East Kent Hospitals University NHS Foundation Trust's internal Root Cause Analysis on baby Harry Richford's death

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I am not sharing the full RCA report for reasons of Sarah Richford's privacy.

The RCA summarised the salient events as follows:

"The locum obstetric Registrar informed the obstetric Consultant on call regarding the plan, as he was confident in being able to deliver the baby.

Unfortunately the baby could not be delivered by forceps due to the malposition and an emergency caesarean section was required. The baby's head was impacted in the mother's pelvis and the locum obstetric Registrar had difficulties in the delivery of the baby at caesarean section due to this.

There was a 12 minute delay which caused hypoxia (a lack of oxygen) in the baby and this required the baby to be resuscitated.

During the baby's resuscitation there was difficulty in obtaining an adequate airway to optimally oxygenate the baby. The baby therefore sustained a further prolonged time of oxygen deprivation and developed significant hypoxic ischaemic encephalopathy requiringcooling and transfer to a Level 3 Neonatal Intensive Care Unit (NICU) at the William Harvey Hospital (WHH). The baby developed prolonged seizures and a magnetic resonance imaging (MRI) scan predicted a poor outcome for the baby. Following discussion with the baby's parents, care was withdrawn. The baby died in the arms of his parents"

The RCA was tentative about the degree of avoidable harm, but it did acknowledge that the outcome might have been different if Harry and Sarah Richford had received better care:

"The outcome may have been different if the mother's labour had been less prolonged and there had been a review by an obstetric Consultant earlier in the labour. Had an earlier review been undertaken, this may have led to an expedited delivery, with the baby suffering less oxygen deprivation and requiring less resuscitation.

It is difficult to predict the final outcome following"g oxygen deprivation during delivery. However the difficulty with resuscitation meant that the initial hypoxia was further compounded leading to increased stress and oxygen deprivation for the baby."

The 71 page long RCA report makes a number of conclusions which place the care failings that led to Harry's death firmly in service failure territory.

The report even concludes explicitly that the case was one of "systems failures":

Using a trust tool (the EKUH "Incident Decision Tree) for assessing failures, the RCA investigation team concluded from this on 26 January 2018 that there had been systems failure:

"Were the actions intended? ***Yes***
Were the adverse consequences intended? ***No***
Does there appear to be evidence of ill health or substance abuse? ***No***
Did the individual depart from agreed protocols or safe procedures? ***Yes***
Were the protocols in routine use? ***No***
Would another individual coming from the professional group, possessing comparable qualifications and experience behave in the same way in similar circumstances? ***Probably.***
This leads us to conclude that this incident occurred due to system failures."

However, the RCA justified the trust's failure to report Harry's death to the Coroner on this basis:

"Why the Coroner was not informed in light of recent government guidelines?

The coroner was not informed as the cause of death was known to be hypoxia and death occurred later than 24 hours from birth. There was a clear sentinel event coupled with difficulty in resuscitation, this fits clearly with HIE. Again coupled with the MRI findings and the MRI report, there was no uncertainty with regards to causation and the death certificate. https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner"

The RCA report notes that Harry's death was only referred to the coroner after the family liaised with the CCG. The trust did not make a referral to the coroner until 20 April 2018, five months after the event.

EKUH's interpretation of the circumstances under which deaths must be referred to a coroner is seriously flawed. Even though the immediate cause of Harry's death was known, there was a question of whether it was 'unnatural' by dint of care failures.

The term 'unnatural' within the meaning of coronial procedure carries a wide meaning, and includes death by neglect, death within 14 days of a clinical procedure or death that might be related to a clinical procedure.

Crucially, this flawed assertion by the RCA revealed that EKUH may not have not been referring all relevant deaths to the coroner when this was required by law.

An important detail from EKUH's RCA is a that a midwife rolled her eyes in Sarah Richford's presence, after the midwife learned which obstetric registrar was on call on the night of Harry's birth. This was admitted:

"The midwife caring for the mother on the night shift rolled her eyes when she was told which Registrar was on call for the night shift. The mother felt this was unprofessional. The mother did feel though that the care that the midwife gave was good.

The midwife wishes to sincerely apologise for this; she was not aware that she rolled her eyes. The midwife is grateful for the mother's kind feedback and acknowledgement of the good care provided on the night shift."

The fact that the midwife reacted in this matter to hearing which registrar was on call raises a question of organisational failure. Her reaction implied that the risk posed by the locum doctor that night was recognised by other staff, and was arguably a foreseeable risk, which the organisation had failed to mitigate.

One of the governance issues arising is one of organisational culture. Why did staff who recognised the risk not raise it with the appropriate managers?

Had they not been educated to raise their concerns?

Were they discouraged by management attitudes to staff raising concerns?

Did they believe that it was pointless to raise concerns?

It is likely that the answer to the last question is "Yes", because a previous RCOG review noted that maternity staff stopped raising concerns because they had learned that concerns would not be acted upon.

Regrettably, the RCA report only noted that the midwife rolled her eyes and it did not explore the matters arising.

However, the EKUH RCA investigators did accept some important organisational failures.

The RCA concluded that multiple errors in CTG (monitoring of the baby's heart rate) interpretation suggested that there was a systems problem:

"The CTG classification was not always correct. This case has highlighted the difficulties with interpreting using current NICE guidelines. ***This appears to be a systematic concern as the CTG was reviewed by three different midwives (two Band 6 Midwives and a Band 7 Midwife)."***

The RCA also concluded that the locum registrar was not suitably experienced, his competency was not properly assessed for on call duties and he was not adequately supported by the on call consultant when the difficulties arose in Harry's care.

"As the SpR was a locum and competency level not fully assessed, it would have been preferable for the obstetric Consultant on call to have attended in person.
RCOG Good Practice No. 8 (2009)"

Highlighting the complexity of the clinical problem on the night of Harry's birth and the indication for consultant intervention to assist an inexperienced locum, the RCA comented:

"Other methods such as tocolytics (medications used to relax the uterus) and breech extraction after extension of the uterine incision (delivery the baby's legs and body before the head at CS) could have been considered however not all SpRs have this experience or have encountered such a difficult delivery"

The RCA identified systems failings of "safety culture" and "leadership" in the trust's handling of risk posed by a locum:

"Safety Culture: *competency not checked.*
Leadership: *remote/absence supervision.*
Situational awareness: *unfamiliar /unexpected situation.*
Team factors/ Human factors: *Stress levels were high in the operating theatre due to the unfamiliar situation."*

In a clear implication that there had been an organisational failure to manage the risks posed by locum staff, the RCA made this recommendation:

"Consultant Obstetrician to attend trial of Instrumental deliveries out of hours if the specialist Registrar on call is not signed off as competent to be able to undertake these procedures; if a locum Registrar cannot produce evidence of sign-off, then they should be regarded by default as being not signed off and the Consultant should attend."

The RCA noted difficulties in Harry's resuscitation by on call paediatric trainees, but did not clearly make any findings of failings, other than a delay in summoning consultant help due to switchboard not being informed of a rota change. It stated very briefly that "experience in neonatal resuscitation" might been a contributory factor.

The RCA noted the MRI findings which consequently showed that Harry had suffered major brain damage due to being under oxygenated:

"MRI report received from the Consultant perinatal neurologist.

MRI SUMMARY:

*This appears to have been a normally formed brain. There are bilateral abnormal signal intensities within the basal ganglia, thalami, posterior limb of the internal capsule and upper brainstem. There are additional focal changes within the superior cortex. These image findings are in keeping with the clinical findings and with the clinical history. There would usually be associated with a poor outcome in the form of a spastic quadriplegia with associated cognitive impairment. There will likely be prolonged feeding difficulties and subsequent poor head growth. He will have a lower threshold for later seizures. I cannot say from these images whether he will be able to maintain independent ventilation but there are no focal lesions within the lower brainstem**."***

The RCA maintained that staff adhered to resuscitation guidance (NLS):

"The descriptions and steps taken were appropriate as per NLS guidelines."

However, external expert evidence later questioned if staff had deviated from this guidance when resuscitating Harry:

"Also not recorded is whether a two person technique or a jaw thrust was applied to optimise the airway. I would consider it sub-optimal effort to maintain an airway if these efforts were not added. All NLS course teach these techniques and they are easy to perform."

The RCA also failed to reveal that the trust had deviated from existing EKHUFT guidance which required the competency of locum staff to be checked by whoever supervised their work at the trust.

Instead, the RCA stated that new guidance would be created:

"To have clear guidance on the department's responsibilities when appointing and supporting locum obstetrics and gynaecology doctors"

This had the effect of deflecting away from the organisational failure to ensure that protocols were followed.

A later Healthcare Safety Investigation Branch (HSIB) investigation unearthed the existence of the human resources policy which applied at the time of Harry's death and which required the trust to check the competence of the locum centrally involved in Harry's death.