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

Report to Performance and Quality Assurance Committee – August 2014				
Reference	**Originating/ Responsible Agency**	**Modifiable Factors / Recommendations**	**Status**	**Source of update and date**
SI 2012/21226	London Ambulance Service (LAS)	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. **Escalation Path - Recommendation** The draft escalation path for Emergency Operation Centre (EOC) when requesting a midwife to be discussed with the Head of Operations for potential inclusion in OP035 Obstetric Care policy and OP061 Dispatch Procedures **Operational Policy Review - Recommendation** The Pre-Arrival Instructions (PAIs) for breech presentation 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. An immediate clinical update is provided to call	The SI is recorded as closed to the LAS Management Group but, due to a number of staff departures and vacant positions, LAS is unable to provide an update on the action plan. This will be followed up by the LAS Clinical Governance post once recruited to. CDOP is currently looking at how updates to SIs are provided to CDOP from both in and out of borough services	

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		handlers to clarify breech birth stages and terminology so that they are clear on which PAIs to follow **Operational Policy Review - Recommendation** Step 5 of the Trust's OP035 Obstetrics Care Policy should be amended to read "presentation of a single limb, i.e. a hand or a foot" to remove ambiguity. It is also recommended that this is discussed with the Joint Royal College Ambulance Liaison Committee (JRCALC) for potential inclusion in later versions of the guidance. The Trust should provide 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 - Recommendation** 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**		
SI 2012/21226	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.	At the time of writing this report, Newham had not yet provided a response to our request for an update.	

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		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.		
SI 2012/21226	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.	1. **E3 a new electronic maternity** This system keeps a permanent record of all calls made to the maternity ward from mothers who are booked at Queens. This has been in place since late 2013.For mothers not booked, a proforma is being trialled. 2. **Direct line number for use by the LAS** This is likely to be up and running by mid September 2014. The installation has been delayed due to no free phone lines. 3. **Telephone recording system** This due to be installed in	Wendy Matthews Director of Midwifery & Divisional Nurse Director 21 August 2014

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			approximately 6-9 months. 4. **Further meetings with LAS** There are issues Queens would like to discuss with LAS. Queens met twice with LAS but LAS has since proved difficult to engage.	
CDOP KG/12/136	London Ambulance Service (LAS)	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	Complete. 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.	LAS Form B completed by Lysa Walder, Head of Safeguarding Children 7 May 2013
CDOP KG/12/137	London Ambulance Service (LAS)	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 to request all vehicles have different sized masks available.	This area of practice has been highlighted to staff to ensure different sized masks are available.	Response letter from Fiona Moore, Medical Director 8 May 2014
CDOP KG/12/137	Partnership of East London Co-operatives (PELC)	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	The outcome has been received and will be discussed out the next CDOP meeting on 24 September 2014. There were no further concerns raised by CDOP and the case was closed	Response letter from Louise Rogers 8 August 2014

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CDOP KG/12/141	NELFT	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	The findings have been communicated to the CDOP Representative who will write to the appropriate Director	
CDOP KG/13/156	NELFT	Alcohol use and co-sleeping Findings to be communicated to NELFT	The findings have been communicated to the CDOP Representative who will write to the appropriate Director	
CDOP/13/001	General Practitioners	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	This has been communicated to the CDOP chair who will write to NHS England.	