NHS Resolution

The second report:
The evolution of the Early Notification Scheme

Part of NHS Resolution's
Maternity campaign 2022/23
#ImprovingMaternityOutcomes

Advise / Resolve / Learn

Contents

Foreword

Each claim is a family

Having a baby experience a severe brain injury can be devastating for families. It also significantly impacts healthcare professionals involved.

When the injury could have been avoided, a further layer of distress is added. Families then have to try to navigate a complex and often lengthy legal process. As parents whose children have experienced significant brain injuries, we know it can add further distress to an already challenging situation.

Each number in this report represents a real family now caring for a child with potentially complex needs. These families will feel the impact of the injury in different ways, at different times. Showing sensitivity to their situation and involving them in the process is vital.

Early Notification (EN) Scheme: Timely support

Traditional claims processes are long, and families have often faced years of financial uncertainty and struggle.

The stress this places on a family cannot be underestimated.

While the injury sadly cannot be reversed, the processes can be made easier for families. With the development of the EN Scheme, NHS Resolution is trying to address these issues and aiming to meet the needs of families more adequately and quickly at this most difficult time.

This timely support means that families can better provide for the child (care needs, therapies, equipment, housing adaptations and so on) and is reassuring for the family – some of whom may have had to leave employment, whether to provide care for the child or due to their own mental health, or a combination.

Families want and need learning

While families need financial support, they are also desperate to know that there has been learning and that changes have been put in place as quickly as possible to ensure others do not have the same experience.

This learning and improvement is essential at local and national levels.

We welcome the national work that has been actioned in response to the recommendations from the first EN Scheme report in 2019. Learning from incidents will ultimately result in fewer incidents occurring and is likely to reduce associated claims – which is something we all want.

EN Scheme Maternity Voices Advisory Group (MVAG)

We are so pleased that NHS Resolution has formed the EN Scheme Maternity Voices Advisory Group to work with family and charity representatives, like us, to jointly ensure the scheme works for families and is responsive to feedback. The focus of the co-production group is covered later in this report.

Families at the centre

If you work in a trust or in a legal team, we ask that you always listen to the family, ensure that they are heard and that their experience and needs are always considered and acted upon.

That families are always at the centre.

Thank you.

Sarah Land, Heidi's mum and co-founder Peeps HIE (@PeepsHie)

Nicky Lyon, Harry's mum and co-founder Campaign for Safer Births (@CfSaferBirths)

Members of the Early Notification Maternity Voices Advisory Group

Chief Executive's introduction

Helen Vernon
Chief Executive, NHS Resolution

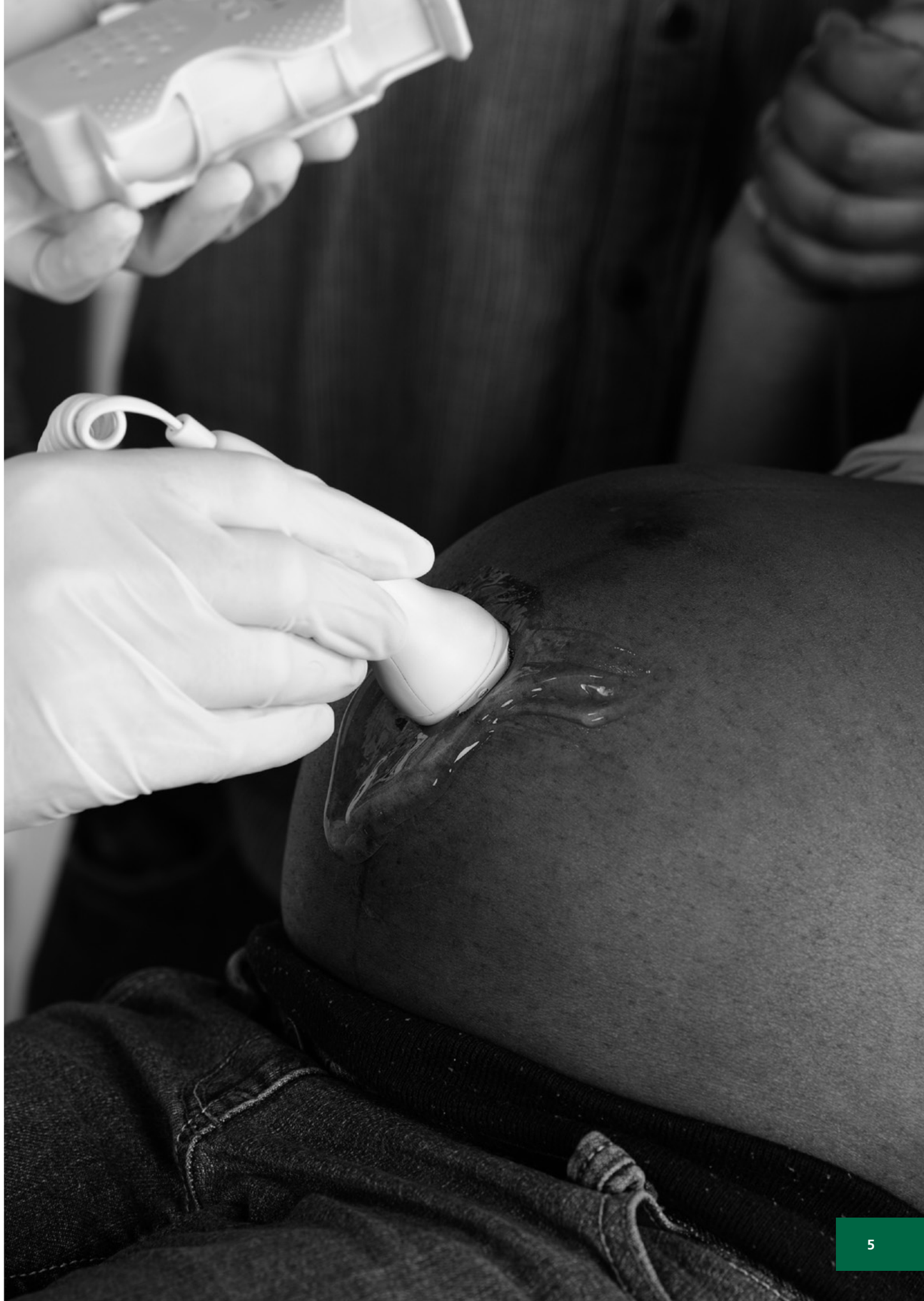
I am pleased to introduce the second report of our Early Notification Scheme. It is a priority for NHS Resolution to do all we can to support improvements in the safety of maternity services and this innovative scheme, which aims to remould traditional litigation processes to deliver better outcomes for families and faster learning for the health service, plays an important part in this.

Compensation costs arising from harm sustained in childbirth are significant and rising, and each and every compensation claim we see represents a baby, parents, families and clinical teams who are profoundly affected by events that could have been avoided. I am extremely grateful to the families and clinicians who have shared their experiences and generously given up their time to support this work. In particular, I would like to acknowledge the invaluable work of our Maternity Voices Advisory Group in helping to build closer links with parents, families and carers in the scheme's development.

This report highlights a significant reduction in the time taken to admit legal liability on cases involving a brain injury at birth. It illustrates how this can facilitate early, interim compensation payments which can make a huge difference to families at the time when they are most needed. The report also provides an update on the progress of safety recommendations made early on in the life of the scheme and makes new recommendations, drawn from learning on recurring themes in relation to antenatal counselling before trial of vaginal birth after caesarean section.

Finally, early signs indicate that the scheme reduces legal costs. The next phase will include an evaluation of the scheme's impact as we reach the tipping point, between when incidents reported to the scheme in year one would have become a claim under the traditional route. We look forward to working with our Advisory Group and other partners in the field of maternity safety to continue to develop the scheme further to fully meet our shared objectives.

Helen Vernon
Chief Executive, NHS Resolution



Executive summary

The EN Scheme is a cornerstone of NHS Resolution's strategy to improve claims resolution and support learning after harm. The scheme, established in April 2017, required early reporting of babies born with evidence of a term intrapartum hypoxic brain injury to support families where clinical negligence is identified.

Our theory of change is that early notification will facilitate early assessment with admission of liability where appropriate, followed by earlier mobilisation of support, including provision of early financial compensation.

Early notification should also facilitate improvements in the safety of maternity care through shared learning closer to the event.

The EN Scheme is a key innovation in NHS Resolution's strategic shift to move closer to the incident and is now a part of the current maternity safety landscape. The scheme contributes to the **National Maternity Safety Ambition** to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury from the 2010 rate by 2025. Since the publication of the year one EN report in September 2019, there have been some significant changes to the scheme. The scheme's reporting criteria have been streamlined, as well as providing a clearer process for families. NHS Resolution is now investigating following an 'outcome-first' approach for the EN Scheme.

Families are central to the EN Scheme and a Maternity Voices Advisory Group (MVAG) has been established to build closer links with parents, families and carers in the scheme. The MVAG will work with the EN team to ensure that the experiences of families who have had a baby diagnosed with a brain injury will inform the work of the scheme and the management of EN cases, as well as collaborating to co-produce family-facing resources.

Further improvements in the legal part of the scheme include the development of an internal pathway to determine when lawyers should be engaged to investigate liability and to formalise the 'Expert Summit' process on cases, particularly multiple cases with shared features. Early pilot data has demonstrated some legal process improvements with reductions in the time to reach a decision on liability.

Finally, we have collected some encouraging preliminary data that early notification has led to associated reductions in the time taken to admit liability. This reduction in time taken to admit liability has not previously been described and should meet the aspiration for the scheme to facilitate early family and staff support post incident.

Revised reporting criteria were embedded from April 2021 and updated guidance on reporting requirements provided to trusts in April 2022. These changes further focused the scheme on those babies who have suffered harm and for whom there is a potential likelihood for complex care needs and a high value financial compensation payment. As of 31 March 2022, we identified 439 claims over the past 5 years that met our revised criteria, and these cases have included a formal apology with early financial assistance for care, in some cases.

A larger evaluation of the EN Scheme will be conducted in 2023 to assess the impact of EN on families, staff and the service.

NHS Resolution aims to work with all the main stakeholders in the maternity safety landscape as a system integrator to expedite system level changes to improve maternity care. Every effort should be made to reduce avoidable harm; however, where harm does occur it is essential to ensure that the post-incident response to harm, communication and pathways are clear for families so that they can easily understand the process of investigation, including navigation through the potentially complex legal system, and families are signposted to appropriate support.

This report is aimed at multiple audiences including staff and clinical teams, trust boards, families and policymakers. The report is divided into six chapters. The first chapter explores the impact of the six EN recommendations outlined in the first EN report. The second explores the potential benefits of early liability investigations after early notification. The third reports our experience of an important emerging clinical theme of impacted fetal head at caesarean section. The fourth provides an overview of the clinical themes derived from a cohort of 98 cases from the EN Scheme. The fifth chapter reports the progress of the EN Scheme and an early investigation of potential benefits, and the sixth chapter outlines three new recommendations.

This report makes the following recommendations:

- NHS Resolution to support the work of royal colleges and wider stakeholders to improve antenatal information provision and counselling before trial of vaginal birth after caesarean*
- NHS Resolution to support the work of royal colleges and wider stakeholders to improve awareness of the options available and the response to harm for families and staff.
- NHS Resolution to support improved working with NHS providers and wider stakeholders, encouraging a joined-up approach between trust legal services and maternity & risk teams.

*A woman gives birth vaginally, having had a caesarean section in the past.

Introduction and background

NHS Resolution is an arm's length body of the Department of Health and Social Care. It provides expertise to the NHS in England on resolving concerns and disputes fairly while sharing learning for improvement and preserving resources for patient care.

The NHS has a well-deserved reputation for delivering one of the safest healthcare systems in the world. However, on rare occasions, things go wrong. When this happens, it is important that those involved are properly informed and supported, and that financial compensation is paid fairly, unnecessary costs are contained, and we learn to improve and prevent the same thing from happening again.

Negligence comes at significant personal and financial cost for the NHS, patients, and their families, not all of which is visible. This is especially evident when things go wrong during childbirth.

The EN Scheme, established in April 2017, introduced an innovative approach for the early reporting of babies born with evidence of a potentially severe hypoxic brain injury following term labour. The primary aims of the EN Scheme at its inception were to support proactive investigation and early resolution of birth injury cases, a reduction in litigation and legal costs arising from these incidents, dissemination of learning across trusts to improve maternity care, and creation of a more transparent process with greater support for families and staff involved.

The scheme epitomises NHS Resolution's strategic shift to do more, closer to the point of harm.

Entry criteria into the scheme were initially based on the Royal College of Obstetricians and Gynaecologists' (RCOG) 'Each Baby Counts' definition[2] of a potentially severe intrapartum brain injury with a focus on babies who:

- Have been diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- Were actively therapeutically cooled; or
- Had decreased central tone and were comatose and had seizures of any kind.

Having received a high number of incidents throughout the first three years of the scheme, these criteria were considered too broad, capturing a large number of babies (around 750 incidents per year) but lacking specificity for the core objectives of the scheme; only a small number (estimated to be around 10%) had evidence of a confirmed brain injury. This work will be described in more detail in chapter 5.

NHS Resolution has a responsibility to maintain the integrity of patient data and confidentiality under data protection laws and we have suppressed low figures as we believe that disclosure of information with this level of granularity would contravene one or more of the data protection principles. The data protection principles are set out in Article 5 of the General Data Protection Regulation.

This review provides a high-level analysis of the data to ensure that claim and patient confidentiality are not prejudiced. As the numbers are small for the EN clinical themes, these are presented as percentages.

Chapter 1

Impact of the EN Scheme and progress with recommendations from the first report

Introduction

The year 1 NHS Resolution Early Notification Scheme report 2019[3] recommended six areas for maternity care improvement based on the findings of the first year of the EN Scheme. Working closely with the maternity system, progress has been made with each of the recommendations. Furthermore, with impactful new qualitative and quantitative research, national action groups have been commissioned to develop tools to improve care and take forward new national policy initiatives. This chapter outlines progress against the recommendations of the first EN report.

Recommendation 1

All families whose baby meets the EN criteria for a potentially severe brain injury are offered a full, open conversation about their care. This should include an apology in accordance with the principles of candour, options for their involvement and description of the national agencies involved in investigating their care.

The EN team supports trusts to involve families from the beginning of any investigation. Open and honest communication is essential for all aspects of maternity care, particularly after poor outcomes. Early parental involvement improves satisfaction, drives improvements in patient safety and promotes an open culture within healthcare. This starts with the Duty of Candour that is mandated by professional regulators, and NHS Resolution requests Duty of Candour correspondence and notes in every EN investigation.

NHS Resolution has produced guidance, ***Saying Sorry***[4], to reinforce the importance of the Duty of Candour, as well as providing practical examples and strategies to improve candour when incidents occur. We have also highlighted the need for a restorative and just learning culture in our report ***Being Fair***[5].

Candour was successfully included as part of safety action 10 for years 3 and 4 of NHS Resolution's Maternity Incentive Scheme[6] to incentivise trusts' compliance with Regulation 20 of the Health and Social Care Act 2008 and Regulations 2014 in respect of the Duty of Candour.

Recommendation 2

An independent package of support should be offered to all NHS staff to manage the distress that can be associated with providing acute health services and those involved in incidents involving possible avoidable harm. Support should address mental health, wellbeing, and post-incident care with access to referral for psychological assessment and intervention where required. This should be confidential and independent of appraisal or revalidation processes.

The year 1 report recognised that staff can be adversely affected after babies are born with potentially severe intrapartum brain injuries and when their care is investigated. We are working with our partners to develop further guidance to support maternity professionals through the processes involved in an EN investigation and to signpost practitioners to available support.

During the Covid-19 pandemic there has been a range of resources and services available for NHS staff support. **See Appendix 1**.

Finally, we encourage trusts to ensure staff have access to dedicated packages of support, including psychological support that is confidential and independent of assessment processes. We recognise that there is more to do, and NHS Resolution is planning to survey clinicians to ascertain what services are available to staff following incidents, to build a picture nationally of the support provided, and to work with stakeholders to drive improvements in this area.

Recommendation 3

There is an urgent need for a standardised approach to intrapartum fetal monitoring based on national guidance.

Computerised CTGs should be used for antenatal assessment.

Effective improvement strategies for fetal monitoring require in-depth understanding of the technical and social mechanisms underpinning the process and there should be more research in this area.

Problems with fetal monitoring were identified as a factor in 70% of EN cases; a finding that resonates with the findings of other national reports.

NHS Resolution is collaborating with professional bodies, including the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) as well as THIS Institute, on the **Avoiding Brain Injury in Childbirth (ABC) programme**.

To accelerate progress towards achieving the Government's National Maternity Ambition to halve the 2010 rate of intrapartum brain injuries by 2025, the Department of Health and Social Care provided £5 million to the ABC collaboration in 2021/22. The programme aims to build consensus on a new approach for improved identification, escalation and action on fetal deterioration in labour and a new protocol for complications that can arise with positioning of the baby at caesarean section (specifically when the fetal head becomes impacted in a woman's pelvis).

The ABC team are currently developing a final pilot programme to develop and test a delivery model for training of the trainers and for site level training ahead of implementation of a National Patient Safety Improvement Programme across maternity services in England.

NHS Resolution is also contributing to the iDecide tool that aims to provide clear information for women and families at key points of their intrapartum care.

Recommendation 4

Increase awareness and further research to support interventions to understand the prevalence, causes and management of impacted fetal head at caesarean section.

Impacted fetal head (IFH) at caesarean section (CS) was a contributory factor in 9% of EN cases in the year 1 report (2019). The publication of this data has increased clinical awareness of this complex obstetric emergency and there are now at least two UK research groups investigating the problem to understand prevalence, causes and strategies to improve care.

NHS Resolution was a co-applicant on a national funding bid to improve care and training for IFH. The results of these collaborative efforts to understand the problem of IFH have been used to create national guidance and algorithms for stepwise management with associated training programmes. The RCOG has already commissioned a scientific impact paper on IFH and NHS Resolution will contribute their data (**Chapter 3**) to the process and paper; this is expected by the end of 2022.

Recommendation 5

Ongoing work to improve the detection of maternal deterioration in labour, understand monitoring practices, use evidence-based guidance, and ensure these are implemented in all birth settings.

Further research is required to understand the prevalence and cause of significant intrapartum hyponatraemia.

NHS England is undertaking work through the maternity and neonatal (MatNeo) safety improvement programme (MatNeoSIP) to produce a national, maternal National Early Warning pathway for mothers. Updates on when the pathways will be launched will be provided by the MatNeoSIP team, with a launch date later in 2022.

We also publish quarterly case stories to disseminate learning specific to these themes within EN, to provide accessible and illustrative clinical examples for units and professionals.

Recommendation 6

Awareness of the importance of high-quality resuscitation and immediate neonatal care on outcomes for newborn babies. This requires collaboration of the whole multi-professional team in setting maternity safety agendas, guidance, investigations and local protocols recognising that neonatal and allied specialties such as anaesthetics are intricately linked with safe maternity care.

Issues with neonatal care were identified as a contributory factor in 32% of EN cases and improvements in neonatal resuscitation was recommended as a priority. This recommendation has been directly incentivised through the Maternity Incentive Scheme with a requirement that trusts provide evidence that staff have attended appropriate multi-professional training for neonatal resuscitation.

In addition, the EN team have recruited a neonatal clinical fellow to support the team with ongoing work, part of whose remit is to analyse and support learning from neonatal claims.

Conclusion

Working with system stakeholders has been integral to actioning the year one EN report recommendations to further enable high-quality maternity care. In going 'upstream' with investigations timed nearer to incidents, it is inherent that learning will be identified and there will be opportunities to improve care.

Our strategy going forward will be to reduce the duplication in reporting and we will continue to work with NHS England to streamline multiple recommendations that arise from national reports in maternity.

We will work with system level partners and stakeholders to co-produce solutions and implementation tools to support personalised and evidence-based care and to increase supported decision-making for pregnant women. In addition, we will work with stakeholders to support staff who have been involved in adverse incidents.

Chapter 2

Analysis of 20 Early Notification liability admissions

Introduction

This chapter presents an analysis of 20 EN cases reported between 2017 and 2020 where liability† was admitted in full. These pilot data are intended to inform the design of a more detailed future evaluation that is likely to be more representative. However, we present these early findings with the caveat that further data will be forthcoming.

Methodology

As of 31 May 2020, admissions had been made through the EN Scheme on 65 eligible EN cases. Of these, 40 were breach of duty only admissions and 25 were breach of duty plus causation of injury admissions, i.e. admissions of liability†.

Of the 25 admissions of liability, five were excluded as the baby did not have a hypoxic brain injury but an alternative injury such as a brachial plexus injury. The remaining 20 cases were analysed; the babies in this cohort were born between April 2017 and April 2019.

Findings

50% of the infants in this cohort have either a diagnosis of cerebral palsy (CP)‡ or evidence of emerging CP. 40% of the infants sadly died within the first two years of life from injuries related to severe hypoxic brain injury.

10% sustained an Erb's palsy injury following shoulder dystocia at delivery, in addition to a potentially severe hypoxic brain injury but with no evidence of CP.

Mode of birth

- 70% of the babies were born by category 1 caesarean section.
  - Of these, 14% involved impacted fetal head at caesarean section.
- 15% of babies were born after an assisted vaginal birth.
- 10% of babies were born by vaginal birth without any apparent complications.
- 5% were born by category 2 (delivery within 75 minutes) caesarean section.

90% of the incidents involved problems with fetal monitoring – both electronic fetal monitoring and intermittent auscultation. In keeping with many recent maternity reports[2,8,9,10], the most common findings were incorrect cardiotocography (CTG) interpretation, delays in escalation and delays in acting on the finding of an abnormal fetal heart rate (on CTG or intermittent auscultation), as well as problems with risk recognition.

† Legal liability: To establish clinical negligence under existing legal principles, it must be proved that a duty of care exists between the patient and healthcare provider, that the care provided fell below a reasonable standard (breach of duty) and that this caused harm (causation).
Whether care is reasonable is assessed using the Bolam and Bolitho principles. Care will be reasonable where it is supported by a responsible body of medical opinion and withstands logical analysis. There must also be a link between the care and harm. Causation is established where substandard care led to the harm directly (on the balance of probabilities) and/or materially contributed to it. The reasonable care test as described above is not directly comparable to avoidable harm which is a concept used in some other jurisdictions.

‡ Cerebral palsy (CP) is a permanent neurological disorder caused by non-progressive disturbances or alterations of a developing brain that results in disordered motor function and posture. CP ranges in severity but often involves problems with muscle tone, balance, co-ordination, epilepsy, difficulties with communication, feeding and behaviour[7].

Neonatal condition

- 90% of the babies were classified as having grade 3 hypoxic ischaemic encephalopathy (HIE 3).
- 10% of the babies were classified as grade 2 HIE (HIE 2).

Paired umbilical cord gas samples were obtained in 70% of the cases. The median arterial cord gas results were pH 6.85 BE -16 and median venous results were pH 7.09 BE -12.

Of the babies classified as having grade 3 hypoxic ischaemic encephalopathy, 89% had abnormal Cerebral Function Monitoring (CFM) and 67% had an abnormal cranial ultrasound.

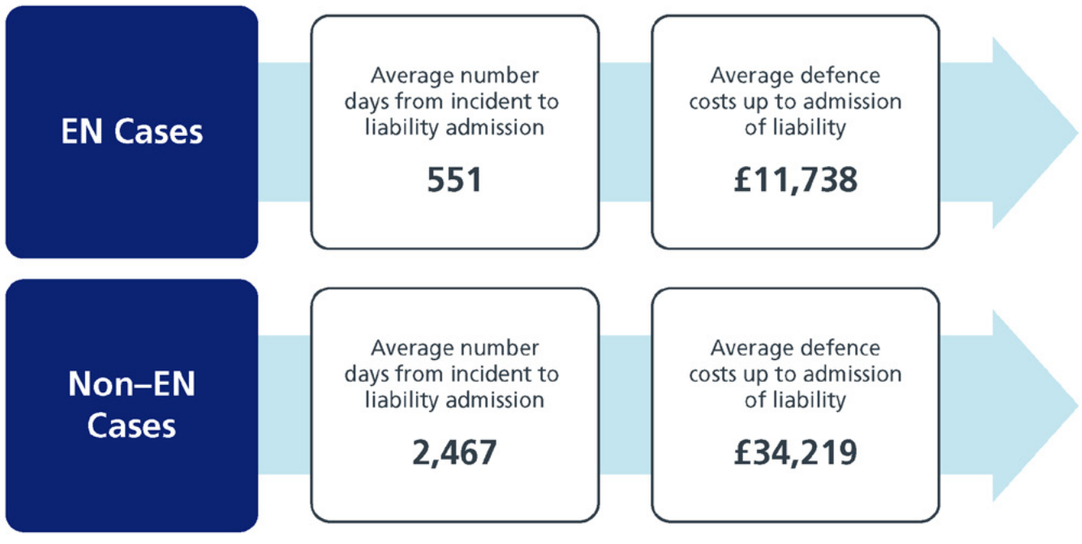
A neonatal brain Magnetic Resonance Imaging (MRI) was performed for 100% of the babies in this cohort between days 5–12 of life. 90% of the MRIs showed evidence of an acute profound/near total hypoxic insult and 70% of the babies had ongoing abnormal neurology at the time of discharge from hospital.

Family involvement

95% of cases complied with mandatory Duty of Candour requirements. There was evidence of family involvement in the investigation process in 18/20 cases. An incident investigation was performed in 95% of cases with 90% of investigations using a Serious Incident format.

Comparative process analysis

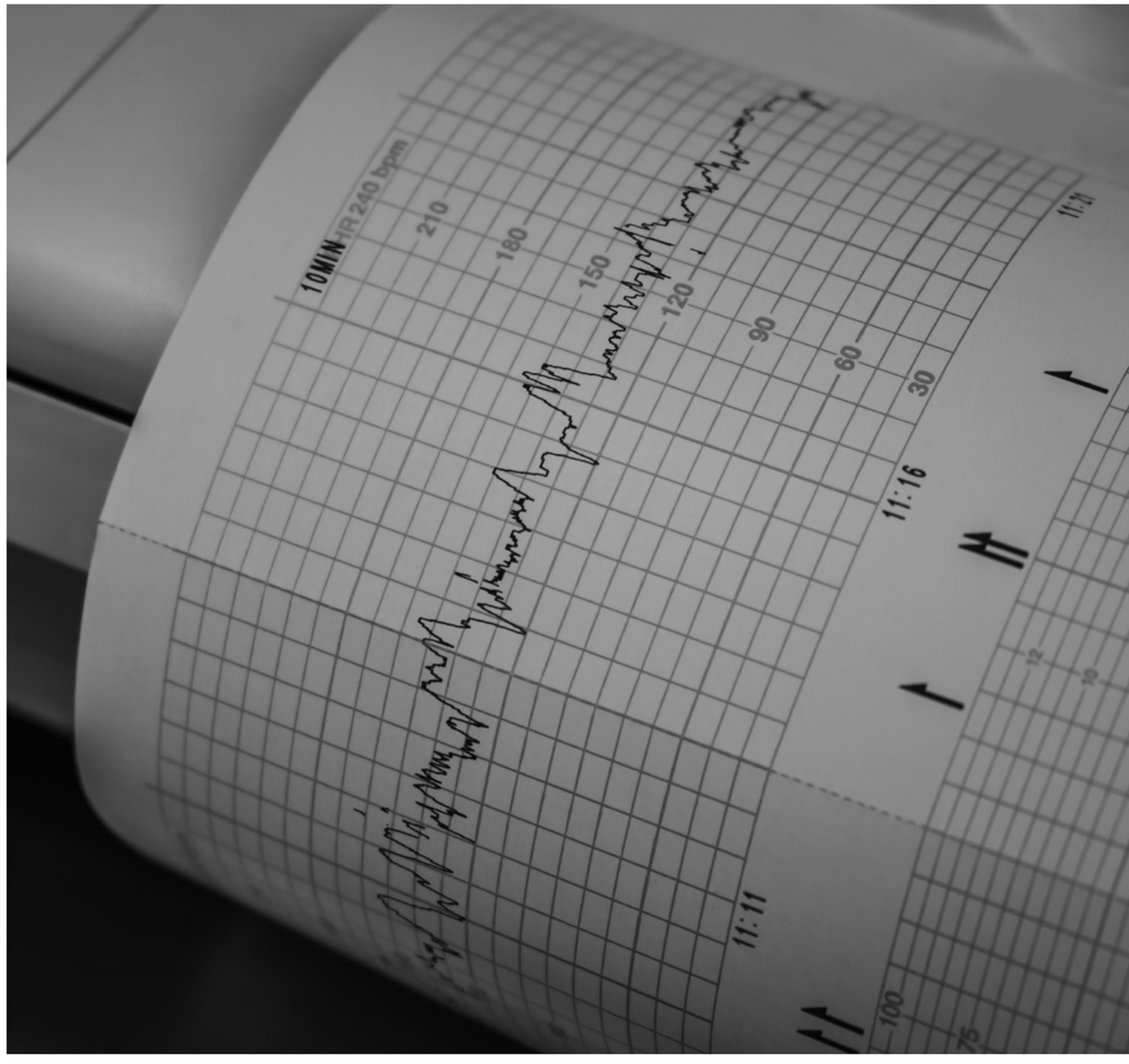
85% of the 20 infants where liability was admitted early had a diagnosis of cerebral palsy (CP). Investigating claims for CP has traditionally been a lengthy and costly process. We compared 10 EN cases with 10 claims that followed a more traditional claims route[§] where liability was admitted following a Letter of Claim, measuring the average time taken from birth to notification and subsequent admission of liability (we have called these 'non-EN' claims). We also undertook a preliminary assessment of the defence costs up to the point of admission of liability to determine any differences.



The average time taken from birth to admission of liability in non-EN claims was 2,467 days (approximately 82 months = close to 7 years). The total time taken from birth to admission of liability in EN cases was 551 days (approximately 18 months). There was a time saving of approximately 5 years per infant/family in the EN cohort, compared to historical controls.

The average defence legal costs for the EN cohort was approximately one-third of the costs for the non-EN claims (£11,738 vs £34,219).

We acknowledge that in some cases where we have not made admissions, admissions may be made later that may increase the overall average time and costs.



[§] I.e. where a Claimant would serve a Letter of Claim on the Defendant and investigations would follow in accordance with the Pre Action Protocol and Civil Procedure Rules.

Conclusions

Acute profound hypoxic brain injury was very highly represented in these early admission of liability cases and all infants had had an MRI at an appropriate neonatal age.

Families were involved in the investigative process in 90% of cases and while this is encouraging, more work is required to understand the family experience of the EN Scheme.

In these preliminary data, there is a very important reduction in the process duration from incident to admission with the EN Scheme: from more than 80 months to less than 18 months – a saving of more than 5 years. A significant saving in defence legal costs has also been demonstrated in this cohort of cases. These findings are encouraging both in terms of the feasibility of investigation and for realising the aspirations of the EN Scheme. However, our findings are preliminary, and a larger dataset is required to confirm these early findings. We will undertake a more robust evaluation, based on these findings, and publish the results.

The small sample size notwithstanding, there appear to be important potential benefits related to the reduction in the time taken to admit liability, not limited to cost savings and resource allocation. There appear to be benefits to the families involved in terms of ensuring they have earlier support by meeting their needs in real time (such as psychological support for the parents or therapeutic support for the baby) as well as any financial support.

There may also be benefits to staff involved (including improving understanding and learning closer to the time of the incident). Early notification, early admission and early investigations should support improvements in clinical practice and outcomes, as those involved in the births are often still working and engaged in treating patients in the same units.

These preliminary data have demonstrated that investigation and analysis of the scheme is feasible and will be used to design and conduct a future, more detailed evaluation of the EN Scheme.

Chapter 3

Impacted fetal head at caesarean section

Introduction

This chapter presents a preliminary analysis of 24 Early Notification Scheme cases where impacted fetal head (IFH) at caesarean section (CS) was recognised to be a contributor to the poor outcome.

Impacted fetal head at caesarean section is a clinical complication that has been identified as a problem in a litigation cohort[3], as well as routine obstetric practice[11]. The EN Scheme's first progress report found that in 9% of the cohort of infants born with suspected intrapartum hypoxic ischaemic brain injury, the birth was complicated by IFH at CS[3]. Since this report, there have been high profile cases investigated by health agencies and coroners in the UK, as well as internationally in Australia and Canada. However, there remains a shortage of information related to IFH at CS.

Methodology

The records of all CS were reviewed manually and IFH was deemed a complication where "impacted fetal head", "deeply engaged fetal head" or "difficult delivery of head" was documented in the CS operation record and/or additional disimpaction techniques were used to deliver the baby.

24 cases met the criteria for IFH. Maternal, perinatal and intrapartum characteristics were collected, including operative details. Infant brain injuries were also collected.

All these infants met EN Scheme entry criteria – hypoxic ischaemic encephalopathy (HIE). However, it is important to note that there were additional injuries reported, including intracranial haemorrhage, subgaleal haemorrhage, skull fracture and perinatal death. Subdural haemorrhage was the most common injury reported (25%) after HIE.

Findings

We have not presented the maternal demographic data to reduce the risk of inadvertent identification.

Findings	Percentage
Duration	
First-stage (hr), mean (SD)	9.5
Second-stage (hr), mean (SD)	2.5
Epidural analgesia, %	50
Induced labour, %	42
Augmentation with oxytocin, %	29
Second stage CS, %	46
Position, %	
Occipital anterior	4
Occipital transverse	21
Occipital posterior	50
Not reported	30
KTS to birth time (m), median (IQR)	(6, 13)
CS indication, %	
Presumed fetal compromise	29
Failure to progress	29
Failed assisted vaginal birth	38
Other	4
Primary operator, %	
Consultant	8
Registrar	79
SHO	4
Consultant present, %	50
No additional technique documented	12
Use of step/lowering of operating table	0
Change of hand	8
Change of operator	54
Tocolysis	25
Vaginal push up	50
Reverse breech extraction	42
T/J incision	29
Fetal pillow	21
Other [a]	33

a = Forceps x5; 'Considerable effort' x1; Cut band of cervix x1; Flexion of maternal hips x1

Analysis of the data

There is no denominator data, and this is a small series, but this cohort, is very similar to the numbers in a recent non-litigation based study that reported outcomes after all emergency CS in a single unit over 1 year (n=838)[11]: IFH complicated 1.5% of all births (11.3% of emergency CS), with 55.8% occurring prior to full cervical dilatation.

In the EN IFH cohort 55% of cases also occurred before the second stage of labour and IFH was also more common with a fetal malposition compared with the unit level study[3]. Although the numbers are small, the EN cohort is likely to be representative. The incision to birth time was a median of 10 minutes.

IFH was associated with a diverse range of infant brain injuries in this EN cohort including, but not limited to, subdural haemorrhage, skull fracture and HIE.

In this cohort, there was a variation in the manoeuvres described, most often more than one. This is likely to reflect the lack of a clear consensus on which manoeuvre is the safest and/or most effective. There are also no national evidence-based guidelines for management in the UK, although a Scientific Impact Paper has been commissioned by the RCOG.

It is concerning that several techniques used in these cases were not consistent with current evidence, including the use of forceps in five of the cases.

Forceps can be used at CS but only after the head is delivered out of the pelvis and they should not be used to deliver an IFH directly. In addition, nearly 50% of IFH in the second stage of labour had an injury after the use of the fetal pillow.

We have not assessed the avoidability of these outcomes, but a recent UK survey of practice has reported limited experience of IFH and that current training is both inadequate and inconsistent[12]. Together with the lack of a national evidence-based algorithm for the management of IFH, training deficiencies are likely to contribute to at least some of these poor outcomes.

Crucially, there is a scarcity of evidence available regarding the mechanisms of severe birth injury associated with IFH and more information is urgently required.

It should be acknowledged that there is a selection bias inherent in the EN Scheme because all the infants in the scheme have been injured and it would be useful to compare this data with a parallel series without injury to garner a better understanding of the condition and overall risk of injury. It would also be prudent to consider the options for medical coding of IFH to facilitate future data analysis.

Conclusion

Our EN Scheme data has identified that the system requires evidence-based guidelines on the management of IFH to promote consistency and evidence-based practice across the maternity system to prevent avoidable harm associated with IFH.

NHS Resolution will continue to work with the national **Avoiding Brain Injury in Childbirth (ABC)** programme to contribute our data to develop evidence-based management algorithms for practice, as well as training for practitioners.

Chapter 4

Ongoing clinical themes from Early Notification cases

Introduction

This chapter reviews the clinical themes from the analysis of a cohort of incidents occurring in year 2 of the scheme. The analysis identifies a series of problems and issues that have been previously recognised and intensively investigated in multiple national reports:

- Delay in birth
  - Loss of situational awareness
  - Issues and problems with escalation
- Fetal monitoring
- Suspected intrapartum infection
- Uterine rupture during VBAC
- Vaginal breech birth.

Methodology

The cohort of incidents for inclusion in year 2 occurred between 1 April 2018 and 31 March 2019. They were identified through a random selection of 100 cases that had been referred to NHS Resolution's commissioned panel of solicitors with an instruction to undertake a liability investigation. Incidents were referred to panel for independent expert review where there was evidence of suboptimal care identified by the trust or NHS Resolution's EN clinical review (clinical review undertaken by NHS Resolution's clinical fellows in specialities of midwifery, obstetrics and neonatology). While the focus of the independent medico-legal experts is to comment on the standard of care to determine whether the legal duty and standard of care was breached, the aim of this analysis was to provide a systems-based understanding of why any harm might have occurred.

Limitations

For year two (2018/19) over 800 incidents meeting the EN criteria were notified to NHS Resolution's EN Scheme. We accept that although incident/claims analyses provide a perspective on clinical negligence that informs litigation systems, this lens can provide a narrow view of adverse incidents for clinicians. However, it is an important opportunity for the identification of remediable errors and system learning.

The 100 incidents were then quality checked by members of the EN clinical team. Seven of these were excluded because they were either a duplication, or they did not meet the criteria for the EN Scheme.

Therefore, the findings of the data analysis are based on a final cohort of 93 incidents. While we appreciate this is a small sample size from which to draw firm conclusions, we feel the analysis provides learning points that are useful for the improvement of maternity services.

A standardised questionnaire highlighting elements of care and outcomes was completed for each of the 93 cases and analysed to provide high-level data based on the responses to the questions. This information then provided the focus for a review of the incidents to identify areas for improvement, which informed recommendations for change at local and national level.

April 2018 saw the roll out of independent investigations into maternity incidents by the Healthcare Safety Investigation Branch (HSIB). Where HSIB were investigating within trusts at the time of the incident, if available, their investigation reports have also been considered as part of independent expert review or EN clinical review.

Demographics

The charts demonstrate some of the key features of the cases analysed, which demonstrate clinical features of the mothers and details of the events of labour.

The charts in figures one and two highlight the number of previous births for a mother, and figure two shows the proportion of women who were assessed as being high risk or low risk antenatally.

Booking details

Figure 1: Cases broken down by number of previous births

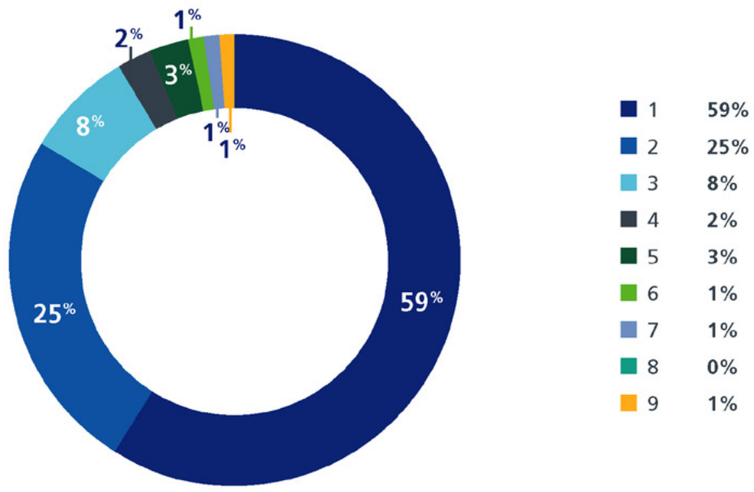
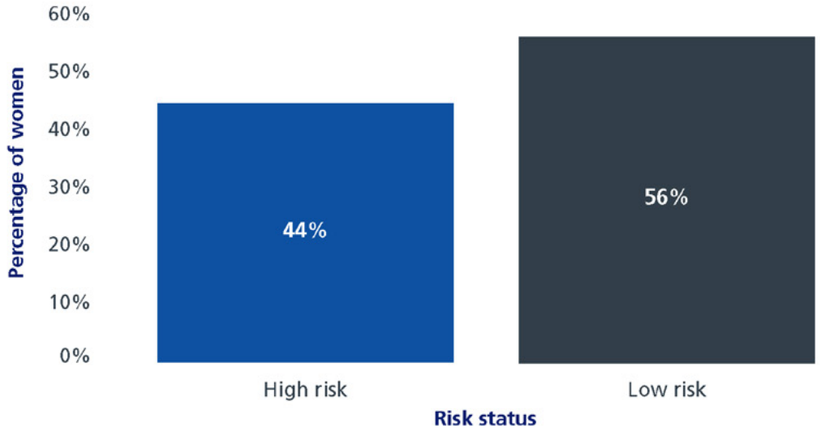


Figure 2: Cases broken down by antenatal risk status



Intrapartum

Figure 3: Cases broken down by location of birth

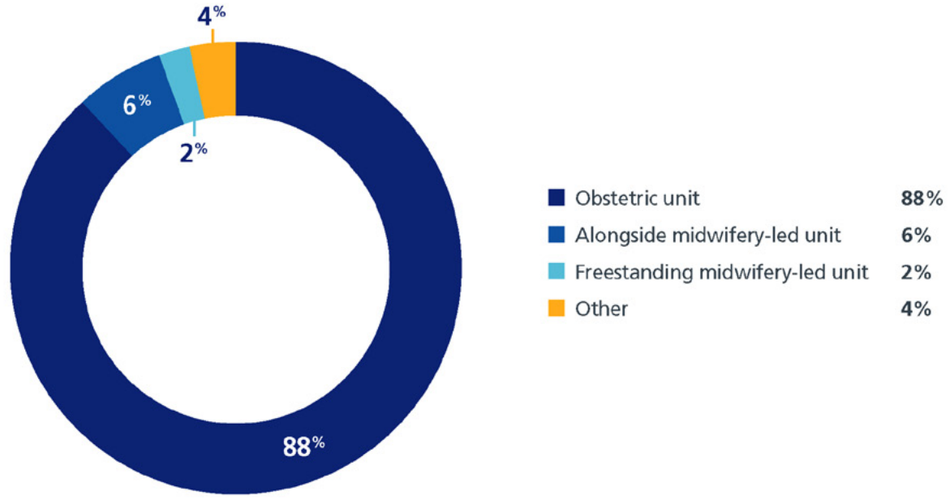
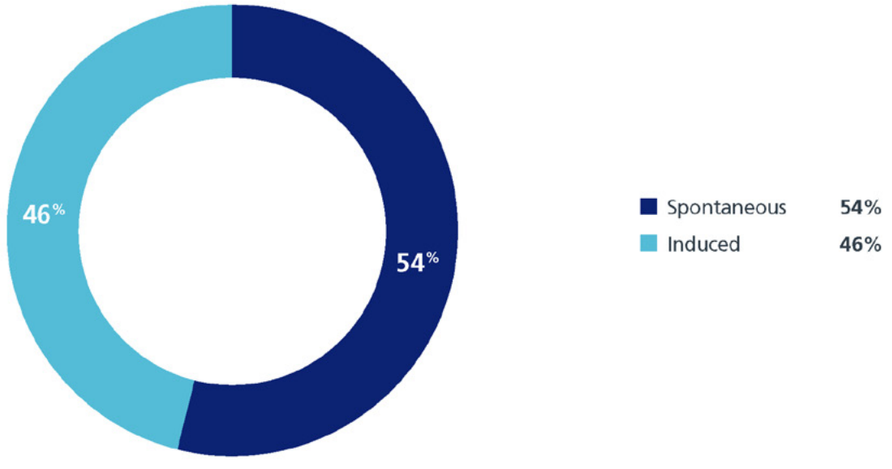


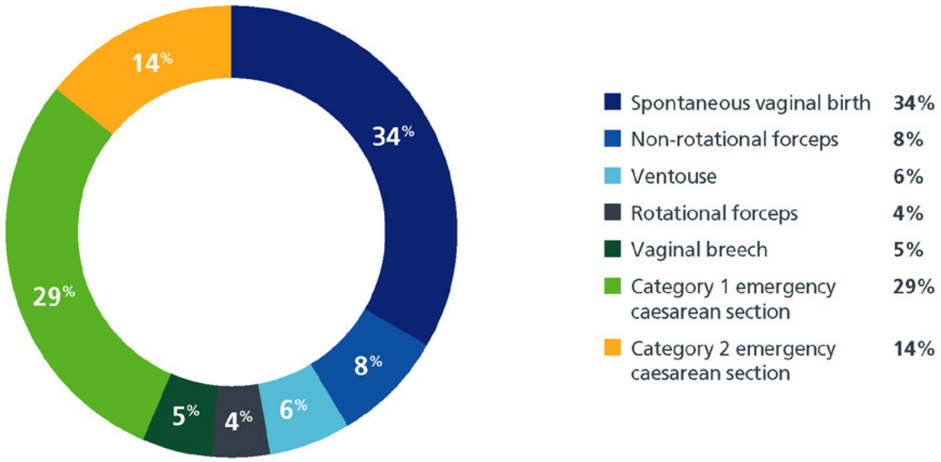
Figure 4: Cases broken down by onset of labour



The majority of cases related to deliveries in obstetric units, but a proportion of births occurred in low-risk settings. 24% of cases in the cohort involved the requirement to transfer the woman from one location to another, and for the majority of cases there was a delay in the transfer. At 46%, induction of labour was higher than the national rate of 33%, but this may be attributable to the underlying reason for induction rather than a reflection on an increased risk due to induction of labour[13].

Mode of delivery is varied in this cohort of women. As expected with the cases referred to EN, emergency caesarean sections comprise 43% of the cases, given the increased likelihood of intrapartum events indicating caesarean section delivery.

Figure 5: Cases broken down by mode of birth



Neonatal outcome

The outcomes for the babies involved in this cohort are demonstrated below.

Figure 6: The percentage of babies who had abnormal neurology

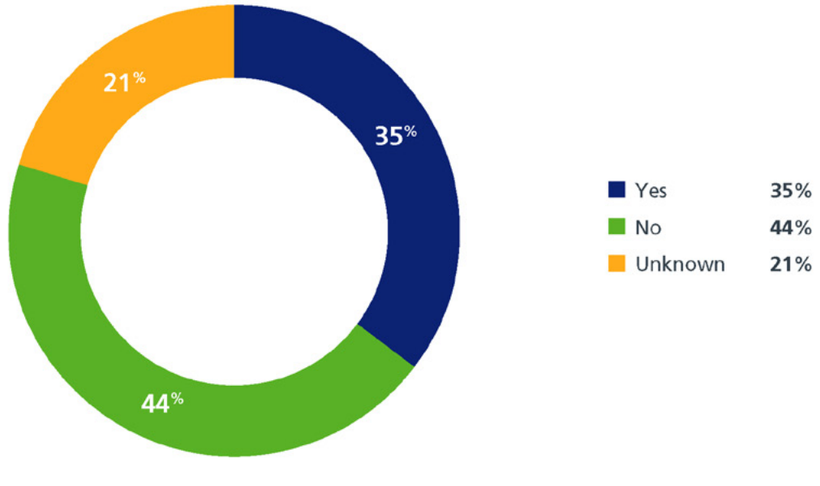
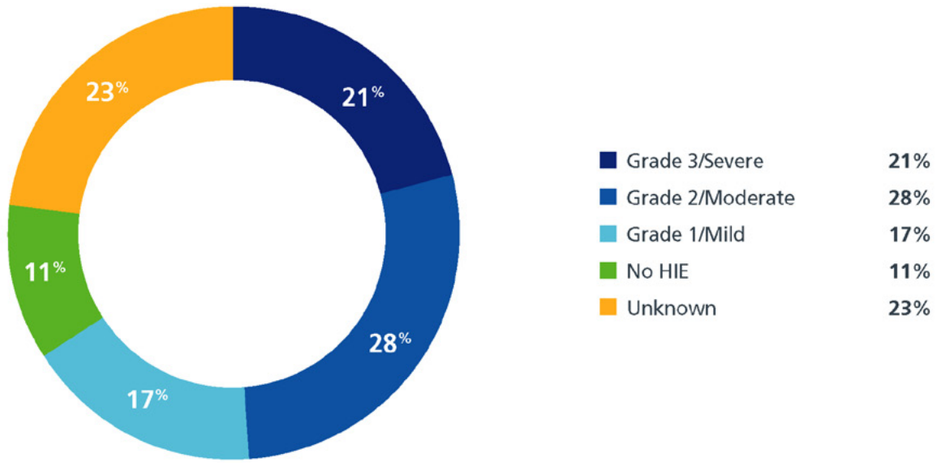


Figure 7: Hypoxic-ischaemic diagnosis for babies



Abnormal neurology was defined as any of ongoing seizures, abnormal tone or inadequate suck requiring nasogastric (NG) feeding at the time of discharge from Newborn Intensive Care Unit (NICU).

22% of cases revealed problems with the neonatal resuscitation, a comparative reduction from year 1 EN report's findings of 32%. Specific issues included:

- Delay in calling for senior help
- Inadequate resuscitation and difficulty intubating
- Communication problems, including problems contacting senior support
- Equipment problems, for example lack of neonatal trolley availability on delivery suite.

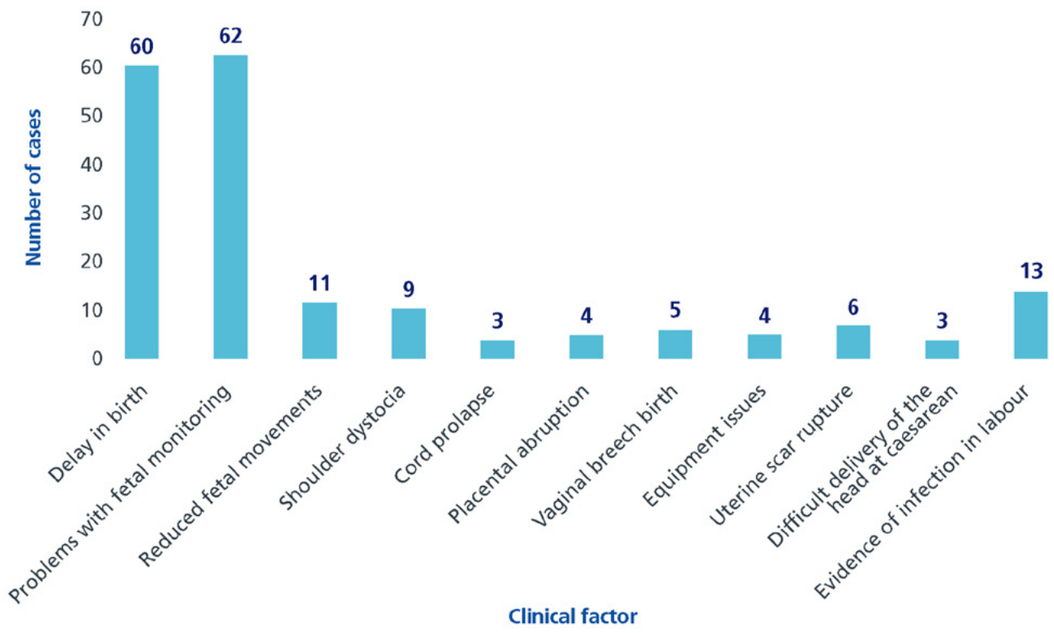
Problems with neonatal resuscitation were identified as potential contributors to poor neonatal outcomes in the year 1 report. Consequently, multidisciplinary neonatal resuscitation training was included in the Maternity Incentive Scheme[6]; Safety Action 8 requires evidence that maternity staff have attended in-house multidisciplinary training for maternity emergencies, including neonatal resuscitation training or Newborn Life Support (NLS).

NHS Resolution has appointed a Neonatal Clinical Fellow to support improved learning from neonatal care issues in perinatal claims and these will be presented in future reports.

Factors impacting neonatal outcome

The analysis of the cases highlights a variety of clinical factors that affected neonatal outcome Cases could have more than one clinical factors that effected the neonatal outcome.

Figure 8: Clinical factors that effected the neonatal outcome



Delay in birth

Delay in birth was found in 64% cases, and this rate is similar to previous data, where 62% of cases were deemed to have been adversely affected by delays expediting birth. Given the ongoing importance of this issue, we will focus on this key theme in detail below.

Fetal monitoring

Problems persist with fetal monitoring and its interpretation, which is a contributing factor to poor outcomes in 67% of year 2 cases, compared with 70% of year 1 cases. This finding has been represented in various other reports[2,3,8,14,15].

The main issues identified in this cohort of cases were:

- incorrect classification of the CTG (13%)
- delay in escalation (13%)
- delay in acting on an abnormal/pathological CTG or abnormal fetal heart on intermittent auscultation (26%)
- guidelines for monitoring not followed (10%).

Evidence of infection

The incidence of maternal infection during labour was 14% of cases. These were often related to prolonged rupture of membranes 54%, and 62% were attributed to chorioamnionitis. A small number of cases were related to Group B Streptoccocus (GBS); the factors included GBS being undiagnosed until the postnatal period, and an antenatal result not being acted on in a timely manner. The EN team has worked closely with Group B Strep Support (GBSS)[16], a leading charity working to eradicate GBS infection in newborns, and has identified three safety themes and recommendations from the GBS cases reported to the scheme:

1. Patient records: improving the process for recording GBS-positive swabs and urine samples within patient records.
2. Follow-up of results: strengthening processes to ensure results are actioned in a timely fashion.
3. Maternal observations: improving recognition of the signs and symptoms of infection in labour and immediately post-delivery.

77% of cases involving infection were associated with delayed delivery, and there were other contributing factors in most cases, including problems with fetal monitoring, shoulder dystocia and impacted fetal head. As such, we decided to focus on key themes that had a more significant impact on the neonatal outcomes for this cohort.

Uterine scar rupture

Uterine scar rupture has increased compared to the year 1 EN data. Five cases were found, representing 42% of the vaginal births after caesarean (VBACs) in this cohort. The contributing factors in these cases will be discussed as the second of our key themes.

Vaginal breech birth

Vaginal breech birth is overrepresented in our sample, compared to the national average of 0.4%[3], and was seen in 5% of cases, similar to the year 1 cohort 4.2%. 80% of these cases were primiparous (women in their first pregnancy), and 60% were planned breech deliveries. Delayed caesarean section delivery in women with diagnosed breech presentations who expressed a preference for caesarean section led to unplanned vaginal breech deliveries in the other 40%: all these cases were identified as breech presentation antenatally.

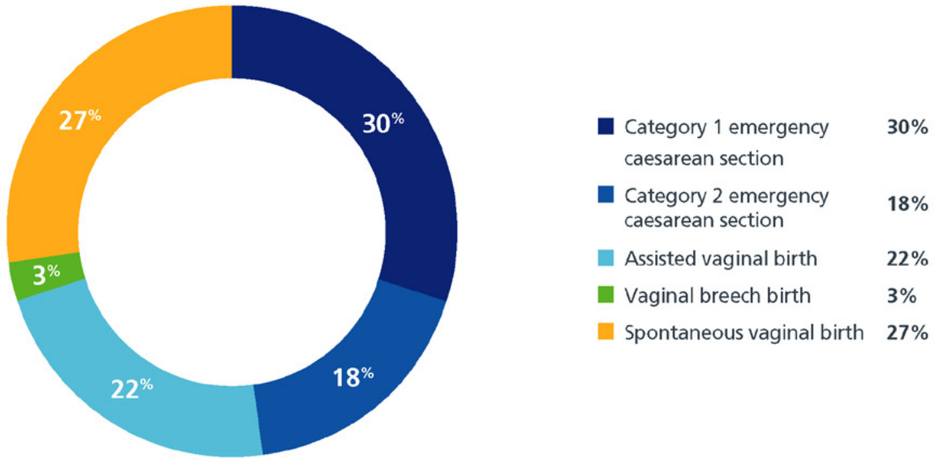
Key theme 1

Delayed delivery

Delayed delivery was a factor in 64% of the incidents. This problem is multifactorial, involving the delivery unit's acuity, the availability of key staff members, equipment or theatre, and the assessment of the clinical situation.

A breakdown related to mode of delivery** can be seen below, highlighting a delay of intervention in the case of operative deliveries, but also a delay in initiating indicated intervention in the 27% spontaneous vaginal births.

Figure 9: Delayed intervention by mode of delivery



**NICE Decision-to-birth interval for unplanned and emergency caesarean birth:

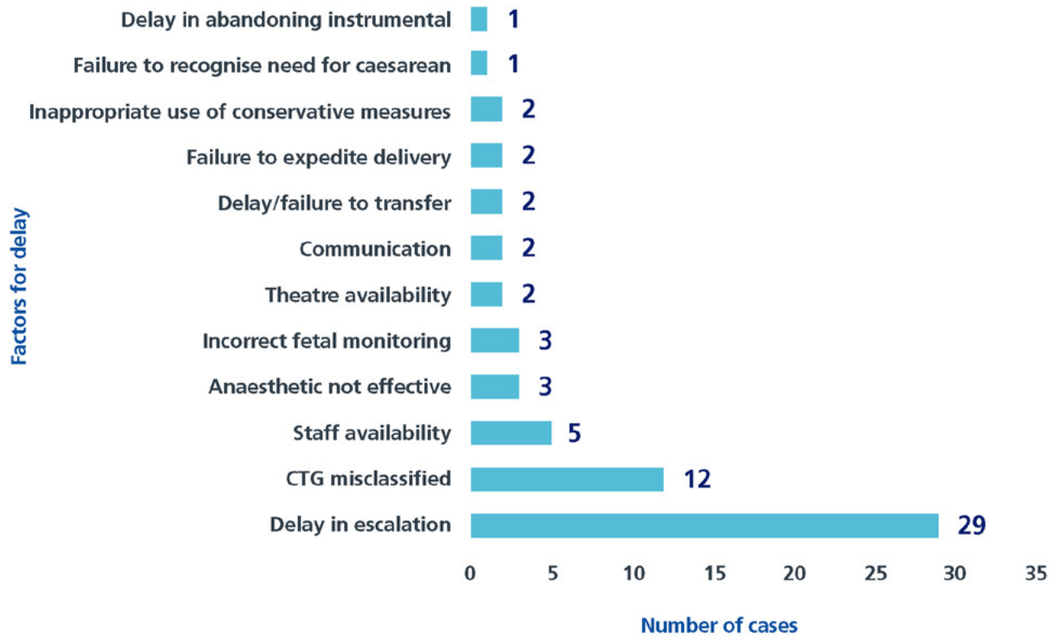
Category 1 caesarean birth is when there is immediate threat to the life of the woman or fetus, and category 2 caesarean birth is when there is maternal or fetal compromise which is not immediately life-threatening.

1.4.3 Perform category 1 caesarean birth as soon as possible, and in most situations within 30 minutes of making the decision. [2011, amended 2021]

1.4.4 Perform category 2 caesarean birth as soon as possible, and in most situations within 75 minutes of making the decision. [2011, amended 2021][17].

The reasons for delayed delivery are multifaceted, as demonstrated below.

Figure 10: Reasons for delays expediting birth

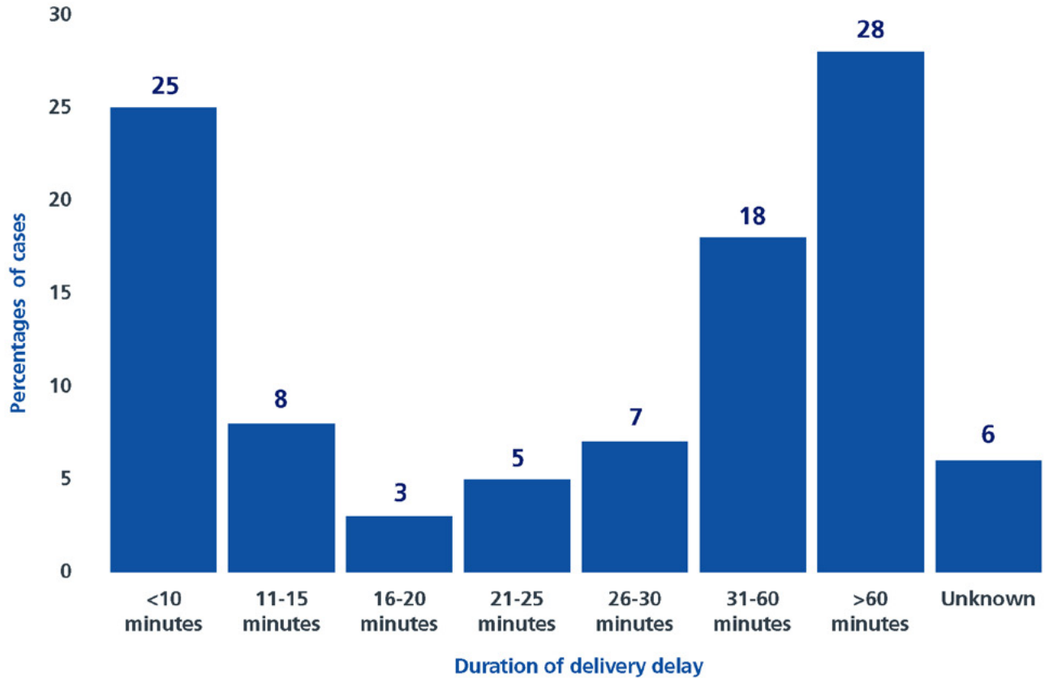


The most identified factor was a delay in escalation. This often involved a loss of situational awareness, where clinicians were overly optimistic that a birth was imminent, and they consequently lost perspective on the total time taken. In these situations, an intervention, such as episiotomy or operative vaginal delivery, may be indicated to expedite delivery.

Situational awareness also impacted on misclassification of the CTG, as individuals did not recognise the length of time that abnormalities had been present, and therefore did not act on pathological CTGs in a sufficiently timely way.

Delay expediting birth intervals ranged from less than 10 minutes to over 61 minutes, as seen below.

Figure 11: Duration of delivery delay



The length of time of delay will have a variable effect on neonatal outcomes based on the reason delivery is indicated – if the indication is failure to progress (with a normal CTG), the chance of compromise is less than for suspected fetal distress. The significance of prolonged delays over 61 minutes, warranted further investigation to understand the underlying causes and consequences of these delays.

Delay greater than 61 minutes

The majority of these women (80%) were labouring for the first time, and the remaining 20% were undergoing vaginal birth after caesarean section (VBAC).

All the women were classified as high risk, but there was evidence in many of the cases that individual risk factors were not considered during intrapartum management.

Delay ranged from 61 minutes to over 12 hours, with the average being around 3.5 hours. Various factors contributed to the delay, and only three cases had a single causative factor; most prolonged delays (80%) were a combination of the factors in figure 10.

The neonatal outcome in these cases is demonstrated in the two charts below.

Figure 12: Neonatal outcome by hypoxic-ischaemic diagnosis

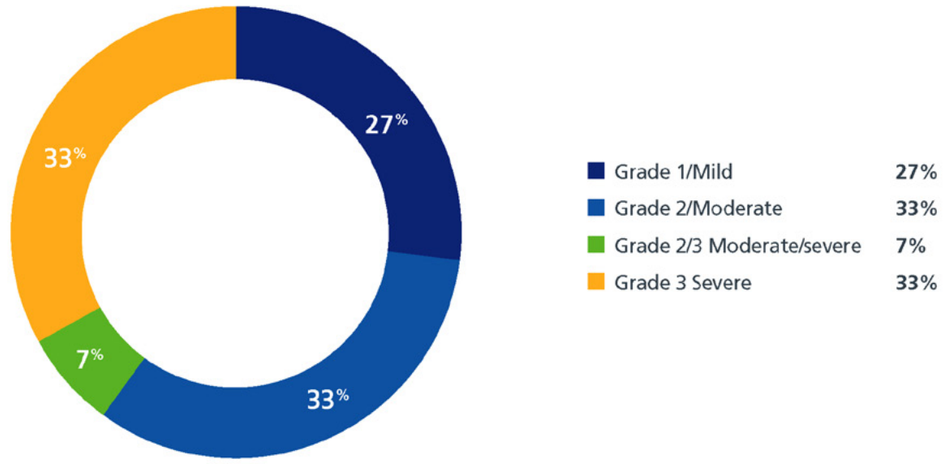
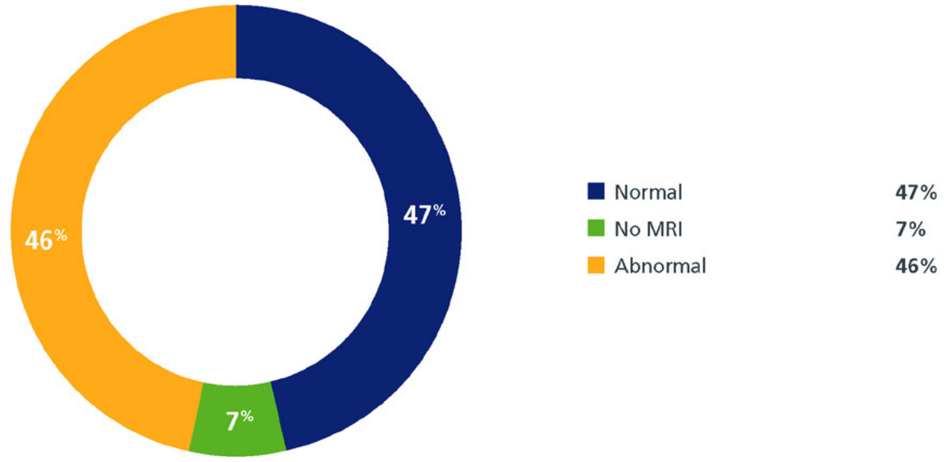


Figure 13: MRI findings



A small proportion of babies in this cohort developed cerebral palsy and have ongoing motor and developmental problems. On occasion, these babies became unwell in the early neonatal period and discussion occurred regarding palliative care.

These outcomes highlight both the immediate and ongoing emotional stress for the families, and additional and often lifelong care requirements for the children in these cases.

Key theme 2

Uterine rupture in women opting for VBAC

The year 2 cohort of incidents identified an increase in the numbers of vaginal birth after caesarean section, with a rate of 13% in year 2 compared to 8% in year 1. There was also an associated increase in the incidence of uterine scar rupture.

While recognising that the sample size is statistically small, the year 1 analysis of incidents determined that uterine scar rupture occurred in 25% of cases; however, this increased to 42% in the year 2 cohort of incidents.

Antenatal counselling

RCOG guidance[18] emphasises the importance of good antenatal counselling and robust documentation of the risks and benefits associated with VBAC to demonstrate best practice and inform decision making. This can be particularly important where there is little or no record of the information provided and/or the discussion of the risks of uterine rupture associated with VBAC.

Antenatal counselling around the risk of uterine rupture was recorded in 83% of incidents. However, analysis of the five incidents where uterine rupture occurred suggests that the quality of information provided was not consistent with the recommended standards.

RCOG guidance recommends that maternity services implement a VBAC vs elective repeat caesarean section checklist or clinical care pathway to facilitate best practice in antenatal counselling, informed decision making and documentation, and that this is supported by the provision of written information.

The risk discussion should include information on success rates and the incidence of uterine rupture, which can be updated according to change in the clinical care pathways. Specific information should be documented when recording antenatal decision-making discussions in line with **RCOG guidance**[18] (**see Appendix 2**).

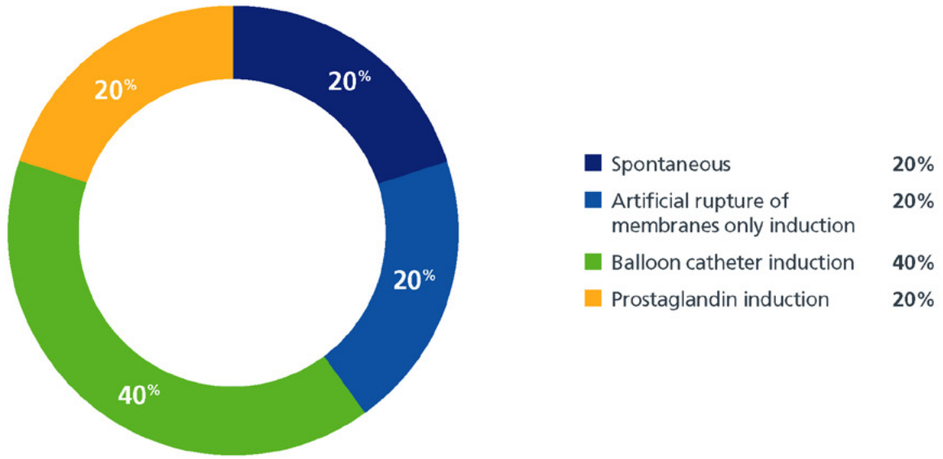
In 60% of incidents where uterine rupture occurred, the antenatal counselling was considered to be below the required standard. The most common feature was that the detail of the risks versus benefits of VBAC discussion was either not documented at all or there was insufficient detail, raising the question of whether the mother was able to make an informed decision regarding the choice of mode of delivery.

NHS Resolution has been working with partner agencies including NHS England and Birthrights[19] on the development of a tool – iDecide – to help clinicians support women to make informed decisions. The tool is being developed initially for use during labour. However, there are plans to extend this work to include antenatal decision making in relation to induction of labour and VBAC.

There were examples of previously documented plans of care being amended or revised, in 40% of cases, which at times appeared to contradict the mother's documented wishes for her labour or mode of delivery. There was also evidence that a senior obstetrician was not involved in the decision to induce labour.

Onset of labour

Figure 14: Incidence of uterine rupture broken down by onset of labour



The RCOG[18] recommends that clinicians should be aware that induction of labour using mechanical methods (amniotomy or balloon catheter) is associated with a lower risk of scar rupture compared with induction using prostaglandins.

The studies that informed the guidance found that the risk of uterine rupture increased from 0.29% to 0.87% when prostaglandin induction occurred.

Administration of oxytocin

We also reviewed the use of oxytocin and the distribution of these cases between spontaneous and induced labour. Studies used to inform the RCOG guidance found that uterine rupture was more likely to occur when oxytocin was used to overcome delayed progress and that exposure to higher dose oxytocin increased the risk of uterine rupture by four-fold or greater[18].

In the year 2 cohort of 12 women, there were five uterine ruptures in women who had a previous caesarean section.

- Of the women who had labour induced and received oxytocin – 80% had a uterine rupture
- 58% of women had a spontaneous onset of labour
- 14% of women experienced a uterine rupture but did not receive oxytocin, 29% were augmented with oxytocin and did not have a uterine rupture.

Delay in recognition

In 80% incidents there was a perceived delay in identifying the uterine rupture.

RCOG guidance[18] reports that scar dehiscence may be asymptomatic in up to 48% of women and the classic triad of a uterine rupture (pain, vaginal bleeding and fetal heart rate abnormalities) may present in less than 10% of cases. The guidance describes an abnormal CTG as the most consistent finding and this was present in 66–76% of these events.

However, there can be a combination of findings (most commonly abnormal CTG and abdominal pain).

The diagnosis is made at emergency caesarean section delivery or postpartum laparotomy.

The most common feature in the cases of uterine rupture was the onset of fetal heart rate changes shortly before or immediately prior to the decision to deliver the baby. A fetal bradycardia occurred in 80% cases. This is consistent with the findings of the studies which informed RCOG guidance[18]. In all cases the fetal heart rate (FHR) concerns had been recognised and escalated but uterine rupture was not clearly identified as the causative factor for the suspected fetal distress.

Other clinical signs of rupture were evident in 40% cases. Increased pain was a feature in 20% cases, which was not recognised by clinical staff as a sign of possible uterine rupture and is therefore likely a true delay in recognising a significant risk factor.

The response, however, was not delayed because of this failure since the fetal heart rate concerns were escalated appropriately. Vaginal bleeding was noted in one case, occurring prior to vaginal assessment in response to FHR changes. The bleeding coincided with increased pain, and other clinical signs of rupture became evident on vaginal examination including presenting part displacement and the onset of active bleeding.

RCOG guidance[18] lists the clinical signs associated with scar rupture as follows:

- abnormal CTG
- severe abdominal pain, especially if persisting between contractions
- acute onset scar tenderness
- abnormal vaginal bleeding
- haematuria
- cessation of previously efficient uterine activity
- maternal tachycardia, hypotension, fainting or shock
- loss of the station of the presenting part, change in abdominal contour and inability to pick up fetal heart rate at the old transducer site.

The lack of classical features in the cases where rupture occurred highlights the importance of clinicians having a low index of suspicion to the possibility of uterine rupture and reacting swiftly to fetal heart rate changes in VBAC.

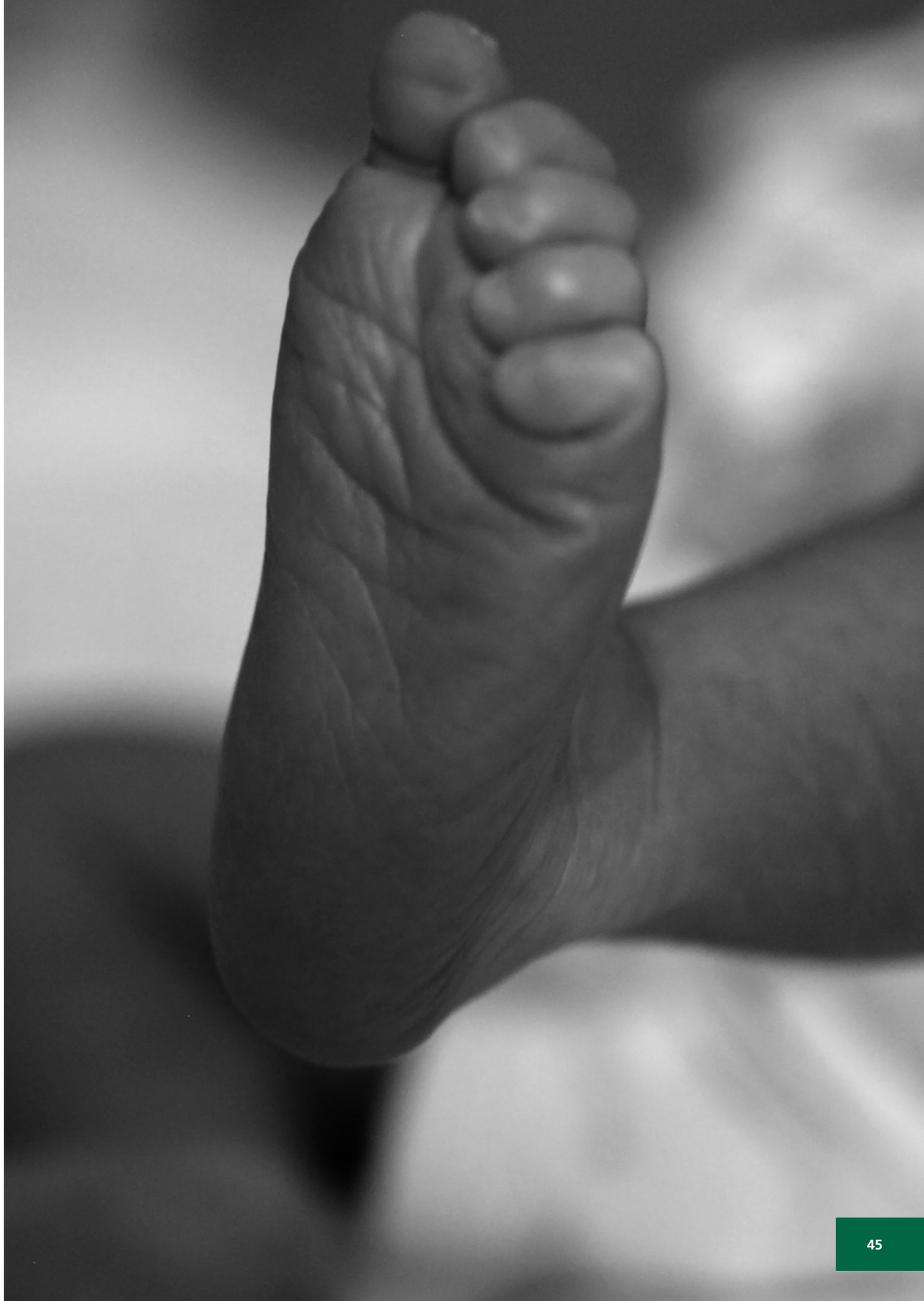
Delay in acting upon the rupture

In 75% incidents there was a subsequent delay in acting upon the rupture when it was identified. Further review of these incidents found that the main factor in the delay in delivery was not specifically in response to the uterine rupture but was the delayed response to fetal heart rate changes which indicated earlier delivery.

Conclusion and recommendations

This chapter reports the clinical themes that were identified through the investigation of 93 EN cases, focusing on two main themes of delays expediting birth, as well as uterine rupture associated with VBAC. Analysis of the incidents has highlighted areas for improvement which have informed our recommendations.

It should be acknowledged that these data are based on a potentially narrow lens of litigation and only a small number of cases were included in this analysis , and we acknowledge that these learning themes appear frequently and therefore potential recommendations are not new to clinical teams in maternity. However, where similar issues are repeatedly identified, there has not been sufficient progress in these areas to improve care. Furthermore our findings are triangulated by similar findings in reports from Each Baby Counts[2] and HSIB[8]. We will work with the royal colleges and other stakeholders to address these issues.



Chapter 5

Progress and evolution of the EN Scheme

Introduction

The EN Scheme has been established for five years. It was launched in April 2017 to improve the management of complex maternity incidents and related claims, particularly to reduce the time from incident to notification and to facilitate earlier admissions of liability where appropriate, as well as the provision of financial and other support to families. Early notification of maternity incidents helps NHS Resolution proactively investigate liability sooner, encourage trusts to be open about incidents, improve candour with families and maximise opportunities for early learning. The Covid-19 pandemic required and provided an opportunity to streamline and refine our processes, particularly the reporting and investigation of babies eligible for the EN Scheme.

Furthermore, during this period, we established the EN Maternity Voices Advisory Group for families and patient safety representatives to contribute their invaluable perspectives, with the key objective of sharing and learning from the experience of families with brain injured children, as well as to co-produce family-facing resources and, in future, co-design a robust evaluation of the scheme.

Aims of the scheme

Following internal review, the aims of the scheme were refined to reflect the changing maternity landscape. The aims of the scheme have evolved to;

- Investigate potential eligibility for compensation in order to take proactive action to reduce legal costs and improve the experience for the family and affected staff;
- Share learning rapidly with the individual trust and the wider system in order to support safety improvement and prevent the same things happening again;
- Build on our ***Saying Sorry*** and ***Being Fair*** work to ensure the process to obtain compensation is not a barrier to openness, candour and learning;
- Preserve evidence to ensure we can respond to cases that a family may choose to bring at a later date; and
- Improve the process for providing compensation for families, meeting needs in real time where possible, to reduce the risk of claims increasing in value or unmet needs (such as psychological support) translating into larger losses.

Obstetrics claims costs

Obstetric claims remain the largest cost to the NHS in terms of the total value of claims. In 2021/22, the cost of obstetric claims was estimated at 62% of the total value of clinical negligence claims dealt with by NHS Resolution despite maternity claims representing 12% of the total volume of new claims received[1].

This volume of obstetrics claims is similar to previous years, but the value of individual maternity claims has increased more than other claims categories. This is in part due to the recognition of additional EN claims, which are reported and dealt with much sooner than traditional claims. Claims in Early Notification are defined as those cases investigated under EN on which early admissions have been made or a claim has been pursued in the traditional way.

Changes to EN Scheme reporting/investigation

In April 2020, the ongoing pressures that the Covid-19 pandemic placed on trusts required changes to be made to the reporting and investigation of infants eligible for the EN Scheme. Trusts were no longer required to report directly to the scheme and were instead required to report eligible cases to the Healthcare Safety Investigation Branch (HSIB). This change remained in place until 31 March 2022, and since 1 April 2022 trusts have been required to report qualifying cases that meet the EN criteria to HSIB and also to NHS Resolution once HSIB have confirmed they are progressing an investigation.

We have continued with the arrangement that HSIB carry out their safety investigation initially, which means that no steps are taken to investigate potential eligibility for financial compensation until HSIB have completed their safety investigation. This has reduced duplication and enabled trusts to focus fully on liaison with HSIB and the family. On receipt of the HSIB report on relevant cases, NHS Resolution overlays an investigation into eligibility for financial compensation based on established legal principles for those cases that meet the EN clinical definition for brain injury.

We identified that the previous requirement for a risk assessment by the referring trust was not useful as they were poorly predictive; only 50% of cases where liability was admitted, were assessed to be likely substandard care by the trust. We have removed this requirement to reduce the workload of local clinical teams and will continue with the amended EN clinical definition of brain injury to assess eligibility for liability investigation.

Outcome-first approach

During the first three years of the scheme, we identified challenges with the original Each Baby Counts eligibility criteria for the EN Scheme. Firstly, there is no national standard for therapeutic neonatal hypothermia, which leads to variation in local case selection. Secondly, we recognised that these criteria have a very low specificity to predict future litigation. Both problems contributed to a high number of investigations, many of which would not be eligible for financial compensation under the existing legal framework for the reasons set out below.

It is important to acknowledge that NHS Resolution employs a litigation lens to assess the standard of medical care provided, which is different to the assessments made by HSIB investigators. Broadly there are two key steps to assessing legal liability, as follows.

Clinical Negligence test

The first step NHS Resolution will consider is whether the trust breached their 'duty of care'. This means that an assessment is made as to whether any aspect of the care they provided fell short of the required standard such as to amount to 'clinical negligence'. NHS Resolution asks independent medical experts in obstetrics and midwifery to give an impartial opinion on whether the care provided to mother and baby was appropriate and logical, i.e. whether the care was in line with what other maternity professionals would have done in the same situation. They do this by considering the medical records and any other relevant documentation that is available, which may include incident investigations, local and national guidance, and policies in place at the time. Although their reports are confidential to the NHS and the EN investigation, the role of the expert is neutral, and they and their opinions are completely independent from the trust or NHS Resolution.

Secondly, if after assessment NHS Resolution concludes that any aspect of the trust's care fell short of the standard the baby or mother was entitled to receive, there is consideration of whether any harm was caused as a result.

An admission of liability requires both breach of duty and causation of injury to be established. It is not possible to determine liability early where there is no radiological evidence of a neonatal brain injury or impairment following intrapartum hypoxic ischaemic encephalopathy. Therefore, NHS Resolution committed to investigate cases where there was a hypoxic ischaemic brain injury confirmed radiologically with ongoing sequelae as these cases are most likely to be suitable for early admissions of liability with the associated potential benefits to families and maternity staff. This is known as the outcome-first approach.

The EN Clinical Definition

We convened an expert group of obstetricians, neonatologists and neuroradiologists who formed a consensus opinion and recommended the following clinical definition for an EN investigation, which was then adopted: "Babies with an MRI scan demonstrating evidence of changes consistent with an intrapartum hypoxic ischaemic encephalopathy (HIE)".

This is consistent with the most recent British Association of Perinatal Medicine (BAPM) framework for therapeutic hypothermia[20] that recommends all babies who have undergone cooling should have an MRI scan between 5 and 15 days, preferably between 5 and 7 days, after birth.

This new definition of qualifying injury introduced on 1 April 2021, has ensured that the scheme is focused on those cases where there is the highest potential for a high value compensation payment.

This again should facilitate early resolution for those families most in need of support, whilst continuing to provide timely feedback and learning for maternity services in England.

In NHS Resolution's **Annual report and accounts 2020/21** a total of 254 Early Notification claims were identified and a further 185 claims have been recognised in 2021/22. In approximately 75% of these claims, liability decisions were established through early proactive investigations.

When admissions of liability are made, they trigger an entitlement to compensation and represent an opportunity for families to engage claimant solicitors to act on their behalf. Early dialogue and engagement with our team supports our aim to investigate potential eligibility for compensation and take proactive action. As the volume of admissions increases, so does the number of interim payments. There are now some children, due to their age and the length of time the scheme has been running, for whom we are able to fully quantify their needs. This has led to an increase in the value of the payments being made, while simultaneously reducing the impact of inflation on these claims.

Streamlining liability processes with Expert Summits

A new, streamlined protocol has been developed by the EN legal team and external panel solicitors to reduce delay in the current investigatory system and to expedite provision of a high-quality response to families that is proportionate in terms of the cost and scope of the investigation.

The "Liability Protocol" is a new, proactive and collaborative system of reviewing EN cases. A key element of the Liability Protocol is the **Expert Summit**. This means that multiple EN cases can be considered at a single point in time which allows for discussions between medico-legal experts, counsel, the instructed panel solicitor and NHS Resolution as well as representatives from the member trust. The discussions remain subject to legal privilege as they are primarily for the purposes of obtaining information and advice in the context of reasonably contemplated litigation. Key information is captured, tested and considered to allow counsel and solicitors to set out a road map towards providing an open and considered letter of explanation to the family, including early admissions of liability and apologies where appropriate. Where further investigation is identified then further actions will be agreed between the parties at the Expert Summit.

To reduce the reporting requirements for frontline maternity staff and streamline our processes, the Liability Protocol requires panel solicitors to collate written evidence of fact as soon as possible and to provide this to the instructed experts to review, so that factual witnesses are only requested to attend the Expert Summit if is considered that their attendance is genuinely necessary to allow the experts to reach a conclusion on liability. This allows the experts and trust representatives to focus solely on the analysis of liability at the summit.

Operating Expert Summits improves efficiency by reducing time demands on legal and medico-legal experts and trust maternity teams because the key individuals attend and discuss multiple live cases at a single event. This has the potential to minimise delays related to difficulties with scheduling and save the costs associated with multiple conferences.

Expert Summits can also successfully run remotely, which allows accommodation of multiple geographic locations, removing the need to allow for travel time, increasing attendee availability and widening the pool of potential attendees and experts. The flexibility of this process has proved particularly valuable in enabling investigations to progress effectively, despite the challenges posed by Covid-19.

The Liability protocol was piloted for a period of one year from 1 April 2020, with regular reviews to evaluate the results and to provide an opportunity for iterative improvement. Preliminary assessment by defendant and claimant solicitors with experience of the conventional system has deemed the Protocol a success and it is now being implemented into routine practice. A more detailed evaluation, including a much broader range of stakeholders, is planned for 2023.

We anticipate that these changes to streamline the EN process will reduce costs, as well as facilitate rapid and robust liability decision making to fulfil our commitments to families and maternity staff. Early admissions in appropriate cases will provide an opportunity to assess the family's needs, consider any rehabilitative needs to improve clinical outcomes and support any therapeutic requirements (including counselling or psychological support) in real time. Innovations in how financial assistance is provided, including proactive family pathfinder meetings and emphasis on real-time disclosure, will also improve the process of compensating families.

It is accepted, however, that the timeframes for progression of these matters may well have been negatively impacted by the Covid-19 pandemic and the pressures placed upon trusts and individuals as a result of the same this year, which we hope will change over the coming years.

Illustrative EN case story and the impact of the Liability Protocol

This illustrative case story involves a mother who had an induction of labour at 38 weeks. Labour progressed well initially, until the later stages at which time there was an unrecognised deterioration of the CTG (which monitors fetal heart rate, as well as maternal contractions during labour). Once this was recognised, the decision was taken to deliver Baby Oliver by emergency caesarean section (CS). Oliver was born in poor condition, required ventilation and was subsequently transferred to a tertiary centre for therapeutic hypothermia and neonatal care. MRI performed at 7 days identified evidence of brain injury related to intrapartum hypoxic ischaemic encephalopathy.

Oliver's birth was referred by the trust to the HSIB who investigated and provided a learning report within six months. The EN team was able to review this matter and instruct panel solicitors within two months of receipt of the HSIB report of Oliver's birth. Independent medico-legal experts were instructed, and within nine months agreed there had been a breach in the legal duty of care held by the trust resulting in an avoidable delay in delivering Oliver.

They agreed that, had this delay not occurred, Oliver would have avoided injury. In summary, NHS Resolution worked with the trust's legal and maternity teams to write to the family within eighteen months of the incident confirming the EN investigation conclusions, apologising for the failings in care and providing an outline of the potential next steps the family might wish to take should they wish to receive compensation. Subsequently, early interim payments were made and funding for counselling was made available for Oliver's parents.

Oliver's birth injuries were avoidable and there is a national drive to improve safety in maternity care to reduce the occurrence of similar incidents. This case story illustrates the benefits to families of the EN Scheme when compared to the significantly longer timeframes associated with the traditional claims process before the EN Scheme was established. The incidents referred to the EN team will be difficult for families and the staff involved but the accelerated liability investigations facilitated by the scheme help provide earlier answers for families into circumstances surrounding their baby's birth. They also provide the opportunity to make early admissions and interim payments, where appropriate, to ensure that early support is provided to babies and families when they need it most. We also anticipate that earlier resolution will be helpful for maternity staff involved.

As part of our continued commitment to evaluate and improve the EN Scheme, we asked for feedback from a number of key stakeholders to ascertain what is working well, and where we can look to improve the scheme in future. Some examples are included in the following pages.

A family involved with the scheme has said:

"The EN Scheme worked very well for our son and for us as a family. It accelerated the investigation process and resulted in an early admission of liability which meant we received interim payments as our son's claim continued. This was so helpful as it meant we could access support and rehabilitation for him when it was needed. It was really beneficial to be able to put in place care, therapy, aids and equipment, and accommodation at an early stage."

Claimant lawyers have said:

"My experience of the scheme has been extremely positive. In particular, the family has been spared the years of stress and uncertainty that usually ensues while liability and causation are established; early interim payments have enabled my client to access specialist case management and a team of therapists."

Partner – Barratts

"It certainly sped up the investigation process, which ultimately resulted in both parties being able to have sensible settlement discussions much earlier than the norm. I would estimate that it shortened the whole Letter of Claim/Letter of Response process by at least 12 months."

Partner – Irwin Mitchell

A medico-legal expert has said:

"The EN Scheme is allowing swifter investigations and rapid resolution for affected families. This has significant benefits for me as a clinician… there is a greater opportunity for the wider system to benefit from a more contemporaneous learning process as a result of the scheme."

Consultant obstetrician & gynaecologist

Defendant lawyers have said:

"What makes the EN Scheme unique is that the mother and baby's experience is kept at the heart of the investigation. What really sets the scheme apart is its collaborative nature, the emphasis on learning and transparency at a point in time where the knowledge gained can directly improve patient safety, and the compassionate approach of the entire team involved in the investigation."

Partner – DAC Beachcroft

"As solicitors, the EN Scheme has changed not only the way we investigate potential brain injury cases but the overall mindset towards these cases… the focus is very much on the family, to provide them with an explanation as to what has happened and get support to them when it really matters… this shift, which has changed the landscape we work in, rightly puts the patient at the heart."

Partner – Browne Jacobson

"The EN Scheme offers a series of significant advantages over the conventional pathway. In short, where care has not met an appropriate standard, the EN Scheme allows for lessons to be learned, for care to be improved, for patients to be kept fully informed and for potential litigation to be resolved swiftly and cost effectively."

Senior barrister – 1 Crown Office Row

Engagement with families

NHS Resolution established a Maternity Voices Advisory Group (MVAG) in January 2021, with representatives from key stakeholders such as PEEPS-HIE, Baby Lifeline and AvMA. The main purpose of the group is to have a platform for a discussion to inform service and product development that can be shared with patients and their families.

The group has identified four key priorities (additional priorities may be added):

- Ensuring that information on EN which is available/being sent to families is in an accessible format, e.g. language and format (visuals).
- Development of learning resources for use at maternity unit level, which will capture the voice and experiences of families (illustrative examples).
- Co-design family-facing products and develop the EN family-facing web pages.
- Obtain feedback from families on their experience of EN (methodology yet to be determined).

This provides a real opportunity to engage with families, to hear about their experiences during one of the most challenging periods following the birth of their baby, and to be responsive to feedback to improve the experience for families. This will mean a different way of working for the majority of the EN team as they will be in direct contact with both families and member trusts, maintaining a continuous level of engagement with both.

In addition, member trusts will continue to maintain a level of direct contact with families, particularly regarding any matters requiring ongoing consideration that fall outside the scope of the EN Scheme. There will therefore be a triangulation of approach from member trusts, which presents a great opportunity for collaborative working to inform future EN Scheme development. Resources that families can access can be found in **Appendix 3**.

Chapter 6

Recommendations

The cases analysed within this report are a small number, and we acknowledge that the learning themes and therefore potential recommendations are not new to clinical teams in maternity. In addition, similar recommendations have already been highlighted in reports such as those written by Each Baby Counts[2] and HSIB[8].

There is currently a plethora of recommendations that apply to maternity services, and therefore NHS Resolution has made a limited number of recommendations for this second year report. For the majority of the remaining learning points, readers are signposted to either existing or planned national workstreams, which have been developed to drive and improve quality and safety in maternity services.

Existing national workstreams

1. Situational awareness

How is this being addressed nationally?

This area for improvement has been identified in multiple national reports. One of the ways the clinical teams are supported and oversight of clinical activity maintained is by ensuring that the delivery suite coordinator has supernumerary status, and this is incentivised as part of Maternity Incentive Scheme Safety Action 5[6].

HSIB is very much in the investigation space within maternity services, and its expertise will ensure that maximum learning will be extracted from incidents to ensure the underlying reasons for incidents occurring are identified and suitable recommendations are made.

2. Escalation of concerns

How is this being addressed nationally?

This has been described as a problem in multiple maternity reports, and there is currently national work underway being led by the RCM, RCOG[21] and NHS England with collaboration from key stakeholders to develop a clear protocol for escalating clinical concerns, detailing the grade of clinician required for specific problems.

In line with the requirements of the Maternity Incentive Scheme[6], trusts should also formulate robust escalation plans for times of increased acuity, ensuring clinical staff know who to contact and what support they can expect to receive.

Ensuring multidisciplinary training, such as PROMPT, is a safe and inclusive space for all staff, allowing breakdown of the traditional hierarchical interprofessional boundaries[6] and promoting psychological safety within clinical teams.

3. Risk assessment

How is this being addressed nationally?

Continuous risk assessment is to be undertaken at each antenatal contact and to continue throughout the intrapartum period, with adjustments made to care as indicated. The Ockenden Reports[22,23] recommend improvements in relation to risk assessments during pregnancy and labour. Immediate and Essential Action 5 requires all trusts to ensure risk assessment occurs at every contact, and Immediate and Essential Action 10 focuses on risk assessments during labour and birth.

4. National programme into brain injuries

NHS Resolution values the opportunity to contribute our findings from the second EN Scheme report to a national programme, which focuses on reducing the impact of avoidable harm in relation to brain injuries. This programme is known as **Avoiding Brain Injury in Childbirth (ABC)**[24]. The benefit of having large-scale national programmes is that the imagination and innovation of the NHS is harnessed, and generating national change will support improvements to clinical practice on a wider scale.

As part of the national programme, it is vital that we identify and learn from maternity units that are performing well, and cascade this valuable information across the NHS.

In addition, the ABC programme will align with existing initiatives, and aim to integrate individual risk factors with the fetal heart rate to improve intrapartum fetal monitoring, for both intermittent auscultation and electronic fetal monitoring.

Recommendations specific to findings from this EN Scheme report

Recommendation 1

NHS Resolution to support the work of royal colleges and wider stakeholders to improve antenatal counselling before trial of vaginal birth after caesarean

Improve awareness in relation to the standards expected for the provision and documentation of antenatal counselling for vaginal birth after caesarean section.

How should this be achieved?

At a national level

NHS Resolution recognises and supports that informed decision making is essential to good care. Therefore, we recommend national tools are developed for intrapartum fetal monitoring and that priority is given to the standardisation of informed decision-making tools for vaginal birth after caesarean section: the iDecide team will take this work forward. The informed decision-making tools should be developed for use in antenatal care and further utilised during intrapartum care.

A good example of an informed decision-making tool that has been developed is the RCOG Covid-19 vaccine decision aid[25].

At a local level

At trust level work should take place to ensure that appropriate antenatal counselling continues in line with national guidance. This can be facilitated by using a VBAC vs elective repeat caesarean section checklist or clinical care pathway to facilitate documentation of the risks and benefits associated with VBAC to share accurate information and support informed decision making.

Recommendation 2

NHS Resolution to support the work of royal colleges and wider stakeholders to improve awareness in relation to response to harm for families and staff

NHS Resolution continues to encourage and support the need for open and transparent conversations with families in line with statutory Duty of Candour requirements. As an organisation we are committed to supporting clinicians and healthcare providers when things go wrong, and steer them to improve systems, processes and principles. We do this to help foster a learning culture, prevent animosity between service users and providers and reduce the risk of recurrent patient safety incidents.

In addition, treating staff fairly when things go wrong allows them to be open about their mistakes and to feel confident to speak up, without fear of being blamed. A just and learning culture in healthcare is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care goes wrong. It is also not about an absence of responsibility and accountability.

How should this be achieved?

NHS Resolution has produced learning materials via its Faculty of Learning to support trusts and clinical teams to respond to patients, families or carers and staff in the appropriate way. The ***Faculty of Learning resources*** include leaflets and videos regarding ***Saying Sorry***, and ***Duty of Candour***, which will aid clinicians to take the right approach in relation to conversations and the provision of support.

In relation to support for staff, it is paramount that staff who have been involved in incidents are treated fairly and with compassion and fairly. The Faculty of Learning has also developed guidance in relation to ***Being Fair*** and a just and learning culture.

At a national level

NHS Resolution welcomes and supports the ongoing work to continue to improve communication with and support for patients, families and carers. For example, the team at NHS England, alongside HSIB and Learn Together researchers, is currently developing guidance for engaging and involving patients, families and staff following a patient safety incident. The guidance was published in August 2022.

At a local level

NHS Resolution encourages trusts to utilise its ***Faculty of Learning resources*** and share experiences and good practice approaches with trusts across local maternity and neonatal systems.

NHS Resolution encourages providers to report patient safety events to the national reporting and learning system, including details of incidents, outcomes, risks and good practice, in a timely manner, both to support appropriate response to events and to contribute to national learning for improvement.

Recommendation 3

NHS Resolution to support the working relationships with NHS providers and wider stakeholders, encouraging a joined-up approach between trust legal services and maternity & risk teams

NHS Resolution recognises the value of proactive co-working between legal and clinical colleagues to respond effectively to incidents meeting the EN criteria for investigation, as well as active and intimated claims. Therefore, NHS Resolution recommends that trusts embed a joined-up approach between trust legal services and maternity and governance/risk teams to:

- Understand what happened;
- Promote efficient investigation;
- Preserve key evidence and documentation including patient maternity records, baby neonatal and paediatric records as well as hospital documents such as staffing rotas, ward notes, etc.
- Identify and record roles and responsibilities to enable identification of clinicians as they rotate across the NHS;
- Identify any human factors that may have contributed to the outcome and how they could be mitigated against in the future;
- Streamline and maintain comprehensive and accessible records of communication with families;
- Support affected staff and communicate outcomes to them; and
- Facilitate learning from claims.

How should this be achieved?

At a local level

Legal and governance staff should be provided with information of any EN incident as soon as reasonably possible by the maternity team, and access provided to documents using the trust incident reporting system.

Where legal investigations are completed by NHS Resolution and admissions of liability are made, we recommend that the Obstetric Clinical Lead for maternity services (or other appropriate person) and Director/Head of midwifery should consider any post-summit reports and/or notes from leading counsel and present the case to their treating clinicians at a Grand Round or equivalent, to discuss the outcome and any learning.

An example of good practice between the trust legal services, maternity and governance/risk teams (including perhaps neonatology or paediatrics teams where the baby continues to be cared for) would be regular collaborative meetings where EN and other maternity cases are discussed and progress is provided in respect of both the legal investigation and the baby's clinical picture.

Following such collaborative meetings, action plans for improvements should be agreed and disseminated by the maternity teams. Any such actions should be communicated to trust legal services for onward communication to NHS Resolution and the family, to encourage continued best practice.

Conclusions

The EN Scheme continues to promote and explore innovative approaches to provide timely, empathic and responsive resolution for some of the highest value and most complex incidents reported to NHS Resolution.

Since its inception in 2017, the EN scheme has evolved, and continues to evolve, to improve the specificity of incidents most likely to be settled early, continue to improve the relationship with families and reduce the timeframe between incident and resolution, while continuing to contribute to improving safety.

NHS Resolution will continue to work with the national Avoiding Brain Injury in Childbirth (ABC) programme (**www.thiscovery.org/project/abc**) to contribute our data to develop evidence-based management algorithms for practice, as well as training for practitioners.

Our ongoing commitment to providing earlier resolution for the families and NHS staff involved in a brain injury claim at birth led us to make several improvements to the EN Scheme and the process of litigation during 2020 and 2021. This includes improving the criteria for investigation by NHS Resolution's EN team to those cases where there is radiological evidence of a hypoxic brain injury, whilst also reducing the potential duplication of investigations by using the reports provided by HSIB. The Liability Protocol has been introduced and streamlined with a clearer focus on investigation and decision making to accelerate admissions of liability wherever appropriate.

This builds upon the improvements (to the time taken to admit liability) which has been analysed for a cohort of 10 EN cases and a cohort of historical comparators in chapter 2.

This preliminary analysis has demonstrated reductions in time taken from incident to notification, and up to admission of liability and a reduction in defence costs under the EN Scheme. We recognise that this is a very small cohort for comparison, and we will undertake a future analysis of a larger data set to confirm these findings.

We also recognise that there is more to do to operationally improve the processes for the benefit of the scheme's aims, working closely with our EN Maternity Voices Advisory Group. We also recognise that not every case can be investigated to a definitive conclusion within 18 months, as referenced by our illustrative case story. However, this process means all cases that fall within the scheme will have been reviewed with a pathway to resolution of liability issues.

Looking to the future, NHS Resolution is engaging with, and seeking views from, stakeholders, including families, to improve payment of financial compensation. This approach aims to work with families and their solicitors to assess the child's immediate and future needs, to provide appropriate packages of care. This would continue our move away from an adversarial approach, where possible, to improve the experience of families and reduce unnecessary costs.

Once a child's future requirements are more certain, NHS Resolution will consider how best to deploy dispute resolution methods to create a more streamlined, collaborative process that is faster and more proportionate.

Finally, a work stream will be established to provide an options appraisal for potential evaluation models to assess the impact of the EN Scheme on safety, costs and the experience of patients and their families.

Acknowledgements

This review was designed and written by the EN team at NHS Resolution. Significant contributions were made to design, data collection and authorship by the following:

Lead author

Ms Jyoti Sidhu, Consultant Obstetrician and Gynaecologist, National Obstetric Clinical Fellow, NHS Resolution, Early Notification Scheme

Chapter 1

Dr Georgie Brehaut – Senior Obstetric Registrar & National Obstetric Clinical Fellow to NHS Resolution, Early Notification Scheme

Chapter 2

Ms Jyoti Sidhu – Consultant Obstetrician and Gynaecologist, National Obstetric Clinical Fellow, NHS Resolution, Early Notification Scheme

Chapter 3

Dr Georgie Brehaut – Senior Obstetric Registrar & National Obstetric Clinical Fellow to NHS Resolution, Early Notification Scheme

Dr Katie Cornthwaite – Clinical Lecturer in Obstetrics & Gynaecology, University of Bristol

Professor Tim Draycott – Senior Maternity Clinical Advisor at NHS Resolution

Chapter 4

Dr Catherine Vaughan – Senior Obstetric Registrar & National Obstetric Clinical Fellow to NHS Resolution, Early Notification Scheme

Lynn Tilley RM – Early Notification Team Safety and Learning Lead

Dr Alexa Vardy – Senior Obstetric Registrar & National Obstetric Clinical Fellow to NHS Resolution, Early Notification Scheme

Dee Davies RM – National Midwifery Clinical Fellow Early Notification Scheme

Chapter 5

Sangita Bodalia – Head of Early Notification (Legal)

Amuthan Ramakrishnalal – Senior Early Notification Case Manager

Amy Pickvance – Senior Early Notification Case Manager

Beth Dickinson – Senior Early Notification Case Manager

Charlotte Austin – Senior Early Notification Case Manager

Guido Mascolo – Senior Early Notification Case Manager

Hannah de Haan – Senior Early Notification Case Manager

Sara Fowler – Senior Early Notification Case Manager

Suba Gnanasekarem – Early Notification Case Assistant

Toyin Douglas – Early Notification Case Assistant

Chapter 6

Dr Catherine Vaughan – Senior Obstetric Registrar & National Obstetric Clinical Fellow to NHS Resolution, Early Notification Scheme

Annette Anderson RM – Head of Early Notification (Clinical)

Sangita Bodalia – Head of Early Notification (Legal)

With special thanks to:

Professor Tim Draycott – Senior Maternity Clinical Advisor

Dr Denise Chaffer – Director of Safety and Learning

Annette Anderson RM – Head of Early Notification (Clinical)

Sangita Bodalia – Head of Early Notification (Legal)

Simon Hammond – Director of Claims

Dr Alex Crowe – Deputy Director for Incentives & Academic Partnerships

All **NHS Resolution panel firm solicitors** with a special mention to Weightmans who assisted with the initial data collection and analysis

EN clinical advisory group members

Nicky Lyon & Sarah Land – Members of the Early Notification Maternity Voices Advisory Group

Business Intelligence and **MSE** teams at NHS Resolution

References

1. NHS Resolution (2021). NHS Resolution Annual Report and Accounts 2020/21. London: NHS Resolution

2. RCOG (2021). Each Baby Counts: 2020 Final Progress Report. London: Royal College of Obstetricians and Gynaecologists.

3. NHS Resolution (2019). The Early Notification scheme progress report: collaboration and improved experience for families. London: NHS Resolution

4. NHS Resolution (2018). Saying Sorry. London: NHS Resolution

5. NHS Resolution (2019). Being Fair. London: NHS Resolution

6. NHS Resolution (2021). Maternity Incentive Scheme – Year Four. London: NHS Resolution

7. Rosenbaum P, Paneth N, Leviton A, Goldstein M, Bax M, Damiano D. A report: the definition and classification of cerebral palsy. Dev Med Child Neurol Suppl. 2007;109(April):8–14

8. HSIB (2020). Summary of Themes arising from Healthcare Safety Investigation Branch Maternity Programme (NLR). Available at: **https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/hsib-national-learning-report-summary-themes-maternity-programme.pdf**. (Accessed 6th September 2021)

9. NHS Resolution (2017). Five Years of Cerebral Palsy Claims. London: NHS Resolution

10. NHS Litigation Authority, 2012. 10 Years of Maternity Claims. London: NHS Litigation Authority

11. Cornthwaite K, et al. Impacted fetal head: a retrospective cohort study of emergency caesarean section. Eur J Obstet Gynecol Reprod Biol. 2021;261:85–91

12. Cornthwaite K, Bahl R, Lenguerrand E, Winter C, Kingdom J, Draycott T. Impacted foetal head at caesarean section: a national survey of practice and training. J Obstet Gynaecol. 2020 Jul 29; 39:1–71

13. NHS Digital (2019). NHS Maternity Statistics 2018–2019.Available at: **https://files.digital.nhs.uk/D0/C26F84/hosp-epis-stat-mat-summary-report-2018-19.pdf**. (Accessed 6th September 2021)

14. MBRRACE-UK (2017). MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton intrapartum-related neonatal deaths. Leicester: MBRRACE-UK

15. NHS England (2016). Better Births: improving outcomes of maternity services in England – a five year forward view for maternity care. London: NHS England

16. GBSS (2020). Preventing Group B Strep infections in babies: failure to turn national recommendations into local guidelines. Available at: **https://gbss.org.uk/wp-content/uploads/2020/12/Preventing-Group-B-Strep-infections-in-babies-failure-to-turn-national-recommendations-into-local-guidelines.pdf**. (Accessed 6th September 2021)

17. NICE (2021). Caesarean Birth. NICE Guidelines [NG192]. Available at: **Recommendations | Caesarean birth | Guidance | NICE**

18. RCOG (2015). Birth after Previous Caesarean Birth (Green-top Guideline No 45). London: RCOG. Available at: **https://www.rcog.org.uk/media/kpkjwd5h/gtg_45.pdf**

19. Birthrights (2020). iDecide – a new consent tool is on its way... Available at: **https://www.birthrights.org.uk/2020/01/30/idecide-a-new-consent-tool-is-on-its-way/**. (Accessed 6th September 2021)

20. BAPM (2020). Therapeutic Hypothermia for Neonatal Encephalopathy. A Framework for Practice. Available at **https://www.bapm.org/resources/237-therapeutic-hypothermia-for-neonatal-encephalopathy**

21. RCOG Each Baby Counts – learn & support **https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/ebc-learn-support/**

22. Ockenden, D (2020). Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. Available at: **https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf**. (Accessed 6th September 2021)

23. Ockenden, D et al (2022). Ockenden Report – Final. Finding, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

24. RCOG (2021). Starting with ABC: working together to avoid brain injury. Available at: **https://www.rcog.org.uk/en/blog/starting-with-abc-working-together-to-avoid-brain-injury-in-childbirth/**. (Accessed 6th September 2021)

25. RCOG (2021). Covid-19 Vaccine information sheet and decision aid. Available at: **https://www.rcog.org.uk/globalassets/documents/guidelines/2021-02-24-combined-info-sheet-and-decision-aid.pdf**. (Accessed 6th September 2021)

Appendix 1

Staff support

What support is available if I have been involved in an incident?

We recognise that being involved in adverse incidents can be emotionally difficult and stressful for the staff involved. NHS Resolution's **Being Fair** guidance promotes a just and learning culture within organisations and illustrates how you should expect your organisation to support you at this time.

Below is a list of supportive services that you may wish to access.

In the first instance, you may wish to seek support from a professional midwifery advocate (PMA) or your educational supervisor within your trust. You could also seek support from your workplace behaviour champion or your maternity/neonatal safety champion.

Attending either a 'group debriefing' 'or 'after action review debrief' (AAR) after the event may alleviate some of the emotional stress experienced, and provide the opportunity to ask further questions.

Staff should also contact their maternity governance teams and/or legal services department for information on providing written statements.

Alternatively, your Occupational Health Safety and Advisory Service (OHSAS) may be able to provide advice and practical assistance as well as confidential counselling.

The **Royal College of Midwives** (RCM) is able to provide support to members on a wide range of issues. Support is largely provided through elected workplace representatives with the support of full time regional and national officers. Details of workplace representatives can be obtained by contacting the RCM on: 0300 303 0444.

The **Royal College of Nursing** (RCN) provides support to members who may include midwives, neonatal nurses and healthcare assistants.

The **Royal College of Obstetricians & Gynaecologists** (RCOG) provides a supporting doctor peer-to-peer support service for members and trainees. Further information on the support available can be accessed on their website.

The **Association of Anaesthetists** provides support information and guidance on your wellbeing.

The **British Medical Association** (BMA) offers free counselling and peer-support services to doctors regardless of whether you are a member or not. Details of how to access these services can be found at **https://www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service**

Practitioner Health provides a free confidential service to doctors and dentists. The service can help with issues relating to a mental health concern, including stress, depression or an addiction problem, in particular where these might affect work. The service is provided by health professionals specialising in mental health support to doctors and is available in various locations across England. Tel: 0300 0303 300

Medical indemnity organisations, including the **Medical Protection Society** (MPS), the **Medical Defence Union** (MDU) and the **Medical and Dental Defence Union of Scotland** (MDDUS), all provide some form of advice or supportive services for members in addition to representation and advice on statement writing with contact details available through their respective websites.

The NHS provides free public access to psychological therapy on a regional basis through the **Improving Access to Psychological Therapy** (IAPT) service. This can be accessed by the following link and services in your area located including self-referral details. **https://www.nhs.uk/Service-Search/Psychological-therapy-(NHS-IAPT)/LocationSearch/396**

Professional support units: There are local services provided for doctors, dentists and pharmacists in training by your postgraduate education provider, which can support you with your health and wellbeing during your training.

Second Victim Support – secondvictim.co.uk is a website designed as a resource for healthcare practitioners who are involved in a patient safety incident, their colleagues and the organisations they work for.

The Samaritans provide a free 24-hour listening and advice service 365 days a year. They can be contacted from any phone anytime by calling 116 123 from the UK and Republic of Ireland. **http://www.samaritans.org**

Further support and information about NHS Resolution and the EN Scheme can be found on our website **https://resolution.nhs.uk**. If you would like to discuss our role, please contact NHS Resolution directly on nhsr.enteam@nhs.net, call us on 0207 811 6326 or speak with the maternity contact at your hospital.

Appendix 2

Documentation of counselling for Vaginal Birth After Caesarean Section[9]

The following points should be documented as part of the informed decision-making process:

- the greatest risk of adverse outcome occurs in a trial of VBAC resulting in emergency caesarean delivery.
- planned VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture.
- the absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women in labour.
- the success rate of planned VBAC is 72–75%.
- there is a two- to three-fold increased risk of uterine rupture and around 1.5-fold increased risk of caesarean delivery in induced and/or augmented labour compared with spontaneous VBAC labour.
- a senior obstetrician should discuss the following with the woman: the decision to induce labour, the proposed method of induction, the decision to augment labour with oxytocin, the time intervals for serial vaginal examination and the selected parameters of progress that would necessitate discontinuing VBAC.
- a final decision for mode of birth should be agreed upon by the woman and member(s) of the maternity team before the expected/planned date of delivery.
- plans for repeat elective caesarean section should contain a plan for labour, should it occur before the planned caesarean section.

Appendix 3

Support for patients, families or carers

Support organisations

We understand that this is a very difficult time for you and your family. There are several organisations that can provide you with specialist advice, including:

Bliss www.bliss.org.uk

Bliss is the national charity that supports babies born premature or sick and their families. They can offer advice and support via a freephone helpline. Tel: 0500 618 140.

NHS Improving Access to Psychological Therapy www.england.nhs.uk/mental-health/adults/iapt/

The NHS provides free access to psychological therapy on a regional basis through the IAPT service. This can be accessed by the link and services in your area located including self-referral details.

Peeps HIE www.peeps-hie.org

Peeps charity provides support to families affected by babies born with hypoxic ischaemic encephalopathy (HIE). Tel: 0800 987 5422.

Sands www.sands.org.uk

A charity set up to offer support to anyone affected by the death of a baby and to improve the care bereaved parents receive.

The Samaritans www.samaritans.org

The Samaritans provide a free 24-hour listening and advice service 365 days a year. They can be contacted from any phone anytime by calling 116 123 from the UK and Republic of Ireland.

Legal advice

Action against Medical Accidents (AvMA) www.avma.org.uk

AvMA is an independent charity which offers free medico-legal advice to people affected by substandard care. They can advise and support families with regard to the EN Scheme or other processes which are open to them. AvMA also accredits specialist clinical negligence solicitors to whom families can be referred, if necessary, or provide families with their details. Their helpline is open between 10am and 3.30pm, Monday to Friday. Tel: 0845 123 2352.

Citizens Advice Bureau citizensadvice.org.uk

The Citizens Advice Bureau provides some free advice and may be able to put you in touch with a legal advisor.

Law Society www.lawsociety.org.uk

For independent legal advice, from a specialist clinical negligence lawyer, you can contact the Law Society.

8th Floor
10 South Colonnade
Canary Wharf
London, E14 4PU
Telephone 020 7811 2700

7 & 8 Wellington Place,
Leeds, LS1 4AP
Telephone 0113 866 5500

www.resolution.nhs.uk

Published: September 2022