Parliamentary
and Health Service
Ombudsman

Four investigation reports concerning the University Hospitals of Morecambe Bay NHS Foundation Trust

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Foreword

The investigations in this report follow the avoidable death of a baby. Our investigations are about a father's attempts to find out what happened and his desire to improve patient safety, to prevent the same thing happening to others.

The Trust could only achieve these things if they answered the family's questions openly and honestly and learnt from what they found.

We have concluded that the Trust did not do this. This is particularly unacceptable when an avoidable death was the cause of the complaints. The fact that the early records were missing compounded the problem.

The care and treatment provided to the baby was the subject of an inquest in 2011 and at the inquest, the events that had taken place became clear. Our investigations were not into the care of the baby, but were about the handling of complaints following this avoidable death.

This report includes the results of our investigations of four complaints from the baby's Father, and one from the baby's Grandfather. All five complaints are about the University Hospitals of Morecambe Bay NHS Foundation Trust and relate to the way in which the Trust handled the family's complaints. The complaints we investigated focused on inappropriate email exchanges, the investigations the Trust carried out into the death of the baby and an allegation of collusion amongst midwives about the fluctuation of the baby's temperature in preparation for the inquest.

We are publishing these reports because we believe there is wider learning for NHS providers.

We have upheld three of the four complaints made to us by the baby's Father. We have not upheld the complaint made to us by the baby's Grandfather.

We also investigated and upheld a complaint from the baby's Father about North West Strategic Health Authority. This concerned how they investigated events at the Trust. We published this report in December 2013 along with our report *Midwifery supervision and regulation: recommendations for change*.

Our view

Looking at all of the complaints together, they demonstrate that a lack of openness by the Trust and the quality of their investigations of these complaints caused a loss of trust and further pain for the family.

Our report *Designing Good Together*, published in 2013, was the result of research with patients, complaint handlers and clinicians and set out what needs to change in hospital complaint handling. In the report, we highlighted the need to overcome the defensive response of hospitals to complaints. This is essential if:

- Patients and their families are to feel confident their concerns and complaints are properly addressed;
- Hospitals are to learn from complaints and improve services for all; and
- Public trust and confidence in a hospital is to be restored.

The relationship between this family and the Trust is a further sad example of the need for this cultural change.

Recommendations for change

Our view is that these investigations reinforce the conclusions that we and others have made about the NHS complaints system. Change is needed in hospitals, in the way investigations are conducted and in the wider health and social care complaints system. At the Parliamentary and Health Service Ombudsman, we are changing our approach too.

Change for hospitals

Cultural change is needed from the ward to the board. Openness and learning must be strongly led and must start with definitive action by hospital boards. Hospital boards should:

- Establish expectations of openness and honesty, seeking feedback in order to learn and improve. They should reward staff who seek and respond well to concerns and complaints, including acknowledging mistakes. This will foster a new culture of remedy and learning.
- Use the ability within the complaints regulations to commission independent investigations if:
  - *'a complaint amounts to an allegation of a serious untoward incident;*
  - *the subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;*
  - *a complaint raises substantive issues of professional misconduct or the performance of senior managers;*
  - *a complaint involves issues about the nature and extent of the services commissioned.'*

This was recommended by the *Mid Staffordshire NHS Trust Public Inquiry*[1] and the government's response *Hard Truths*[2] and echoed by the recent *Review of the Handling of Complaints in NHS Hospitals – Putting Patients Back in the Picture*.[3]

- *Use board scrutiny of insight from complaints to drive a learning culture and ensure action is taken to learn and improve services for all.*
- *Be accountable to commissioners and the wider public for complaint resolution, learning and improvement through regular communication of outcomes and learning.*

Change for investigations

Looking at the root cause of the problem that leads to a complaint and the interactions between people involved are critical tools in helping to learn from complaints. The science of Human Factors seeks to understand the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour. We will expect these tools to be used in future independent investigations.

Organisations commissioning independent investigations should:

- Use Human Factors and Root Cause Analysis to get to the root cause of service failure.

At the Parliamentary and Health Service Ombudsman we have signed up to the National Quality Board's *Human Factors in Healthcare* Concordat. This commits us and others to communicate with commissioners and providers to increase their awareness and understanding of the concept of Human Factors, highlighting how the approach can be used to drive improvement in quality and safety.

This means that we will:

- Develop our expertise to use Human Factors science and Root Cause Analysis to learn from complaints and to understand better why mistakes happen, in order to facilitate learning.
- Encourage the widespread use of these tools in investigations following potentially preventable deaths and other serious incidents.

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1 The Mid Staffordshire NHS Foundation Trust Public Inquiry www.midstaffspublicinquiry.com/report

2 Hard Truths: the journey to putting patients first. Volume one of the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

3 A review of the NHS hospital complaints system. Putting patients back in the picture. Final report. www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

The NHS and other providers should:

- Support the development of curricula, training frameworks and continuing professional development that ensure that the current and future workforce has the right skills, values and behaviours in relation to Human Factors principles and practices.

Changes in the wider NHS and social care

Change is already planned in the way health and social care complaints are dealt with following *Hard Truths*, the Government's response to the Francis report.

The Parliamentary and Health Service Ombudsman is working with the Department of Health, NHS England and other relevant organisations to help them improve complaint handling. This includes working with Healthwatch England to develop a vision and expectations for complaint handling across the NHS and social care. This work will only have an impact, however, if health and social care commissioners, providers, regulators and users align themselves with the new approach.

Changes for the Parliamentary and Health Service Ombudsman

We have learnt from our own handling of the Father's complaints to us along with feedback from other complainants following the potentially preventable death of a family member.

In 2010 my predecessor declined to investigate the Father's first complaint. In the light of new evidence from the coroner's inquest, we later accepted for investigation the elements of this original complaint that were still outstanding. The result is included in this set of reports. Although the decision made at the time was lawful, with the benefit of feedback from the complainant and others, it is not a decision that we would make today. We recognise that had we investigated, this family might have had answers to some of their questions regarding what happened to their baby sooner than they did. We are sorry for the impact that has had on the Father and his family.

In December 2013 we published the final result of another investigation into a complaint by this family, alongside our report *Midwifery supervision and regulation: recommendations for change*. We have acknowledged that our initial 2011 decision on this complaint was flawed and have apologised that it took so long for the family to get the answers they sought.

Feedback from complainants has had profound impact on our service. As a result of this feedback, we commissioned a review by Baroness Rennie Fritchie of our approach to complaints about deaths that potentially could have been avoided. We accepted all of her recommendations and since February 2013 we have begun our consideration of any complaint about the death of a loved one that could potentially have been avoided with the presumption that it will be investigated.

We have further changed our approach so that we can give more people our service. Investigating more complaints also means we share more learning and insight with service providers to enable them to learn and improve.

We are now seeing the impact of this change. We are investigating more cases than ever before and have stated our ambition to investigate around 4,000 cases a year, with a view to resolving more in the longer term.

As the final stage for complaints about NHS services in England, we continually challenge ourselves to learn and improve in the same way that we challenge others involved in the complaints system. Our vision is for complaints to make a difference and to help improve public services for everyone.

Dame Julie Mellor, DBE
Health Service Ombudsman

February 2014

Complaint about the investigation of complaints

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The complaint

1. We have investigated Mr D's complaint that University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust) failed to investigate adequately the events surrounding his son G's death.

2. Mr D complained about the first external report that the Trust commissioned in December 2008. He complained that the report was said to be '*external*' but that in fact one of the authors of the report was '*a friend*' of the chief executive of the Trust at the time. He also complained that the report was littered with typographical and presentation errors and left many of his questions unanswered. Further, Mr D complained that he was repeatedly told by the Trust that there were no discrepancies between the statements from staff and his and his wife's recollection of G's condition at birth, and the care provided for him. He complained that in fact, when he eventually obtained the statements, he saw significant differences. Mr D said that, in addition, he had seen evidence which suggested that further, more comprehensive, statements were prepared in order for staff to '*cover up the negligence that led to* [G's] *death*' and that these were subsequently destroyed before the inquest.

3. Mr D said that all these actions compounded his distress, and this was exacerbated by the fact that the second external report commissioned by the Trust[1] was not shared with the Care Quality Commission[2] (CQC) or Monitor.[3]

4. Mr D believes that the Trust have failed to learn lessons which would ensure that these failings do not occur again. He said he would like our investigation to establish any failings in the way the Trust investigated his complaint about the death of his son and ensure that any systemic failings we identify in the Trust's complaint handling are put right so that they are not repeated.

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1 Later referred to as the Fielding report.

2 The CQC is the independent regulator of all health and social services in England.

3 Monitor has an ongoing role in assessing NHS trusts for foundation trust status and for ensuring that foundation trusts are well led, in terms of both quality and finances.

The decision

5. I have found maladministration in the way in which the Trust investigated the events surrounding G's death. The statements taken as part of the root cause analysis process were not detailed enough. Those statements were not challenged and staff were not re-interviewed by the external reviewers when they were made aware of the differences between these statements and Mr and Mrs D's recollections of G's birth and postnatal care. In addition, I have found that the Trust inappropriately refused to disclose statements which had been provided by staff, even though the Trust knew that these were subject to the provisions on disclosure in the *Data Protection Act 1998* (the Act).

6. I have also found that an injustice to Mr D arose in consequence of this maladministration. I therefore uphold Mr D's complaint about the Trust. I have made recommendations and I am satisfied that, once complied with, these recommendations will provide a suitable response to what has happened. I explain why in this report.

Our role and approach to considering complaints

7. Our role[4] is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.

Powers to obtain information

8. The law allows us to ask anyone to give us information or documents needed for our investigation. They must provide that information.

How we decided whether to uphold this complaint

9. When considering a complaint we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.

10. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure. We then consider 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 action. Our recommendations might include asking the organisation to apologise or to

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

pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.

The relevant standards in this case

Our Principles

11. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[5] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

12. Three of the Principles of Good Complaint Handling particularly relevant to this complaint are:

    - '*Being open and accountable*' – which includes providing honest, evidence-based explanations and giving reasons for decisions;
    - '*Acting fairly and proportionately*' – which includes investigating complaints thoroughly and fairly to establish the facts of the case; and
    - '*Putting things right*' – which includes acknowledging mistakes and apologising where appropriate.

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

5 You can find more detail about our Principles at: www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

The specific standards

14. Section 7 of the Act sets out an individual's right of access to personal data. The Information Commissioner's Office has produced guidance on how this provision of the Act should apply. It states that:

    'If a request does not mention the Act specifically or even say that it is a subject access request, it is nevertheless valid and should be treated as such if it is clear that the individual is asking for their own personal data.'

15. It also says that '*a request is valid even if the individual has not sent it directly to the person who normally deals with such requests*'.

16. The guidance says that a request made under the Act should be responded to within 40 calendar days. This is also set out in section 7(8) of the Act.

The investigation

17. We confirmed the scope of our investigation with Mr D and the Trust on 15 March 2013 and in that same letter, explained how we would investigate the complaint.

18. During this investigation, we have considered relevant documents about Mr D's complaint, including documents relating to the attempts to resolve the complaint at a local level.

19. I have not included in this report everything we looked at during the investigation, but I have included everything important to the complaint and to my findings.

Background

20. The events complained about relate to Mrs D's second pregnancy and the birth of her son G. She did not have any complications during her first pregnancy and gave birth to a healthy baby girl.

21. Mrs D's waters broke on 25 October 2008 and she and her husband went to Furness General Hospital (the Hospital) that evening at approximately 10.50pm. Mr D has told us that in the week before G's birth, he and his wife had felt unwell. He said that they had both experienced headaches and sore throats, and that they explained this to the midwives at the Hospital. These discussions are not documented in Mrs D's notes made by the Trust.

22. On 25 October two sets of observations were carried out on Mrs D, which included measuring her blood pressure, pulse and temperature, and palpating her uterus in order to feel the position of the baby inside. She was told to return the following morning. When she returned on the morning of 26 October, it was documented in Mrs D's notes that she was not yet experiencing contractions, and that she had a mild headache, possibly because she had not slept well the night before. Mrs D was again advised to return the following day.

23. Very early on the morning of 27 October Mrs D began to have contractions and she returned to the Hospital. G was born shortly afterwards, at approximately 7.38am. The notes describe his birth as a '*normal delivery*' and they say that he '*cried immediately*' and was given an APGAR score of nine,[6] although when this was repeated five minutes later, his score was reduced to eight. This was because G's breathing was '*shallow*' and he was therefore taken to the resuscitaire.[7] His score after a further five minutes had increased to ten.

24. Mr D recalls G's birth differently. He says that when he was born, G seemed to struggle with his breathing, and he appeared blue and did not cry. He said that he was taken to one side by one of the midwives, who rubbed his chest. When that did not help him improve, the midwife gave him some oxygen. Mr D said that it was only after this that G improved quickly, and he cried and became pink.

25. The first 25 hours of G's life are poorly documented, because the chart that detailed his observations in those hours went missing around the time G was transferred to St Mary's Hospital (part of Central Manchester University NHS Foundation Trust). What is documented is that at approximately 8.30am on 27 October, Mr D approached staff and said that Mrs D had been feeling unwell, and felt cold and shivery. When her temperature was taken, it was 38.2°C,[8] and intravenous antibiotics and paracetamol were started shortly afterwards.

26. Mr D has told us that he became concerned about G because his wife was unwell. He said that both he and Mrs D were told not to worry by Trust staff as G '*looked fine*', that the paediatrician was

6 An APGAR score assesses the health of a newborn 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.

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

8 Normal body temperature in an adult may vary, but is usually between 36.5°C and 37.4°C.

'too busy' to see him but that G was being monitored closely. Mr D said that G was mucousy, breathing quickly and wheezing. He said that none of the midwives seemed aware that Mrs D was being given antibiotics, and each time he felt he had to explain the situation to them. Mr D said that he asked whether antibiotics were needed for G, but this was dismissed because his temperature was low. He said that he was repeatedly reassured that if G had been suffering from an infection, his temperature would have been high.

27. Without the observation chart, we do not know exactly when G's temperature was taken or what the readings were. However, Mrs D recalls knocking over the observation chart at some point, and seeing entries that reflected that his temperature was 35.8°C and 36.1°C. What we know from the records is that G's temperature fluctuated to the extent that the midwives felt it necessary to transfer him to a heated cot at least twice. The last time was shortly before he collapsed.

28. At around 8.30am on 28 October Mrs D became very concerned about G'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. On 5 November 2008 G sadly died from pneumococcal septicaemia.[9]

Root cause analysis

29. A root cause analysis[10] of the care provided for G was undertaken between November 2008 and January 2009. This analysis included statements taken from staff.

30. The statements from staff set out some of the detail of G's birth and subsequent condition. The midwife involved in G's birth recalled that he *'cried immediately'* and that he was given an APGAR score of nine, with a point having been deducted because he had *'blue extremities'*. The midwife said his APGAR score was eight after five minutes because his respirations were *'shallow'* and *'irregular'* and his *'muscle tone was not as good as when he was first born'*. She said that for this reason she took him to the resuscitaire, inviting Mr D to come with her, and gave G oxygen. At this point he cried immediately, went pink and was then given an APGAR score of ten.

31. One of the midwives caring for Mrs D said that, soon after Mrs D felt ill following G's birth, she had called the on-call paediatrician and told him about Mrs D's history of prolonged rupture of membranes (waters breaking) and raised temperature after G's delivery, and that she had felt unwell. The midwife said that the paediatrician told her that he was happy for midwives to observe the baby, and nothing else was ordered. The sister in charge remembered this call slightly differently, and said that *'in view of the sudden onset post delivery of maternal pyrexia*[11] [the midwife] *asked if*

9 Blood poisoning as a result of an infection caused by a bacterium called *Streptococcus pneumoniae*.

10 A root cause analysis is a well-recognised method of problem solving. It is designed to identify the causes of a patient safety incident in order to help ensure that such incidents are not repeated.

11 This is a body temperature that is higher than 37.5°C.

we should get the baby reviewed by the paediatrician, I agreed'. She said that the midwife then called the paediatrician and G was placed on four-hourly observations. The midwife who saw G after he had collapsed on the morning of 28 October said that in fact, his observation chart was '*three hourly*' (in other words, observations were to be done every three hours). The paediatrician who examined G following his collapse said in his statement that the midwife had explained to G's parents that '[G's] *circumstances had been explained* [to the paediatricians] *and advice was given to monitor every hour*'.

32. In relation to G's condition after his birth, one of the midwives recalled his temperature being '*low*' and that she put him in a cot warmer on the evening of 27 October. She thought that his low temperature was as a result of the room being cold. Another midwife recalled that, on the morning of 28 October, G's observations were all '*within normal limits*', but his temperature had dropped by 0.2 or 0.3 degrees. She said that she placed him in a cot warmer again, because she also felt the room was cold. She said she explained to Mrs D that if G did not maintain his temperature, he would need to be seen by a paediatrician.

33. The root cause analysis report broadly concluded that:

    - '*a review of the baby would have been more prudent than telephone advice*';
    - maternal fever should have been viewed as a risk to G and the fact that it was not was a missed opportunity to identify his illness;
    - the fact that G required three-hourly observations and was not maintaining his temperature should have prompted a paediatric review;
    - it had not been possible to find the observation chart, which had gone missing; and
    - '*the high activity and shift changes at critical points may have contributed to the lack of a considered assessment of this case*' in relation to whether staffing levels were adequate at the time.

The Trust's actions following Mr D's complaint

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

35. In order to respond to Mr D's complaint, the Trust commissioned an external review of the care provided for G. 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).

36. The authors of the report met Mr D and his family in December 2008. During this meeting Mr D said that he wanted '*an acknowledgement that* [G's] *temperature had been low and recognition that he an*d [Mrs D] *had expressed their concern about this*'. The reviewers said that this had been acknowledged by the Trust and that it was '*validated by comments made in staff statements*'. Mr D also described G's condition at birth (namely, that he did not cry, was limp and looked blue) and the fact that he constantly failed to maintain his temperature. Mrs D explained that she recalled knocking over the observation chart and seeing two entries that reflected G's temperatures of 35.8°C and 36.1°C, and

that this was the reason that they were both so concerned about the missing observation chart. The reviewers said that they accepted Mr and Mrs D's version of the care provided for G, and his condition.

37. The external report was produced in February 2009. The report was based on the recollection of the family, Mrs D's and G's records (insofar as these were available), the root cause analysis carried out by the Trust and the staff statements. The authors of the report did not interview or re-interview any of the staff involved in Mrs D's or G's care.

38. The report said that, following the spontaneous rupture of her membranes, Mrs D was managed in line with recognised accepted practice. However, swabs to check for infection were not taken from G. This was contrary to Trust guidelines, which 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 that a standard baby check had been carried out by a midwife when G was born.[12]

39. The report said that there was no evidence of a holistic overview of care, which would have included consideration of the potential consequences for G of the maternal infection. The report also said that there was no evidence of a handover of care for Mrs D and G 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. The report also identified that there appeared to be a lack of staff awareness that persistent hypothermia[13] in a neonate can be a sign of sepsis[14] and that Trust staff had failed to recognise the relevance of neonatal hypothermia and the need to refer G for a medical assessment. The report concluded that if antibiotics had been given to G earlier, he might have survived. The report also said that record keeping following G's birth was of an exceptionally poor standard.

40. The report set out seven key recommendations, which were then incorporated into a 17-point action plan. To improve services the Trust should:

    1) review and clarify their policies for the management of pre-labour rupture of membranes;

    2) review the management of premature newborn infants with prolonged spontaneous rupture of membranes and potential sepsis;

    3) produce a written policy with regard to the calculation of gestation from ultrasound scans, based on current guidance;

    4) review and enhance their policies for the monitoring and care of neonates, including clear indications for medical review by a neonatal paediatrician and identification of trigger factors;

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12 A later investigation by the Local Supervisory Authority took issue with this finding, and said that an electronic audit demonstrated that the initial baby check had been carried out, including weight, size and so on.

13 Mild hypothermia in newborns is defined as a core body temperature of 36°C to 36.4°C, moderate hypothermia as 35.9°C to 32°C and severe hypothermia as less than 32°C [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.

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

5) provide training to staff in relation to neonatal care and observations, and in identifying signs of sepsis;

6) provide information to staff on the management of neonates not maintaining their temperature;

7) improve the standard of record keeping by midwives for neonates;

8) be clear who the named carer is at all times, and ensure that effective handover of care is carried out, with better documentation;

9) the temperature in the rooms in which neonates are nursed should be monitored on a continuous basis;

10) review midwifery staffing in relation to caseload to ensure appropriate staffing levels;

11) seek external advice about ethnic minority women[15] and any possible increase in neonatal infection risks;

12) review the response of paediatricians to midwife referrals to ensure this is appropriate and timely;

13) share with staff the policies and guidelines for obstetrics and maternity services and paediatrics;

14) speak to the paediatrician who failed to respond to midwives' bleep calls on 27 October 2008;

15) ensure that there are regular perinatal meetings at the Hospital;

16) arrange a debrief about what happened to G with relevant staff; and

17) review all critical infrastructure risk for a six-month period in the maternity unit at the Hospital from September 2008 to March 2009, and report on common themes and actions.

41. The report was shared with Mr D and his family during a meeting at the Hospital on 9 February 2009. Four days later, Mr D gave the Trust his preliminary written comments on the report.

42. Mr D said that the report was of poor quality because it had numerous typographical and grammatical errors, and sentences that appeared to be cut short. He asked the Trust whether the report they had provided was the full report, and the only one available, or whether there was a more comprehensive version that had not been shared with him and his wife. He also asked whether the consultant paediatrician (one of the three external reviewers) had provided a fuller and more detailed contribution. On 20 February 2009 Mr D wrote to his MP setting out some of the concerns that the Trust's external report had identified. (These are detailed below.)

43. In March 2009 Mr D met the chief executive of the Trust. They agreed that the Trust would write to Mr D and '*concentrate on answering the outstanding issues that* [were] *clearly outlined*' in Mr D's letter to his MP.

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

15 Mrs D is of Vietnamese origin.

The Trust then proceeded to address the concerns that Mr D had raised with his MP:

- swabs were not taken from G – the Trust said that when Mrs D became ill, this should have triggered a review of G's condition, including taking a swab from him. They said that they would carry out a review of the policy for pre-labour rupture of membranes. They said that this would include a review of when active management following pre-labour rupture of membranes should begin;
- no standard baby check was carried out on G – the Trust said that there was no record in the notes that the initial baby check was carried out. However, they said that G's APGAR scores were recorded and a midwife confirmed that a check was carried out before G was transferred to the maternity ward. The Trust acknowledged that this issue was part of the unacceptable standard of record keeping;
- no holistic overview of care and monitoring of G – the Trust said that they would be reviewing the policies that supported the safe care of neonates, including reviewing the trigger points for infection. They said that the maternity risk management group, together with the clinical leads for obstetrics, paediatrics and midwifery, were ensuring that these policies were being adhered to;
- no examination by a paediatrician – one midwife said that she had contacted the paediatrician on call, who gave an instruction to observe G. However, there were two paediatricians on call, neither of whom had any recollection of that conversation, and they were due to be formally interviewed. The Trust also confirmed that G's estimated likelihood of survival, if antibiotics had been started at the same time as Mrs D's were, would have been around 90%;
- no handover of care to the postnatal ward;
- workload pressures contributed to the inadequate care provided – the Trust explained that they had a policy in place to deal with fluctuating workloads, and this included a '*floating*' midwife who was allocated to any area where the workload was high, as it was when Mrs D became ill. The Trust acknowledged that there was no handover of G's care from the labour ward to the postnatal ward and said that this was unacceptable. However, they said that while the external report did make a reference to '*workload pressures*' potentially having an impact on G's care, they did not accept that staffing levels at the time failed to meet the minimum safe staffing levels. Nonetheless, the Trust said that they would be reviewing staffing levels and that written care plans would be changed to ensure that appropriate handovers took place and were documented;
- ignorance of staff of the relevance of hypothermia – the midwives should have recognised that a low temperature, or a failure to maintain a temperature, was a sign of infection. They said that this was a clear failing by management and that further training about the recognition of neonatal sepsis and neonatal care had been arranged; and
- inadequate record keeping – the standard of record keeping was below an acceptable standard. They said that the clinical audit department would be auditing record keeping and

any shortcomings identified would be dealt with appropriately. They raised particular concerns about two midwives, but said both had been referred for midwifery supervision.

45. The Trust acknowledged the external report's concerns about the appropriateness of the management systems that supported the delivery of midwifery care at the Hospital and said that an external management consultant would review the overall management of the maternity services.

46. Following this response, there were several further exchanges between Mr D and the Trust, and on 9 April 2009 Mr D asked to see the statements provided by staff under the *Freedom of Information Act 2000* (the FOI Act). The Trust refused to allow this. On 14 April 2009 the Trust sought advice from their legal department which said that, while the FOI Act did not apply to this request, the *Data Protection Act 1998* (the Act) would and, in particular, that '*given that the investigation for which the statements were obtained is now complete and* [Mr D] *has a copy of the report, there are no grounds to withhold the substance of the statements under this Act*'. The advice also said that '*refusing to disclose them immediately* [would] *only create suspicion and ill will*'. The chief executive of the Trust, however, responded by saying that he did not want to release the statements because it was not '*in the spirit*' of the way he had been trying to address Mr D's complaint.

47. The Trust eventually disclosed to Mr D the statements taken for the purposes of the root cause analysis on 15 July 2009. The Trust have told us that no further statements were taken from staff involved in Mrs D's and G's care. They said that further unsigned versions of the statements taken for the purposes of the root cause analysis were prepared for the purposes of disclosure to the NMC. These unsigned versions effectively transferred the content of the original statements on to a statement template suitable for disclosure to the NMC as part of the NMC's regulatory process.

Subsequent reports

The Local Supervisory Authority's report

48. On 22 May 2009 the Local Supervisory Authority[16] produced a report about the midwifery care provided for Mrs D and G. It concluded that midwives had missed potential opportunities for intervention, although they said that the changes in G's condition were subtle, in particular, that his temperature fluctuated within normal limits. The Local Supervisory Authority said that it was impossible to say whether these interventions would have altered the outcome. (This is in contrast to the Trust's assessment that G would have had a 90% chance of survival, had he received antibiotics earlier.) The Local Supervisory Authority agreed that there were concerns about the standard of record keeping at the Trust. However, they concluded that, whilst the care given to Mrs D and G was not recorded to a satisfactory standard, the care itself was of a satisfactory standard. They made recommendations (about retraining) for four of the midwives involved in G's care and they said that staffing levels at the maternity unit were appropriate.

16 The Local Supervisory Authority is a statutory function designed to regulate the individual practice of midwives. At the time of the events in question, this function was discharged by the relevant strategic health authority (SHA), in this case NHS North West.

49. Following a separate complaint that Mr D made about this report, one of the midwives was interviewed again and accepted that Mrs D's recollections of G's temperatures were probably accurate.

Implementation of the action plan

50. In June 2009 the Trust, in co-operation with NHS Audit North West,[17] reviewed their progress against the 17-point action plan. The report concluded that progress had been made on each of the action points, but acknowledged that some actions needed further work.

The Fielding report

51. In March 2010 another external report was commissioned by the Trust (the Fielding report). This report referred to Mr D's case (and other incidents). It was a much broader review of the Trust's maternity services, both at the Hospital and at other locations managed by the Trust. The report concluded that the Trust had made considerable progress in addressing the issues that had been identified as a result of what the report called a '*cluster of incidents*' (which included the management of G). However, it highlighted a number of issues that had not been addressed, and it made recommendations for further action. The following recommendations were particularly relevant to this complaint:

    a) all clinical practice issues highlighted as a result of previous investigations should continue to be part of an ongoing audit programme;

    b) management and supervisors of midwives must agree criteria for dealing with staff after incidents;

    c) consideration should be given to ensuring that an appropriate paediatrician in each of the two specialist units managed by the Trust should have dedicated sessions for the neonatal units;

    d) the Trust should consider how to co-ordinate and formalise systems for measuring the quality of patient experience in maternity services;

    e) multidisciplinary ward rounds should be introduced as a matter of priority on labour wards, to provide the opportunity for discussion about what has happened overnight, what activity is expected during the day, whether the right staff are available and what can be done if they are not; and

    f) training opportunities for midwives should be reviewed with a view to ensuring appropriate professional development.

    This report was not disclosed to Monitor in 2010 when the Trust was granted foundation trust status, and was not made public until 2011.

52. In 2011 NHS Audit North West was commissioned by the Trust to '*undertake a review of its response to* [the Fielding report] *and to provide a position statement as to the extent to which actions undertaken can be evidenced*'. The objective of the audit was to '*test the strength of the Trust's evidence of compliance with the recommendations of the Fielding report as at May 2011 and to provide an assurance level at that point in time*'.

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17 NHS Audit North West is a specialist NHS assurance provider that provides auditing and anti-fraud services to a variety of NHS organisations.

53. This report concluded that the Trust had '*produced sufficient evidence to fully or substantially support implementation of a majority of the thirty-six recommendations in the Fielding report*', although work was in progress in some instances. In terms of the recommendations set out at paragraph 51 of this report, four were judged to be '*complete*' (a, b, d and f) while two were either ongoing or partially complete (c and e).

Findings

54. In determining whether the Trust adequately investigated the events surrounding G's death, I refer to the Ombudsman's Principles (paragraphs 9 and 10). In order to 'act fairly and proportionately', the Trust should have investigated the events surrounding G's death thoroughly and fairly to establish the facts. This should have included reviewing G and Mrs D's records, identifying the care that should have been provided for them, and establishing whether this care was actually given. In the absence of records, the investigation should have included detailed statements from members of staff involved in providing care, ensuring that any gaps in the records were appropriately addressed. When responding to Mr D's complaint, the Trust should have been 'open and accountable' by providing clear, evidence-based explanations and reasons for their decisions. They should also have apologised for any failings in care, and set out the actions they intended to take to ensure that any failings identified would not happen again.

The root cause analysis

55. The Trust carried out a root cause analysis between November 2008 and January 2009, which included interviewing members of staff and taking statements from them. Most of the statements were taken during the first week of December 2008. The statements were important in establishing a chronology of the care provided for G, because crucial records, including a chart detailing regular observations by midwives, were missing.

56. The maternity risk manager who collated the statements for the purposes of the root cause analysis should have ensured

that the statements were comprehensive, detailed and consistent. In fact, some of the most important statements lacked detail. For example, one of the statements recalled G's temperatures being '*low*' but no further information was provided, or apparently asked for, as to what '*low*' meant in this context. Another statement said that, if after G had been moved again to a warming cot, he still could not maintain his temperature, a paediatrician would need to review him. There was no explanation for why this midwife did not feel an immediate review was necessary, given that observations had already shown that G was not maintaining his temperature.

57. In addition, not only did the maternity risk manager not challenge the statements when they were vague, she also did not challenge them when they were inconsistent. For example, some of the midwives recalled the observations were being done every three or four hours, while the consultant paediatrician who treated G after he was found collapsed, recalled in his statement that the midwife had explained to G's parents that '[G's] *circumstances had been explained and advice was given to monitor every hour*'. Given that there was no record of a conversation between the midwife and the paediatrician, this was an inconsistency that needed to be resolved.

58. What the root cause analysis did, however, was identify what went wrong during G's care and particularly that '[G's] *inability to maintain his temperature had not been recognised as a potential sign of sepsis*'. In addition, the root cause analysis concluded that there should have been '*a review of the baby*' by a paediatrician, rather than just a telephone conversation, when Mrs D was found to be very ill immediately after G's birth. It also identified '*many missed opportunities for intervention*', including the initial missed paediatric review, and a further missed review when G was transferred to a warming cot for a second time because he was not maintaining his temperature. These were appropriate conclusions about the failings in care and treatment of G.

59. However, the conclusion that, despite these '*missed opportunities*', it was '*impossible*' to say whether those interventions would have altered the outcome, is not supported by a logical assessment in the root cause analysis report. As later confirmed by the Trust, G would have had an excellent chance of survival if opportunities to treat and diagnose his infection had not been missed.

The external report commissioned by the Trust

60. Following the root cause analysis, the Trust commissioned an external review. The external reviewers met Mr D and his family on 31 December 2008, when the family's recollections of G's birth and postnatal care were discussed.

61. In many important respects, their recollections differed from the statements provided by the midwives, and this should have alerted the external reviewers to the potential need to re-interview some members of staff. Mr and Mrs D said that G did not cry at birth and that he '*appeared blue and limp*'. This was very different from what the midwives had said in their statements. They said G had '*cried immediately*' after being born and was given an APGAR score of nine, with a point having been deducted because of blue '*extremities*'. There were also differences in Mr and Mrs D's recollection of G's temperature fluctuations after his birth.

62. Mr D had said that he wanted '*an acknowledgment that* [G's] *temperature had been low and recognition that he and* [Mrs D] *had expressed their concern about this*'. At the meeting, they were told that this had been acknowledged by the Trust and '*validated by comments, made in staff statements*'. However, I have seen no evidence that this was the case. Only one of the midwives (of the nine who provided statements) said that G's temperature was '*low*'. A second midwife said that, following observations which were '*within normal limits*' in the early hours of 28 October 2008, a later set of observations had identified that G's temperature had dropped by 0.2 or 0.3 degrees. Mrs D recalled seeing the observation chart and that G's temperature had dropped to 35.8°C and 36.1°C, but this was not mentioned by any of the midwives. In addition, none of the midwives recalled Mr and Mrs D raising concerns about G's temperatures. It was therefore not appropriate for them to be told that their version of events was validated by staff statements, when it clearly was not.

63. The external reviewers told Mr and Mrs D that they accepted their version of events and, on that basis, re-interviewing staff may have seemed unnecessary. However, it was clearly important to try to resolve any discrepancies, particularly in the absence of clinical records. Re-interviewing the midwives would have made the midwives aware of Mr and Mrs D's version of events, and provided them with an opportunity to try to recall further information and/or to agree with the family. In fact, in June 2009, following the Local Supervisory Authority report, one of the midwives accepted Mrs D's recollection of G's temperatures. If the external reviewers had done this in December, this agreement could have been reached much sooner. The fact that the external reviewers did not re-interview any of the staff was a failing.

64. However, the report provided an evidence-based explanation of the failings in the care provided for G. It identified the fact that swabs were not taken from G, despite the Trust's guidelines being clear that this should have been done, and that there was no holistic overview of care following G's birth. It also appropriately concluded that there appeared to be a lack of staff awareness that persistent hypothermia in a neonate can be a sign of sepsis, and that this would require medical assessment. The report said that at the time, it would have been accepted practice for a paediatrician to have examined G, given his mother's history of prolonged rupture of membranes, and this did not happen. It identified that staff did not refer G for a medical assessment when they should have done, and that the record keeping was exceptionally poor. In addition, the report said that it appeared to the authors that workload pressures may have influenced the care provided. Whilst the presentation of the report is undoubtedly careless (there are numerous typographical errors and grammatical mistakes, and some incomplete sentences), it fully acknowledges and identifies the failings in G's care.

The Trust's letter to Mr D

65. Following a meeting with Mr D to discuss this report, the Trust wrote to Mr D on 25 March 2009 to respond to the concerns he had raised with his MP. This letter '*formally*' recognised that '*the care received by* [G] *was not acceptable*' and that, '*as a direct consequence, he lost his fight for life*' and apologised for this.

66. In this letter, the Trust acknowledged that swabs were not taken from G, and that at the very least this should have been done when Mrs D became ill after his birth. The Trust set out the actions they would be taking to address Mr D's concerns, for example, by reviewing the policies about pre-labour rupture of membranes, including the management of babies. They also said that both doctors on call that day would be formally interviewed by the medical director.[18] The Trust said that G's chances of survival, if he had been given antibiotics at the same time as they were given to Mrs D, would have been about 90%. They set out the further training that would be given to midwives and their plans to audit the record keeping to address the unacceptable standard of record keeping seen in Mrs D's and G's medical records. They confirmed that two of the midwives involved had been referred to the Local Supervisory Authority. The Trust, however, did not accept that there were inadequate staffing levels at the time, although they said that the head of midwifery would undertake a review of the staffing levels.

67. Finally, the Trust also said that the external report had raised concerns about the management system that supported the delivery of midwifery care. An external management consultant had therefore been asked to carry out a review of the overall management of the maternity service.

68. Each concern which Mr D had raised with his MP, and which the Trust agreed to respond to, was addressed, in addition to the failings already clearly identified in the external report, and reiterated at the start of the Trust's letter. The Trust, having acknowledged the failings, addressed Mr D's ongoing concerns as agreed.

The Trust's refusal to disclose the statements from staff

69. Whilst it is not our role to determine whether there has been a breach of the Act, the guidance provided by the Information Commissioner says that even if a request does not mention the Act, it should still be considered as such a request, if it is clear that the request is about the person's own data. In this case, the Trust realised that the request Mr D was making could come under the Act and would have to be disclosed. They should have dealt with his request promptly and within the 40 calendar day period allowed in the Act.

70. There was no reason not to disclose the statements. The Trust had, by this stage, accepted the family's account of events and all the failings in G's care. The Trust's failure to disclose the information was neither in line with the applicable guidance, nor was it 'open and accountable'.

71. In relation to these statements, Mr D has raised an additional concern in that he has told us that further, more comprehensive, statements were produced by staff, and later destroyed. I have seen no evidence that this is the case, and the Trust have told me that no further statements were prepared.

Overall conclusions

72. I have found that the initial root cause analysis identified the most important failings, and the subsequent external

18 At this formal interview, neither doctor admitted taking the call, and there was no way to actually prove which doctor had responded. Therefore, a decision was made to place warning letters on each doctor's file on the basis that one of them must have received the call.

report supported these findings and expanded on them. Mr D has complained that the report was not independent, but the report was produced by three senior professionals from different NHS organisations. Whatever their personal relationship with the chief executive of the Trust, I have seen no evidence that the report approached the events that led to G's tragic death in anything other than an unbiased and critical way. I have found that the external reviewers' decision to speak to Mr D and his family was appropriate, and the Trust's subsequent letter to Mr D responded to his concerns and explained what the Trust would do to ensure that these concerns were addressed.

73. Nonetheless, I have also found that there were serious deficiencies in this process. The statements originally taken from staff were neither detailed enough, nor challenged as part of the root cause analysis process. I have found that the external reviewers should have interviewed or re-interviewed staff when they were alerted to the significant differences between Mr and Mrs D's recollections of G's birth and postnatal care, but they did not. Whilst it might have ultimately been impossible to do, I have found that not enough was done to try to resolve these discrepancies at an early stage. I have also found that the Trust inappropriately refused to disclose the statements that had been provided by staff, even though they knew that these were subject to the provisions on disclosure in the Act.

74. Having considered all the evidence, I find that the failings I have identified were serious because the Trust had a responsibility to ensure that the circumstances of baby G's death were thoroughly investigated. The Trust had already acknowledged failures in G's care and that these failings led to his death. The original failures of care were compounded by the failure to investigate properly and to answer all of Mr D's very legitimate concerns. I therefore find that the failings I have identified amount to maladministration.

Injustice

75. Having found maladministration in the way the Trust investigated the events surrounding G's death, I now consider the impact of that maladministration on Mr D.

76. Mr D has said that these actions by the Trust compounded his distress at a very difficult time. It is clear that, right from the very start, the loss of G's observation chart was very distressing for Mr D. This was the only document that set out objectively what he saw as the clear signs that his son was ill and required care. Without it, Mr D was relying on staff to acknowledge that they had failed to provide appropriate care to G. In addition, he was relying on staff to recall, in detail, the care that they provided. It is quite clear, therefore, that any failure to ensure that these statements were detailed, comprehensive and consistent would considerably hamper the chances of establishing exactly what care was provided for G.

77. The distress Mr D had suffered was exacerbated by the external reviewers' failure to put to staff Mr and Mrs D's account of what had happened. After being told that his account was validated by staff statements, Mr D was eventually confronted with statements that provided a very different account of G's birth and subsequent care. By this stage, nine months had passed since G's time at the Hospital, and it was therefore almost impossible to address any discrepancies. I can understand that this would have been very distressing for Mr D. All of this was an injustice to him that arose from the maladministration identified in this report.

78. In the circumstances, I can understand why Mr D has lost all confidence that the Trust will learn lessons from his son's tragic death. A year after the Trust's response to his complaint, the Trust had not disclosed the contents of an external report on their maternity services to the relevant regulator or to the public. I can understand why this would have further convinced Mr D that the Trust were not committed to learning from the tragic circumstances surrounding the care provided for G while at the Hospital. The further erosion of Mr D's confidence in the Trust is another injustice flowing from the Trust's maladministration.

Recommendations

79. I have considered my findings in the light of the Ombudsman's Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

80. I recommend that the Trust should, within one month of the date of the final report:

    - provide Mr D with an acknowledgement of the failings identified in this report and an apology for the consequential injustice;

    and, within three months of the date of this final report, should prepare an action plan that:

    - describes what the Trust have done to ensure that the organisation has learnt lessons from the failings identified by this upheld complaint; and
    - details what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings.

81. A copy of the action plan should be sent to:

    - Mr D
    - us
    - the Care Quality Commission (CQC)
    - Monitor, and
    - NHS Cumbria Clinical Commissioning Group.

82. The Trust should also ensure that Mr D, the CQC, Monitor and the clinical commissioning group are updated regularly on progress against the action plan.

83. A copy of the apology letter should be sent to us.

The Trust's and Mr D's response to the draft report

84. In response to a draft of this report, the Trust acknowledged and accepted our findings and recommendations.

85. Mr D also accepted our findings and recommendations when we shared the draft report with him.

Conclusion

86. In this report, I have set out our investigation, findings and conclusions and decision with regard to the way in which the Trust investigated the events surrounding G's death. I have found maladministration and concluded that an injustice arose to Mr D in consequence of this maladministration. I therefore uphold the complaint about the Trust.

Complaint about an offensive email

Contents

Introduction

1. This is the final report of the investigation into Mr D's complaint about University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust). This report contains my findings, conclusions and recommendations.[1]

The complaint

2. Mr D has serious concerns relating to an incident that took place on 10 August 2009, in which an email, titled '*NMC shit*', was sent by a Trust midwife. The email was sent in connection to a Nursing and Midwifery Council (NMC)[2] investigation into the midwives' actions surrounding the death of Mr D's baby son, G.

3. We have investigated Mr D's complaint that the Trust failed to tell him about the exact nature of the email from the Trust on 10 August 2009, and that the Trust were not open and accountable in their response to his complaint about the email incident.

4. Mr D says that this episode has added to the distress and upset he is experiencing with regard to his concerns over the care his son received from the Trust. Mr D says that he would like the Trust to acknowledge that (a) he was not fully informed of the incident at the time and that he should have been; (b) the NMC were not made aware of the incident at the time (and the Trust should offer either an apology for this or an explanation as to why not); (c) that a Trust press statement, which implied that Mr D was made aware of the incident at the time, was misleading; and (d) this incident was not dealt with openly and honestly.

5. Mr D would like an apology from the midwives involved with the email and an assurance from the Trust that systems are now in place to deal with situations like this openly and honestly. He would also like an assurance from the Trust that they are not aware of any other similar matters which they have not informed him of.

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1 Since we issued this report, we have changed some of the wording we use. This might account for some minor differences or inconsistencies between the four reports.

2 The Nursing and Midwifery Council regulates nurses and midwives in England, Wales, Scotland, Northern Ireland and the Islands.

The decision

6. Having considered all the available evidence related to Mr D's complaint about the Trust, I have reached a decision.

7. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. The identified maladministration has caused Mr D the injustice of distress.

8. I therefore uphold Mr D's complaint about the Trust.

9. In this report I explain the detailed reasons for my decision and comment on the particular areas where Mr D has expressed concerns to the Health Service Ombudsman.

The Ombudsman's jurisdiction and role

10. By virtue of the *Health Service Commissioners Act 1993*, the Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS bodies such as trusts, family health service providers such as GPs, and independent persons (individuals or bodies) providing a service on behalf of the NHS.

11. In doing so she considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the body, a failure by the body to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the body. Service failure or maladministration may arise from action of the body itself, a person employed by or acting on behalf of the body, or a person to whom the body has delegated any functions.

12. If the Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with the Principles for Remedy, she may recommend redress to remedy any injustice she has found.

The basis for my determination of the complaint

13. In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we generally begin by comparing what actually happened with what should have happened.

14. So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

15. The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

16. Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.

17. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

18. The overall standard I have applied to this investigation is set out below.

The general standard – the Ombudsman's Principles

19. In February 2009 the Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy were republished.[3] These are broad statements of what the Ombudsman considers public bodies should do to deliver good administration and customer service, and how to respond when things go wrong. The six key Principles are:

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

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

- '*Being open and accountable*' – this includes public bodies giving people information that is clear, accurate, complete, relevant and timely.

21. The Principle of Good Complaint Handling particularly relevant to this complaint is:

- '*Being open and accountable*' – this includes public bodies being open and honest when accounting for their decisions and actions.

3 The Ombudsman's Principles is available at www.ombudsman.org.uk.

The investigation

22. We discussed with Mr D the nature of his complaint and how our investigation would proceed on 5 December 2011. We confirmed our understanding of the complaint in our letter of 21 December.

23. During this investigation, we have considered relevant documents about Mr D's complaint, including documents relating to the attempts to resolve the complaint at local level.

24. 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 omitted.

Key events

25. Midwives from the Trust were under investigation by the NMC in relation to their conduct and practice surrounding the sad death of Mr D's baby son, G, in August 2009. An email that contained the draft responses of a midwife to the NMC's questions surrounding G's death was sent from a Trust computer on 10 August 2009. It appears that the midwife asked a colleague to forward a copy of the email from the midwife's work account to the personal email address of her husband so that she could work on this at home. The colleague accessed the midwife's NHS email account but appears to have sent the email to an incorrect email address. This was identified by the midwife when she did not receive the email within two hours. A serious untoward incident report was requested and established by the Trust.

26. The Trust's medical director contacted Mr D on 13 August 2009 to confirm that an email had been sent to an incorrect address and that the email had contained personal information about the D family. Mr D followed this up with the Trust and requested a copy or summary of the email to assure him that nothing in the email would cause any undue concern to the family.

27. The medical director wrote to Mr D on 2 September 2009. He confirmed that the email related to the ongoing NMC investigation into G's care and contained the allegations made by the NMC and the midwife's draft responses. The medical director said that the document referred to the D family by name, but contained no further personal information. He confirmed that the matter had been reported to the Information Commissioner and that a serious untoward incident report was

ongoing. He said that a senior colleague had assured him that the email was a '*comprehensive, professional account of the midwife's recollection of events*' and that the Trust believed the email had been sent to a dormant account that had not been accessed by any member of the public.

28. Mr D subsequently requested a copy of the serious untoward incident report under a freedom of information request in December 2010. Mr D was sent an electronic copy of the email on 7 January 2011. It appears that he was able to remove the electronic redaction on the serious untoward incident report and found that the subject heading of the email in question was '*NMC shit*'.

Local resolution

29. Mr D subsequently notified the NMC about this incident and made a complaint to the Trust on 10 January 2011. These concerns appeared to relate to data protection issues, but he noted the concern that the email had been entitled '*NMC shit*' at this time.

30. The Trust's chief executive responded to Mr D via email on 11 January 2011. He said that he was '*personally disgusted*' and that such behaviour was not condoned. He explained that the title of the email had not been disclosed at the time as it was felt that not all the information was required to be disclosed under the *Freedom of Information Act*. The chief executive's further written response on 25 January explained the background to the freedom of information request and confirmed that the midwives had been investigated under the Trust disciplinary policy. The letter apologised for any additional distress the disclosure caused and hoped that Mr D was assured that necessary action had been taken.

31. The matter came to the attention of the media and the Trust issued a press release on 22 July 2011. The Trust commented that the chief executive had written to Mr D at the time to apologise for the distress caused to their family and that the NMC had been notified of the incident. Mr D made another freedom of information request in August. He discovered that the Trust had not originally notified the NMC of this incident and had only done so once Mr D had raised his concerns with the Trust. Mr D subsequently emailed the Trust on 23 August to ask why a referral had not been made at the time; what had led to the Trust notifying the NMC; and if this notification was purely down to Mr D becoming aware of the nature of the email's title. Mr D also raised concerns about the accuracy of the press release issued by the Trust.

32. The Trust's response was issued by their solicitors on 9 September 2011. The Trust believed that it was appropriate to deal with the email incident as an internal disciplinary matter. It was not considered to be a regulatory matter such as to lead to a notification to the NMC. The Trust said that they did not report all internal disciplinary matters to the regulatory bodies. Information was provided to the NMC, however, following Mr D's notification to the NMC in January 2011. Given this, the Trust said that the press statement was correct in saying that the NMC were notified. The Trust accepted that it was the medical director who originally wrote to Mr D, with the chief executive later apologising on 25 January 2011. The Trust reiterated their previous apologies but said that they had nothing further to add on the matter.

33. Correspondence between Mr D and the Trust continued intermittently before and after Mr D contacted the Ombudsman with his complaint on 14 September 2011.

34. In Mr D's email to the Trust on 13 October 2011, he said that it was quite clear that the Trust had no intention of informing the NMC about the email incident '*as evidenced by the fact that when I* [Mr D] *contacted them in January 2011 they knew nothing of the incident at all*'. In a further email to the Trust on 14 October, Mr D said that the Trust did not inform him about the email incident at the time and that they were fully aware that the key facts of the matter were hidden from him. He said that but for his '*accidental disclosure*' the Trust would have had no intention of informing the NMC. In their reply of 18 October, the Trust's solicitors said that the Trust had already provided an explanation as to their handling of the incident and did not want to enter into further protracted correspondence now that the matter had been referred to this Office.

Findings

35. In determining whether there has been service failure or maladministration, I refer to the Principles of Good Administration. In particular, I have assessed against the Principle of '*Being open and accountable*' – that is, public organisations giving people information that is clear, accurate, complete, relevant and timely. I have also assessed against the Principle of Good Complaint Handling, in particular, the Principle of '*Being open and accountable*' – that is, public organisations being open and honest when accounting for their decisions and actions.

36. Mr D was notified by the Trust within three days that an email containing personal information about his family had been sent to an incorrect address. In doing so, the Trust acted in an 'open and accountable' manner.

37. The Trust followed up their initial contact with a letter to Mr D on 2 September 2009. The letter was sent by the medical director. This letter said that the email in question was a '*comprehensive and professional account of the midwife's recollection of events*' concerning his son's care. This cannot be said to be true as the email was titled '*NMC shit*'. Given the email's offensive title, Mr D was misinformed by the Trust when they stated that the email was a '*professional account*'. Although we can understand the Trust's inclination to spare Mr D further anguish by not disclosing the title of the email, they were not 'open and accountable' in their response.

38. In their press release of 22 July 2011 the Trust said that the chief executive had written to Mr D around the time of the email incident to apologise. The press release also said that the NMC had been

informed about the incident. As later acknowledged by the Trust, the chief executive did not write to Mr D and apologise at the time of the incident. The chief executive did not do so until January 2011, nearly 17 months after the email had been sent and was found to have gone astray. The Trust were not 'open and accountable' in saying that the chief executive had apologised to Mr D at the time of the incident.

39. Mr D has apparently inferred from the press release that the Trust informed the NMC at the time the email incident was reported. The Trust have said their statement that the NMC had been notified was correct, coming as it did after Mr D had informed the NMC in January 2011. It is clear that the Trust and Mr D have interpreted this part of the press release in a different way. As the Trust did not explicitly say that they had notified the NMC at the time of the email incident, I am unable to say with any certainty that their actions in this regard were contrary to the Principle of '*Being open and accountable*'. The Trust, however, have not answered Mr D's question as to why they did not notify the NMC about the email incident until after Mr D had contacted the NMC. Although it was reasonable for the Trust to say that they do not routinely refer all disciplinary matters to the NMC, this does not address Mr D's concerns as to why they subsequently decided to do so. The Trust have not been 'open and accountable' in this regard.

40. When looked at in the round, the Trust have not acted in a manner that can be described as appropriately 'open and accountable'. They misinformed Mr D as to the exact nature of the email and issued a press release which incorrectly stated that the chief executive had apologised to Mr D at the time of the incident. The Trust have not addressed all of Mr D's concerns, particularly that of why they decided to refer the matter to the NMC. I find that, in view of these shortcomings, both the Trust's initial response to the email incident and the Trust's subsequent handling of Mr D's complaint fell so far below the applicable standard as to amount to maladministration.

Injustice

41. I now consider whether the maladministration I have identified led to an injustice to Mr D.

42. Mr D says that this episode has added to the distress and upset he is experiencing with regard to his concerns over the care his son received from the Trust.

43. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. I note that the Trust have apologised for the distress caused by the disclosure of the email and that they have acknowledged that aspects of their press release in July 2011 were incorrect. It remains, however, that the Trust's actions since Mr D was informed of the email's disclosure has unnecessarily, and unjustifiably, caused him further distress.

44. Even with the benefit of hindsight, all of the identified shortcomings were eminently avoidable and have served to worsen a situation caused by the inexplicable sending of an insensitively titled email. It has without question further undermined Mr D's confidence in the Trust. Indeed, Mr D remains concerned that there are other matters with the Trust concerning him and his family that he may as yet be unaware of. This is the injustice to Mr D.

Final remarks

45. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. The identified maladministration has caused Mr D the injustice of distress.

46. I therefore uphold the complaint about the Trust.

Recommendations

47. I have considered my findings in the light of the Ombudsman's Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

48. I have already asked the Trust to prepare an action plan to remedy the poor complaint handling we have identified in a number of cases involving the Trust. In addition I have recommended an individual remedy for Mr D. I therefore recommend that the Trust should:

    (a) within one month of the date of this final report, write to Mr D to acknowledge the maladministration and apologise for the injustice I have identified. A copy of their letter should be sent to the Ombudsman;

    (b) within one month of the date of this final report, respond in full to Mr D's outstanding concerns regarding the Trust's original description of the email as a professional account and their decision to report the matter to the NMC; a copy of their response should be sent to the Ombudsman.

    (c) within three months of the date of this report, offer financial redress of £1,000 to Mr D for the injustice he has suffered – the distress he endured as a result of their poor complaint handling.

49. Both Mr D and the Trust have accepted our findings and recommendations.

Conclusion

50. In this report I have set out our investigation, findings, conclusions and decision with regard to the service Mr D received from the Trust. I hope this report will provide Mr D with the outcomes he seeks and bring this unfortunate case to a close.

Complaint about inappropriate email

Contents

The complaint

1. Mr D complained about email correspondence sent between University Hospitals of Morecambe Bay NHS Foundation Trust's (the Trust) customer care manager and the Trust's head of midwifery on 10 June 2010. He complained that the content of that correspondence was offensive to him and his family, particularly his wife, who is Vietnamese. He also complained about the Trust's response to his complaint about that email correspondence. Mr D said that since his baby son's death in 2008 (which happened nine days after his birth at the Trust's Furness General Hospital) the Trust has '*viewed* [him] *as an issue – a problem they wanted to go away*'.

2. Mr D said that he and his family have been caused distress by the content of the emails, and suffered further distress and frustration because of the Trust's response to his complaint.

3. Mr D said he would like: an explanation regarding the emails and an apology from those involved; for the Trust to say whether they found the emails complained about unacceptable; a summary of the Trust's internal investigation regarding the emails; to know whether the Trust have found other offensive communications; and to know whether '*the Trust have taken any action to reduce the chance of other families being exposed to this kind of behaviour in the future*'.

The decision

4. I uphold Mr D's complaint. This is because I have found maladministration in the actions of the head of midwifery and the Trust, which resulted in an injustice to Mr D and his family. The head of midwifery's email was not respectful and, in their response to Mr D's complaint about that email correspondence, the Trust were not 'open and accountable' or 'customer focused'. I have made recommendations and I am satisfied that, once complied with, these recommendations will provide a suitable response to what has happened. I explain why in this report.

Our role and approach to considering complaints

5. Our role[1] is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.

How we decided whether to uphold this complaint

6. When considering a complaint, we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure.

7. We then consider 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 action. Our recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.

The relevant standards in this case

8. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[2] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

9. The Principles of Good Administration particularly relevant to this complaint are:

   - '*Being open and accountable*' – which includes public organisations being transparent and providing clear, accurate and complete information while respecting the privacy of personal and confidential information.
   - '*Acting fairly and proportionately*' – which includes dealing with people fairly, and with respect and courtesy.

10. The Principles of Good Complaint Handling that are particularly relevant to this complaint are:

    - '*Being open and accountable*' – which includes providing evidenced-based explanations and giving reasons for decisions.
    - '*Acting fairly and proportionately*' – which includes public organisations investigating complaints thoroughly and fairly, and acting fairly towards staff complained about, as well as towards complainants.

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

2 You can find more detail about our Principles at www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

- *'Putting things right'* – which includes acknowledging mistakes and apologising where appropriate, and providing appropriate remedies.

11. The Principle for Remedy that is particularly relevant to this complaint is:

    - *'Being customer focused'* – which includes providing remedies that take account of people's individual circumstances.

The investigation

12. We have looked at all the relevant evidence for this case, including the papers showing how the Trust handled Mr D's complaint. We also spoke to Mr D, and asked the customer care manager and the head of midwifery to explain why they wrote what they did on 10 June 2010 and what was meant. The Trust, the customer care manager and the head of midwifery have had the opportunity to comment on a draft of this report, as has Mr D, and their responses have been considered. I have not included in this report everything we looked at during the investigation, but I have included everything important to the complaint and to my findings.

Contextual information

13. In November 2008 Mr D's son, G, died nine days after his birth at the Trust's Furness General Hospital. Mr D has since pursued a complaint about his son's death and raised concerns about the Trust's maternity services.

14. In August 2009 midwives from the Trust were under investigation by the Nursing and Midwifery Council (the NMC) in relation to their conduct and practice around G's death. An email that contained one of the midwives' draft responses to the NMC's questions was sent from a Trust computer on 10 August. However, it was misdirected. Mr D was informed that an email containing personal information about the D family had been sent to the wrong email address. The Trust told Mr D that the misdirected email was a '*comprehensive, professional account of* [the midwife's] *recollection of events*'. He later discovered that this email was entitled '*NMC shit*'.

15. Mr D was concerned about this incident and the title of the email, and complained to the Trust. His subsequent complaint to us about this matter was upheld. We found that the Trust were not 'open and accountable' in either their description of the misdirected email or their response to Mr D's complaint about the incident.

Key events

16. On 10 June 2010 at 10.35am Mr D sent an email to the customer care manager explaining that he was '*becoming extremely distressed and anxious about*' the progress of his complaint about his son's death. He wrote:

    '*... I* [realise] *that I need to step back now and that I'm not going to achieve anything else from my efforts, which would be better spent on looking after the family I still have.*

    '*Please inform* [the chief executive] *that I do not want replies to any of my recent letters and that moving forward I want the inquest to take its course and the Trust to continue efforts to make sure what happened to* [G] *doesn't happen again. I cannot have done any more to raise aware*[ness] *of the deep concerns I have but it is up to the Trust and the Regulators to act on these ... .*'

17. The customer care manager emailed the head of midwifery the same day at 3.38pm, saying that there was '*Good news to pass on re* [Mr D]'. The head of midwifery replied at 7pm: '*Has* [Mr D] *moved to Thailand? What is the good news?*'.

18. In March 2011 the head of midwifery took a career break from the Trust to volunteer abroad.

Mr D's complaint to the Trust

19. Mr D became aware of this email correspondence when he obtained a large amount of information from the Trust under the *Data Protection Act 1998* in August 2012. On 8, 9 and 10 August 2012 he sent emails to the Trust complaining about the email correspondence and, on

12 August, he wrote an email to the Trust that read:

> *'... here we are again faced with yet more upsetting remarks, which demonstrate the deeply unpleasant and uncaring attitude which some staff at the Trust have in relation to* [G]*'s death and my family.'*

20. At this time Mr D told his local newspaper – the *North West Evening Mail* – that he felt this email correspondence '*hint*[ed] *at an underlying prejudice*'. The news article continued: '*Mr* [D] *said the latest email exchange is "deeply offensive and hurtful" but "sadly typical" of the attitude towards his son's death*'.

21. On 15 August 2012 the Trust told Mr D that the executive chief nurse had, on being made aware on 2 August of the content of the email correspondence, '*asked for an investigation to commence immediately*'.

22. The Trust updated Mr D on 7 September 2012. They wrote:

> *'Following the discovery of a further email*[3] *which we felt was inappropriate, we instructed the division responsible to conduct an investigation into this matter. We are in the process of reviewing a large number of emails that have been sent and released to you and we aim to have completed this process by the end of September.*
>
> *'Please accept our sincere apologies for the further distress that these emails have caused you and your family ...*
>
> *'The Trust is required to investigate this matter fully before taking disciplinary action, if any ...'*

23. The investigation was conducted by the general manager for the women and children's division and completed at the end of September 2012. The report read:

> *'... Terms of reference for the investigation*
>
> - *'To review email correspondence between* [the head of midwifery], [the customer service manager] *and* [the maternity risk manager] *to ascertain if there were any emails that may cause offence or distress.*
>
> *'The search of email correspondence took place on 15 and 16 August 2012 and was undertaken by the Trust's Informatics Service ... Following the email search a total of 1502 emails were identified between the correspondents. All 1502 emails were read and assessed by an independent person. The independent person was an employee of the Trust who did not personally know any of the correspondents.*
>
> *'I can confirm that no further emails contained content which could cause offence or distress.'*

24. On 28 September 2012 the Trust confirmed by email to Mr D that their investigation was complete and that the Trust was considering the outcome. On the same day, the assistant chief executive drafted a letter to Mr D for approval by the Trust's solicitor and the deputy director of human resources. In a covering email, the assistant chief executive described her draft letter as '*circumspect*'.

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3 The Trust have confirmed that the '*further email*' referred to is the correspondence of 10 June 2010.

25. On 8 October 2012 the Trust sent Mr D the following response to his complaint:

> '... [the] *investigation has now taken place and has concluded. The Trust will take any appropriate action necessary as a result of the findings of the investigation. Unfortunately the Trust is unable to give you any further information regarding any action taken due to its obligations under the Data Protection Act 1998.*
>
> *'I would like to take this opportunity to apologise once again for any distress caused to you and your family by the original email correspondence. The Trust expects all staff to act in a respectful, sensitive and professional manner at all times and any behaviour that does not meet these standards is considered to be unacceptable.'*

26. Mr D complained to us on 9 October 2012. He said that he found the Trust's response to his complaint '*completely unacceptable*' because the Trust did not:

    - confirm whether this was an isolated incident or whether other offensive communications had been found;
    - say whether they found the email communication of 10 June 2010 to be '*unacceptable*'; or
    - offer an explanation for the email communication or an apology from the staff involved.

27. Overall, Mr D said that the Trust had not been 'open and accountable' in its response.

Events since Mr D complained to us

28. A meeting took place on 13 December 2012 between the customer care manager, the head of nursing and the assistant chief executive to discuss the email correspondence. The notes of that meeting include the following:

> '[The customer care manager] *said she was sorry the meaning of her words had been misinterpreted by* [Mr D] *and that she would be happy to explain her intended meaning in a letter to* [Mr D] *or at a meeting with him. Discussion took place whether it would be appropriate or not to send such a letter but it was suggested that a letter would be drafted from the chief executive ... quoting wording provided by* [the customer care manager].'

29. The Trust has since confirmed to us that no letter such as that described in these notes was ever sent to Mr D. They say that this is because, shortly after the meeting, they became aware that we intended to investigate.

The Trust's comments

30. In response to our proposal to investigate Mr D's complaint the Trust wrote in February 2013: '*The Trust is now in the process of concluding a disciplinary investigation into this issue however the individual concerned remains overseas*'.

31. On 11 April 2013 we asked the Trust to explain what, if any, other action it took to investigate the email correspondence of 10 June 2010. The Trust replied:

    '... [the former head of midwifery] *was interviewed on 26 March 2013 in relation, amongst other issues, to the email that she sent* [the customer care manager] *on 10 June 2010. Draft meeting notes have been prepared following this meeting in which* [the former head of midwifery] *states:*

        "I don't understand the reference to Thailand; I've no memory of making that point. I know his wife is from Vietnam ... by that time I had applied to work with [Voluntary Service Overseas] *... Thailand was very much in my mind ... Why I've made that comment it is* [sic] *completely out of character, it's embarrassing.'"*

32. The Trust went on to explain that because of a dispute about whether or not the former head of midwifery is still a member of Trust staff '*no further work has been undertaken on the investigation*'.

The customer care manager's statement

33. We asked the customer care manager for a statement explaining why she wrote what she did on 10 June 2010 and what was meant. She provided the following:

    '*... I received the email from the complainant advising that he had made a decision to step back from further contact with the Trust in pursuit of his concerns, due to the effect it was having on him; he also telephoned me to confirm this. I forwarded the email to the Chief Executive, Medical Director and Nursing Director, advising them that I had passed on the best wishes of the Chief Executive and had also assured him that work would continue to raise the standard of Maternity Services. I later* [in response to an email she had received from the head of midwifery about an unrelated matter, she emailed the head of midwifery and] *... made the "Good news" comment.*

    '*I had been the complainant's primary point of contact with the Trust since he first raised concerns about the care of his wife and son and believed I had formed a good relationship with him and that he accepted I was genuinely concerned for his welfare. We had had many lengthy conversations and during some of these he was clearly distressed and related how he was feeling at those times.* [The head of midwifery] *had previously verbalised her concerns about the complainant's well-being to me. I was fully aware that there was an inquest pending and that issues identified by this case were being followed up by a number of agencies. I honestly believed that the work to continue* [improving] *Maternity Services would progress whether or not the complainant remained personally involved.*

'The "Good news" comment ... was therefore made in relation to the complainant's well-being and nothing more as I believed she had shared my concerns for his welfare. On receipt of [the head of midwifery's] *response at the end of the email chain, I did not reply ...*

'I truly regret that my comment has unintentionally caused distress to the complainant and his family. I am very sorry that the complainant misinterpreted my comment but recognise why this is the case. I would like to offer him and his family my sincere apologies and wish to emphasise that I in no way intended to be disrespectful — I have always had great sympathy for them and continue to do so. I hope that the complainant is able to accept my explanation ... I always endeavoured to represent his concerns and feeling[s] *to colleagues in the Trust throughout my years of contact with him.'*

34. The customer care manager's statement also included some information about how the Trust had handled Mr D's complaint about the email correspondence:

'When the complainant submitted his complaint by email last August he included me on the circulation and I immediately forwarded it to the Chief Executive and Head of Communications offering to provide an explanation. I was informed by the Nursing Director that the division were carrying out an investigation and that relevant staff would be contacted to provide a statement. I was not contacted and, on making enquiries (around last October, I think) as to whether a response had been sent, I was informed that a letter had gone to the complainant; I have never seen that letter.

'I was later seen by the Head of Nursing and Assistant Chief Executive on 13 December [2012] *and asked about the email chain. I stated that I was sorry the comment had been misinterpreted and would be happy to meet with the complainant and provide an explanation to him, or to do so in a letter to him, perhaps to be sent under cover of a letter from the Chief Executive. It was suggested that a paragraph of explanation be provided by me, to be included in a letter from the Chief Executive and I provided this by email to the Head of Nursing on the following day ... .'*

The head of midwifery's statement

35. We asked the head of midwifery for a statement explaining why she wrote what she did on 10 June 2010 and what was meant. She provided the following:

'... I am writing this to the best of my memory and based on my usual practice ... [I] *cannot recall every detail ...*

'... I think I remember that [Mr D] *intended to spend an extended holiday in South East Asia. I cannot remember if the holiday was before or after the*

10 June [2010]. *I remember that he has lived and worked there before and therefore maybe wondered if he was going to live there again.*

'At the same time, I had applied to work as a volunteer clinical midwife with [Voluntary Service Overseas and] *International and South East Asia was my first choice of posting ... What I can say with absolute certainty is that the comment about Thailand had no racial prejudice connotations whatsoever and I was deeply distressed and sorry that Mr* [D] *... or others might interpret it this way.*

'At 19.00 hours on 10 June 2010, the day before I was to start annual leave, I know I would be very tired and stressed, I am guessing that I did get Thailand and Vietnam confused perhaps as I was reading a lot at the time about Thailand as I thought [Voluntary Service Overseas] *may propose sending me there. I know that Mrs* [D] *is from Vietnam.*

'... I welcome this opportunity to try to explain the comment but this is difficult as I do not remember making it, I apologise if I have got some of the details not quite accurate. I also welcome the opportunity to apologise for the comment causing distress – I am certain it was entirely unintentional, but ... I cannot remember the exact circumstances leading me to write it.'

Further information from the customer care manager

36. In a telephone conversation with the customer care manager on 6 June 2013 we asked her if she had any idea why the head of midwifery made the reference to Thailand. The customer care manager replied, '*No, only that we were dealing with a number of cases at that time involving mothers from ethnic minorities*'.

Findings

37. The customer care manager should have, in accordance with the Principles of Good Administration, acted fairly towards Mr D and treated him with respect. I am persuaded by the customer care manager's statement that she was concerned for Mr D's well-being and that this is what prompted her to describe Mr D's decision to '*step back*' from his complaint regarding his son's death as '*Good news*'. However, by using words which were open to misinterpretation, she gave the impression that she agreed that Mr D should stop his '*efforts to make sure what happened to* [G] [didn't] *happen again*'; and that she would be relieved not to have to deal with him. I can quite understand how, on discovering this email correspondence, Mr D interpreted the content as '*deeply unpleasant and uncaring*', and felt that the Trust '*viewed* [him] *as ... a problem they wanted to go away*'. Mr D had, after all, described himself in his email as '*extremely distressed and anxious*', and the customer care manager passed this on as '*Good news*'.

38. The customer care manager should have been more conscious that her words could be misinterpreted as being disrespectful to Mr D and the tragic circumstances that had led to his complaint. Her choice of words was ill-judged. However, because her intention was, I believe, to reflect her genuine concern for Mr D, I do not think that her actions amounted to maladministration. I note that she has said that she truly regrets the distress she has caused Mr D.

39. The head of midwifery should similarly have acted in accordance with the Principles of Good Administration by being fair to Mr D and respectful when she replied to the customer care manager's email. However, her reply indicated that she would regard Mr D moving to another continent as '*Good news*'. This was disrespectful and created an impression that she would have liked Mr D to '*go away*'.

40. Mr D believes that his wife's ethnicity is, albeit inaccurately, referred to in the head of midwifery's reply, and that it '*hint*[ed] *at an underlying prejudice*'. The head of midwifery says that she only mentioned Thailand because, for personal reasons, that country was '*very much in* [her] *mind*' at that time. It seems highly unlikely that her decision to mention a country so close to the area of the world that Mrs D is from was a coincidence and completely unrelated to Mrs D's ethnicity. Indeed, she goes some way to admitting that it was a reference to Mrs D; she said in her statement '*I am guessing that I did get Thailand and Vietnam confused ... I know that Mrs* [D] *is from Vietnam*'. Her email therefore shows that she had Mrs D's ethnicity in mind when thinking about this family. That said, I cannot go so far as to say that her response reveals any racial or ethnic '*prejudice*'. I can only conclude that, for the head of midwifery, '*Good news*' would have been news that Mr D was moving far away. That in itself is not in line with the principle of '*Acting fairly and proportionately*'. I find that the head of midwifery's email fell so far below the standards of respect and courtesy to be expected in these circumstances that it amounted to maladministration.

41. When Mr D became aware of this email correspondence and made his complaint about it, he was entitled to expect that the Trust would be: 'open and accountable' by providing him with a transparent, clear, complete and evidence-based explanation; 'fair and proportionate' by investigating his complaint thoroughly; and that they would 'put things right' and be 'customer focused' by providing a remedy that took account of his individual circumstances.

42. Although I recognise that the Trust explicitly said, in their letter of 7 September 2012, that the email correspondence of 10 June 2010 was '*inappropriate*', and also offered a '*sincere apolog*[y]', I do not consider that the Trust conducted a thorough investigation of this incident. The Trust reviewed a significant amount of email correspondence but they did not seek to understand why the individuals had written what they did or what was meant. Seeking to understand this was particularly important, given Mr D's obvious concern that the head of midwifery's words were, in some way, racially motivated. The Trust did not seek statements from the customer care manager or the head of midwifery until long after their final response to the complaint had been sent on 8 October 2012. (The customer care manager was spoken to in December 2012 and the head of midwifery was spoken to in March 2013.) The customer care manager was clearly willing to provide her explanation quite early in the complaint, but the Trust did not contact her.

43. The Trust's response of 8 October 2012 rightly sought to respect the privacy of personal and confidential information relating to their staff. It also included a further apology. However, the Trust's response did not give sufficiently clear or complete information to demonstrate what investigation and action had taken place. The letter was not transparent. The Trust did not use the evidence acquired from the investigation to confirm to Mr D that '*no further emails contain*[ing] *content which could cause offence or distress*' had been found. Nor did they explicitly say that the email correspondence of 10 June 2013 was '*unacceptable*'. Furthermore, the Trust could not offer any reassurance, apologies or explanations from the staff involved because they had not, at that stage, been spoken to.

44. The Trust also failed to provide Mr D with an appropriate remedy that took into account his individual circumstances (Principles for Remedy). The Trust should have taken into account the fact that Mr D had already had cause to complain about an email which was disrespectfully titled '*NMC shit*'.

45. Overall, I find that the Trust were not 'open and accountable' and failed to 'put things right' or act in a 'customer focused' way. Their response to Mr D's complaint about the email correspondence fell short in so many respects that it amounted to maladministration.

Injustice

46. I now consider whether the maladministration I have identified led to an injustice to Mr D.

47. Mr D says that he and his family have been caused distress by the content of the emails, and suffered further distress and frustration because of the Trust's response to his complaint. As I have already acknowledged, I can quite understand how, on discovering this email correspondence, Mr D interpreted the content as '*deeply unpleasant and uncaring*', and felt that the Trust '*viewed* [him] *as ... a problem they wanted to go away*'. Although the customer care manager's part in the exchange was, I believe, well-intentioned and did not amount to maladministration, the head of midwifery's words were disrespectful and undoubtedly caused Mr D and his family upset and distress. This was an injustice which was compounded by the Trust's failure to conduct a thorough investigation of his complaint.

48. As a consequence of the Trust's maladministration in this case, Mr D was left without any explanation for the email correspondence, no meaningful apology, and no reassurance about the existence of further emails. I can appreciate that this caused Mr D further distress and frustration. This was an injustice.

Recommendations

49. I have considered my findings in the light of our Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

50. I recommend that the Trust should, within one month of the date of this final report:

    - provide Mr D with an acknowledgement of the failings identified in this report and an apology for the consequential injustice; and
    - consider what it can do now to rebuild the relationship with Mr D;

    and, within three months of the date of this final report, prepare an action plan that:

    - describes what the Trust have done to ensure that the organisation has learnt lessons from the failings identified by this upheld complaint; and
    - details what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings.

51. A copy of the action plan should be sent to:

- Mr D
- us
- the Care Quality Commission (CQC)
- Monitor, and
- NHS Cumbria Clinical Commissioning Group.

52. The Trust should also ensure that Mr D, the CQC, Monitor and the clinical commissioning group are updated regularly on progress against the action plan.

53. A copy of the apology letter should be sent to us.

The Trust's and Mr D's response to the draft report

54. In response to a draft of this report, the Trust acknowledged and accepted our findings and recommendations. The customer care manager also accepted our findings and reiterated her apologies to Mr D and his family. She wrote:

> *'I hope he knows that I personally have never "viewed* [him] *as an issue – a problem* [I] *wanted to go away" and was genuine in my efforts to support him and represent his concerns and feelings.'*

55. The head of midwifery accepted that her email was '*inappropriate*' and apologised '*unreservedly for the distress caused*'. She wrote:

> *'I again apologise sincerely to Mr and Mrs* [D] *if they felt the comment to be racially prejudiced against her and would like to assure them that there was no prejudice intended ... .'*

56. Mr D accepted our findings and recommendations.

Conclusion

57. In this report I have set out our investigation, findings, conclusions and decision with regard to the service Mr D received from the Trust. I have found maladministration in the head of midwifery's part in the email correspondence, and I have found maladministration in the Trust's handling of Mr D's complaint about this. The identified maladministration has caused Mr D the injustice of distress. I therefore uphold the complaint about the Trust. I am satisfied that my recommendations will remedy the failings identified.

Complaint about allegations of collusion

Contents

Foreword

This is the report on our investigation into one of four complaints that we have considered from Mr D about the Trust. In this case, Mr D complained that there was collusion by midwives in preparation for an inquest.

The role of the Ombudsman service when investigating a complaint is to establish whether that complaint should be upheld. It is not always possible to determine what did or did not occur.

In order to uphold the complaint put to us we needed to establish that there was evidence of collusion on the part of the midwives. We have found no evidence that collusion took place and therefore we have not upheld the complaint.

It is important to remember that our decision not to uphold the complaint does not entail a definitive statement of what did or did not occur.

It is important to note that the fact that we have found no evidence of collusion on the part of the midwives does not contradict the views that the Coroner expressed.

The complaint

1. Mr D complained about the way the Trust prepared their staff, particularly midwives, for the inquest into his son's death. He said that he could not '*think of a more inappropriate process than the events that the Trust admits took place*' prior to the inquest. He said that staff '*colluded to present false evidence*' at the inquest, and that '*rehearsed answers to questions thought likely to be asked by the Coroner*' were distributed to midwives. He also complained about the way the Trust have responded to his concerns about those preparations. He said that the responses have been '*disingenuous and misleading*'. Mr D said that '*as a result of* [his] *having to investigate these issues, through an unnecessarily protracted process* [he] *has been caused extreme stress and distress, that has inevitably been communicated to* [his] *family ...*'.

2. Mr D Senior complained about the way the Trust have responded to his son's, Mr D's, complaints of collusion. He said that senior managers at the Trust have defended the midwives' collusion, and that they '*allowed* [the midwives] *to collude prior to* [the] *inquest in order to agree a description of events that paints the hospital Trust in the best possible light*'. He complained that a document prepared in advance of the inquest and circulated to the midwives (the '*Issues*' document) was intended to be a '*defence*' of the midwifery shortcomings and an attempt to absolve the midwives from '*personal blame*'. He has said: '*The midwives responsible for the care of* [my grandson] *did have a strong motive for covering up their failures*'.

3. Mr D wanted the Trust to change the defensive and misleading approach that he believes they have taken with him since his son's death. He said:

   > '*... all I want from my complaint is for the approach the Trust are taking with me to now stop, and that the legitimate concerns I have raised with them are dealt with in an open and accountable manner, not by a legal team acting as if they are defending the reputation of a "corporate entity". All I want is an end to this approach (which is causing us massive distress) and nothing more.*'

   He also wanted someone to take a view on whether what the Trust did in preparation for the inquest was appropriate.

4. Mr D Senior wanted '*the withdrawal of the statements of the* [Trust] *in defending the collusion of its staff prior to G's inquest, and the setting up of a proper enquiry into how and why such collusion was allowed to take place*'. He said that his '*right to find out the true circumstances and responsibilities for G's death have been compromised by the improper collusion organised and condoned by the Trust*'.

5. We have investigated Mr D's and Mr D Senior's complaints that the midwives colluded about the accounts they would give of their knowledge of the implications of a low temperature in a baby; that the Trust acted unreasonably in preparing the midwives for the inquest; and that the Trust failed to respond reasonably to Mr D's complaint about that.

6. We have investigated Mr D's and Mr D Senior's complaints that the Trust acted unreasonably in preparing the staff involved in G's care for an inquest into his death in 2011. The Coroner observed, as part of his summing up, that he thought the midwives had '*got together*' and agreed

to give evidence that '*none of them had any suspicion that a low temperature in a baby could indicate sepsis*'. On the basis of the Coroner's comment and some Trust documents that Mr D subsequently received as part of a data access request, the D family complained to the Trust, alleging that the midwives had been coached on the answers they should give at the inquest. We looked at that complaint and, specifically, at whether the midwives colluded about the accounts they would give of their knowledge of the implications of a low temperature in a baby. We have not investigated G's care and treatment as part of this investigation; the significant failings in the care he received had already been identified by the Coroner and accepted by the Trust.

The decision

7. I do not uphold Mr D's complaint and I do not uphold Mr D Senior's complaint. This is because I have found no evidence that the Trust, when preparing for the inquest, failed to comply with the law or act in accordance with established good practice. I have seen no evidence that the Trust's solicitor acted inappropriately, and no evidence that the midwives colluded to present '*false evidence*' about their knowledge of the implications of a low temperature in a baby. In short, I have found no evidence of maladministration. I explain why in this report.

Our role and approach to considering complaints

8. Our role[1] is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.

Powers to obtain information

9. The law allows us to ask anyone to give us information or documents needed for our investigation. They must provide that information.

How we decided whether or not to uphold this complaint

10. When considering a complaint, we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think public organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.

11. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure. We then consider 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 action. Our recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.

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

The relevant standards in this case

Our Principles

12. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[2] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

13. The Principles of Good Administration particularly relevant to this complaint are:

    - '*Getting it right*' – which includes public organisations complying with the law[3] and acting in accordance with established good practice.
    - '*Being open and accountable*' – which includes public organisations being transparent, open and truthful when accounting for their decisions and actions.
    - '*Acting fairly and proportionately*' – which includes public organisations acting fairly and in a way that is free from any personal bias or interests that could prejudice their actions and decisions.

14. The Principles of Good Complaint Handling that are particularly relevant to this complaint are:

    - '*Being open and accountable*' – which includes public organisations being open and honest when accounting for their decisions and actions, and taking responsibility for the actions of their staff, and those acting on their behalf.
    - '*Acting fairly and proportionately*' – which includes public organisations investigating complaints thoroughly and fairly, basing their decisions on the available facts and evidence.

The purpose of a Coroner's inquest

15. The Ministry of Justice publishes the *Guide to Coroners and Inquests* (2012). This explains:

    > *'The purposes of the coroner service, when a death is reported to it, are: ...*
    >
    > *to establish the identity of the person who has died, and how, when, and where the person came by their death, to assist in the prevention of future deaths; and to provide public reassurance.*
    >
    > *'An inquest is a limited, fact-finding inquiry to establish who has died, and how, when and where the death occurred. An inquest does not establish any matter of liability or blame. Although it receives evidence from witnesses, an inquest does not have prosecution and defence teams, like a criminal trial; the coroner and all those with "proper interests"* [relatives and others closely connected with the deceased] *simply seek the answers to the above questions ...*
    >
    > *'Witnesses will be first questioned by the coroner and then additional*

2 You can find more detail about our Principles at www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

3 It is not our role to decide whether an organisation has broken the law: that is the job of the courts. However, if a public organisation cannot show that it has complied with the law we will take that fact into account when we decide whether there has been maladministration.

relevant questions may be asked by any properly interested person or their legal representative ... Where relevant, the coroner will warn a witness that he or she is not obliged to answer any question which might incriminate him or herself ... Inquest evidence cannot be used directly in other proceedings.'

Standards regarding inquest preparation

Case law

16. In *R v Momodou* (2005)[4] a man convicted of violent offences appealed his conviction arguing that the prosecution witnesses had received pre-trial coaching or training. Due to the traumatic nature of the events that had led to the charges, several parties were given counselling in groups in which they were encouraged to discuss their feelings and reactions. No notes were taken and they took place before any witness statements were taken by the police.

17. The appeal was dismissed and the conviction upheld. The court noted that each witness had been cross examined regarding the counselling sessions and the jury had all the facts to hand and a list of all those witnesses who had undergone counselling. The court pointed to the dangers of the contamination of evidence from group sessions, but indicated that it is a matter for the court or jury to decide how much weight is to be given to such evidence.

18. The court in this case also gave guidance on the issue of handling witnesses for criminal trials. However, this guidance is specific to criminal trials. Inquests are not criminal trials, and so that guidance is not binding on them and I have not included it here.

Standards regarding the conduct of solicitors

19. The Solicitors Regulation Authority *Code of Conduct* (2007) (the Code of Conduct) explains the core duties of solicitors:

    '1.01 Justice and the rule of law

    You must uphold the rule of law and the proper administration of justice.

    '1.02 Integrity

    You must act with integrity.

    '1.03 Independence

    You must not allow your independence to be compromised.

    '1.06 Public confidence

    You must not behave in a way that is likely to diminish the trust the public places in you or the legal profession.'

20. In the section of the Code of Conduct entitled '*Litigation and advocacy*', it says that solicitors:

    '11.01 ... must never deceive or knowingly or recklessly mislead the court or knowingly allow the court to be misled.

    '(3) You must not construct facts supporting your client's case or draft any documents relating to any proceedings containing:

    (a) any contention which you do not consider to be properly arguable; ... .'

4 The Court of Appeal citation for this case is 2005 EWCA Crim 177.

Standards regarding the conduct of midwives

21. The Nursing and Midwifery Council (the NMC – the organisation responsible for the professional regulation of midwives) published *The Code: Standards of conduct, performance and ethics for nurses and midwives* (the NMC Code) in 2008. The NMC Code tells midwives that they must: '*Be open and honest, act with integrity and uphold the reputation of* [their] *profession'*.

22. The Code explains that to fulfil this requirement midwives should '*adhere to the laws of the country in which* [they] *are practising*', '*give a constructive and honest response to anyone who complains about the care they have received*' and *'co-operate with internal and external investigations*'.

The investigation

23. We have looked at all the relevant evidence for this case, including the papers showing how the Trust prepared for the inquest and handled Mr D's complaint about that preparation. We also spoke to both complainants, and had access to the evidence gathered by Cumbria police during their investigation into allegations of perjury[5] and attempting to pervert the course of justice.[6] The Trust, the Trust's solicitor, the maternity risk manager, Mr D, and Mr D Senior have had the opportunity to comment on a draft of this report and their responses have been considered. I have not included in this report everything we looked at during the investigation, but I have included everything important to the complaint and to my findings.

5 Under section 1 of the *Perjury Act 1911*, it is an offence for a lawfully sworn witness in judicial proceedings (including an inquest) wilfully to make a statement, material in those proceedings, which they knew to be false or did not believe to be true.

6 Attempting to pervert the course of justice is a common law criminal offence that can include persuading, or attempting to persuade, a witness to alter his evidence or to give false evidence, and agreeing to give false evidence.

Background

24. Mr D's son, G, was born at the Trust's Furness General Hospital at 7:38am on 27 October 2008, but died a few days later from pneumococcal septicaemia (blood poisoning caused by bacteria in the bloodstream). Two days before her labour began, Mrs D's waters had broken.[7] Twenty minutes after the birth, she had a raised temperature and was given antibiotics. G was not given antibiotics. The Trust admitted liability for G's death and compensation was paid. Several inquiries have reviewed the care provided to G specifically, and maternity services at the Trust more generally (see below). Although Mr D's request for an inquest was initially refused, it was subsequently granted and an inquest took place in June 2011.

Earlier inquiries regarding the care provided to G

25. I include here background information about the inquiries that took place before the inquest, and specifically their findings in relation to the midwives' knowledge of the implications of G's low temperature.[8] For the purposes of the Trust's initial internal investigation/ root cause analysis, which was prepared between October 2008 and January 2009, statements were taken in December 2008 from nine midwives, a non-clinical maternity assistant, and the maternity ward manager. All but one of these individuals (Midwife P) subsequently gave evidence at the inquest.

26. In her statement for the initial internal investigation, Midwife E said that on the morning of 27 October 2008, G's temperature was recorded as 37.2°C. Midwife F said that when she did G's observations during the evening of 27 October 2008, his temperature was low. (She did not give a figure but later accepted, when presented with Mrs D's recollections, that his temperature could have been as low as 35.8°C.) She went on to explain:

    '*... the room was also cold, therefore I first placed an overhead heater in the room to warm it, this was not placed over baby, but purely to warm the room. Following this I then placed baby onto the cot heater. From memory I feel that the baby did respond to the warming cot. I then continued periodically to check the temperature, the heart rate, the respiration rate, baby's tone and baby's colour. These were all within normal limits ... .*'

27. Midwife H said that when she carried out observations on G at approximately 11pm on 27 October 2008, his temperature was 36.8°C. She added '*I know baby's temperature was normal as I said it didn't need to be on* [the] *bed warmer and it wasn't high*'.

28. Midwife J said that when she did G's observations in the early hours of 28 October 2008 '*his temperature, respirations and heart rate were within normal limits*', and that when she repeated his observations at approximately 6.50am

7 When the waters break before the onset of labour, it is known as premature rupture of membranes. Prolonged rupture of membranes is a recognised risk factor for infection.

8 The normal temperature range for a newborn is 36.4°C to 37.5°C. www.nhs.uk/conditions/pregnancy-and-baby/pages/treating-high-temperature-children.aspx#close.

'all observations were within normal limits except his temperature which had dropped slightly by approximately 0.2 to 0.3°C'. Midwife J's statement continued:

> *'At this time the room was very cold and the room also had two ceiling vents which were causing a draught. We decided to put baby back on the warming cot for a short period due to the temperature of the room. I informed Mrs D at this time that if baby was unable to maintain his temperature then he would need to be reviewed by a paediatrician.'*

29. According to the maternity ward manager's statement for the initial internal investigation, G's temperature was 36.8°C at approximately 8:15am on 28 October 2008. Shortly after this he collapsed and was transferred to the special care baby unit.

30. The Trust's initial investigation/root cause analysis noted that it was identified shortly after G's death that his '*inability to maintain his temperature had not been recognised as a potential sign of sepsis*' and that this was '*shared with all staff at the Obstetric update days in November* [2008]'. The root cause analysis concluded that: '*Babies who are unable to maintain their temperature may be developing sepsis and should be reviewed by the paediatric team*'.

31. The Trust also commissioned an external investigation, which reported in February 2009 – this has become known as the Chandler and Hopps report. The authors of this report had access to the statements made by staff for the initial internal investigation, but they did not seek further statements or carry out interviews with staff. The Chandler and Hopps report found that:

> *'There* [was] *a lack of recognition by staff of the relevance of neonatal hypothermia*[9] *and the need to refer for a medical assessment. There* [was] *a lack of awareness by the staff that persistent hypothermia in a neonate can indicate sepsis.'*

32. The report concluded that the Trust should '*provide training to staff in relation to the care of the neonate and in particular signs of sepsis*'.

33. Mr D was not satisfied with the Chandler and Hopps report and in March 2009, following a meeting with the Trust's chief executive, it was agreed that his ongoing concerns would be responded to under the NHS complaints procedure. On 25 March the chief executive sent Mr D a response to his complaint, which acknowledged that '*the care received by G was not acceptable*' and explicitly stated that the midwives involved had been ignorant of the relevance of G's low temperature. The Trust accepted that this was a failing by management, and said that training for midwives in the recognition of neonatal sepsis had been arranged.

34. In May 2009 the North West Local Supervisory Authority (LSA)[10] reported the outcome of its investigation into

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9 Mild hypothermia in newborns is defined as a core body temperature of 36°C to 36.4°C, moderate hypothermia as 35.9°C to 32°C and severe hypothermia as less than 32°C. 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.

10 The LSA supports the local Supervisors of Midwives to develop and maintain safe practice and ensure that a high standard of care is provided.

the events leading up to G's transfer to the special care baby unit. One area of concern identified in this report was '*the management of the fluctuations in the temperature of a high risk baby*'. Midwife F was interviewed by the local Supervisor of Midwives. She explained that she:

> '*... identified that G's temperature was "low", but the room was cold. She placed an overhead heater in the room, and placed the baby in the warming cot, as the remainder of G's observations were within normal limits and she understood the lower temperature to be the normal response of a newborn in a cooler room ... To her recollection, baby G responded to the warming cot ...* [She] *reflected that she had not understood this drop in temperature to be significant of sepsis as all other parameters were normal.*'

35. Midwife J and Midwife H were also interviewed by the Supervisor of Midwives. Midwife J said that the '*small temperature loss*' which she noticed at 6.50am was '*attributed to the very cold room*'. She said that '*G was placed back into the* [warming cot] *as a prophylactic*[11] *measure*'. Midwife H said that she:

> '*... was aware that a low temperature would indicate hypothermia* [not infection] *and that this would necessitate medical assessment ... She maintained that* [his] *temperature was normal.*'

36. The LSA found that these midwives had failed to recognise the significance of G's low temperature.

The LSA report explained:

> '... [Information requested from staff] *suggested that the fluctuations in G's temperature were between 36.4°C and 36.8°C, which did not prompt a request for a paediatric review of this baby with an additional risk factor* [Mrs D's fever], *but was managed by warming a cold room and the use of a cot warmer.*
>
> '*Further investigation by the Head of Midwifery revealed that this degree of fluctuation in a newborn's temperature may not have prompted a request for a paediatric review by other midwives in the service either, but may have been seen as the normal variation in temperature of a newborn that can occur in response to the environment.*'

37. The LSA concluded that, because other midwives in the service would not have responded differently to G's temperature, the failure to request a paediatric review was a '*system failure*' rather than one attributable to any individuals. The LSA report explained that staff had now been made aware of '*the possible implications of a fluctuating temperature*' and '*risk factors for neonatal infection*', and highlighted that '*further training on neonatal sepsis, normal neonatal parameters and* [a] *new* [observation] *chart*' had been provided.

38. The LSA report included an annex containing a number of responses to specific issues raised by Mr D. Under the heading '*Failure of the midwife regarding: Recognising signs of infection*' the LSA explained:

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11 Preventative

'G's inability to maintain a steady temperature was thought to be due to the cold room, rather than the overall picture being considered, i.e. a "high risk" baby displaying possible signs of infection.'

39. On 14 June 2009 Mr D wrote to the LSA raising a number of queries about its report. Included in the LSA's response (dated 29 June) was the following:

    'Regarding G's temperature; [Midwife F] *has been re-interviewed and whilst she still cannot remember the exact temperature readings that she recorded on the observation chart, accepts the information that we now have from* [Mrs D] *and agrees that these could have been 35.8°C and 36.1°C. She knows that G's temperature was significantly lower than would have been expected, that is why she placed him in a warming cot. This midwife also states that she is sure all other parameters of G's observations were normal at that time and explains because of that, she did not take any further action. She recollects that G's temperature did respond to the warming cot which reassured her that appropriate action had been taken.'*

40. In March 2010 the Trust commissioned a further external report to review the maternity service more generally – this has become known as the Fielding report. This report noted that at Furness General Hospital:

    '[The Trust had] *a stable cadre of experienced nursing and midwifery staff but* [that], *perhaps because of the unit's geographical location which places it in the most remote and inaccessible corner of the Trust's catchment area, the Trust* [had] *found it increasingly difficult to attract and appoint high calibre staff … .'*

41. In response to the report made to the National Patient Safety Agency (the NPSA) by Mr D about G's death, the NPSA published, in October 2010, a *Signals*[12] piece *'concern*[ing] *risks to newborn babies from failing to recognise that problems in maintaining body temperature may be a sign of sepsis in "at risk" infants'*. The piece explained that a review had identified that G's inability to maintain his temperature had not been recognised as a potential sign of infection. The piece continued:

    'Hypothermia is a common sign of sepsis with fever being less common. Signs of early-onset sepsis in newborn babies are often vague and therefore a greater level of vigilance is required to ensure the monitoring of infants who are identified as having a higher risk of developing neonatal sepsis … Healthcare professionals caring for newborn babies need to be aware that a low temperature in an at-risk infant may be a sign of sepsis and an indication to take appropriate action.'

12 Key risks emerging from reviews of serious incidents reported by the NHS to its National Reporting and Learning System (NRLS) are shared in the form of '*Signals*'.

Key events in the Trust's preparation for the inquest

42. Some of the midwives were told about the decision to hold an inquest in May 2010. The maternity risk manager sent an email to the Trust's head of legal services on 24 May explaining: '*as you can imagine they have some concerns and anxieties ... and would very much like to speak to a "legal" person*'.

43. The head of legal services responded, explaining that at this stage they did not know which witnesses would be called, or which issues the Coroner would want to explore. She said that once this was known, the Trust's solicitor would '*propose to meet with the relevant staff to prepare for the hearing*' and that, in the meantime, she could only provide some '*general information about inquests*'. The midwives still wanted to meet a '*legal person*' to ask about the format of inquests (they were particularly concerned about giving evidence in the same room as Mr D) and '*other general questions*', and a meeting was arranged for 14 June 2010. In a telephone conversation with the Trust's solicitor, the head of legal services said that she would be meeting the midwives '*to go through the generic process*'.

44. On the morning of 15 June 2010 the head of legal services emailed the Trust's solicitor to update her about the meeting with the midwives. This email contained the following:

    '....[I] *met with midwives* [E, H, F and J] *along with the maternity risk manager, late yesterday afternoon. None of the midwives had been to an inquest before, so I explained the purpose of the inquest and the procedure and gave some advice on giving evidence but their concern is focused less on the inquest itself and more on* [G's] *father. I understand that when he received a copy of the LSA report, he reacted badly and went down to the unit. This has obviously frightened the staff and they are concerned about being in the same room as him and his knowing their names. I have explained that at the end of last week the father's attitude appeared to have changed, and having spoken to* [the customer care manager] *this morning, it appears this bad reaction was based on some misunderstanding, but nevertheless, the midwives are clearly very anxious. They are also interested in why there was no* [post mortem] *and inquest at the time* [G] *died. Hope this background will be useful when you come to meet with the witnesses yourself in due course.*'

45. The Trust's solicitor has confirmed that the head of legal services had no further involvement in her inquest preparations. Indeed, the Trust has confirmed that the head of legal services was on leave from the Trust between August 2010 and July 2011.

46. Ten months later, on 11 April 2011, the Trust's solicitor and the chief executive met some of the midwives who were due to give evidence at the inquest. According to the Trust's solicitor's note of that meeting, this is what happened:

    '... *The meeting was a preliminary meeting to talk about the inquest in general terms and it was therefore agreed that the midwives did need to do some detailed preparation for attendance at the inquest to ensure that they were aware of each other's evidence, the actions taken since by*

the Trust and that they were very clear about their own evidence and how that fitted in to the overall picture. The midwives seemed very keen to get together to discuss these matters and seemed very keen to have copies of the [root cause analysis] *report and the LSA report and the Trust's action plans, which I mentioned it would be a good idea for them to review briefly.* [The maternity risk manager] *is going to speak to them about the actions taken since etc so that they were all clear as to the changes that have happened since and how it affects them all in their day to day work. They therefore arranged to have a further meeting on 27 April and it was agreed that after that, we would arrange to have a further meeting altogether sometime in May to go through the issues in detail* ... [I] *confirmed that* [the midwives who had also been referred to the NMC] *should attend* [the inquest] *and use it as a "test" for the NMC process and give their evidence honestly and professionally and without being defensive ...*

'It was confirmed that I would send through to the midwives my list of issues to assist with their meeting on 27 April ... .'

47. Before this meeting the Trust's solicitor had created a document entitled '*Issues*', which set out a series of points about G's care (Annex A, column 1). On 27 April 2011 the maternity risk manager met some of the midwives who were due to give evidence at the inquest. On 9 May the maternity risk manager sent an email entitled '*Response to queries for baby* [D] *inquest*' to the midwives who attended that meeting, attaching a document entitled '*Response to questions from staff for* [the Trust's solicitor]' (Annex A, column 2 - this document was the '*Issues*' document, as amended by the maternity risk manager). The email read:

    'Please find attached the responses to the questions that we discussed at the pre-inquest meeting on 27/04/11. I have documented the answers from the notes I made and [the Matron for Midwifery] *has made some additions. If you think they are incorrect in any way or we need to add something just let me know and I will amend and send to* [the Trust's solicitor] ... .'

48. The Trust's solicitor met '*some of the midwives*' and the chief executive again on 18 May 2011. According to the solicitor's notes of that meeting, this is what happened:

    'We went through all of the issues noted on the "issues" document. I asked the [Trust] *if they would be able to provide me with a number of documents to disclose to the Coroner including the new guidelines on the management of neonatal hypothermia, ... the new observations chart with triggers for referral to the Paediatricians and with the parameters for normal* [observations] *and a copy set of the new records which are now in use ...* [We agreed] *that it would be helpful to have all of those documents so that* [the Trust] *could show the Coroner what had changed since. It would also be helpful for the midwives to be able to refer to those if necessary ...*

    'We ran through the possible verdicts and I made it clear that a verdict of Neglect or Systemic Neglect or a very critical Narrative Verdict was possible ... [I said a Narrative Verdict] *would be*

critical in setting out the failures that occurred. The Trust is well aware of this … .'

49. During this meeting, the Trust's solicitor made some handwritten notes on her copy of the amended '*Issues*' document (Annex A, column 3).

50. The maternity risk manager sent a further email to a group of midwives on 20 May 2011 entitled '*Information*'. In it, she explained that she had '*a copy of the full files in* [her] *office if anyone want*[ed] *to check/read before the inquest*'. The information available included '*two black files*' and '*a copy of Mr & Mrs D's statements to the Coroner*'. The email also explained that the Trust's solicitor would be available to talk to on 23 May.

51. On 23 May 2011 the Trust's solicitor met one of the paediatricians involved in G's care to help him prepare for the inquest. After this, she met Midwife K, Midwife E, Midwife F, the non-clinical maternity assistant and the maternity ward manager. Her note of this meeting reads:

    '… We also tried to contact [Midwife L] *as I had not yet had the chance to meet with her; however she was not answering her phone. I therefore discussed the positions of* [Midwife L] *and* [the maternity ward sister*] with* [the maternity ward manager] *and she confirmed she would meet with them over the course of the next couple of days to discuss the issues with them and ask them to give me a call if they had any concerns. I handed out a number of business cards to all of them. I agreed to be at the Town Hall for at least 30 mins to 1 hour before the inquest started on each day to enable them to speak to me if they wanted.*

    'It was clear that they all appreciated the support that was being given, but felt it was too late i.e. they had not received any such support during the two years since [G's] *death and felt as if the Trust had simply criticised and pointed the finger of blame. It was very clear* [that one attendee] *… felt that they had all been denied the opportunity to give their true story and agreed with me that Mr & Mrs D would now use* [the inquest] *as their first opportunity to discuss matters properly with those concerned in* [G's] *care and that therefore they* [the midwives] *could expect to receive a significant number of queries, questions and suggestions from Mr & Mrs D's barrister …*

    'The midwives I spoke to were concerned that they had attended a meeting with maternity managers and [the chief executive] *was present, and therefore appreciated meeting with me individually today … .'*

52. On 1 June 2011, a document entitled '*Inquest – G D Q&As*' (Annex A, column 4) was produced by the Trust's communications department. We have seen no evidence that this document was circulated outside the communications department. This document was almost identical to the revised '*Issues*' document circulated by the maternity risk manager on 9 May. However, the wording had been altered slightly to phrase the issues as questions, and the document included '*Notes to Editors*', suggesting that it was intended for eventual distribution to the media.

The inquest

53. The inquest took place in June 2011. During the inquest, witnesses were able to listen to the evidence given by other witnesses. At the inquest, the maternity risk manager said, when asked what it means when a baby is not maintaining his temperature, that midwifery training focuses on prevention of hypothermia in the newborn baby and the use of clothing and warming cots to achieve that aim. She said that, in 2008, she would not have recognised a baby's inability to maintain his temperature as a sign of infection. When asked whether she was speaking for just herself when she said that she was not aware or would not have recognised a failure to maintain temperature as a possible sign of infection, she said:

    'That's myself but also the Head of Midwifery, following [G's] *illness, asked midwives in all three units in Morecambe Bay what their understanding would be of a low temperature in a baby, the majority of those said that they would not recognise that as a sign of sepsis, which is why we went on then to do the training ... .'*

54. The midwife who delivered G (Midwife S) said that she '*would be concerned*' if a baby did not maintain its temperature and if its temperature dropped. However, she said '*I wouldn't have been thinking about infection ... I would more think about prematurity. I would check the dates again to make sure about the gestation*'.

55. The maternity ward sister said that in 2008 she did not think that a low temperature might give rise to suspicion of infection. She added '*I've worked in other units and that was never highlighted as an indicator for sepsis in a newborn baby ... I have never ever heard, until this case, of a low temperature being an indicator for sepsis. It has always been a high temperature.*'

56. Midwife E said that she did not know '*that not keeping up a temperature and having a low temperature might be a sign of infection in a baby*'.

57. The senior midwife who was on day shift on the labour ward on 27 October 2008, Midwife W, said that she was '*unaware*' in 2008 that a low temperature '*might give rise to suspicion of infection*'. Midwife W was also asked: '*If* [a] *paediatrician gives instructions to do ... observations* [on a baby] *and those observations fall outside normal parameters, would you expect that to be reported back to the paediatrician?*'. Midwife W replied '*Yes*'.

58. Midwife F was asked whether G's low temperature worried her. She replied, '*babies often get low temperatures*'. In response to a further question about her knowledge of the implications of a low temperature, Midwife F said '*... The only education I had was that a low temperature was a sign of a cold baby in response to a cold environment. I didn't know it was a sign of sepsis*'.

59. Midwife L was asked '*did you have any insight into the fact that a baby whose temperature drops might be suffering from an infection?*' She replied '*I had no idea*'. However, Midwife L also said that she would have acted on any temperature observation under 36.5°C.

60. Midwife H explained at the inquest:

    '... Regarding a low temperature I would be thinking of hypoglycaemia,[13]

[13] An abnormally low level of sugar (glucose) in the blood.

wanting to keep the baby warm so it wasn't using up glucose to keep warm and wouldn't develop hypoglycaemia leading to respiratory distress. I would be thinking along those lines because of a low temperature ... I didn't have a link to infection and low temperature at that time.'

61. Midwife H further explained that if she had observed a temperature as low as Mrs D recollected (35.8°C) she would have '*informed the paediatrician*'. She added '*... in my training ... any baby with a temperature of 36.2°C* [or below] *was automatically referred to a paediatrician ... '*.

62. Midwife J said that she was not aware in 2008 that a low temperature in a newborn baby might be a sign of infection.

63. When he gave evidence towards the end of the inquest, the Trust's chief executive was asked for his views on the fact that the midwives did not recognise that low temperature was a sign of infection. He replied:

    '... In my personal opinion, I think I would expect midwives to understand that low temperature in a baby is a cause for concern. If they don't, then I would certainly expect for a midwife to understand that a baby who is not maintaining his temperature is a cause for concern.'

64. At the end of the final day of the inquest, and before the summing up, the Coroner said *'I certainly think it should be within the knowledge of anybody in the field that a low temperature can be a problem and a failure to maintain temperature can be a problem and can be an indicator of sepsis*'.

65. The Coroner recorded a narrative verdict: that '[G D] *died from natural causes following a number of missed opportunities to identify that he was ill and to provide him with appropriate treatment*'. The Coroner acknowledged that staff had looked in on G and taken his temperature, but said that they did not recognise the signs that they were seeing as something very important.

66. Aside from the lack of knowledge regarding the implications of a low temperature/ inability to maintain temperature, the Coroner identified a number of other issues which contributed to G's death. These included: poor record keeping; poor team working; workload pressures; a failure to notice and act upon other signs of infection; an absence of continuity of care; and an overly rigid application of guidelines relating to premature rupture of membranes and raised temperature during labour. The Coroner echoed what had previously been said in the annex to the LSA report (paragraph 38) about the failure of midwives to consider G's temperature instability in the context of the '*overall picture*'. The Coroner said:

    '... nobody ... was able to stand back, [take] *an overall view, think about the prolonged rupture of membranes, G not feeding well, failure to maintain his temperature, Mum had collapsed 20 minutes after labour, had produced G, and put all that together and think, yes, there is a potential problem here, nobody ever did ...*

    'I think that Mrs D and G were treated as two unrelated individuals, and thought was not given to the fact that if something was affecting Mrs D it might have a bearing on how G was.

There was a failure to think laterally, a failure to think holistically, not just for each of them, but for the two as mother and baby.'

67. The Coroner also remarked:

> *'I have got to say that the evidence given by the midwives on* [their knowledge of the implications of a low temperature in a baby] *was so consistent and so clear, not one of them had any suspicion that a low temperature in a baby could indicate sepsis. I have to say, I think they got together at some point earlier and if the discussion went something like this; well, some of them had forgotten that, or never knew it, and some of them did, and I honestly believe that they collaborated and decided that they are going to stick together on that point, and say that, no, none of them did know that. I find it absolutely inconceivable that nobody on the department knew that simple basic fact ... as I say, I find it* [in]*conceivable that every single midwife on that unit did not know that as a basic fact.'*

Mr D's complaint to the Trust

68. Mr D wrote to the Trust on 5 November 2011 asking them '*... to confirm that representatives acting for the Trust and senior managers of the Trust had no involvement in any alleged "get together" described by the Coroner*'. The Trust's solicitor responded to him on 8 December, stating that neither the Trust's solicitors nor the Trust's senior managers were aware of any '*collusion or collaboration*', and had no reason to believe that any had taken place.

69. Mr D subsequently, in April 2012, obtained a significant amount of documentation from the Trust under the *Data Protection Act 1998*. This included a copy of a document entitled '*Inquest – G D Q&As*'. In the covering letter to this documentation, the Trust wrote:

> *'Included within the documentation being disclosed to you are records which pertain to the Trust's preparations for the inquest into your son's death which took place in June 2011.*
>
> *'When preparing for inquests, it is standard practice for NHS trusts to provide appropriate support to their staff through what can be a very unfamiliar and daunting process for them. Furthermore, an NHS trust, as an employer, also owes a duty of care to employees in these circumstances. In fulfilling its obligations to its employees, NHS trusts routinely disseminate all information, including statements and all relevant documentation, to all members of staff being called to give*

evidence and the likely issues to be explored at the inquest discussed and documented.'

70. Mr D believed that this document indicated that staff had been coached on the answers they should give to the inquest. Following some correspondence with the Trust's chief executive in April 2012 – in which the chief executive asserted that the *'Q&A'* document *'was prepared by the Trust's Communications Team to assist the team to anticipate any press enquiries ... the document was not in fact circulated to anyone within our Trust'* Mr D wrote to the Trust on 7 May 2012 presenting his *'formal complaint'*. He explained his view that the actions of the Trust in preparing the midwives for the inquest were *'evidence of professional wrongdoing'* and he complained that the Trust was *'refusing to investigate'*. He wrote:

    'This does not seem to me to be an open and accountable way of responding to these concerns and has unfortunate echoes of the defensive attitude of the Trust that we have had to confront ever since G's death.'

71. In June 2012 the Trust reiterated to Mr D that the *'Q&A'* document had not been circulated to anyone in the Trust. However, they explained that the *'Q&A'* document had been based on *'Issues'*. They said that the *'Issues'* document had been prepared by the Trust's solicitor (*'based on issues identified by the various investigations that had been undertaken both internally and externally'*) and was *'an entirely normal part of the process of preparing for an inquest where we are supported by our solicitors'*. A copy of *'Issues'* was then provided to Mr D.

72. The Trust explained to Mr D that there had been a meeting with the midwives and the maternity risk manager on 27 April 2011, which it also described as *'an entirely normal part of preparing for an inquest'*, after which the maternity risk manager sent the midwives a copy of the updated *'Issues'* document on 9 May. The Trust said that in response to Mr D's complaint, they had interviewed six of the midwives involved in G's care, of whom four said they did not recall having seen *'Q&A'* and two *'stated they did not see it'*.

73. On 28 June 2012 the Trust's chair confirmed that none of the midwives could *'specifically recall having seen the "Q&A" document'*. He wrote:

    'You have asked the Trust to investigate why the midwives said they had not seen the Q&A document when, in your view, it is the same as the "Issues document". I agree that the documents contain similar content, however, the two documents look very different in terms of their titles and formatting. The 'Issues document' was circulated to the midwives, as you are aware, on 9 May 2011 whereas the Q&A document is dated 1 June 2011 which may have contributed to the midwives' reasonable belief that they had not seen the Q&A document. The Trust considers that the midwives' responses are reasonable ... The Trust will be taking no further action in relation to the answers the midwives gave regarding the Q&A document.'

74. Mr D was dissatisfied with the Trust's explanations about these matters and complained to us in July 2012. Mr D Senior complained to us in August 2012.

Mr D's comments

75. On 14 January 2013 Mr D sent an email to us explaining his view that it was only when his wife gave her recollection of the temperatures recorded on G's observation chart, '*that a decision appears to have been made by all the midwives involved to claim that they were not aware that a low temperature was an indication of neonatal sepsis*'. He said that he agreed with the Coroner that it was '*absolutely inconceivable*' that none of the midwives '*had any suspicion that a low temperature in a baby could indicate sepsis*'. He added: '*the main reason why the midwives never called a doctor, relates to the dysfunctional breakdown of the relationship between the midwives and doctors ... '*.

Mr D Senior's comments

76. Mr D Senior said that the email that the maternity risk manager sent on 9 May 2011 (paragraph 47) '*proves that collusion in some form took place*'. He says that the

    '*nub of* [his] *complaint* [is] *against the chair and the chief executive of the Trust ...* [for] *failing to recognise that the process of construction of agreed "answers to questions" anticipated as arising at the inquest was wrong, both procedurally and morally.*'

    Mr D Senior says that the then chair and the then chief executive of the Trust condoned the collusion and have refused to investigate it.

The Trust's comments

77. We wrote to the Trust on 11 April 2013 asking for a statement about their preparation of staff for the inquest. The Trust responded on 20 May with the following statement from their solicitor:

    '*... The Trust was notified of the Coroner's intention to hold an inquest in early April 2010. Prior to this, the Trust had undertaken and/or commissioned a number of investigations, both internal and external, into the circumstances surrounding G's care and subsequent death ...*

    '*Members of Trust staff involved in G's care had been asked by the Trust to prepare statements shortly after G's death for the purposes of the Trust's internal root cause analysis investigation. Statements were prepared by the midwives involved in G's care in December 2008 ... As part of the Trust's internal root cause analysis investigation, those investigating met with the midwives and others involved in G's care to elicit further information to assist with the investigation. An external investigation was commissioned at roughly the same time and the information gathered as part of the internal investigation was shared with the external investigators. The Local Supervising Authority (*[the LSA] *supervisors of midwives) also instigated an investigation into the midwives' care of G and meetings were held between the LSA and individual midwives ...*

    '*The Trust's internal investigation concluded in March 2009 and the then chief executive of the Trust ... wrote to* [Mr D] *to admit that the care provided to G by the Trust was unacceptable and that there had been a failure to recognise the sepsis that ultimately led to G's death.*'

'... [the legal firm used by the Trust] *was instructed in April 2010 to represent the Trust and its staff at G's inquest. It is normal practice for the Trust to seek legal advice and/or representation, if deemed required, in connection with legal proceedings, including inquests. It was felt that advice and support was required in view of the circumstances of G's death, the number of staff involved and in the context of the many investigations and reviews that had either been concluded or were on-going at that time.*

'[The Trust's solicitor] *advised the Coroner of her instruction and spoke to the Trust to obtain full instructions on 16th April 2010. The Coroner had opened the inquest and requested all relevant documents held by the Trust ...'*

' ... The view was taken that all potentially relevant documentation and information should be shared and that the decision as to what documentation and information was required for the purposes of the inquest should rest with the Coroner ... The disclosure process and the process of corresponding with the Coroner to agree information and witnesses required for the purposes of his inquiry took almost 12 months.

'The statements prepared by the midwives and others back in 2008 were disclosed to the Coroner in June 2010. As the statements were brief in their content, the Coroner was asked to confirm whether he would like [the Trust's solicitor] *to coordinate the collection of further detailed statements from those involved in G's care. The Coroner confirmed that he did not require any further statements.*

'At a pre-inquest review hearing on 23rd November 2010, the Coroner confirmed that he required all midwives involved in G's care to give evidence at the inquest. The Coroner had also identified a number of individuals from G's case notes from whom he required statements (who had not previously prepared statements) and statements were subsequently provided by those individuals. Prior to this time, little information about the inquest had been provided by the Trust to those involved in G's care as it was not known the extent to which those involved in the care would be required to participate in the inquest process, and the Trust did not want to cause any unnecessary distress or concern amongst staff. When it was confirmed that all staff involved in G's care would be required to give evidence at the inquest (including staff who were no longer employed by the Trust), the Trust notified such members of staff and, with the assistance of [the Trust's solicitor], *located and made contact with former members of staff to advise them of the same.*

'The members of staff were informed that they would all be given the opportunity to meet with [the Trust's solicitor] *and managers within the Trust so that the necessary support and information as to what to expect at the inquest could be provided. The majority of staff had not attended at court previously and were understandably concerned about the process. Once the date of the inquest was known this was communicated to all witnesses and efforts were then made to ensure that all witnesses were available to attend to give their evidence.*

'In view of the process detailed above and the availability of the staff affected, it was not until 11 April 2011 that [the Trust's solicitor] *had the opportunity to meet with the inquest witnesses. Prior to this meeting,* [the Trust's solicitor] *had prepared a document, which has been referred to as the "Issues" document, detailing the likely issues that she anticipated being raised as part of the inquest process. This document was effectively a culmination of the issues/queries that had arisen in relation to G's care since the time of his death (information pulled together into one composite document from the many documents that were in existence and formed part of the inquest bundle). The document was intended to assist* [the Trust's solicitor] *in ensuring that the Trust and its staff were fully aware of the possible issues that might arise so as to ensure in turn that the Trust and the witnesses were in a position to be able to participate fully in the inquest process and assist the Coroner with his enquiries.*

'At the meeting on 11 April, it was very clear that those witnesses present (not all witnesses were able to attend) were anxious about giving evidence and had been provided with very little information since the Trust's internal root cause analysis investigation at the end of 2008 about the many reviews, investigations, issues and so forth that had arisen since that time. Some of the witnesses present had not refreshed their memories of the case note entries or of their own statements prepared in 2008. As a consequence, they felt unable to discuss the list of issues and unable to give clear instructions to [the Trust's solicitor] *as to their involvement in G's care.*

'A further meeting of the midwives involved was therefore facilitated by [the maternity risk manager], *and took place on 27 April 2011. It is understood that the purpose of this meeting was to give the midwives the opportunity to review the case notes, their statements, and the many reports/reviews that had taken place, and to consider the list of issues. The meeting also enabled the Trust to provide support to staff, in line with their duty of care as an employer, during what was a difficult process. To assist with this process,* [the Trust's solicitor] *was asked if it was possible for her to send through to the witnesses the list of issues so that the list could be considered further.* [The Trust's solicitor] *sent the list by email on 13 April 2011.*

'The list was returned to [the Trust's solicitor] *by email on 9 May 2011.* [The maternity risk manager] *and others had attempted to populate the list with information discussed during the meeting on 27 April 2011 – effectively the information provided was confirmation of internal policies/ procedures referred to in the document and confirmation of information that was contained within the midwives' statements or in the case notes as to G's care. It was the information that* [the Trust's solicitor] *had anticipated collating at her meeting on 11 April so as to assist her with her preparation for the inquest and so as to ensure that she had all the information she would require to provide appropriate representation for the Trust and its staff.*

'[The Trust's solicitor] *met again with the witnesses (including some she had met with previously and others who had not been able to attend the*

previous meeting) on 18 May 2011 and 23 May 2011. On this latter date, [the Trust's solicitor] *met with a number of the midwives individually to address specific concerns they had with regard to their participation in the inquest process.*

'Essentially, the Trust's preparation for the inquest consisted of document collation and review, and meetings with the witnesses to provide the necessary support. The witnesses were provided with information on what to expect from the inquest process, and how to prepare themselves for giving evidence. The list of issues was also discussed to ensure that those involved in the process were aware of the possible extent of the inquiry and to allow them the opportunity to consider their own personal involvement in G's care and how they might best ensure that all relevant information that they may have been able to provide was communicated to the Coroner and to G's family to assist with their understanding as to the circumstances surrounding G's death.

'The issue of the midwives' knowledge of the implications of a low temperature in a baby was raised during the course of the meetings referred to above. Each midwife spoken to by [the Trust's solicitor] *confirmed that she had not been aware at the time (in 2008) of the implications of a low temperature in a baby. (The midwives' statements confirmed that G's temperature had been low on occasions.) This confirmation had previously been given by the midwives as part of the Trust's internal root cause analysis investigation back in 2008. The report of that investigation concluded that G's inability to maintain his temperature had not been recognised as a potential sign of sepsis by the midwives. The subsequent external investigation commissioned by the Trust also concluded that there was a lack of recognition by the staff of the relevance of neonatal hypothermia. The LSA report reached the same conclusion and identified this as a training issue. The information provided to* [the Trust's solicitor] *as part of the inquest preparations was fully consistent with that given previously by the midwives in 2008.*

'In addition to the legal support referred to above, the Trust's Communications Team was also involved in preparations for the inquest in view of the extensive local and national publicity that this particular case and other matters were generating at that time. The Trust anticipated that there would be a significant level of media interest in the outcome of the inquest. As a consequence of this the Trust's Communications Team prepared an internal Questions and Answers (Q&A) document to assist with any potential press enquiries.'

Statements taken by Cumbria police

78. In 2012 and early 2013 Cumbria police investigated Mr D's allegations of perjury and attempting to pervert the course of justice. As part of their investigation, the police interviewed Trust staff under caution. (They were not arrested but they were informed of their rights and that the information gathered could be used as evidence.) I include here extracts of the evidence obtained through those interviews. The Coroner was also asked by the police to give a statement about his comments regarding '*collaboration*'. He declined.

79. Midwife E gave a written statement to the police in which she wrote: '*I do not accept that anyone tried to influence me to give evidence in a particular way ... I gave evidence at the inquest. The evidence I gave, to the best of my knowledge and belief, was a true and accurate account of my actions*'.

80. Midwife F gave a written statement to the police that read:

    '*... G's is the only baby death I have been involved in. I have no experience of dealing with a Coroner's investigation or attending an inquest. I was advised that I would be supported throughout the process by the Trust and their lawyer. In preparation for the inquest I was asked by senior management to attend at least two meetings ... The meetings were held as group meetings. At no point during the meetings was I asked to discuss my evidence or advised by any person to influence the outcome of the inquest.*'

81. Midwife H's written statement included the following:

    '*I confirm that I attended a group meeting with the Trust solicitor prior to the Coroner's inquest. I attended on the premise that I would receive information about the inquest. At no point was I asked to alter the evidence that I intended to give at the Coroner's court under oath. I deny that I colluded with any of my colleagues and agreed to give my evidence in a particular way.*'

82. Midwife J provided a written statement in which she explained:

    '*... in preparation for the inquest I attended two meetings. The first meeting ... I attended ... along with* [the maternity risk manager], [the Matron for Midwifery] *and the Trust solicitor. There were other midwives who were involved in G's care also present ... no specific details of G's case were discussed. The meeting just touched on what happens at an inquest and what to expect.*

    '*The second meeting was much larger.* [The chief executive] *... attended ... The meeting went on for some time. The solicitor had compiled a note of points she anticipated would be raised at the inquest. None of the points she had noted involved my evidence. At no time during the meeting was my evidence discussed. Not all the points that the solicitor wanted to discuss were* [as] *we ran out of time ...*

    '*The solicitor gave some general advice about how to give evidence in a Coroners' court, such as to answer the questions asked and if you do not*

know or cannot recall an answer, to say so ...

'I have been shown two e-mails, one of which is addressed to me ... The contents of the attachment [the '*Issues*' document as amended by the maternity risk manager] *do not appear to be relevant to my evidence and in no way influenced the evidence I gave at the inquest ... I gave my evidence in accordance with my recollection of the events ... .'*

83. The maternity ward manager explained in her written statement:

'I have attended meetings in the past at the request of my employer as I felt duty bound to do so, however, at no stage have I tailored my evidence at the request of any person or organisation.'

84. A nurse who had care of G on the special care baby unit gave the following information at interview:

'... She did not actually meet [the Trust's solicitor] *until the day of the inquest*. [She] *was aware of meetings that had been attended by midwives and the general talk on the Ward was of the guidelines and of babies being cold and sepsis ...* [When shown the '*Issues*' document] *she confirmed it was not given to her to prepare for the inquest ... She believed it was sent for information to explain where changes/ guidelines were occurring* [sic] *as following the D death there had been many changes ... .'*

85. The maternity risk manager made the following statement:

'... [the statements taken in 2008] *were written/typed by the various members of staff. I had no input into the narrative of those statements ... Prior to the inquest a number of midwives were somewhat concerned and confused as to the inquest proceedings and what was expected of them ...* [The Trust's solicitor] *suggested that a meeting could be set up to enable her to explain the inquest procedure ...*

'Subsequent to the [first] *meeting,* [the Trust's solicitor] *sent me an email attaching a list of issues that she felt were relevant to the forthcoming inquest. In particular Mr & Mrs D had raised a number of concerns and they deserved a proper response.* [The Trust's solicitor] *suggested that it may be helpful if we discussed the issues at the second meeting which was to be held on 27 April 2011.*

'I took [the Trust's solicitor's] *advice in good faith. She had raised a number of issues and she gave me the impression that she wanted a response in relation to the same.* [At the second meeting] *the issues raised by* [the Trust's solicitor] *were discussed and the responses from the midwives were documented by me.*

'At no point during any of the meetings did I, or anyone else, seek to influence any midwife as to the evidence they intended to give at the inquest ...

'I typed up my notes and circulated them ... I specifically asked the midwives to notify me if they felt that my notes were inaccurate in anyway or if I had missed anything out. At no point was I told or warned that [this] *was inappropriate in any way.*

'... These meetings were an exercise [in] *facilitating the truth and not conspiring to pervert the course of justice as suggested ... I simply raised the issues*

and documented the responses ...

'I have been asked to comment upon my knowledge of two black files which were made available to staff prior to the inquest. The black files in question contained health records, statements and other documentation relating to baby G.

'Given the passage of time, namely 2 ½ years, I felt that some of the midwives may have benefitted from re-freshing their memory as to the events in October 2008. It would've been absolutely absurd had the midwives attended the inquest and not been in a position to assist the Coroner in what is essentially a fact find[ing] *exercise ... I have never suggested to any person that they should say anything but the truth at the inquest ... .'*

86. Although the matron for midwifery did not give evidence during the inquest, her contribution to the preparations is mentioned in the maternity risk manager's email of 9 May 2011. The matron for midwifery was therefore asked to give a statement to the police. It included:

    '... At no point have I ever suggested to any midwife that they should say anything but the truth at the inquest. I have never sought to influence any midwife at the evidence they intended to give at the inquest ... .'

87. The record for the Trust's chief executive's police interview includes the following:

    '[The chief executive explained] *... It is not uncommon after an incident to discuss what has happened in a joint forum to learn from it ...* [The chief executive] *was asked if he ever influenced staff what to do* [in relation to their initial statements] *he replied, "absolutely not and at the time there wasn't an inquest". He stated there would have been no benefit to anyone changing their statement as* [the] *Trust already admitted failings. He stated, "we got it wrong and had no intention to fight it" ...*

    '[The chief executive] *went on to explain how they prepared for the inquest, which involved a number of meetings, the purpose of these meetings were to make sure people understood how an inquest works and that they* [were] *supported as staff were frightened. There was a lot of publicity and questions being asked about the legal process and handling the media ...*

    '[The chief executive] *remembered attending one meeting with the Trust's solicitor ... They went through the legal process, what to do and how to handle it, he believes it had been arranged by* [the head of midwifery or the head of legal services]. *He does not know who asked for it to happen but he wanted it to take place to support staff. It was also to introduce staff to* [the Trust's solicitor].

    '[The chief executive] *went on to explain it was the point at which staff needed to be honest and* [identify] *if anything had been missed ... He did remember saying to staff* [that the inquest] *was not to catch anybody out and that they were to answer questions honestly ...*

    '... he stated ... they were all sat in a circle talking through the incident and taking questions about staff concerns especially regarding the media. He stated he had attended

similar meetings in the past to prepare for inquests; it was not unusual. He personally did not attend all meetings but this inquest was a particularly difficult case ... [He] *reiterated that the meeting was absolutely not to influence staff.* [He] *stated he believed the meeting had not gone beyond normal preparation for an inquest of this nature and the meeting was optional and was to give support to staff, it was not compulsory to attend.*

'[The '*Issues*' document] *was handed over to* [the chief executive]. *He stated he may have seen it before but did not recognise it ... He was surprised it had been sent to everyone before the inquest ...*

'It was put to [the chief executive] *that did it not suit him to influence the evidence given at the inquest to proportion* [sic] *blame to the midwives and their care of G to avert the attention away from him ... he categorically denied* [this] *... Again it was put to* [the chief executive] *that he has influenced staff in tailoring their evidence as it suited him to keep the evidence narrow in order to protect his professional reputation and that was the motivation in calling the meetings. Again, he denied this ... .'*

88. The Trust's solicitor was also interviewed by Cumbria police and was asked about the files of information that were made available to staff prior to the inquest:

'... She stated that she gave no specific instructions as to what the Trust staff were to do with [their copy of the papers she had prepared for the Coroner], *the Coroner had not given any instructions regarding the security of it. It would be usual for witnesses to have access to it prior* [to] *and during the inquest in order to refresh memory or if witnesses needed to refer to any documents within ... She stated that draft statements would not however be contained in the* [papers] *and in any case all the statements in the case had been submitted in 2008 before being disclosed to the Coroner by her in 2010.'*

89. With regard to the meetings which took place, the Trust's solicitor explained the following to the police:

'[The first meeting] *was* [a] *group meeting ... She got the impression that staff did know some of each other's evidence but didn't know how they came by this information.'*

90. The Trust's solicitor was also asked about the '*Issues*' document:

'[She] *commented on the fact that she was just doing her job in making her client aware of the issues in the case and that this was a usual process in order that the witnesses could serve the purpose of the inquest and offer up the best information for the Coroner ... She however was surprised to receive an email back from* [the maternity risk manager] *with so-called answers to her issues on ... She stated that the return document from* [the maternity risk manager] *was helpful as she herself did not fully understand some of the issues ... She appreciated that it does look a bit odd but there was nothing sinister in it ... She added that in any case the further information on the documents would not have coloured the evidence given as there was nothing additional on them ...*

'She said she would not coach witnesses and would only advise them on the process and how to help

the hearing ... At no point during her involvement with this case did she receive instructions from the Trust to limit the blame to the midwives only ... [She] *stated that no collaboration took place to obscure or alter the evidence.'*

The outcome of Cumbria police's investigation

91. No charges have been brought relating to Cumbria police's perjury/perverting the course of justice investigation. The senior investigating officer explained to us that while the Trust's preparations for the inquest could be described as '*naïve and open to poor perception*', they found no evidence of criminal activity in those preparations.

Midwifery advice

92. We asked the Midwifery Adviser whether, in October 2008, the midwives should have known that low temperature/inability to maintain temperature in a newborn could be a sign of infection. The Midwifery Adviser explained that, in the postnatal period, the midwives should observe the baby to ascertain its health and wellbeing. This observation should include the baby's colour, warmth, respiratory effort, muscle tone, nappy contents and behaviour (such as crying and feeding). She explained that thermal control is often poor in the early postnatal period because babies are wet when they are born and emerge from a warm environment (inside their mother) into a cooler atmosphere, causing rapid cooling. She further explained that babies have a single layer of fat under the skin and therefore little insulation. She added that the mechanism for a baby to maintain its own temperature is a complex process, and it is therefore essential that the baby is helped to keep warm by the provision of suitable clothing and a warm environment.

93. She advised that a healthy newborn baby should be able to maintain its temperature. She referred to the National Institute for Clinical Excellence's clinical guideline 37 *Routine postnatal care of women and their babies* (NICE, 2006) which explains:

    'Healthy babies should have normal colour for their ethnicity, maintain a stable body temperature, and pass urine and stools at regular intervals. They initiate feeds, suck well on the breast (or bottle) and settle between feeds. They are not excessively irritable, tense, sleepy or floppy. The vital signs

of a healthy baby should fall within the following ranges:

- *respiratory rate normally 30-60 breaths per minute*
- *heart rate normally between 100 and 160 beats per minute in a newborn*
- *temperature in a normal room environment of around 37°C (if measured).*

'... A temperature of 38°C or more is abnormal and the cause should be evaluated (emergency action). A full assessment, including physical examination, should be undertaken.'

94. The guideline is silent about low temperatures in a newborn baby.

95. The Midwifery Adviser explained that a baby's inability to maintain temperature can be due to a range of problems including: prematurity, inability to feed adequately, low blood sugar, inadequate clothing or low environmental temperature or illness, including infection. She said that midwives play a central role in the diagnosis and treatment of illness in both the mother and the baby and should be aware of all the potential causes of low temperature. The Midwifery Adviser referred to *Myles Textbook for Midwives*[14] (14th edition, 2003) which explains:

    'In the newborn, early signs of infection may be subtle and difficult to distinguish from other problems; the mother or midwife may simply feel that the baby is 'off-colour'.

    '***Individual risk factors for infection***. *These include:*

    - *a maternal history of prolonged rupture of the membranes*
    - *...*

    '***Physical assessment.*** *This can include observation of:*

    - *temperature instability*
    - *lethargy or poor feeding, ... hypothermia ... .'*

96. In conclusion, the Midwifery Adviser said that the midwives should have known that low temperature/inability to maintain temperature in a newborn could be a sign of illness in the baby, including infection, and this should have prompted a medical review.

14 Fraser, D and Cooper, M (eds).

Legal advice

97. The Legal Adviser explained that there is no guidance on the preparation of witnesses for inquests or any other legal proceedings; the only guidance on what is and is not acceptable comes from case law (paragraphs 16 to 18). She went on to explain that it is not acceptable for a solicitor to coach a witness for a hearing, and that giving witnesses the answers to likely questions would be considered coaching. However, she explained that it is acceptable for a solicitor to familiarise witnesses with the task of giving evidence coherently by talking to witnesses about what they will experience and the likely areas of questioning they will face.

Findings

98. In making findings I have organised key considerations around several distinct areas of content. These allow important elements of the case to be placed in context so that they underpin the conclusions reached following the investigation.

What we would expect the midwives to know?

99. Our Midwifery Adviser has said unequivocally that the midwives should have known that low temperature in a baby could be a sign of illness, including infection. Arguably more importantly, they did not respond appropriately to G's temperature instability and take an '*overall view ... and think, yes, there is a potential problem here*'.

100. On the other hand, I have also taken into account that fact that the NICE guidance referred to by the Midwifery Adviser specifically mentions that a temperature of above 38°C is '*abnormal*' but does not include a similar warning about low temperature. I have also considered the suggestion that this maternity unit '*found it increasingly difficult to ... appoint high calibre staff*'.

101. We have seen that the Trust took action to address what they saw as a recognised gap in knowledge regarding the issue of low temperature and sepsis in that the midwives received training in 2008/09 specifically following the investigations into G's case.

102. Ignorance amongst the midwives about the implications of a low temperature in a baby was also highlighted in February 2009 in the Chandler and Hopps report, which reported that: '*There* [was] *a lack of awareness by the staff that persistent hypothermia in a neonate can indicate sepsis*'.

103. By the time of the inquest, the NPSA *Signals* piece had been published, in October 2010, and made public that ignorance of a low temperature was an issue in G's care.

104. I have outlined above a number of considerations that have been part of our investigation and that I have taken account of. However, I do not consider that any of those considerations constitutes evidence of whether there was collusion or not.

Preparation for the inquest

105. I have found no evidence that the Trust, when preparing for the inquest, failed to comply with the law or act in accordance with established good practice ('*Getting it right*').

106. Mr D Senior suggested that the midwives agreed a '*description of events that paint*[ed] *the hospital Trust in the best possible light*'. However, I do not see how asking the midwives to '*collaborate*' on the temperature issue would have achieved that. Even before the inquest, the Trust were aware that they were likely to be criticised for a much broader range of failures. The midwives' evidence showed the Trust in a very poor light and exposed a '*system failure*' that the Local Supervisory Authority report had noted and which the chief executive had already accepted in March 2009. Arguably, the general lack of awareness amongst their staff placed the Trust and the chief executive in a worse position, since they were responsible for the continuing professional development of their staff.

107. It is also important to set the suspicion of collusion on one particular point in that wider context. The Coroner did not suggest that the midwives '*got together*' to agree a story about any other aspect of G's care, nor did he see the low temperature as the sole indicator that something was seriously amiss. There were other signals that should have prompted action that might have saved G's life. As outlined in paragraph 66, the Coroner said:

> '*... nobody ... was able to stand back, [take] an overall view, think about the prolonged rupture of membranes, G not feeding well, failure to maintain his temperature, Mum had collapsed 20 minutes after labour, had produced G, and put all that together and think, yes, there is a potential problem here, nobody ever did ...*
>
> '*I think that Mrs D and G were treated as two unrelated individuals, and thought was not given to the fact that if something was affecting Mrs D it might have a bearing on how G was. There was a failure to think laterally, a failure to think holistically, not just for each of them, but for the two as mother and baby.*'

108. Turning to the concerns about the '*Q&A*' document, although it was drafted in the form of questions and answers regarding issues thought likely to arise at the inquest, there is no evidence that it was circulated to the midwives in this format. Nor is there any evidence to suggest that it was intended to be '*rehearsed answers*' for the midwives to learn and give to the Coroner.

109. It is clear that the Trust missed an opportunity when corresponding with

Mr D in December 2011 to be more open with him about the origin of the '*Q&A*' document. The Trust should have said earlier that it was based on the '*Issues*' document, which had been circulated. However, despite the fact that the Trust's actions in relation to this point were not in the spirit of the *Principles of Good Complaint Handling*, I do not think they were maladministrative.

110. Turning to the '*Issues*' document, which was circulated to the midwives, this document summarised issues taken from earlier inquiries and reports regarding the care provided to G. These are not something that the Trust would have needed to persuade the midwives about; they were already well known by, or accessible to, everybody close to the case. I do not agree that the circulation of the '*Issues*' document '*proves that collusion in some form took place*'.

111. Annex A to this report tracks the development of the '*Issues*' document during the Trust's inquest preparations. Analysed in this tabulated format, it is clear that none of the information added at any of the meetings was anything other than a clarification of the evidence gathered in earlier inquiries and reports. I have not taken a view, as part of this investigation, about the accuracy of that information and so I am not commenting on that. However, I am persuaded that the 'Issues' document was created for no other reason than to help the Trust's solicitor identify the issues that might arise at the inquest, and facilitate the proper familiarisation of the midwives with the areas of questioning they were likely to face. Indeed, I acknowledge that the Trust's solicitor's note of 11 April 2011 specifically mentions that the midwives were told to give evidence '*honestly and professionally*'. In short, I have seen no evidence that the Trust's solicitor acted inappropriately in this respect, and I consider that the Trust's preparations for the inquest were reasonable and appropriate.

112. I have seen no evidence that the midwives agreed to give '*false evidence*' about the accounts they would give at the inquest of their knowledge of the implications of a low temperature in a baby. The root cause analysis noted that, shortly after G's death, it was identified that his '*inability to maintain his temperature had not been recognised as a potential sign of sepsis*'.

113. It is also relevant that the midwives asked about this by the Coroner all said that they did not know **specifically** about the link between low temperature/inability to maintain temperature and infection. However, when questioned they did not all say that they would have responded as Midwife F and Midwife J had done if they had observed G's low temperatures. Indeed, Midwife H, Midwife L and Midwife W suggested that if they had observed G's abnormal temperatures, a referral to the paediatrician would have been made.

114. On the '*specific point*' of their knowledge of the implications of a low temperature in a baby, it seems that the Coroner suspected that some of the midwives had had this knowledge but had forgotten it, and some had never known it or did know but had failed to apply it because they just did not think about it. The Coroner said

'... I did consider the possibility of natural causes with neglect. I have not gone for that. Neglect is a gross failure to provide medical care ... this is not the Scribes and the Pharisees walking past on the other side of the road ignoring somebody who needs help ... It is just that they did not recognise the signs that they were seeing as being what it was, which is a signpost to something very important.' (My emphasis.)

He continued:

'... although readings were being taken, they were not being taken to heart if you like, they were not being acted upon, because those readings ... should have triggered off a report to a paediatrician ... So, as I say, although records are being taken, thought is not being applied to what those records say.'

115. For completeness, I should say something about the inquest process more generally. Firstly, an inquest is different from a criminal trial and what is considered reasonable preparation for an inquest may not be considered so for a criminal trial. That distinction arises because an inquest is essentially a fact-finding process; an inquest does not establish any matter of liability or blame, witnesses are not obliged to answer incriminating questions, and inquest evidence cannot be used directly in other proceedings (paragraph 15).

116. Second, during an inquest the witnesses are able to listen to the evidence given by other witnesses. This means that each midwife was able to listen to colleagues answer questions about their knowledge of the link between low temperature and infection, before being asked those questions themselves.

117. Throughout this investigation, I have kept in mind the Coroner's observation that it was 'inconceivable' that none of the midwives knew of the link between low temperature and infection. It was for him to come to a view on that. However, his view is not in itself evidence that the midwives colluded on this point.

118. We also must keep in mind the fact that during an inquest the witnesses are able to listen to the evidence given by other witnesses. This means that each midwife was able to listen to colleagues answer questions about their knowledge of the link between low temperature and infection, before being asked those questions themselves.

119. Case law also tells us that it is for the court or jury to decide how much weight is to be given to evidence that is thought to have been contaminated by pre trial group meetings (paragraphs 16 to 18). The Coroner said that he suspected '*collaboration*', and it was for him to weigh up the midwives' evidence with that in mind.

120. Overall, I have seen no evidence that before the inquest, the midwives colluded about the accounts they gave regarding their knowledge of the implications of a low temperature in a baby. I have seen no evidence that the midwives breached the NMC Code (paragraphs 21 and 22), and no evidence of '*professional wrongdoing*' in their preparations for, or conduct at, the inquest.

Responses to the draft report

121. Responses to the draft report from the Trust and the complainants are included in Annexes B-G.

Conclusion

122. There are compelling perspectives and opinions about what parties should have known and done alongside those regarding what they must have known and done. In acknowledging such views, having considered the material, I have not found evidence that collusion took place between the midwives in preparation for the inquest. Therefore, I cannot uphold a complaint that collusion took place.

Annex A: The development of the 'Issues' document

The original '*Issues*' document 11 April 2011 The italicised text appears to be findings from earlier reports/inquiries.	The '*Issues*' document post 27 April 2011	The Trust's solicitor's handwritten notes 18 May 2011	The '*Q&A*' document 1 June 2011
Prenatal care			
Mrs D was sent home from hospital on two occasions after her waters had broken.	Nothing altered/added.	NICE states expectant man[agement] should not exceed 36 hours. Was expectant man[agement] appr[opriate] if suspicion of infection from urine? No [midstream sample of urine] taken on 25/10.	No change to text.
(According to the family) Mrs D was advised to stay at home when she contacted the hospital to advise that the discharge had turned slightly yellow in a telephone call during early hours of 27 October [2008]. This call/advice is not recorded in notes.	[The midwife who spoke to Mr D at 5.30am on 27 October – Midwife S] has no recollection of phone call, but the advice given regarding 'yellow' discharge was appropriate. A green or black discharge would have been of concern.		No change to text.
Membranes were ruptured for 34 hours.	Nothing altered/added.		No change to text.

Infection			
Failure to respond to parents' concerns that infection would have passed from mum to child and to give G antibiotics.	Paed was contacted to obtain advice on management of G. Advised to observe.	SHOs obs + gynae did not consider infection passing to baby. What observing for?	Wording altered slightly to phrase issue as a question (that is, why did you not respond ...)
Failure to record and respond to information reported by parents to midwives several times that Mrs D had recently been unwell.	Midwives A and B have no recollection of being told [Mrs D] had recently been unwell. However, Midwife B did record that [Mrs D] had a headache at the second attendance, which [Mrs D] attributed to lack of sleep.		As above (that is, why did you fail ...)
Parents feel that the due date calculated by date of last period (rather than scan) should have been used. If this date was used then would have fallen within protocol guidelines for automatic antibiotic treatment following [premature rupture of membranes]. As (earlier) scan date used, [Mrs D] just (21 hours) outside the timescale for automatic provision of [antibiotics]. *The agreed system within the Department of calculating the* [estimated due date] *is from the ultrasound scan date as per NICE guidelines.*	The calculation of the [estimated due date] from the [ultrasound scan] follows national recommendations. (NICE, 2003 Antenatal Care)	Infection risk increases as time progresses from [spontaneous rupture of membranes] – failure to keep check on [Mrs D]? Significance of urine tests prior to admission. Did not know about infection until [Mrs D] ill on 27/10.	Again wording changed slightly to phrase issue as a question (that is, why did you use the date of the scan ...)

Infection			
[Mrs D] was told not to breastfeed G after he was born but on the postnatal ward was advised that there was no reason why she should not breastfeed.	[Mrs D] was not well enough to breastfeed on [labour ward], which is why a supplementary feed was given (not by bottle, as this may interfere with G's ability to latch at breast). As her condition improved on Maternity Ward, breastfeeding was then commenced.	Feeding cup not avail. By syringe? No issue re not to breastfeed because of infection?	Again wording changed slightly to phrase issue as a question (that is, why was [Mrs D] told not to breastfeed ...)
Care of G			
Failure to examine G appropriately after birth. No examination by a paediatrician and standard baby check delayed. *Initial baby check was carried out but not recorded until later on in the shift. The record-keeping at this stage was poor. The initial baby check is shown in the audit trail of electronic records as they show what details were documented and at what time but the printouts from Evolution do not show all the information that would reflect this. This is a failure within the software.*	Nothing altered/added.	Routine exam by paed. due before discharge.	As above (that is, why was G not examined ...)

Care of G			
Who instigated the call to the paediatrician? Family say they asked about the risk of infection passing from mum to baby and this instigated the call, but [the maternity ward sister] says she and [Midwife F] instigated the call. The call is not recorded in the notes, neither is the advice allegedly given by the paediatrician. Does the bleep log evidence the call was made?	[Midwife F] recollects discussing [Mrs D's] condition with [them], and agreeing that she would contact the paediatrician for advice. Following discussion she contacted the paediatrician and informed him of [Mrs D's] condition and management of the baby. She fed back the advice given to [Mr and Mrs D] and observations were commenced. Bleep log query – [complaints manager] can you answer this?		Slight change to text but does not change meaning.

Care of G			
Parents allege that APGAR scores recorded in notes cannot possibly be correct and allege that they were added later to support the midwives' version of events concerning G's condition immediately after birth. They disagree, for example, that he cried immediately.	Midwives [S and C] were the midwives attending the birth. Midwife S assessed the APGAR @ 1 minute as 9. The baby was placed in mother's arms, after she was assisted into a sitting position, as she had birthed in the 'all fours' position. The record of the birth was documented in the health records by Midwife S, before she went off duty at the end of her nightshift (approximately 8.30am). It is normal practice to complete the records as soon as possible after the birth. This documentation has not been added to and was written prior to [Mrs D] becoming unwell. The information was put onto Evolution at 10:50am, as verified by audit trail.	Paed[iatrician] should have told midwives what to look out for if not intending to attend to G himself. Policy page 5 followed.	Slight change to text but does not change meaning.
A paediatrician did not come to see G until 24 hours after birth (upon collapse).	True – the midwife was advised by the paediatrician to observe the baby when contacted by telephone.		No change to text.

Care of G			
Hourly monitoring of G not carried out in accordance with the paediatrician's verbal instructions – although midwives seem to confirm that the instructions were actually for three hourly obs. [The maternity ward manager] refers to a three hourly obs chart; [the maternity ward sister] refers to a four hourly obs chart. The advice given by the paediatrician needs to be confirmed. Was that advice followed?	The Term pre-labour/ prolonged spontaneous rupture of membranes guideline (2006-2009) recommended four hourly temperature, pulse and respiration rate. In practice they would be performed 3 to 4 hourly around the baby's feeding pattern. The chart may be called different names by individual midwives, but is essentially an observation chart.	What advice did paed[iatrician] give? What were you observing for? Why no ear swab in [accordance with] policy Were those 3/4 hourly obs? More or less from obs chart?	No change to text.
Swabs were not taken from G following delivery in line with Trust guidelines when membranes have been ruptured in excess of 24 hours.	The guidance for 'Management for pre-labour/ prolonged [spontaneous rupture of membranes]' (2006-2009) in use 2008 did recommend an ear swab to be taken. However, in June 2008 it was agreed between the obstetric and paediatric teams that the practice of taking an ear swab should cease in line with national guidance. The guideline was in the process of being formally reviewed, but clinical practice had changed to not taking a swab.	What was this [national guidance]? Policy suggests swabs taken routinely when [premature rupture of membranes more than] 24 hours (page 4) does change in practice refer to all swabs (pages 4 and 5)? Was this change recorded in writing? Change not agreed (page 24 of LSA report).	No change to text.

Care of G			
Lack of recognition by the staff of the relevance of neonatal hypothermia and the need to refer for a medical assessment. *Further training on this issue has been carried out and it will be included in the annual training. The LSA report found that this was a systems failure and individual midwives could not be blamed. Care of high risk neonates had gradually transferred from the neonatal and special care units to the maternity wards, with no additional training or resources. Is this correct?*	Yes. Additional training was given in 2009/10, focusing on the revised guidance on the management of neonates at risk of infection, and the neonatal vigilance process that provides clear parameters for neonatal observations and triggers for referral to a paediatrician. The implementation of this process has been audited and re-audited, with findings shared with staff and management.	And covered in obstetric update days in Nov. 2008. Need + new [spontaneous rupture of membranes] policy + new obs chart?	Slight change to text but does not change meaning.

Care of G			
Lack of awareness by the staff that persistent hypothermia in the neonate can indicate sepsis: they responded to his hypothermia by warming the room and/or placing him in a warming cot. *Thermometers now in postnatal ward to ensure temperature of room can be correctly assessed.*	Midwives responded to the drop in temperature by placing G in the warming cot on two occasions. The midwives who cared for G trained and worked different trusts, in addition to [Furness General Hospital]. During their training the prevention, management and consequences of neonatal hypothermia focused on achieving normathermia, by maintaining a warm environment, warm hat and clothes and promoting early feeding. (See attached Hypothermia guideline).	Midwives aware of [conseq] uences of neonatal hypothermia? Didn't connect [with] infection.	The word 'correctly' has been inserted between the words 'Midwives' and 'responded'.
Failure to treat G with antibiotics. The paediatric adviser to the external review was of the opinion that had antibiotics been given to G earlier in his life then he may have survived.	For paediatricians to answer.	Infection not identified to lead to antibiotic treatment.	Wording changed slightly to phrase issue as a question.

Factual dispute re: recorded temperatures and APGAR scores (heightened by loss of chart)			
The parents vehemently dispute the temperatures detailed in the midwives' statements prepared for the LSA which are all within the normal range. They state that [Mrs D] can remember two temperatures of below 36° being recorded. *The Trust accepts* [Mrs D's] *recollection. Examination findings re: G should have been recorded in the paediatric care plan and paediatric notes.*	[Mrs D's] recollections of temperatures below 36° were not shared with the midwifery staff until after the publication of the LSA report. This information was revealed at the meeting between the family and the external review team, who never interviewed the midwives involved. The midwives' recollection is that the temperature was '*low*' on two occasions, but they cannot remember the actual figure: at 16:00 hours on 27/10/08 and 06:50 hours on 28/10/08 the drop in temperature prompted the use of the warming cot. (See attached observation chart formulated from midwives recollection).	[Midwife J] gives figures. [Midwife F] doesn't but LSA letter to Mr D after LSA report = [Midwife F] accepts [Mrs D's] recollection may be true.	The lines '*Trust accepts* [Mrs D's] *recollection. Examination findings re: G should have been recorded in the paediatric care plan and paediatric notes.*' have been removed from this version.
This is compounded by the loss of the chart, which the parents believe is a cover-up.	The police investigation did not conclude there was a cover-up. The midwives need the chart as it is the only record of the observations. The chart went missing from [the special care baby unit] where no midwives work.		This version adds: '*All the chart would show is G's observations and that his temperature was low. This has been stated by the staff involved at all stages of every investigation into the case.*'

Factual dispute re: recorded temperatures and APGAR scores (heightened by loss of chart)			
The parents dispute the APGAR scores recorded relating to G – allege midwives have contrived their "absurd" description of G's birth to fit around APGAR scores attributed to him in error.	See response to 'Care of G' point three.		No change to text.
Joined up care			
Failure to respond adequately to temperature drops, breathing difficulties, mum's illness and premature rupture of membranes in examining G.	We would dispute there were any breathing difficulties. [Mrs D] raised concerns following a breastfeed at approx 2:30am on 28/10/08 that G was breathing fast. G was taken to the resource room where the lighting was better. Temperature, [heart rate] and [respiration rate] at that time were within normal limits (statement Midwife J). However, we accept that the additional risk factor of postpartum maternal pyrexia should have resulted in a paediatrician reviewing the baby.		Slight changes to text but does not change meaning.
No mention in the records of Mrs D being unwell in the days prior to delivery, although parents clearly remember telling the midwives about this.	See 'Infection' bullet point two.		Wording changed slightly to phrase issue as a question.

Joined up care			
Staff on the postnatal ward were not aware that mum had collapsed after birth and had needed antibiotics is this correct?	The staff on the Postnatal Ward were fully aware that [Mrs D] was unwell and had had 'rigors' shortly after birth and had commenced IV antibiotics 4-hourly. This information is recorded on the [postnatal] care plan, the delivery summary printout from Evolution and continued observations are recorded on the maternity observation chart. The administration of the [intravenous] antibiotics is recorded on prescription chart. It is not clear whether [Mrs D] was nursed in the isolation cubicle due to suspected infection or due to capacity.	[The maternity ward sister] says because of [fever].	Wording changed slightly to phrase issue as a question.
No handover of care to postnatal ward.	As above.		Wording changed slightly to phrase issue as a question.
Family "forgotten about" on postnatal ward as they were in single room due to infection – midwives admitted this.	The continued observations, administration of antibiotics and help and advice with infant feeding demonstrate the family were not forgotten about. However, the ward was full on that day so staff may have 'apologised' if they felt they had not been as attentive as they would want to have been.		Wording changed slightly to phrase issue as a question.

Joined up care			
Workload pressures contributed to inadequate care provided.	See above. Skill mix and staffing levels were appropriate for the workload.	Result of birth rate – plus review on staffing levels – Trust implemented recommendations?	Wording changed slightly to phrase issue as a question.
No joined up care, failing to put all indicators together to conclude that G might be seriously ill. G lethargic, not feeding properly, wheezing and breathing quickly, failing to maintain temperature. *This incident has led to a review of the Trust's policies and procedures with regard to the trigger point for referral to paediatricians.* [A Trust paediatrician] *confirms that there was a policy for monitoring ladies who rupture membranes early and are at risk of infections. Following delivery, and in the presence of premature rupture of membranes with maternal* [fever] *shortly after delivery and the baby's symptoms of hypothermia, poor feeding and respiratory difficulties with excessive secretions, this should have led to G being treated earlier. G was monitored by three different shifts post delivery and at no point were the signs and symptoms put together to take more proactive action.*	We acknowledge that the additional risk factor of maternal pyrexia did not trigger the request for a paediatric review, but we would dispute that G was lethargic, or breathing quick, wheezy apart from the one occasion of [Mrs D's] concerns regarding fast breathing when the [respiration rate] was found to be normal. G's breastfeeding pattern and respiratory rate was typical of a newborn baby in the first 24 hours who was mucousy.	[Fever] in labour was a trigger acc. to policy. Improvement of relationship between midwives + medical – now easier to identify and share concerns (CQC review).	Wording changed slightly to phrase issue as a question.

The practice of allocating women and their babies to a specific midwife on the early shift was not replicated on the late and night shifts. This inhibited holistic overview of care and monitoring. Allocation of care now takes place for 24-hour period. The new records have designated sections for recording this.	[The Trust paediatrician] would need to verify this statement as in 2008 postnatal maternal pyrexia was not an identified trigger, and the other issues re poor feeding, respiratory difficulties and excessive secretions were not the assessment of the midwives caring for G.		
Care post collapse			
Following G's deterioration on 28 October [2008], staff from [Furness General Hospital] suggested G had a defective oesophagus and a heart defect, but neither of these were found to be present upon further investigation by the team at ... Manchester. *Differential diagnosis of severe infection or a heart condition as, if the baby is born with a heart condition they tend to collapse in the first few days of life due to some changes in circulation and the closure of the duct which maintains some pulmonary and systemic circulation.*	Nothing added/ altered.		No change to text.

Care post collapse			
Mr D concerned about negative effects of Prostin – medicine to keep the duct open – which was given for the differential diagnosis of heart condition. *There is no evidence that this could have changed or affected his infection given it is a medicine given to keep his small blood vessels open until a more definite diagnosis has been made.*	Nothing added/ altered.		Question added: '*Could this have contributed to G's death?*'
Recording			
Loss of G's observation chart. Parents felt this was deliberate to conceal evidence re temperatures etc.	This was not the conclusion of a very thorough police investigation.		This version adds: '*All the chart would show is G's observations and that his temperature was low. This has been stated by the staff involved at all stages of every investigation into the case.*'

Recording			
Mum's ethnicity recorded incorrectly (notes record Phillippino [sic] when in fact Vietnamese) query whether significant re risk of infection.	We cannot find this error?		This version adds: '*Is this because there is a greater risk of infection if she is Vietnamese and you wanted to try to hide it?*'
Inadequate record-keeping. *This is accepted. The documentation for G appears to have been reliant upon the missing neonatal observation chart as there is no documentation in the baby section of the postnatal care plan, as would be expected for a high risk baby on regular observations. Following the incident the Trust agreed to purchase the Perinatal Institute Postnatal Care Records for mothers and babies to assist midwives in improving record-keeping standards. These were to be implemented following training in June 2009.*	Audit of these records demonstrate that the standard of documentation has improved.	Example of new notes? – Easy-to-use? (Fielding rep. implies not) + transfer policy.	No change to text.

Annex B: Mr D's letter of 13 January 2014

'Dear Dame Julie

'I write further to my emails to [investigator's name] *on 29 November in which I set out my initial response to the above report in relation to my complaint about the conduct of* [the Trust's] *staff before, during and after my son's inquest.*

'This letter sets out my rejection of the draft report of the Ombudsman into my complaint and the reasons for this ...

'The fundamental failures of your investigation and its conclusions

'At the heart of these failures is the true evidence of my wife and I compared to the false account of some midwives. The conclusion of your investigation into my complaint must imply that the eye witness evidence of my wife and I is false, therefore we are lying or have misremembered key facts.

'The Ombudsman correctly concludes that the Police investigation has been unable to find sufficient evidence to support criminal charges in relation to collusion. This does not mean that significant evidence does not exist. All the Police evidence has been handed by the police to the Kirkup investigation, whose conclusions will be based on the "balance of probability" rather than, "beyond reasonable doubt". The Kirkup investigation will therefore have to make judgements regarding the reliability of the witnesses providing this evidence and compare it with the evidence of my wife and I. Either you have not done that, or else you have drawn conclusions that are not justified by the evidence.

'The evidence of my wife and I is based on notes I made while we were resident in relative's accommodation at the Freeman Hospital in Newcastle in the days before G died. My parents were also staying in a Newcastle hotel for most of this period looking after our daughter, who was three years old at the time. We spent most of every day in each other's company. Our conversations were mainly focussed, as you can imagine, on G's chances of recovery and how he came to be critically ill. When we were not at G's intensive care ECMO[15] *cot, or discussing his condition with the excellent Freeman Hospital consultants and doctors, we were reflecting on our then very recent, direct experience and observations of what had happened to G at Furness General Hospital. During this time, despite our upset, my father encouraged me to write a precise chronology of significant events and our interactions with the midwives, while it was still absolutely fresh in our minds.*

'We constructed the chronology in order to ensure that a fully accurate contemporaneous record should exist that we would be able to pass on to the Trust to help them carry out their own investigation into the failures that led to G's death. That such failures were serious was evident from our discussions with the Freeman Hospital doctors. [A consultant in paediatric intensive care medicine at the Freeman Hospital] *and her team were appalled at what we told them. Given our account of Mrs D's pre-labour history, they were astonished that our baby had neither been administered with antibiotics nor even*

15 Extra corporeal membrane oxygenation is the use of an artificial lung (membrane) located outside the body (extra corporeal), that puts oxygen into the blood (oxygenation) and continuously pumps this blood into and around the body. ECMO provides respiratory support to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function.

been examined by a paediatrician before his collapse. They gave the impression of never having come across such a thing in their medical careers.

'My chronology was therefore constructed with complete honesty and ignorance of the significance it was later to have. It has never been changed or amended. It was used by the Chandler [and] *Hopps enquiry as the factual basis for what had taken place. Up until the LSA report, we were repeatedly told by the Trust that it also accepted this chronology as a full and accurate record. When* [the chief executive] *repeatedly told us this we were reassured on the assumption that the midwives, individually and collectively were party to the Trust's acceptance of the truth and reliability of our evidence. Quite reasonably therefore, up to that point we believed that there would be no factual differences between our account and that of the midwives, either individually or collectively. My contemporaneous chronology was therefore constructed on the assumption that the midwives would agree with us on the basic facts of what happened to our son. It was never intended as a document designed or required to challenge a conflicting account.*

'In reality, several staff involved in the care of G had provided statements that differed from the events that my wife and I know to be true, these difference were hidden from our family and false assurances were given that no such differences existed. All the key differences concerned aspects of G's care that could have implied individual negligence or fault in terms of the actual care G received.

'The LSA Report, written by the maternity risk manager, who referred to her midwives as her "Musketeers" (presumably meaning "all for one and one for all") in an email of 19 April 2009, indeed concluded that the midwives "did nothing wrong".

'The Chandler [and] *Hopps report was based not on any cross examination of the midwives, but solely on written statements they were asked to provide, apparently not for some weeks following G's death. These initial statements were not published in the report and the Trust persistently refused to provide us with copies until eventually compelled under* [the Data Protection Act 1998] *to do so many months later. Documented emails exist that show that when my family made repeated requests for the statements to be released to us, legal advice was sought to see if the statements could be retracted.*

'I can think of no legitimate reason why any member of staff would seek to retract honest statements made in relation to an adverse event simply because the family had asked to see copies of the statements. However, I can fully understand why staff involved in G's care would not have wanted my family and I to see the dishonest statements written in relation to what happened. It would have been very apparent that my wife and I would immediately recognise and react to this dishonestly.

'Your 'investigation' of my complaint appears to be entirely based on the examination of documents without any attempt to consider the possibility that critical evidence given in some of the documents is unreliable or false. To do this will require witnesses to be cross examined and their evidence cross referenced. You appear not to have done this, therefore it is unsurprising that you have failed to come to valid and reliable conclusions.

'The cover up in relation to G's care and the systemic risks caused by continuing dysfunction in the maternity unit at [Furness General Hospital] *was embedded by the failure of every organisation involved,* [the Health and Safety Executive, the Care Quality Commission, the] *Ombudsman*, [the] *LSA and*

the Trust themselves to carry out any kind of proper or robust investigation. This situation was dramatically altered by the granting of the belated inquest. This was not expected by the Trust or any of the other organisations involved.

'By this time the midwives and the maternity risk manager had already committed to a false versions of the key events. If all the staff involved in G's care and the Trust themselves had been consistently honest regarding what happened from the beginning, there would have been no reason for the actions taken by the Trust, its legal team and the staff involved in G's care prior to his inquest.

'The [Trust's solicitor] *was integrated into a pre-inquest preparation group administered for the Trust by the maternity risk manager (who is, significantly, the author of the subsequently discredited LSA Report). This is confirmed in the email of 9 May 2011 to the solicitor, all the midwives involved and other senior Trust staff. In this email the maternity risk manager states:*

'"Please find attached the responses to the questions that we discussed at the pre inquest meeting on 27 April 2011. I have documented the answers from the notes I made and [the matron for midwifery] has made some additions."

'The "questions" presumably arose from our truthful chronology and the "answers" were presumably the collective agreed response of all the midwives, advised by senior Trust staff.

'The Ombudsman defends this process on the basis that it was simply sharing of evidence as part of a proper process of preparing witnesses for the inquest. This only stands up if the agreed "answers" are true.

'The direct product of these events was the "Issues" and "Q & A" documents (that are virtually identical), the former being circulated prior to the inquest to all the midwives called to give evidence.

'The Ombudsman has supported the Trust's case that the "Issues" and "Q & A" documents had been produced as a result of a normal and proper process of preparing employees for an Inquest. It is not clear whether this refers to the view of the Trust under the chairmanship of [name of previous Chair] *(when my complaint was made), or the view of the current Trust management under the chairmanship of* [name of current Chair]. *Has the Ombudsman directly asked* [the current Chair] *about this? I understand that the current Trust management has made no comment on the Ombudsman's dismissal of my complaint. There are many possible reasons for this other than that they agree with the Ombudsman's conclusions and the statements made in the past on behalf of the Trust.*

*'**What was acknowledged in the initial Trust RCA and LSA reports?***

'My wife and I know for certain that on at least one occasion, G's temperature was as low as 35.8°C and that this temperature was written on the yellow observation chart because my wife saw it and remembers it. This fact was accepted at the inquest.

'At some point this critical yellow record of G's postnatal monitoring went missing. This only emerged much later when we requested copies of all G's medical records. We were only informed that this crucial document was missing moments before I was due to collect G's medical records from Furness General Hospital at a pre-arranged date and time.

'During the inquest, the Coroner set out his thoughts regarding the circumstances of the missing observation chart. This is what he said:

'"As for the document itself, this is a yellow card or sheet of paper, it seems to me that

there are a number of possibilities, the first being that it never got photocopied, and the original went to Manchester with the rest of the copied notes. I cannot see why that would have happened, but it is theoretically possible. If that had happened that it would firstly have stood out, because it was yellow and everything else is a photocopy, therefore white. Manchester have not lost anything else, they have passed on notes, and they went with G when he ended up in Newcastle. So, I cannot really see how we can say that Manchester is likely to have lost the single bit of paper that was yellow that contains this important information. The second alternative is that it was not photocopied and it stayed in Barrow, in which case what happened to it, which I will come back to. The third possibility is that it was in fact photocopied, in which case both the original and the copy have mysteriously gone missing, which is hardly credible at all, because they would not have stayed in one place.

'"One would have stayed in Barrow, one would have gone to Manchester. So, to say, well amazingly both have got lost, one in Barrow and one in Manchester or later in Newcastle, is just not credible. So, if it did not get copied, but stayed in Barrow, then I have to say it is not beyond the bounds of possibility that it was destroyed, and if it was destroyed that could only have been done deliberately.

'"This is a piece of information about healthcare, it is records of a human being, and it could not accidentally be thought to be a worthless piece of paper and thrown into recycling, or the bin. So, the possibility does exist [there is no direct evidence about that, but nonetheless the possibility does exist] *that somebody deliberately got rid of it because they realised that it did contain information, i.e. the readings that really could not be defended on the basis of no action being taken."*

'G was clinically hypothermic, but the staff involved in G's care and the maternity risk manager (in the absence of any medical records) did not report this immediately after his collapse. The LSA report referred to the initial RCA report and stated:

'"The staff were asked for their recollections and any observations they could remember, until the chart could be retrieved from Manchester, as it was understood the chart had been sent with the copied set of notes transferred with G. This information suggested that the fluctuations in G's temperature were between 36.4°C and 36.8°C, which did not prompt a request for a paediatric review of this baby with an additional risk factor (Mrs D's pyrexia), but was managed by warming a cold room and the use of a cot warmer. Further investigation by the Head of Midwifery revealed that this degree of fluctuation in a newborn's temperature may not have prompted a request for a paediatric review by other midwives in the service either, but may have been seen as the normal variation in temperature of a newborn that can occur in response to the environment. In view of these findings it was agreed that this was a system failure and the individual midwives should not be blamed."

'The LSA report went on to describe the actions taken by individual midwives, for example in relation to Midwife J, the LSA report states:

'"G D's observation chart has never been traced; the last recorded sighting was on the Special Care Baby Unit at Furness General Hospital, where all other documentation had been photocopied prior to transfer to a regional unit. I am therefore not able to comment on the observations recorded on G, nor as to whether he became hypothermic, i.e. <36.5 degrees Celsius or hyperthermic >37.5, as I do not have the observation chart to refer to. However, the interviews with the

night staff ***do not imply this*** [emphasis added]. *The observations were considered to be of a prophylactic measure, in view of maternal symptoms and history.*

'"Midwife J is an experienced midwife, competent in her professional knowledge and judgement and experienced in providing care in the antenatal, intrapartum and postnatal periods and in the care of the normal neonate. Midwife J is able to recognise deviations from normal and refer appropriately. There are no documented previous concerns regarding her practice."

'In relation to Midwife H, the LSA report states:

'"I am satisfied that Midwife H is able to recognise deviations from normal whilst carrying out observations. Her recollection of G's temperature as being 36.8 degrees Celsius was within normal limits. Local policy indicates that a paediatric review is necessary for a temperature 36.5 degrees Celsius or lower. I also believe that if deviations from normal were found, then she would seek medical assistance."

'The initial response of the midwives to my son's death was to deny that he was hypothermic. In the case of the night shift staff, they specifically reported that G's observations did not 'imply' hypothermia. The maternity risk manager specifically stated in relation to Midwife J that she was "an experienced midwife, competent in her professional knowledge and judgement ... and able to recognise deviations from normal". In relation to midwife H, the LSA report states "I believe that if deviations from normal were found, then she would seek medical assistance".

'During the meeting I had on Tuesday, 2nd June 2009 with the LSA, [the LSA Midwifery Officer] *told me that the midwives involved in G's care "did not do anything wrong other than the record keeping ... the only action that they didn't do was to record what they did."*

'So, far from an account being given that G was repeatedly hypothermic and that the midwives failed to understand the significance of this in relation to his developing sepsis, a very different account and explanation was presented.

'What was indisputable however, was the fact that G was repeatedly put in and out of a heated cot. The dishonest line agreed at this stage was that whilst G's specific temperatures were within a 'normal range', the fact that he required repeatedly heating (i.e. the fluctuation in his temperature) should have triggered a paediatric review. This was accepted as a failure and put down to a training issue, mitigated by the false claim that the room was cold and his other symptoms of sepsis were 'subtle'.

'The Ombudsman's report repeatedly confuses these very different issues. The truth in relation to G was that he was a baby who had ***specific*** *temperatures recorded on his observation chart that were so low they should have triggered an urgent referral for a paediatric review from any competent midwife who observed them (this would have been any midwife who actually reviewed the yellow observation chart). In fact, the initial RCA report and the LSA report deny that this was the case. This is crucial evidence the significance of which appears to have been missed by the Ombudsman.*

'The fact that the initial RCA and the LSA report acknowledged that even though G's temperatures were within a normal range, his fluctuations in temperature should have been recognised as a sign of sepsis is not the same issue as that which the Coroner accused the midwives of colluding over at the

inquest. This issue is confused throughout the Ombudsman report and is a fundamental flaw.

'For example, paragraph 97 [paragraph 100] *of the Ombudsman's report states: "The root cause analysis noted that, shortly after G's death, it was identified that his 'inability to maintain his temperature had not been recognised as a potential sign of sepsis'". The issue at the inquest was not in relation to the failure to recognise fluctuations in temperatures (themselves within a normal range) as a possible sign of infection, it was in relation to whether or not midwives were aware that a specific low temperature (i.e. not within a normal range) in a baby indicates a need for a medical assessment.*

'The evidence given by the midwives at the inquest that they each, individually, were unaware that hypothermia was an indicator of possible neonatal sepsis.

'For the case created in the 'Issues' document to stand up it is necessary that all the midwives involved in G's care (including the night shift staff) must have shared the ignorance that neonatal hyperthermia [sic] *would necessitate referral for medical assessment. The 'Issues' documents asserts that there was 'a lack of recognition by the staff of the relevance of neonatal hyp*[o] *thermia and the need to refer for medical assessment'.*

'The Coroner asked every midwife whether or not they understood that a low temperature in a neonate could indicate possible sepsis. If any midwife answered 'yes' to this question during the inquest, then this would clearly contradict the statement given in the 'Issues' document as it is not conceivable that a midwife who understood G's low temperatures as being a possible sign of sepsis would not have also understood that this would necessitate a medical assessment.

'This is what the Coroner said:

'"I have got to say that the evidence given by the midwives on that specific point was so consistent and so clear, not one of them had any suspicion that a low temperature in a baby could indicate sepsis. I have to say, I think they got together at some point earlier and [if] *the discussion was something like this; well, some of them had forgotten that, or never knew it, and some of them did, and I honestly believe that they collaborated and decided that they were are going to stick together on that point, and say that, no, none of them* [knew] *that this was the case, a low temperature in a baby could be a sign of sepsis. I think some of them did know that. I find it absolutely inconceivable that nobody on the department knew that simple* [basic] *fact, which is in textbooks, and which they ought to have learned in basic training, and it's all very well saying, 'We never had training on that issue', No, they probably never did have specific training in-service to say low temperature equals suspicion of sepsis, but as* [the chief executive] *said this morning, 'Well, you would not really need that, it is so obvious, it is so basic that everybody should know that. A newborn baby cannot maintain temperature in a way that an adult can, is susceptible' and as I say, I find it* [in] *conceivable that every single midwife on that unit did not know that as a basic fact."*

'Page 80 of the summing up document states: "[A consultant in paediatric intensive care medicine at the Freeman Hospital], *in her evidence, told us that failure to maintain temperature in a baby is a sign of infection, and she said again, with no hesitation at all, 'Well, a midwife should know that'.*

'If some midwives did in fact know that low temperatures of a baby could indicate sepsis, or require the urgent attention of a paediatrician for other reasons, why did no one call a paediatrician?

'There are a number of possible reasons why. One is that the relationship between the paediatricians and the midwives was so strained at the time of G's birth that there was an unjustifiable reluctance to do so. There is considerable evidence for this from remarks made by the Coroner at the inquest into the death of another baby at [Furness General Hospital] *a few weeks before G's birth and the continuing difficulty of confirming the accounts of the midwives that a paediatrician was 'bleeped' after G's birth. This has been vigorously denied by all the paediatricians on duty at that time, together with the claim that the midwife spoke to an unidentified paediatrician who gave an instruction to 'keep G under observation'. The LSA report supports the midwives' claim and by implication accused the unknown paediatrician for the failure to see G.*

'The other possibility is that during the night shift, G's temperatures were being taken by low grade staff, e.g. the maternity assistant or the unidentified person who Mrs D observed taking G's temperatures the previous day (another matter that remains unresolved). It is possible that the person taking G's temperatures during the night shift (if we assume G's temperatures were being regularly taken by night shift staff) was genuinely unaware that a low temperature was a serious indication that urgent action was needed, or even understood why G was being monitored at all.

'However, the situation changed at 2am in the morning when Mrs D called the bell by her bed and asked for help because G was grunting. At this time, a maternity assistant took G out of the room and gave him to Midwife H [the initial statements suggest that G was taken to Midwife J]. *We know that on his observation chart, temperatures at least as low as 35.8°C were recorded. During the inquest I recall that Midwife H was asked if she reviewed G's observation chart at this time and she said that she did but that there were no observations outside normal parameters. This statement cannot have been true. It is possible that Midwife H did not review G's observation chart at this time. There is no mention of this having been done in her statement. Indeed, it is highly possible that the other midwives on the nightshift did not look at the observation chart either.*

'After G's collapse and transfer, the observation chart was a clear record of specific low temperatures and other indications of sepsis that some midwives must have realised could not be defended in the light of no action being taken. As the Coroner alluded, I believe that this is a credible explanation of why G's observation chart may have been deliberately destroyed.

'Other key issues were deliberately misreported by the midwives. This would explain why, on 3 May 2009 Midwife H sent this email that was circulated to all the other midwives and the Executive Chief Nurse.

'"I have asked if we are within our rights to retract our statements that we have made ..."

'The reason given in the email was that the D family may request copies via their solicitor.

'Is it possible that 11 midwives involved in the monitoring and care of 'at risk' babies at FGH were all not aware that a low temperature was a possible sign of sepsis?

'Having been aware that G had a persistently low temperature in the 24 hours following his birth, the first time I became aware that low temperature was a classic sign of infection was when I spoke to [a paramedic] *sent from St Mary's hospital as part of the emergency transfer team to collect G on 28 October 2008. When I mentioned to him that G had a low temperature,* [the paramedic] *told me*

immediately that this was a 'classic' sign of neonatal infection. [He] *was not a doctor or a nurse, but a paramedic and was able to tell me this fact without hesitation.*

'I have since spoken to numerous experts in the field of maternity or paediatrics and they have all told me that anyone who works with babies should know that low temperature is a possible sign of neonatal infection. Evidence to this effect was clearly and categorically given by [a consultant in paediatric intensive care medicine at the Freeman Hospital] *during the inquest and even echoed by* [the chief executive*] himself, who is a medically trained nurse.*

'If in 2008 such a gap in knowledge was prevalent in UK midwives, the consequences for patient safety would have been far reaching. However, when I contacted the National Patient Safety Agency (NPSA), they informed me that they had searched all the reported incidents, of which there were several million and not found a single other case on record where a baby had come to harm because of a failure to recognise low temperature as a sign of neonatal sepsis. Neonatal infection is a relatively common problem, affecting a significant percentage of babies. If there was a widespread problem in the UK relating to the failure of midwifery staff to understand basic signs of neonatal sepsis, at least some incidents of harm would have been reported via the National Reporting and Learning System (NRLS) which indentified [sic] *this as an issue. In fact, the NPSA did not find that this was the case and no other incidents on record existed which indentified this as a contributory factor.*

'Furthermore, before the inquest the Trust themselves made inquiries with the NPSA which confirmed this to be the case. On 19 March 2010, the Trust's Head of Midwifery ... sent an email to senior Trust staff including the chief executive, Medical Director and crucially the maternity risk manager which stated the following:

'"I have just been speaking to [the NPSA]. *Mr D sent them his whole case to consider. They have looked at it and they do not think that there is a (sic) major national learning needed from the case."*

'Despite the fact that the Trust were well aware that this was the case, the Trust's legal team made false representations to the coroner that the piece of work undertaken by the NPSA (which was only in response to my contact with them) was proof that at the time of G's birth, poor recognition of signs of neonatal infection was a 'national problem'. This is yet another example of the disingenuous way in which the Trust and it's [sic] *legal team approached the inquest into the death of my son.*

'There was therefore no national problem in midwifery training in relation to this issue at the time of G's birth. I would expect the Ombudsman to research this before giving any credibility to such a claim.

'As stated by the Trust, the midwives involved in G's care were trained in different places in the UK. This means that any alleged lack of knowledge could not have been due to a local training issue.

'However, let us hypothesise that there could have been such a national problem. Let us first assume that as many as 1 in 4 midwives in the UK in 2008 were unaware that a low temperature in a newborn baby was a potential sign of neonatal sepsis. If this was the case many hundreds of incidents would have been taking place each year. In fact, the NHSLA confirmed that there were no other similar incidents on record.

'What would be the mathematical probability of 11 midwives (trained in different places) all within the same maternity unit,

independently not knowing this basic medical fact? The mathematics are easy. The chance is 0.25 to the power of 11. This gives a probability of 0.00000024, or less than 4 million to one.

'But 1 in 4 midwives being so ignorant is far too high to be a conceivable estimate. What would be the corresponding probability if 10 percent of midwives did not know this? This is still a ludicrously high estimate that would constitute a national midwifery scandal and be the cause of hundreds of neonatal incidents like that involving G. This gives a probability of 0.10 to the power of 11. This is 100 billion to one. The age of the universe is 13 billion years.

'These reasons alone justify the Coroner's comments that it is 'absolutely inconceivable' that all 11 midwives could have been independently ignorant that low temperature in a neonate is a sign of sepsis.

'Paragraph 102 [paragraph 106] of the Ombudsman's [draft] report states: "Taking all the available evidence into account, I do not agree that the collective ignorance of the midwives was 'inconceivable'. I can conceive of a situation, particularly in a unit which had 'found it increasingly difficult to ... appoint high calibre staff', where this might be the case." The implication is that the calibre of staff had been acknowledged as an issue and therefore this increases the likelihood that the midwives were unaware that low neonatal temperature was a possible sign of neonatal sepsis.

'Even if low calibre staff doubled such a risk this would make no significant difference to the impossibility of it being feasible. The probability would increase from a chance of one in 100 billion to one in 50 billion.

'This assertion by the Ombudsman is not just a baseless challenge to the view of the Coroner, but does not make mathematical sense.

'Another very important issue is raised. Paragraph 19 of the Ombudsman's [draft report] draws attention to the Solicitor's Code of Conduct. 11.01 (3) states that solicitors, "must not construct facts supporting your client's case or draft any documents relating to any proceedings containing: (a) any contention which you do not consider to be properly arguable."

'Not only is this without doubt such a contention, it is at the heart of the arguments so carefully constructed in the 'Issues' and 'Q & A Documents'. This means that both documents cannot be 'properly arguable'. It therefore follows that the midwives must be, to say the least 'unreliable witnesses' for seeking collectively to make a claim that is mathematically impossible. As this is the case it follows all the other reasons given by the Ombudsman for dismissing my complaint fail.

'It also calls into question the conduct of the solicitor in question, who can surely be assumed to be numerate in terms of assessing probabilities. Not only should she have been aware of the impossibility of the contention, this also applies to the Trust, which is ultimately responsible for the two documents.

'The fact that the maternity risk manager asserted in her LSA Report that at least two of the midwives were aware of the serious implications of neonatal hypothermia raises serious questions about the probity of her management and involvement in the Trust's pre-inquest preparations of the midwives. "I am satisfied that Midwife H is able to recognise deviations from normal whilst carrying out observations. Her recollection of G's temperature as being 36.8 degrees

Celsius was within normal limits. Local policy indicates that a paediatric review is necessary for a temperature 36.5 degrees Celsius or lower. I also believe that if deviations from normal were found, then she would seek medical assistance."

'This statement directly conflicts with the 'Issues' document which was circulated to all midwives prior to G's inquest which asserts there was a "lack of recognition by the staff of the relevance of neonatal hypothermia and the need to refer for medical assessment". Both statements cannot possibly be true. This alone shows that the 'Issues' document cannot properly be arguable. The LSA report clearly states that Midwife H was "competent in her professional knowledge" and if "deviations from normal were found, then she would seek medical assistance".

'There are further issues raised in respect of the maternity risk manager by [the chief executive] himself. He wrote to [the LSA] on 16th July 2009 raising a number of concerns about the LSA report, including "... there are assumptions made that are inappropriate, for example Mrs D clearly remembers a temperature being recorded below 36[°C]. Although no midwife recalls recording that temperature, your report dismisses it out of hand on the grounds that a midwife would have called a doctor if that was the case. You cannot make that assumption."

'More problems for the evidence of midwives

'There is evidence of unofficial meetings between the midwives before those involving the Trust's solicitor took place. Paragraph 86 [paragraph 89] *of the Ombudsman's report states: "The Trust's solicitor explained the following to the Police: '*[The first meeting] *was [a] group meeting ...* ***She got the impression that staff did know some of each others evidence but didn't know how they came by this information****'* [emphasis added]*"*

'Following the inquest, when I asked if the Trust or its legal representatives were aware of any 'get together' as asserted by the Coroner, this same solicitor wrote to me to unequivocally deny that any such meeting took place.

'Surely the Trust should have been expected to obtain independent statements from the midwives as soon as the circumstances relating to G's eventual death became known to them, immediately after G's collapse and transfer. Surely the Trust should have been in contact with the ECMO unit at the Freeman Hospital in Newcastle as soon as G had been admitted, many days before he died, in order to swiftly begin the process of investigating what gone wrong in their maternity unit and in particular the role of individual midwives in the failures. Instead, no such investigation took place. No proper investigation by the Trust has ever taken place. The only actions taken by the Trust were not just far too late to prevent collusion between the midwives, but this was actually encouraged, assisted and facilitated by the Trust.

'More dishonesty in the 'Issues' document

'The 'Issues' document contains many more examples of significant dishonesty in relation to the truth about what happened to G. Either this is the case, or my wife and I have repeatedly lied about what we know, from our personal direct observations, of what happened to our son. These dishonest aspects include the following:

'1) The statement that Midwifes A and B have "no recollection of being told Mrs D had been unwell" cannot be true. ***My wife and I clearly discussed feeling unwell with staff before the labou****r. We also discussed this with my father and mother on the first and only occasion that they saw G conscious the day after his birth. We were all very concerned about why in view of Mrs D's infection,*

together with her collapse and subsequent recovery after receiving antibiotics, G had not also immediately been treated with antibiotics. The family retains a feeling of guilt about our acceptance of reassurances from the midwives and our failure to insist on a paediatric examination of G, which may well have saved his life even at that late stage. ***So the family is quite clear on this issue****.*

'2) ***The statement that Mrs D was told she could not breastfeed G because she was "not well enough to breastfeed" is not true.*** *We were told this in response to our own questions about wanting to breastfeed G but being worried about doing do because of concern about the infection Mrs D had and was receiving antibiotics for.*

'3) The document contains a statement: "There was a lack of recognition by the staff of the relevance of neonatal hypothermia and the need to refer for a medical assessment". The documents states "Yes, Additional training was given in 2009/10".

'This point is so important I am going to repeat it again here. It is not possible that this is a true statement for all the midwives involved in G's care. For example, in relation to Midwife H, the LSA reports states:

'"On further questioning, Midwife H was aware that a low temperature would indicate hypothermia and that this would necessitate medical assessment. If this was the case, she would call a Paediatrician. She maintained that the temperature was normal."

'4) ***The description of G's claimed APGAR assessment of his birth condition given in the document is entirely false****. I was a direct witness to what really happened.*

'5) The assertion of the midwives that the need to apply warming to G was because the room was cold is not true. ***The room(s) were all warm.***

'6) ***I saw a midwife placing a direct radiant heater over G contrary to recommended practice. I also saw her touch G's face and then remove the heater when she realised his skin was hot and he was in danger of being burned. The fact that so much of the content of the 'Issues' document is not true and/or not possible, means that it is impossible that the process undertaken in creating the document was proper.***

'The conclusions of the Ombudsman report can only be valid if my wife and I have repeatedly lied about these issues. I completely reject any notion that this could be the case.

'Summary

'Although they cannot, apparently, be proved beyond reasonable doubt the following facts and explanations appear to be far more probable than the account constructed through the process of collusion set out in my complaint and repeated here that was organised and arranged by the Trust, and wrongly accepted by the Ombudsman as a proper process. The truth is as follows.

1. *G had specific low temperatures that were lower than 36.5°C and therefore, according to the Trust's own guidelines should have triggered a paediatric review.*
2. *After G's death, his observation chart went missing and any records of his true temperatures were 'lost'.*
3. *Instead of honestly reporting the true circumstances of G's care, statements containing misinformation were produced. These statements and the loss of critical medical records enabled the RCA and LSA reports to conclude "the fluctuations in G's temperature were between 36.4°C and 36.8°C" and to state "this degree of fluctuation in a newborn's temperature may not have prompted a request for a*

paediatric review by other midwives in the service either, but may have been seen as the normal variation in temperature of a newborn that can occur in response to the environment".

4. *The initial LSA report and RCA report specifically concluded that some midwives involved in G's care were "aware that a low temperature would indicate hypothermia and that this would necessitate medical assessment", and specifically gave the reason why such a medical assessment was not prompted as being that G's temperatures were not lower that 36.5°C.*

5. *It is therefore wrong to say that, "The information provided to the [Trust's solicitor] as part of the inquest preparations was fully consistent with that given previously by the midwives in 2008". The exact opposite is true.*

6. *The LSA report confirmed that at least some of the nightshift staff involved in G's case were aware that a low temperature would necessitate a paediatric referral. The reason they did not request a paediatric referral was stated as being that G's temperature were not lower than 36.5°C. This cannot be true if the testimony of [my] wife is accepted.*

7. *During the inquest, the nightshift staff claimed to have reviewed G's observation chart and have said that all his observation were 'normal'. This is another claim that cannot possibly be true.*

8. *The early acceptance in relation to G's care that his fluctuations in temperatures (which were reported as being within a 'normal range') should have prompted a paediatric review, is an entirely separate matter which the Ombudsman's report repeatedly confuses throughout the report.*

9. *The Ombudsman's report draws upon statements given to the Police. Given that the nature of my complaint includes the midwives being dishonest under oath at an inquest, as publicly noted as likely by the Coroner, little weight should be given to statements to the Police. Anyone having made false statements during an inquest, would be unlikely to admit to such in subsequent statements given to the Police.*

10. *All of these facts and evidence clearly show that the 'Issues' document cannot possibly have been created via a proper process designed to assist the staff involved in G's care to give honest and clear evidence to the inquest. Rather the process undertook enabled staff to share dishonest information with each other and collectively rehearse written answers to questions, some of which could not possibly have been true for all the midwifes involved in G's care. Indeed, without any prior knowledge of these circumstances, the coroner deduced that such collusion must have taken place from the implausibility of what he was told and the consistency and lack of hesitation with which the evidence was delivered.*

'My view of what the Ombudsman should do with this draft report

'It is not fit for purpose and should be withdrawn.

'I do not now have any confidence in the ability of the Ombudsman to conduct a satisfactory investigation into my complaint.

'The Kirkup investigation is currently taking place and will investigate all the issues covered in this letter. Unlike the Ombudsman, the Kirkup investigation will question witnesses and cross reference responses.

'The Kirkup investigation will also be able to consider this evidence in context of other preventable deaths at the maternity unit at Furness General Hospital, many of which I know are also characterised by missing critical medical records and discrepancies between what family members recall and events reported by the staff involved.

'If the Ombudsman decides to publish this flawed report, with substantially the same conclusions, then my family will publicly reject it.

'I intend to submit both the Ombudsman's draft report, together with this response, to the Kirkup investigation and ask for both to be considered within its remit.

Yours sincerely

[Mr D]

Annex C: Mr D Senior's letter of 13 January 2014

'Dear Dame Julie

'I am writing to formally reject the conclusions of the Ombudsman in respect of my complaint.

'I support all the arguments given by my son in his detailed response to you that he has shared with me.

'In particular, I wish to confirm the statements made by my son while we were together in Newcastle after G had been admitted to the Freeman Hospital, with regard to the conversations my wife and I had with him and Mrs D and my encouragement for his making of notes about what had happened to G at FGH.

'I also confirm [Mr D]*'s statements about the concerns of my wife and I on the occasion that we saw G on the day after his birth, and that* [Mr D] *told us then how the midwives had been fully informed as to Mrs D feeling unwell.*

'The Ombudsman's case that the preparations of witnesses organised by the Trust for G's inquest were entirely proper rests on the premise that the evidence given by the midwives at the inquest and set out for and by them in the 'Issues' document is honest and true.

'It is a matter of fact that if this is the case then the contrary evidence of [Mr D] *and Mrs D must be mistaken and/or false. Given that this evidence is all based on notes made in Newcastle before G died and only a few days after G's collapse from infection at Furness General Hospital at a time when our assumption was that this truthful account would not be contradicted by the midwives, I am confident that it is true and that therefore that the contrary accounts of the midwives are false.*

'The crucial claim by each midwife that they were independently ignorant of the implications of neonatal hypothermia is not just false but mathematically impossible.

'The key involvement of the maternity risk manager in the pre-inquest preparation itself renders the process and everything about it unsatisfactory and unreliable, because it is clear that she must have known that at least some of the evidence agreed in the 'Issues' document is inconsistent with that in the [Local Supervisory Authority] *report that she herself wrote.*

'The 'Issues' document contains not only false records of the actions of the midwives, the Trust must have known this to be the case not only at the time it was produced, but crucially in respect to my complaint, at the time that the then Chair of the Trust refused my request for an investigation into the collusion alleged by the Coroner.

'....

'I share [Mr D]*'s view that we can now have no confidence in the ability of the Ombudsman to properly investigate this matter and I intend to ask the Kirkup enquiry to take up the matter.*

'I am therefore asking you to withdraw this report pending the outcome of the Kirkup enquiry.

'Yours sincerely

'Mr D Senior'

Annex D: Mr D Senior's letter of 3 February 2014

'Dear Dame Julie

'I refer to my letter of 26 January.

'I understand from [Mr D] *that his loss of confidence in your organisation is such that he no longer wishes to co-operate with your investigation of his complaint.*

'I fully understand the frustration and anger that [Mr D] *feels as a result of all his dealings with the Ombudsman in respect of the death of G, but I wish to emphasise that mine is a separate complaint to that of* [Mr D]*...*

'I am also writing to you again because of a new development that is of relevance to the conclusions of your draft report. This relates to a recent NMC Fitness to Practise hearing in respect of former Furness General Hospital [Midwife C]. *The NMC judgement report has been published by the NMC and is attached.*

'[Midwife C] *was the midwife that delivered G* [the initial statements suggest that Midwife C only assisted in G's delivery] *and is therefore one of the eleven 'Muskateers' as referred to by the maternity risk manager. The following is a quote from the NMC judgement.*

'"The panel noted that the allegations against [Midwife C] *are serious in nature, multiple and wide-ranging. The panel was helped by a recent Supervisory Investigation Report written by* [the Supervisor of Midwives] *appointed to North West Local Supervising Authority ("the Investigation Report") dated 2 December 2013, relating to the September 2013 incident, which noted specifically the following alleged failures in her practice as a midwife, namely; failure to obtain consent, failure to document care given, failure to support colleagues, failure to call for help/escalate concerns, teamwork concerns, communication concerns and concerns regarding* [Midwife C's] *general patient care."*

'You will note that many of these NMC allegations are common to failures associated with the death of G, which I must remind you have to this day never been fully and independently investigated by you (despite your having had many invitations and opportunities), the Trust, the [Strategic Health Authority] *or anybody else (pending the Kirkup enquiry). My understanding of the Police enquiry is that it made little progress as a result of the decisions of some of those interviewed to refuse to answer police questions.*

'This NMC judgement of [Midwife C's] *midwifery practice is relevant to your draft report for the following reasons that I quote from* [Mr D]*'s detailed response to you.*

'"This bizarre judgement on the part of the Ombudsman must also require that the evidence of my wife and I is false in the many crucial instances where it conflicts with that set out in the 'Issues' and 'Q & A' documents provided and agreed by the midwives as a group set up by the Trust and supported by the maternity risk manager and other senior Trust staff. The implication is that my wife and I, compared to the midwives and the maternity risk manager are unreliable witnesses and that my chronology is factually incorrect."

'"The description of G's birth condition within the document is entirely false. I was a direct witness to what really happened."

'Of particular relevance to [Midwife C], *is the issue of G's recorded APGAR scores. This is dealt with in the 'Issues' document under 'Care of G - bullet point 3'. I have attached the 'Issues' document again for your convenience.*

'[Mr D]*was a direct witness to G's birth condition. He is unlikely to have*

misremembered such a key incident in G's short and tragic life. He has discussed this with us (his parents) on many occasions starting before G died in Newcastle. His account has never changed. Here it is again.

'"G was born blue, limp and not breathing. He was taken to a table at the side of my wife's bed and then had his tummy rubbed - when he remained blue, limp and not crying - he was taken out of the room and given oxygen. At this point - he cried and went pink."

'The 'Issues' document gives an account that is entirely contradictory in every respect. It states that two midwives, [Midwife S] *and* [Midwife C] *attended the birth. The accounts are so divergent that the differences cannot be put down to honest failures of memory on the part of* [Mr D] *and/or the midwives. The conclusion must be that either* [Mr D] *or* [Midwife S] *and* [Midwife C] *are lying. We now have good reason to believe from the NMC judgement that* [Midwife C] *may not be a reliable witness. If she is lying about the APGAR scores then so is* [Midwife S]. *That makes the issue one of conspiracy and collusion.*

'[Midwife S] *and* [Midwife C] *were party to the production of the 'Issues' document. Furthermore, if the midwifery performance of* [Midwife C] *was as poor as is judged by the NMC, over such a prolonged period, the other midwives must have been aware of these shortcomings. So why did they accept her's and* [Midwife S]*'s account of the APGAR scores as set out in the 'Issues' document? At the very least this indicates a possible failure of professional responsibility on the part of the other midwives not to 'cover up' poor practice.*

'Of even more importance is the fact that other senior Trust staff were fully involved in the production of the 'Issues' document including the maternity risk manager, the Head of Midwifery and the Chief Nurse. Given the prolonged period of dangerous practice on the part of [Midwife C], *why were these senior members of staff (of all people) so readily prepared to accept* [Midwife C]*'s version over* [Mr D]*'s, which they had been aware of since 2008?*

'I therefore come back to the fact that for the process of producing the 'Issues' document to be reasonable and proper, which is your conclusion, then you must be accepting that [Mr D] *is lying and that* [Midwife C], *as well as the other midwives, are telling the truth. This is a bizarre conclusion that defies reason especially now we have the NMC's documented failings of* [Midwife C].

'My understanding is that all of the most senior Trust staff involved in the production of the 'Issues' document are now no longer in post, including the chief executive. Have you asked the current chair and chief executive why this the case, and for the details related to their leaving their posts? If not, why not? Is it not possible that the answers may cast further doubts about the credibility of the 'Issues' document being the result of a proper and reasonable process? I must remind you that unlike that of [Mr D], *my complaint is not against the Trust at the time of the collusion and certainly not against the current Trust chair and chief executive. It is against the actions of* [the chair and chief executive in 2011/12], *for refusing to investigate the collusion.* [The chair in 2011/12 was chair] *when the financial arrangements for the departure of [the chief executive in 2008] were agreed. These have recently been subject to severe criticism by a Parliamentary Select Committee. To his great credit, the* [current chair] *has made these arrangements public.*

'In conclusion, I return to the first issue that I raise in this letter, which is the rift that has emerged between you and [Mr D]. *I believe this to be extremely regrettable.* [Mr D] *is*

aware that this is my view. I am therefore asking you to approach [Mr D] *again with a view to exploring how the rift might be healed and co operation restored, I strongly believe that this would be beneficial for patient safety in general and not just necessary for the proper resolution of our complaints.*

'With regard to your draft report, I believe it should now be withdrawn, if only on the basis of the new developments to which I have referred. It seems to me necessary for you to put your report on hold pending the outcome of the Kirkup enquiry, that will deal with all the issues related to mine and [Mr D]*'s complaint.*

'Please acknowledge receipt of this letter.

'Yours sincerely

'[Mr D Senior]'

Annex E: Our analysis of Mr D's comments on the draft report

Summary of Mr D's comments and our response

1. In response to a draft of this report, Mr D rejected our findings, describing the report as a '*flawed and biased piece of work*'. He responded in an email dated 29 November 2013 and a 12-page letter dated 13 January 2014. On 29 November 2013 Mr D sent us another email in which he said, among other things,

   > '*I fully accept that finding conclusive proof that* [the] *midwives colluded prior to G's inquest is difficult and may be impossible but to interpret the evidence you have as conclusive proof that they didn't when there is overwhelming evidence and motive suggesting they did is unacceptable.*'

   We met Mr D on 17 February 2014 to discuss his comments.

2. Mr D raised five main issues: that there are unresolved discrepancies between his family's recollection of events and the versions of events presented by other witnesses at the inquest; that the midwives changed their accounts between the Local Supervisory Authority report in 2009 and the inquest in 2011; that there is an inconsistency between the Trust's long-standing position on lack of recognition of the significance of neonatal hypothermia and the Local Supervisory Authority's findings about Midwife H; that consistently honest people need not prepare for an inquest; and that it is statistically unlikely that the midwives did not know about the link between a low temperature and infection in a small baby.

Unresolved discrepancies in the accounts given to the inquest

3. Our findings do not, in any way, call into question Mr and Mrs D's account of the care and treatment G received. Our findings relate only to whether or not the midwives colluded about one very specific piece of knowledge before the inquest. The scope of the complaint we agreed to investigate did not extend to establishing the facts of G's care and treatment or trying to resolve the discrepancies between Mr and Mrs D's account of events in 2008 and the accounts given by the midwives. This is because the complaints were brought to us on the basis of the Coroner's comments and it seems to us that the Coroner suspected collaboration only on the specific point of the midwives' knowledge of the link between low temperature and infection. We cannot see that the Coroner suggested that the midwives' evidence was '*unreliable or false*' in any other respect.

Changes in the midwives' accounts between 2009 and 2011

4. Mr D says that the midwives initially denied that G was hypothermic, but later accepted that G was hypothermic and then added that they '*failed to understand the significance of this in relation to his developing sepsis*'. However, the evidence we have seen shows that the midwives' accounts have remained consistent since 2008. Two of the midwives said, from the outset, that G had had at least one 'low' temperature reading.

Inconsistency between the Trust's long-standing position and the Local Supervisory Authority findings

5. Mr D says that the Trust's position that there was a general lack of knowledge about the link between neonatal hypothermia and infection cannot be reconciled with the Local Supervisory Authority's findings in relation to Midwife H. We do not see that the two positions are mutually exclusive. It is entirely possible to have recognised the need to refer a baby with a low temperature for paediatric review without recognising specifically that low temperature might be a sign of infection. Midwife H told the inquest that she had noticed that one low temperature had been recorded but there had been two or three 'normal' readings recorded before she took his temperature and that she did not observe any low temperatures during her shift.

The need to prepare for an inquest

6. We simply do not agree with Mr D's assertion that '*consistently honest*' people have no reason to meet to prepare for an inquest. Most people have little experience of courts and are anxious when they are required to attend, even as a witness. It is understandable that they would want some form of preparation for what they might face, and preparation for inquests and other court appearances is common and lawful.

The statistical likelihood that the midwives did not know about the significance of neonatal hypothermia

7. Mr D's analysis does not take into account the fact that this group of midwives had worked together for a number of years; they had in common a lack of regular exposure to 'at risk' babies; and they are likely to have had a shared absence of reinforcement of some elements of what they had learnt during training.

Mr D's comments in detail

8. The scope of our investigation included the Trust's preparation of their staff for the inquest (an inquest which, as Mr D points out, they were not expecting until Spring 2010), and whether the midwives colluded about the accounts they would give at the inquest of their knowledge of the implications of a low temperature in a baby. The scope of our investigation did not extend to establishing the facts of G's care and treatment. As Mr D acknowledges, the inquest had, by the time we started this investigation, already conducted a '*proper* [and] *robust investigation*' of G's care. It was not for us to try to resolve the discrepancies between Mr and Mrs D's account of events in 2008 and the accounts given by the midwives. Such discrepancies had already been addressed by the Coroner. For example, the Coroner accepts that Mr and Mrs D told the midwife whom they saw on 26 October 2008 that Mrs D was feeling '*poorly*' but that the midwife '*did not take it on board ... did not really acknowledge it fully*'. The Coroner also addresses the different descriptions of G's condition at birth, and offers an explanation for the discrepancy. He says:

'I will deal in some detail with the state of G at birth. We had conflicting evidence here. Mrs D described him as blue, limp and not making any noise and she said she was scared. Mr D pretty well confirmed that and he says that the midwife rubbed his chest and took him out for some oxygen, at which point he cried. [Midwife C] *says, "well, he was fine, he was a bit blue around the edges, that is quite normal" and she scored him at APGAR score nine at one minute, eight at five minutes, and it is in the notes 10 at 10 minutes.*

'Now, I would have to say the importance of this dispute about the facts in relation to the outcome is very low. It is not a terribly significant dispute as to what ultimately happened. Certainly it looks as though G was not crying at the point that he was born, and remembering that Mr and Mrs D's experience would probably be limited to [their daughter] *only, his quietness would certainly have worried them. On the other hand, to an experienced midwife, it was not a particular concern, she had seen many, many babies born, some make a lot of noise, some do not, and she was not concerned about G, and within certainly a few minutes, if not a few seconds, she had got him going, if you like, applied pressure to the chest, rubbed his chest, given him some oxygen. The timescale is unclear and* [at] *such a time, a few seconds to Mr and Mrs D might seem a great deal longer, especially in hindsight, and to the midwife who is doing a routine, to her, job, time will not seem to have stood still ... .'*

9. In his response to the draft report, Mr D suggests that 'consistently honest' people have no reason to meet to prepare for an inquest. However, we have established through our investigation that it is acceptable for prospective witnesses who are not used to appearing in court and giving evidence, to meet and talk about the likely areas of questioning they will face. Furthermore, it is to be expected that these midwives, who continued to work together immediately after G's transfer to Manchester, would have discussed this case amongst themselves, perhaps many times, between October 2008 and June 2011. Such discussions could not reasonably have been prevented by the Trust, and we do not agree that the very fact that they may have taken place prior to the inquest is evidence of dishonesty.

10. Mr D says, in his response to the draft report, that the midwives initially denied that G's temperature was anything other than normal. This is not the case. Midwife F said that during the evening of 27 October 2008 (between 4pm and 8.45pm) G's '*temperature was low on examination*'. She did not give a figure in her initial statement, but when presented with Mrs D's recollection that G's temperature was as low as 35.8°C, she accepted that. In other words, she accepted that she observed G's temperature being outside normal parameters. Midwife J also said that while G's temperature was within normal parameters in the early hours of 28 October 2008, when she repeated his observations just before 7am '*all observations were within normal limits* ***except*** *his temperature*' (emphasis added). Her initial statement is that G's temperature was normal overnight, but not normal just before 7am. It was these statements, statements that do not deny

that G was hypothermic on two occasions, which prompted the root cause analysis to conclude that '*the staff did not recognise that a low temperature may have indicated that G was unwell*'.

11. Mr D sees an inconsistency between the Trust's long-standing position that there was a lack of recognition by staff of the relevance of neonatal hypothermia, and the LSA's findings in relation to Midwife H. He says that both positions '*cannot possibly be true*'. The two positions are not mutually exclusive. Midwife H, says that she did not observe any low temperatures during her shift. (Her shift had started at around 9pm on 27 October 2008; after G had been in the warming cot for the first time and his temperature had, according to Midwife F, returned to normal.) Midwife H told the Coroner that, if she had observed, as Midwife F had done earlier, a temperature as low as 35.8°C, she would have acted differently from her colleague and informed the paediatrician. It is possible that Midwife H lacked the specific knowledge that hypothermia could be a sign of infection but she would, nonetheless, have sought medical assistance if she had found '*deviations from normal*'. She says she did not do so in G's case because she did not personally observe any low temperatures, and she thought that Midwife F had already told the paediatrician about the earlier need to put G in a warming cot.

12. Midwife H does not deny that G's observation chart included low temperatures. At the inquest she explained that at handover at around 8.55pm on 27 October 2008 she was informed '*that the baby had dropped its temperature once and had been put on the cot warmer, but was now off the cot warmer and the temperature was now normal*'. She also said that when she recorded her own observations on the chart she noticed that, '*there was one low temperature, but ... two or three normal temperatures before* [her] *own*'. Similarly, Midwife J said that she was aware that G's temperature had 'dropped' before she came on shift at around the same time as Midwife H. This is not a case of the nightshift staff denying that G was ever hypothermic during his time at Furness General Hospital. The nightshift's evidence, which has been consistent since 2008, is only that G's temperature remained normal between 9pm on 27 October and 6.50am on 28 October 2008.

13. We have not suggested that the NPSA *Signals* piece was written in response to a national problem, or to address a national learning need. We have acknowledged that the piece was prompted only by Mr D's personal report to the NPSA. However, the publication of the *Signals* piece in October 2010 is relevant to our assessment of whether the midwives colluded about their knowledge. By putting the identified gap in knowledge firmly in the public domain, the Signals piece made any collaboration on this issue before the inquest unnecessary.

14. Mr D says that it is not mathematically possible that '*11 midwives involved in the monitoring and care of 'at risk' babies at FGH were all not aware that a low temperature was a possible sign of sepsis*'. We do not consider that mathematical probability is a sound basis for reaching conclusions about human behaviour. However, in response to Mr D's comments on this point, we would point out that the nine midwives who were asked about their knowledge at the inquest (nine because although the maternity risk manager was not involved in G's care, she was asked

about her knowledge at the inquest) were not routinely involved in caring for 'at risk' babies. This was not a special care baby unit, it was a general maternity ward. Whilst each midwife might have trained independently, by the time of these events, a number of factors linked them (and their professional knowledge) together. For example, they had worked together for a number of years without regular exposure to 'at risk' babies, and hence without practical reinforcement of what they might have learnt when they first trained. Just as knowledge can be reinforced by practical experience and association with colleagues, so can a lack of knowledge. This lack of statistical independence between the midwives, insofar as it is relevant, can be demonstrated by the fact that if they were all asked today whether they are aware of a link between low temperature and infection, they would be more likely to answer 'yes' because of their collective experience of G's case.

15. The Coroner said he thought it was '*inconceivable*' that the midwives asked about their knowledge at the inquest were unaware of the specific link between low temperature/inability to maintain temperature and infection. It is accepted that they should have been aware of this link, and that those who observed low temperatures should have referred G to the paediatricians. Indeed, regardless of whether they knew of the specific link between low temperature and infection, Midwife H and Midwife W have acknowledged that they would have made the paediatricians aware if they had observed G's low temperature. Furthermore, the actions of Midwife F and Midwife J indicate that when they observed low temperatures in G, they did not make the link with possible infection.

16. When read in context, it is clear that the Coroner did not suggest that the midwives' other evidence was '*unreliable or false*'. The Coroner seems to have suspected that some of the midwives had had this knowledge but had forgotten it, some had never known it or did know but had failed to apply it because they just did not think about it.

17. It is important to remember that the Coroner identified failings in G's care and treatment that were much broader than the midwives' response to G's temperature. The Coroner says:

    '... I did consider the possibility of natural causes with neglect. I have not gone for that. Neglect is a gross failure to provide medical care ... this is not the Scribes and the Pharisees walking past on the other side of the road ignoring somebody who needs help ... ***It is just that they did not recognise the signs that they were seeing as being what it was, which is a signpost to something very important.****'* (My emphasis.)

Annex F: Our response to Mr D Senior's comments on the draft report

1. In response to a draft of this report, Mr D Senior echoed his son's rejection of our findings, in correspondence dated 13 January and 3 February 2014.

2. Although I understand that Mr D Senior has concerns about Midwife C's involvement in G's delivery, Midwife C is not one of the midwives who gave evidence at the inquest about her knowledge of the implications of low temperature in a baby.

3. While Mr D is convinced that the discrepancies between his son and daughter-in-law's account of G's condition at birth and those of Midwives C and S are evidence of '*conspiracy and collusion*', the Coroner described '*the importance of this dispute about the facts in relation to the outcome* [a]*s very low*'.

4. Finally, both complaints and the scope of this investigation, a scope agreed by both complainants at the outset, were formed on this basis of the Coroner's comments. The Coroner did not suggest that the midwives '*collaborated*' about anything other than their knowledge regarding the relevance of low temperature.

Annex G: The Trust's response to the draft report

1. In response to a draft of this report, the Trust acknowledged and accepted our findings. They added that the report was '*a comprehensive, fair and balanced review*'. The Trust's solicitor also accepted our findings and clarified some points of fact.

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