

The Shrewsbury and Telford Hospital NHS Trust

EXTRAORDINARY TRUST BOARD MEETING
Held on Monday 4 April 2016
Seminar Rooms 1&2, Shropshire Education & Conference Centre, RSH

PUBLIC SESSION MINUTES

Present:	Mr P Latchford Mr P Cronin Mrs D Leeding Mr B Newman Dr S Walford Mr S Wright Mrs S Bloomfield Dr E Borman Mrs D Kadum	Chair Designate Non-Executive Director (NED) Non-Executive Director (NED) Non-Executive Director (NED) Non-Executive Director (NED) Chief Executive Officer (CEO) Director of Nursing and Quality (DNQ) Medical Director (MD) Chief Operating Officer (COO)
In attendance	Mr T Holt	Clinical Governance Manager – Representing Director of Corporate Governance / Company Secretary
Meeting Secretary	Mrs S Matthey	Committee Secretary (CS)
Apologies:	Mr H Darbhanga Mr C Deadman Dr R Hooper Mr N Nisbet Mrs J Clarke	Non-Executive Director (NED) Non-Executive Director (NED) Non-Executive Director (NED) Finance Director (FD) Company Secretary (CS)

2016.2/51

WELCOME:

The Chair welcomed members to the Extraordinary Board and reported that it is a meeting in public rather than a public meeting, where very real issues will be discussed. There will be an opportunity for questions to be asked at the end; however the Chair reserves the right to change this approach. In accordance with Board meetings, the Chair reminded the members that neither cameras nor recordings could be used during this session.

2016.2/52

INTRODUCTION

The Chair highlighted that the meeting was being held to focus on Kate Stanton-Davies and her parents and the impact that her death has had on her family and those around them over the last 7 years.

The core of the meeting will be to receive the Independent Review which will be presented by its author, Ms Debbie Graham, via conference call; prior to that, Kate's parents, Ms Rhiannon Davies and Mr Richard Stanton will present Kate's Story.

2016.2/53

STATEMENT FROM THE CHAIR

The Chair provided the following statement on behalf of the Trust:

"The central principle that guides everything we do as a Trust is Putting Patients First. These are not just words. This is something we truly believe in and strive to achieve every single day with every single patient. That is why it is particularly distressing when something like the case of Kate occurs.

..... Chair
28 April 2016

Clearly, in this case, we did not put Kate first. We did not put Kate's mother first. For this I, and the rest of the Board, want to publicly say sorry.

We want to say sorry that we failed to protect Kate and her family. We want to say sorry that our subsequent handling of Mr Stanton and Ms Davies' concerns and complaints fell way short of the standards we should all accept.

We want to say sorry to other mothers-to-be and to other patients because, understandably, the report into this case may give others cause for concern.

I believe we have learned, as a Trust, over the last few years, and I hope that some of what is said today will go some way to reassuring both Kate's parents and all of those who place their care in our hands that we have taken important lessons from this tragic incident and ensured those lessons are learnt.

You will hear people say that this report makes uncomfortable reading. That's true, it does. But it is also essential reading if we are to be satisfied that we are doing everything in our power to ensure every lesson and every concern raised is addressed.

Sorry will not change what happened to Kate and will not make up for the loss that Ms Davies and Mr Stanton have suffered and continue to suffer. But we truly are sorry, and we hope and believe our learning from this experience will demonstrate how seriously we take what has happened, and we thank Kate's parents for their tenacity and determination in bringing us to where we are today".

2016.2/54

KATE'S STORY

Mr Stanton and Ms Davies provided their account of Kate's Story to the Board.

Ms Davies reported that Kate Stanton-Davies' case was not formally investigated until last year. She highlighted that the Independent Review highlighted many failures and was irreparably compounded by the Trust's culture within Women & Children's, particularly Maternity Services; as well as the defensive attitudes of previous Trust Chief Executive's, Tom Taylor and Peter Herring.

The members were informed that neither a Root Cause Analysis (RCA) or Serious Incident (SI) investigation were undertaken following Kate's death. It was also reported that the Ludlow Midwifery Led Unit (MLU) did not have a specific Operational Policy in place c2009 – 2015.

Ms Davies reported that she and Mr Stanton have given up 7 years of their life to establish what happened to their daughter which has prevented them from being able to grieve. She highlighted that the Trust members involved in Kate's case failed in their jobs and acted without any compassion; some senior members have since been promoted and are still employed by the Trust.

Ms Davies informed the members of the improvements that have been made by the West Midlands Ambulance Service (WMAS) to ensure best practice; these include changes to their equipment, changes to their Policy, improved staff training and the roll-out of a Family Liaison Officer Scheme entitled 'Kate's Care', which they endeavour to roll-out nationally.

Ms Davies reported that the Trust is now in receipt of the independent evidence and implored the Chair and Chief Executive to take robust action to ensure what happened to Kate does not happen again.

Mr Stanton and Ms Davies thanked those involved for their support and reported that Kate's Story should never be forgotten and it's now time that the Trust did the right thing.

..... Chair
28 April 2016

The Chair thanked Mr Stanton and Ms Davies for their commitment and for presenting Kate's Story.

The Chair and Chief Executive expressed their personal apologies for the events that have unfolded over the past 7 years and the Chair reported that the journey has commenced and today is a defining moment for the organisation.

The Chair adjourned the meeting at 3.40pm for a 10 minute comfort break; the meeting re-convened at 3.50pm.

2016.2/55

PRESENTATION OF THE INDEPENDENT REVIEW OF THE CASE OF KATE SEREN STANTON-DAVIES

The Chair welcomed the author of the Independent Review, Ms Debbie Graham, to the meeting via conference call.

Ms Graham provided the following Executive Summary of the Independent Review and its Recommendations:

Kate Seren Stanton-Davies was born at 10.03hrs on 1st March 2009 at the Ludlow Midwife Led Unit (MLU), part of The Shrewsbury and Telford Hospital NHS Trust (SaTH). Kate was the first child of her mother Rhiannon Davies and her father Richard Stanton. She was a normal delivery at term and Ms Davies' pregnancy had been assessed as low-risk. Sometime after 11.35hrs on the morning of her birth, Kate was found in a state of collapse in her cot by a nursing assistant (NA). A 999 call was logged by the Ambulance Service at 12.07hrs and at 12.17hrs two paramedics arrived at Ludlow MLU. At 12.30hrs Kate was transferred by ambulance to an air ambulance. At 12.50hrs the air ambulance took off to transport Kate to a neonatal unit. Initially it was thought that she would be taken to the Royal Shrewsbury Hospital (RSH) however as the helipad at RSH was closed, Kate was taken to Birmingham Heartlands Hospital neonatal unit where sadly, at 16.05hrs, she died.

The NHS has a responsibility to ensure that incidents where something has gone wrong are properly investigated to determine: what happened, the root cause and what can be done to prevent recurrence. This professional responsibility predated the legal duty of candour that was placed on NHS staff in 2015.

The issues relating to Kate's transfer to the neonatal unit at Birmingham Heartlands Hospital were previously investigated by the West Midlands Ambulance Service (WMAS) and did not form part of the scope of this review. However, SaTH did not raise Kate's death as a Serious Incident (SI) or undertake Root Cause Analysis (RCA) into the standard of care and treatment provided for Kate and Ms Davies by the Trust.

A High Risk Case Review (also known as a Death Review) was held. This is a round table meeting to which documents (including the clinical notes) and other evidence are submitted for review. Key evidence for a clinical incident includes: the events timeline, the action taken by the staff and the standard of care provided. In the case of Kate's review this evidence was provided by the findings from a Supervisory Investigation.

The Local Supervisory Authority (LSA) instigated a Supervisory Investigation into the incident; conducted by a Supervisor of Midwives (SoM) employed by SaTH. It is of note that when undertaking an investigation the SoM is responsible to the Local Supervising Authority Midwifery Officer (LSAMO) and not to an employer. The Supervisory Investigation identified issues relating to: poor intrapartum record keeping; Kate's transfer from Ludlow MLU to Birmingham Heartlands Hospital; and difficulties in arranging transportation for Kate's parents to be taken to the neonatal unit. The Supervisory Investigation concluded that there had been 'no breach' in the duty of care and recommended a period of developmental support for the two case midwives and that a memorandum be sent to the antenatal ward to highlight the importance of record keeping.

..... Chair
28 April 2016

Since 2009 Ms Davies and Mr Stanton have made three formal complaints to SaTH, one of which raised their concerns regarding issues relating to the ambulance service which was appropriately forwarded to WMAS. The remaining two complaints raised their concerns regarding the standard of care and treatment received by Kate and Ms Davies whilst patients at the Trust. Neither of these complaints was upheld by SaTH who based their responses on the findings from the High Risk Case review which had accepted the findings of the LSA Supervisory Investigation.

At Ms Davies' and Mr Stanton's instigation, a Coroner's Inquest into the case was held in 2012 and, in 2014, the Parliamentary and Health Service Ombudsman for England (HSOE) carried out an investigation. Both the Inquest and HSOE investigation found that Kate's death was avoidable. In January 2015 following receipt of the HSOE Report, Ms Davies and Mr Stanton received a written apology from SaTH.

An Independent Review was commissioned by SaTH to carry out an independent review of the case of Kate Seren Stanton-Davies. This was undertaken by Debbie Graham, Independent Maternity Services Expert Advisor and Registered Midwife (referred to as the Reviewer).

Conclusions and Key Findings:

The Reviewer found that SaTH failed to fulfil its responsibility to establish the facts of this case and failed to establish accountability. Rather, the Trust abdicated its responsibility to the LSA, an organisation with no accountability to the Trust.

The Reviewer found that although clinical governance processes were in place c2009 there was a disconnection 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 resulted in Kate's death not being raised as a SI and a Trust managerial investigation being instigated. The findings and recommendations from the Supervisory Investigation, along with the findings from the High Risk Case Review were utilized for the Trust's response, learning and establishment of accountability for this incident up until the findings of the Coroner's Inquest was accepted by the Trust in 2015.

The Trust has therefore, to date, not held staff accountable for the standard of care and treatment provided for Kate and Ms Davies by the Trust.

Following a formal complaint, made by Ms Davies and Mr Stanton in 2015 to NHS England as LSA for England, an independent review found the Supervisory Investigation not fit for purpose.

The Trust also relied on the findings of the Supervisory Investigation and High Risk Case review when responding to Ms Davies' and Mr Stanton's concerns.

Culture also appears to play a part in the responses received by Ms Davies and Mr Stanton to their formal letters of complaint. The Reviewer found that the Trust did not put Kate or her parents at the centre of their response, failed to address all the issues raised by Ms Davies and Mr Stanton and contained factual inaccuracies. In addition, the review found that the failure to establish a clear co-ordinator role between the different organisations involved with the case contributed substantially to the inadequate response by SaTH to Ms Davies' and Mr Stanton's complaints and concerns.

The Trust's inappropriate reliance on the Supervisory Investigation and failure to follow-up on outstanding issues resulted in the identification of only some of the required learning in 2009. It is only due to the determination of Kate's parents, Ms Davies and Mr Stanton that the remaining issues came to light through the findings of external reviews of this case.

..... Chair
28 April 2016

Finally, the Reviewer found 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 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.

Recommendations

1. Midwife 2's conduct should be reviewed in line with the Trust's Performance Improvement Policy
2. The Trust should seek assurance that all maternity guidelines and policies are formatted and ratified in line with Trust clinical governance processes.
3. To better understand whether women birthing in a stand-alone MLU had fully understood their birth choice; an audit of women who have required intrapartum transfer in to RSH from a MLU should be undertaken.
4. To ensure that good practice models are utilized; a review of the current system for the provision of antenatal care should be conducted with the aim of identifying which groups of women would most benefit from receiving continuity of care.
5. Review of the evidence base for midwives to 'double glove' when providing intrapartum care
6. The Trust should seek assurance that all maternity incidents are subjected to an internal investigation, in line with Trust policy.
7. SaTH should formally inform Ms Davies and Mr Stanton of the lessons learnt by the Trust from Kate's death, including action plans developed to address identified issues.
8. The Trust should publically acknowledge the failings identified in this review and the harm they have caused Ms Davies and Mr Stanton.
9. The Trust should work with Ms Davies and Mr Stanton to establish a fitting memory to their daughter, Kate.

Ms Graham reported that the review found Kate's death as not being reported correctly as there was no Serious Incident (SI) or Root Cause Analysis (RCA) undertaken and the facts were not established. It has taken Mr Stanton and Ms Davies 7 years for the facts to be established.

The Chair enquired if there are any additional issues over and above the recommendations.

- Ms Davies informed the members it appeared at inquest that the midwives had been coached in relation to Apgar Scores; and she enquired what action has been / is being undertaken in relation to Apgar score training. The DNQ asked Ms Graham, as Independent Maternity Services Expert Advisor, to provide an explanation re: Apgar scores. Ms Graham reported that Apgar training is undertaken as part of a midwife's basic training. An Apgar is assessed in several ways which include i) baby born, ii) rub baby with towel, iii) baby takes big breath, iv) baby gives a hearty cry, v) baby pinks up. A healthy baby would have normal respirations and colour, but if the baby is not fully pink, it should be taken to the resusitaire for further assessment.
- Mr Stanton informed members that the Trust's internet site reports the timing of the journey from Ludlow to the Women & Children's Centre at PRH as a 52 minute journey; however he highlighted that this could take up to 1½ hours following handover, etc, and felt it is not correctly communicated within the Trust literature.
- The members were informed that many of the Trust's maternity policies which related to Kate's care were out of date. Ms Graham reported that there is a window of time when guidelines are due for review; the guidelines/policies/procedures should not therefore have been out of date.

..... Chair
28 April 2016

- Mrs Leeding (NED) highlighted the non-compliance to the overall standards and practices and requested assurance that this is no longer happening. Ms Graham highlighted that current clinical governance practice, including policies and procedures, is now very good.
- It was reported that there were three Datix incidents raised in relation to transport issues, but not in relation to either Ms Davies or Kate's care and that they were recorded as 'no harm'.
- The CEO enquired if there was evidence of a constant level of risk throughout the progression of Ms Davies' pregnancy. Ms Graham reported that the key events of Ms Davies' care are recorded in the report. Ms Davies was seen by a number of obstetricians and should have been flagged as a high risk case and a full case history undertaken.

During the investigation, it was identified that RCA training did not take place in 2009. A workshop was held where very informal training occurred. It was also reported that there were very weak governance processes in place during 2009.

The Trust had an opportunity to investigate the case in 2012; however, the DNO that was in employed by the Trust in 2012 felt all avenues had been investigated.

Mr Stanton enquired if the Board felt assured of the learning culture within the Trust. Ms Graham confirmed that she has obtained five examples of recent root cause analyses, and all five are of good quality.

Mr Cronin (NED) enquired what needs to be learned and undertaken to demonstrate good practice within the organisation, going forward.

Ms Graham reported that the Trust must operate an open and honest policy, which was possibly not the culture during 2009.

Mr Stanton and Ms Davies asked the Board to look closely at the new LSA investigation which was undertaken during January 2016 as it provides detail relating to culture.

Complaints Management (c2009)

It was reported that Mr Stanton and Ms Davies submitted three complaints during 2009 – 2012; the timeline was within the expected standards, however Mr Stanton and Ms Davies thought it was clear that the CEO's letter of response had been drafted by the former Head of Midwifery. Ms Davies informed the members that it was suggested a complaint meeting with them be held at the Ludlow MLU; she highlighted the lack of compassion from the Trust.

Ms Davies reported that she received a very compassionate response from the West Midlands Ambulance Service (WMAS); who are also very mindful when sending a letter of response to ensure it is not received over the weekend period.

The CEO suggested there was lack of a robust clinical governance system during that period; however the Trust now operates improved practices, including the reporting of Serious Incidents / themes to the Trust Board on a monthly basis.

Mr Stanton reported that their GP practice (Ludlow) raised a Purple Card, although neither he nor Ms Davies received a response or any further information in relation to the Purple Card. Ms Graham confirmed that she investigated the Purple Card but as it related to the transfer, it was closed down.

Mrs Leeding (NED) suggested undertaking account management of complaints to ensure the complainant is kept informed of the action that the Trust is undertaking.

..... Chair
28 April 2016

Mr Stanton and Ms Davies suggested using an alternative term rather than referring to people as 'complainants' and to be careful and considerate with the language used.

The Chair adjourned the meeting at 5.35pm for a 20 minute comfort break; the meeting reconvened at 5.55pm.

Following discussion, the Chair thanked Ms Graham for undertaking the Independent Review and highlighted that although a number of considerable improvements have been introduced, it is important that all recommendations are progressed.

2016.2/56

LEARNING

The DNQ presented a paper which outlined the learning and actions that have taken place, either wholly or partly as a result of the avoidable death of Kate Stanton Davies in the period 2009 – 2015.

The paper also identified learning still in progress; this will be monitored by the Quality & Safety Committee which provides assurance to the Trust Board. The DNQ reported that the Quality and Safety Committee was not in place in 2009; this has since been established and is a formal sub-Committee of the Trust Board. It is chaired by a Non-Executive Director and attended by two further Non-Executive Directors to ensure a good level of challenge

The DNQ informed the members that importance should be placed on ensuring learning and improvement actions are robustly tested and audited to ensure they are in place and embedded.

It was reported that a piece of work will be undertaken in the future in relation to Kate's story and the impact of Kate's death on anyone who has been involved with her case, in a bid to train Trust staff and set clear expectations with regard to incident reporting, investigation and honesty and transparency.

The Chair adjourned the meeting at 6.20pm for a period of 25 minutes to enable the CEO to provide a press interview. The meeting reconvened at 6.45pm

The Chair reported that the Extraordinary Board meeting was a defining moment and although it's early in the journey, the Board acknowledged that they are to earn the right to take the burden off of Mr Stanton and Ms Davies to strive towards becoming the safest and kindest organisation.

The CEO highlighted that culture starts at the top; it is therefore the Board's responsibility to promote an exemplary culture within the organisation and not stray away from it.

The COO informed the members that in the past the Board has discussed the 'abnormal becoming the normal'. Following discussion, the Board agreed the need for a change in culture.

The Board members expanded on the following three themes that had become apparent throughout the meeting:

Compliance –

The Chair highlighted that the Trust must be exemplary in its processes, ensuring they are robust, fair and fully actioned.

Policies and guidelines are in place to protect both patients and staff; and the Trust must ensure they are relevant and update to date, simple to use and accessible to the workforce, and are being fully complied with.

..... Chair
28 April 2016

Accountability –

The DNQ reported that Registered Nurses and Midwives are taught to be proud of accountability. The Trust must therefore ensure its nursing and midwifery staff are empowered to raise concerns, and to be honest and open about reporting to eradicate the Trust's previous 'blame' culture.

Kindness / Culture Change –

The Chair unreservedly apologised to Ms Davies and Mr Stanton for the failures presented to them and to their baby, and for the difficulties they have experienced in obtaining information relating to the case. He reported that the Trust must create a culture of kindness to ensure patients and carers are protected; and to engage the workforce to be able to 'stop the line' when concerns are highlighted. Mrs Leeding (NED) highlighted that the communication and engagement around cultural change will be extensive and suggested a plan be devised.

The CEO suggested that the Executive Team should become far more visible throughout the organisation to check its approaches/rules/gestures. He reported that the Trust should continue to use independent scrutiny to seek assurance, and also utilise other Agencies, if required. The CEO believes if the above measures are achieved, the hospital will become the learning organisation which Ms Davies and Mr Stanton and the wider population deserves.

Ms Davies and Mr Stanton highlighted the culture and effects that the then Head of Midwifery has had on the staff over the past 7 years. It was emphasised that Mrs Smith remains an employee of the Trust and Mr Stanton and Ms Davies requested the Board to act on their concern accordingly and provide support to the DNQ to do so.

2016.2/57

QUESTIONS FROM THE FLOOR

Q1 Member of the public, Mrs Irene Beesty, enquired if serious incidents are being looked into, since Kate Stanton-Davies incident in 2009, including stillborn incidents.

A1 The DNQ confirmed that the Trust is looking back at a number of incidents from 2009 onwards. This is being undertaken with external help and support. Findings will be reported to the Quality & Safety Committee which provides assurance to the Board.

As Chair of the Mortality Group, the MD reported that reviews are being performed into neonatal mortality for the last three years. In addition, serious incidents and root cause analyses involving neonates are being reviewed. The governance systems now in place provide a greater level of peer review and more direct challenge.

Q2 As a member of the public and as Councillor for Clunbury, Ms Sylvia Jones feels there is a recurring theme of bullying within the health service, from the top down. She reported that she cannot understand the callousness of the organisation throughout Kate Stanton-Davies' case. She supported Mr Stanton and Mrs Davies' courage, tenacity and sheer grit in exposing the problems within the organisation and enquired if it is occurring within other areas of the Trust. Ms Jones reported that the Trust is looking to divest 25-30% into the hospital community and highlighted her concerns that if such issues occur within hospital environments, what could happen to people in their own homes.

Q3 Ms Jones also reported that births at the Ludlow MLU have plummeted and this tragedy should not be used to close the Unit; instead it should be well resourced and staffed, in honour of Kate Stanton-Davies, to become a Centre of Excellence in Ludlow.

Q4 Ms Jones queried how many enquiries the Trust has received in relation to alleged 'avoidable deaths' over the last 7 years.

..... Chair
28 April 2016

- A4** The DNO reported that there have been a small number of enquiries; if any other areas of concern were found within our review of cases then the family would be informed and involved as they wished.
The DNO also reported that when an SI occurs, the family is informed and offered meetings to ensure understanding and involvement with the RCA process.
Dr Walford (NED) reported that this level of information is reported during the Private Board sessions due to accountability and disciplinary processes; however, the CEO suggested it should be shared in the public domain, as part of the Quality & Safety Committee Summary, to provide a degree of transparency.
- Q5** A member of the public enquired if there are enough full-time midwives currently in post to perform their role safely.
- A5** The DNO reported that the Trust uses the Birthrate Plus & Safer Nursing Care Tool (SNCT) models to identify the correct staff to midwife:birth ratio and nurse:patient ratio, and confirmed that the Trust does have the correct staffing for the service.
The DNO also reported that at the end of last year, the Trust had a waiting list for midwives to join the Trust which is very encouraging.
- Q6** Mr Stanton highlighted that the role of an on-call midwife is an unsafe practice. He reported that the West Midlands Ambulance Service requires paramedics to live close enough to be able to respond within the appropriate time. He suggested the Trust creates its own Policy which states it is an expectation to live or be within a certain amount of time to respond.
- A6** The CEO reported that the Trust is currently reviewing this policy and confirmed he would provide feedback to Mr Stanton and Ms Davies as soon as it is complete.
- Q7** Mrs Beesty informed the members that she was in attendance as a grieving grandmother following an incident which occurred in 2013, and also as an employee of the Trust.

She enquired of the arrangements in relation to the Consultant on-call being required to be in the building, as this was not the case with regards to her grandchild.
- A7** The MD reported that the Trust is separating the rotas to ensure the Consultants with most skills are available for the Labour Ward; however, unfortunately the Trust does not have enough Consultants to cover every hour, but they are able to cover the majority of the times when they are most likely to be required. The CEO confirmed that a shift system is utilised.
- Q8** Mrs Beesty felt it would have been beneficial for Cathy Smith and a Senior Obstetrician to have been present at the Extraordinary Board meeting.

The Chair and CEO informed Mrs Beesty that they would like to hold a conversation with her with regards to her granddaughter's case.

2016.2/58

ANY OTHER BUSINESS

Ms Davies reported that the burden of responsibility in this case fell to both Mr Stanton and herself and she highlighted that the process for people to be able to raise concerns or complaints should be made easier for people to be heard.

The Chair agreed and informed the members that the way to become the safest and kindest is to be engaged with the population and to be transparent, so that the people we serve are the Trust's eyes and ears. It is the population's hospital and it is a journey that we must take.

..... Chair
28 April 2016

The Chair reported that there is clearly more to be undertaken to ensure learning is put into practice and to provide every level of assurance. This will be seen through and reported to the public Trust Board on a regular basis via the Trust Quality & Safety Committee.

The Chair thanked Ms Davies and Mr Stanton and those in attendance and highlighted once again that they are to hold the Board to account.

The meeting closed at 7.50pm

2016.2/59

DATE OF NEXT PUBLIC TRUST BOARD MEETING

Thursday 28 April 2016 at 2 pm at the Severn Centre, Bridgnorth Road, Highley, Nr Bridgnorth, WV16 6JG.

..... Chair
28 April 2016