Parliamentary and Health Service Ombudsman

Midwifery supervision and regulation

A report by the Health Service Ombudsman of an investigation into a complaint from Ms Q and Mr R about the North West Strategic Health Authority

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Foreword

We are laying before Parliament, under section 14(4) of the *Health Service Commissioners Act 1993*, this report on an investigation into a complaint made to us as Health Service Ombudsman for England.

The report is being laid before Parliament to help others learn from the maladministration it describes.

The complaint is about the North West Strategic Health Authority (the SHA). Ms Q and Mr R complained to us that the SHA failed to carry out adequately its functions as the Local Supervising Authority (LSA) after their baby son's stillbirth at Furness General Hospital in September 2008.

This is one of three complaints we are publishing which deal with midwifery supervision and regulation under the SHA. All three cases are cited in *Midwifery supervision and regulation: recommendations for change*, which calls for changes in the interests of the safety of mothers and babies.

Dame Julie Mellor, DBE
Health Service Ombudsman

December 2013

Summary

Baby Q

What happened

Ms Q went to Furness General Hospital in September 2008 and had her labour induced. There were complications during labour and, sadly, Baby Q was stillborn. The post mortem showed that Baby Q had not had enough oxygen during the birth.

Seven months later, one of the Local Supervising Authority's (LSA) Supervisors of Midwives (Midwife B) reported on her investigation into the care provided by the two midwives at the birth. She concluded that both midwives needed more training on monitoring a baby during labour. There was then a second investigation by the Trust into 11 cases in which one of the midwives had provided care. The report of this investigation recommended that the midwife should undergo supervised practice for at least 150 hours.

Ms Q and Mr R complained to us that the LSA had failed to carry out an open and effective investigation into the death of Baby Q and that the Strategic Health Authority (SHA) had not dealt with their complaint about this effectively. This added to the distress they felt as a result of their loss.

What we found

The supervisory investigation should have taken place in 20 days. It was seven months before it was started. The investigation was not independent and subsequent reports were not thorough. This meant that they did not identify that care fell short of relevant guidelines and good practice.

Midwife B did not identify all the failings in midwifery care given to Ms Q, and she did not establish why some actions were not carried out, for example, why the midwife had not started electronic monitoring of Baby Q's heart when it was beating faster than normal. Midwife B also did not explore in enough detail an earlier failure by one of the midwives to start electronic fetal heart monitoring. The LSA Midwifery Officer had an opportunity to explore some of the issues that had arisen from the supervisory investigations and raised a query about whether midwives were comfortable in contacting consultants, but did not follow this up. Overall, the LSA failed to carry out its functions adequately.

When Ms Q complained to us about the SHA, they said they would investigate. They tried to be open and accountable in their review but Ms Q had to wait more than a year for their response. This meant that the reassurance she might have had from their report was diluted by the delay.

The complaint

1. We have investigated Ms Q's and Mr R's complaint that the North West Strategic Health Authority[1] (the SHA) failed to carry out adequately its functions as the Local Supervising Authority[2] (LSA) for midwives in relation to open and effective supervisory investigations of midwives following their baby son's stillbirth at Furness General Hospital (part of University Hospitals of Morecambe Bay NHS Foundation Trust – the Trust[3]) on 6 September 2008 and the death of another baby in similar circumstances in February 2004.

2 We have also investigated Ms Q's and Mr R's concerns that the SHA failed to deal with their complaint about this effectively.

3. Ms Q and Mr R complained that the failure by the LSA to properly investigate the death of their son Baby Q compounded the distress that they continue to experience as a result of their loss. They said they would like an assurance that their concerns have been addressed and that significant changes will take place to ensure that the LSA properly carries out its functions in future.

Our decision

4. Having considered all the available evidence related to Ms Q's and Mr R's complaint about the SHA, and having taken account of the clinical advice I received, I have reached a decision.

5. I have found that the SHA did not carry out its functions adequately as the LSA for midwives following Baby Q's death. I have concluded that this was maladministration. I have also found maladministration in the way the SHA handled Ms Q's and Mr R's complaint.

6. I have found that an injustice arose to Ms Q and Mr R in consequence of this maladministration because the supervisory investigations took too long, were superficial and the recommendations did not fully address the failings that had been identified, and this undoubtedly caused Ms Q and Mr R distress. This was compounded by the knowledge that a subsequent LSA investigation recommended that Midwife C undergo a period of supervised practice. In addition, after making her complaint to the SHA, it took far too long to resolve it, despite telling her that it would respond by August 2012.

7. Therefore, I uphold Ms Q's and Mr R's complaint about the SHA.

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1 At the time of the events complained about, the North West Strategic Health Authority was responsible for discharging the LSA function. Since 1 April 2013, SHAs no longer exist, and while LSA Midwifery Officers are to remain in place as before, the overall statutory responsibility for the LSA is now with NHS England.

2 LSAs are impartial organisations responsible for ensuring statutory supervision of midwives is undertaken according to Nursing and Midwifery Council's (NMC) standards.

3 The actions taken by the Trust and the clinical care provided are not part of the scope of our investigation.

The Health Service Ombudsman's jurisdiction and role

8. Our role[4] is to look at complaints about the NHS in England. We can investigate complaints about NHS organisations such as trusts, strategic health authorities, family health service providers such as GPs, and independent persons (individuals or organisations) providing a service on behalf of the NHS.

9. Our approach when investigating is to consider whether there is evidence to show that maladministration or service failure has happened. We then look at whether that has led to an injustice or hardship that has not been put right. If we find an injustice that has not been put right, we will recommend that the NHS take action. Our recommendations may include asking the organisation to apologise, or to pay for any financial loss, inconvenience or worry caused. We may also recommend that the organisation takes action to stop the same mistakes happening again.

How we decided whether to uphold this complaint

10. When looking at a complaint we generally begin by comparing what happened with what should have happened. So, as well as finding out the facts of the complaint, we look at what the organisation should have been doing at the time. We look at the general principles of good administration that we think all public organisations should follow. We also look at the relevant law and policy that the organisation should have used at the time.

11. Once we have found out what should have happened we look at whether those things did happen or not. We look at whether the organisation's actions, or lack of them, were in line with what they should have been doing. If not, we decide whether that was so bad that it is maladministration or service failure.

4 Our role is formally set out in the *Health Service Commissioners Act 1993*.

What should have happened?

12. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy are broad statements of what public organisations should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles appear in each of the three documents. These six Principles are:

    - Getting it right
    - Being customer focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right, and
    - Seeking continuous improvement.

13. The Principle of Good Administration particularly relevant to this complaint is:

    - *'Getting it right'* – which among other things means that public organisations must act in accordance with recognised quality standards, established good practice or both.

14. Two of the Principles of Good Complaint Handling particularly relevant to this complaint are:

    - *'Being open and accountable'* – which includes public organisations providing honest, evidence-based explanations and giving reasons for decisions. They should keep full and accurate records; and
    - *'Acting fairly and proportionately'* – which includes ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

15. In addition to these principles, there are specific standards that were relevant to our investigation of this case.

Background information

16. Supervision is a statutory responsibility based in the Nursing and Midwifery Council's *Midwives rules and standards* (2004). Supervision provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice. Supervision is a means of promoting excellence in midwifery care, by supporting midwives to practise with confidence, therefore preventing poor practice.[5]

17. Each Local Supervising Authority (LSA – in this case the SHA) is responsible for ensuring that statutory supervision of all midwives, as required in the *Nursing and Midwifery Order* (2001) and the Nursing and Midwifery Council's *Midwives rules and standards* (2004) is exercised to a satisfactory standard within its geographical boundary. LSA arrangements differ across the UK. In 2008 in England the responsibility for the LSA function lay with the SHAs.

18. Each LSA appoints and employs a practising midwife to undertake the role of Local Supervising Authority Midwifery Officer[6] (LSAMO) who has the responsibility of ensuring that the statutory supervision of midwives is carried out to a satisfactory standard. The LSAMO is based within the SHA. The LSAMO appoints Supervisors of Midwives, who operate locally (that is, they are employed by the relevant NHS organisation) and who are directly accountable to the LSA for all matters relating to the statutory supervision of midwives. Local frameworks exist to support the statutory function. Every midwife will have their own named Supervisor of Midwives, with whom they will have regular contact (Rule 12).

19. When an incident occurs and a decision on whether a supervisory investigation is required, the Supervisors of Midwives will discuss and decide which Supervisor will carry out the initial investigation. This Supervisor cannot be the named Supervisor of the midwife or midwives who provided the care, nor can it be a Supervisor of Midwives who provided care during the incident.

The specific standards

The Nursing and Midwifery Council - *Standards for the supervised practice of midwives* (2007)

20. Standard 1.1 says that:

> *'Following an untoward event or the recognition of circumstances indicating lack of competence, a Supervisor of Midwives, independent of any management investigation, should undertake a full supervisory investigation of untoward incidents or circumstances. This should include where necessary a risk analysis and root cause analysis.'*

21. Standard 1.2 says that:

> *'Supervisory investigations should take place as soon as possible after any untoward event or circumstances, and may be initiated*

5 *Modern Supervision in Action* (August 2009 – NMC and LSAMO Forum UK). LSAMO stands for Local Supervising Authority Midwifery Officer.

6 LSAMOs are a point of contact for supervisors of midwives for advice on aspects of supervision, especially difficult or challenging situations.

by a Supervisor of Midwives regardless of any employment processes. The Local Supervising Authority should be informed that a supervisory investigation has commenced.'

22. In its explanatory notes to standard 1 (*'Investigating alleged lack of competence'*), the NMC Standards say that it is essential that a *'thorough and independent investigation of an untoward event or near miss be carried out by a Supervisor of Midwives to ensure that midwifery practice has been safe'*.

23. They also say that the investigating Supervisor of Midwives should not have been involved in the original incident in order to reduce any potential conflict of interest. They say that it is *'in the interest of protection of the public that such investigations take place and are concluded promptly'* and that, in general, it *'would be reasonable for a 20-day investigation period for instance, following events or receipt of complaints'*.

North West LSA *Guidance for Supervisors of Midwives* (2005 - revised 2008)

24. The North West LSA *Guidance for Supervisors of Midwives*, 2005 (revised 2008 – the guidance) provided guidance for midwifery supervision at the time of the episode complained about. This guidance incorporated parts of the Nursing and Midwifery Council's *Midwives rules and standards* (2004). In the section relating to *'reporting and monitoring of serious untoward incidents'* the guidance says that:a Supervisor of Midwives must be notified of all serious untoward incidents;

    - if appropriate, a local untoward incident policy should be activated and an internal investigation initiated;
    - the LSA should be notified of any maternal death;
    - The LSA should be notified of all unexpected intrauterine or neonatal deaths.

25. In cases where there are any uncertainties, the LSA should be contacted for advice.

National Institute for Health and Clinical Excellence (NICE) guidelines on Intrapartum care: care of healthy women and their babies during childbirth[7] (NICE guidelines – September 2007)

26. The NICE[8] guidelines say that, in low-risk women, intermittent auscultation[9] of the baby's heart should be changed to continuous fetal heart monitoring (using an electronic fetal heart monitor or cardiotocograph, CTG[10]) when an abnormal heart rate is detected in the baby, either because it is less than 110 beats per minute, or because it is greater than 160 beats per

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7 Intrapartum means the time period going from labour to delivery.

8 This organisation has recently changed its name, and is now known as the National Institute for Health and Care Excellence (NICE). Its functions are the same: to provide national guidance and advice to improve health and social care.

9 This is a systematic way of listening to the baby's heart by using an acoustical device (similar to a stethoscope) or hand-held ultrasound device (this sends high frequency sound waves into the uterus and provides a reading based on the sound bouncing back).

10 A CTG is a means of recording the baby's heart and the mother's uterine contractions.

minute, or because it decelerates after the mother's contractions. CTG should also be considered in cases where the liquid is stained with meconium (the baby's first faeces which have leaked into the uterus).

27. In women who have had more than one birth (parous women), the NICE guidelines say that birth would be expected to take place within two hours of the start of the active second stage of labour[11] in most women. They say that a diagnosis of delay in the active second stage of labour should be made when it has lasted more than one hour, and the mother should be referred to a healthcare professional trained to undertake an operative vaginal birth[12] if birth is not imminent.

28. During the second stage or labour, intermittent auscultation of the fetal heart should occur after a contraction for at least one minute, at least every five minutes.

The investigation

29. We confirmed our understanding of Ms Q's and Mr R's complaint in our letter of 11 October 2012. We also interviewed them on 20 November to discuss the nature of their complaint and how our investigation would proceed.

30. During this investigation, we have considered relevant documents about Ms Q's and Mr R's complaint, including documents relating to the attempts to resolve the complaint at the local level.

31. We obtained expert advice from one of our clinical advisers: a practising midwife and LSAMO (the Adviser). Our clinical advisers are experts in their field. In their role as advisers they are completely independent of the NHS.

32. In this report I have referred to a background case about Mrs K and the death of her baby in 2004 (Annex A). Mrs K has asked not to be identified and did not wish to make a complaint to us. However, she gave us permission to use the details of her case insofar as these were relevant to the complaints we investigated.

33. I have not referred to all the information examined in the course of the investigation, but I am satisfied that nothing significant to the complaint or my findings has been left out.

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11 The second stage of labour includes the part from the full dilatation of the cervix until the baby is completely out of the birth canal.

12 An instrumental delivery (or operative delivery) is one carried out with the help of forceps, an instrument, similar to a large tong which encircles the baby's head and helps delivery. An instrumental delivery can also be carried out with a ventouse, which is a vacuum device used to assist delivery.

Key events

34. Ms Q, who was 23 at the time of the events in question, was admitted to Furness General Hospital on 4 September 2008. A decision was made that her labour should be induced[13] and she was admitted to the labour ward on 6 September, under the care of Midwife C. Ms Q's records say that she was experiencing three to four contractions every 10 minutes at this stage.

35. At approximately 6.15pm Ms Q began spontaneously pushing[14] and at 6.45pm, when she had been pushing for 30 minutes, a vaginal examination was performed. Midwife C assessed Ms Q's cervix to be fully dilated.[15] At 7.45pm, there were no other signs of second stage labour (for example, the baby's head was not visible), and so a senior midwife was asked to carry out a vaginal examination in order to provide a second opinion. The midwife noted that the anterior rim of the cervix[16] was still apparent (which meant that Ms Q's cervix was not fully dilated).

36. Ms Q's progress was reviewed at approximately 7.54pm, by the obstetric registrar. This review did not include an examination, but he agreed that delivery of the baby was imminent. Ms Q's records say that 20 minutes later her baby's head was at the ischial spines.[17] According to her records, her baby's head was visible 15 minutes later, and at approximately 8.45pm her baby's head was on the perineum (the area between the vaginal opening and the rectum). At about 9pm Midwife D took over from Midwife C, to allow her to complete her records, and about five minutes later she listened to the baby's heart with a handheld ultrasound and noted that it was initially fast (tachycardia) and then slowed down (decelerated) following Ms Q's contraction. She called a junior doctor, who said that Ms Q would probably need an instrumental delivery.[18]

37. After the baby's head had reached the perineum, it took a further 50 minutes for the baby's head to be delivered (at 9.35pm). Shortly before his birth the umbilical cord was felt to be tightly around the baby's neck. The cord was clamped and cut to help with delivery, and at 9.39pm Baby Q was born. His records say that he was pale, not breathing and had no heart rate. Resuscitation efforts, including cardio pulmonary resuscitation[19] (CPR), administration of adrenaline[20] and intubation[21] were carried out for

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13 Induction of labour means that labour is induced artificially, by inserting a gel (or pessary), or tablet into the vagina. Sometimes a hormone drip is also used.

14 This normally occurs during the second stage of labour.

15 It is likely, though not set out in the records, that Midwife C thought that Ms Q had entered into the second stage of labour because she thought her cervix was fully dilated.

16 The cervix is the lower, narrow portion of the uterus.

17 Part of the pelvic bone. The baby's position in relation to the ischial spines is an indicator of labour progress.

18 Footnote 12.

19 This is an emergency procedure in which the heart and the lungs are made to work by manually compressing the chest overlying the heart and forcing air into the lungs.

20 This is a hormone which is given in order to stimulate the heart.

21 This means that a tube was inserted into Baby Q's throat to help him to breathe.

approximately 28 minutes. Sadly, these efforts failed and Baby Q was pronounced stillborn.

38. A consultant paediatrician who was involved in the attempts to resuscitate Baby Q (but not involved in any other aspect of his birth) reported Baby Q's death to the Coroner for South and East Cumbria. He explained that Baby Q was alive 20 minutes before delivery and so he considered that this constituted a death within the first 24 hours whilst in hospital (which is one of the criteria for referring a death to a coroner).

39. On 10 September 2008 an autopsy (an examination of the body to determine the causes of death) was carried out. No abnormalities were found with any of Baby Q's organs, or his appearance, and the conclusion was that the cause of death was *'unascertained'*. The Coroner said that in his opinion, *'death ... is due to perinatal asphyxia*[22] *whether or not the infant is considered to be live born or still born'*.

The local investigation on behalf of the LSA

40. On 21 April 2009 one of the LSA's Supervisors of Midwives (Midwife B) produced two reports of her supervisory investigations about Midwives C and D. The delay was apparently due to a meeting convened on 1 December 2008 by the Chief Executive of the Trust at the time. At this meeting a separate neonatal death was discussed, and an independent review of this incident (which would be carried out by the Head of Midwifery and two consultants from another trust) was agreed. The understanding appeared to be that all other investigations should stop while this was being carried out. It is unclear from the records why the decision to carry out a supervisory investigation was not taken as soon as possible after Baby Q's stillbirth.

Midwife C

41. Midwife B interviewed Midwife C on 7 April 2009 and produced her report based on the discussions during that interview. She shared both reports with the LSAMO on 21 April 2009.

42. The report says that Midwife C had, overall, provided a good level of care. Midwife C had appropriately asked for a senior midwife to assess Ms Q when she had been pushing for over an hour (7.45pm) and then asked for a medical opinion at 7.54pm. During her interview with Midwife B, Midwife C said that she had agreed with the registrar that the delivery of Ms Q's baby was imminent at that stage, primarily because she had been pushing more effectively and the baby's head was level with the ischial spines. She said that the baby's heart rate had remained *'reassuring'* during the active pushing. Midwife B said that '[Midwife C] *clearly documented her discussions with* [Ms Q], *respecting her choices and care decisions i.e. preference not to have an episiotomy'*.[23]

43. Midwife B found that Midwife C's record keeping was *'contemporaneous, clear, unambiguous and accurate'*. She said that they provided *'evidence of the high standard of midwifery care and support given to* [Ms Q] *by* [Midwife C]'. Midwife B also said that there was *'clear evidence that* [Midwife C] *communicated effectively and worked collaboratively*

[22] A lack of oxygen to the baby during birth, which lasts long enough to cause physical harm to the baby.

[23] A surgical cut made at the opening of the vagina during childbirth, in order to help with the delivery of the baby.

with both her medical and midwifery colleagues'. She said that Midwife C's *'record-keeping was excellent'* and her professional conduct *'was exemplary'*.

44. Midwife B did say that there was no record of electronic fetal heart monitoring having been done since the early hours of the previous day. She said that given the position of the baby, and the fact that Ms Q was having her labour induced, *'best practice would have been to undertake EFM* [electronic fetal heart monitoring] *following the spontaneous rupture of the membranes'*. However, in response to this, Midwife B said that at the interview, Midwife C explained that in view of the clear liquor[24] that had been draining, and the fact that she was accomplished in intermittent auscultation of the fetal heart rate, she was satisfied that the fetal heart rate was within normal limits. She also explained that she preferred intermittent auscultation *'in order to promote normality'* during Ms Q's labour. Midwife B concluded that while it *'may arguably have been best practice to apply a fetal scalp electrode*[25] *at this time, further delay before delivery was not anticipated'*.

45. In the report, Midwife B documented that there had been a previous incident in 2004[26] involving Midwife C and in that case there was a failure to monitor the fetal heart rate in the last 43 minutes of labour. The baby in that case was also stillborn. Midwife B noted that the records from that case were limited, and in particular there was a lack of documentation surrounding the actual review, and whether the LSA was involved at that time. She said that the review had identified some training needs for Midwife C, particularly in relation to monitoring and recording of the fetal heart rate during labour.

46. Midwife B concluded that she was *'satisfied that* [Midwife C] *provided a high standard of intrapartum care for* [Ms Q], *in accordance with both local and national guidelines'*. She said that her actions, including her record keeping, and her *'timely and appropriate referral for obstetric opinion*' were in accordance with the NMC *Midwives Rules and Standards* and the Code of Conduct. She said that while she had taken into account the previous incident in 2004, she (and other Supervisors of Midwives who had discussed Midwife C's case) felt that given the length of time that had elapsed, and the fact that Midwife C was noted as conducting the highest number of vaginal births per year, she should start training focused on monitoring the fetal heart rate.

Midwife D

47. In her report, Midwife B documented that Midwife D was involved in only the last 45 minutes of Ms Q's labour. She said that Midwife D had introduced herself and explained her role, had listened to the baby's heart and, on noticing a fast heart rate, immediately called the night shift doctor. This doctor made the decision that an instrumental delivery would be required.

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[24] Liquor refers to the amniotic fluid, in other words the waters which surround the baby while in the uterus. Clear liquor would be in contrast to meconium stained liquor, which could be a cause for concern and would require the setting up of a CTG. It can sometimes lead to brain damage in the baby (NICE guidelines *'Use of electronic fetal monitoring'* and paragraph 26 above).

[25] This is the instrument which is used to electronically and continuously monitor a baby's heart beat during labour.

[26] This is the case of Mrs K, set out in Annex A.

48. Midwife B said that Midwife D's records were contemporaneous, clear, unambiguous and accurate, and that there was *'clear evidence'* that she had communicated effectively and worked collaboratively with her colleagues. She also said that there was clear evidence that Midwife D applied her professional knowledge and experience in providing care to Ms Q.

49. Midwife B also asked Midwife D whether, given the abnormal heart rate of the baby between 9.05pm and 9.10pm, Midwife D had considered that a fetal scalp electrode might have been required. Midwife D explained that there was no fetal scalp electrode in the room and she had expected delivery to be imminent, therefore, there did not appear to be a need for this.

50. Midwife B concluded that she was satisfied that Midwife D had provided a high standard of care for Ms Q. Her recommendation was that Midwife D also attend the fetal heart monitoring training.

51. In concluding both reports Midwife B also took responsibility for the delay in carrying out the investigation, and explained that it was in part due to the Trust carrying out its own internal investigation, and the fact that two experienced Supervisors of Midwives had recently left the unit.

The LSAMO's comments

52. On 1 May 2009, the LSAMO responded to Midwife B. She said that it appeared to her that, notwithstanding the issues surrounding the timing of the investigation, the process appeared to her to *'have been undertaken in a robust manner and the reports are well written and appropriate'*. She asked for confirmation that Midwife B and the other local Supervisors of Midwives agreed that supervised practice[27] was not required, and she broadly agreed with the recommendations for both Midwife C and Midwife D.

53. However, she recommended that, as a result of the previous similar incident in 2004, Midwife C should also produce a reflective essay, which would *'provide evidence and assurance that* [Midwife C] *has learned from the two incidents and ... reflected on her practice'*. She had no comments in relation to the recommendation that Midwife D undertake the same training.

54. The LSAMO also asked whether the group of Supervisors of Midwives *'consider whether or not all midwives in the unit feel confident in contacting a Consultant Obstetrician directly'*. She said that it was not clear from either of the reports, or from the chronology of the events surrounding Ms Q's labour, whether the two midwives were concerned about the junior doctor's decisions and, if they were, why they did not notify a consultant.

The second supervisory investigation into Midwife C

55. On 1 July 2009 the Executive Director of Nursing at the Trust asked the Head of Midwifery to look into the two incidents involving Midwife C in more detail. An external audit of 11 cases (including Ms Q's) in which Midwife C had provided midwifery care was commissioned,

[27] Supervised practice involves the midwife working with a peer colleague in a supervised capacity for a set number of hours. There is an academic component and a clinical component which the midwife needs to satisfy. Once the midwife has undergone supervised practice for the requisite number of hours and satisfied both components, she is deemed competent to practise midwifery.

and carried out by the Acting Head of Midwifery from another NHS trust. The outcome of this audit led to a second supervisory investigation by a different Supervisor of Midwives, who interviewed Midwife C on 1 March 2010, and a report was sent to the LSAMO on 17 March.

56. This report concluded that Midwife C had *'failed to maintain accurate and contemporaneous records'* and that she was *'unaware of the importance of accurate completion of both written and computerised records'*. It also said that Midwife C '*appeared to demonstrate genuine lack of knowledge with regard to the need to both store and document CTG recordings*'.

57. The investigation concluded that these were breaches of NMC guidelines and local policies which *'potentially compromised her ability to provide safe and effective care'*, and recommended that Midwife C undergo a period of supervised practice of not less than 150 hours.

58. On 6 September 2010 this period of supervised practice was completed successfully and the LSAMO was notified.

Local resolution

59. On 5 March 2012 Ms Q made a complaint to us about the SHA, which she copied to the SHA. She raised *'concerns* [about] *the failure of the NWLSA to properly review the midwifery failures which led to my son's death on 6 September 2008'*. She explained that since the death of her son she and Mr R had only recently *'felt strong enough to start looking further into the events surrounding* [Baby Q's] *preventable death in more detail'*. She said that she also now understood more about the LSA system. Ms Q's complaint included five key concerns:

    '1) The failure of the LSA to investigate [Baby Q's] *death within the stipulated timeframe;*

    2) The apparent failure of the LSA to investigate or learn from previous incidents, including a case referred to by [a doctor from the Trust]*;*

    3) The attitude displayed by [the Supervisor of Midwives who had carried out the investigations] *in describing the concerns (which have now been substantiated) raised by the consultant paediatrician with my family as "unfortunate". Identifying mistakes and learning from serious incidents should not be considered "unfortunate";*

    4) The failure of the LSA to disclose the first LSA report regarding [Baby Q's] *death in full;*

    5) The failure of the LSA supervisory system to learn lessons from [Baby Q's] *death, demonstrated by the similarities made clear by the Coroner in relation to the death of* [another baby]*, and more recently, by the significant ongoing risks identified by the Monitor report.'*[28]

60. On 12 March 2012 we contacted the SHA about Ms Q's complaint and it gave us the SHA's comments on 26 March.

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[28] *Report of the Diagnostic Review undertaken at University Hospitals Morecambe Bay NHS Foundation Trust* (Central Manchester University Hospitals NHS Foundation Trust – Commissioned by Monitor, December 2011). Monitor is a healthcare regulator which is supposed to protect and promote the interests of patients by promoting the provision of health care services which is effective, efficient and economic, and maintains or improves the quality of services.

61. The SHA said that it had not received a complaint from Ms Q, and as a result it had not had an opportunity to respond to the specific concerns that she had raised in her complaint to us. The SHA confirmed that it had seen the letter, which Ms Q had sent to us with the detail of her complaint. It said that the only contact it had with Ms Q in relation to this matter was a series of exchanges between her lawyers at the time, and the lawyers representing the SHA, about enquiries raised under the *Data Protection Act 1998* as to whether a supervisory review was ever undertaken.

62. The SHA said that, having looked at her letter of complaint, it believed that it should *'investigate her complaint in full under the NHS complaints procedures'* and on 6 June 2012 it wrote to Ms Q and set out the terms of reference for the review of her complaint. It said that it expected to be able to provide a full response by mid-August 2012.

63. On 6 June 2012 we wrote to the SHA to explain that, although its investigation was still ongoing, we were going to take a closer look at Ms Q's complaint and on 11 October, we explained that we had agreed to investigate it.

The SHA's draft report

64. On 31 October 2012 the SHA shared with us a copy of a draft report, which it said was still subject to accuracy checks and final authorisation. The report was a *'review of the Local Supervisory* [sic] *Authority (LSA) process in response to the complaint made by* [Ms Q] a*s detailed in the letter of 17 May 2012'*. NHS England shared the final version of this draft with us on 10 October 2013.

65. The SHA's report outlined the terms of reference of the review and set out a chronology of the events between 2008 and 2012, including the supervisory investigations, the Trust investigations, the inquest, and our involvement.

66. The SHA was critical of the supervisory investigations carried out in 2009 (the first supervisory investigations on the care provided for Ms Q by Midwife C and Midwife D). It said that the investigations were not started as soon as possible and Midwife B did not contact the LSAMO as soon as possible for advice. The SHA also said that the relationship between the supervisory investigation and the Trust's own risk management process meant that the supervisory investigations were not independent, and relied heavily on the Trust's root cause analysis, which did not identify any midwifery practice issues. The SHA said that root cause analyses were not *'the vehicle for investigating issues of competence or misconduct'*.

67. The SHA questioned the reports themselves, concluding that '[p]*ractice was not examined thoroughly'* because *'the failure to monitor fetal progress was not fully assessed against the standards in place at the time'*. The SHA also said that the impact on Baby Q was not critically reviewed, nor was it entirely clear whether any consideration was given to the similarities between the incident in 2004 and the care Midwife C provided for Ms Q.

68. The SHA concluded that these investigations and the associated reports did not examine practice thoroughly, *'which meant that it did not achieve a key objective of supervision which is to protect women and babies by ensuring that a midwife's practice is safe, effective and appropriate'*. It said that the

Supervisors of Midwives *'confused their responsibilities as senior midwives to the Head of Midwifery and accountability to the LSA for delivering the local elements of the LSA function'*. The SHA acknowledged that although there was a delay in starting the investigation, once the decision had been made the investigation was carried out promptly. However, *'it lacked the rigour and independence required to understand if the midwife's practice was safe'*.

Our clinical advice

69. The Adviser said that the decision by the LSA to carry out an investigation into Baby Q's death was appropriate, because there were clear reasons for concern about some of the midwifery care provided to Ms Q while she was in labour. She said that while the decision to carry out an investigation was therefore sound, there was a delay of over seven months before it was started. She said that whatever the reason for the delay Midwife B should not have stopped her investigation. If she had any concerns about continuing with it, she should have sought advice from the LSAMO.

Midwifery care

70. The Adviser said that the supervisory review of the clinical records should have identified a number of issues with the midwifery care.

71. She said that the second stage of labour was protracted and that from 6.15pm to 7.45pm, Ms Q was encouraged to push even though the second stage of labour was not confirmed by a vaginal examination and there were no visible signs of the baby's head descending.

72. She said that while Midwife C thought that Ms Q's cervix had been fully dilated at 6.45pm, the records say that the vaginal examination carried out at 7.45pm demonstrated the anterior rim of her cervix was still apparent. That meant that her cervix was not fully dilated. The Adviser said that by 7.45pm Ms Q had been actively pushing for an hour and a half and, therefore, in line with NICE guidance (paragraph 27), this review should have been carried out by a doctor. She added that it was concerning that, despite the

examination at 7.45pm demonstrating that Ms Q's cervix was not fully dilated, she was still being encouraged to push.[29]

73. In addition, the Adviser said that at 7.54pm the obstetric registrar reviewed, but did not examine Ms Q. There is nothing in the records to evidence what the midwife actually told him or whether she raised any concerns. She said that at 8.15pm a vaginal examination was done, but was not fully documented in the records. The Adviser also said that the midwife should have assessed the baby's heart rate every five minutes from 6.45pm, when Midwife C had thought Ms Q was in the second stage of labour.

74. The Adviser said the baby had a fast heart rate (tachycardia), 175 beats per minute, when his heart was heard at 9pm. She said that during the next two contractions the heart rate was 174 and then 184 beats per minute, which should have raised concerns for Midwife D (who by this time had taken over briefly in order to allow Midwife C to complete her records). At 9.05pm the heart rate was 168 to 174 and it fell to 127 beats per minute with the next contraction. Ms Q's pulse was not taken and electronic fetal monitoring was not commenced because Midwife D thought the birth was imminent.

75. The Adviser said that it was not clear from the records whether Midwife D had listened to the baby's heart rate between 9.10pm and 9.20pm. She said that Midwife C listened to the heart rate at 9.25pm, by which time it was 155 beats per minute. The baby's heart beat was not listened to again.

76. Finally, the Adviser said that the midwives involved in Ms Q's care did not begin electronic fetal monitoring when abnormalities in the heart rate were identified – namely the fast heart rate at 9.05pm and then the subsequent deceleration of the heart following the contraction. This was not in line with the relevant NICE guideline (paragraph 26).

77. The Adviser said that in her view a supervisory investigation should have been undertaken. She said that an LSA investigation should have identified whether any actions were required to address any midwifery practice issues, or whether a referral to the NMC was appropriate.

The reports of the supervisory investigations

The supervisory report about Midwife C

78. The Adviser said that the supervisory report made reference to a similar case in 2004 in which Midwife C was involved. While it was unclear whether a supervisory investigation was carried out in 2004 (there are no records to that effect), the Adviser said that it was clear that Midwife C had undergone additional training on the monitoring and recording of the fetal heart in labour as a result of that case.

79. The Adviser said that Midwife B's analysis of Ms Q's midwifery care was very limited. The report does not comment on the fact that Midwife C had not listened to the fetal heart beat every five minutes when she thought that Ms Q was in the second stage of labour. The report also did not comment on the fact that Midwife C encouraged Ms Q to continue pushing

[29] Directed pushing, as in this case, should only happen once the cervix has fully dilated and therefore the woman is in the second stage of labour.

after 7.45pm, when it should have been clear that Ms Q had not, in fact, entered the second stage of labour. The Adviser said that the report therefore lacked detail. She said she would have expected Midwife B to have wanted to see evidence that Midwife C understood about the development of fetal hypoxia. The Adviser said that she would have wanted to be reassured that Midwife C had competent knowledge about fetal oxygenation in the second stage of labour.

80. The Adviser said that the purpose of the supervisory investigation was to identify whether there were any failings in Midwife C's practice and, if there were, to put in place measures to address such failures locally, if possible. If not, the midwife should have been referred to the NMC. The Adviser said that on the basis of her review of the records she possibly would not have referred Midwife C to the NMC as she would have wanted to explore the facts of the case with the midwife at the interview stage to discuss with the midwife her conduct and her midwifery competence (knowledge, skills and decision making skills). Depending on what was said at the interview it would then assist with making a decision about whether Midwife C needed a specific development programme or supervised practice. The Adviser concluded that the report was not detailed enough and that the recommendation to complete training that had already been completed in 2004 was not specific enough to demonstrate that the midwife was safe to practise unsupervised.

The supervisory report about Midwife D

81. The Adviser said that Midwife D was only involved during Ms Q's labour for the last 40 minutes. She took over in order to enable Midwife C to write her records. As soon as she heard the baby's heart rate she realised there was a problem and within five minutes she had contacted the doctor who decided that an instrumental delivery would be required. At this stage it was felt that the birth was imminent, and so Midwife D called Midwife C back into the room. It is not clear from the records whether Midwife D listened to the fetal heart every five minutes for the time she was providing the care.

82. On conclusion of the supervisory investigation, Midwife B recommended that Midwife D complete the same training course on fetal heart rate monitoring as Midwife C.

83. The Adviser said that the supervisory investigation report and recommendation for Midwife D was appropriate, but lacked sufficient detail.

Findings

The supervisory investigations

84. In order for the SHA to 'get it right' and adequately carry out its duty to do open and effective supervisory investigations of midwives, Midwife B and the LSAMO should have acted in accordance with the relevant standards, and with established good practice, as described by the Adviser:

    - Baby Q's death should have been reported to the LSAMO because it was unexpected. His death was not reported as it should have been;
    - A decision about whether to undertake a supervisory investigation should also have been made as soon as possible, and it should have been completed within 20 days. It took seven months to make a decision and that was unreasonable;
    - The investigation and subsequent reports should have been thorough and independent, in order to ensure that the midwifery care provided was safe and woman-centred. The reports should have identified midwifery care that fell short of relevant NICE guidelines or established good practice. The reports failed to do that; and
    - When the reports were shared with the LSAMO, she should have made sure that any concerns she had were addressed by Midwife B, given that the LSAMO had statutory responsibility for ensuring that the standards for supervision of midwives and midwifery practice met the requirements set by the NMC. The LSAMO did not do that.

85. The SHA said that Midwife B and other Supervisors of Midwives *'confused their responsibilities as senior midwives to the Head of Midwifery and accountability to the LSA for delivering the local elements of the LSA function'*. This is particularly true when it delayed the start of the investigation, although I have not seen any evidence that this potential conflict of interest influenced her decision in Ms Q's case. Nonetheless, I can quite understand why the possibility of a conflict would be a worry for any parent finding themselves in this position. For that reason, I am deeply concerned that the regulations allow potential muddling of the supervisory and regulatory roles of midwives or even the possibility of a perceived conflict. That cannot be in the interests of the safety of mothers and babies. And, it is inherently unfair to service users and to midwives themselves.

86. Putting aside the question of any perceived conflict of interest, the reports produced by Midwife B lacked detail, and were not thorough. They did not identify all the midwifery issues relating to the monitoring of Baby Q's heart rate, and the SHA itself has accepted that it was too heavily reliant on the Trust's root cause analysis. Whilst there was reference to similar errors by Midwife C in 2004, the report did not explore whether this warranted further investigation. An assumption was made that the length of time that had passed was sufficient to conclude that there was no pattern and that training would be enough.

87. Midwife B correctly identified that electronic fetal heart monitoring should have started when Baby Q's heart was noted to be fast but she did not question Midwife D's explanation about why this was not done. She did not explore to

what extent Midwife D understood the importance of electronic fetal heart monitoring, and did not acknowledge that the failure to monitor the fetal heart beat in this way was not in line with NICE guidelines.

88. When the LSAMO became involved the LSA had another chance to ensure that all midwifery practice concerns had been addressed appropriately. She did not fully explore (or ask Midwife B to explore) the significance of the midwives' failure to start electronic fetal heart monitoring, or the significance of the earlier case involving Midwife C. She asked whether the Supervisors of Midwives agreed that Midwife C did not need supervised practice, but did not say whether she felt the reports supported such a measure. She raised a significant concern about whether midwives in general felt confident to obtain advice from consultants, but she did not follow this up. She did not say whether she felt the supervisory investigations needed to explore this. These were significant failures.

89. Ultimately, the LSA failed to ensure that the standards for the supervision of midwives and midwifery practice met the requirements set by the NMC. For all these reasons, I find that the LSA did not adequately carry out its function as the LSA for midwives following Baby Q's death on 6 September 2008. I conclude that this amounts to maladministration.

Ms Q's complaint

90. The SHA undertook to respond to Ms Q's complaint in May 2012 when it commissioned a review to look at her outstanding concerns. In dealing with Ms Q's complaint, the SHA should have been more customer focused, by responding to her concerns promptly, keeping her regularly informed about the progress of her complaint and telling her how long she could expect to wait before receiving their response. It should also have been open and accountable, by providing honest and evidence-based explanations. The final version of this draft was only completed in October 2013. That is clearly unacceptable.

91. The SHA has recognised that the decision to investigate was delayed and there was no clear reason why Midwife B did not contact the LSA as soon as possible after Baby Q's death. The SHA has recognised that the midwifery practice was not examined thoroughly and, ultimately, the investigation *'lacked the rigour and independence required to understand if the midwife's practice was safe'*. The SHA concluded that, overall, the supervisory investigation *'did not therefore deliver a key objective of supervision in terms of determining if the midwives' practice was safe, effective and appropriate'*. I strongly agree.

92. Ms Q has had to wait for the Ombudsman's investigation report to see the SHA's draft conclusions on the supervisory process and she has had to wait over 18 months before seeing the SHA address her concerns. More than a year after her complaint was brought to the SHA's attention, this is unacceptable. Whilst the draft report is evidence that the SHA has tried to be open and accountable, it has not been customer focused because it took too long to share the conclusions with Ms Q. I find that on balance, the SHA's failure to address Ms Q's concerns over a year after she made her complaint amounts to maladministration.

Injustice

93. I can understand why Ms Q and Mr R feel that the LSA failed to learn from their baby's death. The supervisory investigations took too long, were superficial, and the recommendations did not fully address the failings that had been identified. The distress that that has caused them is an injustice arising from the maladministration identified in this report.

94. Midwife C was later involved in a second supervisory investigation, as a result of which she underwent a period of supervised practice. That leads me to think that for almost two years a midwife with potentially unsafe practice was not appropriately supervised because the LSA had failed to identify that her practice in Baby Q's case was not in line with the standards required by the NMC. I have no doubt that this knowledge has since compounded the distress Ms Q and Mr R experienced at the time, and I have no doubt it will continue to do so. I find that this injustice arose in consequence of the maladministration I have identified.

95. In addition, when the SHA had the opportunity to respond to Ms Q's complaint, it failed to do so in a timely fashion. The draft report we have seen, and the final version which will be shared with Ms Q, would go some way to showing Ms Q that some lessons have been learnt and possibly that such errors would not be repeated in future. But, whatever reassurance she might have got from the content of the report has been diluted by delay. I find that the SHA's failure to respond to Ms Q in a timely fashion, particularly when it had told her that it would do so by mid-August 2012, is an injustice to her which also arose in consequence of the maladministration I have identified.

Recommendations

96. This is one of three complaints we have investigated which deal with midwifery supervision and regulation under the SHA. In all three cases, the midwifery supervision and regulatory arrangements at the local level failed to identify poor midwifery practice. As we have said, we think these cases clearly illuminate a potential muddling the supervisory and regulatory roles of Supervisors of Midwives.

97. We brought together leaders in the field of midwifery and regulation to discuss the strengths and weaknesses of the current system and what needs to change to enhance the safety of mothers and babies.

98. We have worked with the NMC, the Professional Standards Authority for Health and Social Care, NHS England and the Department of Health. In our publication *Midwifery supervision and regulation: recommendations for change*, we have identified two key principles that will form the basis of proposals to change the system of midwifery regulation.

    The two principles are:

    - that midwifery supervision and regulation should be separated;
    - that the NMC should be in direct control of regulatory activity.

99. We recommend that these principles inform the future model of midwifery regulation.

100. We recognise that the regulatory framework for midwifery is a UK-wide framework and changes need to be negotiated with stakeholders across the UK. We undertake to share our conclusions and reasoning with the other UK ombudsmen and we look to the Department of Health to convey these recommendations to its counterparts in Northern Ireland, Scotland and Wales.

101. We recommend that the NMC works together with NHS England and the Department of Health to develop proposals to put these principles into effect. This will include developing and consulting on proportionate approaches to midwifery supervision and midwifery regulation. We recommend that this is done in the context of the anticipated Bill on the future of healthcare regulation. We also recommend that the Professional Standards Authority advises and reports on progress.

Annex A: Background case

Key events

Mrs K was considered to be a high-risk mother because she had high blood pressure,[30] which was being managed with medication and she was having a planned induction of labour at Furness General Hospital. After a number of failed attempts to induce labour, she was re-admitted to the Hospital on 23 February 2004, and her labour started at approximately 3.25pm on 25 February 2004. She was reviewed at the time by a doctor who noted that she was having contraction pains every ten minutes. On examination her cervix was found to be five to six centimetres dilated.

No further observations were recorded by either midwives or doctors until 7.20pm when a record was made that the baby's (fetal) heartbeat had been heard with an ultrasound and that nothing abnormal was detected. At 8.15pm Midwife C listened to the baby's heart using a stethoscope and a reading of 130 to 140 beats per minute was noted.

Shortly after this Mrs K started the second stage of labour. There were no further records of the baby's health or heart. Mrs K's daughter was born at 8.58pm, but sadly died shortly after.

Actions taken by the LSA

Although the SHA was unable to provide any records relating to whether a supervisory investigation of the midwifery care was undertaken at the time, an email from the Trust's Director of Nursing and Modernisation in relation to the inquest into the death of Ms Q's son, Baby Q, says that *'I can confirm that a supervisory review was undertaken on 26 February 2004'*. The conclusions of this review were that aspects of Midwife C's care were lacking around fetal heart monitoring and record keeping, and Midwife C was instructed to undertake fetal heart monitoring training. No other actions in relation to Midwife C were taken. These conclusions were also re-iterated in the supervisory report into the care Midwife C provided for Ms Q.

Clinical advice

The Adviser was critical of a number of aspects of the care given to Mrs K.

She said that on 25 February 2004, at 3.25pm the doctor and Midwife C had written in the clinical record, but that there were no further entries by the midwife until 7.15pm. Retrospective entries were made several days later to reflect the midwifery care. This was not in line with the NMC rules in force at the time, which required that records be completed as soon as possible after an event has occurred.[31]

She said that the baby's heart rate was not monitored adequately between 3.25pm and 8.58pm, when Mrs K gave birth. She said that there was no evidence that a CTG was done and there were no regular recordings of the heart rate. The Adviser said that she would have expected the midwife to start electronic fetal heart monitoring with a CTG, given that Mrs K's labour was being induced and that she was also being treated for high blood pressure. However, she said that as late as 7.20pm, when

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30 According to NICE Inherited Clinical Guideline C *The use of electronic fetal monitoring* (May 2001, reviewed January 2003), where the mother displays certain risk factors, electronic fetal heart monitoring (CTG) should be offered and recommended. In this case, Mrs K was having her labour induced and had high blood pressure, both of which are factors set out in the guidelines' *Clinical Practice Algorithm*, which made her pregnancy high-risk.

31 NMC *The Code: standards of conduct, performance and ethics for nurses and midwives* (2004).

there is a record that the heart was listened to with the aid of an ultrasound, the CTG had still not been started.

The Adviser said that once Mrs K was transferred to the labour ward at 8.15pm, a doctor reviewed her and found that her cervix was eight to nine centimetres dilated and an artificial rupture of the membranes was done.[32] She said that there was still no evidence of a CTG and that the baby's heart was listened to only once at 8.15pm, and there were no further entries until her baby was born.

The Adviser said that Mrs K's labour should have been managed as a high-risk pregnancy, but the care provided to her was below the standard which would have been expected even if she had been a low-risk pregnancy. If Mrs K had been treated as a high-risk mother, her baby's heart would have been continuously monitored using a CTG. However, even if Mrs K was considered low-risk, the baby's heart should have been listened to every 15 minutes from 3.30pm and appropriate entries made in the records. Instead there are only two entries between 3.30pm and 8.58pm when the baby was born.

In addition, the Adviser said that there was an inadequate assessment of Mrs K between 3.30pm and 8.58pm. She said that despite the risks associated with Mrs K's labour, her blood pressure, pulse and temperature had not been measured since 10am that morning.

The Adviser concluded that Mrs K should have been assessed and monitored more closely whilst in labour. She said that despite the fact that Mrs K was a high-risk mother, her baby was not monitored with a CTG and the midwifery care provided for her was below the appropriate standard at the time.

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[32] This involves a midwife or an obstetrician breaking the mother's membranes in order to induce or accelerate labour.

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