

OCKENDEN REPORT

Emerging Findings and Recommendations
from the Independent Review of

MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

OCKENDEN REPORT

Return to an Address of the
Honourable the House of Commons
dated 10 December 2020 for

**Emerging Findings and
Recommendations from the
Independent Review of Maternity
Services at The Shrewsbury and
Telford Hospital NHS Trust**

**Our First Report following
250 Clinical Reviews**

HC 1081

Ordered by the House of Commons to be printed on 10 December 2020



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ISBN 978-1-5286-2304-9

CCS1220667936 12/20

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office

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

10 December 2020

Dear Secretary of State

I publish this emerging findings report at a time when the NHS is facing further challenging months ahead as a result of the Covid 19 pandemic. We are all aware that frontline NHS staff have, day after day, risen to these challenges, demonstrating their commitment to providing excellent care in what are often seen and described as the most difficult of circumstances.

Whilst this year, especially, has been about the pride our country has quite rightly in our NHS, this independent maternity review is about those families who have suffered harm as a result of their NHS care at a time when they had planned for a joyous event. Families have told us of their experiences of pregnancies ending with stillbirth, newborn brain damage and the deaths of both babies and mothers. These families have shared with us their accounts of the overwhelming pain and sadness that never leaves them.

We have met face to face with families who have suffered as a result of the loss of brothers and sisters or, from a young age, have also been carers to profoundly disabled siblings. We have met many parents where there have been breakdowns in relationships as a result of the strain of caring for a severely disabled child, the grief after the death of a baby or resultant complications following childbirth.

Following the review of 250 cases we want to bring to your attention actions which we believe need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that we recommend be shared and acted on by maternity services across England.

Your predecessor, the former Secretary of State Jeremy Hunt, requested an *‘independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust’*. When I started work as chair of this review, 23 cases had been identified after considerable efforts by the parents of Kate Stanton Davies and Pippa Griffiths who both died just after their births in 2009 and 2016, respectively. Since the review commenced, the number of families who have directly contacted my team, together with cases provided by the Trust for review, has now reached 1,862. When the review is completed, this is likely to be the largest number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

Understandably, examining the details of 1,862 cases is taking time and we continue to face many challenges which are out of our control, including adapting to new ways of working during the COVID19 pandemic.

Due to the significant increase in numbers, I was asked by the Minister of State for Mental Health, Suicide Prevention and Patient Safety to do my utmost to enable initial learning for The Shrewsbury and Telford Hospital NHS Trust and the wider NHS in this calendar year. Therefore, I publish this first emerging first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

My team and I have also held conversations with more than 800 families who have raised serious concerns about their care. These are in addition to the 250 cases considered in this

report and have also informed our findings in this report. We would like to pay tribute to all the families who have approached us to share their experiences.

We have identified a number of important themes which we believe must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement we are sharing emerging findings and themes, have formed **Local Actions for Learning** and make early recommendations which we see as **Immediate and Essential Actions**. We appeal for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

Secretary of State, through our work to date we have recognised a need for critical oversight of patient safety in maternity units. This oversight must be strengthened by increasing partnerships across trusts within local networks of neighbouring trusts. Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

We have no doubt that, had a similar structure of partnership working been in place, The Shrewsbury and Telford Hospital NHS Trust would have been alerted much earlier for the need to scrutinise its governance processes and learn from its serious incidents.

For this structure to be effective we have identified the need to give increased authority and accountability to Local Maternity Systems (LMS) to ensure safety and quality in the maternity services they represent. They must have knowledge of all serious maternity incidents within their LMS with input to and oversight of these investigations and their resultant outcomes and recommendations. Of significance is that we are convinced that an LMS cannot function effectively when limited to one maternity service only. We also consider it imperative that family voices are strongly and effectively represented in each LMS through the Maternity Voices Partnerships.

This is just one of seven **Immediate and Essential Actions** we outline in this first report. We will add to and strengthen these recommendations in our final report following completion of this review as per the terms of reference. We are certain that these **Local Actions for Learning** and **Immediate and Essential Actions** will improve safety in the maternity service at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England provided that implementation is approached with urgency and determination.

Thank you Secretary of State for your ongoing support.

Yours sincerely,

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

Donna Ockenden
Chair of the Independent Maternity Review

Acknowledgements

This first report and the work that will follow owes its origins to Kate Stanton Davies and her parents Rhiannon Davies and Richard Stanton and to Pippa Griffiths and her parents Kayleigh and Colin Griffiths.

Kate's death in 2009 and Pippa's death in 2016 were avoidable. Their parents' unrelenting commitment to ensuring their daughters' lives were not lost in vain continues to be remarkable. In a void described by the families as 'incomprehensible pain', they undertook their own investigations to highlight the deaths of their newborn daughters, and to insist upon meaningful change in maternity services that would save other lives.

Rhiannon, Richard, Kayleigh and Colin persisted in their call for an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust; through their tenacity and efforts this review was instigated.

We remain indebted to all the families contributing to this maternity review. Their experiences continue to shape the learning which will transform maternity care for the better. Finally, we convey our sincere gratitude to the many families who tried to raise serious concerns about maternity care and safety at the Trust who have told us they were not listened to.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

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Explanation of Maternity specific terminology used in this report

Throughout the text this report sometimes uses terms and words that may be unfamiliar to some readers. Although use of these are kept to a minimum, on occasions they are essential because this is a report about maternity services. These terms and words are highlighted in ***bold italics*** at the first use with further explanations for them found in the Glossary at the end of this report.

Chapter 1

Introduction

- 1.1** In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.
- 1.2** The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. The current terms of reference can be found in Appendix 1.
- 1.3** Since the commencement of this review many more families have directly approached the review team, voicing similar concerns to those raised by the original cohort of 23 families. Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.
- 1.4** In addition, The Shrewsbury and Telford Hospital NHS Trust, supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of **stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths**. Through these reviews, known as the ‘Open Book’, which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.
- 1.5** Direct contact from families together with the Trust’s referrals led to us reporting in July 2020 that the review numbers had increased to encompass 1,862 families. We are aware that a number of families made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage we are unable to say whether all of the poor outcomes reported to us occurred as a result of poor care.
- 1.6** It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted us directly with concerns preceding the year 2000, we agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

- 1.7** It is important that we explore the experiences of staff working in the maternity units at The Shrewsbury and Telford Hospital NHS Trust. To do this we will scrutinise staff surveys where available and are working towards a process to hearing from staff directly. In addition we aim to examine past and current governance procedures within maternity services at the Trust that are applicable for the core period of this review.
- 1.8** To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, we anticipate a publication date for the second and final report in 2021.
- 1.9** To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore we have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.
- 1.10** For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. We also refer to in depth conversations and contact with a further 800 families, but we are mindful that these cases have not yet been subject to systematic and independent review by our team.
- 1.11** Our first objective in publishing these emerging themes and findings and their corresponding **Local Actions for Learning** is to support the improvement work currently underway in the maternity services at the Trust. A second objective is to ensure that these emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** are carefully considered by all maternity services in England. We strongly believe we have identified a need for structural changes which, if implemented nationwide with our recommendations will reduce cases of harm to mothers and babies.
- 1.12** It is important to note that we would not have been able to identify these objectives without carefully considering the voices of families which underpin this report.
- 1.13** Over the years, many important recommendations from previous national maternity reviews^{1 2 3} and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases we can confirm that we have identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, we are unable to comment any further on any individual family cases until the full review of all cases is completed.
- 1.14** Having listened to families we state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action. We expect to see real change and improved safety in maternity services as a result of

1 Northwick Park (2008) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557922/> <https://www2.harrow.gov.uk/documents/s30776/Maternity%20Review%20Report.pdf>

2 Morecambe Bay (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

3 Saving Babies Lives (2019) <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>

findings from these 250 case reviews and our resultant **Local Actions for Learning and Immediate and Essential Actions** whilst we continue to work towards completion of the full and final report.

- 1.15 Furthermore, we recommend that the **Immediate and Essential Actions** which we have identified should also inform the decision-making of those who lead maternity services at local, regional and national levels.
- 1.16 Everyone has a part to play. The Shrewsbury and Telford Hospital NHS Trust Board and local commissioners must urgently focus on expediting implementation of the **Local Actions for Learning and Immediate and Essential Actions** outlined within this first report. This will ensure that consistently safe maternity care is provided to its local population.
- 1.17 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the **Care Quality Commission**, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning and Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.
- 1.18 Repeatedly, families have told us of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.
- 1.19 We owe it to the 1,862 families who are contributing to this review to bring about rapid, positive and sustainable change across the maternity service at The Shrewsbury and Telford Hospital NHS Trust. Implementation of the recommendations from this first report and the final report in 2021 will be their legacy.

Chapter 2:

How we approached this Review

What kind of clinical incident is this review considering?

- 2.1** This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.
- 2.2** In addition, a small number of earlier cases have emerged where families have raised significant concerns with the review team. These are being reviewed by the independent team wherever medical records are available from which it may then be possible to answer family questions. These earlier cases are those proactively reported to us by families, rather than systematically provided to us by the Trust. In all likelihood these are not the actual number of events. The earlier cases which occurred in the years immediately prior to 2000 are of importance to this review to establish whether there is evidence of embedded learning in subsequent cases.
- 2.3** The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led us to publish this first report whilst our work continues towards completion of the remaining cases.

Methodology

- 2.4** For this first report the care that 250 mothers and their babies received has been reviewed as fully as possible on the evidence available. All clinical reviews have been undertaken by a team of independent expert clinicians. All review team members work outside the Trust and region and have no current or previous association with the Trust.
- 2.5** All reviews have been undertaken to date with benchmarking and consideration of the standards of care, policies and practice that would have been considered acceptable at the time the incident or concern occurred. The review team have had access to a range of local and national policies and guidance whilst undertaking their work. All the team members reviewing each case are experienced in clinical practice at the time the issue or incident of concern occurred.
- 2.6** The review team comprises obstetricians, midwives and neonatologists working collaboratively. Where specialist advice is required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians are available in the review team.

Listening to family voices

- 2.7** Family voices have been heard by the review team, either through face to face individual interviews held in Shrewsbury in a non-NHS location or via telephone or a

videoconferencing platform. Interviews are recorded electronically and typed up using a transcribing service of which a copy of the transcript is then shared with the family. There is a comprehensive support service available to all families in the review following initial assessment with a trained professional. The review team works in collaboration with SANDS, Child Bereavement UK and Bereavement Training International in offering this service. From early 2021 this will be extended to include support from the Midlands Partnership NHS Foundation Trust.

Listening to the views and voices of staff working at the Trust

2.8 Arrangements are under way to ensure that staff voices of current and former employees within the maternity and neonatal services at the Trust will be heard and carefully considered. We will review the information already available about staff views over the years from a number of sources, including staff surveys undertaken by the Care Quality Commission, the *'Mat Neo' Collaborative*⁴ and the NHS annual staff survey⁵. Following analysis of this information we will offer both former and current employees of the Trust the opportunity to speak with members of the review team in confidence.

Review of the Trust's maternity governance processes

2.9 The maternity review team has received a large volume of governance documentation from the Trust that is of importance and is of relevance to the review. It is now believed that the Trust have provided us with all the governance documentation that they have available that refers to the main time period under review. Findings following consideration of this documentation will be included in our final report.

2.10 For the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.

2.11 To date, the review team have also found inconsistent multiprofessional engagement with the investigations of maternity serious incidents at the Trust. There is evidence that when cases were reviewed the process was sometimes cursory. In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care. The review team has also seen correspondence and documentation which often focussed on blaming the mothers rather than considering objectively the systems, structures and processes underpinning maternity services at the Trust.

2.12 Further, whilst the action plans and recommendations that the review team have seen so far provide some limited evidence of feedback to staff, we have found clear examples of failure to learn lessons and implement changes in practice. This is notable in the selection of, or advice around, place of birth for mothers, the management of labour overall, the injudicious use of oxytocin, the failure to escalate concerns in care to senior levels when problems became apparent, with continuing errors in the assessment of fetal wellbeing.

2.13 This indicates that opportunities for valuable learning to improve care and the prevention of similar occurrences in the future were lost. The frequency with which particular issues have re-occurred, even within the limited group of cases reviewed so far, is entirely consistent with that conclusion. In the sections below we have provided anonymised

⁴ <https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/>

⁵ From 2003 to 2019 and provided by the Trust to the review team 10.11.20

vignettes of some of the mothers’ and babies’ stories; these are illustrative of the types of incidents which have occurred, and which might have been avoided had lessons been learned from previous events and changes in practice been implemented accordingly.

2.14 Within the 250 cases reviewed to date, we have also found that a number of the earlier cases of significant concern were not investigated at the time, although this appears to improve over the period under review. The Trust underwent external review and scrutiny by the CQC in 2015, 2018 and 2020⁶, and by The Royal College of Obstetricians and Gynaecologists (RCOG)⁷ in 2017. However, even within this later timeframe, there is evidence that some serious incidents were not investigated using a systematic and multiprofessional approach, and evidence is lacking that lessons were learned and applied in practice to improve care.

⁶ https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report 2015

⁷ <https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/>

Chapter 3

Trust Board oversight and External Reviews

3.1 As we have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as we review the remaining cases, but the following are noted by the maternity review team at this early stage:

Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory

3.2 We understand from documents supplied to us by the Trust that there have been ten Chief Executive Officers (CEOs) from 2000 to early 2020, with eight in post between 2010 and the current day. Four of those eight were employed as interim CEOs⁸. Since 2000 there have been ten Executive Board Chairs. There has also been considerable Board level turnover amongst both Executive and Non-Executive Directors since the year 2000.

3.3 We have concluded that, it is probable that this lack of continuity at Board level has resulted in a loss of organisational memory. As new CEOs started at the Trust there was a tendency, until at least 2019, to regard problems at the Trust as *'historical'* or as a *'legacy'* from previous years. Indeed, one of the groups of cases of potentially significant concern submitted to the review team by the Trust, ranging from between 1998 and 2017 and therefore, includes some relatively recent cases, was titled *'The Legacy'* cohort by the Trust.

What the Care Quality Commission (CQC) said about the Trust

CQC Reports

3.4 The CQC reports in 2015⁹, 2018¹⁰ and 2020¹¹ vary considerably. We note that the two later reports are critical of leadership at the Trust. The 2015 CQC report graded the maternity and gynaecology services *'good'* across all five domains of safe, effective, caring, responsive and well led, with an overall rating of *'good'*. (CQC 2015, page 21). Oswestry, Ludlow and Bridgnorth Midwifery Led Units (MLUs) were also rated *'good'* across all 5 domains. The 2015 report noted that *'The Trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal [hospital] site. This had seen all consultant led maternity services and inpatient paediatrics move across from the Royal Shrewsbury [hospital] site. We found that this had had a positive impact on these services.'* (CQC 2015, page 2)

The CQC reports in 2018 and 2020

3.5 We note that in the 2018 and 2020 reports the Trust's overall rating of the domain *'well led'* was *'inadequate'*. The 2020 report states that there is a lack of stability in the Executive team. Overall, the CQC told the Trust they must *'ensure that there are effective governance systems and processes in place to effectively assess, monitor and improve the quality and safety of services'*. (CQC 2020, page 6).

⁸ Who's Who at the Trust – internal document – received by the review team 9th September 2020

⁹ https://www.cqc.org.uk/sites/default/files/new_reports/AAA3868.pdf CQC report January 2015

¹⁰ <https://www.cqc.org.uk/provider/RXW> CQC report 29th November 2018

¹¹ <https://www.cqc.org.uk/provider/RXW> CQC report January 2020

3.6 In respect of maternity services at the Princess Royal Hospital, the CQC advised that the Trust must:

- *Ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults*
- *Ensure high risk women are reviewed in the appropriate environment by the correct member of staff*
- *Ensure grading of incidents reflects the level of harm, to make sure the duty of candour is carried out as soon as reasonably practical*
- *Ensure all women receive one to one care when in established labour*
(CQC 2020, page 8)

The review team will further consider these CQC reports of the maternity service and the Trust's responses to them in its final report.

MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)

Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017

- 3.7** Stillbirths, neonatal deaths and perinatal mortality rates for the UK are published by MBRRACE-UK in Perinatal Mortality Surveillance Reports¹². These reports publish stabilised and adjusted mortality rates to adjust for chance variation due to small numbers and for key factors known to increase the risk of perinatal mortality such as mother's age, socio-economic deprivation, baby's ethnicity, baby's sex, multiple births and gestational age at birth (for neonatal deaths only).
- 3.8** MBRRACE issues individual reports to NHS Trusts indicating the local perinatal mortality rates. These Trust-specific reports recommend that Trusts should review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care have been implemented.
- 3.9** MBRRACE reports show that for the years 2013-2016 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were up to or more than 10% higher than comparable UK NHS Trusts. For the year 2017 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were reported as up to 5% higher or up to 5% lower than the UK average (suggesting roughly comparable rates with other UK Trusts). Perinatal mortality rates for 2018 were not published at the time of writing this report.

Clinical Commissioning Group (CCG) oversight of the Trust

- 3.10** There are two CCGs in the local area, Telford and Wrekin CCG and Shropshire CCG. They were formally established in April 2013 and from 2019 have engaged in '*bringing their decision-making processes closer together*'¹³.

¹² <https://www.npeu.ox.ac.uk/mbrance-uk/reports>

¹³ <https://www.healthwatchtelfordandwrekin.co.uk/news/new-board-members-join-shropshire-ccg-and-telford-and-wrekin-ccg/>

- 3.11** The Maternity review team will have the opportunity to consider a range of maternity specific documentation from the two CCGs. As commissioners, the interactions with the Trust and the CCGs and the *Primary Care Trusts (PCTs)* before them, will provide valuable insight into the local external oversight the Trust's maternity services received during the timespan of the maternity review.
- 3.12** We note that during the inaugural Telford and Wrekin CCG Board meeting in April 2013¹⁴ there appeared to have been some concerns raised about maternity services at the Trust, leading to the CCG intending to write to the Trust '*with regards to concerns with Midwifery numbers.*' (page 4).
- 3.13** In June 2013 the Telford and Wrekin CCG Quality and Safety report¹⁵ describes that, following concerns raised by both CCGs, a 'Risk Summit' led by the NHS England Area Team had been held in May 2013. Concerns specific to maternity services were: '*Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI...*' (page 5). In July 2013 a CCG led review of maternity services at the Trust¹⁶ was commenced with the stated '*Lack of improvement in maternity services*' recorded as a 'risk' as follows:
- 'Risk 3 - Lack of Improvement in Maternity Services
External review of maternity services across the local health economy has now formally commenced and will report to Boards by September 2013.'* (page 4)
- 3.14** The resulting report¹⁷ published jointly by both CCGs in October 2013 will be considered more fully in the final report, as will further documentation received from the CCGs.

The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust

- 3.15** Prior to its demise in 2017 the purpose of statutory supervision of midwives was to protect the public by ensuring a safe standard of midwifery practice through enhanced quality and safety.
- 3.16** As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by supervisors of midwives at the Trust. The review team will continue to consider all available supervisory governance documentation relating to any individual cases in this maternity review.

¹⁴ See Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413 –page 4
<https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/may-3/444-03-ccg-board-minutes-9th-april-2013-v1/file>

¹⁵ <https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/june-3/542-10-5-twccg-board-quality-and-safety-june-2013-report/file>

¹⁶ <https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/july-3/585-11-3-ccg-board-quality-and-safety-report-9th-july-2013/file>

¹⁷ <https://shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf>

Review of Maternity Services 2007- 2017

3.17 In June 2017 the Trust conducted an internal review of maternity services¹⁸. It considered the history of maternity services between 2007 and 2017, focussing on issues of patient safety, learning, and engagement with bereaved parents. The report concluded that *‘all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service.’* The report further stated that the service must *‘create a coordinated approach to the maternity safety improvement plan’* and that *‘safety in maternity is protected by the efforts of the staff and supported by leaders.’* (2017, page 28.)

¹⁸ <https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf>

Chapter 4

Multidisciplinary Review: Our findings following review of 250 cases

Midwifery and Obstetric issues identified in the review of 250 cases at the Trust

The roles of midwives and obstetricians in the multidisciplinary maternity team

- 4.1** Midwives and obstetricians work closely together providing maternity care. Midwives are specialists in the provision of normal pregnancy care throughout the pregnancy pathway. Obstetricians are the lead clinicians providing care for complex pregnancies and births in an obstetric unit working in collaboration with midwives and other health care professionals including obstetric anaesthetists. The following is a reflection of emerging themes identified from the 250 cases reviewed to date by the independent review team.
- 4.2** The midwifery and obstetric issues identified from these cases are merged for the purposes of this report, which recognises the close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

- 4.3** One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.
- 4.4** Evidence for this theme was found in the women's medical records, in documentation provided by the Trust and families, in letters sent to families by the Trust and from through the families' voices heard through the interviews with the review team. Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.
- 4.5** *Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby...' There were no words of condolences or sympathy within the body of the letter. (2001)*
- 4.6** *A woman was in agony but told that it was 'nothing'; staff were dismissive and made her feel 'pathetic'. This was further compounded by the obstetrician using flippant and abrupt language and calling her 'lazy' at one point. (2011)*
- 4.7** *A woman was in great pain after delivery and left screaming for hours before it was identified that there were problems that needed intervention. The attitude of some of the midwives also made the situation worse. (2013)*

- 4.8** There are several examples from the cases reviewed to date indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted. There are some examples of midwives and doctors who have made a huge difference to the women and families due to the care they provided and kindness they showed. However, kind and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

Place of birth: Assessment of risk

- 4.9** At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth. This can be at home, a midwifery led unit or an obstetric-led unit. Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.
- 4.10** *A woman was considered appropriate for birth in a remote stand-alone birth centre despite developing known risk factors in the weeks leading up to her delivery. There were then errors in the fetal monitoring in labour. After birth the baby was not monitored appropriately despite clear warning signs, and was transferred, too late, to a specialist unit where the baby died. (2009)*
- 4.11** *A woman who laboured at the birth centre was not adequately monitored as ‘the unit was busy’. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*
- 4.12** *A woman who delivered in a stand alone birth centre suffered a catastrophic haemorrhage requiring transfer to the consultant unit, where she died. Her family stated that there had not been an explanation of the risks of birth in a midwifery led unit, nor information on the need for transfer if complications arose. (2017)*

Clinical care and competency: management of the complex woman

- 4.13** At the point of registration a midwife will have achieved competency in the required academic and clinical subject areas and therefore qualify for entry to the Nursing and Midwifery Council register. In a significant number of cases the review team found evidence that the clinical care and decision making of the midwives did not demonstrate the appropriate level of competence, with consequences for the mothers and babies in their care. One aspect is failure to recognise deviation from the norm and so failure to escalate appropriately.
- 4.14** In some cases the review team has found evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

- 4.15** *A woman in the early third trimester of her pregnancy was admitted to the antenatal ward with severe pre-eclampsia, characterised by new onset hypertension and proteinuria. Shortly after her discharge home she had an eclamptic seizure and was taken to a neighbouring unit, where she delivered. (2011)*
- 4.16** *A woman developed severe high blood pressure and was managed on the labour ward. There was a delay in treating her high blood pressure and, following delivery, there was a further delay in seeking senior clinical advice. She subsequently died in another hospital. (2011)*
- 4.17** *A pregnant woman who was known to have large uterine fibroids had midwifery led care and was not referred to an obstetrician as her condition should have required. There were errors in the interpretation of the baby's growth and an obstetric opinion or ultrasound scan was not obtained. The baby was delivered around ten weeks early, was growth restricted and died the same day from a severe hypoxic birth injury. (2016)*

Escalation of concerns

- 4.18** In the cases reviewed so far, concerns regarding escalation have evolved as an overarching theme. The cases show repeated failures to escalate for further opinion and review. This is a key element of the role of the midwife and an integral part of safe practice. There is also evidence that when concerns were escalated they were not then acted upon appropriately or escalated further to the appropriate level. This may indicate a lack of multidisciplinary communication and collaboration and/or senior clinical supervision, both of which are key to providing safe care.
- 4.19** The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed to date these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents which had resulted in stillborn or severely brain damaged babies.
- 4.20** *A woman was induced for raised blood pressure at 37 weeks. The fetal heart rate was normal on arrival on labour ward. After artificial rupture of the membranes there was a failure by the midwife to record the fetal heart rate or escalate any concern and the baby was subsequently stillborn. The family did not feel that they were involved in the investigation and did not receive an apology. (2015)*
- 4.21** *A woman who was admitted with contractions and early signs of infection late in her second trimester of pregnancy was seen by a junior doctor and discharged without higher level assessment. Her management was not subsequently discussed with a senior colleague. Several hours later she was re-admitted and delivered a premature baby. (2015)*

Management of labour: monitoring of fetal wellbeing, use of oxytocin

- 4.22** Fetal heart rate (FHR) monitoring is an essential component of the safe management of labour. When labour is managed in a midwife-led setting the FHR is monitored using intermittent auscultation (IA). On the labour ward setting the FHR is usually monitored continuously with the **cardiotocograph** (CTG). The review team found significant problems with the conduct of intermittent auscultation and in the interpretation of CTG traces.

- 4.23** Oxytocin is an intravenous infusion commonly used in obstetric labour wards to increase the frequency, strength and length of uterine contractions. There are guidelines for its use and it should be used carefully and reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns. Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.
- 4.24** Long labour exacerbated by use of oxytocin can result in an obstructed labour leading to fetal distress and also difficult caesarean delivery because the fetal head is deeply in the pelvis. Long labours can also increase the risks of infection and excessive haemorrhage after birth. The review team noted many examples where oxytocin was used injudiciously; these cases occurred across the time period of the 250 cases reviewed, which suggests a failure to learn from previous cases where the outcome was poor.
- 4.25** *A woman who had a previous caesarean section was induced and had a long labour using oxytocin. The baby's head was in the occiput posterior position and this made the delivery by caesarean section difficult. The mother said afterwards that she had the impression that the Trust were trying to keep the caesarean section rate low. (2000)*
- 4.26** *A mother, admitted in labour with a breech presentation, had inappropriate use of oxytocin for her long labour with CTG concerns. Standard obstetric teaching is to avoid the use of oxytocin in breech labour and especially in this case, where there was the added complication of FHR abnormalities. Her baby was born in very poor condition and died a few days later. (2006)*
- 4.27** *A woman presented in labour at 39 weeks. There were CTG abnormalities in labour, which were not escalated. Oxytocin was used despite an abnormal CTG. The baby was delivered normally but developed a hypoxic brain injury and cerebral palsy. (2006)*
- 4.28** *A woman had a prolonged labour at a birth centre despite earlier concerns over abnormal CTG tracings during the antenatal period. She was transferred to the labour ward but her baby was stillborn shortly afterwards. Despite the failure to adequately monitor both the mother and the baby there was no investigation or learning. The mother and father did not receive an apology. (2007)*
- 4.29** *A woman was in labour and there were fetal heart rate concerns. Despite the abnormal CTG oxytocin use was continued throughout the labour. At the caesarean section there was evidence that there had been an obstructed labour. The baby suffered from hypoxic brain injury and died some months after birth. (2009)*
- 4.30** *A woman had oxytocin commenced in the later stage of delivery with CTG abnormalities. There was a ventouse delivery and the baby was delivered in poor condition and developed a hypoxic brain injury. (2010)*
- 4.31** *A woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken but it failed to identify or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change clinical practice in future. (2014)*
- 4.32** *A woman had a previous caesarean section followed by a normal delivery. The following pregnancy she was induced at term. Oxytocin was used in the presence of CTG*

abnormalities and there was excessive uterine action (hyper stimulation). There was also a failure to monitor the fetal heart during siting of epidural. An emergency caesarean section was performed and the baby was delivered in a poor condition. The investigation did not address the management of labour and CTG interpretation or the injudicious use of oxytocin. (2014)

- 4.33** *A woman was admitted in normal labour. There were CTG abnormalities in the second stage, which were not recognised and later it was also not recognised that the maternal heart rate was being recorded rather than the fetal heart. The baby was born in poor condition, developed hypoxic brain injury, and died several months later. (2015)*
- 4.34** *A woman had a failed ventouse delivery and emergency caesarean section in a previous pregnancy. In the next pregnancy the baby was found to be macrosomic (large) on scan at 36 weeks. The woman was admitted in labour and despite requests for a caesarean section she was persuaded to attempt a vaginal birth. This was complicated by a pathological CTG in labour with inappropriate use of oxytocin and shoulder dystocia. The baby died a few days later from hypoxic brain injury and complications of the shoulder dystocia. The family were dissatisfied with the investigation. The investigation failed to acknowledge omissions in care, which prevented future learning. (2015)*
- 4.35** *A woman who laboured at the birth centre was not adequately monitored as ‘the unit was busy’. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation, and correspondence with the Trust, and said during a meeting with the Review Chair that they had been ‘put off, fobbed off and had obstacles put in our way’. (2016)*

Traumatic birth

- 4.36** Some cases involving long labour with injudicious use of oxytocin resulted in women becoming fully dilated and consequently being assessed for instrumental vaginal delivery. The review team found evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences. There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.
- 4.37** *A woman laboured and had repeated attempts at forceps delivery. The baby sustained multiple skull fractures and subsequently died. (2007)*
- 4.38** *A woman who was known to have a big baby was refused her request for a caesarean section and encouraged to labour. She had a forceps delivery and the baby had **shoulder dystocia** with a resulting fractured **humerus**. In her letter to the Trust afterwards the mother wrote that she felt her request for a caesarean section was refused because the Trust wanted to keep their caesarean section rates low. There was no incident form or investigation. (2012)*
- 4.39** *A baby died following a traumatic forceps delivery. There were repeated attempts by two doctors to deliver the baby with forceps. (2013)*
- 4.40** *A woman had repeated attempts to deliver the baby using forceps. The baby was found to have skull fractures after birth and subsequently developed cerebral palsy. There was no investigation. The family were very dissatisfied with the Trust’s response to their concerns. (2017)*

4.41 The reviews of these and other cases indicate that efforts to ensure a vaginal delivery either should not have been attempted or should have been abandoned and the baby delivered by caesarean section. Some of these deliveries were undertaken by consultant obstetricians, which was particularly concerning.

Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust

4.42 Caesarean section rates have risen in the UK over the two decades of this review. It is notable that for this period the caesarean section rate at The Shrewsbury and Telford Hospital NHS Trust has consistently been 8%-12% below the England average and those of its neighbouring units (Table 1). Over the years this has been positively reported in the local press with it widely known in the local community.

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

4.43 The review team came across many cases where women said that they had been aware The Shrewsbury and Telford Hospital NHS Trust wished to keep caesarean section rates low. A typical quote during interviews was that *‘they didn’t like to do caesarean sections’*. The review team observed that women who accessed the Trust’s maternity service appeared to have little or no freedom to express a preference for caesarean section or exercise any choice on their mode of delivery.

4.44 The review team have the clear impression that there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit. Whereas it is not possible to correlate this culture with overall poor obstetric outcomes, the previous vignettes show that in some individual cases earlier recourse to a caesarean delivery would have avoided death and injury.

Overall there did not seem to be a consideration of whether this culture contributed to unnecessary harm.

Bereavement care

- 4.45** It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.
- 4.46** The Stillbirth and Neonatal Death Society (SANDS)¹⁹ states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. This may be decision making with regards to delivery, seeing their baby, funerals and post mortem, to name a few aspects. Midwives and obstetricians need to have an awareness of these key issues and also an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long lasting influence on the experience families have at this time.
- 4.47** Whilst there is some limited evidence that parents were supported to spend time with their baby after death and to create memories from the very limited time they were able to spend together, there is also little evidence of follow up support being provided as would be expected and recommended. There are several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.
- 4.48** Not only was bereavement care poor in a number of the 250 cases reviewed to date, there are also examples of completely inappropriate comments made to some family members after the loss of their baby. There are several examples where mothers say that they were made to feel responsible by Trust staff for the loss of their babies.
- 4.49** *One mother complained about the consultant obstetrician's attitude when seen on the neonatal ward. She described the consultant as being rude and completely dismissive of the family's concerns. She also complained about postnatal care saying that the staff were not aware of the issues and she had to keep explaining distressing details at every shift change. There was no investigation or learning. (2009)*
- 4.50** *A woman whose baby died after a particularly traumatic delivery was seen by the consultant afterwards. The consultant was described as having 'no compassion or understanding of the trauma experienced'. (2013)*
- 4.51** *The family had received limited bereavement support on Day 17 after birth. The family found this unhelpful and unprofessional.bereavement care was lacking to the point of being completely inadequate. The Trust's bereavement service should have made contact much sooner. There is no record that any follow up support and advice was given. (2016)*
- 4.52** *A mother experienced a neonatal death at 17 hours of age. She and her partner described the bereavement service 'as offering no support, lacking in compassion and actually making it so many times worse'. (2016)*

¹⁹ <https://nbcpathway.org.uk/about-nbcp/national-bereavement-care-pathway-background-project>

4.53 *A woman had an apparently uncomplicated homebirth. Later the same day and overnight she repeatedly rang the midwifery unit to say that she was concerned that the baby wasn't feeding properly. She was reassured but the baby collapsed and died the next day. The family felt they had to 'push for an investigation' and that the Trust did not listen to them. They believed that the bereavement care they received was inadequate. (2016)*

LOCAL ACTIONS FOR LEARNING: MATERNITY CARE

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

- **4.54** A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.
- **4.55** All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.
- **4.56** The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.
- **4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2²⁰ (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.
- **4.58** Staff must use NICE Guidance (2017)²¹ on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
- **4.59** The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.
- **4.60** The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse

²⁰ <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>

²¹ <https://www.nice.org.uk/guidance/cg190>

outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015²².

- **4.61** Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.
- **4.62** There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training²³.
- **4.63** Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.
- **4.64** The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.
- **4.65** The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.
- **4.66** The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

Maternal Deaths

- 4.67** Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust. The review team were also contacted by two families who had experienced the death of their mothers whilst under maternity care at the Trust before 2000. These will be reviewed if clinical records become available.
- 4.68** The review team identified recurrent themes in the care of some mothers who died, which present opportunities for important learning from the initial evaluation of these occurrences.
- 4.69** In the cases reviewed from 2000 onwards there appears to have been a lack of antenatal multidisciplinary team planning for women with significant pre-existing comorbidities and/or other medical risk factors. Whilst the women appear to have been correctly identified as ‘high risk’ at booking, the review team were unable to identify the lead clinician with overall responsibility for the care of the woman in the majority of cases. Whilst pathways seem to have existed for referral to other medical specialities, once referred for specialist care, the resultant assessments were frequently conducted by junior doctors. There appear to have been no joint clinics and multidisciplinary care planning for antenatal monitoring, labour, delivery or postnatal care.

²² <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

²³ https://www.hsib.org.uk/documents/261/HSIB_Delays_to_intrapartum_intervention_once_fetal_compromise_is_suspected_Report.pdf

4.70 In some cases there was poor completion of the **maternal early warning score (MEWS)** which might have prompted escalation if completed appropriately, and there was frequently a failure to recognise the deteriorating patient. High risk and significantly sick women on the delivery suite were reviewed by junior medical staff without involvement of consultant obstetricians or consultant obstetric anaesthetists for lengthy time periods. There were delays in initiating appropriate investigations and treatment which also led to delayed escalation. These delays impacted on timely transfers to a higher level facility such as high dependency or intensive care.

4.71 The review team is further concerned about the rigour and quality of investigations after serious incidents such as a maternal death. In some cases no investigation was initiated. Some cases were investigated internally by a small governance team, no learning appears to have been identified and the cases were subsequently closed with it deemed that no further action was required. A number of investigations lacked visibility and input from the wider multidisciplinary team, resulting in missed opportunities for important learning.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

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

- **4.72** The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.
- **4.73** Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.
- **4.74** There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.

Obstetric Anaesthesia

4.75 Obstetric anaesthetists are an integral part of the labour ward team. Over 60 % of all women entering the labour ward require anaesthetic interventions, and many more are assessed by an obstetric anaesthetist in the antenatal or postnatal period²⁴. The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work²⁵.

²⁴ RCoA Guidelines for the Provision of Anaesthesia Services (GPAS); Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020 "Raising the Standards", RCoA Quality Improvement Compendium, 4th Edition, May 2020, page 241-268; www.rcoa.ac.uk

²⁵ OAA/AABGI Guidelines for Obstetric Anaesthesia Services 2013

- 4.76** The number of women requiring advanced levels of medical and anaesthetic care from maternity services has risen over the last 20 years, due to a number of factors including increasing levels of maternal obesity and its associated co-morbidities such as Type 2 diabetes, high blood pressure and cardiac disease. More women conceive with pre-existing medical problems and/or are delaying motherhood until they are older and may therefore have developed more underlying medical conditions²⁶.
- 4.77** The trend towards an older obstetric population with increasing morbidities and significant levels of maternal obesity means obstetric anaesthetists are increasingly required to take on the role of peri-partum physician dealing with the management of these underlying medical conditions in labour and in acute settings, as well as providing their traditional services such as pain relief in labour and anaesthesia for operative delivery or immediate surgery postpartum. The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability ‘around the clock’, as maternity is a 24 hours a day and 7 days a week service.
- 4.78** In considering the cases for this first report, the review team have identified several areas of concern relating to obstetric anaesthesia practice. The reviewers found a tendency towards simple task focus, e.g. siting an epidural, or administering anaesthesia, without a holistic assessment of the patient and appreciation of the wider clinical picture.

Poor obstetric anaesthesia practice

- 4.79** *A woman with severe and rapidly progressive pre-eclampsia and uncontrolled blood pressure (BP) was taken to theatre for an emergency caesarean section. The labour ward team failed to control her blood pressure and the duty anaesthetist compounded the issue when inducing general anaesthesia without administration of any drugs to attenuate the potential BP rise during intubation. This failure exposed the woman to an increased risk of cerebrovascular accident (CVA) or a stroke. (2011)*
- 4.80** *A woman requested epidural analgesia in labour. She had frequent contractions and felt the urge to push, although diagnosed as being in the first stage of labour. There were significant concerns about fetal wellbeing on the basis of the cardiotocograph (CTG). Despite this, the CTG was discontinued for a significant time to site the epidural. When the CTG was recommenced immediately after siting of the epidural, the fetal heart rate was difficult to obtain and an emergency caesarean section was indicated. The anaesthetist did not seek clarification on the CTG and possible urgency of delivery before siting the epidural. The baby was born in poor condition, requiring neonatal resuscitation. (2014)*

Lack of escalation to, and involvement of, senior anaesthetists

- 4.81** We also found several examples of lack of senior involvement from the consultant anaesthetists on call. Even in periods of high workload there was limited support by the consultant anaesthetist responsible for the delivery suite out-of-hours. Complex obstetric complications, for example severe sepsis or pre-eclampsia, or women with significant pre-existing underlying co-morbidities, were treated by very junior staff for extended periods of time even when the complexity of work clearly required senior input. There were some cases where there was an evident delay in escalating to the

26 Knight M et al on behalf of MBRACE-UK. Saving Lives, Improving Mother's Care- Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013 – 2015. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017

consultant anaesthetist on call. However, when requested by junior doctors, we also found instances where the consultant anaesthetist failed to attend in a timely manner.

- 4.82** *A woman who had an epidural for pain relief in childbirth developed a significant headache and unspecific neurological symptoms after birth. She was seen over several days by a junior doctor. Only one review was documented in the notes. There was a significant delay requesting further diagnostic tests and involving the consultant anaesthetist. Subsequent imaging showed significant pathology that should have been detected earlier. The delay put the woman at significant risk for further complications. (2012)*

Limited consultant anaesthetist representation in incident investigation and multidisciplinary team meetings after significant incidents

- 4.83** The review team found instances of maternal deaths or cases of severe complications, where the obstetric anaesthesia team was requested by the obstetric risk management team to ‘perform their own incident investigation’ and not participate in any wider investigation or contribute recommendations to prevent such occurrences in future. Sometimes only junior anaesthetic staff attended initial root cause analysis meetings or obstetric anaesthetists were not represented at all in investigation panels or team meetings. This undermines the concept of multidisciplinary team working and indicates to the external review team that obstetric anaesthetists were not perceived as an integral part of the maternity team.
- 4.84** As late as 2016 the review team saw serious incident investigations without input from obstetric anaesthetists or relevant other sub-specialities. The lack of a well-functioning multidisciplinary team represented a significant weakness in the structure of the Trust’s maternity services with a significant impact on wider learning from adverse events and ultimately a detrimental impact on patient safety.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

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

- **4.85** Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.
- **4.86** Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.
- **4.87** Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.

Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.

- **4.88** Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.
- **4.89** The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 ‘Guidelines for Provision of Anaesthetic Services’, section 7 ‘Obstetric Practice’²⁷.
- **4.90** The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.
- **4.91** The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

Neonatology

- 4.92** From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.
- 4.93** Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.
- 4.94** We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.
- 4.95** It appears from the majority of the 250 medical records reviewed to date that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents.

²⁷ <http://www.csen.com/GPAS.pdf>

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

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

- **4.97** Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.
- **4.98** There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.
- **4.99** The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.
- **4.100** There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

Chapter 5

Immediate and Essential Actions to Improve Care and Safety in Maternity Services

We include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked us, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. We are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

Recommendations are of limited use if they are not implemented; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred. Relying on the strength of our collective clinical experience we have named our conclusions as **Immediate and Essential Actions** – i.e. these are things which we say must be implemented now if not already done so.

As a team of clinicians we are engaged in practice across eleven Trusts in London and the South East and South West of England. In addition to clinical practice, our current roles, or those we have held in the recent past include midwifery, clinical and divisional director roles, consultant midwives, leads for governance, labour ward coordinators, clinical matrons and educational leads. Many of us have been active in leading and supporting regional and national maternity safety initiatives and have published their expertise in maternal and child health on a national and international level²⁸.

Many of our **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which we have referred below. We have formed our ‘musts’ from recurrent themes we have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

²⁸ <http://www.ockendenmaternityreview.org.uk/>

1: ENHANCED SAFETY

Essential Action

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.

Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
- An LMS cannot function as one maternity service only.
- The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women’s voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY	
<p>Essential Action</p> <p>There must be robust pathways in place for managing women with complex pregnancies</p> <p>Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.</p>	<ul style="list-style-type: none"> • Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services.

5: RISK ASSESSMENT THROUGHOUT PREGNANCY	
<p>Essential Action</p> <p>Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.</p>	<ul style="list-style-type: none"> • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
 - Improving the practice of monitoring fetal wellbeing
 - Consolidating existing knowledge of monitoring fetal wellbeing
 - Keeping abreast of developments in the field
 - Raising the profile of fetal wellbeing monitoring
 - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
 - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT

Essential Action

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.
- Women’s choices following a shared and informed decision making process must be respected.

Our Ongoing Work

I am grateful to my Independent Review Team who continue to support me with this review. We have taken these initial steps, through the publication of this first report, towards making a significant difference in helping to improve safety in maternity services. This review of 250 cases at the Trust can now impact positively on the maternity care provision for women and their families in Shropshire with the Trust working with their commissioners to ensure this happens.

As our work continues, we implore maternity services across England to also carefully consider this first report, and to make ambitious plans to ensure timely implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** takes place.

Donna Ockenden

Appendix 1: Terms of Reference

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an ‘independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.’ Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:
 - a. appropriate investigations were conducted; and
 - b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the ‘Open Book’ review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:
 - a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
 - b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
 - c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
 - d. Consider how the parents, patients and families of patients were engaged with during these investigations;
 - e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and
 - f. The review team will present cases internally, and on an as required basis seek further external advice
11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.
12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.
13. Directions to the Review Team:
 - a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

- b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?
- c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
- d. Were families involved in the investigation in an appropriate and sympathetic way?

Key Principles

14. The review will be expected to:
 - a. Engage widely, openly and transparently with all relevant parties participating in the review process;
 - b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
 - c. Adopt an evidence-based approach;
 - d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;
 - e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and
 - f. Consider the challenge of implementing proposals, including the workforce.
 - g. Handle data and information with care and in accordance with good information governance practice
15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.
16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.
17. In 2018 NHS Improvement commissioned an ‘Open Book’ review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to ‘open its books’ in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).
18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:
 - a. Maternal deaths

- b. Stillbirths
- c. Neonatal deaths
- d. Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.

Appendix 2: Glossary

Definitions and Medical and Midwifery terms used throughout this Report

Glossary of terms used

Birthing centre	A birth centre staffed by midwives, they may be ‘stand alone’, (some distance from a Consultant led unit) or alongside- often in the same building/ on the same floor as a Consultant led unit
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Clinical Commissioning Groups (CCG)	Groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby’s head in order to guide the baby out of the birth canal
HSIB	The Healthcare Safety Investigation Branch. They investigate incidents that meet the Each baby Counts criteria and their defined criteria for maternal deaths https://www.hsib.org.uk/maternity/what-we-investigate/

Hypoxic ischaemic encephalopathy (HIE)	A newborn brain injury caused by oxygen deprivation to the brain. Graded into HIE grades 1-3 depending on severity
Humerus	The long bone in the arm
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Maternal Death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
MatNeo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a 'Modified Early Obstetric Warning System'
MBRRACE-UK	(Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) – a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life <ul style="list-style-type: none"> - Early neonatal death – a liveborn baby who died before 7 completed days after birth - Late neonatal death – a liveborn baby who died after 7 completed days but before 28 completed days after birth
Non Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation

Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Perinatal death	A stillbirth or early neonatal death
Pre-eclampsia	A disease of high blood pressure, proteinuria and organ dysfunction occurring in pregnancy
Primary Care Trust or PCT	were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups or CCGs.
Shrewsbury and Telford Hospital NHS Trust or the Trust	
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal

