Meeting:	Board Of Directors
Date of meeting:	8 February 2021
Title of paper:	Maternity Incidents and Investigations Overview 25th December 2020 – 25th January 2021

Executive Summary:

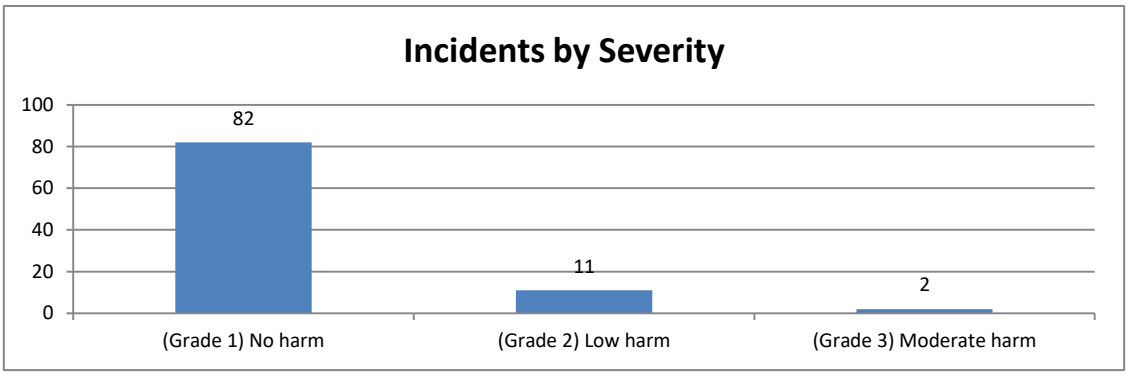
Following the publication of the Ockenden Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust in December 2020, NHSE/I have issued a series of steps to be taken by all NHS Trusts providing maternity services. One of these requirements is that all maternity Serious Incidents (SI's) are shared with Trust Board on a monthly basis.

This report will detail incidents from 25th December 2020 – 25th January 2021.

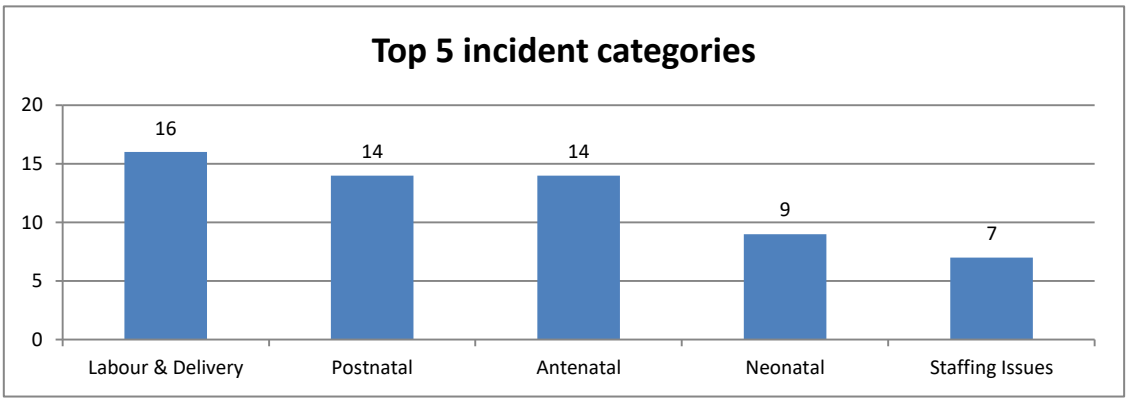
Maternity Incidents 25th December 2020 – 25th January 2021Overview

Between 25th December 2020 and 25th January 2021 there were 95 Maternity Service related incidents reported on Datix. The full listing report can be seen at appendix 1. Of these incidents 82 are classified as 'no harm' incidents, 11 as 'low harm' incidents and there has been 2 'moderate harm' incident reported.

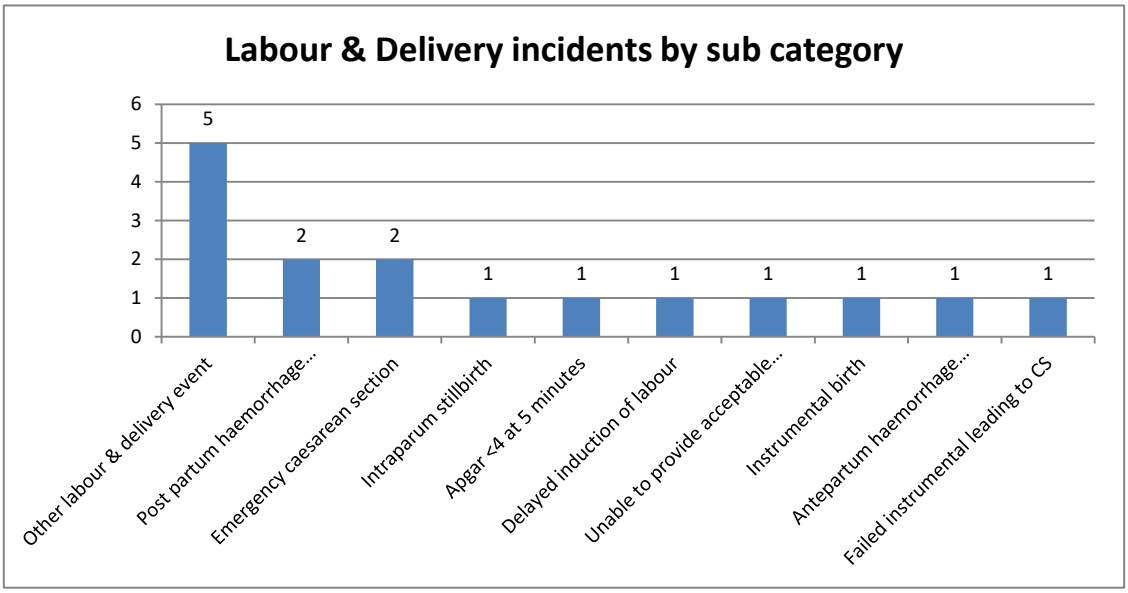
The incidents are broken down by grade in the graph below:



The top 5 occurring reporting categories are detailed in the following graph:



As can be seen the most commonly reported incidents are in regard to labour and delivery. This category is further broken down in the graph below:



Serious Incidents

During this time period there have been no incidents reported that meet the Serious Incident Framework criteria.

There has been one incident meeting HSIB and ENS reporting criteria which will be detailed later in the report.

There have been 2 moderate harm incidents reported both of which are currently going through the Divisional fact finding and governance processes:

- Potential congenital abnormality not identifued at new born examination prior to discharge.
- Unexpected transfer to NICU.

Investigation Reports Signed Off and Investigations Commissioned

During this reporting period there has been one final STEIS Level investigation report heard at the Trust Sign Off meeting (TSO) and signed off by the Chief Nurse and the Medical Director.

This incident was detailed in last month's report and relates to a maternal death incident thought to have been caused by a PE but the post mortem results are not yet available to confirm or refute this. The final report for this STEIS investigation has now been signed off by TSO and has been submitted to the CCG for sign off form a STEIS perspective. This incident met the criteria for reporting to HSIB, but HSIB were unable to gain the required consent.

There have been a further three incidents heard at the Trust Scoping meeting:

- Suspension of Maternity Service declared at 21:00 on Wednesday the 30th of December 2020 due to Acuity. The Unit resumed services at 02:12 on Thursday the 31st of December with a total suspension time of 5 hours and 12 minutes. Two women were diverted during this time. The Divisional Head of Nursing and Midwifery has written to them to apologise and offer an opportunity to discuss further with her if required. Further investigation not required.
- Term admission to NICU post emergency caesarean section requiring active cooling. Referred to HSIB for external investigation, however they have confirmed that they will not be investigating this case as it does not meet their revised guidelines during the Covid pandemic. There is a local investigation commissioned to explore communication within theatres.
- Antenatal Intrauterine fetal death secondary to placental abruption. Local investigation commissioned as there are potential concerns that the *Management of a Small for Gestation Age Fetus* was not followed.

Next steps:

All maternity related incidents reported will continue to be reviewed and escalated accordingly in line with the Trust Incident Reporting Policy and Procedures, MBRACE and HSIB reporting criteria

Trust Board will receive a monthly update to include all incidents meeting the SI framework criteria as required by NHSE/I in response to the Ockenden Report 2020 findings and recommendations.

Submitting Author:	Julie Hogg Chief Nurse
Action required:	For information and discussion.