Factual accuracy comments for report: 2009-2490

Date report sent to trust: 01/02/21
Date for report to be returned to HSIB: 15/02/21
HSIB factual accuracy review meeting (FARM) held: 17/2/21
Bradford comments in black font, Royal Free Hospital comments in purple font, no comments made by Camden social care services.

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Section reviewed	Trust comments	Page/ paragraph	HSIB response	Additional Information
Section 3 Summary report	Agree with Summary report.			
Section 4 Facts of the case. The incident	Agree with the information regarding Incident.			
Section 5. Findings and analysis	A detailed SBAR handover was required from the paramedic to the midwife out of the room due to the safeguarding concerns. The unit was in escalation and therefore a student midwife was the only available person to be present with the lady immediately following admission. There is no reference in the report of the challenges in fetal monitoring of a lady with a BMI of over 50.	29/3	The facts of the case have been amended slightly (page 16) to make it clearer that the student midwife took the Mother into the room whilst the midwife took a handover from the ambulance crew. Also slightly reworded info on page 29. **FARM agreed this addition.** The analysis section does make reference to the maternity unit being in escalation (second paragraph of this section). 'The Mother's BMI was calculated to be over 50 kg/m^2 and this created a challenge when trying to auscultate and monitor the Baby's heart rate' has been added to the report. **FARM agreed this addition.**	
	The lady was unbooked /unknown to Bradford and was providing false name and obstetric details including an incorrect gestation of 36+ weeks and did not inform the staff of a previous caesarean section. The staff were trying to locate the lady on the national spine to create a health care record which would enable us to obtain and send blood samples. The unit was in escalation, the Registrar and the anaesthetist were involved in an emergency on the	29/5	The first paragraphs of this section of analysis acknowledge that the Mother was unbooked, had given inaccurate information, that the maternity unit was in escalation and, the information about the registrar being in another room with another potential emergency in now clearer.	

	Birth Centre when this lady was admitted. Maternal risk factors, including a significantly high BMI, also needed to be taken into consideration when making a safe decision for a caesarean section and therefore we would dispute the 17 minutes timeframe from decision to delivery. It is normal practice to rely on accurate information provided by women and families to inform safe decision making. It is impractical to rely on staff to review national safeguarding alerts to provide previous obstetric history. Particularly in an acute situation and when the woman requires urgent and immediate care on the LW		Amended wording to 'it would have been reasonable to make a decision to deliver the Baby and transfer the Mother to the OT, at 14:17 hours, 13 minutes after her admission to the labour ward'. **Agreed at FARM.** No changes made to the report. The report does not suggest that staff would not rely on information give by the parents. The report provides context that on a normal day, where able to do so, further information could have been gained from the safeguarding alerts and may have aided decision making. **Agreed at FARM.**	
	Following a conversation with the midwife involved in this case they have disputed the 17 minute delay of the clinician being in the room and commencement of the CTG from time of admission at 14:00. The ambulance arrived at the destination and observations were taken at 14:02 by the paramedics (documented on the YAS form). This would have been done in the ambulance before transfer to the labour ward. The admission time which is the entry on medway under the short booking is entered as 14:04. The women was of high BMI, in advanced labour and it was a challenging transfer to the labour ward bed. CTG was commenced at 14:15. The midwife that was responsible for care reported she was out of the room for only 2 minutes to receive the details regarding safeguarding issues from the paramedic.	29/5	The chronology of events and draft report have been reviewed. There are a number of times on various pieces of documentation between 14:00 – 14:04 (as discussed with Vicky). It has been agreed that the time of admission will be changed to 14:04, using the time from the Medway admission. The facts of the case will state that the ambulance arrived at the maternity unit at 14:02 hours. This also affects the timing of the panel's opinion about the transfer to the operating theatre, which is now 13 minutes after admission, not 17. The facts of the case do now state, that the midwife remained outside the room to take handover from the paramedics. The analysis does not suggest there was a 17 minute delay of the midwife entering the delivery room. The following sentence has also been added to the facts of the case: The HSIB investigation learnt that the women was of high BMI, in advanced labour and it was a challenging transfer to the labour ward bed.	
	The clinical information provided by the lady (P1, previous normal delivery, 36 week gestation)	29/5	Imminency of birth has been discussed at a number of HSIB clinical panels and FARM. Staff interviews or	

	impacted on the decision making by the clinician as it would be expected that a breech delivery would be imminent in this case. The decision for a caesarean section given the maternal risk factors (BMI 50+, full dilatation, breech on the perineum, no antenatal history) would not be made in haste. Had the staff been made aware of her full history in that she was a multiparous and a previous caesarean section and 41 weeks gestation a decision would most likely have been to go to theatre.		documentation does not indicate the presenting part was on the perineum and therefore does not suggest the birth was immediately imminent. This with the pathological CTG from the outset suggests it would have been reasonable to make the decision to deliver and move the Mother to the operating theatre. Imminency has been discussed in the report (page 31). The report acknowledges that knowledge of the Mother having had a previous CS, may influenced the staff to transfer straight to the OT, which could have led to an earlier delivery of the Baby (page 30). No changes made to the report.	
	The decision to delivery at 14:17 was only 2 minutes after commencement of the CTG and an obstetric review had not yet occurred		As above : 'it would have been reasonable to make a decision to deliver the Baby and transfer the Mother to the OT, at 14:17 hours, 13 minutes after her admission to the labour ward'. **Agreed at FARM.** Detail from staff interviews suggest the consultant obstetrician was already in the room.	
	If the safeguarding database had been checked this would not have provided any further information as an incorrect name was provided to the paramedics and on admission to the Labour ward. Therefore the staff would not have located this lady on the system. In an acute situation with a unit in escalation reviewing a national safeguarding system would have delayed immediate and necessary emergency care and is not feasible as the condition of the mother and the baby is the primary concern.	30/2	Additional info added 'In this case, the alert also included a photo of the Mother, which may have helped to identify her, regardless of using a false name', to provide further info gained from staff interviews. **Agreed at FARM.** No further changes made as this section does acknowledge that events in the room were unfolding at speed and the maternity unit was busy, so staff were unable to check the safeguarding information. This section is aiming to provide an understanding of why staff could not view the information and how it may have been helpful to them if they could have done so.	
	'The HSIB investigation team learnt that in "their experience" staff thought that a vaginal breech	30/3	This needs to be looked at internally with regards to training and communication.	

	birth was imminent (likely to happen soon) after the first VE. This influenced the decision to move the Mother from the initial small delivery room to a larger delivery room, to facilitate a vaginal breech birth' (Quote from the HSIB report). Trust comment: The decision to move to a larger room was made by the Obstetric Consultant based on the VE findings by the lead midwife as she felt birth was imminent. Had a VE taken place by the Obstetrician in the smaller room the decision to transfer immediately to theatre may have been made but decisions were made on the background of incorrect information provided by the woman.		No changes made.	
	'This describes a loss of situation awareness (Endsley, 2015)'. (Quote from the HSIB report). We disagree that the staff lost situational awareness as prompt action was taken at the time on the clinical information that they were given. There were also many other aspects of care which were being undertaken in preparation for the safe delivery of the baby i.e. Cannulation, bloods. All whilst the mother was in advanced labour and the communication challenges this brings.	31/1	Sentence amended to add 'possible': This describes a possible loss of situation awareness (Endsley, 2015). **Agreed at FARM.** **After discussion at FARM, the following has also been added '**The HSIB investigation also considers that there evidence of task overload, where there was a number of tasks the staff were undertaking. This can result in reduced mental and physical capacity to achieve each task, with increased susceptibility to losing situational awareness'. This has been added to discuss the distraction of numerous tasks being undertaken and how this contributed to situational awareness.	
	'The HSIB clinical panel considers that this did delay the timing of the Baby's birth and may have affected the outcome'. (Quote from the HSIB report). There is no way of knowing how long the CTG had been abnormal and the CTG may have been abnormal for a long time before the couple sought advice. Therefore it is difficult to determine if the	31/5	Wording added made: The HSIB clinical panel considers that the CTG and blood gases suggested the insult to the Baby had happened for some time prior to delivery. It is difficult to know how much of a difference an earlier delivery would have made. The HSIB clinical panel considers that the staff made	

	baby had been delivered sooner, if the outcome would have been different.		decisions based on the information they were given at the time, which was considered against their clinical experience. This information influenced their decisions, which were complicated by the speed at which events were unfolding and the belief that the Baby would be born by vaginal breech birth quickly. The HSIB clinical panel considers that this did delay the timing of the Baby's birth and may have affected the outcome. **Agreed at FARM.**	
Section 6 HSIB findings and safety recommendations	Point 5 (from the Royal Free Hospital) Trust A - Did Not Attend (DNA) Policy confirms after there are 3 x missed appointments a home visit may be undertaken. SEE below - Due the Father of the Unborn aggressive and agitated behaviour towards hospital staff, home visits were not considered due to the safety of staff. Parents were in contact with the Named Midwife when appointments were missed and other professional agencies were involved with care for the Family.	Page 34	The guidance attached does state that if contact is difficult to establish, a community midwife should visit the house on the second DNA. There is evidence that at 15+3 and 17+1 weeks the Mother DNA'd and midwifery staff made attempts to contact her. This was one example where we could see that the local guidance was not followed. The following has been added to page 27 of the report: The HSIB investigation team learnt that there was a risk assessment in place, preventing staff visiting the family, due to aggression towards health care professions from the Father. This created a barrier to the home visit. Local guidance does not suggest what staff should do in that situation.	

	freenet2.royalfree.nhs.uk/documents/preview/45582/Maternity-DNA-Women-Who-Fail-To-Attend-Routine-Antenatal-and-Ultrasound-Visits-in-the IT Self Service Portal · IT system status · Suggested Sites · Imported From IE **Pathway for Women who do not Attend Scheduled Antenatal Maternity Appointments** **1st DNA** • Confirm still pregnant with GP, or hospital (this is particularly relevant for women under 20 weeks). • Consider contacting the women at home by telephone, but we aware of the sensitivity of doing so (and do not routinely leave a message unless this is considered appropriate). • Check telephone and address with GP. If necessary, ensure that the woman is currently registered with the recorded GP. • For hospital non attendances, inform the woman's named midwife, usually the community midwife and establish whether she has any further information. Where appropriate arrange a repeat hospital appointment. • Check for any recent in-patient admissions/ current admission. • If unable to make contact on the telephone within 2-5 working days (depending on urgency), send further appointment. • Document action(s) on the DNA on Antenatal Summary Sheet on EPR with date, time and signature on antenatal visit card. **2nd DNA** • Follow actions as for the first DNA, if appropriate. • If the woman has older children under 5, the health visitor should be contacted to see if there is an update. • Ascertain if the woman is receiving antenatal care with the GP, hospital or another community midwife, and find out the last visit and any future visit planned. • It should be noted that for women who live outside the area covered by the RFL Community Midwife Service, it may be appropriate to contact the local Maternity Hospital that covers that area to discuss any concerns and on-going actions that may be required. • Make contact again by telephone and/ or letter, clarifying the need for antenatal care and identifying any difficulties with attending appointments. • If contact is still difficult to establish, the community midwife should visit the house. Ensure a card is left inviting contact with midwife/GP/hospital as soon as possible. Offer alternative arrangements for antenatal visits. • Informing the woman's named caseload midwife and Community Team Leader. • Document all efforts to make contact in the Antenatal Summary/ caseload/ audit sheet or on CERNER in the Antenatal record card on EPR. • If there is a second rescheduled appointment, the call centre must inform the midwife whom will contact the women and ascertain if there is any contributory factors which make it difficult for the women to attend or other problems. • Call centre staff to ensure women's appointments have not been removed from the Electronic Systems (CERNER, EPR) system – the appointment should reflect that it has been cancelled and rescheduled. **3rd DNA** • Write to the woman again, clarifying the need to attend antenatal appointments and offer the options of a GP appointment, change of midwife, further home visit or hospital appointment as appropriate. • If a home visit is undertaken and contact is made with the women it is important to stress the importance of attending antenatal visits, discuss the rationale for DNAs with the woman, check and update her details and arrange another appointment. • If no contact is made with the woman then written information should be left for the woman and the procedures outlines below for the 3rd consecutive DNA should be implemented. • Referral should be made to the vulnerable team and safeguarding lead should be informed. • Consider referral to children's social care (and/ or police, if appropriate). This is particularly recommended if the non-attendance has occurred on more than 3 occasions, where there are child protection concerns, a history of domestic violence/ self-harm, or a previous poor pregnancy outcome. • Document actions taken on EPR. • Ensure the GP has been informed and ask them to document the concern on their computer system.

Section 7 Safety recommendations	**HSIB safety recommendation 1.** Not agreed by Bradford Royal Infirmary. The woman with a complex and unknown history was admitted and a qualified clinician was allocated to her care and an urgent escalation to the obstetric team took place.	**Accepted:** Yes / No **This has been added to the report following FARM:** The HSIB clinical panel considers that assistance could have been by pulling the emergency call bell, enabling the qualified staff to remain in the room and assist the clinician in training. **This provides some additional context around the recommendation.**
	HSIB safety recommendation 2. Not agreed by Bradford Royal Infirmary.	**Accepted:** Yes / No The report does acknowledge that there was another possible emergency and that once made, the DDI was within recommended

	There was a lady on the Birth Centre that staff were considering taking to theatre and this needed to be considered. Once a decision was made to go to theatre this took place promptly.	timeframes. The recommendation came about because the staff felt the birth was imminent, but there was no indication of imminency e.g. no presenting part on the perineum. After discussion at FARM, the recommendation was reworded to: The Trust to ensure that when there is fetal compromise and birth is not imminent, a mother is transferred directly to the operating theatre where further assessment can take place. This should be reflected in the multi-disciplinary emergency skills training.
Appendices		
Any other comments	Comment received from obstetric staff interviewed: 'I think it is important to mention in the report that at the time assessing this patient in the small room, another patient was being assessed by registrar for prolonged bradycardia with a view to cat 1 section'.	Added to page 29 of analysis.