Appendix 1 – Modifiable Factors / Recommendations to child death reviews 2013-14

No.	Agency	Un/expected classification	Modifiable factors/ recommendations	Status
1.	London Ambulance Service (LAS)	UN	Due to a lack of formalised processes to support clear communication and decision making to respond to LAS requests for urgent assistance, Newham University Hospital failed to provide a midwife to attend the birth. No root cause was attributed to the London Ambulance Service. The LAS actions below arise from lessons learned from this incident. **Escalation Path** The Consultant Midwife has drafted an escalation path for Emergency Operation Centre (EOC) when requesting a midwife, which includes statements for EOC to make regarding the Hospital Trusts' statutory obligation to provide a midwife, as per SHA/London Midwifery Supervisors recommendations. The investigation recommends that this is discussed with the Head of Operations for potential inclusion in OP035 Obstetric Care policy and OP061 Dispatch Procedures **Operational Policy Review** Pre-Arrival Instructions (PAIs) for breech presentation do not include a situation where a baby's foot is out. The Emergency Medical Dispatcher (EMD) had a choice between a) baby is born and b) baby's head is stuck (arms out) and decided that the latter was the most appropriate and continued with the next relevant card on delivery. EMDs are not clinically trained, but the PAIs are very detailed and did allow the EMD to provide instructions and reassurance to the patient's husband before the crew arrived. The investigation recommends that the PAIs for protocol 23 are reviewed by the Consultant Midwife to ensure that all clinical scenarios are covered. If any additional scenarios are felt essential and not adequately covered by the current PAIs this will be highlighted to the Academy for international review as to whether the PAIs should be amended. If the review identifies that this is training issue on the process flow of the PAIs, a clinical bulletin will be issued to Control Room staff.	

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			The investigation also recommends that an immediate clinical update is provided to call handlers to clarify breech birth stages and terminology so that they are clear on which PAIs to follow **Operational Policy Review** The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Birth Imminent (normal delivery and delivery complications) provides a decision tree on maternity assessment and early identification of obstetric high risk complications, which is mirrored in the Trust's OP035 Obstetrics Care Policy. However, step 5 of the obstetric high risk complications states if "presentation of part other than head/buttocks/feet" is ambiguous and open to interpretation. The investigation recommends that statement 5 in OP035 should be amended to "presentation of a single limb, i.e. a hand or a foot" to remove the ambiguity. It is also recommended that this is discussed with JRCALC for potential inclusion in later versions of the guidance. The JRCALC/OP035 maternity assessment does not provide any clinical, environmental or logistical criteria to allow the crew to fully assess the risk to either the mother or the baby in immediately transporting to the nearest obstetric unit. The investigation recommends that the Trust provides clear guidance to staff on the risk factors involved in immediately transporting the mother, when birth is in progress. This guidance should be included in the obstetric training programme. **Risk Register Review** That the existing Risk Register entry Reference 031-2002 is reviewed in the light of recent Serious Incidents declared around the Trust's capacity to respond to obstetric emergencies. **Target Date for implementation: 31 March 2013**	

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	Newham General Hospital		Newham University Hospital to review local guidance for responding to LAS calls for assistance. Local flowchart to record all LAS calls and support clear communication and decision making. Local Supervisory Authority; to investigate into midwifery practice. Obstetric staff to receive training regarding their role in relation to LAS calls. Review midwifery mandatory training. Recommendation that Line manager review the leadership skills of the Coordinator as a Band 7 midwife in line with Capability Policy.	
	Queens Hospital		Excerpt taken from LAS Serious Incident Report: *"Although Queens Hospital has not provided the LAS with a formal report, from the information provided in the call transcripts and in discussions with the Risk Manager, it would appear that the hospital also lacks formalised processes to support clear communication and decision making to respond to LAS requests for urgent assistance".* Calls and triage notes into the labour ward at Queens will be reviewed to ensure documentation of appropriate advice is relayed to LAS and families.	
2.	London Ambulance Service (LAS)	UN	The call handler should have employed the shift function and selected the '*Third Trimester Haemorrhage'* which would have resulted in a 'R2' priority level – returning a higher priority response time A Quality Assurance manager has fed back to the call hander concerned and provided advice and guidance. We are confident this will enhance the future practice of the member of staff involved accordingly.	Complete
3.	London Ambulance Service (LAS)	UN	No suitable sized mask, to bag and mask ventilate this baby either at the scene or on the way to the hospital. CDOP to write to LAS	Complete – March 2013

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4.	Partnership of East London Co-operatives (PELC)	UN	An investigation and review to be carried out into whether the Urgent Care Centre at Queens has the equipment to carry out eye swabs in the event of an emergency	
5.		UN	Issues identified were co-sleeping 2 days prior to death and baby put face down to sleep – not in accordance with national recommendation Findings to be communicated to NELFT	
6.		UN	Alcohol use and co-sleeping Findings to be communicated to NELFT	
7.	General Practitioners	UN	Changes in NHS from 2013 have presented challenges in performance management of general practitioners' responses to CDOP learning and contributions, as well as how learning is incorporated into general practice. CDOP recommends that there is an NHS England representative on CDOP	