Root Cause Analysis Investigation Report

Incident Investigation Title:	**Intrapartum Stillbirth at 40 weeks and 6 days gestation**
Incident Date:	**17/04/2016**
Incident Number:	**2016-23984**
Author(s) and Job Titles	**Dr Cornelia Wiesender** Consultant Obstetrician &Gynaecologist **Lorraine Purcell** Risk Midwife Derby Hospital **Dr Penny McParland** Consultant Obstetrician
Investigation Report Date:	**FINAL REPORT 11/12/2017**

Executive Summary

- **Brief incident description:**

  SP was a 33 year old Gravida 2, para 0+1 who on 17.4.2016 had an intrapartum stillbirth following a prolonged, dysfunctional labour which was not recognized as such. Baby H was then born after a significantly prolonged second stage of labour.

- **Incident date:**

  17.4.2016

- **Incident type:**

  Intrauterine fetal death / intrapartum stillbirth

- **Healthcare Specialty:**

  Maternity Services

- **Actual effect on patient and/or service:**

  The incident resulted in the unexpected intrapartum death of SP and JH's baby daughter

- **Actual severity of incident:**

  The incident was escalated by NUH as a Serious Incident following concerns raised by the family.

Level of investigation conducted

A National Patient Safety Agency Level Three (Independent) type of Patient Safety investigation was undertaken using root cause analysis tools and techniques. The purpose of the incident investigation was to review events from first contact of SP with NUH with contractions to the stillbirth of baby H and the subsequent investigation of the case by NUH.

Involvement and support of the patient and/or relatives

A meeting was held with the parents of baby H on the 10th July 2017. This provided an opportunity for the external review panel to hear their account of the care they received. Communication with the parents during the independent review has been coordinated by the Commissioners and Lead Investigator.

Care and service delivery problems

The care delivery problems and contributory factors are outlined in detail within the main body of the report however they are listed below:

1. Failure in recording all phone calls to Maternity Triage
2. Important omission of information on Antenatal Advice Sheet
3. Failure to take a full clinical history and therefore failure to see full picture

4. Administration of opiates in latent phase of labour and failure to recognize prolonged latent phase/ dysfunctional labour
5. Failure of adherence to local Latent Phase of labour guideline
6. Failure to advise admission after closure of the Labour Ward at QMC
7. Admission to low risk Birth Centre despite possibility of cord prolapse
8. Delay in applying appropriate fetal monitoring
9. Delay in administration of epidural
10. Delay in senior obstetric review and management plan
11. Significantly prolonged second stage of labour
12. Failure to follow the Risk Management Policy for maternity
13. Misinterpretation of the post mortem findings and failure to make appropriate clinic-pathological correlation.

Contributory factors

The following NPSA contributory factors were identified:

Communication factors:

- Inadequate systems and processes to support effective communication of clinical information.
- Incomplete clinical records
- Unreliable access to triage phone logs

Task factors:

- Strict adherence to definition of established labour in NICE intrapartum guideline
- Ambiguity of NUH latent phase guideline leading to inconsistency in its application to practice
- Lack of midwifery leadership
- Lack of obstetric leadership
- Lack of senior anesthetic support

Team factors:

- Lack of midwifery leadership and senior support in Birth Centre
- Poor communication and hand over between midwifery and medical staff

Organisational factors

- Poor safety culture
- Lack of governance in relation to reporting serious clinical incidents

Root causes

- Failure to recognize physiological changes which indicated the onset of established labour in a primigravid woman (cervical effacement, bulging membranes, onset of painful contractions) and instead focusing on the need to reach 4cm dilatation for a diagnosis of labour to be confirmed.

- Inadequate systems and processes which did not support the sharing of clinical information, records of phone calls and hospital admissions and an inability to access these records in all clinical areas across both sites

- Lack of clarity in the NUH Latent Phase Labour Guideline regarding use of opiate analgesia and regarding management when multiple contacts with services are made.
- Lack of midwifery and obstetric leadership and team working

Lessons learned

- When assessing women presenting with suspected labour, a full clinical picture and history needs to be taken into account to establish appropriate pathways of care
- When there is uncertainty about the clinical presentation, senior advice must be sought and available
- Structures have to be in place which support the sharing of clinical information in particular triage of phone calls and admissions, to enhance the effectiveness of cross site communication
- Good communication between midwifery and medical teams is essential.
- Robust governance structures need to be in place which underpin safe practice and shared learning
- It is desirable for parents to have the opportunity to be involved in the perinatal mortality review process.

Conclusion

The overall conclusion of this investigation was that the death of baby H was almost certainly preventable.

Recommendations

The recommendations are outlined below.

1. The maternity service should review the feasibility of implementing an Information Technology system which enables all staff to review contemporaneous antenatal records easily across both sites

2. Provide the environment and ensure safe staffing levels to facilitate electronic recording/documentation of phone calls at all times and audit/monitor this.

3. The multidisciplinary team must review the Latent Phase Labour guideline ensuring clarity regarding the process for referral and review. Clarification on use of opiates during latent phase should be agreed with clear guidance for midwives when to seek a medical opinion.

4. Review and improve the clarity of the local fetal loss guideline regarding term or near-term intrapartum stillbirth, in particular regarding senior medical input (this should state that a Consultant must attend immediately or as soon as feasible and provide a management plan)

5. The governance process in relation to recognizing, reporting and escalating perinatal mortality should be reviewed. Consider utilizing the national Perinatal Mortality Review Tool when implemented by MBRRACE. Ensure that the unit reports cases that fit the inclusion criteria to the RCOG, Each Baby Counts quality improvement program.

6. Review the Maternity Risk Management Policy regarding perinatal mortality, particularly regarding term intrapartum stillbirths. It must be very clear that this is a rare event which must be escalated and investigated and reported as an SI.

7. The maternity service should ensure that there is a strong model of midwifery clinical leadership and supervision in place that supports the continued monitoring, evaluation and quality assurance of safe maternity care.

8. Present this case at a multidisciplinary educational meeting highlighting the importance of good communication, the need to review the full picture and to provide strong leadership managing the labour and subsequent reporting and investigation of events.

9. Review the educational opportunities for the multidisciplinary team in the recognition of dysfunctional/obstructed labour and its management.

Arrangements for sharing learning

Arrangements for communication, monitoring and shared learning is the responsibility of the commissioning body