Safer Maternity Care

Issue 5

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From the editorial suite

After a substantial hiatus, SMC is back in circulation. As before we will provide a mixture of news, views and features, and we hope to wax stronger this time. Readers' feedback would be most welcome. In particular, it would be nice to use this forum to share lessons learned and successes achieved in promoting safer care. Let's hear from you!

In this issue we focus on lessons from coroners' inquests into maternal or fetal death. Three recent cases are briefly presented.

Maternal death from unsafe practice

> "I love you; if anything happens just make sure you look after the boys."

These were the last words of a mother who died from a cardiac arrest sequel to secondary post-partum haemorrhage after an emergency Caesarean delivery.

The coroner found that Frances Cappuccini, a school teacher nicknamed 'Mrs Coffee' by pupils because of her surname, died 'as a result of failures and inadequate diagnosis and treatment' at a hospital in southeast England.

The inquest held in January 2017 found the following failures and contributory factors:

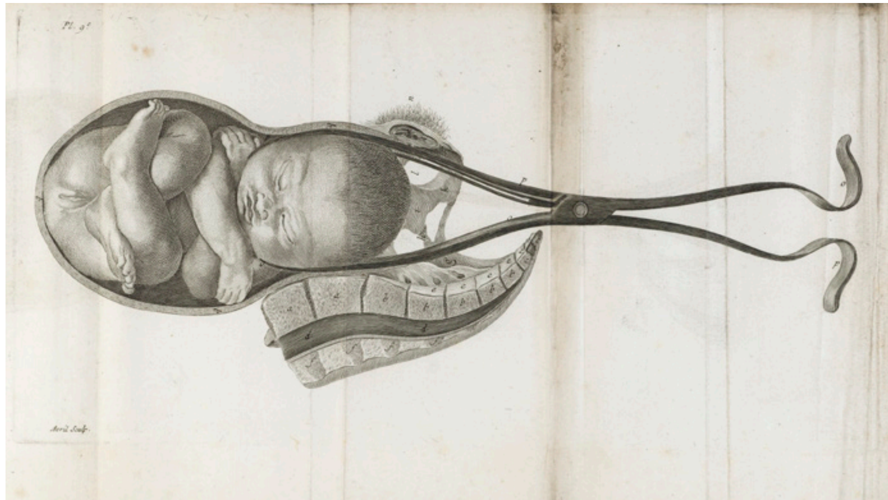
- failure to recognise, diagnose or treat sepsis or probable kidney injury when she was admitted
- prolonged labour (12 hours). She had requested a Caesarean delivery when admitted
- retained placental tissue (about 2.5 inch)
- poor fluid management
- failure to follow the hospital's protocols for management of post-partum haemorrhage
- anaesthetic incident resulting in inadequate ventilation
- inadequate supervision of the anaesthetist
- 'woefully inadequate' documentation

Sadly, most of these are recurring themes in safety incident investigations.

Mrs Cappuccini was admitted in labour two days before a scheduled Caesarean delivery but was persuaded to try for a vaginal birth.

Editor's note: Retained placental tissue at Caesarean section should be a NEVER EVENT. It is no different from a retained swab or other foreign body. The uterine cavity is open and the surgeon must take due care to ensure that the cavity is emptied before closure. (A **Never Event** is a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented).

Stillbirth following failed instrumental delivery



Baby Kristian died at the age of 5 days after a traumatic birth at a London hospital. His mother, Miss Tracey Taylor, had been taken to the operating room for a caesarean delivery because of an abnormal fetal heart rate. In theatre, the registrar performed an internal examination and felt that the baby could be delivered vaginally. After failed attempts with ventouse and forceps, a Caesarean delivery was performed but Kristian was born in a poor condition.

At an inquest into Kristian's death, the coroner determined that asphyxia as a consequence of prolonged and extended instrumental delivery was the likely cause of death.

The coroner said there was a 'presumption in favour of vaginal delivery based partly on cost' and warned that unless action is taken there is a risk that more deaths in similar circumstances will occur.

Miss Taylor said she had been told after the birth of her first child that she should have a Caesarean birth the next time, but this was not documented in her health records. She said she was treated like an over-anxious woman' when she brought this to the attention of staff.

The hospital accepted liability but said cost was not a consideration.

Editor's note: Harm to the baby (stillbirth, brain injury or other) as a result of injudicious attempts to deliver vaginally when a Caesarean section is indicated for fetal heart rate abnormalities occurs more commonly than most obstetricians realise – and involves consultants as well as registrars. In the face of an abnormal cardiotocograph, an instrumental delivery should only be attempted if the pelvis is clinically adequate and the fetal station indicates a low cavity delivery. The application of forceps causes raised intracranial pressure and the subsequent baroreceptor response reduces the fetal heart rate. Unless it is a 'lift out' the obstetrician should think twice before applying forceps in cases of fetal distress – a failed trial prolongs the duration of exposure to hypoxia.

There are other lessons from this case:

- Beware of the perils of dual instrumentation. If it's not coming, don't force it!
- Situational awareness is a critical component of good practice in operative vaginal delivery
- The woman's concerns should be addressed rather than be attributed to anxiety

Maternal death after 'missed opportunities'

Ms O'Sullivan was a high risk patient: Previous Caesarean section, Blood clotting disorder, Twin pregnancy, Prelabour rupture of fetal membranes.

She lost 3 litres of blood at emergency Caesarean section, suffered a cardiac arrest on the operating table and died.

At the inquest questions were raised about:

- delays in blood transfusion
- why platelets assigned for this patient were given to another patient
- the emergency call button not working
- a faulty defibrillator (low battery)
- errors in estimating blood loss
- wrong blood group entered in her records

The coroner said that her death followed a series of 'missed opportunities.' He felt that the Caesarean section could have been performed earlier. Fluid resuscitation was not aggressive enough.

Lofty ambition for safety in childbirth

The UK Government made a commitment in November 2015 to reduce the number of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and by 50% by 2030. In furtherance of this commitment, the Department of Health published an action plan, *Safer Maternity Care*, in October 2016 which set out the five key drivers for achieving the set goals. These drivers and the initial targets are reproduced below. Most of the target dates are due about now. How is your unit doing?

Focus on leadership

- Board level *Maternity Champion* appointed.

  Target date: January 2017.

- *Maternity Safety Champion* appointed in Maternity Clinical Networks.

  Target date: February 2017.

- Trusts will have one obstetrician and one midwife jointly responsible for championing maternity safety in their organisation.

  Target date: February 2017.

- Bespoke *Maternity Safety Improvement Plan* agreed and made public.

  Target date: January 2017.

Focus on learning and best practice

- Informed by the independent evaluation, NHS England will publish the final version of the *Saving Babies' Lives* care bundle for use by maternity commissioners and providers by ***April 2018***.
- A package of publications and resources will be available for maternity and neonatal teams to support them to provide safer care and avoid unnecessary separation of mother and baby.

  Target date: January 2017.

Focus on teams

- Learning and development plan in place for entire multi-disciplinary team.

  Target date: January 2017.

- The maternity team has attended maternity safety training, with funding from the Maternity Safety Training Fund.

  Target date: March 2017.

Focus on data

- Trust is reporting to *Maternity Services Dataset* and other key data sets such as *MBRRACE-UK*, the Royal College of Obstetricians and Gynaecologists' *Each Baby Counts* programme, the *National Neonatal Dataset* and the new *National Maternity and Perinatal Audit*.

  Target date: September 2018 although trusts should prioritise early implementation wherever possible.

- Maternity and neonatal teams are using the *Standardised Perinatal Mortality Review Tool* to review and share learning from every stillbirth and neonatal death, when it is available.
- Maternity team is using national indicators dashboard to track their outcomes over time and benchmark against other organisations in their local maternity system and across the region.

  Target date: March 2018.

Focus on innovation

- The maternity team will be taking part in the new national *Maternal and Neonatal Health Quality Improvement Programme* in their region.

  Target date: February 2017.

- Individual or team may have applied for and used funding from the *Maternity Safety Innovation Fund* to develop an innovative idea.

  Target date: March 2017.

Is your unit febrile? Check it with the Maternity Safety Thermometer

The *Maternity Safety Thermometer* checks how UK maternity units are doing in respect of a selection of clinical and psychological indices. These include Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. It also captures data on babies with an Apgar score of <7 at five minutes and babies admitted to the Neonatal Unit. Pertinent data in respect of all postnatal mothers and babies are collected on one day per month in each maternity service. For further information, visit the website **www.safetythermometer.nhs.uk** or send an email to **info.SafetyThermometer@nhs.net**

The rising tide of clinical negligence

The spending on maternity clinical negligence cover in the UK equates to nearly a fifth of the spending on maternity services.

In 2012-13, there were **1,146 clinical negligence claims** relating to maternity care in the UK, equivalent to around **one claim for every 600 births**, and the number of claims increased by **80 per cent** in the five years from 2007-08 to 2012-13.

Safety tip

Once a plan has been agreed by the team and accepted by the woman after explanation, do not subsequently change it without taking a step back and double-checking that it is right to change course.

Safety tip

When performing a caesarean section on a woman with a previous Caesarean, always check (before starting the operation) whether the placenta is anterior or posterior.

Share your own views and experience

Email **smc@clinicalriskconsulting.com**. You can also download previous versions of this newsletter at **clinicalriskconsulting.com/news**

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