The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board.
1 BACKGROUND

The Welsh Government commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) to undertake a multidisciplinary review of aspects of the maternity service provided by the then Cwm Taf University Health Board following the discovery of under-reporting of Serious Incident (SI) cases. A look-back exercise to January 2016 had previously identified 43 cases for review. These 43 cases were subject to internal review which identified shortfalls in service delivery and were submitted to the health board during September 2018. By analysing the findings from a Datix search for stillbirths dating back to 2010, a Consultant Midwife also identified 67 stillbirths which had not been reported by the Health Board via Datix.

The college assessors visited the Royal Glamorgan and Prince Charles Hospital sites within Cwm Taf University Health Board between 15 and 17 January 2019. The assessors found a service working under extreme pressure with sub-optimal clinical and managerial leadership. The Health Board’s identification of SI under-reporting had resulted in increased internal and external scrutiny, highlighting that basic governance processes were not properly in place. The service was also expected to imminently merge two separate consultant-led units onto one site with a freestanding midwifery-led unit on the other site, with no evidence that clinical teams were engaged with and supportive of this decision and process. This was further compounded by a shortfall in the midwifery establishment, sub-optimal senior clinical leadership, a significant use of locum medical staff at both junior and consultant level alongside a lack of established standards of practice. The service was also seen to be operating under a high level of public and media scrutiny.

As part of the RCOG/RCM review, a patient and public engagement event was held in the form of a public meeting. In addition to this, an online survey was developed (hosted by the RCOG) which remained open for six weeks and one-to-one telephone interviews were conducted. The overriding message from women and their families was a desire to prevent the reoccurrence of their experiences. A full report of the findings from the public engagement process was later published, entitled Listening to women and families about maternity Care in Cwm Taf.

The immediate concerns regarding the safety of the maternity service were escalated by the assessors at 13:00 on 16 January 2019 to the Welsh Government and the Royal Colleges. Feedback was provided to the Welsh Government and key members of the Health Board’s Executive Team on areas of concern requiring immediate action to ensure patient safety at 14:00 on 17 January 2019.

In response to the publication of the review the maternity services of the former Cwm Taf were placed into ‘special measures’ by the Minister for Health and Social Services. Consequently, an Independent Maternity Service Oversight Panel (IMSOP) was commissioned by the Welsh Government to provide the oversight to seek assurance that the Health Board is implementing the recommendations of the RCOG/RCM report in a timely, open and transparent manner.
It should also be noted that services within the Bridgend locality, including Princess of Wales Hospital merged with Cwm Taf on 1 April 2019 to become Cwm Taf Morgannwg University Health Board (CTMUHB).

1.1 IMSOP TERMS OF REFERENCE

- Provide oversight of CTMUHB Improvement Plans to seek assurance that recommendations of the Royal Colleges are being implemented, including progress tracking against agreed milestones.
- Agree and establish an independent clinical review process as detailed below.
- Advise CTMUHB on the actions required for effective public and patient involvement and engagement in all aspects of the maternity improvement required and to rebuild public trust and confidence.
- Escalate any wider governance issues or concerns to the Board of CTMUHB and Welsh Government.
- Advise the Minister on any other action the Panel consider is required to ensure improvement in maternity services.

1.2 OVERARCHING AIM OF THE CLINICAL REVIEW STRATEGY

The Clinical Review Strategy seeks to ensure that:

- A robust clinical review process is in place;
- Identified findings/themes from the review process are reported back to CTMUHB in the form of a report to ensure learning and improvement;
- Mechanisms are in place to report cases to the Coroner or individuals to the NMC or GMC if required;
- Lessons are being learned by CTMUHB through the review of evidence to improve the safety, quality and responsiveness of the maternity service;
- Women and their families are engaged in the process and given feedback as required;
- Staff engagement occurs during the review process and that feedback is given regarding the outcome;
- Quality assurance of Serious Incident Reviews that have occurred post-October 2018 is completed;
- Women and their families can have confidence in the maternity services at CTMUHB.

In response, the Health Board have:

- Developed a comprehensive Maternity Service Improvement Plan which is work stream and pathway-led;
- Reviewed the maternity service governance structure with the establishment of The Quality, Safety & Risk Management Meeting for Maternity Services. The main purpose of the group is to receive and provide assurance of the quality and safety of maternity services, to monitor risks and, when appropriate, to escalate identified risks to the Maternity Improvement Board and the Health Board’s Quality, Safety & Risk Committee.
2 SCOPE AND PURPOSE OF THE INDEPENDENT CLINICAL REVIEWS

The independent review of all identified cases will be carried out by multidisciplinary teams of independent external reviewers who have experience of undertaking clinical reviews.

The REVIEW TEAMS will submit their findings to Alan Cameron and Christine Bell, the Review Panel’s Obstetric & Midwifery representatives who also form an integral part of IMSOP. The REVIEW PANEL will not be responsible for undertaking any of the look-back reviews but will oversee and quality assure the process.

There are four areas within the look-back review process:

1. The 01 January 2016 - 30 September 2018 cases identified in advance of the RCOG Review (referred to as the 43).
2. The 01 January 2016 - 30 September 2018 cases subsequently identified using the look-back inclusion criteria established by the Review Panel (see Appendix 1).
3. The 2010 to 2016 look-back. The criteria utilised for this group will be determined using the outcomes from the above two cohorts.
4. Those women and families who have self-referred will have a review of their care regardless of whether or not they fit the inclusion criteria.

Priority will be given in the order they appear above, however some self-referred cases may fall within the other criteria and hence will be considered within the relevant cohort.

The REVIEW TEAMS will consist of a minimum of an obstetrician and a midwife in cases of stillbirth but all teams reviewing cases with a live born neonate will be comprised of an obstetrician, a midwife and a neonatologist. In specific cases where there are potential anaesthetic issues or in all cases where the mother was admitted to the Intensive Care Unit, an anaesthetist will form part of the multidisciplinary review team.

2.1 LAY REVIEWERS

It is important that clinical reviews are fully informed by families (where they wish to do so) in order for learning to be identified from their experiences whilst helping to provide answers to any questions and concerns they may have. If families want to be involved, lay reviewers will be incorporated into the review teams to interview parents.

It is anticipated that the individuals chosen to conduct the reviews will be approached via the relevant Royal Colleges. Many of the Royal Colleges that undertake Invited Reviews include lay assessors as equal members of the review teams to offer a non-clinical viewpoint, focusing particularly on the patient and public perspective when reviewing the service. Their objective is to bring the patient journey and overall experience of the service user and their family into the heart of the review, alongside the safety and quality elements.
The experience of lay assessors in engaging patients and the public in a range of methods, including one-to-one interviews, to gain their perspective on the issues under review will be helpful in terms of the clinical review process.

They have experience in empathetic communication with women and families directly affected by adverse outcomes, near misses or serious incidents and often engage with aggrieved or bereaved families. They utilise feedback from engagement to build a comprehensive picture of the impact on patient safety, standards of care and service delivery issues.

A number of the Royal Colleges have access to a pool of trained and approved lay assessors. Details of the relevant experience and background of the lay assessors identified for the pool of lay reviewers for the clinical review will be available to support their selection for review teams.

The Welsh Government will be responsible for procuring the clinical review teams on behalf of the Panel.

2.2 POST-OCTOBER 2018 REPORTED SERIOUS INCIDENTS

All cases after 01 October 2018 are to be reviewed by the Health Board under normal ‘business as usual’ procedures. These reports will be quality assured by the REVIEW PANEL to validate and, if applicable, provide assurance to the Welsh Government on the robustness of the Health Board’s governance processes.

2.3 SCOPE AND TERMS OF REFERENCE FOR THE 43 CASES AND THOSE CASES SUBSEQUENTLY IDENTIFIED

The multidisciplinary REVIEW TEAMS will:

- Involve families in the investigation process should they wish to be included;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents utilising an agreed review mechanism;
- Identify whether the investigations appropriately addressed the relevant concerns and issues pertaining to those incidents, and provided sufficient externality and independence of opinion;
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents and families were engaged with during these investigations, and how the results of the investigation were communicated to them;
- Consider how staff members involved were engaged in the review process and how the outcomes/learning were shared either individually or throughout the wider maternity service and embedded into practice;
- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.
### 2.4 Scope and Terms of Reference for the 2010 to 2016 Look-Back

The multidisciplinary REVIEW TEAMS will:

- Involve families in the investigation process should they wish to be included;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues pertaining to those incidents and provided enough externality and independence of opinion;
- Reserve the right to carry out a RCA (Root Cause Analysis) review of the cases where no investigation was undertaken if deemed appropriate following agreement by the Independent Maternity Services Oversight Panel;
- Establish whether recommendations were accepted, and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents and families were engaged with during these investigations and how the results of the investigation were communicated to them;
- Consider how staff members involved were engaged in the review process and how the outcomes/learning were shared either individually or throughout the wider maternity service and embedded into practice.
- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

### 2.5 Scope and Terms of Reference for the Review of Those Women Who Have Self-Referred

- Involve families in the investigation process should they wish to be included;
- Reserve the right to carry out a RCA review of the cases where no investigation was undertaken if deemed appropriate following agreement with the Independent Maternity Services Oversight Panel;
- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

### 2.6 Role of the Independent Maternity Oversight Review Panel

The REVIEW PANEL will:

- Receive and quality assure the REVIEW TEAM’s findings in each case reviewed;
- Develop the report of the review’s findings which will include analysis of identified themes from each cohort;
- Actively engage and communicate with families relevant to the specified cases - where they have expressed a preference for such engagement - regarding the review’s findings and recommendations;
- Advise the Health Board where further action is required from them in the form of redress or where follow up has been requested by families for example with reference to management of subsequent pregnancies.
3 ROLE OF THE HEALTH BOARD IN THE REVIEW PROCESS

3.1 PATIENT DATABASE

- The database is the responsibility of the Health Board and should be kept up to date, be GDPR compliant, and contain all the information required by the Welsh Government and IMSOP;
- Provide Welsh Government and IMSOP with assurance around content to reduce risk of reputational damage to the review process.

3.2 SUPPORTING THE CLINICAL REVIEW PROCESS

The Health Board will support the clinical review process by providing:

- A suitable venue;
- Support during the review process to address queries/provide further information;
- Patient records including CTG’s;
- Investigation paperwork/supervisory reports/staff statements;
- Patient stories;
- Guidelines in place at the time of the event;
- Action plans in relation to the incident;
- Complaint referral paperwork.

Access to all documentation is to be compliant with the Health Board’s Information Sharing Protocol.

3.3 SUPPORTING FAMILIES

- The Health Board is responsible for the ongoing communication with families during the review process, providing support as required.
- Women and families who have or are experiencing bereavement will be treated with compassion and empathy with communication and support in line with the Stillbirth Pathway (NBC Pathway). They will be supported by appropriately skilled Bereavement Midwives, Counsellors and have access to SANDS and other advocacy services, including the CHC, in order to provide feedback on their experience and identify their continuing needs.
4 THE REVIEW PROCESS

A review of all investigations in the cohort including but not limited to RCAs, preliminary fact-finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Health Board policy and National Guidance;

- A review of the relevant/associated improvement plan and pace of improvement against the timelines identified in the plan; and
- Contact with parents or relatives to establish an understanding of their involvement in previous investigations.

The REVIEW PANEL will provide the REVIEW TEAMS with direction in relation to the conduct of the review to ensure that there is a consistent approach to each case. To achieve this, the REVIEW TEAMS will use an agreed review tool – the perinatal mortality review tool that was used in the Morecambe Bay inquiry (see Appendix 2). The REVIEW TEAMS and the REVIEW PANEL will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process. It is anticipated that the reviews conducted by the review teams will enable themes to be identified and these will be compared to the themes identified in other National inquiries such as Each Baby Counts and the Healthcare Safety Investigation Branch.

4.1 PROCESS FOR ESCALATING CONCERNS

In the event of the REVIEW TEAMS identifying any material concerns requiring further investigation, review, referral to professional bodies or the Coroner, this should be escalated initially to the REVIEW PANEL. The Panel will advise the Health Board and ensure a referral is made.

The REVIEW TEAMS will be provided with a copy of the guidance ‘Referral of deaths to HM Coroner, South Wales Central’ (June 2019) as a guide. The REVIEW PANEL will provide the Coroner with any referrals in a ‘block report’ at the end of each stage of the review process to ensure capture of any themes for further investigation.

Where it is felt that there is a case for referral to a professional body, this will be escalated initially to the REVIEW PANEL who will advise the Health Board’s Director of Nursing and/or Medical Director as appropriate. If the individuals are no longer employed by the Health Board the REVIEW PANEL will communicate directly with the appropriate professional body.

The REVIEW PANEL are working with the Safeguarding Board to ensure there is alignment between the Clinical Reviews and a number of Safeguarding Reviews being undertaken concurrently. Any safeguarding concerns identified during the review process will be escalated by the REVIEW PANEL to the Safeguarding Board.
4.2 REPORTING

The REVIEW PANEL will provide a report and recommendations of any actions required to the Health Board at the end of each of the review cohorts. Each report should ideally be available within one month of the Panel receiving feedback from the REVIEW TEAMS.
5 Key Principles of the Review

The review will be expected to:

- Engage widely, openly and transparently with all relevant individuals participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving positive outcomes for women and children; and
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management.

The following questions will crucially inform each stage of the review process:

1. Did the Health Board have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Health Board now have these mechanisms in place?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Health Board policies, including enough externality and independence?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were staff members involved in the incidents engaged in the investigation process and were outcomes and learning shared?
5. Were families involved in the investigation in an appropriate and sympathetic way?
APPENDIX 1

INCLUSION CRITERIA FOR 2016-2018 CASES

Additional cases from 01 January 2016 – 30 September 2018 will be identified using the inclusion criteria set out below:

1. MBRRACE reported cases >26 weeks
2. All Each Baby Count Cases
3. All maternal admissions to ICU

To ensure wider learning, in addition to the above criteria, all cases of transfers out will be evaluated by the REVIEW PANEL to determine whether a clinical review is necessary. Therefore, the two additional criteria to be considered are:

4. All cases where the mother was transferred out for delivery
5. All cases where the neonate was transferred out for further care

Explanatory Notes

In order to achieve consistency it is crucial that the database of clinical cases has clear inclusion criteria. It is anticipated that the findings from this criteria will inform the criteria agreed for the 2010 look-back.

The most representative surrogate marker for quality care obstetric outcome is the criteria used in the Each Baby Counts (EBC) project at the Royal College of Obstetricians and Gynaecologists (RCOG). It is therefore recommended that the database includes all cases that have been reported to the EBC team.

The EBC criteria for eligibility are for babies born > 37 weeks gestation where the outcome was as follows:

1. Intrapartum stillbirth: when the baby was thought to be alive at the start of labour but was born with no signs of life.
2. Early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.
3. Severe brain injury diagnosed in the first 7 days of life, when the baby:
   o was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); OR
   o was therapeutically cooled (active cooling only); OR
   o had decreased central tone AND was comatose AND had seizures of any kind.

The definition of labour for EBC includes:

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4 cm cervical dilatation;
- When the woman called the unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions or suspected ruptured membranes;
- Induction of labour;
• When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

The EBC definition of labour will be used for this inclusion criteria. The rationale for this is to have an inclusive definition of labour to include as many babies as possible and to identify babies who are affected in the latent phase of labour.

In addition to the EBC criteria, all cases of stillbirth at gestations > 26 weeks will be reviewed. These are the cases that are currently submitted to MBRRACE.

Cases where the mother was transferred out for delivery (e.g. prematurity) or cases where a baby was transferred out for further management will also be reviewed. This will ensure adverse outcomes on other sites following care in the former Cwm Taf UHB will be identified.

As a surrogate marker for maternal morbidity the panel will also review all cases where the mother is transferred to the Intensive Care Unit.
APPENDIX 2

AUDIT OF PERINATAL DEATHS:
ASSESSMENT OF MODIFIABLE FACTORS

1. Were there modifiable factors present in this case?
   - Yes
   - No \(\Rightarrow\) If no, please go to Page 24

   If yes, please check all relevant factors. Then, turn to the appropriate page in the form to provide more information about each factor or event.

2. Please tick the best category for each factor present in this case (you may tick more than one).

Factors related to Healthcare Professionals
   - Pre-pregnancy or preconception care \(\Rightarrow\) Go to Section 3, page 2
   - Assessment or point of entry to care \(\Rightarrow\) Go to Section 4, page 4
   - Diagnosis or in the recognition of high-risk status \(\Rightarrow\) Go to Section 5, page 6
   - Referral to a specialist \(\Rightarrow\) Go to Section 6, page 8
   - Treatment \(\Rightarrow\) Go to Section 7, page 10
   - Clinical leadership \(\Rightarrow\) Go to Section 8, page 12
   - Education, Knowledge, Training \(\Rightarrow\) Go to Section 9, page 14
   - Documentation \(\Rightarrow\) Go to Section 10, page 16
   - Discharge or transfer from care \(\Rightarrow\) Go to Section 11, page 18

Factors related to Services
   - Communication \(\Rightarrow\) Go to Section 12, page 20
   - Policies and procedures \(\Rightarrow\) Go to Section 13, page 22

Factors related to the Woman or her Family
   - Woman or her family \(\Rightarrow\) Go to Section 14, page 23

Factors related to Healthcare Professionals

3. Was there an avoidable factor / event during pre-pregnancy or preconception care?
   - Yes
☐ No

3a. If yes, then please tick each relevant factor or event.

☐ Professional failed to provide pre-pregnancy counselling.

☐ Professional failed to get complete medical history.

☐ Other pre-pregnancy or preconception issue.

(Please specify) __________________________________________________________

3b. Description of relevant issue.

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________________________________________________________________________

3c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes ☐ No

3d. If yes, were they followed?  ☐ Yes ☐ No

3e. Please note the relevant guidelines or standards.

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3f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.

3g. Please note the main clinician or health care professional responsible for this factor or event.
☐ GP
☐ Hospital Midwife
☐ Community Midwife
☐ Obstetrician
☐ Anaesthetist
☐ A & E physician
☐ Psychiatrist
☐ Ambulance paramedic
☐ ICU physician
☐ Nurse
☐ Other (Please specify) ____________________________________________

3h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

______________________________________________
4. Was there a modifiable factors / event during assessment or point of entry to care?

☐ Yes
☐ No

4a. If yes, then please tick each relevant factor or event.

☐ Mother was denied access to care or appointment (including unit was closed to admission)
☐ Professional failed to offer preventative treatment
☐ Professional delayed assessment/evaluation of patient
☐ Professional failed to get complete medical history
☐ Other assessment issue
(Please specify) __________________________________________________________

4b. Description of relevant issue.

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________________________________
________________________________

4c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes  ☐ No

4d. If yes, were they followed?

☐ Yes  ☐ No

4e. Please note the relevant guidelines or standards.

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________________________________
________________________________
4f. Please note the significance of this factor or event.

- Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.
- Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.
- Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.

4g. Please note the main clinician or health care professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (Please specify) ________________________________________________________________

4h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

____________________________________
5. Was there modifiable factors / event during the patient’s diagnosis or in the recognition of high-risk status at any stage?

☐ Yes
☐ No

5a. If yes, then please tick each relevant factor or event.

☐ Inappropriate diagnosis or categorisation of risk status
☐ Inadequate monitoring of fetal growth
☐ Inadequate fetal heart rate monitoring during labour
☐ Delay in diagnosis or recognition of high-risk status
☐ Delay in ordering or checking investigations
☐ Delay in recognition of abnormal vitals
☐ Delay in recognition of surgical complications
☐ Other delay
(Please specify) _____________________________________________

☐ Failure in recognition of high-risk status (including failure to recognise intrauterine growth restriction)
☐ Failure in ordering or checking investigations (including failure to do or to repeat glucose tolerance test)
☐ Failure in recognition of abnormal vitals
☐ Failure in recognition of surgical complications
☐ Other failure
(Please specify) _____________________________________________

5b. Description of relevant issue.

___________________________________________________________________________________________________
___________________________________________________________________________________________________
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5c. Were there national guidelines / standards related to the relevant factor or event?  ☐ Yes  ☐ No
5d. If yes, were they followed?  
☐ Yes ☐ No

5e. Please note the relevant guidelines or standards.
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____________________________________________________________________________

5f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.

5g. Please note the main clinician or health care professional responsible for this factor or event.

☐ GP
☐ Hospital Midwife
☐ Community Midwife
☐ Obstetrician
☐ Anaesthetist
☐ A & E physician
☐ Psychiatrist
☐ Ambulance paramedic
☐ ICU physician
☐ Nurse
☐ Other (Please specify)____________________________________________________________________________

5h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.
____________________________________________________________________________
6. Was there modifiable factors / event regarding referral to a specialist?
   - Yes
   - No

6a. If yes, then please tick each relevant factor or event.
   - Delay in referral
   - Failure to refer
   - Appropriate person was not available or did not respond
   - Services not available

6b. Description of relevant issue.

6c. Were there national guidelines/standards related to the relevant factor or event?  
   - Yes
   - No

6d. If yes, were they followed?
   - Yes
   - No

6e. Please note the relevant guidelines or standards.

6f. Please note the significance of this factor or event.
   - Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.
   - Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.
   - Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
6g. Please note the main clinician or health care professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (Please specify) __________________________________________________________

6h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

________________________________________
7. Was there modifiable factors / event regarding treatment?

☐ Yes
☐ No

7a. If yes, then please tick each relevant factor or event.

☐ No plan of care/management
☐ Delay in treatment (including delayed operation)
☐ Inappropriate treatment
☐ Poor diabetic management
☐ Failure to treat. If yes, then was the failure one of the following:

☐ Failure to act on high-risk situation/history
☐ Failure to act on intra-uterine growth restriction
☐ Failure to act on decreased fetal movements
☐ Failure to act on raised blood pressure and/or proteinuria
☐ Failure to act on suspicious antenatal cardiograph
☐ Failure to resuscitate a newborn

7b. Description of relevant issue.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

7c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes  ☐ No

7d. If yes, were they followed?  ☐ Yes  ☐ No

7e. Please note the relevant guidelines or standards.

________________________________________________________________________________________
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________________________________________________________________________________________
________________________________________________________________________________________
7f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.

7g. Please note the main clinician or health care professional responsible for this factor or event.

☐ GP
☐ Hospital Midwife
☐ Community Midwife
☐ Obstetrician
☐ Anaesthetist
☐ A & E physician
☐ Psychiatrist
☐ Ambulance paramedic
☐ ICU physician
☐ Nurse
☐ Other (Please specify) ____________________________________________________________

7h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

___________________________________________
8. Was there modifiable factors / event regarding clinical leadership?

☐ Yes
☐ No

8a. If yes, then please tick each relevant factor or event.

☐ Fail to check on junior’s work (e.g., senior did not attend)
☐ Fail to consult superior
☐ Inappropriate grade of staff involved in care

8b. Description of relevant issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes ☐ No

8d. If yes, were they followed?  ☐ Yes ☐ No

8e. Please note the relevant guidelines or standards.

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8f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
8g. Please note the main clinician or health care professional responsible for this factor or event.

☐ GP
☐ Hospital Midwife
☐ Community Midwife
☐ Obstetrician
☐ Anaesthetist
☐ A & E physician
☐ Psychiatrist
☐ Ambulance paramedic
☐ ICU physician
☐ Nurse
☐ Other (Please specify)__________________________________________________________

8h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

______________________________________________
9. Was there modifiable factors / event regarding education of health professional?

☐ Yes
☐ No

9a. If yes, then please tick the relevant factor or event.

☐ Lack of knowledge or training

9b. Description of relevant issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes  ☐ No

9d. If yes, were they followed?  ☐ Yes  ☐ No

9e. Please note the relevant guidelines or standards.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
9g. Please note the main clinician or health care professional responsible for this factor or event.

☐ GP  
☐ Hospital Midwife  
☐ Community Midwife  
☐ Obstetrician  
☐ Anaesthetist  
☐ A & E physician  
☐ Psychiatrist  
☐ Ambulance paramedic  
☐ ICU physician  
☐ Nurse  
☐ Other (Please specify) ____________________________________________________________

9h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

________________________________________
10. Was there modifiable factors / event regarding documentation?

☐ Yes
☐ No

10a. If yes, then please tick each relevant factor or event.

☐ Poor documentation
☐ Failure to document / incomplete records

10b. Description of relevant issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes  ☐ No

10d. If yes, were they followed?  ☐ Yes  ☐ No

10e. Please note the relevant guidelines or standards.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
10g. Please note the main clinician or health care professional responsible for this factor or event.

- [ ] GP
- [ ] Hospital Midwife
- [ ] Community Midwife
- [ ] Obstetrician
- [ ] Anaesthetist
- [ ] A & E physician
- [ ] Psychiatrist
- [ ] Ambulance paramedic
- [ ] ICU physician
- [ ] Nurse
- [ ] Other (Please specify) __________________________________________

10h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

______________________________
11. Was there modifiable factors / event regarding during the post-delivery or discharge period?

☐ Yes
☐ No

11a. If yes, then please tick each relevant factor or event.

☐ Inappropriate transfer home
☐ Inappropriate discharge from care
☐ Failure to counsel patient
☐ Failure to arrange appropriate ongoing treatment / care
☐ Failure to follow up after transfer home
☐ Inadequate screening following a stillbirth
☐ Problems with the post mortem examination including failure to send samples
☐ Insufficient bereavement support

11b. Description of relevant issue.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

11c. Were there national guidelines/standards related to the relevant factor or event?  ☐ Yes  ☐ No

11d. If yes, were they followed?  ☐ Yes  ☐ No

11e. Please note the relevant guidelines or standards.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
11f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.

11g. Please note the main clinician or health care professional responsible for this factor or event.

☐ GP
☐ Hospital Midwife
☐ Community Midwife
☐ Obstetrician
☐ Anaesthetist
☐ A & E physician
☐ Psychiatrist
☐ Ambulance paramedic
☐ ICU physician
☐ Nurse
☐ Other (Please specify) ____________________________________________________________

11h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

_________________________________________
Factors related to Services

12. Was there modifiable factors / event due to communication problems?
   - Yes
   - No

12a. If yes, then please tick each relevant factor or event.
   - Between doctors
   - Between midwives and doctors
   - Between nursing and doctors
   - Between departments / specialists
   - Between hospitals
   - Between health professional and woman (including importance of changes in fetal movement not explained to woman)

12b. Description of relevant issue.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

12c. Were there national guidelines/standards related to the relevant factor or event?  
   - Yes
   - No

12d. If yes, were they followed? 
   - Yes
   - No

12e. Please note the relevant guidelines or standards.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
12f. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
13. Was there modifiable factors / event due to policy or procedure problems?

☐ Yes
☐ No

13a. If yes, then please tick each relevant factor or event.

☐ Regarding lab facilities or results
☐ Regarding oversight of others (e.g., no senior on call)
☐ Regarding scheduling and assessment
☐ Regarding emergency preparedness (e.g., ICU full or too distant, lack of theatre, lack of blood)
☐ Regarding patient education
☐ Regarding availability of records (e.g., at time of birth)
☐ Regarding staff workload
☐ Other
(Please specify)________________________________________________________________________________________

13b. Description of relevant issue.
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

13c. Were there national guidelines/standards related to the relevant factor or event? ☐ Yes ☐ No

13d. Please note the relevant guidelines or standards.
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

13e. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
Factors related to the Woman and her Family

14. Was there modifiable factors / event due to the woman or her family?

☐ Yes
☐ No

14a. If yes, then please tick each relevant factor or event.

☐ Non-compliance with medical advice (e.g., refused treatment, refused blood)
☐ Failure to seek care (including failure to report decreased fetal movements until after delivery)
☐ Failure to attend scheduled care, including inadequate antenatal care
☐ Substance misuse
☐ Other
(Please specify)__________________________________________________________

14b. Description of relevant issue.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

14c. Please note the significance of this factor or event.

☐ Major- Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

☐ Minor- Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

☐ Irrelevant- Although lessons can be learned, it did not affect the eventual outcome.
Assessment of Care

15. Does the panel think overall care of the mother and baby was optimal, adequate, or poor?

<table>
<thead>
<tr>
<th>Antenatal Care</th>
<th>Optimal</th>
<th>Adequate</th>
<th>Poor</th>
<th>Insufficient information in notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapartum Care</td>
<td>Optimal</td>
<td>Adequate</td>
<td>Poor</td>
<td>Insufficient information in notes</td>
</tr>
<tr>
<td>Postpartum care</td>
<td>Optimal</td>
<td>Adequate</td>
<td>Poor</td>
<td>Insufficient information in notes</td>
</tr>
</tbody>
</table>

15a. Please highlight any particular instances of optimal care or care that went above and beyond expectations.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

16. Please summarise recommendations and learning points illustrated by this case.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
### Internal Reviews

17. Was there a Serious Untoward Incident (SUI) triggered?  
- [ ] Yes  
- [ ] No

18. Was there a Trust internal review?  
- [ ] Yes  
- [ ] No

18a. What was the conclusion of the internal review?  
- ___________________________________________  
- ___________________________________________  
- ___________________________________________

18b. Does the panel agree with the conclusion of the internal review?  
- [ ] Yes  
- [ ] No

18c. Please specify.  
- ___________________________________________  
- ___________________________________________  
- ___________________________________________  
- ___________________________________________

- ___________________________________________

- ___________________________________________  
- ___________________________________________  
- ___________________________________________  
- ___________________________________________