2024-15

REPLY BY THE PRESIDENT OF
THE COMMITTEE FOR HEALTH & SOCIAL CARE
TO QUESTIONS POSED BY DEPUTY ST PIER PURSUANT TO RULE 14 OF THE RULES OF PROCEDURE

In December 2023, Health & Social Care commented publicly in relation to the inquest of baby Oliver Veron who died in April 2016 that, "Even though *the independent reviews found no fault in the care provided*, we will review the findings of the inquest to see if there is any additional learning from this tragic case." (emphasis added.)

a) An independent review from Portsmouth Hospitals' NHS Trust[1] ("the Portsmouth Report") into the case was commissioned by HSC.
- **HM Comptroller[2] noted that "the summary of findings of the Portsmouth Report identified one major concern, seven concerns and thirty learning issues"; and**
- **The Portsmouth Report stated, "the care received by Baby OV was below the expected standard" and "there are serious concerns about the evidence used to withdraw the care from Baby OV."**

b) An independent review undertaken by Dr Catherine Harrison[3] concluded that, "Oliver received timely and appropriate neonatal care initially. The timing of the decision to withdraw active care in my opinion was not appropriate, due to the interpretation of minimal investigations reflecting a single point of time and the lack of repeating these to ascertain any improvement, with non-tertiary level input in decision making or clinical care provision".

1. In light of the conclusions from two independent reviews, how did HSC reach its conclusion that "the independent reviews found no fault in the care provided"?

The independent reviews identified that the Obstetric emergency care was managed well. The concerns raised were in connection with the evidence used on which the decision to withdraw active care from baby OV in the Special Care Baby Unit was based.

2. Does HSC now have locally written end-of-life protocols?

HSC follows the British Association of British Perinatal Medicine (BAPM) guidance. All babies requiring intensive care are routinely discussed with a tertiary centre. This ensures that bespoke care management programmes are in place. This includes end life care options if appropriate.

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[1] External review by Portsmouth Hospitals NHS Trust in respect of the care provided to Mrs V by The States of Guernsey Health and Social Services and St John's Emergency Ambulance Services: Finalised 22nd March 2017: Update 22nd July 2017; Amended April/May 2018 (in blue text)

[2] Paragraph 48, HMC Report (Resumption) (Summary relating to the death of Oliver Veron) *UPDATED (12.12.2023)*

[3] HM Comptroller commissioned an independent medical expert, **Dr Catherine Harrison**, Consultant Neonatologist, to review the medical evidence and the reports commissioned by HSC and to address concerns raised by Mr and Mrs Veron concerning the care of Mrs Veron and of Oliver.

3. **Does HSC now have procedures in the case of neonatal deaths which clearly provide for segregation of responsibility and/or 'four eyes' checks between the clinicians involved, those signing the death certificate and those advising the Law Officers that there are no circumstances warranting an inquest?**

No. The form of medical certificate of cause of death is prescribed under the Law relating to the Registration of Births and Death in the Bailiwick and doctors completing a medical certificate of cause of death are expected to state the cause of death to the best of their knowledge and belief. The Law Officers of the Crown, in exercise of their customary law powers, may open Inquests into the cause of a death where death appears to be due to unknown, violent or unnatural causes, death occurs in prison or other detention, or they believe it to be in the public interest to hold an Inquest.

Neonatal deaths occurring in the Bailiwick are additionally reported to the Child Death Overview Panel overseen by Southampton, and to the MBRRACE-UK perinatal confidential enquiry (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK).

4. **Does HSC now have a locally written guideline on unplanned homebirths?**

Yes, HSC guidance document number MG1016, 'Born Before Arrival'. This guideline provides information and guidance for the maternity service that will assist in the management of unattended births.

5. **Does HSC now have a protocol that any malpresentation noted at delivery has a 'scoop and run' approach?**

St John Ambulance Service now has a policy in place that clearly states that they will 'scoop and run' for any presentation unless a birth is imminent. In the latter case, the Ambulance crew will collect and transfer, immediately stopping en-route should the delivery progress. The priority is always to transfer a woman to a place of safety. The Ambulance service use National guidance in practice from the 'Joint Royal Colleges Ambulance Liaison Committee' (JRCALC). The only deviation from this guidance locally is that a midwife will not be deployed to the home.

The Maternity service also provide 'maternity first responder training' to Ambulance personnel, annually.

6. **Has HSC relaunched or designed a pathway to ensure that other specialities document findings in the chronology of the antenatal section of the handheld notes?**

No, the system whereby a mother keeps the hand held notes where pregnancy related consultations are documented remains.

To highlight why this is important; if an Anaesthetic review is carried out, it is vital that any previous assessments and actions are readily available. If an assessment such as this was notated in the hand held notes, then if the woman requires an anaesthetic in future, it may not be obvious to the clinicians that a previous review had occurred.

7. Why has it not been possible to establish formal links or affiliation with tertiary units or neo-natal networks as recommended by the Portsmouth Report?

Due to the NHS commissioning arrangements which are beyond HSC's control, HSC is unable to formally join the Thames Valley and Wessex Neonatal Operational Delivery Network, however, we engage with them on an informal basis.

HSC also has a 'round the clock' point of contact with Southmead Lead Neonatal clinicians for advice and guidance.

8. Which 'learnings' identified in the Portsmouth Report have resulted in changes in protocol, process or approach?

The key learning points have helped develop the processes for managing unattended births and ensuring the mother and child are delivered to a safe place as urgently as possible.

Additionally, the introduction of 'fresh eyes' notation in the care record has standardised the documentation of CTG interpretation.

9. Which 'learnings' identified in the Portsmouth Report have not resulted in changes in protocol, process or approach?

The only outstanding Learning point which has not yet resulted in a change to process relates to the keeping of separate sets of notes at the MSG and not integrating these with hospital notes.

Correspondence from MSG is copied to the main health record held at HSC. However, this is a manual process and potentially subject to error or oversight. The aim is for the integration of health records through the delivery of the new electronic patient record system.

10. What additional learnings has HSC identified from its review of the findings of the inquest?

Maternity staff do not, now, attend any unplanned birth in the community. When the risk is unknown, it is vital to transfer the woman to the Maternity unit where the entire team can be ready to receive the service user. The team includes obstetrician, anaesthetist, midwives, paediatrician, support staff, theatre team etc.

Additionally, Paediatricians do not attend patient's homes under any circumstances. Where there is concern over a Neonate, Paediatricians follow BAPM and Royal College of Paediatrics and Child Health guidance and discuss with a tertiary centre. Most likely the baby would be transferred to a tertiary unit, if further specialised care is required.

Due to the size of the island, rapid transfer of women in labour to hospital is possible. Delivering at home increases risks to the woman and her baby.

Date of receipt of questions: 17th April 2024
Date of response: 2nd May 2024