Parliamentary and Health Service Ombudsman

Midwifery supervision and regulation

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

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Foreword

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

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

The complaint is about the North West Strategic Health Authority (the SHA). Mr L complained to us that the SHA had failed to carry out adequately its functions as the Local Supervising Authority (LSA) following the care provided for his baby son at Furness General Hospital in October 2008, which contributed to his death at Freeman Hospital early in November.

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

Dame Julie Mellor, DBE
Health Service Ombudsman

December 2013

Summary

Baby L

What happened

Mrs L went to Furness General Hospital in October 2008 when her waters broke. She explained that she had been poorly for a few days, but after two sets of observations she was told she could go home and return the next day. Two days later she started to have contractions and Baby L was born. Mrs L was given antibiotics because she felt unwell, but no antibiotics were given to Baby L, who was only seen by a paediatrician 24 hours later. Baby L's condition deteriorated and he was transferred to two different trusts for intensive treatment. Sadly, he died from pneumococcal septicaemia in another hospital early in November.

The Trust commissioned an external review of Baby L's care but this was difficult because Baby L's observation chart went missing around the time he was transferred to another hospital. The external report said that *'the care received by* [Baby L] *was not acceptable'* and that *'as a direct consequence, he lost his fight for life'*.

After the external inquiry, the Local Supervising Authority (LSA) issued their report. This report did not agree with all of the findings of the external report, and Mr L felt it was fundamentally flawed. The SHA agreed to commission an external review of the report and then, following Mr L's complaint about this first review, a second review, jointly with the Nursing and Midwifery Council (NMC).

What we found

The LSA did not carry out its duty to perform open and effective supervisory investigations in line with relevant standards and established good practice. The supervisory investigation should have been completed in 20 days but it was delayed until after the Trust's external investigation. This meant that events were no longer fresh in the midwives' minds, which was particularly important without the observation chart. The report was of poor quality, and was based on assumptions. It did not establish why Baby L was put on a cot warmer on more than one occasion, why the midwives had not asked for paediatric support and whether they would do so in future.

When Mr L provided fresh information about Baby L's temperature, which was accepted by the midwives, this meant that the original report was unsound. But the LSA Midwifery Officer did not tell the NMC about the new information and so failed to take an opportunity to put things right.

The first review commissioned by the SHA took six months and it did not consider the actual midwifery care provided to mother and baby. As a result, these six months were wasted. The second review was open and accountable and correctly identified many of the issues.

The complaint

1. We have investigated Mr L's complaint that North West Strategic Health Authority[1] (the SHA) failed to carry out adequately its functions as the Local Supervising Authority[2] (LSA) for midwives in relation to open and effective supervisory investigations of midwives following the care provided for his son, Baby L, in October 2008, which contributed to Baby L's death on 5 November 2008 at Freeman Hospital (managed by Newcastle upon Tyne Hospitals NHS Foundation Trust[3]). This followed infant and in some cases maternal deaths at Furness General Hospital (the Hospital – part of University Hospitals of Morecambe Bay NHS Foundation Trust – the Trust[4]) in February 2004 and during 2008.

2. We have also investigated Mr L's complaint that the SHA failed to deal with his complaint about this effectively.

3. Mr L said that he did not have confidence in the ability of a risk manager employed by the Trust who was also acting as a Supervisor of Midwives for the LSA.[5] He felt that in his case, either the processes in place did not work, or were not allowed to work because they were not properly followed. He also said that because the LSA investigations into previous unexpected and maternal and neonatal deaths were not robust, lessons were not learnt that could have improved the care for his wife and son. He said that previous cases highlighted a dysfunctional relationship between midwives and doctors, which he believes could have been highlighted by appropriate LSA investigations in those cases. He believes that, if those investigations had happened, it was possible that midwives might have been more proactive when providing care for Baby L.

4. Mr L hopes that our investigation will lead to improvements in services and help make maternal care safer.

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

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

3 The actions taken by Newcastle upon Tyne Hospitals NHS Foundation Trust and the care provided are not part of the scope of our investigation.

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

5 I have referred to this person as Midwife A for the remainder of this report.

Our decision

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

6. I have found that the SHA did not carry out its functions adequately as the LSA for midwives following Baby L's death. I have concluded that this was maladministration. I have also found maladministration in the way the SHA handled Mr L's complaint. I have found that Mr L was right that the supervisory processes had not been followed properly, and where they were followed, they had not worked. I found that the initial review by the SHA was never likely to address Mr L's concerns, and it therefore prolonged and exacerbated the considerable distress already caused to him and his family. I found that all this was an injustice to Mr L that arose in consequence of the maladministration I identified.

7. I therefore uphold this aspect of Mr L's complaint about the SHA.

8. I have also found that the SHA did not carry out its functions adequately as the LSA for midwives in relation to open and effective supervisory investigations in the other two complaints we have investigated (Annexes A and B). I concluded in both cases that this amounted to maladministration. However, I have found that no injustice arose to Mr L in consequence of this maladministration.

The Health Service Ombudsman's jurisdiction and role

9. Our role[6] is to look at complaints about the NHS in England. We can investigate complaints about NHS organisations such as trusts, strategic health authorities, family health service providers such as GPs, and independent persons (individuals or organisations) providing a service on behalf of the NHS.

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

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

How we decided whether to uphold this complaint

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

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

What should have happened?

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

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

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

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

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

    - *'Being open and accountable'* – which includes public organisations providing honest, evidence-based explanations and giving reasons for decisions. They should keep full and accurate records; and

    - *'Acting fairly and proportionately'* – which includes ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

16. In addition to these Principles, there are specific standards which were relevant to our investigation of this case.

Background information

17. Supervision is a statutory responsibility based on the Nursing and Midwifery Council's (the NMC, the nursing and midwifery regulator) *Midwives rules and standards* (2004) (the midwives rules), which provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice. Supervision is a means of promoting excellence in midwifery care, by supporting midwives to practise with confidence, therefore preventing poor practice.[7]

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

19. Each LSA appoints and employs a practising midwife to undertake the role of Local Supervising Authority Midwifery Officer (LSAMO).[8] This person is responsible for ensuring that the statutory Supervision of Midwives is carried out to a satisfactory standard. The LSAMO was based within the SHA. The LSAMO appoints supervisors of midwives, who operate locally (that is, they are employed by the relevant NHS organisation) and who are directly accountable to the LSA for all matters relating to the statutory supervision of midwives. Local frameworks exist to support the statutory function. Every midwife will have her own named Supervisor of Midwives, with whom she will have regular contact (Rule 12).

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

The specific standards

The NMC's *Standards for the supervised practice of midwives* (2007)

21. Standard 1.1 of the NMC's *Standards for the supervised practice of midwives* (the NMC Standards) states that:

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

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

8 LSAMOs are a point of contact for Supervisors of Midwives for advice on aspects of supervision, especially difficult or challenging situations.

22. Standard 1.2 says that:

> *'Supervisory investigations should take place as soon as possible after any untoward event or circumstances, and may be initiated by a Supervisor of Midwives regardless of any employment processes. The Local Supervising Authority should be informed that a supervisory investigation has commenced.'*

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

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

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

25. The North West LSA *Guidance for Supervisors of Midwives* 2005 (revised 2008, the guidance) provided guidance for midwifery supervision at the time of the episode complained about. The guidance incorporated parts of the NMC's *Midwives rules and standards* (paragraph 17). In the section relating to *'reporting and monitoring of serious untoward incidents'* the guidance says that:

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

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

National Institute for Health and Clinical Excellence (NICE)[9] *Intrapartum care*:[10] *care of healthy women and their babies during childbirth* (NICE guideline 55 – September 2007)

27. The NICE guidelines say that, in low-risk women, intermittent auscultation[11] of the baby's heart should be changed to continuous fetal heart monitoring (using an electronic fetal heart monitor or cardiotocograph, CTG[12]) when an abnormal

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

10 Intrapartum means the time from labour to delivery.

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

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

heart rate is detected in the baby, either because it is less than 110 beats per minute, or because it is greater than 160 beats per minute, or because it decelerates after the mother's contractions.

28. In women who have had more than one birth (parous women), the NICE guidelines say that birth would be expected to take place within two hours. They say that a diagnosis of delay in the active second stage of labour should be made when it has lasted more than one hour, and the mother should be referred to a healthcare professional.

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

30. The guidelines also say that asymptomatic term babies[13] born to women with pre-labour rupture of the membranes (more than 24 hours before labour) should be closely observed for the first 12 hours of life (at one hour, two hours and then two hourly for ten hours).

31. These observations should include:

    - general wellbeing
    - chest movements and nasal flare
    - skin colour including perfusion, by testing capillary refill
    - feeding
    - muscle tone
    - temperature
    - heart rate and respiration.

32. A baby with any symptom of possible sepsis, or born to a woman who has evidence of chorioamnionitis,[14] should immediately be referred to a neonatal care specialist.

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13 This means babies born after 37 weeks pregnancy, without any symptoms of being ill.

14 Chorioamnionitis occurs when the membranes that surround the baby in the mother's womb become inflamed, normally as a result of a bacterial infection. This is a dangerous condition for both the mother and the baby.

The investigation

33. We confirmed our understanding of Mr L's complaint in our letter of 11 October 2012, and we interviewed him on 23 October to discuss in more detail the nature of his complaint and how our investigation would proceed.

34. We shared a draft version of this report with NHS England and Mr L, and we took into account their comments before completing our report.

35. During this investigation, we have considered relevant documents about Mr L's complaint, including documents relating to the attempts by the SHA to resolve his complaint.

36. We have taken advice from one of our clinical advisers: a practising midwife and Local Supervisory Authority Midwifery Officer (the Adviser). Our clinical advisers are experts in their field. In their role as advisers, they are completely independent of the NHS.

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

38. In addition to the relevant documents about Mr L's complaint, we have also considered two other investigations we have conducted into the SHA. This is because the investigations arose from events that occurred within a few months of Baby L's birth, at the same hospital, and they relate to part of Mr L's claimed injustice. The anonymised summaries of these two cases are set out at Annex A and B.

Key events

39. Mrs L already had a daughter, before she became pregnant with Baby L, and she did not have any complications during her first pregnancy.

40. On 25 October 2008 Mrs L's waters broke. She went to the Hospital at about 10.50pm and her temperature was recorded as 37.1.[15] Mr and Mrs L said that they spoke to a midwife and explained that they had been poorly for a few days, with symptoms including headaches and sore throats. This discussion was not documented in Mrs L's notes. At this stage it was noted that Mrs L's pregnancy had lasted for about 37 weeks, which meant that her pregnancy had reached term.[16]

41. Two sets of observations were carried out on Mrs L, which included measuring her blood pressure, pulse, and temperature and palpating her uterus in order to feel the position of the baby. It was also documented that clear, non-smelling liquor[17] was draining from her, and that the baby's heart was heard at 115 to 135 beats per minute.[18] The notes say that it was agreed that Mrs L should stay a little while longer in hospital *'to observe'* and at 11.45pm Mr and Mrs L were told that they could go home and return the following morning. Staff did not take a mid-stream

15 Normal body temperature in an adult fluctuates between 36 and 37 degrees.

16 A term pregnancy is one in which the baby has fully developed inside the womb and is ready to be born. In England, 37 weeks is considered to be full term, although the actual birth may occur some weeks later.

17 Liquor refers to the amniotic fluid, in other words the waters which surround the baby while in the uterus.

18 Normal heartbeat would be between 110bpm and 160bpm, NICE Guidelines (*fetal heart assessment and reasons for transfer to electronic fetal heart monitoring*).

specimen of urine or a vaginal swab to screen for infection.

42. At 11.20am on 26 October, Mrs L returned to the Hospital. It is documented in her records that she did not have a raised temperature (36.3), and that the liquor that was draining was still clear but she was not yet having contractions. A CTG trace was done that did not show anything abnormal. The notes say that Mrs L had a *'very mild headache'* and that she had not slept well the night before but she was otherwise *'asymptomatic'*. The notes also say that Mrs L was happy to go home and return the next day.

43. On 27 October, at approximately 5am, Mrs L started to have contractions and she returned to the Hospital an hour or so later. The notes say that shortly after she arrived, a vaginal examination was performed, showing that her cervix was *'fully effaced'*.[19] Shortly after this, Baby L's head was visible, and so Mrs L was helped onto the bed for delivery.

44. Baby L was born at 7.38am on 27 October, after what was described in the notes as a *'normal delivery'*. The notes say that he *'cried immediately'* and was given an APGAR score of nine,[20] although when this was repeated after five minutes, it was eight. This was because his respirations were *'shallow'* and he was therefore taken to the resuscitaire.[21] His records show that his APGAR score was 10 after ten minutes.

45. Mr L recalls Baby L's birth differently. He says that when he was born, Baby L seemed to struggle with his breathing, and he appeared blue and did not cry. He said that he was taken to one side, his chest was rubbed and when he did not improve, the midwife gave him some oxygen. After this, Baby L improved quickly, and he cried and went pink.

46. The first 25 hours of Baby L's life are poorly documented, because the chart that detailed his observations in those hours went missing around the time Baby L was transferred to St Mary's Hospital (part of Central Manchester University Hospitals NHS Foundation Trust).[22] What is documented is that at approximately 8.30am on 27 October, Mr L approached staff and said that Mrs L had been feeling unwell, and particularly cold and shivery. When her temperature was taken it was 38.2. Intravenous antibiotics and paracetamol were started shortly afterwards.

47. Mr L says he became concerned about Baby L because his wife was unwell. He said that both he and Mrs L were told not to worry by Trust staff as Baby L *'looked fine'*; that the paediatrician[23] was *'too busy'* to see him, but that Baby L was being monitored closely. Mr L says that Baby L was mucousy, breathing quickly and wheezing and that none of the midwives seemed aware that Mrs L was being given antibiotics. Mr L told us that he repeatedly

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19 The cervix is a narrow passage forming the lower end of the uterus. As labour progresses, it becomes thinner and shorter, and this is called effacement. Delivery occurs when it is fully effaced.

20 An APGAR score assesses the health of a newly born baby. It includes five criteria; skin colour, pulse rate, reflex irritability, muscle tone and breathing. Each criterion is given a score of 0 to 2. The maximum score is 10, which means the baby is perfectly healthy.

21 A specialist unit for babies who need a little help with their breathing.

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

23 A doctor specialising in the health of babies and children.

expressed concern for Baby L, including asking for antibiotics for him, but he was told that Baby L was fine, and that it was his wife he needed to worry about. He said that when he realised that Baby L's temperature was low, he assumed this meant Baby L did not have an infection, and he was reassured by the midwives that this was the case. For the first 24 hours, Baby L's temperature kept dropping and he was transferred to a heated cot on three occasions. Each time he was taken out of the cot his temperature dropped again.

48. Mr L has told us that around 2am on the morning of 28 October 2008, Mrs L rang the emergency bell because she could hear Baby L *'grunting'* and that she raised concerns about his breathing with staff at that time, who took Baby L out of the room for around 30 minutes. At around 8.30am the same day Mrs L became very concerned about Baby L's condition, and he was seen by a paediatrician for the first time. His condition continued to deteriorate and he was transferred to two different Trusts for intensive treatment. Sadly, on 5 November 2008 Baby L died from pneumococcal septicaemia.

Mr L's complaint to the Trust

49. On 15 November 2008 Mr L made a complaint to the Trust about the care and treatment provided for his son and his wife.

50. In December the Trust commissioned an external review of the care provided for Baby L. This review was carried out by the head of midwifery at Macclesfield District General Hospital (managed by East Cheshire NHS Trust), a consultant obstetrician and gynaecologist and a consultant paediatrician both from the Royal Albert Edward Infirmary Wigan (managed by Wrightington Wigan and Leigh NHS Foundation Trust).

51. The external report was produced in February 2009. The report was based on the recollection of the family, Mrs L's and Baby L's records (insofar as these were available), a root cause analysis carried out by the Trust and the staff's statements. The report said that, following the spontaneous rupture of her membranes, Mrs L was managed in line with accepted practice. However, swabs to check for infection had not been taken from Baby L, which was contrary to Trust guidelines. These said that a swab should be done when membranes have been ruptured for more than 24 hours. The report said that there was no evidence of a holistic overview of care, which would have included consideration of the potential consequences of the maternal infection for Baby L. The report also said that there was no evidence of a handover of care for Mrs L and Baby L when they were transferred from the labour ward to the postnatal ward, and that it appeared that *'workload pressures'* may have influenced the care that was provided.

52. The report also identified that there appeared to be a lack of staff awareness that persistent hypothermia[24] in a neonate can be a sign of sepsis[25] and that Trust staff had failed to recognise the relevance

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[24] Mild hypothermia in newborns is defined as a core body temperature of 36 to 36.4, moderate hypothermia as 35.9 to 32 and severe hypothermia as less than 32. Department of Reproductive Health and Research (RHR), World Health Organisation. *Thermal protection of the newborn: A practical guide* (WHO/RHT/MSM/97.2). Geneva: World Health Organisation. 1997.

[25] Sepsis is a life-threatening illness that is caused by the body overreacting to an infection.

of neonatal hypothermia and the need to refer Baby L for a medical assessment. The report concluded that if antibiotics had been given to Baby L earlier, he might have survived. The report also said that the Trust's record keeping following Baby L's birth was of an exceptionally poor standard.

53. On 25 March 2009 the Trust wrote to Mr L and acknowledged the external report's fundamental conclusion, which was that *'the care received by* [Baby L] *was not acceptable'* and that *'as a direct consequence, he lost his fight for life'*.

54. As a result of this external inquiry, the Trust had asked all other investigations to stop until the inquiry had been concluded. This included the supervisory investigations that Midwife A was due to carry out. Once the external report was issued, Midwife A carried out her supervisory investigation.

The local supervisory investigation on behalf of the LSA

55. The LSA issued the report on 22 May 2009. The report was produced by Midwife A and specifically referred to the Trust's own root cause analysis, which Midwife A had also carried out. There was also reference to the external report that had been commissioned in December 2008.

56. Although the LSA report referred to some of the findings of the external report, it did not agree with all of them. It agreed that midwives had missed potential opportunities for intervention, although it said that the changes in Baby L's condition were subtle. The report concluded that it was impossible to say whether these interventions would have altered the outcome. (This is in contrast to the Trust's estimate that Baby L would have had a 90% chance of survival had he received antibiotics earlier.) The LSA agreed that there were concerns about the standard of record keeping at the Trust. They concluded that, whilst the care given to Mrs L and Baby L was not recorded to a satisfactory standard, the care itself was satisfactory. They recommended retraining for four of the midwives involved in Baby L's care. They said that the staffing levels at the maternity unit were at a normal level. The LSA responded to Mr L's remaining concerns that were within their remit that:

1. **There were no medical records available for Baby L for the first 24 hours** – the LSA concluded that the standard of record keeping was unacceptable. (However, there was detailed documentation of maternal care.) They also said that staff were unable to find Baby L's observations charts for his first 24 hours.

2. **The failure of the midwives regarding:**

    a. **paediatric examination** – the actions of the paediatrician should be criticised. They said that the midwife gave the paediatrician adequate information about the gestation of the baby, how long the membranes had been ruptured and that Mrs L had a raised temperature following delivery. They also said that three-hourly observations were commenced.

    b. **taking a swab** – revised guidelines had been implemented since Baby L's death to help maternity staff manage babies at risk following prolonged rupture of the membrane.

    c. **recognising signs of infection** – Baby L's temperature ranged

between 36.4 and 36.8. Baby L's inability to maintain a steady temperature was thought to be due to the cold room. Staff training days were to be organised to help with recognising the signs of infection.

3. **Why Baby L was not examined by a paediatrician immediately after birth and why was a paediatrician not consulted when Mrs L complained about Baby L's laboured breathing** – it was a paediatric decision not to examine Baby L and the midwives set up the regular observations as instructed. They said that, in terms of Baby L's laboured breathing, all his observations were within normal limits and he was '*thoroughly checked*'. They said that for this reason, they did not think it had been necessary to inform a paediatrician about Mrs L's concerns.

4. **Why Baby L was monitored by the same lady who had served Mrs L food** – they said that only qualified staff were involved in monitoring Baby L. They said that the rota showed a maternity assistant, trained to undertake neonatal observations, was on duty that day. They also explained that her role included giving out the meals.

5. **Why staff did not adhere to NMC Standards and complete records after Baby L's collapse** – they said the documentation of Baby L's care was unacceptable and that this was being addressed by the recommendations from the internal and external reports.

Mr L's complaint about the LSA report

57. Mr and Mrs L, and Mr L's father, met the LSAMO and Midwife A on 2 June 2009. Mr L then wrote to the SHA on 14 June 2009 outlining the areas of the LSA report that he was concerned about. The LSAMO responded on 29 June, on behalf of the SHA.

58. The LSAMO said that in terms of Mr L's concern about Baby L's temperature, they had re-interviewed the midwife who had placed Baby L in the warming cot. This midwife could not remember the temperature readings on the observation chart, which had gone missing, but she accepted Mrs L's recollection that Baby L's temperature was 35.8 and then 36.1. However, the midwife also said that she was sure that all of Baby L's other observations were normal. She said that she was reassured when she placed Baby L in a warming cot and he responded well, and for that reason she thought that appropriate action had been taken.

59. The LSAMO also addressed the different recollections of Baby L's condition at birth. She said that Mr and Mrs L's recollections of Baby L at birth (that he was blue and not breathing immediately) were not unusual. She said that the APGAR scores that were given to Baby L after he was born reflected the descriptions that Mr and Mrs L had given about his condition. However, the LSAMO concluded that *'clearly, the actions taken by the midwives to stimulate* [Baby L] *were effective – as his APGAR score increased to 10 at ten minutes after birth'*.

60. Finally, she said that the midwives involved in Mrs L's care were not aware of how ill she felt, only that she had a headache. She said that when they had been asked again following their meeting of 2 June, they still did not recall any of the other symptoms that Mr and Mrs L said that they had explained at the time. She concluded that since these additional symptoms had not

been recorded, it was *'difficult to pursue this issue any further'*. The LSAMO said that since Mr L had referred his son's case to the NMC, who also had a copy of the LSA report, it was for them to *'reach a decision regarding further investigation of midwifery practice and appropriate action'*.

The SHA's first external review of the LSA report

61. On 4 July 2009 Mr L wrote back and said that the LSA report, as it stood, was *'fundamentally flawed'*. Following several other letters from Mr L, and a letter from the NMC in November 2009 expressing Mr L's concerns about the LSA report, the SHA agreed to commission an external review of the LSA report. The terms of reference of this review excluded any consideration of the midwifery care provided to Mrs L and Baby L. The review would be done by an LSAMO from a different LSA. On 25 June 2010 the SHA sent this report to Mr L. The report concluded that the LSA had *'followed proper process in conducting the original investigation on the actions of midwives'*.

62. Mr L was concerned that the family's recollections had been discounted, but the reviewer found that *'in all cases the queries* [raised] *had been followed through, the evidence checked and a response provided'*. The SHA said that it was not for the review to solve the discrepancies between what the family said and what the midwives maintained or had documented in the records. The reviewer concluded that without the missing observation chart, she had not been *'in a position to challenge the midwives' recollection of events'*. The reviewer shared the concerns identified in the LSA report about poor record keeping but concluded, after checking the electronic records, that the midwives had not changed their records after the event. Finally, the review concluded that the original LSA report correctly identified the areas of practice that required development. The reviewer also confirmed that there was no conflict of interest in the maternity risk manager (Midwife A) carrying out the supervisory investigation.

The SHA's second external review of the LSA report

63. Mr L was not happy with the conclusions of the review, and reiterated his concerns that the content and conclusions of the original LSA report were based on the accounts of the midwives, without taking into account the evidence he and his wife were able to provide. He said that:

    - the reviewer had missed the point about the maternity risk manager carrying out the LSA investigation. He said that she was the person accountable for clinical risk management when Baby L died, and as such, there was clearly a conflict of interest in her carrying out the supervisory investigation;
    - he acknowledged that when he raised the issue of the discrepancies between his recollections and those of the midwives, these were looked into. However, he said that in the end *'no other action was taken in response and the report and its conclusions remained the same'*; and
    - in terms of the record keeping, he said that he had not suggested that the midwives had retrospectively changed the records. He said that the

descriptions of Baby L at birth, and the related APGAR scores, were not possible.

64. Mr L concluded that in his view, the review did not address the complaint he had made about the LSA report.

65. Following further exchanges between Mr L and the SHA, and a meeting with the SHA on 16 November 2010 (where the SHA apologised for the distress the initial review had caused Mr L), the SHA, jointly with the NMC, completed a second review of the LSA process on 8 December 2010. This review identified a number of concerns. In particular, it found that the supervisory investigation was delayed and that the original LSA report had exceeded its remit by addressing service issues that were not related to the individual midwives' fitness to practise. It acknowledged that allowing the Trust's maternity risk manager to carry out the supervisory investigations was intended to strengthen the process but had led to the two investigations being blurred. This in turn meant that the supervisory investigation was no longer independent.

66. The SHA said that the review demonstrated that the process was not as robust as it should have been and that the LSA appeal process (in other words, the first review) had not helped resolve Mr L's key issues. The SHA concluded that the *'LSA report lacked a logical analysis of the evidence and that the evidence was not clearly presented to support the conclusions'*.

67. Mr L wrote to the SHA on 3 January 2011 asking for a new local supervisory investigation to be conducted, given the failings that the SHA had identified in the original LSA investigation. The SHA replied on 28 January and explained that it would not be appropriate to have another investigation because the matter had now been escalated to the NMC. The formal proceedings that were taking place against four midwives would provide a thorough investigation into the actions of the midwives with regard to their care of Baby L.

Our clinical advice

68. The Adviser said that the purpose of the supervisory investigation would be to review the fitness to practise of the midwives and make a decision about whether any local remedial action was required, for example, supervised practice or developmental support programmes. It could also establish whether to refer the matter to the NMC if serious misconduct or serious incompetence was identified.

69. The Adviser said that the aim of the investigation would be to focus on midwifery practice issues only. It would be for the LSA to decide whether to suspend the midwife, or midwives, from practice if serious misconduct or incompetence was found.

The midwifery care

70. The Adviser said that while NICE guidelines suggest that induction of labour is appropriate approximately 24 hours after the rupture of membranes, this would have meant inducing Mrs L's labour at around 9pm on 26 October. She said that it would be usual to wait until the following morning and not to ask a woman to return late at night to start labour unless there were signs of infection. She said that NICE guidelines suggested that women should be asked to measure their temperature every four hours and report immediately any change in the colour or smell of the liquid draining. The Adviser said that Mrs L was given a thermometer and told to return if she felt unwell, or if she saw blood, or black staining, or could not feel the baby moving.

71. The Adviser noted that an hour after birth, Mrs L was unwell, with a high temperature and felt cold and shivery. She said that chorioamnionitis was probably suspected because the midwives called an obstetric doctor.[26] She said that nothing was documented by the doctor, and so she could not say whether any tests were carried out to confirm the diagnosis. She said that a sample of the placenta[27] (a placental swab) taken on 27 October, and reported on two days later, showed streptococcus pneumonia.[28] NICE guidelines say that a baby born to a woman who has evidence of chorioamnionitis should immediately be referred to a neonatal care specialist. The Adviser said that Baby L should have been reviewed by a paediatrician and the midwife should have recognised the need for this review, because there could have been a link between the mother's infection and the health of the baby. (Although the midwife asserted that she called a paediatrician, there are no records to corroborate this or what was said, other than a record that a bleep was made.)

72. The Adviser said that although there was initial disagreement about the temperatures recorded on the observation chart that had gone missing, the midwife did recall that at 4pm on 27 October 2008 Baby L's temperature was *'low'*. The Adviser said that this should have prompted the midwife to refer the baby to a paediatrician.

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[26] A doctor specialising in the health of pregnant women.

[27] The membrane that lines the uterine wall during pregnancy.

[28] A type of bacteria that can cause pneumonia and other diseases.

73. The Adviser said that there were other missed opportunities to refer Baby L to a paediatrician. She said that at 6.50am on 28 October, when Baby L was put back into the cot warmer, the paediatrician should have been called to check Baby L because he was being placed in the cot warmer for a second time.

74. The Adviser concluded that the midwifery care provided to Mrs L and Baby L was below established good practice at the time, and there were missed opportunities to refer Baby L to the paediatric team. She said that midwives should refer to an appropriate professional when deviations from normal are identified. Baby L should have been referred to a paediatrician when his temperature was found to be low.

The LSA actions

75. The Adviser acknowledged Mr L's concerns about the dual role of Midwife A. The Adviser said that she did not have concerns about Midwife A undertaking the supervisory investigation as long as she was not the named supervisor of any of the midwives involved in Mrs L's care and had the necessary skills to carry out the investigation.

The LSA report

76. The LSA report looked at a number of issues, and specifically at the actions of four of the midwives who had looked after Mrs L and Baby L. The Adviser said that Midwife A had made an assumption, based on the recollections of the midwives, that Baby L's temperature ranged between 36.4 and 36.8, which would have been normal. There were no records to support that.

77. Midwife A said that the lack of documentation of Baby L's observations, including the missing neonatal chart, constituted *'poor practice'*, which *'did not reflect the care given'*. The Adviser said that Midwife A should not have made that assumption. Without the records, she could not assume the standard of care that was provided for Baby L.

The individual midwives

78. The LSA report then examines the midwifery care provided by each of the four midwives.

Midwife E

79. No practice issues were identified for the first midwife (Midwife E), on the basis that the only criticism of her practice (in the external report commissioned by the Trust) was that she did not carry out an initial baby check when she took over the care of Mrs L and Baby L. However, the LSA report said that an audit of the electronic records showed that Midwife E had carried out the initial baby check, and had recorded the birth details as required. It said that the printouts from the system did not show all the information that would reflect this, but concluded that this was a failure in their information system. The Adviser did not make any criticism of this finding, although she said she would have expected more detail in the record of the initial examination.

Midwife F

80. Midwife A said, in the report, that Midwife F had approached her following Baby L's collapse, as she was *'very concerned that her documentation was incomplete and did not reflect the care that was given'*, and that she had been distressed at not having insisted that the paediatrician reviewed Baby L. The Adviser

said that the LSA should have explored further whether the midwife knew that, given the circumstances of Mrs L's collapse and the pre-labour rupture of membranes, she should have asked a paediatrician to review Baby L, or whether she lacked the knowledge necessary to realise that this review was needed.

81. The Adviser was also critical of Midwife A's failure to explore the midwife's recollection that Baby L's temperature had been *'low'*. There was no explanation of what she meant by *'low'*. The midwife did acknowledge that she had not identified that Baby L's drop in temperature might be an indication of sepsis, because all of his other observations were normal. The Adviser said that Midwife A should have explored with the midwife whether she now had the relevant knowledge and skills to practise as a midwife, and to recognise neonatal sepsis. (By the time the report was produced, this midwife had already undergone retraining about neonatal sepsis.)

Midwife J

82. Midwife A concluded that she was *'satisfied that this midwife provided a high standard of care despite the lack of appropriate evidence'*. The Adviser said that this was an assumption and Midwife A should have explained how she reached this conclusion. The Adviser said that if Baby L's temperature was within the normal range, as Midwife J said, then it was not clear why he was placed in a cot warmer. And, if he needed to be in a cot warmer, a paediatrician should have been called.

Midwife H

83. The Adviser said that again, Midwife A made an assumption about the midwife's fitness to practise. Midwife A had said that she believed that if this midwife had found any deviations from normal in Baby L's condition, she would have asked for medical assistance.

Conclusions of the LSA report

84. The Adviser said that the conclusions of the report were also assumptions. She said that while the report said that changes in Baby L's condition were subtle and not easy to recognise, Midwife F had recalled that Baby L's temperature was low. The Adviser said that the basic conclusion that it was *'impossible to say whether these interventions would have altered the outcome'* was inappropriate, because the LSA report should have focused on whether the individual midwives were fit to practise.

Subsequent actions by the SHA/LSA

Subsequent interview with Midwife F

85. The LSAMO told Mr L that when Midwife F had been interviewed again, she agreed that Baby L's temperatures could have been 35.8 and 36.1. She admitted to knowing that Baby L's temperature was lower than expected. This was the reason she placed him in a warming cot.

86. The Adviser said that this letter lacked detail about the action the LSA was going to take in light of this new information. The Adviser said that both Midwife A and the LSAMO missed an opportunity to review the supervisory investigation in the light of fresh evidence. She said that although that midwife had since undergone training, there was no assessment or comment about her level of competence.

The external review of the supervisory investigation

87. The Adviser said that this review would have been difficult to carry out, given that the terms of reference specially excluded any consideration of the midwifery care that was provided. She said that a review of the midwifery care would be needed in order to determine whether the supervisory investigation was carried out appropriately and had reached appropriate conclusions.

Findings

The supervisory investigations

88. In order for the SHA to 'get it right' and adequately carry out its duty to perform open and effective supervisory investigations, Midwife A and the LSAMO should have acted in accordance with the relevant standards and with established good practice at the time, as described by the Adviser. A decision about whether to undertake a supervisory investigation should have been made as soon as possible. That investigation should have been completed within 20 days. The investigation and subsequent report should have been thorough and independent, in order to ensure that the midwifery care provided was safe and woman-centred. The report should have identified midwifery care that fell short of relevant NICE guidelines or established good practice.

89. The supervisory investigation into the midwifery care provided for Mrs L and Baby L was complicated by a number of factors. A crucial document detailing Baby L's observations was missing. The investigation itself was delayed as a result of the Trust's decision to commission an external investigation into the care provided to Mrs L and Baby L. Ultimately, it was a failing that the investigation was not carried out as soon as possible. Midwife A should have known that, in her capacity as supervisor, she was not bound to delay her investigation while the Trust was investigating the care provided for Mrs L and her son. The failure to go ahead with a supervisory investigation immediately meant that when staff were interviewed, the events were not as fresh in their minds as they might otherwise have been.

Without the neonatal observation chart, the recollections of staff were particularly important, and so the delay was a serious failure.

90. It was not against the then guidance for Midwife A to carry out a statutory investigation and I have not seen any evidence that a conflict of interest influenced her decision in Mr L's case. Nonetheless, I can quite understand why the possibility of a conflict would be a worry for any parent finding themselves in this position. For that reason, I am deeply concerned that the regulations allow potential muddling of the supervisory and regulatory roles of midwives or even the possibility of a perceived conflict. That cannot be in the interest of patient safety. And it is inherently unfair to service users and to midwives themselves.

91. Putting aside the question of any perceived conflict of interest, the report itself was deficient in many respects. Most of the report is based on assumptions, either about the care given or about Baby L's temperature. Whilst I accept that at the time of writing the report, Midwife A was unaware that Mrs L recalled that Baby L's temperature had dropped to 35.8 and 36.1, Midwife F recalled his temperature being *'low'*. The report did not address this, it did not seek to explore what *'low'* meant, or why the midwife did not take further action. Other assumptions were made. The report highlights a general concern about record keeping, yet Midwife A asserts with absolute confidence that the midwifery care provided was of a high standard. There was ample evidence from the records that Baby L's temperature could not have been entirely within normal limits: he was placed in a cot warmer on more than one occasion, including an hour or so before his collapse. The report did not establish why the midwives had taken this action, why they had not asked for paediatric support, or whether they would do so in future.

92. I agree with the conclusion of the SHA's second review, carried out jointly with the NMC, that the original LSA report *'lacked a logical analysis of the evidence and that the evidence was not clearly presented to support the conclusions'*.

93. The failings of the original LSA report were compounded when fresh information was provided by Mr L about Mrs L's recollection of Baby L's temperature. When re-interviewed, Midwife F accepted that Baby L's temperatures could have been as low as 35.8 and 36.1. By implication, this meant that she accepted that Baby L might have been displaying signs of hypothermia but she did not take appropriate action to address this. This information from Mr L should have prompted Midwife A, or the LSAMO herself, to reconsider the basic conclusions of the LSA report. I accept that there might have been some difficulty with this, as it appears the report had already been shared with the NMC. But that does not excuse the failure to act. The fact remains that much of the LSA report was based on the premise that Baby L's temperature did not fluctuate outside normal parameters and that the signs that he might be ill were subtle. If this premise was open to question, then the original report itself was unsound. The document designed to identify possible fitness to practise issues did not achieve its objective.

94. Finally, the LSAMO appeared not to recognise the issues with the original LSA report once the fluctuations in Baby L's temperatures had been accepted. In her letter of 29 June 2009, she suggested that since Mr L had referred Baby L's case to the NMC and they had a copy of the

LSA report, it was for them to reach a decision regarding further investigation of midwifery practice. She failed to appreciate the need to alert the NMC to the new information that Mr L had provided and that Midwife F had accepted as accurate.

95. Having considered the evidence, and the advice I have received, I have found several failings in the way in which the SHA discharged its function as the LSA for midwives. I have found that there was a delay in carrying out the supervisory investigations, and that there were serious deficiencies in the report that was eventually produced. I have found that when faced with opportunities to put those deficiencies right, the LSA failed to take them, failing in its duty to supervise the practice of midwives. I find that these failings amounted to maladministration and, consequently, that the SHA failed to adequately carry out its functions as the LSA for midwives in relation to open and effective supervisory investigations following Baby L's death.

Mr L's complaint to the SHA

96. The SHA first commissioned an external review of the supervisory process that had been followed in this case on 1 April 2010. Following Mr L's complaint to the SHA about this review, the SHA jointly with the NMC produced a second review of the supervisory process on 8 December 2010.

97. In commissioning these reviews in order to address Mr L's complaints, the SHA should have ensured that the terms of reference for each review would allow it to be open and accountable. This means that the reviews should have allowed the SHA to be open and honest when accounting for the decisions taken during the supervisory investigations, including providing clear, evidence-based explanations and reasons for the decisions that were made.

98. The first review commissioned by the SHA was not open and accountable, nor was it ever likely to be. Its terms of reference specifically excluded considering the actual midwifery care provided to Mrs L and Baby L. Without a consideration of the midwifery issues, including those issues raised by Mr L following the original LSA report, it would have been impossible for the reviewer to consider whether the original supervisory investigation was sound, and the LSA report appropriate. The midwifery care provided was the substance of the LSA report and supervisory investigation. It was this substance that underpinned Mr L's complaint about the LSA and, therefore, a review that excluded a review of this was never likely to answer his concerns.

99. The SHA's second review, conducted jointly with the NMC, was much broader in scope. In its letter of 8 December 2010, it confirmed that it had also considered the conclusions that the LSA report reached in more depth and had considered the points which Mr L had raised about the evidence base for some of the conclusions reached in the original LSA report. This second review concluded that *'the overall process was not as robust as we would have wished'*. It acknowledged that the first review that had been done *'did not assist in resolving key issues and was more of a peer review'*. This was an obvious conclusion, but one which demonstrated that the SHA was being open and accountable.

100. The second review went further when criticising the original LSA report, by saying that it *'lacked a logical analysis of the evidence'* and that *'the evidence was not clearly presented to support the conclusions'*. The confirmation, at the

end of the letter, that the findings of this second review would be shared with the coroner at Baby L's inquest demonstrated a commitment to ensuring that the deficiencies identified in the original LSA process were shared externally. The SHA also confirmed that the NMC had used the outcome of this second review and shared it with their own fitness to practise team.

101. Mr L also asked for the LSA investigation to be done again. We considered whether a fresh LSA investigation should have been carried out after the second review. The investigation side of the LSA function is only one aspect of how LSAs are designed to *'actively promote safe standards of midwifery practice'*. The LSA investigation is designed to determine whether *'the midwifery practice has been safe'* (paragraph 23). If they are to be effective, LSA investigations should be carried out as quickly as possible, but by December 2010 too much time had passed for an LSA investigation to achieve that aim. However, the SHA had carried out two reviews, and had shared their findings with the NMC, which was investigating the fitness to practise of the midwives concerned. An LSA investigation would have been redundant by then because the NMC's determination on these issues would have been final, no matter what the LSA investigation found.

102. In these circumstances, I do not criticise the SHA for declining to carry out a new LSA investigation into the midwifery care provided for Mrs L and Baby L. The SHA should have carried out a better investigation in the first instance, but any investigation by them at this stage was unlikely to add real value.

103. Having considered all the evidence, I have found that the second review, done jointly with the NMC, was open and accountable and correctly identified many of the issues. I have also concluded that the SHA's decision not carry out a further LSA investigation was reasonable. However, I have found that the original review following Mr L's complaint was too narrow in scope, and meant that the SHA was not open and accountable. This was a failing. In considering whether this failing amounted to maladministration, I have also taken into account the fact that it took over six months for this initial review to be completed. The fact that from the very beginning the review would not look at the midwifery aspects of Mrs L's care, which underpinned Mr L's complaint about the report, meant that it would almost inevitably fail to address Mr L's complaint. This in turn meant that these were six months wasted. Overall therefore, while I acknowledge that much of what the SHA subsequently did was open and accountable, the failure to get it right first time amounted to maladministration.

Injustice

104. Given the poor quality of the original LSA report, Mr L was right that the supervisory processes had not been followed properly and that where they had been followed, they had not worked. Ultimately, the supervisory investigation did not establish where the midwifery care went wrong and, consequently, what was required in order to ensure that similar failings will not be repeated. I can understand why that was the source of profound distress for Mr L. This is an injustice to him, which arose in consequence of the maladministration I have identified.

105. In addition, I have found that following Mr L's complaint to the SHA, its initial review did not identify any of the failings we have identified. This is because it

specifically excluded a consideration of the midwifery care, which would have been essential to address Mr L's concerns. Whilst much of what the SHA subsequently did revealed the deficiencies in the supervisory investigation and the original LSA report, it took several complaints and over 18 months for Mr L's concerns to be appropriately addressed. That exacerbated the considerable distress already caused to him and his family. This is also an injustice to him that arose in consequence of the maladministration I have identified.

106. Mr L was deeply distressed by the thought that Baby L might have received better care if the LSA had carried out better and more timely investigations into two earlier complaints about midwives at the Hospital. The midwives primarily responsible for Baby L's care were not the same midwives involved in the other two cases. Even if they had been, the focus of the midwifery practice issues in the other two cases was around intrapartum care and, specifically, fetal heart monitoring. In Mr L's case, the midwifery issues arose following Baby L's birth and related to understanding and acting on signs of neonatal sepsis. Mr L has told us that previous cases highlighted a dysfunctional relationship between midwives and doctors, which he believes could have been highlighted by appropriate LSA investigations into those cases. He said that, if that had happened, it was possible that midwives might been more proactive in contacting a paediatrician after Baby L's birth.

107. I can understand why this possibility remains a cause for deep concern for Mr L. I can neither rule in or out the possibility that learning from thorough investigation of the earlier cases could have improved the care Baby L received. In reaching that decision I am mindful that the presenting clinical issues in Baby L's case were different from those identified in the other two cases. I am also mindful that LSA investigations focus on midwifery care. A potential weakness of this approach is that dysfunctional relationships across clinical disciplines might not be considered as part of such investigations. Even if dysfunctional relationships had been highlighted by earlier investigations, given the difference in the presenting clinical issues, I cannot say the learning would probably have improved the care Baby L received. On balance, I cannot say that more thorough LSA investigations in the earlier cases would more likely than not have made a difference to Baby L's care.

Recommendations

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

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

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

    The two principles are:

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

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

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

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

Annex A: Findings – Mr M's complaint about the LSA

We investigated whether the SHA adequately carried out its function as the LSA for midwives in relation to open and effective supervisory investigations of midwives following Mrs M's and Baby M's death in 2008.

Mrs M attended Furness General Hospital in late July 2008, for the birth of her son. Sadly, there were problems during her labour and Mrs M died after the birth of her son on 31 July 2008, despite attempts to resuscitate her. Her son, Baby M, died the next day as a consequence of being deprived of oxygen during the birthing process, which led to brain damage and ultimately his death.

Midwife A and another midwife reviewed the midwifery records and decided that there were no midwifery concerns that would warrant a supervisory investigation.

We found that Midwife A should have identified a number of failings in the midwifery care provided for Mrs M, including monitoring of the baby's heart at the intervals required for a high-risk mother (or even a low-risk mother), and using continuous fetal heart monitoring. We were advised that if these concerns had been identified, they would have warranted a supervisory investigation in order to ensure that the relevant midwife had the knowledge and skills to be a competent practitioner. We therefore concluded that this decision amounted to maladministration.

Annex B: Findings – Ms Q's complaint about the LSA

We investigated whether the SHA adequately carried out its function as the LSA for midwives in relation to open and effective supervisory investigations for midwives following Baby Q's death in 2008.

Ms Q attended Furness General Hospital in early September 2008 and had her labour induced. There were complications during labour and sadly Baby Q was stillborn. A paediatrician who was involved in attempts to resuscitate him reported his death to the coroner. Following a post mortem, the cause of death was established as lack of oxygen to the baby during birth.

Midwife B carried out a supervisory investigation into the midwifery care provided by two midwives. The reports concluded that both midwives required further training on monitoring of a baby during birth.

We found that Midwife B did not identify all the failings in midwifery care provided for Ms Q, and she did not thoroughly establish why certain actions were not carried out, for example, why the midwife had not started electronic monitoring of the baby's heart when Baby Q's heart was found to be beating faster than normal. We also found that Midwife B did not explore in enough detail an earlier failure by one of the midwives to start electronic fetal heart monitoring. We found that the LSAMO had an opportunity to explore some of the issues that had arisen from the supervisory investigations (including the failure to start electronic monitoring of the baby's heart), and raised a query about whether midwives were comfortable in contacting consultants, but did not follow this up. Overall, we concluded that the LSA did not adequately carry out its function as the LSA for midwives following Baby Q's death on 6 September 2008, and this amounted to maladministration.

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