they would come to me if they had concerns'.

Another contributor added: *'...at no stage did me, and this is my fault, but at no stage did I pick up that there was such a deep-seated problem in that service...'*

- 1.47** Other staff members told the review team:

'.....we got best performing and we got CNST Level 3, you know, so these are independent organisations coming in, looking at it. Therefore..... you should have some confidence in what these bodies are telling you...'

'.....when scrutinised by quality and safety, when scrutinised by the Trust Board to give a reasonable account of their abilities to maintain their service. We did develop "deep dive" reviews at various stages and there was a sense that compared with some other areas of difficulty within the Trust, Maternity was not on the radar at that stage. That, of course, was triangulated with other perspectives, so views from the CQC, and you'll be aware that in the early phases, the CQC reports were positive ones. They were rated as good.'

'....it was published and it obviously came to our Board meeting, we discussed it in the Board. I think, I mean the overall message from that report was that.... they said safe and good quality services in a learning organisation.'

'It was presented to us, I think, by SaTH as being more positive than it actually was. It was a kind of oh well, the RCOG think we're okay.'

'They were one of the ones I trusted and, given all the external results we were getting that actually confirmed how good the service was they ran'.

'.....we were working within a Trust that had considerable financial challenges, some challenged services, and that was the focus of the Trust, really. So, maternity and women's and children's was referred to as the flagship of the organisation, and trying to get additional resources into the care group was really difficult.'

‘...we’d achieved CNST level three gold standards, and that was ... I don’t know, not a badge of honour, but there was a lot of interest within the Trust that we should be awarded that....gave evidence with others at a parliamentary review into maternity care, and we were asked to go as one of those services that was considered to be providing good care, and we gave our evidence there. So, I think from that time, 2004 onwards there was this perception that we had a really good service, and we were regularly reviewed and visited.’

‘As a maternity service, we were considered to be very good, which is why it’s been a bit of a shock, all this happening. We were considered to be very good....’

Staffing

1.48 It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response. The following six vignettes highlight some of the concerns expressed about staffing:

‘...it was really clear just how difficult it was to sustain a safe level of cover...’

‘I don’t remember them actually saying that they needed more funding for midwifery staff, but certainly they raised staffing as an issue repeatedly.’

‘I asked for a Birthrate Plus review..... which - surprise, surprise - really showed everything that we’d felt..... deficit 30 whole time [posts].... Were your co-coordinators supernumerary? Not always, usually because of the staffing levels.’

‘...the midwives, they were obviously short-staffed..... The shift leader was constantly having a patient.... When you’re working on the labour ward, you sometimes couldn’t get hold of the shift leader because she was in looking after a woman..... Was not supernumerary and it was really difficult.’

‘...but a lot of the shifts there were like by the grace of God that one could have been me... it was scary.... it was a system issue, as in this lady needs to go and we can’t get her, she can’t go, there aren’t enough midwives, you know. They were the issues.’

‘I feel like there isn’t enough of everyone to kind of go round to make sure that everybody’s getting the care that they need.’

In 2018, 46% of respondents to the MatNeo survey reported concerns about poor levels of staffing.

Patient Safety

1.49 Within the staff voices survey, 62% of respondents reported they had been concerned about patient safety, with many feeling their concerns were not adequately addressed.

‘The patient safety issues I would say they were probably more when I worked on the wards, and that was mainly again just staffing. I spent a lot of time on the antenatal ward, and the amount of times, you know, you needed to get a lady to labour ward and “no staff, no staff, I can’t take her, I can’t take her” or “Yes, you can bring her, but you will have to come with her”, you know, leaving just one other member of staff, you know, that, that, they were the main things really, was trying to get ladies to labour ward in a timely manner. I think they would be the biggest, biggest issues I had seen really.’

‘..Nobody went out at any time wanting to harm anybody, it’s just we didn’t have the training and we didn’t have the staff and that’s how it was, unfortunately, and we didn’t know any different.’

‘We’re not giving them the right tools here, we’re not supporting them, and we’re not giving them the right staffing levels.’

Caesarean section

- 1.50** Staff commented on the low caesarean section rate at the Trust, which was discussed in our first report. There was disagreement from the staff who contributed to the review as to whether there was a reluctance to offer caesarean section when requested. One staff member said:

'There was always a perception that we were reluctant to offer maternal request caesarean section, which wasn't true but we had a policy to arrange appointments with senior clinicians in order to fully understand the request and provide advice.'

- 1.51** However, a number of other staff interviewed had differing recollections on the same topic, with examples from four staff shared below:

'....and they would definitely try to avoid a caesarean section..... they were always trying to, how can you put it, try for a normal birth all the time..... it was a couple of times, I pulled the emergency bell because I had a bradycardia going on. They came in and I was actually told off for pulling the emergency bell. I thought to myself, "What's going on here?" I absolutely did not understand it. It's like, you know, they would just let things run purely because they didn't want the doctors to come in, and sometimes you could see some of the shift leaders not wanting to call the registrar in or any of the doctors in

'They were always very proud of their low caesarean rates.....I personally found all the failed/attempted instrumental deliveries very difficult to deal with. I had never seen so many injuries/HIE/resuscitations from this. Nothing to be proud of.'

'I was worried with this escalation thing especially with the patients who are going with the emergency caesarean section..... when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly.....because they told me they want to keep the caesarean section really low.'

'I couldn't believe that that was still, the culture was the same – it was almost we have to do everything to get a vaginal delivery and we've got to keep the section rate low, we've got to keep the epidural rate low..... In 2014 it was the same guys that I'd seen in early 90s', very much the same culture.'

Midwifery led units

- 1.52** A number of staff discussed the safety of working in the Midwifery Led Units (MLUs) and the challenges they faced. Examples from three staff are shared below:

'....that to run five midwifery-led units out of our establishment, I questioned whether our model was fit for modern-day purpose..... but Shropshire, you know, its accolade was, "We've got five midwifery-led units". ... one of the consultants described it as, you know, the MLU as being the sacred cow, and that's how it felt, that it was okay to have five midwifery-led units if we were staffing the whole organisation in the way that it needed to be done, but we weren't, and it just felt as if you'd got two completely opposite ends of the care that was being given.'

'So, I was put in this really difficult situation of knowing what to do with this woman who's booked at the consultant unit and they could have transferred her earlier. I mean, by the time I went into the room, right, I mean this woman was delivering anyway, but it was... you could say it's a near-miss really, that it was a near miss.'

'The one thing I was really struggling with was whenever the consultant unit was short-staffed, they would take MLU staff, but they wouldn't close the MLUs at that time. So some MLUs were left with one midwife available and no on-call midwife and hope that a woman didn't come in in labour because there wouldn't be a second MLU midwife to back her up and that troubled me no end. It was not a safe situation and it was a disaster waiting to happen.'

Escalating concerns

- 1.53** Within the survey, when asked whether they had ever raised any professional or clinical concerns, 57% responded with 'yes'. Of these, 52% said there was a clear pathway to follow to escalate professional or clinical concerns. Examples from staff are shared below:

'The culture at SaTH is that if you have done something wrong, keep it in-house and we punish you for that, you know, whether that's you're investigated or whether that's you're moved on a change list or we make your life very difficult or you end up handing your notice in because you have been almost hounded in a way to the point where you have left because of your mental health, you become more and more reluctant to speak out and that's the danger, isn't it?'

'...has actually told us off for putting in Datix, or raising critical incidents about concerns we have, because this is, [they] would describe it as whistleblowing and it's wrong.... to have significant individuals in the organisation telling you that isn't what you should do is very harmful.'

'...So I went along and was basically, yes, told that everything was, I shouldn't be raising concerns and, you know, that I didn't understand the system and that everything was fine and, you know, again just not to raise concerns. I was in tears because I was basically a rotten person and I shouldn't be upsetting the apple cart and, you know, it was irresponsible to go raising these concerns. Afterwards I was completely shocked, I actually couldn't face going in for a few days.'

'It is difficult to know where to take concerns when you have escalated through relatively senior channels and there is no improvement. A clear pathway or process would, I believe, support staff in expressing these frustrations - everyone is under immense pressure and everything is a priority however there needs to be a means of acknowledging concerns and identifying how to implement an improvement strategy irrespective of if this needs to be over a long period of time.'

'So I think we've been proportionate when we've raised concerns but most of the time people say yes, we understand, that's a valid concern, but there's no practical solution to it.'

Multidisciplinary team (MDT) working and training

- 1.54** Some staff were keen to share with the review team that they had positive working relationships across the multidisciplinary teams, that the Trust was a good place to work and they were focussed on giving high standards of care. When asked within the survey whether they felt the MDT works well together 87% responded with 'yes' or 'sometimes'. 37% of respondents replied that they 'rarely' or 'never' took part in MDT training, 36% said 'sometimes' and 27% 'often' and 'always'.

- 1.55** Some staff described fractious relationships amongst the teams that may have presented as barriers to effective communication.

'.....but there were fallings out between the Band 7s and the consultants, I remember there being arguments, maybe clashes in personality..... some of the Band 7s....., maybe weren't as much good communicators.'

'...was so arrogant and rude, you'd be afraid to ring [X] with any concerns. [X] was intimidating..... was very derogatory about midwives,... the midwives found [X] very rude and arrogant and intimidating and would prefer not to deal with [X]...'

'We would find that the doctors would walk in and just come and look at what was going on because there wouldn't be that communication from the coordinator to the doctors. You just felt like there was very much an "us and them".'

'I think bullying was rife on the maternity unit and this is part of it, that these consultants, there were one or two or even three that would intimidate the midwives and junior doctors, and make sure that they are not approachable'

'...this collaboration of training together, it really wasn't happening'

Improvements

- 1.56** Within the survey, staff were asked whether they felt there were any barriers to attempts to make improvements to the maternity service. 50% of respondents replied ‘yes’ and a further 25% replied ‘sometimes’.

‘So we’re going to put that into our protocols and policies and before it was just “mañana”, we’ll do it tomorrow. Tomorrow never comes. There’s no urgency to address or change or do anything. They’ll do that and if it works for them, we’ll do it. No, we have to do it. We’re answerable, we’re accountable’.

‘I think we have always wanted to improve the services because things never, you know, they must obviously change in order to improve, you just can’t carry on the same way as you are. So, as far as I was concerned, yes, there was a thirst for improvement, for learning, you know, and how we can actually change things as well’.

‘I wholeheartedly believe, and I know my colleagues believe senior management have been a barrier for change’.

- 1.57** Other staff, however, reported that continuous improvements within maternity had been made over the years and the unit had engaged with national initiatives such as customised growth charts, the maternity early warning score and ‘Saving Babies Lives’. A staff member told the review team:

‘Since my appointment to consultant I have been involved in, instigated and led a number of improvement projects within the maternity department. All of the projects became multidisciplinary from an early stage.’

Impact of the review on staff

- 1.58** Staff reported being deeply affected by the ongoing review. Some staff explained that they would decline to meet with the review team for this very reason. One of the criticisms levied at the review team was there were misconceptions regarding the culture at the Trust.

‘I feel that the culture in the unit now is different, I think there’s a lot of people who have struggled, and personally my health’s not been good as a result of this. ..there’s been a lot of people who have really struggled from a mental health point of view, physical health point of view, because of this..... there’s a resolve in the unit that we will improve and get better but there’s also a sadness in the unit that we’ve ended up where we’ve ended up, and I think it is quite hard for the staff who’ve been there a long time.’

- 1.59** Other members of staff told the review team:

‘...there’s a number of colleagues who will never recover from this...’

‘From the media perspective, it feels like people like me or my colleagues are portrayed as some sort of perpetrators, villains, but actually, I do feel we should all be on the same side here, but it doesn’t feel like it.’

Response to the Independent Maternity Review

- 1.60** Staff who spoke to the review team were generally positive about the changes they had witnessed following the publication of our first report and the maternity services improvement programme:

‘I think that the lessons from this inquiry are going to be transferable to the whole NHS’. The same staff member continued: *‘....so the really great thing to come out of the external review has actually been the funding to expand ... and I’m really grateful for that, really, really grateful’.*

- 1.61** Another staff member told the review team:

‘No, I really hope that things change. I hope it changes for the.....good..... It’s not all bad, and for the families, first and foremost really, because it’s heart-breaking to see some things on Facebook where [The] Shropshire Star have put something up and if you read the comments from public members it’s horrible to see people questioning whether they’re going to be safe or not, when I know that there are so many staff there, I would quite happily let them look after me and have done.’

- 1.62** Further staff comments included their distress at not being listened to when they had tried to raise concerns at an earlier time *‘... we were all just shell-shocked. Whenever a report comes in, you read it and there are bits you identify with and I couldn’t even talk. I broke downI remember breaking down and they were proper angry sobs, it’s not just, “I’m upset because families have gone through this, clinicians have gone through this”, I am angry and I am hurt and I’m angry because nobody has listened and I don’t believe the change has happened quick enough and I tried to explain that.’*

‘I do feel very sorry about what’s happened and I’ve reflected a lot on what I could have done differently...’

There were a number of positive comments about the first report from a range of staff including:

‘I was impressed by the report identifying the need for nationwide improvements, learning from this experience. I think there’s a story there that has been identified and it will be lovely to see that being implemented more effectively, more widely.’

‘I mean maybe actually we didn’t know necessarily the right questions to ask, so knowing some of the right questions to ask would have been helpful. For instance, I had no idea that they didn’t have an adequate anaesthetic service, so that, if you haven’t got adequate anaesthetic cover for your sections, obviously you’re not going to do one if you can get away with it, or think you can get away with it, and that was something I had never thought of asking. So maybe it’s about actually having a national sense of exactly what we should be checking on, as commissioners, so that we’re not falsely reassured.’

‘...it was shocking and very upsetting to see that those things hadn’t come to light during the time that I thought that we were doing as good a job as we could at understanding what was going on in the services that we commissioned.’

Conclusions

- 1.63** This engagement strategy reached out to staff through liaising directly with the Trust and through social media platforms and local media reporting. We are extremely grateful to the staff who have been willing to share their experiences as we appreciate how difficult it has been to make that decision. Some expressed feelings of guilt at speaking with us and many were tearful as they recalled individual experiences and what they had observed in dealing with other colleagues and within their service over many years.
- 1.64** The members of staff who engaged with us really matter and their voices must be heard. They speak about the culture and raising concerns but not being heard. They speak about trying to do things to the best of their ability without the necessary frameworks in place that would enable them to learn from any errors made. What they say is supported by what we have seen throughout this review- that maternity services within the Trust had poor governance systems for a long time, which allowed it as an individual service to develop its own systems in isolation without effective internal and external surveillance.
- 1.65** We cannot underestimate the toll on staff of being under constant intense scrutiny. We met staff who were deeply affected by what had happened in their service. However, many of the staff who engaged with us stated that they were adamant to learn and do all they could to ensure their maternity services were safe for the families in Shropshire.

LOCAL ACTIONS FOR LEARNING: HEARING THE VOICES OF STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- 1.66** The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey and the recent feedback from current staff.

Appendix 2: Immediate and Essential Actions from our first report

Immediate and Essential Actions to improve care and safety in maternity services as outlined in our first report

1: ENHANCED SAFETY	
<p>Essential Action</p> <p>Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.</p> <p>Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.</p>	<ul style="list-style-type: none">• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.• External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.• LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.• An LMS cannot function as one maternity service only.• The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.• All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY

Essential Action

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead.
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
- This must also include regional integration of maternal mental health services..

5: RISK ASSESSMENT THROUGHOUT PREGNANCY

Essential Action

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
 - Improving the practice of monitoring fetal wellbeing
 - Consolidating existing knowledge of monitoring fetal wellbeing
 - Keeping abreast of developments in the field
 - Raising the profile of fetal wellbeing monitoring
 - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
 - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT

Essential Action

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.
- Women’s choices following a shared and informed decision making process must be respected.

Appendix 3: Glossary of terms

Definitions and medical and midwifery terms used throughout our report

Abruption	Is the early separation of a placenta (afterbirth) from the lining of the uterus before completion of the second stage of labour. It is one of the causes of bleeding during the second half of pregnancy.
Abscess	Collection of pus
Absent End-Diastolic Flow	Is a useful feature which indicates underlying fetal vascular stress if detected in mid or late pregnancy
Acidaemia	A condition of raised blood acidity
Acute respiratory distress syndrome (ARDS)	A life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body
Advanced neonatal nurse practitioners (ANNP)	Introduced to undertake the Tier 1 duties on the neonatal rota, jointly shared with ST1 - 3s. The post holders practice at a senior practitioner level to provide autonomous clinical care
Anomalous Left Coronary Artery to Pulmonary Artery (ALCAPA)	A very rare form of congenital heart disease
Amniocentesis	A medical procedure to obtain a small amount of amniotic fluid that is used to further investigate suspected fetal chromosomal abnormalities
Amnio-infusion	Refers to the instillation of fluid into the amniotic cavity
Amniotic Fluid Embolism	A rare condition where the amniotic fluid – which surrounds and protects a baby inside the womb – can leak into the mother’s blood vessels during labour, causing a blockage. This can lead to breathing problems, a drop in blood pressure and loss of consciousness. A small number of women survive amniotic fluid embolism with risks of long-term complications including neurological problems because of a lack of oxygen to the brain, however most women do not survive
Amniotomy	Artificial rupture of the membranes (ARM)
Anaemic	Lack of enough red blood cells to carry adequate oxygen to the body’s tissues
Antepartum	The period of pregnancy that includes the 24th week of pregnancy until birth

Antihypertensive medication

Drugs used to control high blood pressure

Apgar score

This is an accepted method of assessing how a newborn baby has adapted to extrauterine life, immediately following birth

Augmentation of labour

Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/ or artificial rupture of membranes. It can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and facilitate cervical dilatation and vaginal birth

Auscultation

A method of periodically listening to the fetal heart with a stethoscope

Arachnoid cyst

Benign cyst in the brain

BCH

Birmingham Children's Hospital

Birthing centre

A birth centre staffed by midwives, they may be "stand alone", (some distance from a consultant-led unit) or alongside, often in the same building/ on the same floor as a consultant-led unit.

Birthrate Plus® (BRP)

Is a method for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From the data collated, the methodology calculates the number of midwives required to meet the defined standards and models of care whilst informing local workforce requirements, holiday and travel allowances etc

BLISS

A charity for babies born premature or sick

Born Before Arrival (BBA)

Refers to a birth which takes place before arrival to a maternity unit, or a homebirth before the arrival of a midwife

Bougie

A small wire over which a breathing tube can be passed in difficult airways

British Association of Perinatal Medicine (BAPM)

Is a professional association and registered charity. They aim to improve standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families

Cabergoline

A drug used to suppress lactation (milk production).

Caesarean hysterectomy

Hysterectomy (surgical removal of the womb) at the time of, or soon after, delivery by caesarean section

CAF	Common Assessment Framework is a tool designed to help practitioners working with children, young people and families to assess children and young people's additional needs and strengths for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them
Cardiopulmonary	Relating to the heart and lungs
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Category 1 caesarean section	Is when there is immediate threat to the life of the woman or fetus and delivery is recommended within 30 minutes
Category 2 caesarean section	Is when there is maternal or fetal compromise which is not immediately life-threatening and delivery is recommended within 75 minutes.
Catheter	Tube (usually to drain the bladder)
CBT	Cognitive Behavioural Therapy
CDH	Congenital diaphragmatic hernia, a serious congenital anomaly where some of the bowel lies within the chest and causes breathing difficulties
CEMACH	Confidential Enquiry into Maternal and Child Health
Cerebral Palsy	Is caused by a problem within the brain that develops before, during or soon after birth. Cerebral Palsy affects movement and coordination
Clinical Commissioning Groups (CCG)	Were established as part of the Health and Social Care Act in 2012, and consist of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums
Chorioamnionitis	A serious condition in pregnant women in which the membranes that surround the fetus and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death

Coagulopathy	Coagulopathy is often broadly defined as any derangement of haemostasis resulting in either excessive bleeding or clotting, although most typically it is defined as impaired clot formation
Colloid fluid	Non-crystal fluid used as a temporary substitute for blood
Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)	Was created to improve the understanding of the causes of death in late fetal life (from 20 weeks post-conception) to infancy (one year after birth). CESDI created a standardised grading system to categorise mortality reviews and identify cases of suboptimal care
Consultant-led Unit (CU)	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum or postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Continuous Positive Airway Pressure (CPAP)	It is a type of non-invasive ventilation (NIV) or breathing support
Cooling	Therapeutic hypothermia is an effective way to treat newborn babies who have experienced a lack of oxygen and/or blood flow to the brain and other organs before or during labour and delivery. Reducing a baby's body temperature to 33.5oC to protect the brain
Cord prolapse	Happens when the umbilical cord slips down in front of the baby after the waters have broken. The cord can then come through the open cervix (entrance of the womb)
Counselling	Professional guidance and discussion to support complex choices with families that ensures sharing of evidenced-based information to enable informed decision and personalised care
CPR	Cardio pulmonary resuscitation (chest compressions and breaths)
Critical care unit	Intensive care or high dependency care unit
CRP	C-reactive protein. A marker of infection or inflammation
Crystalloid	A solution of water and salts for intravenous administration
Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations

Diaphragmatic Hernia	Diaphragmatic hernia is a birth defect where there is a hole in the diaphragm
DATIX	An incident reporting form
Dichorionic, diamniotic (DCDA) twins	Each has their own separate placenta with its own separate inner membrane (amnion) and outer membrane (chorion)
Direct Maternal Deaths	Are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received.
Deflexed occipito-posterior position	Poor position of the fetal head
Diuretics	Drugs used to increase urine production
Doppler assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA)
Dual instruments	There are two main instruments used in operative deliveries – the ventouse and the forceps. In general, the first instrument used is the most likely to succeed. Dual instrumentation describes both types of instruments being used to perform an operative vaginal delivery
Duty of candour	Legislation to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. This improvement programme is now closed
Eclamptic fit	A fit occurring as a consequence of severe pre-eclampsia
E. Coli	A bacterium that can cause infection
EMDR	Eye Movement Desensitisation and Reprocessing
Empyema	Pus in a body cavity
Endometritis	Infection within the uterus (womb)
Escalate	To become more important or serious, or to make something or someone do this.
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death

External Cephalic Version (ECV)

Is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first. It is a manual procedure that is recommended by national guidelines for breech presentation of a pregnancy with a single baby, in order to enable vaginal delivery

Extradural haematoma

A sub-periosteal haematoma located on the inside of the skull, between the inner table of the skull and parietal layer of the dura mater (which is the periosteum)

Extubation

Removal of an artificial breathing tube from a baby's airway

EUA

Examination under anaesthetic

Faecal incontinence

Lack of bowel control

Fetal blood sampling (FBS)

Is a procedure to take a small amount of blood from an unborn baby (fetus) during pregnancy. FBS should be advised in the presence of a pathological fetal heart rate (FHR) trace unless there is clear evidence of acute compromise (i.e. immediate delivery is thought necessary)

Fetal bradycardia

Fetal heart rate of less than 120 beats per minute

Fetomaternal haemorrhage

The entry of fetal blood into the maternal circulation before or during delivery

Fibroids

A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus

Footling breech

Is when one or both of the baby's feet are born first

Forceps

An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal

Fresh eyes assessment

Refers to a "buddy system" of CTG review to improve interpretation and documentation

Funisitis

Inflammation of the connective tissue of the umbilical cord that occurs with chorioamnionitis

Furosemide

A drug that promotes removal of fluid from the body by production of urine, a diuretic

GAP

The Growth Assessment Protocol: a national programme to improve patient safety in maternity care

Gastroschisis

A defect of the abdominal wall where intestines are found outside of the baby's body, exiting through a hole alongside the umbilicus (belly button)

General Medical Council (GMC)

A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC works with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems

Governance	The way that organisations are managed at the highest level, and the systems for doing this. Clinical governance can be defined as a framework through which the National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care
GROW Chart	Customised antenatal charts for plotting fundal height and estimated fetal weight
Growth retardation	Growth significantly less than expected
Grunting/grunty	An abnormal noise made by a newborn baby with breathing issues
Guedel airway	A device placed in the mouth to keep the airway open
Haematoma	Blood clot (not in a blood vessel)
Haematologist	A doctor specialising in disorders of the blood
Haematuria	Blood in the urine
Haemodynamic	Relating to the flow of blood
Haemoperitoneum	Blood in the abdominal cavity
Hb	Haemoglobin level i.e. assessment of anaemia
HDU	High Dependency Unit
Healthcare Commission (HCC)	The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009
Headbox oxygen	An oxygen hood or head box is used for babies who can breathe on their own but still need extra oxygen. A hood is a plastic dome or box with warm, moist oxygen inside. The hood is placed over the baby's head
HELLP	Haemolysis (of red blood cells): Elevated Liver (enzymes): Low Platelets. HELLP is a syndrome that occurs with serious pre-eclampsia, and indicates severely deteriorating organ function
High frequency oscillatory ventilation (HFOV)	An advanced form of respiratory support
Hypoxic ischemic encephalopathy (HIE)	Refers to the damage caused in a baby's brain when the baby does not receive enough oxygen and / or blood flow around the time of birth, or during pregnancy. Graded into HIE grades 1-3 depending on severity
High Risk Case Review (HRCR)	An internal process used in Shrewsbury and Telford Hospitals NHS Trust over the period of this review created to investigate incidents which were said to not meet the threshold for being a Serious Incident

The Healthcare Safety Investigation Branch (HSIB)	They investigate incidents that meet the Each Baby Counts criteria and their defined criteria for maternal deaths www.hsib.org.uk/maternity/what-we-investigate/
Higher Specialist Trainee (HST)	Middle grade, or Tier 2 doctor, registrar
‘Hub and Spoke’ Model	Refers to a specific type of service model design consisting of a main base supported by additional bases or branches. In maternity services, the hub is the consultant-led unit and the spokes are midwifery-led units or community bases
Human factors	Refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety
Humerus	The long bone in the arm
Hydronephrosis	Swelling of the system that collects urine from the kidney, usually because of obstruction lower down the renal tract
Hypercalcaemic	High calcium levels in the blood
Hyperinsulinism	Excessive secretion of insulin, leading to low blood sugar
Hypertension	High blood pressure
Hypotension	Low blood pressure
Hypotensive	Abnormally low blood pressure
Hypothermic cooling	Involves cooling the baby down to a temperature below homeostasis to allow the brain to recover from a hypoxic-ischemic injury
Hypovolaemia	Low blood volume, usually secondary to blood loss
Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia)
Indirect Maternal Deaths	Are those associated with a disorder, the effect of which is exacerbated by pregnancy
Indices of Deprivation	Are datasets used to classify levels of deprivation within small areas. Deprivation rates are measured by the assessment of various factors including income, employment rates, education, housing and crime
Inflammatory markers	Substances that can be measured in blood tests that, when elevated, indicate that there is inflammation occurring within the body
Infused	Given intravenous fluid (not blood)
Inotropes	Intravenous medication to treat very low blood pressure

International Normalised Ratio (INR)	A blood test/ calculation which assesses the time taken for blood to clot
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Instrumental delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby
Intrapartum	During labour
Intrauterine death (IUD)	Also called stillbirth: An unborn baby dies inside the womb before birth. This is described as ‘late’ when it happens in a woman who is 24 weeks pregnant or more, and is estimated to occur in 1% of all pregnancies
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain
ITU	Intensive therapy (care) unit
Intubation	Placing a breathing tube in a baby’s airway to assist ventilation
Intraventricular haemorrhage (IVH)	Bleeding into the fluid cavities within the brain, usually in preterm babies
Ketonuria	Occurs when high levels of ketone bodies which occur when cells are broken down for energy are present in the urine
KIDS-NTS	Children’s and Neonatal Transport team for the West Midlands
Labour ward coordinator	Senior midwives who coordinate the clinical workload and activity on the labour ward
Laparotomy	Surgical opening of the abdomen
Laryngeal mask	A device placed in the airway instead of intubation
Liquor	The water surrounding the baby in the womb
Left ventricular failure	When the left side of the heart is unable to pump blood to the body effectively such that it is insufficient for the body’s needs
Level 3 neonatal unit	Neonatal units are graded 1-3, 3 being equipped to care for the most pre-term and unwell infants requiring the highest levels of investigation and treatment
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit (formerly known as level 2 neonatal unit)
Local Authority	Refers to an organisation within local government which is responsible for public services and facilities.

Local Maternity System (LMS)

The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board

Local Supervising Authority Midwifery Officer (LSAMO)

A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was abolished in 2017

Local Supervisory Authority (LSA)

This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) which set rules and standards for midwifery. This authority was disbanded when Supervision of Midwifery was abolished

Loculated empyema

Pockets of pus that have collected inside a body cavity

LSCS

Lower segment caesarean section

Lower specialist trainee (LST)

Tier 1 doctor or Senior House Officer

Macrosomic

A newborn baby that is much larger than expected

Magnesium infusion

Drip used to decrease the risk of an eclamptic fit

Malpositioned baby

Usually the fetal head engages in the occipito-anterior position (more often left occipito-anterior (LOA) rather than right) and then undergoes a short rotation to be directly occipito-anterior in the mid-cavity. Malpositions are abnormal positions of the vertex of the fetal head relative to the maternal pelvis

Maternal death

Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy

Maternity Dashboard

Is a tool which can be used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of delivery

Maternity and Neonatal Collaboration

The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England

Maternity Transformation Programme

The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally

Maternity Voices Partnerships (MVP)

A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care

Mat Neo collaborative

The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England

MBRRACE-UK

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. A national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths

MDT

Multi-disciplinary Team

Meconium

Baby's bowel contents in the liquor (water) which sometimes suggests fetal distress (thick meconium is more likely to suggest this)

MEWS or MEOWS

An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a Modified Early Obstetric Warning System

Midwife-led units (MLU)

Are another name for birth centres that are run by midwives and have a home-like environment. They are most suitable for women without complications and can be next to a hospital maternity unit ('alongside') or situated in the community ('freestanding')

Midwifery Continuity of Carer (MCoC)

Midwifery continuity of care is a model of care, which aims to limit the number of different healthcare professionals a woman sees throughout her pregnancy. Its aim is that the pregnant woman will receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity

Mifepristone

A drug used to prepare the uterus (womb) for early contractions usually induced by another drug given approximately 36 hours later

Monochorionic twins

Twins sharing the same blood supply from the placenta. This can lead to unequal sharing of the blood supply which can lead to the death of one or both twins

Moulding

The bones of the fetal head can move closer together or overlap to help the head fit through the pelvis.

MRI scan

Magnetic Resonance Imaging –detailed scan, often of the brain

Multiparous

A woman who has given birth once or more

Multidisciplinary team	Is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended care. In maternity this tends to be midwives, obstetricians, anaesthetists and neonatologists
Myelomeningocele	A form of spina bifida where the spinal cord is exposed at birth. This is when a sac of fluid comes through an opening in the baby’s back. Part of the spinal cord/ nerves can be in the sac and are damaged
Neonatal Data Analysis Unit (NDAU)	Analyses neonatal data nationally
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life <ul style="list-style-type: none">• Early neonatal death - a live born baby who died before 7 completed days after birth• Late neonatal death - a live born baby who died after 7 completed days but before 28 completed days after birth
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also known as ‘managed clinical networks’ or ‘operational delivery networks’
NHS England and NHS Improvement (NHSE&I)	The body that leads the NHS in England
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manages negligence and other claims against the NHS in England on behalf of its member organisations. Its aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff
NHS Resolution	A body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care
National Institute for Health and Care Excellence (NICE)	Provides national guidance and advice to improve health and social care
NICHE	An independent consultancy service available to all healthcare providers (including mental health, acute, specialist, ambulance, primary and community), social care partners, commissioners, local authorities and regulatory organisations
NICU	Neonatal intensive care unit
NLS	Newborn Life Support Course (national training course)

NMR	Neonatal mortality rate (deaths within 28 days of life)
National Neonatal Audit Project (NNAP)	National audit of neonatal outcomes
NNU	Neonatal unit
Non-Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation
NQM	Newly qualified midwife of less than one year since becoming a professional registrant.
Nulliparous	Describes a mother who has not given birth before
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oedema	Accumulation of fluid in bodily tissues
Office of National Statistics (ONS)	Is responsible for collating and publishing statistics relating to health, economy, population and society at local, regional and national levels
Open Book	The cases identified by the Open Book arose from the Shrewsbury and Telford Hospital NHS Trust (supported by NHSI) undergoing its own investigation of cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. These were then reported to the review team
Operative delivery	Refers to a delivery in which the operator uses forceps, a vacuum, or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing
Operative vaginal delivery	Vaginal birth assisted with forceps or ventouse
Organisational structure	The way in which a large company or organisation is organised, for example, the types of relationships that exist between managers and employees
Oscillator	A form of high frequency ventilatory support that keeps the lungs open with a constant positive end-expiratory pressure
Oxygen saturation	Concentration of oxygen carried in the blood
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Paediatric	Branch of medicine that is dealing with infants, children and adolescents
Parliamentary and Health Service Ombudsman (PHSO)	An organisation which works with individuals and groups in an organisation to explore and assist them in determining options to help resolve conflicts, problematic issues or concerns, and to bring systemic concerns to the attention of the organisation for resolution

PCT	Primary Care Trust
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth
Perinatal death	A stillbirth or early neonatal death
Perineal tear	A tear occurring during childbirth. 1st and 2nd degree tears are common, and not serious. A 3rd degree tear involves the anal sphincters as well as skin, vagina and muscle. A 4th degree tear extends into the rectum
Perineal follow-up clinic	A clinic to follow-up women who have experienced 3rd and 4th degree tears
Perinatal loss	Loss of a baby during pregnancy or soon after birth. Includes stillbirths and neonatal deaths
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it
Placental	Reference to the 'afterbirth'
Placental abruption	When the placenta separates from the uterine wall either before or during labour
Placenta accreta	Abnormally deep attachment of the placenta into the muscle of the uterus (womb)
Perinatal mortality rate (PMR)	Stillbirths and deaths within 7 days of life
Post-partum haemorrhage (PPH)	Significant bleed after giving birth
Post-partum	After the birth
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby
Pre-labour preterm rupture of membranes (P-PROM)	Is the rupture of membranes prior to the onset of labour, in a patient who is at less than 37 weeks of gestation
PRH	Princess Royal Hospital- Telford- current location of neonatal service
Primary Care Trust (PCT)	Were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCGs)
Primiparous or Primigravid	A woman who is pregnant for the first time

Professional Midwifery Advocates (PMAs)	Support midwives to ensure that women and babies receive good quality, safe care
Prophylactic	Intended to prevent something occurring by being given early – for example a medication
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation)
Proteinuria	Protein detected in a urine sample
Pulmonary	Relating to the lungs
Pulmonary oedema	An excess of watery fluid in the lungs
Pyelonephritis	Severe kidney infection
Pyrexia	High temperature
Qualified in Speciality (QIS)	Postgraduate specialist training for neonatal nurses
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce
Royal College of Obstetricians & Gynaecologists (RCOG)	Professional body of obstetricians to improve healthcare for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women’s healthcare worldwide
RCPCH	Royal College of Paediatrics and Child Health
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs
Retained products	Pieces of placenta and/or membrane left in the uterus (womb) after delivery of the placenta (afterbirth)
Retropubic haematoma	Blood clot formed behind the pubic bone
Rectovaginal fistula	An abnormal channel that has developed between the rectum and vagina usually as a consequence of childbirth
Rectus sheath haematoma	Blood clot caused by bleeding from the rectus abdominus muscle (i.e. abdominal wall muscle)
Risk Management Strategy	The systematic identification, assessment and evaluation of risk. Used properly in healthcare, it can not only be a process to report incidents, but also minimise the harm that clinical or resourcing errors can cause to patients and staff
Root Cause Analysis (RCA)	Is the process of examining what happened in order to establish, how and fundamentally why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.
RSH	Royal Shrewsbury Hospital – former location of neonatal service
SANDS	Stillbirth and neonatal death support charity

SaTH	Shrewsbury and Telford Hospital or NHS Trust or the Trust
Situation, Background, Assessment and Recommendation (SBAR)	An easy to use, structured form of communication that enables information to be transferred accurately between individuals
SBR	Serum bilirubin – to determine the level of jaundice in a baby
Serious Incidents (SI)	Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death, serious harm or injury. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Previously known as Serious Untoward Incidents (SUI)
Sepsis	Severe infection
Septicaemia	Blood poisoning
Shock	Fall in blood perfusing organs, usually recognised because of a fall in blood pressure and a rise in heart rate. Shock has a number of possible causes, blood loss being the most common in maternity patients
Shoulder dystocia	Shoulder dystocia is when a baby’s head has been born but one of the shoulders becomes stuck behind the mother’s pubic bone, delaying the birth of the baby’s body
Situational awareness	Can be defined simply as ‘knowing what is going on around us’, or – more technically – as ‘the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future’
Spina Bifida	A condition that affects the spine and is usually apparent at birth. It is a type of neural tube defect (NTD)
Squamous epithelial cells in the pulmonary vessels	Cells from the baby found in the lung vessels of the mother
SSCBCN	Staffordshire, Shropshire and Black Country Neonatal Network
SSCBCODN	Staffordshire, Shropshire and Black Country Operational Delivery Network
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antenatal stillbirth occurs at or prior to the onset of labour. An intrapartum stillbirth occurs after the onset of labour

Subarachnoid haemorrhage	Bleeding in the space between the brain and the skull
Surfactant	A medicine given directly into the lungs of premature babies
Symphysis fundal height	A measurement from the Symphysis Pubis to the top of the fundus (womb) that monitors fetal growth
'T' incision	When the cut made on the uterus is both horizontal and vertical. The subsequent scar is weak, and therefore there is a greater risk of uterine rupture in a future pregnancy
Tachycardia	Fast heart rate
Talipes	A condition affecting one or both feet that is caused by a shortened Achilles tendon or as a result of fetal lie within the womb. Usually self-resolving with exercise or physiotherapy, but in some cases requires further intervention
Tethered Conus	Neurological condition where the end of the spinal cord is fixed by tissue attachments at the bottom of the spinal canal rather than moving freely
Therapeutic lactation suppression	Use of drugs to suppress milk production
Thermoregulate	Whereby the body maintains its core temperature
Third or fourth degree perineal tear	A perineal tear which involves damage to the fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter
Thrombosis	Blood clot in a blood vessel, usually in a vein
TOBY registry	A national register of babies that received cooling for HIE
Tocophobia	Is a pathological fear of pregnancy and can lead to avoidance of childbirth
Transfused	Given a blood transfusion
Transport team	A specialist service for safely transferring babies between care providers
Trial of instrumental birth	A term used when a difficult instrumental birth is anticipated, usually performed in an operating theatre with quick and easy recourse to caesarean section
Twin to twin transfusion syndrome (TTTS)	Is a rare condition that occurs during a twin pregnancy when blood moves from one twin (the 'donor twin') to the other (the 'recipient twin') while in the womb
UHNM	University Hospitals of North Midlands (Royal Stoke University Hospital)
Ureter	Tube down which urine passes from the kidney to the bladder
Ureteric obstruction	Blockage of the ureter

Urologist	A doctor specialising in disorders of the urinary tract
Uterine artery	Main artery (but not only artery) supplying blood to the uterus (womb)
Uterine rupture	When the uterine wall bursts, this usually occurs during labour, but can occur during pregnancy. Uterine rupture generally occurs when the uterus has a previous scar. Some types of scar, increase the risk of rupture in future pregnancies
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal
WMNODN	West Midlands Neonatal Operational Delivery Network

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Hearing the voices of staff

Provided to the review team by the Trust

Appendix 5: Terms of reference (TOR)

Original terms of reference as of May 2018

An independent review of the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust).

The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary **REVIEW TEAM** of independent external reviewers who will submit their findings to an **INDEPENDENT REVIEW PANEL**.

The **REVIEW TEAM** will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary **REVIEW TEAM** will undertake to:

- Review only those cases for which consent is granted to access the records pertaining to the case;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
 - Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
 - Consider how the parents, patients and families of patients were engaged with during these investigations;
- Reserve the right to undertake a second-stage review of primary cases should the considerations

above justify such action following agreement with the Executive Medical Director NHS Improvement and

- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The **INDEPENDENT REVIEW PANEL** will undertake to:

Receive and quality assure the **REVIEW TEAM's** findings in each case reviewed;

- Under the leadership of the chair, develop the report of the findings of the review and
- Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review's findings and recommendations.

In addition the **INDEPENDENT REVIEW TEAM** will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:

- A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
- A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
- Contact with parents or relatives to establish their understanding of their involvement in previous investigations.

The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

The Review Panel

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manger from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/ neonatologist
- NHS England midwifery representative from outside the region.

Key Principles

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

Timeframe

The final review report and proposals should ideally be available within one month of the review being completed.

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. Did the Trust have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 6:

Revised terms of Reference (TOR)

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:
 - a. appropriate investigations were conducted; and
 - b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:
 - a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
 - b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
 - c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
 - d. Consider how the parents, patients and families of patients were engaged with during these investigations;
 - e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and
 - f. The review team will present cases internally, and on an as required basis seek further external advice
11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.
12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.
13. Directions to the Review Team:
 - a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
 - b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?
 - c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
 - d. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 7:

Review team members

Ms Donna Ockenden – Director, Donna Ockenden Limited, Chair of the review.

Donna Ockenden was assisted and supported by the following team members
(In alphabetical order from their first name):

Obstetricians

Mr Alexander Taylor – from June 2020

Dr Anthony Falconer – from November 2018 until September 2020

Dr Antoinette Johnson – from March 2021

Dr Austin Ugwumadu – from July 2020

Dr Bode Williams – from April 2021

Dr Bronwyn Middleton – from November 2020

Dr Clare Tower – from March 2021

Professor Dharmintra Pasupathy – from October 2019

Dr Elisabeth Peregrine – from February 2021

Dr Heather Brown – from November 2018 until June 2020

Dr Joanne Page – from November 2020

Dr Jonathan Frappell – from December 2019 until March 2021

Dr Louise M Page – from November 2018 until October 2020

Dr Karin Leslie – from August 2020 until March 2021

Dr Marwan Salloum – from August 2020

Dr Matthew Cauldwell – from January 2021

Dr Michael Magro – from March 2021

Dr Nikki Jackson – from October 2020

Dr Paula Galea – from September 2020

Dr Penny Law – from November 2018 until June 2021

Dr Rachel Marshall-Roberts – from September 2020 until November 2021

Mr Richard Howard – from November 2018

Dr Sandra Newbold – from January 2020

Dr Umber Agarwal – from April 2021

Midwives

Amanda Mansfield – from November 2018 until June 2020 and from March 2021

Amanda Davey – from May 2017

Angela Frankland – from May 2021

Angie West – from May 2017

Bronwen Grigg – from January 2021

Caroline Clarke – from May 2017

Carolyn Romer – from November 2018 until August 2021

Ceri Staples – from September 2020

Charlotte James – from July 2019 until January 2022

Helen Harling – from December 2020 until May 2021

Helen Smith – from March 2020

Jacqueline Oliver – from May 2019

Jane Patten – from May 2017

Jessica Scoble – from September 2019 until September 2020

John Bell – from July 2019

Julie Jones – from November 2018

Dr Kate Nash – from April 2020

Kerry Madgwick – from January 2021

Kerry Thompson – from June 2020

Konstantina Stavrakelli – from September 2020

Lauren Graham – from September 2020

Merida Sculthorpe – from November 2020

Natalie Adams – from September 2020

Nicola Rose-Stone – from November 2019 until November 2020

Teresa Manders – from October 2019

Tina Spiers – from October 2020

Neonatologists

Dr Alison Jobling – from April 2020 until October 2021

Dr Chris Day – from March 2021

Dr Charlotte Groves – from November 2018 until June 2020

Dr Eilean Crosbie – from March 2021

Dr Huw Jones – from November 2018 until March 2021

Dr Lawrence Miall – from March 2021

Dr Michelle Parr – from March 2021

Dr Michael Hall – from March 2019

Professor Minesh Khashu – from June 2021

Dr Ngozi Edi-Osagie – from March 2021

Dr Paul Crawshaw – from February 2019

Dr Ranganna Ranganath – from April 2021 until October 2021

Dr Ryan Watkins – from December 2018 until March 2021

Dr Sarah Davidson – from July 2021

Dr Sunita Seal – from April 2021

Dr Tosin Otunla – from February 2020

Dr Vimal Vasu – from February 2019 until September 2020

Paediatricians

Dr David Gibson – from August 2021

Professor Ian Maconochie – from November 2018 until June 2021

Dr Julian Sandell – from March 2019 until April 2021

Obstetric Physician

Dr Anita Banerjee – from November 2018

Anaesthetist

Dr Andrew Combeer – from February 2021

Dr Elizabeth Combeer – from February 2021

Dr Renate Wendler – from November 2018

Neurologist

Dr Sean J Slaght – from December 2019

Cardiologist

Dr Richard Jones – from May 2020

Intensivist

Dr Phil Young – from July 2020 until March 2021

Dr Frank Schroeder – from May 2021 until December 2021

Family Support and Psychology Provision for Families

Maternity Review Psychology Service, hosted by Midlands Partnership NHS Foundation Trust

Dr Katie Bohane – Lead for Psychology Service from January 2021

Dr Katie Woodward – Clinical Psychologist from April 2021

Eloise Lea – Clinical Psychologist from April 2021

Emma Campbell – Assistant Psychologist from October 2021

Dr Kirsty Langley – Clinical Psychologist from July 2021

Dr Rachel Lucas – Trust Recovery Lead and Director of Psychological Services from June 2020

Dr Ursula Bacon – Clinical Psychologist from September 2021

Dr Victoria Caines – Clinical Psychologist from November 2021

SANDS – Stillbirth and neonatal death charity

Dr Clea Harmer – Chief Executive of Sands from January 2021

Jen Coates – Director of Bereavement Support and Volunteering from June 2020

Maria Huant – Bereavement Support Services Manager from June 2020

Bereavement Training International

Paula Abramson - Bereavement Training International and lead for the Listening Ear Service from June 2020

CBUK – Child Bereavement UK

Ann Chalmers – CEO, Child Bereavement UK from June 2020

Karen Smith – PA to the Chief Executive & Executive Manager from June 2020

Sarah Harris – Director of Bereavement Support and Education from November 2021

Administrative support provided by:

Aimee Humphrey - Administration for the Maternity Review from May 2021

Barbara Watkinson – Administration for the Maternity Review from April 2019 until July 2020

Charlotte Lidster – Administration for the Maternity Review from January 2020 until December 2020

Michelle Wright – First Rate PA, Administration for the Maternity Review from April 2018

Monika Niziol – Administration Assistant to Donna Ockenden the Chair of the Maternity Review from July 2020

Rebecca Jones – Administration Assistant for the Maternity Review from October 2020 until December 2021

Sara Kempton-Hayes – Administration for the Maternity Review from February 2019 until July 2020

Zoe Bolt – Administration for the Maternity Review until September 2018

HR and Employment Law specialist:

Dianne Lambdin, Director Sussex HR Hub Ltd

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Kristianah Fasunloye – Astraea PR

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Louis Dady – Millstream Productions, film and video production

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Patrick Arben

Sarah Grey

Claire Van Ristell

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Jane Blaber – Liberty Bookkeeping

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Hilary Julian – Maximus Accountancy Services Limited

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VENOM IT – IT services provider

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