

Independent review of the case of
Kate Seren Stanton-Davies at the
Shrewsbury and Telford Hospitals NHS Trust

Debbie Graham, RM, LLM Medical Law and Ethics

Independent Maternity Services Expert Advisor

D.A.G Consultancy Ltd

November 2015

Contents		Page
1.0	Executive summary	2
2.0	Recommendations	4
3.0	Scope of Review	5
4.0	Background	5
5.0	Key clinical events	8
6.0	Missed Opportunities or areas of poor practice identified and action plans	23
7.0	Clinical Governance	29
8.0	Complaints Management	37
9.0	Conclusion	44
Acknowledgments		44
References		
List of tables		
Table 1	Complaints, investigations and findings since 2009	6
Table 2	Key events in Rhiannon Davies' antenatal care	9
Table 3	Key events in Rhiannon Davies' intrapartum care	13
Table 4	Care timeline for Kate Seren Stanton-Davies from time of birth to transfer 1 st March 2009	16
Table 5	Actions reported as completed from all action plans	26
Appendices		
Appendix 1	Terms of Reference for review	46
Appendix 2	People consultant and documents read as part of the review	46
Appendix 3	Glossary of abbreviations	48
Appendix 4	Comprehensive table of complaints investigations and findings since 2009	49

Version	Date	Action and changes	Changed by
1	25/11/15	Report submitted to Sarah Bloomfield (SB)	
1.1	18/12/15	Minor changes to text and anonymisation requested by SB	Debbie Graham (DG)
2	22/1/16	Redraft to narrative to clarify findings	DG
3	4/3/16	Changes to text in response to comments from Ms Davies and Mr Stanton	DG
4	30/03/16	Factual changes/additions and further anonymisation	SB

1.0 Executive Summary

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 term¹ 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 unit². Initially it was thought that she would be taken to the Royal Shrewsbury Hospital³ (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 investigated by SaTH and West Midlands Ambulance Service (WMAS). However SaTH did not raise Kate's death as a Serious Incident (SI) or undertake root cause analysis⁴ (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

¹ Term is defined as at or beyond 37 completed weeks of gestation

² All times as reported by the Ambulance Service (SaTH Death Review notes - 30.4.09). Kate arrived at Heartlands Hospital at 13.07hrs. The time taken from Kate leaving Ludlow MLU to her arrival at Heartlands Hospital has been investigated by West Midlands Ambulance Service and is not part of the scope of this review.

³ Difficulties were encountered when attempting to arrange transport for Kate's parents to the neonatal unit, which resulted in them using their own transport. Unaware that the air ambulance had diverted to Heartlands Hospital Kate's parents initially believed she was at SaTH but rerouted towards Birmingham not knowing which hospital she was at, and ringing each Birmingham hospital in turn. En route Ms Davies collapsed and was transferred by ambulance to Worcester Hospital. Having left his details at each hospital he contacted, Mr Stanton was called back by the attending consultant neonatologist at Heartlands to advise that she had received Kate, and in order to try and locate Ms Davies. Mr Stanton was told to get to Heartlands as quickly as possible and Mr Stanton arrived at Heartlands Hospital shortly before Kate died. Ms Davies arrived at Heartlands over an hour after her daughter's death. This incident was investigated by SaTH and the West Midlands Ambulance Service and is not part of the scope of this review.

⁴ RCA – recognised tool for identifying how and why safety incidents happen.

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 intrapartum⁵ 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 midwives⁶ and that a memorandum be sent to the antenatal ward to highlight the importance of record keeping.

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 Inquest⁷ into the case was held in 2012 and, in 2013, the Parliamentary and Health Service Ombudsman for England⁸ (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.

In September 2015 Debbie Graham, Independent Maternity Services Expert Advisor and Registered Midwife (henceforth referred to as the Reviewer) was commissioned by SaTH to carry out an independent review of the case of Kate Seren Stanton-Davies.

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

⁵ During labour

⁶ Developmental support recommended as follows:

Midwife 2:

1. ... to be formally reminded of the importance of recording fetal heart observations in accordance with NICE and the midwifery guidelines on low risk intrapartum care and to write a piece of reflective writing to demonstrate increase awareness of this.
2. To undertake record keeping study day ... and to complete a piece of reflection within 30 days of attendance at the study day.
3. ... named supervisor to audit 3 records of intrapartum care within 3 months

Midwife 1:

1. Undertake a reflective piece of writing within 30 days on importance of recording fetal heart monitoring in accordance with NICE and local guidance and to also include the screening and management of [REDACTED] health issues...

⁷ Narrative verdict, H.M. Coroner J.P Ellery, South Shropshire Coroner's District, 7th – 16th November 2012

⁸ Report by the Health Service Ombudsman for England of an investigation into a complaint made by Ms Rhiannon Davies and Mr Richard Stanton, 31 December 2014

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.

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.

2.0 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.

3.0 Scope of review

This review

- Was commissioned by Sarah Bloomfield, Director of Nursing and Quality, SaTH, in response to the complaints received from Ms Rhiannon Davies and Mr Richard Stanton and concerns raised by organisations external to the Trust.
- Presents a review of the documentation submitted by Ms Davies and Mr Stanton⁹ and SaTH. In addition the Reviewer collated information via telephone conversations or face-to-face meetings with key people, as identified by the Reviewer.
- The methods used by the Reviewer to undertake the review involved a systematic analysis of the documents, incident mapping and the application of the principles of root cause analysis.
- Proposes recommendations based on the submitted documentation, analysis and interviews.

The Reviewer is not responsible for any inaccuracies in the source data or for conclusions reached on the basis of inaccurate data.

The terms of reference can be seen at appendix 1. A list of the people consulted and documents read by the Reviewer to undertake this review can be seen at appendix 2. Abbreviations have been defined when first used and included in a glossary at appendix 3.

4.0 Background

In the six years since Kate's death Ms Davies and Mr Stanton have endeavoured to obtain: a comprehensive account of the standard of care provided to both Kate and Ms Davies by SaTH, for the facts of this case to be established and for the Trust to formally acknowledge and embed the lessons to be learnt from identified failures. To that end Ms Davies and Mr Stanton have sought the input of external bodies as well as that of SaTH.

Table 1 below details (by year and by organisation) the actions, investigations and (where applicable) investigation findings/outcomes to date, of selected organisations. A more comprehensive table can be seen at appendix 4.

⁹ Compendium of Evidence compiled by Rhiannon Davies and Richard Stanton

Table 1 Complaints, investigations and findings since 2009 – direct quotes are shown in italics.

Year	Organisation	Action	Outcome/Findings (direct quotes given in italics)
2009	SaTH	High Risk Case Review held (also known as Death Review)	<i>This is a routine meeting that does not go into the cause of death and why this happened, but explores events surrounding the incident. This discussion then forms a part of the improvement for service delivery as well as clarifying the events for any discussion with the patients involved.</i> ¹⁰
2009	LSA	Supervisory Investigation	<i>It would seem according to their statements that all three midwives have acted in accordance with their code with respect to their role and duty of care to the baby but the records cannot verify this</i> ¹¹ . <i>It would seem duty of care not breached, but poor record keeping means that it is difficult to qualify this and the root cause analysis</i> ¹² <i>identified that there were also system failure in the formal guidance for transfer of a sick baby.</i> ¹³
2009	SaTH	Formal complaint	SaTH accepted the findings and recommendations of the Supervisory Investigation and the complaint was not upheld.
2009	SaTH	Review of reduced fetal movements – labour ward protocol	Guideline reviewed
2009	West Midlands Ambulance Service	Formal complaint	See below
2009	SaTH and West Midlands Ambulance Service	Investigation of: 1. Events relating to Kate’s transfer by air ambulance. 2. Difficulties in arranging transport to take Ms Davies and Mr Stanton to the neonatal unit.	Investigation undertaken

¹⁰ Quoted from letter to Rhiannon Davies from consultant obstetrician 1, Consultant in Fetomaternal Medicine & Gynaecology, SaTH, dated 3 June 2009,

¹¹ Supervisory Investigation Report, Section 4, (2009)

¹² The investigating SoM has documented in her Supervisory Investigation Report that she undertook a root cause analysis.

¹³ Ibid - Section 5 summary

Year	Organisation	Action	Outcome/Findings (direct quotes given in italics)
2009	NMC	Formal complaint re midwives fitness to practice.	Case closed
2009	NHS West Midlands	Formal complaint	? outcome
2012	HM Coroner	Inquest	Jury found that Ms Davies should not have delivered Kate <i>at the Ludlow MLU and that allowing her to do so caused or contributed more than trivially or minimally to the death of Kate.</i> ¹⁴
2012	SaTH	2 nd formal complaint citing verdict of Coroner's Inquest	Complaint not upheld
2013	NMC	Formal complaint re midwives fitness to practice	Case remains open, on-hold
2013	West Mercia Police	Formal complaint leading to investigation	Found that the allegation of manslaughter against the midwives caring for Ms Davies and Kate and later corporate manslaughter could not be upheld.
2013	Care Quality Commission	Formal complaint	View taken that the case did not fall within Care Quality Commission's remit.
2013	HSEO	Formal complaint leading to investigation	Found that Kate's death was avoidable along with serious failing in Kate's neonatal care by SaTH ¹⁵ .
2013	Health and Safety Executive	Formal complaint	View taken that the case did not fall within Health and Safety Executive's jurisdiction.
2015	SaTH	3 rd formal complaint	<ol style="list-style-type: none"> 1. Apologised unreservedly for the failings identified in the Health Service Ombudsman investigation 2. Acknowledged service failure. 3. Acknowledged failings in the Trust's complaint handling process.

¹⁴ Ibid (n7)

¹⁵ Ibid (n8)

The above table shows that both the jury at the Coroner's Inquest and the Health Service Ombudsman for England's investigation found that Kate's death was avoidable.

The remainder of this report will: provide an expert opinion on the standard of care and treatment received by Kate and Ms Davies; present the findings of a review of the reporting and investigation of the incident of Kate's death and examine the Trust's management of the concerns and complaints raised by Kate's parents, Ms Davies and Mr Stanton.

5.0 Key clinical events

To identify the areas of practice and the standards of care that should have been investigated by the Trust the Reviewer reviewed Ms Davies' clinical records. Key events were identified by the Reviewer from the records and compiled into the following tables:

- Table 3 - Rhiannon Davies - key events in antenatal care
- Table 4 – Rhiannon Davies – chronology of intrapartum key events
- Table 5 – Kate Seren Stanton-Davies - timeline of care from birth to transfer.

These tables are presented below along with the Reviewer's comments for each event.

5.1 Table 2 key events in Rhiannon Davies' antenatal care – direct quotes are shown in italics

Date	Event	Reviewer's opinion
undated	Notification of Pregnancy Form <i>Reasons that may require Additional Care – box for [REDACTED] or disorder' ticked and annotated [REDACTED]</i>	No action documented. This is non-compliant with SaTH guidelines ¹⁶ which states for women presenting with a [REDACTED] history: <i>Amber Light: Refer to Antenatal Triage & Support Midwife at RSH or PRH</i>
17.7.08	Record of Clinical Attendance, entry reads: <i>7+ called in for chat, [REDACTED] very nauseas advised re diet + fluids feeling [REDACTED] advised normal for early pregnancy, also has had small pv bleed and tenderness advised by GP not problem (locum) reassured – to arrange EPAS appt asap¹⁷. Recently moved to area, no family, friends, works from home, can't talk to family at present as they don't know about pregnancy! [REDACTED] [REDACTED], advised if feels that [REDACTED] she can phone us at any time to talk, unable to discuss further as next appt already waiting. Pregnancy info book given</i>	Inadequate response from midwife – [REDACTED] [REDACTED] An emergency referral to the [REDACTED] [REDACTED] health services should have been made and GP and community midwife follow-up arranged. The midwife who saw Ms Davies on this occasion also attended Ms Davies in labour and provided postnatal care to Ms Davies and Kate. Henceforth referred to as midwife 2
2.8.08	Booking History: [REDACTED] box was ticked [REDACTED]' box was ticked and annotated [REDACTED] 1 [REDACTED] [REDACTED] [REDACTED]	No action documented. This is non-compliant with SaTH guideline ¹⁸ which states: <i>Antenatal Care Weak/Moderate Predicting Factors [REDACTED]) If the [REDACTED]) score and clinical interview identifies weak predicting factors, it will be necessary to identify a strategy of care, which incorporates supportive visits and active reflexive listening.</i>

¹⁶ Booking Criteria for the Shropshire Maternity Service Ref No: 3722 (Nov 2008 – Dec 2008)

¹⁷ There is no documented evidence that Ms Davies received a referral and Ms Davies confirmed with the Reviewer that she had not received a referral

¹⁸ [REDACTED] in Pregnancy Ref No 3729 (Dec 2006 – Dec 2008)

Date	Event	Reviewer's opinion
Contd.		<i>Delivery:</i> <i>Each case needs to be reviewed individually¹⁹ and it will be necessary to evaluate the need for delivery on the Consultant unit.</i> Source: bullet 5.3 (Reviewer's emphasis)
2.8.08	Pregnancy Health Records Box for planned place of confinement not completed	There is no documented evidence of a discussion between a care professional and Ms Davies re the risks, benefits and alternatives of place of birth.
10.11.08	Seen by consultant obstetrician 1 in ANC entry in clinical records reads ' <i>RIF pain irregularly last ~ 30 secs, in region of (illegible) Low risk care + delivery</i> ' ²⁰	No written evidence of consideration or awareness of [REDACTED] and [REDACTED] [REDACTED] [REDACTED] This is a missed opportunity to evaluate the need for Ms Davies to deliver on the Consultant Unit as per guideline
23.11.08	Home visit by cmw ' <i>long discussion re moods feeling generally well. Will make necessary referrals</i> '. ' <i>consented to referral to GP +HV + to (Clinical Nurse Specialist [REDACTED] [REDACTED] [REDACTED] clinic. Will arrange referral mane + telephone Rhiannon re details.</i>	See below for comments
24.11.08	DW (names midwife) <i>who will forward referral to me via email. Clinical Nurse Specialist doing clinic tomorrow who will pick up referral + phone Rhiannon tomorrow. Referred to GP + HV. DW names Health Visitor</i>	No written evidence that the referral plan was actioned. Ms Davies informed the Reviewer that she did not have contact with Clinical Nurse Specialist during her antenatal period.
14.2.09	<i>19.30hrs 'no fetal movements today. Visiting on unit (Ludlow MLU) feels FMs have been reduced for past 2 days..... CTG commenced. FMS x 5 during trace long CTG as few accelerations only, lots of uterine activity experiencing irregular painful Braxton Hicks... final 10 minutes of trace more reactive.....faxed to RSH and let Rhiannon know outcome.</i>	Ms Davies was in her 38 th week of pregnancy. This was the first reported incidence of reduced fetal movements. This was the first documented cardiotocograph (CTG) trace. Good practice to advise Ms Davies to re-attend for USS

¹⁹ This is particularly pertinent as Ms Davies had disclosed [REDACTED]

²⁰ There is no written evidence that an informed discussion occurred re place of birth or that Ms Davies was informed of the co-located MLU at RSH at this consultation.

	<i>21.20hrs spoke to wd 20 CTG satis rang Rhiannon + informed her. Pains</i>	
Date	Event	Reviewer's opinion
	<p><i>settled, feeling less anxious. Has appt in 4/7 knows to monitor FM's.</i></p> <p><i>21.30hrs ward 20 rang back – following discussion between L/W sisters they feel that Rhiannon should come to PANDA (Day-Assessment ward) tomorrow for an USS to assess fetal wellbeing. Rhiannon not contacted again this evening in view of her [REDACTED] to ring mane</i></p>	

15.2.09	<p>Unable to contact Rhiannon during morning until 13.30 no scan available in Panda this pm therefore appointment made by [REDACTED] for 16.00 on 16/2/09. Rhiannon informed FMs still reduced today so far advised CTG in Ludlow again today.</p> <p>Pm called into unit for CTG unreactive trace of baseline FH ~130bpm reduced variability tightenings evident. Faxed to and d/w Sr (illegible) on wd 20. To review a further 20 minutes trace. Further trace unreassuring – for transfer to wd 20 RSH.</p> <p>19.15hrs admitted to RSH. History taken and abdominal examination performed. '19.20hrs CTG commenced.</p> <p>19.40hrs CTG initially unreactive. Baseline 140bpm, reduced variability. Different positions tried.</p> <p>20.15 CTG has been reactive for 20 mins with a few FMF. To discuss with Registrar'.</p> <p>Dr's r/v ? grade 'CTG baseline good variability acc+ °Dec Prev CTG – no accelerations. No scan slot today. Plan:</p> <ul style="list-style-type: none"> - To stay in - Rpt CTG later tonight 10 – 11pm - ? sweep - ?? Clinical Nurse Specialist (perinatal [REDACTED]) ref if any concerns (did not want to talk today) Leave until scan done. <p>22.00 CTG commenced. Reactive good beat to beat variability to ward 19.</p>	<p>This is the second reported incidence of reduced fetal movements.</p> <p>This is the second documented CTG trace</p> <p>This is Ms Davies first antenatal admission</p> <p>This is the third documented CTG trace</p> <p>This is the fourth documented CTG trace</p>
Date	Event	Reviewer's opinion
16.2.09	<p>08.00 CTG 'reactive trace with accelerations. Fetal movements now felt. Awaiting scan for liquor volume + growth + Doppler. 11.00hrs S/B (consultant obstetrician 2) on ward round – no need for growth on scan at 38/40. 12.00hrs ultra sound scan performed. Good liquor volume at 5cm</p>	<p>This is the fifth documented CTG trace.</p> <p>Second opportunity missed by a consultant obstetrician to discuss place of birth with Ms Davies</p> <p>The inability for Ms Davies to be reviewed by the [REDACTED]</p>

	<i>pool and EDF present. Dr's happy with scan – may go home. 12.30 spoke to names (■■■■■ ■■■■■ Health service) – she cannot see (Ms Davies) before she delivers – so discussed re postnatal consideration of her postnatal needs.</i>	■■■■■ ■■■■■ service in a timely manner should have been raised as a service issue and the capacity of the service to meet demand reviewed.
20.2.09	<i>20.00 Called unit with h/o ↓FM today – to have dinner and a cold drink and will call back in 1hr. 21.00 x2 movements since earlier call, calling in for CTG at 11.30 tomorrow.</i>	This is the third reported incidence of reduced fetal movement
21.2.09	<i>CTG – unreactive initially then reactive faxed to wd 20 all OK</i>	This is the sixth documented CTG trace
25.2.09	<i>Maternity unit Royal Shrewsbury Hospital 18.35 Referred via GP c/o (r) sided chest pain. SOB since 21/2/09. Sudden onset painful to touch + breathe deeply. Went to routine antenatal check today + midwife asked Rhiannon to see GP. S/B GP – unsure of diagnosis so referred to ward 20. Observations were taken and abdominal examination performed. CTG commenced. Following a doctor's review an impression of 'muscular skeletal ?PE' was noted. The plan of care was made: weightv Tinz + tedsv Analgesia MSU V/Q mane Bloods for FBCv/U+Ev/CRPv</i>	This is Ms Davies' second antenatal admission This is the seventh documented CTG trace
26.2.09	<i>11.00 S/B (consultant obstetrician 3), for ECG + VQ scan. 11.30 ECGV VQ form sent 15.00 X-ray department called – VQ machine being serviced today therefore</i>	Third opportunity missed by a consultant obstetrician to discuss place of birth with Ms Davies
Date	Event	Reviewer's opinion
	<i>VQ scan cannot be done until tomorrow. They will call with time when known.</i>	
27.2.09	<i>10.30 Off to VQ scan 11.50 FMs good, FHHReg (with) sonicaid 140bpm. CTG commenced.</i>	This is the eighth documented CTG trace

	12.50 CTG reactive + reassuring, active fetus, accelerative (therefore) disc. Dr's review VQ Scan – normal – discharged home with 'GP f/u as required'.	
--	--	--

5.2 Table 3 key events in Rhiannon Davies' intrapartum care – direct quotes are shown in italics

Time	Event	Reviewer's opinion
00.20	Care by m/w 1 Admitted with history of contractions entry reads ' <i>investigated 2 days ago for ?PE in Rt side of chest – apparently NAD. Notes in RSTH and nil in hand held records. Sr on ward 20 contacted – to check hospital records – all investigations NAD ... 'low-risk suitable for Ludlow'contractions now 1-3-4 good. TENS in use with good effect. FHH 130R</i>	This is non-compliant with SaTH guideline ²¹ which states: <i>If the medical records are unavailable on site, then the relevant information should be faxed to the appropriate unit for review, adhering to the principles of confidentiality '</i>
02.05	<i>VE to assess as conts stronger now. 5cms dilated FHH ↓100bpm on completion with FMs + Quick recovery of FHRate – 130</i>	There is no documented record of maternal position or the maternal pulse rate during the deceleration of the fetal heart (FH). This is non-compliant with SaTH guidelines ²² which states: <i>It is important to differentiate the fetal heart rate from maternal pulse by palpating the maternal pulse and comparing the rate with the fetal heart.</i>
02.08	<i>FH 130R Rhiannon + Richard pleased with progress</i>	The entry notes that the FH following the recorded deceleration was 130 (value not noted). There is no record of how long the midwife listened to the fetal heart, whether she listened during and after a contraction. This is below the expected level of record keeping ²³
Date	Event	Reviewer's opinion
02.08 contd		The FH was documented twice following the recorded deceleration: @ 02.08 and 02.10. There is no record of whether these recordings complied with best practice of listening during and after a contraction for a minimum of 60 seconds.

²¹ Intrapartum Care of the Midwife Led Unit or Home Birth Ref No: 0303 (2006)

²² Ibid

²³ Guidelines for records and record keeping (NMC 2002)

02.10	<i>B/P 130/76 Contractions 1-2-3 FH 130R No further decelerations hear. Rhiannon wishes Pethidine now.</i>	<p>Pethidine 50mgs IM was administered 10 minutes following the recorded FH deceleration. As Pethidine may cause short-term fetal respiratory depression,²⁴ good practice would indicate that midwife 1 should have encouraged Ms Davies to continue use of Entonox until a longer period of assessment of the FH could have been undertaken</p> <p>From 02.30hrs – 09.00hrs the fetal heart rate was recorded in either the clinical records or on the partogramme every 30 minutes (except between 04.00 and 04.10hrs) This is non-compliant with NICE²⁵ and SaTH guidelines²⁶ which states: <i>The fetal heart rate should be auscultated in line with the NICE Guidelines (2001) ie every 15 minutes in the first stage of labour</i></p>
04.10	<i>VE to assess prior to second dose of Pethidine</i>	<p>Vaginal examinations were performed at:</p> <ol style="list-style-type: none"> 1. 02.05hrs – <i>to assess as contracting stronger now</i> 2. 04.10hrs – <i>to assess prior to Pethidine</i> 3. 07.15hrs – <i>to assess progress</i> 4. 08.20hrs – <i>to assess</i> 5. 09.15hrs – <i>with consent to confirm 2nd stage</i> <p>This is non-compliant with NICE guidelines²⁷ which states: <i>Vaginal examination 4hrly, or where there is concern about progress or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).</i></p>
08.20	<i>Slight pale ? meconium in blood stained show on pad</i>	<p>There is no further documented assessment in the clinical record or partogramme of liquor assessment. This is below the expected standard of record keeping²⁸ and non-compliant with NICE guidelines²⁹ which states:</p>
Date	Event	Reviewer's opinion
08.20 Contd.		<i>Continuous EFM (electronic fetal monitoring) should be considered for women with light meconium-stained liquor depending on a risk assessment which should include as a minimum</i>

²⁴ Intrapartum care: management and delivery of care to women in labour, NICE (2007)

²⁵ Ibid

²⁶ Ibid (n21)

²⁷ Ibid (n24)

²⁸ Ibid (n23)

²⁹ Ibid (n24)

		<i>their stage of labour, volume of liquor, parity, the FHR and, where applicable, transfer pathway.</i>
08.45	Ms Davies care was taken over by midwife 2	
09.15	VE confirmed 2 nd stage of labour..... <i>FHHR on completion</i> (value not stated) Fetal heart rate documented in clinical record as follows: ➤ 09.20hrs – <i>FH 132bpm</i> ➤ 09.40hrs – <i>FH slight decelerations with contractions ↓80bpm but good recovery.</i> ➤ 09.50hrs – <i>FH still small decelerations but good recovery</i>	This is non-compliant with NICE ³⁰ and SaTH guidelines ³¹ which states: <i>The fetal heart rate should be auscultated every five minutes for a minimum of sixty seconds and recorded in the labour notes.</i> When interviewed by the investigating SoM midwife 2 stated ‘ <i>I listened every 5 minutes, but didn’t write it down because I was wearing gloves and had to ensure hands were clinically clean</i> ’ Documenting contemporaneous records during the second stage of labour is a requirement (and therefore a standard procedure) for all midwives. Midwife 2 (or someone assisting her) must have held either a sonicaid or pinnard to listen to the FH therefore could have documented the FH rate. Similarly following confirmation that Ms Davies was in the second stage of labour a further 6 entries have been written in the clinical notes. It is therefore unclear why the FH rate could not have been documented at the same time. See below for further discussion.
10.03	<i>Normal delivery live girl Apgars 9@1 9@5 No apparent abnormalities, baby pale, floppy reluctant to feed. Passed meconium at birth not pu’d</i>	The assigned Apgar score does not match the description of Kate @ 1 and 5 minutes. A baby assessed as ‘pale’ would score 0 for colour ³² and ‘floppy’ would score 0 for tone ³³ giving a possible maximum Apgar score of 6. SaTH guidelines for neonatal resuscitation states: <i>Those babies with a low APGAR score (below 7) will have their care and management fully investigated through the Clinical Risk reporting scheme.</i> ³⁴

5.3 Table 4 Care timeline for Kate Seren Stanton-Davies from time of birth to transfer 1st March 2009

Name/Source	Time: 10.03	Reviewer’s opinion
-------------	-------------	--------------------

³⁰ Ibid

³¹ Ibid (n21)

³² To score ‘1’ for colour the baby’s body would be assessed as pink.

³³ To score ‘1’ for tone the baby’s arms and legs would be assessed as having some flexion

³⁴ Neonatal Resuscitation and when to summon assistance, Ref No 3754 (2006)

Midwife 2 clinical notes	Kate assigned Apgars 9@1 9@5 Kate was placed on Rhiannon's abdomen The cord was clamped and cut by Richard. <i>baby pale, floppy reluctant to feed. Passed meconium at birth not pu'd. Temp 36.06°c skin to skin with extra blankets on</i>	Both midwife 2 and midwife 1 have used the term 'floppy' to describe Kate's tone at birth. This calls in to doubt midwife 2's later revised description of Kate having 'poor tone' at birth. See below for further discussion. Midwife 1 has stated that the resuscitaire had been prepared for Kate's birth. Good practice would have been to transfer Kate to the resuscitaire to make a full assessment at 5 minutes rather than leaving her on her mother's abdomen.
Midwife 2 statement	Kate was covered with a towel by Sr Midwife 1 when placed on Rhiannon's abdomen. <i>... the baby was quiet but did cry a couple of times. I have recorded on the baby Shannon (cardex system) that the baby was floppy at delivery this should have been recorded as poor tone, no resuscitation was required and the apgar should have been recorded as 8.</i>	
Midwife 1 Statement	<i>Approx 09.45 returned to the labour room..... I checked the resuscitaire and heater were turned on and the baby clothes and towels were warming. I prepared the syntometrine for active 3rd stage having prior consent from Rhiannon. The fetal heart rate was heard 120bpm at this time. At 10.03 normal delivery of a live girl onto Rhiannon's abdomen skin to skin with a warm towel over baby. The baby cried twice then remained quiet in mother's arms.</i>	
Midwife 1 SoM interview	<i>I agree that the baby was pale and floppy and would have loss (sic) a score for each one of these, if you ask me the apgar I would have assess (sic) it to be 7/1 or 8/1</i>	
Midwife 2 evidence HM Coroner's Inquest	Kate had 'poor tone' at birth rather than presenting as 'floppy'. <i>'We are not trained to listen to a heart rate for an APGAR score'</i>	Listening to the heart rate with a stethoscope is a required competency for midwives undertaking Apgar score assessments.

Name/ Source	Time: 10.15	Reviewer's opinion
Midwife 2 clinical notes	Placenta + membranes delivered by CCT. 2° tear to perineum noted.	As Kate was noted to be 'pale' and 'floppy' at 1min and 5mins good practice would have been to reassess her Apgar score at 10mins.
Midwife 1 statement	<i>3rd stage was completed. Assisted Sr midwife 2 to weigh the very large placenta. Sr midwife 2 examined the placenta.</i>	
Name/ Source	Time: 10.20	Reviewer's opinion

Midwife 2 statement	<i>Attempted to put baby to breast at 10.20hrs but she wasn't interested so we left her skin to skin against the breast I checked her temperature via the axilla and found it to be 36.06 so changed her towel to a dry one and placed another dry towel doubled over baby and Rhiannon ensuring that her head was covered, and leaving her skin to skin.</i>	<p>This is non-compliant with SaTH guidelines³⁵ which states:</p> <ul style="list-style-type: none"> • Provide for the baby's nutritional needs • place in hot cot/incubator <p>A plan of care should have been written by midwife 2</p> <p>The SoM's interview notes records midwife 2 as stating '<i>I consider 36c to be Okay – the baby didn't feel cold</i>'. In her evidence to the Coroner midwife 2 did not recall making this statement.</p>
Midwife 1 statement	Went off duty	

Name/ Source	Time: 10.30	Reviewer's opinion
Midwife 2 clinical notes	<i>(Kate) wrapped warmly given to dad to cuddle slight, grunting, baby remains pale floppy.</i>	Kate was now 27mins old. She was hypothermic, pale, floppy, reluctant to feed and grunting.
Midwife 2 statement	<i>A client arrived at the unit for a check I asked NA 1 to ask them to return at another time as I wanted to suture Rhiannon first. I sutured Rhiannon and during this procedure baby was given to Richard to cuddle</i>	Midwife 2 should have recognised the signs of deviation from the norm, telephoned RSH neonatal unit for advice and arranged for Kate to be transferred to the neonatal unit at RSH. Consideration should also have been given to the time it would take to transfer Kate to the neonatal unit as Ludlow MLU is a standalone unit situated 30 miles from RSH.

³⁵ Neonatal Care (including: neonatal thermoregulation, hypoglycaemia and the neonatal hypoglycaemia guideline as appendix 1) Ref No 0307 (Oct 2008 – Oct 2010)

Name/ Source	Time: 10.45	Reviewer's opinion
Midwife 2 clinical notes	Perineal repair carried out.	There is a discrepancy in midwife 2's documented clinical notes and her statement of the time Kate was noted to start grunting. The Supervisory Investigation did not explore this discrepancy. Kate was now 42minutes old she remained hypothermic, pale, floppy, grunting and not feeding – midwife2 should have expedited transfer.
Midwife 2 statement	<i>It was approximately 10.45when (Kate) started to grunt a little, this was an expiratory grunt and when I observed the baby, after completion of the suturing, there was no nasal flaring or intercostal recession.</i>	

Name/ Source	Time: 11.00	Reviewer's opinion
Midwife 2 clinical notes	<i>Attempted to BF again reluctant, poor sucking reflex. Mum wishes bath so baby dressed warmly Vit K 0.1ml given IM.</i>	There is a lack of recognition of the seriousness of Kate's symptoms. In addition to Kate's previous disinterest in feeding midwife 2 has noted that Kate was now showing a 'poor sucking reflex'.
Midwife 2 statement	<i>Another client arrived again she was asked to return but she wished to wait. After suturing Rhiannon's second degree tear we attempted to put baby back on the breast as she was still grunting and I felt she needed to feed we tried both breasts but baby still wouldn't feed, she had a very poor sucking reflex. Baby felt warm to touch so I left Rhiannon cuddling baby skin to skin to attend the other client.</i>	

Name/ Source	Time: 11.15	Reviewer's opinion
Midwife 2 clinical notes	N.B. There are no further contemporaneous notes documented for either Kate or Ms Davies. ³⁶	Actions were non-compliant with SaTH guidance ³⁷ as discussed above. Midwife2 did not telephone the neonatal unit to advise them of her plan to transfer Kate. A plan of care should have been written. There is a discrepancy in timing between the documented clinical record and midwife2's
Midwife 2 statement	<i>I checked Rhiannon's observations as she had requested a bath, these were OK so NA 1 ran the bath and assisted Rhiannon in to the bathroom, Richard went home and baby was placed in a cot. Whilst Rhiannon was in the bath, I checked Kate over, she remained pale and her temp hadn't risen it remained at 36 degrees, I auscultated her chest with a stethoscope everything sounded normal at this time, so I gave the Vit K dressed her and wrapped her</i>	

³⁶ During her SoM interview midwife Midwife 2 stated that she had written her notes '4hrs after the event'

³⁷ Ibid (n35)

Name/ Source	Time: 11.15	Reviewer's opinion
Contd.	<i>warmly, she was still grunting but there were still no other signs of respiratory distress, but I wasn't happy so decided then that I would transfer her to RSMH when Rhiannon was out of the bath. I did not perceive this to be a 'blue light' situation at this time.</i>	statement of the time when Kate was dressed warmly.

Name/ Source	Time: 11.20	Reviewer's opinion
Midwife 2 statement	<i>At 11.20 the other mum in the ward was waiting to go home I went and checked her did a nursery exam on the baby and advised all letters would be brought to her home tomorrow when we visited.</i>	<p>At this point midwife 2 and NA 1 were providing care for the following :</p> <ul style="list-style-type: none"> • Ms Davies + Kate • 1 woman + baby postnatal care/transfer to community • 1 woman arrived for a 'check' but sent home to return 'later'. In addition • At approx. 11.30 'another lady arrived for a check' <p>The MLU policy for the ratio of midwife to woman and escalation during times of high activity should have been reviewed as part of the investigation.</p>

Name/ Source	Time: 11.30	Reviewer's opinion
Midwife 2 statement	<i>Another lady arrived for a check at approx. 11.30 I started to do her check but hadn't got a sonic aid so returned to the delivery room for one, Rhiannon was coming out of the bath and was feeling a bit faint so NA 1 got a chair from the bathroom and we sat Rhiannon down, NA 1 got a cold cloth to place on her forehead, it was at this time I told Rhiannon that I wasn't happy with babe and was going to transfer her, she was very upset and cried I tried to explain that it was best for baby and I would sort out an ambulance, it was at this time that NA 1 touched my shoulder and asked me to check baby. Baby was lifeless, she was quiet, and not responsive to stimulus had very poor tone</i>	<p>Between 11.15hrs when Kate's observations were taken and her being found by NA 1 there is a possible period of ±20 min when Kate was unobserved.</p> <p>This gap was not explored in the Supervisory Investigation.</p> <p>To establish the facts a full statement was required from NA 1.</p>

Name/ Source	Time: 11.35-11.49	Reviewer's opinion
Midwife 2 clinical notes	<p><i>Baby went quiet, looked at baby, unresponsive to response stimulation, baby to resuscitaire O² given via face mask, 5 long rescue breaths, cardiac massage given. HR 80bpm lungs sound clear. 999 call made paramedic arrived, still giving baby O² via face mask and HR remains 80bpm. BS by paramedic 25.6 oral airway inserted face mask change to portable baby lungs now sounding very crackly. To air ambulance stat → Heartlands hospital</i></p>	<p>There is a discrepancy in the time the 999 call was placed. In her statement midwife 2 states that she called 999 at 11.38hrs (as logged by ambulance control) however at the Death Review meeting³⁸ the ambulance service reported the time that the 999 call was logged as 12.07hrs – a difference of 29 mins.</p>
Midwife 2 statement	<p><i>I phoned 999 (see below for further information).... with the phone on speaker beside us and placed baby on the resuscitaire turning on the heater I also contacted Wd20. I commenced active resuscitation, on my own as NA 1 was coping with Rhiannon who was distraught. I checked Kate's airway with a laryngoscope and found it to be clear, baby was dressed so I can't comment on chest midwife 1 movements at this time, but I put the stethoscope under her vest opening up her baby grow, she had a pronounced bradycardia, her heart rate was below 40bpm, so I gave 5 rescue breaths via a face mask and listening to her heart with a stethoscope I commenced cardiac massage, she seemed to respond after the second set of rescue breaths and she was breathing unaided, but I left the O² in place over her face, her heart rate improved slightly but was still only 80bpm, I continued cardiac massage, her chest suddenly went very crackly on both sides and I was struggling to hear her heart rate, and was very glad when the paramedics arrived, I can't remember exact times and I didn't turn the clock on, on the resuscitaire, they changed her oxygen to their portable cylinder put a different face mask on that showed she was breathing unaided, he (paramedic) did a BM was 26.5 and asked his partner to call for the air ambulance he put in an airway.</i></p>	<p>The timings of events and the actions taken by midwife 2 following Kate's collapse have not been established.</p> <p>The transcript of the 999 call placed by midwife 2 (seen by the Reviewer) records that she did not inform Ambulance Control that she had commenced cardiac massage. Furthermore in the statement made by the paramedic who first attended Kate (and seen by the Reviewer) it states at point 7 that on his arrival at 12.17hrs Kate was being administered oxygen 'no resuscitation was taking place at this time', and at point 15 that the midwife had given him a history of 'severe respiratory distress'.</p> <p>The issue of the difference in recorded timings was investigated by SaTH as part of the Trust's collation of evidence for the pending Coroner's Inquest. An email seen by the Reviewer states 'the clock used by the PCT owned phonex system in Ludlow at the</p>

³⁸ SaTH Death Review notes dated 30.04.09

		<i>time, was not accurate, Therefore any phone logs would not reflect the actual time they took place³⁹.</i>
Midwife 2 statement contd.	<i>I asked NA 1 to tell everyone waiting to go home and call [REDACTED] as the on call midwife was an hour away.</i>	<p>The issue of the 'on-call' midwife being an hour away was investigated by SaTH. The Reviewer has seen the following statement⁴⁰ 'At SaTH there is an expectation that an on call midwife/on call manager should live within 40 minutes of the unit.'</p> <p>Assistance from paramedics was available to midwife 2 within 10 minutes of placing a 999 call. She should have utilized the skills of NA 1 by requesting her to:</p> <ul style="list-style-type: none"> • place a 999 call whilst she commenced resuscitation • Assist with the resuscitation⁴¹ and document events/actions.

Name/ Source	Time: 11.50	Reviewer's opinion
Midwife 3 statement	<i>At approx. 11.50 NA 1 called asking me to attend immediately. I was not on call at this time and was about 10mins drive away. The mw who was on call at that time lives at least 45 mins drive time from Ludlow.</i>	It was inappropriate for midwife 2 to call [REDACTED] to assist in an emergency. It was commendable for [REDACTED] to attend when called. See below for further discussion

³⁹ Email from Patient Experience Advisor, Women & Children to, Head of Patient and Corporate Services dated 3rd August 2012

⁴⁰ On-call arrangements for Maternity staff working in the MLU's – senior midwife (unsigned/undated)

⁴¹ Nursing Assistants deployed to Midwifery Led Units receive basic neonatal life support training

Name/ Source	Time: 12.00	Reviewer's opinion
Midwife 2 statement	████████ arrived and I asked her to check baby's heart rate, we heard the air ambulance arrive, and I was asked to get some details to take with baby, I wrote some information on a cot card and when I returned they were all in the ambulance with the doors closed and ██████████ was sat in the back of the ambulance with the baby, I gave the card to the driver	The sequence of events is unclear. The 999 call was logged by the ambulance service at 12.07hrs. Midwife 3 has stated that she was called by NA 1 at 11.50hrs. This is before the time the 999 call was placed.
Midwife 3 statement	When I arrived at the unit an ambulance had arrived. On entering the ward I could see that NS 1 was attempting to console Rhiannon Davies who was lying on the bed in a very distressed state. NA 1 sent me to the labour room. On entering the room I saw baby Davies on the resuscitaire with Sr midwife 2 in attendance. Two paramedics were also in the room. I approached the baby who was very pale an oral airway had been inserted and oxygen was being administered by a facemask. Midwife 2 told me that the baby was approx 2 hrs old and had become unresponsive. She then left the room to sort out some paperwork and I stayed with the baby. Baby was floppy with no tone.	To establish the facts a full statement should have been requested from ██████████. The Reviewer could find no further evidence of actions taken by SaTH to investigate this time discrepancy.

Name/ Source	Time: 12.05	Reviewer's opinion
Midwife 3 statement	After approx. 2 mins the paramedic was informed that the air ambulance was about to land he then picked up the baby from the resuscitaire and asked me to carry the portable oxygen cylinder and some hand luggage to the ambulance as soon as we entered the ambulance it left to meet the helicopter with myself accompanying the baby.	It is unclear why midwife 2 did not swap places with midwife 3 and accompany Kate when she was transferred by land ambulance to the air ambulance. As the case midwife, midwife 2 was the best placed person to provide a detailed handover to the paramedics and air ambulance doctor.
Midwife 2 statement	I wrote some information on a cot card and when I returned they were all in the ambulance with the doors closed and ██████████ was sat in the back of the ambulance with the baby, I gave the card to the driver.	
Midwife 2 SoM interview	Question – who accompanied baby in Air ambulance and why? Response midwife 3 was in the transfer ambulance but she did not accompany the baby in the air ambulance.	
Kate's transfer and the subsequent events has been the subject of an earlier investigation undertaken by SaTH and WMAS and are not within the scope of this review.		

6.0 Missed opportunities or areas of poor practice identified in relation to Rhiannon Davies and Kate Seren Stanton-Davies' care

6.1 Investigations undertaken by SaTH following Kate's death

On the 30th April 2009 a High Risk Case /Death Review meeting into the events surrounding Kate's death was held by SaTH. To assist in identifying contributing issues this meeting relied on the LSA Supervisory Investigation, the records documented in Ms Davies' clinical notes and the attendance of the two case midwives⁴². The issues identified at this meeting related to: standards of record keeping, compliance with guidelines when monitoring the fetal heart during labour, documentation of management plans and the availability of 'on-call' midwives for MLUs. For further discussion please see Clinical Governance section below.

6.2 Issues identified by the Reviewer not identified by SaTH

The Reviewer has identified the following events and areas of practice that should also have been identified and investigated by SaTH:

6.2.1 Failure to identify a sick neonate

Midwife 2 failed to recognise deviation from the norm in the neonate. At 10.30hrs Kate was hypothermic, pale, floppy⁴³, reluctant to feed and grunting. It is the Reviewer's opinion that given the whole clinical picture, Kate did not present as a normal neonate and therefore midwife2 should have sought medical advice and expedited transfer. In particular the following questions should have been investigated:

- Apgar score – if Kate was placed on her mother's abdomen covered with a towel, was it possible to accurately assess her heartrate and respiratory effort? Why was the heated resuscitaire not used to examine Kate given that she was assessed as 'pale' and 'floppy'? Why was the Apgar assessment not repeated at 10 minutes in line with good practice?
- No plan of care - why did midwife 2 not document a plan of care for Kate?
- Did not seek advice - why did midwife 2 not telephone the neonatal unit at RSH for advice? Did she consider the delay in transfer time given the distance from Ludlow MLU to RSH?
- Discrepancy in the timings for when Kate:
 - Commenced grunting
 - Was dressed warmly by midwife 2
 - Was found in a state of collapse in her cot by NA 1
- Midwife 2 failed to prioritise Kate's care. Another occasion when midwife 2 failed to prioritise needs can be evidenced when she saw Ms Davies for an antenatal appointment on 17th July 2008 and failed to refer Ms Davies for an emergency perinatal [REDACTED] review.

⁴² Midwife 2 and Midwife 1

⁴³ In her evidence to the Coroner, midwife 2 stated that Kate had lacked tone rather than presented as 'floppy' and that she was '*not alabaster*' white. It is the Reviewer's opinion that a newborn presenting with an initial lack of tone, of itself would not be abnormal. However in conjunction with Kate's other signs, and given that Kate was never noted to have gained full tone, any lack of tone should have been recognised as abnormal.

6.2.2 Failure to establish the facts

Both midwife 2 and midwife 1 attended the Death Review meeting held to discuss the case on 30th April 2009. The Reviewer was informed that as both midwives were in a state of distress during the meeting, those present found it difficult to obtain a clear account of the events from Kate's birth until her transfer.

It is the Reviewer's understanding that an alternative opportunity for midwives 2 and Midwife 1 to provide an account of their practice was not afforded to them. SaTH therefore failed to take effective actions to establish the facts and failed to hold the midwives to account for their practice. In particular SaTH failed to establish the time Kate was found in a collapsed state in her cot and the sequence of events/actions taken between finding her collapsed and the placement of the 999 call – a possible period of ± 32minutes.

In her statement, submitted as part of the Supervisory Investigation, [REDACTED] stated that she was called by NA 1 at 11.50hrs – a period of 17 minutes before the 999 call was placed (see section below for further information). It is unclear how both [REDACTED] and midwife 2 made the same error in the timing of when NA 1 called [REDACTED] as the time of the call could have been traced via [REDACTED]'s phone records.

6.2.3 Operational Policy Ludlow MLU

Midwife 2 relied on an off-duty midwife whom she knew lived close to Ludlow MLU, to come to her assistance. Although it was commendable of [REDACTED] to attend when called, it was inappropriate for her to have been asked. The policies for Ludlow MLU emergency procedures, including escalation of staff during times of high activity or emergency, communication standards and neonatal transfer should have been utilized. The Reviewer was informed that c2009 operational issues relating to Ludlow MLU were incorporated into several policies rather than a specific Operational Policy for Ludlow MLU.

The Reviewer has reviewed the relevant guidelines and noted the following:

- Despite reviewing all submitted documentation no definitive guidance for the operating of Ludlow MLU c2009 could be found.
- A lack of clarity regarding Trust 'guidelines' and 'policies'⁴⁴. This was evidenced by a copy of the Maternity Escalation Guideline (2010)⁴⁵ (post incident date) seen by the Reviewer in which, although titled as a 'guideline', the introduction states '*this escalation policy*'. The Reviewer suggests this is another example of weak clinical governance arrangements c2009.
- The current Operational Policy for Ludlow MLU⁴⁶ (2015) does not clearly set out: guidance and instruction for staff working in the service; how compliance with the policy will be monitored. It is of concern to the Reviewer that this policy is non-compliant with Trust standards.

⁴⁴ Guidelines are intended to reduce unacceptable or undesirable variation but can be deviated from. Policies are rigid statements allowing little or no variation or flexibility.

⁴⁵ Maternity Escalation Guideline, Version 1, first developed June 2010, SaTH

⁴⁶ Operational Policy for: Ludlow Maternity Unit, Version 1, July 2015, Women and Children's Care Group, SaTH

6.2.4 No documented evidence of place of birth discussion

All providers of NHS services have a responsibility to ensure that service users are provided with the information required to make an informed choice. There is no documented evidence of a discussion between a care professional and Ms Davies regarding the risks, benefits and alternatives of place of birth including ensuring that Ms Davies understood that her choice of place of birth would affect the choice of pain relief available to her.⁴⁷ Ultimately, however, the choice of place of birth should be that of the woman, rather than providers adopting a paternalistic approach⁴⁸.

Ms Davies was admitted twice during her antenatal period. On both occasions her care and treatment was compliant with local and national guidelines c2009. However Ms Davies was reviewed by three consultant obstetricians during her two antenatal admissions. Each of these occasions provided an opportunity for Ms Davies' whole clinical picture to have been taken into consideration and an individualised plan of care made.

It is the Reviewer's opinion that as Ms Davies had been admitted on two occasions and had required eight CTG traces to be taken during the continuum of her pregnancy, the option of birthing at the co-located MLU should have been offered as one of her place of birth choices. This option would have mitigated the requirement for Ms Davies to be transferred to the maternity unit at SaTH by ambulance should such an event have proven necessary.

It is not within the remit of this review to provide an opinion as to whether Ms Davies was suitable to birth at Ludlow MLU. This has been reviewed both during the HM Coroner's Inquest and the investigation undertaken by the Health Service Ombudsman for England⁴⁹.

6.2.5 Continuity of antenatal care

From the signatures in her antenatal records Ms Davies appears to have received antenatal care from more than 5 midwives. This lack of continuity of carer is highly likely to have contributed to the failure to carry out the referrals Ms Davies required^{50,51}.

6.2.6 [REDACTED] pathway

The inability for Ms Davies to be reviewed by the [REDACTED] [REDACTED] [REDACTED] service in a timely manner should have been identified as a service issue and the capacity of the service to meet demand reviewed.

⁴⁷ Maternity Matters: Choice, access and continuity of care in a safe service, DH (2007)

⁴⁸ Paternalism represents the concept that a professional knows better than a competent adult

⁴⁹ Ibid (n8)

⁵⁰ It is well documented that the greater the number of 'hand-offs' (i.e. the transfer of information, authority and responsibility) which take place in a patient's care, the greater the risk that one will be ineffective which can contribute to serious risks in healthcare delivery. For further information see <http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf>

⁵¹ Review of SaTH maternity services (2013) Lack of continuity during the antenatal period was identified as an issue and noted '*locality issues around named midwife versus different midwives emerged – this had repercussions around choice as well as the quality and continuity of care, communications, relationship building and the 'mechanistic' approach to appointment's*'.

6.3 Action plans

The actions to be taken by SaTH in response to Kate’s death were initially identified and developed from the findings of the High Risk Case/Death Review and LSA Supervisory Investigation. As this review has established, neither of these investigations identified all of the issues relating to Kate’s death. The subsequent action plans are therefore limited.

However, in response to the findings of the Coroner’s Inquest into Kate’s death, further action plans were developed by SaTH. The Reviewer has reviewed all of the action plans submitted as part of this review and found that the monitoring and completion of actions are within the expected standards.

It should be noted that to date, Ms Davies and Mr Stanton have not been formally informed by SaTH of the lessons learnt from Kate’s death and the subsequent actions taken by the trust. Evidence was, however, submitted by the trust to the Coroner as part of the Inquest into Kate’s death.

Table 5 below shows the actions, reported as completed from all action plans, as seen by the Reviewer.

Table 5 actions reported as completed from all action plans

Issue	Reported completed actions
Ms Davies reported reduced fetal movements	<ul style="list-style-type: none"> • Review of documented care given to Ms Davies against the reduced fetal movements guideline • Guidance in relation to Reduced Fetal Movement updated in line with Royal College of Obstetricians and Gynaecologist publication in 2011
No documented discussion re place of birth	<ul style="list-style-type: none"> • Revised section within the Antenatal Appointment Record to clarify Antenatal Risk Assessments • Information available on the Trust website providing information regarding place of birth • Updated patient information booklet to include risks and benefits of Midwife Led Unit births. • Final report of an audit of clinical risk assessment conducted in 2015 - the audit benchmarked compliance against the standards set out in two versions of the appropriate guideline (versions 10.5 and 11.0)⁵². The criterion included documentation of place of birth, mode of delivery, and management of care, at the 36 week antenatal appointment and again at the on-set of labour. The audit findings reported a mean compliance of 88% with version 10.5 and 98% with version 11.0.
Ms Davies clinical notes not available in Ludlow MLU	<ul style="list-style-type: none"> • Introduction of Hand Held Records
Midwives documentation below expected standard	<ul style="list-style-type: none"> • Audits of record keeping in Ludlow have taken place and are satisfactory
Delay in transferring Kate	<ul style="list-style-type: none"> • Guidance strengthened to ensure midwives are aware of the importance to transfer when circumstances no longer

⁵² Clinical Risk Assessment (Antenatal) version 10.5 and version 11 SaTH (dates not stated)

	remain normal
Availability of second midwife	<ul style="list-style-type: none"> Review of midwife on-call arrangements
Issue	Reported completed actions
in MLU	
Neonatal resuscitation in MLU	<ul style="list-style-type: none"> Continued support to enhanced resuscitation training for midwives.
Neonatal resuscitation in MLU Contd.	<ul style="list-style-type: none"> Local guidelines reviewed by the Consultant Neonatologist All midwives attend an annual in house training update Training facilitator handbook updated Midwives working within the community settings have been given priority for attendance at external, enhanced resuscitation training The service was granted financial educational award to further enhance skills to stabilise sick new-born babies prior to transfer to the Neonatal Unit Various actions relating to transfer of the neonate – most notably the purchase of ‘pods’ for the transfer of neonates. Local guidance updated to draw midwives attention to the possible significance of a large placenta.
██████████ pathway	<ul style="list-style-type: none"> Evidence of work undertaken to strengthening of the ██████████ pathway included: updating the relevant guideline; improving training; introduction of a ██████████ midwife and ██████████ group. ██████████ training is included in the Training Needs Analysis and is monitored bi-monthly along with other training. An audit of compliance with identification and referral against guidelines was conducted in 2013 with a finding of 100% compliance. This is to be commended. The Reviewer was informed that an audit of the capacity of the ██████████ provision to meet demand would be included in the next audit cycle.

In addition, the Reviewer was informed that all women have a named midwife. However the provision of continuity of care was difficult to provide due to approximately 80% of midwives working part-time.^{53,54} The most recent figures shown to the Reviewer for the percentage of women ‘with access to same midwife throughout pregnancy’ indicated a rate of 60%.⁵⁵

6.3.1 Issues not identified in the action plans

- Midwife 2 has not been held to account by SaTH for her actions or the standard of care she gave to Kate from Kate’s birth until she was found in her cot in a state of collapse and a 999 call was placed.
- The weaknesses in the clinical governance system c2009, including that the incident of Kate’s death should have been raised as a SI.

⁵³ Meeting HoM c2009 and Debbie Graham 23.10.15

⁵⁴ Ibid (n51) reported 22% of respondents to an online survey stated that they had seen the same midwife throughout their pregnancy.

⁵⁵ April to October 2015

An emergent issue was identified by the Reviewer who noted the following:

Following Supervisory Investigation May 2009, it was agreed to include advice in the low risk intrapartum care guideline on how to document FH during delivery when only one midwife attending – superseded by decision to have two midwives in attendance during second stage⁵⁶.

As has been argued elsewhere in this review, documenting contemporaneous records during the second stage of labour is a requirement (and therefore a standard procedure) for all midwives. As birthing is not a sterile procedure, midwives wear gloves for protection purposes and it is the Reviewer's experience that midwives are adept at putting on gloves immediately before delivery.

It is unclear to the Reviewer the evidence base for the following statement incorporated in to the Intrapartum Care guidelines *'if necessary double gloving may help to maintain a clean technique during the final stages of delivery when auscultating and documenting the fetal heart rate'⁵⁷.*

Evidence suggests gloves should not be worn unnecessarily because prolonged and indiscriminate use may cause adverse reactions and skin sensitivity^{58,59}

6.4 Review of the care and treatment provided to Kate and Ms Davies conclusions

The Terms of Reference for this review set the following questions to be addressed regarding the standard of care and treatment provided by SaTH to Kate and Ms Davies.

1. a) To review the care and treatment provided to Kate Seren Stanton-Davies and her mother Rhiannon Davies against Trust policies and nation best practice standards applicable to 2009.
b) can missed opportunities or areas of poor practice be identified in relation to Rhiannon Davies and Kate Seren Stanton-Davies' care?
2. To examine whether serious failings occurred and, if found, to identify:
 - a) The cause of those failings (and)
The impact on Kate and her family
 - b) What were the consequences for Kate Stanton-Davies and her family?
 - c) Who was responsible/accountable for areas of poor care or missed opportunities?
3. Did the action plans:
 - Address all identified issues/causative factors
 - Include lessons that may be applied to prevent other adverse events
 - Include arrangements to ensure progress monitoring and implementation of the action plan

⁵⁶ Review of action plans following Neonatal Death Review (undated)

⁵⁷ Maternity Guidelines for Intrapartum Care on a Midwife Led Unit or Home Birth, SaTH version 4 ((2010)

⁵⁸ Pratt, R.J. et al, The epic Project: Developing National Evidence-based Guidelines for Preventing Healthcare associated Infections. Phase 1: Guidelines for Preventing Hospital-acquired Infections. Journal of Hospital Infection; 47(Supplement):S1-S82 (2001).

⁵⁹ Clark, L. et al, Protective Clothing; Principles and Guidance. London: Infection Control Nurses Association. (2002)

The Reviewer found that the standard of Ms Davies clinical care was non-compliant with good practice standards regarding: place of birth discussion, [REDACTED] care pathway and continuity of care. In addition, the Reviewer found that the standard of Ms Davies' intrapartum care was non-compliant with national guidance for fetal heart monitoring, for which the attending midwife should be held to account.

In the standard of Kate's clinical care the Reviewer has identified multiple areas of clinical practice where the attending midwife needs to account for her practice.

This review has found that SaTH failed to identify all the contributory issues in this case and therefore the action plans and lessons learned were limited. The Reviewer found that the action plans developed by SaTH were monitored and implemented within expected standards.

It is the Reviewer's opinion that following the findings of the Coroner's Inquest and the independent review of the LSA Supervisory Investigation all contributing issues have now been identified.

6.5 Recommendations relating to the care of Kate and her mother Ms Davies

1. Midwife 2's conduct should be reviewed in line with the Trust's Performance Improvement Policy
2. Midwife 1 should be held to account for the standard of intrapartum care provided to Ms Davies.
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 identify which groups of women would most benefit from receiving continuity of care.
5. The Trust should seek assurance that all maternity guidelines and policies (commencing with Ludlow MLU Operational Policy) are formatted and ratified in line with Trust clinical governance processes.
6. Review of the evidence base for midwives to 'double glove' when providing intrapartum care.
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.

7.0 Clinical Governance

7.1 Background

Following a serious incident, organisations providing NHS funded care in England are required to demonstrate accountability for effective governance and learning. This professional responsibility predated the legal duty of candour that was introduced into the NHS in 2015.

The NHS has a responsibility to ensure that when a serious incident does happen, there are systemic measures in place for safeguarding people, property, the service's resources and its reputation, and for understanding why the event occurred. There is also a responsibility to ensure that steps are taken to reduce the chance of a similar incident happening again.

To ensure relevant incidents are investigated and managed appropriately, all organisations should ensure their staff understand what constitutes a serious incident and are familiar with the Trust's policy for incident reporting. There is clear board-level responsibility for implementing and monitoring the requirements of the organisation's clinical governance framework.

7.2 SaTH Clinical Governance c2009

The Reviewer was provided with the following information regarding the reporting of incidents c2009:

In 2009, the process was the incidents would be discussed at service level and if a decision was made that this was a Serious Untoward Incident, then this would be escalated to the Patient Safety Team Manager or (Head of Assurance) and we would discuss with the Medical Director. A template form would have been completed and would be emailed to the MD for review.... Once the text of the incident had been approved, this would be entered on STEIS by myself or (Patient Safety Team Manager). I don't believe that any discussion took place about reporting Kate's death as an SUI at that time.⁶⁰

The Reviewer also received the following information

...there was far more discussion about the circumstances of this case than the documentation suggests and that there was a Trust process.....Kate's collapse, complicated transfer and death was notified to clinical managers and the patient safety team including by the clinical incidence alert system (datix). The clinical risk advisor's log notes the incident was reported to the labour ward co-ordinator and consultant unit risk co-ordinator who started to collate information pertaining to Rhiannon and Kate's care. The clinical risk co-ordinator for the MLU and community services was then informed. In addition both the patient safety manager and head of risk and assurance were advised of events on the 2/3/2009.....Kate's collapse was reported to the appropriate Clinical Risk Co-ordinator within the service using the Trust format.....All incidents are reviewed by the Clinical Risk coordinator and Patient Safety Advisor for Women and Children's Services, this case was selected for review at the Maternity Governance for a decision at this meeting as to whether a full high risk case review is required. The initial findings were shared at the governance meeting date 4/3/2009 at which I was present and I was involved in the decision (with the patient risk advisor, clinical risk co-ordinators) that a high risk case review (death review) was required to understand the circumstances and events. This is a SaTH governance investigation in line with (refers to two policies⁶¹⁶²)

Following Kate's death three Datix reports were submitted by staff, each of which identified issues relating to Kate's transfer to the neonatal unit at Birmingham Heartland's Hospital and to the transport difficulties experienced by Ms Davies and Mr Stanton. These Datix reports were recorded as "none" under the severity of harm heading. These issues were subject to an earlier investigation and are not included in the scope of this review.

⁶⁰ Email from Head of Assurance, 13th November 2015

⁶¹ Women's Services Risk Management Strategy, SaTH (2008)

Procedure for the reporting and investigation of incidents, complaints and claims (2007)

⁶² Email from HoM c2009 dated 16th November 2015

The Reviewer has found no documented evidence that the standard of Ms Davies' intrapartum care or the standard of care provided for Kate from her birth until her transfer to the neonatal unit at Heartland's Hospital, were investigated by SaTH using RCA.

An investigation into the incident of Kate's death was instigated by the LSA. Supervisory Investigations are undertaken to assure the LSA of a midwife's fitness to practice, not to assure the Trust. It is of note that although a Supervisory Investigation is usually undertaken by a SoM who is an employee of an organisation where an incident has occurred, the SoM is responsible to the LSAMO and not to an employer. The LSA investigatory guidance states

A Supervisory Investigation is independent of an investigation by a manager..... The Supervisor is undertaking an investigation on behalf of the LSA and the recommendations made will be independent of any managerial outcomes'.⁶³

The Supervisory Investigation concluded that there had been no breach in the duty of care by the two case midwives who provided intrapartum care for Ms Davies and care for Kate. The investigation recommended a period of developmental support for both midwives. In 2015, an independent review of the LSA Supervisory Investigation found it not fit for purpose.

SaTH held a High Risk Case/Death Review meeting on 30th April 2009. The minutes from the meeting state, '██████████ presented the case with the assistance of the medical records and the time line which has been prepared by (the investigating SoM) , as part of her Supervisory Investigation. The minutes also record the identification of the following 'Discussion Issues':⁶⁴

1. 'Some aspects of antenatal notes were not as detailed as we would have wished' – **Action:** Supervisory issue.
2. Fetal heart recording as per midwifery guidelines not documented in records. Assured by midwife at delivery that it is done using pinnard but she commented that it is very difficult to document, when delivering mother and already gloved up – **Action** to review guideline and advise midwives accordingly.
3. Mum had identified ██████████ at 7/52,⁶⁵ a limited management plan put in place that was developed at 24 weeks – **Action** Supervisory issue
4. Midwife present highlighted the difficulty of single-handedly dealing with an acute emergency – **Action** consider reviewing "on call" arrangements for MLU's.

Issues were also noted as raised in relation to the availability of clinical notes of women birthing at Ludlow MLU and the transfer of neonates. It should be noted that the Supervisory time line utilized at this meeting was later found to be not fit for purpose.

As shown in the above quotation, two issues were identified as 'supervisory issues'. This is an incorrect interpretation of the function of supervision. All of the issues identified should have been subjected to a managerial investigation, the findings of which may have included the recommendation for a period of supervisory support for the midwives under investigation. It is of note that no issues relating to the standard of Kate's care, prior to the events relating to her

⁶³ Guideline for Investigation of a midwife's fitness to practise, LSA National Forum (UK) (2007)

⁶⁴ Ibid (n38)

⁶⁵ 7 weeks of pregnancy

transfer, were minuted as identified at the Death Review meeting. This was due to the acceptance of the (later discredited) findings of the LSA Supervisory Investigation by the Death Review team.

The Reviewer identified two occasions when concerns regarding midwifery care were raised. The first occasion was noted in the minutes from the Perinatal Mortality Meeting held on 5th June 2009 which notes *'concerns raised re: midwifery input postnatally'*. The Reviewer could find no evidence that these concerns were subsequently followed-up.

The second occasion was noted in the minutes of the Maternity Governance Meeting held on the 20th January 2010 which noted *'issues have been identified of discrepancy between time documented by midwife as 11.38hrs. Ambulance have 12.07 when ambulance arrived leaving 30 minutes unaccounted for. Times requested from Ambulance Service.'*

It should be noted that the ambulance service representative had reported the time ambulance control received the 999 call at the Death Review meeting held on 30th April 2009. The Reviewer could find no evidence that these concerns were subsequently followed up through SaTH clinical governance processes. Rather there was an inappropriate reliance on the LSA Supervisory Investigation to establish the facts through the account of the case midwife. The Reviewer has seen an email dated 3rd August 2012 which reported that the *'Clock used by the PCT owned phonex system in Ludlow at the time, was not accurate. Therefore any phone logs would not reflect the actual time they took place.'*⁶⁶ The Reviewer was surprised that no further evidence of attempts to address the time discrepancy in the accounts for when the 999 call was placed was evident. However, this may have been due to the significance of the discrepancy not being fully appreciated given the (false) reassurance from the Supervisory Investigation that all care had been compliant with good practice.

It is the Reviewer's opinion that Kate's death should have been raised as a Serious Incident for the following reasons: Ms Davies' pregnancy had been treated as low risk; Kate was a term baby, anticipated to be healthy. However, she had been found in a state of collapse in a stand-alone MLU. She had required resuscitation and airlifting to a neonatal unit where she died shortly following admission. The Reviewer refers to the following SaTH documents when forming this opinion:

- Serious Untoward Incident (SUI) Policy (2008⁶⁷) which identifies *'sudden unexpected death in infancy'* as a SI⁶⁸
- Risk Management Strategy (February 2009⁶⁹) which states *'learning from experience is critical to the Trust in delivering a safe and effective service to patients and clients.....It is expected that root-cause analysis will be carried out on all serious and high risk cases'*
- Women's Services Risk Management Strategy (October 2008)⁷⁰ which states that where a claim is likely (which it can be argued should have been anticipated in this case) *'it is particularly important to clarify the various timings set out in the notes and to ensure that any discrepancies are referred to in the brief factual statements'*

⁶⁶ Internal email from Patient Experience Advisor to Head of Patient and Corporate Services

⁶⁷ Serious Untoward Incident (SUI) Policy, SaTH (2008)

⁶⁸ The Reviewer was informed that c2009 'sudden unexpected death in infancy' was interpreted as applying to 'cot deaths' – email from Head of Assurance to Debbie Graham, 13th November 2015

⁶⁹ Risk Management Strategy V8 (SaTH) (February 2009)

⁷⁰ Ibid (n61)

The Reviewer found that had the incident been reported as a SI, the relevant SaTH policies⁷¹ c2009 were compliant with national standards. However, the Reviewer noted that the *Maternity Incident Flow Chart*⁷² omitted the requirement to set up an investigation team and was, therefore, non-compliant with expected standards. The remit for an investigation team would include undertaking a root cause analysis of the incident. As this report has established, a RCA into the events of Kate's death has, to date, never been carried out by SaTH.

The flow chart indicates that incidents would be reported via the professional leads and Patient Safety Advisor to the Maternity Governance Group. The Reviewer was informed that c2009, it was at the governance group that a decision would be made whether to refer a case for a High Risk Case/Death review. The Reviewer requested but was informed that there were no Terms of Reference for a High Risk Case/Death Review. The Reviewer was surprised at this finding given that the High Risk Case Review is a formal step in the Trust's Clinical Governance process and suggests that this is further evidence of the weak clinical governance process within the Trust c2009.

The Reviewer requested information regarding RCA training for staff undertaking investigations c2009. The following information was provided:

*I can confirm that after (names) started in the patient safety team, she identified a need to roll out root cause analysis training and spent a significant amount of time developing and delivering this during latter half of 2010 to good numbers of the matrons and other senior nurses. Prior to this the SHA had delivered a short workshop at the Trust – but I cannot find any record of when that was or who was trained.*⁷³

Furthermore, the Risk Management Policy and Procedure (2007) states '*Specialist Risk advisors are trained in Root cause analysis*'.⁷⁴

The Reviewer was surprised by this finding given that clinical governance had been introduced into the NHS in 2000⁷⁵ and suggests that this finding provides an insight into the culture of the organisation c2009.

It is the Reviewer's opinion that SaTH failed in its duty to undertake an internal investigation into the standard of care provided by the Trust for Kate and Ms Davies. This failure was due to the organisations weak clinical governance processes c2009, a systems failure for which the Trust Board were accountable. The Trust inappropriately relied on the findings of a Supervisory Investigation⁷⁶, which was subsequently found not fit for purpose.

⁷¹ Serious Untoward Incident (SUI) Policy 2004 and Risk Management Strategy 2009

⁷² Ibid (n67) Appendix 1

⁷³ Email Head of Assurance dated 13th November 2015

⁷⁴ Risk Management Policies and Procedures v3 SaTH (2007)

⁷⁵ An organisation with a memory, Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer, DH (2000)

⁷⁶ Confusion between the employer's role in investigations and the role of the midwifery Supervisory Investigation was identified in the King's Fund report *Midwifery regulation in the United Kingdom (2015)*⁷⁶. The King's Fund report found that the '*additional layer of regulation*' of supervision in midwifery risks undermining

The findings of the Coroner's Inquest, held in November 2012, exposed both the gaps in the comprehensiveness of the Supervisory Investigation and the trust's failings to establish both accountability and facts in the serious incident of Kate's death. These findings should, therefore, have prompted SaTH to instigate an investigation into the standard of care provided by the trust for Kate and Ms Davies.

The Reviewer was informed that in 2012 the (then) Director of Nursing led on the trust's response to the findings of the Coroner's Inquest. It is also the Reviewer's understanding that the management of complaints sat within the portfolio of the Director of Nursing.

The Reviewer has spoken to the (then) CE at SaTH who was newly in post in 2012. He informed the Reviewer that, given that this case was now 3 years old, he had relied on the information and assurances given to him by the Director of Nursing (who had organisational memory of the case) that Kate's and Ms Davies' case had been robustly investigated. The CE also recalled meeting with the Head of Midwifery and the Clinical Director for obstetrics neither of whom raised concerns with him regarding this case. The CE also informed the Reviewer that he had only recently become aware that the supervisor undertaking the Supervisory Investigation was a member of staff and not an independent external expert⁷⁷.

The Reviewer was informed⁷⁸ that reassurance had been taken by the trust from the NMC's finding that there was 'no case to answer' in the standard of midwifery care provided for Kate and Ms Davies. Furthermore, legal advice to the trust was that the NMC would not reopen a closed case⁷⁹. Moreover, the trust's expert witness had found no breach in the duty of care provided to Kate and Ms Davies. The trust did not, therefore, instigate an investigation⁸⁰.

It is the Reviewer's opinion that it is a Head of Midwifery's role to provide professional midwifery advice to the trust board and the Director of Nursing. The evidence examined at the Coroner's Inquest should have alerted the Head of Midwifery to the gaps in the trust's knowledge of the facts of this case and to the inadequacy of the Supervisory Investigation. However the Head of Midwifery took false reassurance from the Supervisory Investigation and the NMC's findings. This calls into question the Head of Midwifery's professional judgement. It can be argued that the Head of Midwifery's apparent reluctance to accept that there remained un-investigated midwifery practice issues in this case suggest a defensive attitude which prevented the lessons required to be learnt

'the responsibilities of employers in investigations and therefore weakens one stage in the process towards potential referral to the NMC As such this confusion could be seen to undermine one element (employer responsibilities in the overall approach toward professional regulation.

The King's Fund report concluded with the recommendation that the 'additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end'.

In January 2015, following the publication of the King's Fund report, the Nursing and Midwifery Council took the decision to ask for a change in legislation governing the regulation of midwives and removing statutory supervision. The timings of change will depend on Parliament timelines in tabling a Section 60 order⁷⁶, but is thought likely to be completed by the 31st March 2017. Following the removal of supervision from statute, SoMs will no longer carry out investigations.

⁷⁷ Telephone conversation with CE

⁷⁸ Telephone conversations with former HoM, Clinical Director and CE

⁷⁹ Telephone conversations with former HoM and Clinical Director

⁸⁰ A review of maternity services provision was undertaken by the commissioning CCG in response to the Coroner's findings. Ibid (n51)

from this case from being learned. It is the Reviewer's opinion that the Head of Midwifery should have advised the CE and the Director of Nursing that the quality of the Supervisory Investigation was such that the trust needed to undertake its own management investigation thus ensuring that all staff was held to account and all lessons learnt.

Ms Davies and Mr Stanton raised their concern regarding a possible conflict of interest. They were concerned that the SoM who carried out the Supervisory Investigation on behalf of the LSA was employed by SaTH as the Professional Development midwife and as such would have been responsible for midwives training. In particular, the recognition of a sick newborn and neonatal resuscitation skills.

The Reviewer has seen evidence of the planned annual mandatory update on neonatal resuscitation for midwives 2008 – 2010 which states that the sessions would be facilitated by Neonatal Life Support trainers and Advanced Neonatal Practitioners. It is the Reviewer's understanding that the investigating SoM did not hold these qualifications and was therefore unlikely to have facilitated this update.

However a conflict of interest remains, in that the investigating SoM was employed by SaTH. This is a recognised inherent weakness in the midwifery supervisory process.⁸¹

7.3 SaTH Clinical Governance c2015

To provide assurance of current clinical governance processes the Reviewer:

- Requested and was provided with five anonymised maternity RCA investigations (including one 'Never Event'⁸²). No comment can be made on the facts of the cases. The Reviewer found that the quality of the investigations was good. In particular 4 of the 5 cases reviewed had both a midwife and medic documented as jointly leading the investigation. All actions had been completed within target date except for two. It was not possible from the documentation for the Reviewer to understand whether the deferred dates were justifiable or not.
- Reviewed all current Trust policies and guidelines relevant to the case of Ms Davies' and her daughter Kate. All were found to be compliant with national standards.
- The Reviewer also approached the local LSAMO to request copies of three anonymised Instigation of Supervisory Investigation notifications submitted in relation to SaTH where it had been documented that a Trust clinical governance investigation had also been initiated. On the 13th November 2015 the Reviewer requested SaTH to provide evidence of a clinical governance investigation for the identified cases within five working days. This evidence was not made available to the Reviewer.
- Noted that the Maternity Services Review reported '*openness and transparency in reporting and investigation, although this has led to a higher reporting of serious incidents than would have been reported elsewhere.*'⁸³

⁸¹ Midwifery Regulation in the United Kingdom, Baird et al, The King's Fund (2015)

⁸² Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers

⁸³ Ibid (51)

- Noted that dissemination of learning points is covered in a number of documents including the Learning from Adverse Events Policy (2012)⁸⁴

Finally the Reviewer noted that SaTH maternity services attained Level 3 CNST in 2014⁸⁵ and was assessed as 'Good' by the CQC in 2015⁸⁶

7.4 Clinical Governance conclusions

The Terms of Reference for this review set the following questions to be addressed regarding the standard of clinical governance processes at SaTH c2009.

1. Was the incident of Kate's death reported correctly and in a timely manner?
2. Was the incident investigation/RCA completed thoroughly and transparently and did it take into account all relevant information available at the time?
3. Review the adequacy of the Trust's Risk Management arrangements to ensure learning from the identified failings.
4. To review the Trust handling and governance of the incident and determine if this was managed appropriately and in a timely way, in accordance with national policy at the time.
5. To review Trust policies and procedures available at the time of the incident to establish their relation to national policy and evidence based practice.

This review has found that Kate's death was not reported correctly. Due to the Trust's weak clinical governance processes, identified in this review, Kate's death was not raised as a SI, a RCA was not undertaken and the facts were therefore not established. This failure by SaTH to identify all of the contributing factors and issues resulted in the required lessons not being learned through the mechanism of the Trust's Risk Management arrangements.

The Reviewer found a disconnection between the Trust's Risk Management policies and the systemic measures in place to enable staff compliance with the Trust clinical governance policies. The accountability for the Trust's lack of a robust clinical governance process sits with the Trust Board c2009.

It is of note that the requirement for staff to undertake RCA training was instigated following the appointment of a key member of staff who recognised the importance.

The Reviewer was reassured by the evidence submitted for this review of the current clinical governance policies and procedures. The Reviewer found these to be compliant with national standards with good examples of how clinical governance has been embedded within maternity services evidenced. However, due to time constraints, the Reviewer is unable to provide assurance that all maternity incidents investigated by the LSA are also subjected to an internal investigation.

7.5 Recommendations relating to governance issues

⁸⁴ Learning from Adverse Events Policy, SaTH (2012)

⁸⁵ NHS Litigation Authority Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards 2013-14, March 2014

⁸⁶ Shrewsbury and Telford Hospital NHS Trust Quality Report, CQC (2015)

1. The Trust should seek assurance that all maternity incidents are subjected to an internal investigation in line with Trust policy.
2. The Trust should seek assurance that all maternity guidelines and policies are formatted and ratified in line with Trust clinical governance processes.

8.0 Complaints Management

*Chief Executives and Boards must take active responsibility to learn from complaints and to create a culture that is able to take a positive attitude towards complaints*⁸⁷.

Complaints should be welcomed as an early warning system that can provide insight into areas for improvement and provide valuable feedback about service users' experiences.

The Reviewer reviewed the Trust's complaints process c2009⁸⁸ which were found to be broadly compliant with national standards. The Reviewer was surprised however to read the following statement in the Complaints Policy (2007) '*Serial complainants are becoming an increasing problem for NHS staff*'.⁸⁹

This can be compared with the 2014 Complaints Policy which states '*in a minority of cases, complainants can become vexatious and persistent in pursuit of the complaints, despite reasonable attempts to resolve matters*'⁹⁰ and, it can be argued, provides another insight into the organisational culture c2009.

The Reviewer was informed that c2009

Complaints received in the Trust were forwarded to the Complaints team for acknowledgement. The complaint was then forwarded to a Matron in the relevant area who would then co-ordinate statements/reports etc. These would be forwarded to the Complaints team for them to draft a response for the Chief Executive.

*Women & Children's had a different process in place – this covered all complaints relating to Obstetrics, gynaecology and paediatrics. The complaint was sent to their Patient Experience Midwife who co-ordinated the investigation. The Patient Experience Midwife would obtain statements from medical staff and it is my understanding that she would meet with clinicians and midwives to discuss the case. The Patient Experience Midwife would then formulate the Trust's response and would forward this to the Complaints Team – no statements, reports or action plans were sent. A member of the Complaints team would transfer the response onto letter headed paper for the Chief Executive to sign.*⁹¹

Between 2009 and 2012, Ms Davies and Mr Stanton submitted a total of five formal complaints to three organisations regarding the standard of care and treatment received by Kate and Ms Davies whilst under the care of SaTH. Three of these complaints were made to SaTH, one to Ms Davies' GP

⁸⁷ A Review of the NHS Hospitals Complaints System, Putting Patients Back in the Picture, Clwyd A; Hart T (2013)

⁸⁸ Complaints Procedure V8.1 SaTH (2007)

⁸⁹ Ibid

⁹⁰ Concerns and Complaints, Policy and Procedure, SaTH (2014)

⁹¹ Email from Head of PALs and Complaints, 2nd November 2015

and one to Shropshire PCT. It is the Reviewer's opinion that the failure to identify and maintain a key co-ordinator role⁹² between the organisations contributed substantially to the inadequate response by SaTH to Ms Davies' and Mr Stanton's complaints and concerns as set out below.

The Reviewer has reviewed the response timeline for the three formal complaints made to SaTH. These were found to be compliant with the expected standard for complainants in complex cases to receive a final written response within 40 days of receipt of a complaint.

It is the Reviewer's understanding that at this time complaints management sat within the portfolio of the Director of Nursing. The reference provided on the trust's second formal response to Ms Davies' and Mr Stanton's formal complaint indicates that the letter was drafted by a former Head of Midwifery who was then employed in a supporting role at the trust. There is no identifying reference on the trust's final formal response. When questioned by the Reviewer, key people⁹³ had no recollection of who had drafted this response.

The Reviewer reviewed the Trust's final written response to each of the three formal complaints⁹⁴ made by Ms Davies and Mr Stanton to SaTH. The Reviewer found the following:

1. The first complaint made by Ms Davies and Mr Stanton was dated 19th May 2009 and raised their concerns regarding issues relating to the West Midlands ambulance service. They received a response from the then Chief Executive (CE 1), acknowledging their letter of complaint, enclosing a Trust complaints leaflet and requesting permission from Ms Davies and Mr Stanton to forward their complaint to the West Midlands ambulance service. Following receipt of their permission the complaint was appropriately forwarded to the ambulance service.
2. The second complaint was dated 22nd June and raised Ms Davies' and Mr Stanton's concerns regarding the 'lack' of progress to their complaints dated 19th May 2009 and 29th May (the later had been addressed and sent to Ms Davies' GP and was forwarded to the Trust on 9th June 2009). They also raised their concern regarding the Post Mortem process, including the investigations undertaken and final report of Kate's death.

In their letter of complaint to Ms Davies' GP, Ms Davies and Mr Stanton had set out their concerns regarding Ms Davies' antenatal and intrapartum care and the standard of care provided for Kate. The Reviewer is unaware if Ms Davies and Mr Stanton received a response from Ms Davies' GP to this letter.

Ms Davies and Mr Stanton received a final written response to their second letter of complaint (sent 22nd June 2009) from (new CE 2) on the 17th July 2009. This letter should also have addressed the issues raised by Ms Davies and Mr Stanton in their letter to their GP (subsequently forwarded to the

⁹² A letter dated 9th June 2009 from the Clinical Governance Manager, Shropshire PCT to Head of Patient and Corporate Services identifies states that she had been asked by Ms Davies' GP to support Kate's parents.

⁹³ Telephone conversations with [REDACTED], [REDACTED]

⁹⁴ The Reviewer noted a reference to a letter dated 30th September sent from the CE to Ms Davies and Mr Stanton. However the Trust was unable to trace a copy of the letter when requested by the Reviewer.

Trust). The Reviewer found that the response was not evidence based⁹⁵, was factually incorrect⁹⁶, badly phrased⁹⁷, judgemental⁹⁸ and made unsubstantiated statements⁹⁹. Furthermore not all of the issues raised by Ms Davies and Mr Stanton (including those regarding the Post Mortem process) were addressed.

3. Ms Davies' and Mr Stanton's third formal complaint to SaTH was dated 20th November 2012 and was made following the jury's findings at the Coroner's Inquest into Kate's death. In their letter of complaint they set out their concerns (as identified during the Inquest) and requested that staff employed by SaTH involved in the care of Ms Davies and Kate, be held to account.

Ms Davies and Mr Stanton received a final written response to their third letter of complaint from (new CE 3) on the 16th January 2013. The response does not address the key issues raised by Ms Davies and Mr Stanton and used, as its main point of reference, the findings of the LSA Supervisory Investigation and *'the Maternity Services ... in-depth case review following Kate's death in 2009'*¹⁰⁰. It should be noted that the issues raised by Ms Davies and Mr Stanton, and identified during the Coroner's Inquest, were not fully identified or addressed in either the LSA Supervisory Investigation or the *'case review'* referred to in the response. Furthermore, the weaknesses in the Supervisory Investigation were highlighted during the Inquest and had been referred to in Ms Davies' and Mr Stanton's letter of complaint.

4. In January 2015, following the findings from the Parliamentary and Health Service Ombudsman review into Kate's death, Ms Davies and Mr Stanton were sent an 'unreserved apology' for the Trust's failure to investigate the treatment and standard of care received by Ms Davies and Kate. The Trust also apologised for *'the failings in the Trust's complaint handling process and for the injustice and added distress that this caused to both of you'*.¹⁰¹

Ms Davies and Mr Stanton also wrote to consultant obstetrician 1, consultant in Fetomaternal Medicine and Gynaecology on 27th May 2009 setting out their concerns regarding Ms Davies' antenatal care and requesting a meeting with him. However a meeting arranged to take place on the 22nd June 2009 was subsequently cancelled¹⁰² at Ms Davies and Mr Stanton's request as they *'did not feel that we couldrevisit the circumstances of Kate's death'*.¹⁰³

⁹⁵ Letter to Ms Davies and Mr Stanton dated 17th July 2009 *'the position the fetus adopts at the end of the pregnancy with the fetal head dipping into the pelvis and the baby's back swinging around to the front means the perception of movement is more difficult'*

⁹⁶ Ibid (Kate) at 10.15hrs... had a temperature of 36.6"

⁹⁷ Ibid *'the (CTG) traces were never bad enough to require immediate or emergency treatment'*

⁹⁸ Ibid *'your labour was very good indeed'*

⁹⁹ Ibid *'midwife 2 did a good job in resuscitating Kate'*. Concerns had been raised re: midwifery input postnatally at the Perinatal Mortality Meeting held on 5th June 2009

¹⁰⁰ This 'case review' refers to the High Risk/Death Review meeting which had relied on the Supervisory Investigation

¹⁰¹ Letter to Ms Davies and Mrs Stanton dated 16th January 2015

¹⁰² Letter dated 16th June 2009 to Ms Davies from the Acting Head of Patient Services confirming cancellation of meeting

¹⁰³ Letter from Ms Davies and Mr Stanton to CE 2 dated 14th October 2009

Information about an incident must be given to patients, service users', their families and carers in a truthful and open manner by an appropriately nominated person. A step-by-step explanation of what happened should be provided, that considers their individual needs and is delivered openly.

Good practice indicates that consideration should have been given to the location of the meeting with Ms Davies and Mr Stanton, and an offer made for a senior clinician and manager to have met them in their home.

The Reviewer has seen evidence that several attempts to rearrange a meeting with Ms Davies and Mr Stanton was made by consultant obstetrician 1, namely:

- A letter from CE 2 to Ms Davies and Mr Stanton dated 24th June 2009 states 'Consultant obstetrician 1 ... *remains anxious to discuss the post mortem report and the medical implications of the latest findings with you as a couple If you wish to accept this opportunity, I will be pleased to make convenient arrangements.*
- Minutes from the Maternity Governance Meeting held on 2nd September 2009 which notes consultant obstetrician 1 '*will be meeting the family soon*'.

The following emails:

- Consultant obstetrician 1 *had contacted* (Clinical Risk Manager, Shropshire CCG) *and asked her to speak to Miss Davies and Mr Stanton to reinstate their meeting. She does not feel this is appropriate as the parents are adamant that they do not want to meet at the moment.*¹⁰⁴
- *The first date which the GP can attend* (meeting with Ms Davies and Mr Stanton) *is October 2nd (9am – 11am). Don't think the parents have been told yet but can you make this date?*¹⁰⁵
- *Am on call that Fri but given the hassle to arrange I will arrange swap*¹⁰⁶
- An email confirming that a meeting had been arranged for 2nd October 2009 between Ms Davies, Mr Stanton, consultant obstetrician 1 (names two members of staff), Ms Davies' GP and '*? the neonatologist from Heartlands*¹⁰⁷' was also seen by the Reviewer.

In addition, consultant obstetrician 1 informed the Reviewer that although he had tried to set up a meeting with Ms Davies and Mr Stanton he had found it difficult due to the complexity of arranging through a third party¹⁰⁸.

In addition to their formal letters of complaint, Ms Davies and Mr Stanton submitted, under the Freedom of Information Act, two requests to SaTH (dated 5th June 2009 and 6th August 2009) for copies of Ms Davies' medical notes and '*meeting notes*¹⁰⁹', and copies of '*3 other reports relating to our daughter*¹¹⁰'. Responses were sent by SaTH dated 31st July 2009 and 3rd September 2009. Ms Davies and Mr Stanton raised their concerns that two of the documents sent to them were redacted. The Reviewer has reviewed the two documents in questions and makes the following observations:

¹⁰⁴ Email from (designation unknown) to Litigation Manager dated 23rd June 2009

¹⁰⁵ Email from (Project Lead Midwife) to consultant obstetrician 1, dated 17th August 2009

¹⁰⁶ Email from consultant obstetrician 1 to Project Lead Midwife dated 24th August 2009

¹⁰⁷ Email from Project Lead Midwife to former Head of Midwifery, consultant obstetrician 4, consultant obstetrician 1 and Patient Safety Advisor dated 24th August 2009

¹⁰⁸ Telephone conversation consultant obstetrician 1 and Debbie Graham 20th November 2015

¹⁰⁹ Letter sent to PALs dated 5th June 2009

¹¹⁰ Letter from Ms Davies and Mr Stanton to Legal and Compliance Manager dated 6th August 2009

- Document 1 comprised of the minutes from the Neonatal & Maternity Governance Meeting held on 15th May 2009. The redacted information pertained to cases other than that of Ms Davies and Kate and it was, therefore, appropriate to send a redacted copy to Ms Davies and Mr Stanton.¹¹¹
- Document 2 comprised of the minutes from a Meeting with Ambulance dated 23rd July 2009. The redacted information pertains to guidelines, processes, equipment and agreed actions. It is unclear to the Reviewer why this information was redacted from the copy sent to Ms Davies and Mr Stanton.

Since 2009 SaTH has introduced changes to strengthen the Trust's complaints and concerns processes. This includes the introduction of the role of 'Bereavement Midwife' whose role includes the remit to: 'provide bereavement support and co-ordinate follow up for patients who have experienced pregnancy loss'¹¹² and a process redesign led by the Head of PALS and Complaints.

The Reviewer was informed of the following:

Following my appointment in July 2013 I restructured the team so that a Complaints Case Manager was linked to each Care Group and co-ordinated the investigation of the complaints for that area rather than forwarding to a Matron. The Case Managers formulate the Trust's response and all of these are quality checked etc by me. Action plans are produced where appropriate and these are tracked by my team.

I met with Women & Children as I had hoped to have a standard process throughout the Trust. Women & Children's wished to maintain control over their complaints in terms of co-ordinating their investigation and drafting the Trust's response. They agreed to forward all statements and reports with this draft response along with an action plan. All draft responses were then reviewed by the Case Manager and as with all other complaints were reviewed by me.... Further discussion took place in 2014 with W&C as although reports from medical staff were received, with Midwifery/nursing only statements were sent to the complaints team with no overarching investigation report. They now send a report – it is a report by the Patient Experience Midwife. In 2015, W&C agreed that the Complaints team could draft the response from the Chief Executive.¹¹³

8.1 Complaints Management conclusions

The Terms of Reference for this review set the following questions to be addressed regarding the management of Ms Davies' and Mr Stanton's formal complaints to SaTH:

- 1) To review Trust policies and procedures available at the time of the incident to establish their relation to national policy and evidence based practice.
- 2) Was the Trust complaints procedure followed correctly when complaints and concerns were received?

¹¹¹ Data Protection Act 1998, Section 40 of the Freedom of Information Act 2000

¹¹² Bereavement Midwife Job Description, SaTH (undated)

¹¹³ Email from Head of PALS and Complaints dated 2nd October 2015

- 3) Were responses to complaints and concerns full, open and transparent covering all the issues raised? Were each of the issues and concerns raised by Ms Davies and Mr Stanton fully addressed by the Trust Board and assurance given to them that, where required, mitigating actions had been taken?

This review has found that the timeline for the Trust's formal response to Ms Davies' and Mr Stanton's complaints was compliant with the expected standard. As Ms Davies and Mr Stanton had submitted formal complaints to three organisations a key co-ordinator for the complaints should have been identified and maintained between the organisations. Failure to do so resulted in a blurring of responsibilities and perceived delays in response times.

The Reviewer reviewed the Trust's Complaints Policy c2009 and was surprised to see a reference to '*an increasing problem*' in the NHS of '*serial complainants*', which the Reviewer took to evidence a negative organisational attitude to complaints at that time.

The Trust's responses to Ms Davies' and Mr Stanton's complaints met good practice standards in that they were signed-off by the CE. However due to the Trusts' weak clinical governance processes and the organisational approach to complaints identified in this review the Reviewer found the following:

- A lack of sympathy and sensitivity in the tone of the letters to Ms Davies and Mr Stanton
- A lack of honesty, openness and an apparent unwillingness to listen to their complaints
- The responses did not address all of the issues raised by Ms Davies and Mr Stanton and contained inaccurate information. The Reviewer formed the opinion that the service rather than the service user was placed at the centre of the Trust's response.

Finally, the Reviewer found that the Trust's negative attitude to Ms Davies' and Mr Stanton's complaints substantially contributed to the missed opportunities to learn from the events surrounding Kate's death as all of the concerns raised by Ms Davies and Mr Stanton in their complaints were subsequently substantiated through findings of organisations external to the Trust.

The Reviewer was reassured by the evidence submitted for this review of the current complaints management policies and procedures. The Reviewer found these to be compliant with national standards with good examples of how complaints management has been embedded within the Trust. This included evidence of Board level scrutiny of complaints. The Reviewer notes that the strengthening of the complaints process was instigated by a newly appointed key member of staff.

8.2 Recommendations relating to complaints issues

1. The Trust should publically acknowledge the failings identified in this review and the harm they have caused Ms Davies and Mr Stanton.

9.0 Conclusion

The tragedy at the centre of this investigation is the avoidable¹¹⁴ death of a child, which most profoundly affects her parents, her sibling, their wider family and friends. The overarching purpose of this report is to determine whether SaTH fulfilled its responsibility to establish the facts of why Kate's death occurred, thus ensuring that the vital lessons and changes required to improve quality of care was identified and accountability established.

The Reviewer found that SaTH failed to fulfil its responsibility to establish the facts of this case and to establish accountability. Rather the Trust abdicated its responsibility to the LSA, an organisation with no accountability to the Trust and whose investigation was subsequently found not fit for purpose.

In particular the review found that the Trust:

- Failed to investigate Kate's death through a robust managerial investigation
- Failed to hold staff to account
- Failed to address concerns raised by Ms Davies and Mr Stanton, particularly those pertaining to the inadequacy of the Supervisory Investigation

It is the Reviewer's opinion that the above mentioned failures were caused by organisational weaknesses for which the Trust Board are accountable. This does not distract from the staff involved' professional responsibility and accountability as set out in their codes of conduct on practice.

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' 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.

The lessons learnt and subsequent changes made to improve the quality of care were not all directly developed from Kate's death. Many resulted from the findings from external reviews of the case instigated by Ms Davies and Mr Stanton. Without their tenacity in seeking the truth of the circumstances surrounding Kate's death vital lessons would not have been learnt. For this, the Trust is indebted to Ms Davies and Mr Stanton. The Trust should work in partnership with Kate's parents to establish a fitting acknowledgement of the contribution they have made to the safety and quality of maternity services at SaTH.

Recommendation

1. The Trust should work with Ms Davies and Mr Stanton to establish a fitting memory to their daughter, Kate.

¹¹⁴ Ibid (n7) (n8)

Acknowledgements

This review would not have been possible without the cooperation and support of many people, to all of whom I wish to extend my thanks and gratitude.

References

A Review of the NHS Hospitals Complaints System, Putting Patients Back in the Picture, Clwyd A; Hart T (2013)

An organisation with a memory, Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer, DH (2000)

Bereavement Midwife Job Description, SaTH (undated)

Booking Criteria for the Shropshire Maternity Service Ref No: 3722 (Nov 2008 – Dec 2008)

Clark, L. et al, Protective Clothing; Principles and Guidance. London: Infection Control Nurses Association. (2002)

Clinical Risk Assessment (Antenatal) version 10.5 and version 11 SaTH (dates not stated)

Compendium of Evidence compiled by Rhiannon Davies and Richard Stanton

Complaints Procedure V8.1 SaTH (2007)

Concerns and Complaints, Policy and Procedure, SaTH (2014)

Data Protection Act 1998, Section 40 of the Freedom of Information Act 2000

██████████ in Pregnancy Ref No 3729 (Dec 2006 – Dec 2008)

Guideline for Investigation of a midwife's fitness to practise, LSA National Forum (UK) (2007)

Guidelines for records and record keeping (NMC 2002)

Infections. Journal of Hospital Infection; 47(Supplement):S1-S82 (2001).

Intrapartum Care of the Midwife Led Unit or Home Birth Ref No: 0303 (2006)

Intrapartum care: management and delivery of care to women in labour, NICE (2007)

Learning from Adverse Events Policy, SaTH (2012)

Maternity Escalation Guideline, Version 1, first developed June 2010, SaTH

Maternity Guidelines for Intrapartum Care on a Midwife Led Unit or Home Birth, SaTH version 4 (2010)

Maternity Matters: Choice, access and continuity of care in a safe service, DH (2007)

Midwifery Regulation in the United Kingdom, Baird et al, The King's Fund (2014)

Narrative verdict, H.M. Coroner J.P Ellery, South Shropshire Coroner's District, 7th – 16th November 2012

Neonatal Care (including: neonatal thermoregulation, hypoglycaemia and the neonatal hypoglycaemia guideline as appendix 1) Ref No 0307 (Oct 2008 – Oct 2010)

Neonatal Resuscitation and when to summon assistance, Ref No 3754 (2006)

NHS Litigation Authority Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards 2013-14, March 2014

Operational Policy for: Ludlow Maternity Unit, Version 1, July 2015, Women and Children's Care Group, SaTH

Pratt, R.J. et al, The epic Project: Developing National Evidence-based Guidelines for

Preventing Healthcare associated Infections. Phase 1: Guidelines for Preventing Hospital-acquired

Procedure for the reporting and investigation of incidents, complaints and claims (2007)

Report by the Health Service Ombudsman for England of an investigation into a complaint made by Ms Rhiannon Davies and Mr Richard Stanton, 31 December 2014

Review of SaTH maternity services (2013)

Risk Management Policies and Procedures v3 SaTH (2007)

Risk Management Strategy 2009

Risk Management Strategy V8 (SaTH) (February 2009)

Serious Untoward Incident (SUI) Policy 2004

Serious Untoward Incident (SUI) Policy, SaTH (2008)

Shrewsbury and Telford Hospital NHS Trust Quality Report, CQC (2015)

Supervisory Investigation Report, (2009)

Women's Services Risk Management Strategy, SaTH (2008)

Websites

Appendices

Appendix 1 Terms of Reference



Independent review
ToRs final.pdf

Appendix 2

People consulted as part of this review:

Designation

Kate's parents

Consultant in Fetomaternal Medicine & Gynaecology

Clinical Director for Obstetrics

Patient Safety Advisor

Virginia Mason/KPO Lead

Head of Assurance

Head of PALS and Complaints

Director of Corporate Governance

Director of Nursing and Quality, SaTH

Chief Executive

Detective Chief Inspector, West Mercia Police

(Former) Chief Executive

Documents read as part of this review:

Being Open Policy SaTH (2006)

Compendium of evidence submitted by Ms Rhiannon Davies and Mr Richard Stanton

Correspondence from Ms Davies and Mr Stanton to SaTH as submitted for the review

Correspondence from SaTH to Ms Davies and Mr Stanton as submitted for the review

Datix Managers Forms (DIF2), ID 38305,38278,38206 SaTH

Death Review – Shrewsbury and Telford Hospital (SaTH) (30th April 2009)

Guideline for the investigation of a midwife's fitness to practice LSA (2007)

Health Service Ombudsman – Investigation Report (December 2014)

Health Service Ombudsman – letter to Trust with detailed feedback dated 31st December 2014

HM Coroner Inquisition notice (30/11/12)

Maternity Services Review, The Shrewsbury and Telford Hospital NHS Trust (2013), Telford and Wrekin CCG, Shropshire CCG

Minutes from meetings submitted as part of the review

Miscellaneous letters

Ms Rhiannon Davies’ maternity clinical records

NHS Litigation Authority Clinical Negligence Scheme for Trusts – Maternity Clinical Risk Management Standards 2013-14

Operational Policy for Oswestry Maternity Unit SaTH (2007-2008)

Policy on the Management of Claims SaTH (2007)

RCOG: Reduced fetal movements – GG57 (2011)

Reduced Fetal Movements Green-top Guideline No 57 RCOG (2011)

Risk Management Policies and Procedures (2007)

Serious Untoward Incident (SUI) Policy SaTH (2008)

Serious Untoward Incident (SUI) Policy v5.2 (2008)

Statement - Midwife 1 (unsigned and undated)

Statement – investigating SoM (unsigned and undated)

Statement – Midwife 2 (undated)

Statement – Midwife 3 (undated)

Statement of – (paramedic)

Supervisory Investigation – questions for Midwife 1 (undated)

Supervisory Investigation – questions for Midwife 2 (undated)

Supervisory Investigation Report submitted 14th May

Training Record for midwife 2, Midwife 1 and midwife 3

Transcript of Coroner’s Inquest evidence from key witnesses

Two lever arch files submitted by SaTH containing ‘Evidence – Incorporation of Trust Policy 2015’

Various audits submitted for review

Women's Services Risk Management Strategy (2008)

SaTH Clinical Guidelines:

Antenatal and Intrapartum Fetal Heart Rate Monitoring Ref No: 3720 (2008)

Booking Criteria for the Shropshire Maternity Service Ref No: 3722 v6 (2008)

Booking Criteria for the Shropshire Maternity Service Ref No: 3722 v5 (2006)

CTG monitoring antenatal or intrapartum Ref No: 0595 (2008)

██████████ In Pregnancy Ref No: 3729 (2006)

Fetal Movements – Reduced Ref No: 3733 (2006)

Intrapartum Care on the Midwife Led Unit or Home Birth Ref No 0303 (2006)

Managing Emergency Pressures within the Maternity Unit Escalation Policy Draft SaTH (May 2009)

Maternity Guideline on Neonatal Care (Including: neonatal thermoregulation, hypoglycaemia and the neonatal hypoglycaemia guidelines as appendix 1 – Ref No: 0307 (2008)

Maternity Guidelines for Intrapartum Care on a Midwife Led Unit or Home v4 Birth SaTH (2010)

Maternity Escalation Guideline V1 SaTH (2010)

Neonatal Resuscitation and when to summon assistance Ref No: 3754 (2006)

Reduced Fetal Movements v3 SaTH (2015)

Reduced Fetal Movements v3.1 (2015)

Reduced Fetal Movements v4 (2015)

Transfer of a Baby to Another Unit Within and Outside the Geographical Boundary, Excluding the Neonatal Unit Ref No 0311

Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife-Led Unit SaTH (2010)

Appendix 3

Glossary of abbreviations

CTG	Cardiotocograph
FH	Fetal heart
GBS	Group B streptococcus

HSOE	Health Service Ombudsman for England
IPP	Intermittent positive pressure (ventilation)
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
MLU	Midwifery Led Unit
NA	Nursing Assistant
RCA	Root cause analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SoM	Supervisor of Midwives

Appendix 4



Annon Appendix 4
comprehensive table