09 July 2024

Shared Insights

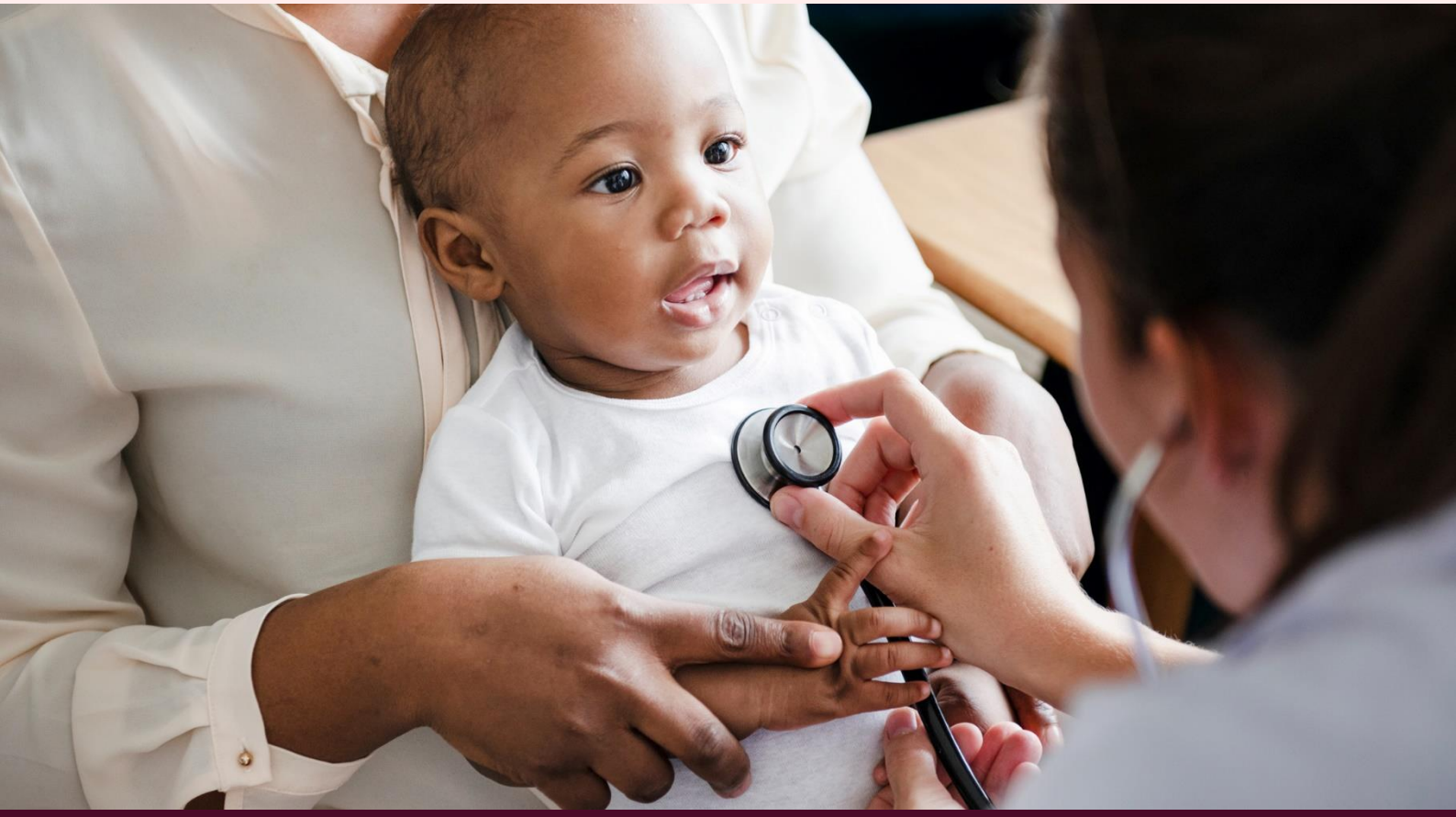
Focus on maternity and neonatal safety

Panel of speakers

Amelia Newbold – Risk Management Lead, Browne Jacobson
Sian Brown – Partner, Browne Jacobson
Bridget Prosser – Partner, Browne Jacobson
Sarah Noble – Director of Midwifery at University Hospitals of Derby and Burton NHS Foundation Trust
Julie Shaw – Maternity Investigations Team Leader (Midlands & East Central North) from the Maternity and Newborn Safety Investigations

MNSI Maternity & Newborn Safety Investigations

NHS University Hospitals of Derby and Burton NHS Foundation Trust



Browne Jacobson

Introduction

There is rightly considerable national focus on supporting maternity services to learn from harm in a meaningful way, but with increased scrutiny can come increased pressure on staff.

This session focussed on insights from our extensive experience of supporting maternity staff through high profile maternity inquests and complex and high-value maternity claims. We looked at how to ensure that there is accountability and openness with families in an environment which supports staff when things sadly go wrong.

Chairs Amelia Newbold, Risk Management Lead and Sian Brown, Partner in our specialist maternity division were joined by Bridget Prosser, Partner in our employment team. We were also delighted to hear insights from experienced professionals working in maternity services, including: **Sarah Noble**, Director of Midwifery at University Hospitals of Derby and Burton NHS Foundation Trust and **Julie Shaw**, Maternity Investigations Team Leader (Midlands & East Central North) from the Maternity and Newborn Safety Investigations (MNSI).

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How we can help

Our specialist Maternity Division, Inquest and Advisory teams provide expert legal advice to organisations across the public and independent health and care sector. Please do contact us if we can assist.

Services we offer include:

- Our dedicated Maternity Services Resources Hub is a unique facility providing free resources and training materials to help maternity services improve and follow best practice. It includes support, advice and a number of training guides and videos for staff attending inquests (full list and links on page 7).
- Our Mock Inquest Course see details and register your place here which includes a bespoke module on inquests involving maternity services.
- Bespoke maternity investigations toolkits, Board briefings and assistance with triangulation of themes and trends from incidents.
- Training packages for clinical or patient safety teams on topics such as creating a culture of candour, supporting staff to escalate concerns, complying with the Trust's statutory duties in relation to whistle-blowers, best practice when responding to complaints and supporting staff through legal processes.
- We have a track record of delivering high quality HR investigations within maternity and obstetric specialties.

Empowering staff to speak up – insights from an employment lawyer

Bridget Prosser, Partner in the Employment Team at Browne Jacobson

Bridget shared her valuable insights on how to empower and support staff to raise concerns from the outset of an incident and uphold the Duty of Candour based on her experience in complex workplace investigations.

Speak up culture

- Create a safe environment and foster a speak up culture for staff to raise concerns knowing they are protected from reprisals from their colleagues or organisation.
- Be aware of any power dynamic and consider whether the culture allows staff at all levels, from junior midwives to consultants, to raise concerns.
- Review how your organisation maintains a culture that empowers staff to raise concerns:
  - What is the follow up like?
  - Do you thank staff for speaking up?
  - Do you ensure that there are no adverse consequences for speaking up?
  - Do staff understand what action has been taken and has it been fed back to them?
  - Do you monitor the themes of concerns raised and capture data to feed back into learning?

Supporting staff

- When a formal investigation concerning someone's acts or omissions takes place, it can be easy to lose sight of the fact that there is a person at the heart of the process who will be feeling incredibly anxious.
- Create an environment where staff feel empowered to acknowledge and learn from mistakes. If not, it is possible they might try to hide them.
- Foster a culture that is supportive rather than punitive when mistakes are made.
- Communication is key. Explain clearly what is being investigated and allow the individual to contribute fully to the process.
- Delays can creep in to investigations, which can heighten anxiety. Try to minimise these where possible and consider whether your organisation's investigatory processes are taking too long.
- Provide non-clinical staff with an appropriate clinical buddy to guide them through the process.

Duty of Candour

- Applies to individual practitioners under the NMC and GMC codes of conduct.
- Applies to the organisation itself to ensure transparency and accountability (statutory duty of candour).
- Requires healthcare professionals to be open and honest with their colleagues and employer when things go wrong.
- Letters to families should be written in accessible language that is clear and uncomplicated to ensure that anyone reading the letter can understand in clear terms what has happened.
- Ensure that any learning reflected in the letter is implemented, e.g. by requiring the staff involved to attend mandatory training.

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MNSI's investigation process: a focus on support and learning

Julie Shaw – Maternity Investigations Team Leader (Midlands & East Central North) from the Maternity and Newborn Safety Investigations (MNSI).

The maternity investigation programme was established in 2018 as part of the Healthcare Safety Investigation Branch (HSIB). However, since October 2023, it is known as the Maternity and Newborn Safety Investigations (MNSI) programme. It is hosted by the CQC, although it remains independent and has no regulatory powers.

Julie expressed that first and foremost, MNSI acknowledges and empathises with the devastating impact that an adverse maternity incident has on both the families and staff involved.

The aim of an investigation is to gather the evidence to establish what went wrong, whether it be in the room, in the system or nationally, and put together a report making safety recommendations to prevent similar events from happening again in the future.

It does not try to find or place blame on individuals and investigation reports are anonymous.

Investigation process

- MNSI understands that the investigation process can be a daunting experience and its main priority is to be supportive, caring, and empathetic to help reduce the anxiety of those involved.
- When a maternity incident occurs, the Trust will let staff members know if it is has been referred to MNSI for investigation. MNSI will then contact the staff member directly and offer to speak face-to-face or via Teams, whatever suits them best.
- MNSI understands revisiting events can be difficult and staff are welcome to bring someone with them for support during the interview. This should preferably be someone professional such as a work colleague and not a family member or friend. Staff can also bring notes or records to the interview to help with their recollection.
- It is rare for the investigator to ask direct questions, as they will want to focus on the staff member's narrative as to what happened and what they remember about the incident.
- Interviews are usually audio-recorded to allow the investigators to focus on what is being said and be attentive to the person's needs rather than taking detailed notes. Medical defence unions also recommend audio recording to accurately capture the evidence given in interviews.
- Recordings are stored in an encrypted database. The key message is that the person that has been interviewed can request a copy afterwards through a Subject Access Request. The recording is stored for about 20 years.
- MNSI will never release the interview to the Trust or anyone else unless there is a court order to do so or under Schedule 5 of the Coroners and Justice Act 2009.

Julie concluded by emphasising that MNSI is quite a young organisation and also a learning organisation and they don't always get it right. They are keen to receive feedback on anything that can be done differently to improve the process for NHS staff involved in MNSI investigations.

Delegate Questions

There were several questions about the potential disclosure of interview recordings made by MNSI which we have sought to clarify here:

Can an interview recording be shared with the clinician?

Yes, the clinician can request the recording through a Subject Access Request.

Can the NMC request recordings / documents?

The NMC has powers to seek disclosure in certain circumstances Disclosure - The Nursing and Midwifery Council (nmc.org.uk) and Collecting information throughout an investigation - The Nursing and Midwifery Council (nmc.org.uk)

Are the recordings subject to requests under the Freedom of Information (FOI) Act?

MNSI interviews with NHS staff are treated as confidential and as such, will be exempt from a FOI request (section 41 FOI Act 2000).

Would medical examiner scrutiny notes be disclosable as part of the MNSI investigation?

MNSI would review the medical notes written by the medical examiner in the process of its investigation as receiving them would be covered within its consent process. MNSI would not review the notes with a view to deciding if it was correctly allocated as a coronial case or not. If MNSI had a concern that a case should be coronial, it would raise this through its internal Concerns and Escalations process.

It is worth noting that disclosure is only likely to be ordered by the Court where there is a discrepancy between the factual account of events given to MNSI and a parallel process e.g. at an inquest.

Resources

MNSI's website provides helpful information and resources for NHS staff, including an information video on the investigation process:

Home (mnsi.org.uk)

For NHS (mnsi.org.uk)

MNSI Staff Information Video (youtube.com)

From Incident to Inquest: A Trust Perspective

Sarah Noble – Director of Midwifery at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

Sarah shared valuable insights and lessons learned from her experience supporting staff and engaging with families after an adverse event, from initial management of the incident through to giving evidence at Court and beyond.

Current Challenges

UHDB is a large multisite organisation with approximately 10,000 births annually. It is currently under scrutiny after its maternity services were rated inadequate by the CQC in August 2023. However, the Trust acknowledges its challenges and proactively elected to join the national Maternity Safety Support Programme as part of its commitment to improve maternity and neonatal services.

Incident Management

Sarah gave an overview of the Trust's initial response to incidents in maternity care.

- A hot debrief takes place immediately after an incident, followed by several briefings within the first few days.
- This includes a 72-hour report, which identifies actions that need to be taken straight away. The Trust is working to encourage more clinical staff to attend the review, although recognises that it can be difficult to release them from clinical duties.
- There is then often a long gap between the incident investigation and any subsequent Inquest or claim. The Trust is looking at what ongoing pastoral support can be provided to its staff, including the development of a standard operating procedure for periodic check ins through midwifery advocates, line management support and an informal buddy system.

Sarah emphasised the importance of fostering a **non-blame culture focussed on learning**. She described the Trust's positive relationship with MNSI, which provides a supportive space to look at incidents, what can be learned from them and implement preventive measures to avoid it happening again.

Preparation for Court

Sarah shared her experience of supporting staff in preparation for giving evidence at Court.

- It must be recognised that this can be scary for those involved and whilst information can help to demystify the process, it doesn't make it any less daunting. This is why it is important for staff to have protected preparation time, which the Trust does in two ways:

1. Legal support with the Court processes, including preparing a statement and giving evidence.
2. A wellbeing briefing before the hearing, to see how staff are feeling and explore what additional support they might need.

- The staff are prepared for media interest. Whilst this doesn't make the prospect or experience of being named in the media any easier, you can ensure that staff are aware this may happen and give practical support such as meeting in a pre-arranged place and walking into Court together.
- The end of an inquest is not the end for staff or for families. The Trust and Browne Jacobson's legal team always have a post-inquest debrief with staff, which is largely pastoral and encourages those involved to share the personal impact of the inquest on them, particularly senior staff who often seem to be coping well but may also have found the experience very stressful.

Family and Stakeholder Engagement

Sarah emphasised that you can't talk about the impact on staff without acknowledging the impact on the family. She highlighted the Trust's approach to being open, honest and upfront, with families. Addressing questions and making any necessary admissions before the Inquest can make a real difference to the tone of the hearing and is beneficial for both the family and NHS staff.

The Trust also encourages its staff to maintain good links with the family. Often the families don't directly blame individual clinicians and keeping lines of communication open can be cathartic for all involved.

Sarah's role at the Inquest is to talk about organisational learning, which is something that needs to be done sensitively because you are talking about putting something in place which, had it been in place before, would have made a difference to the outcome of someone's loved one. She therefore tries to speak to families before the inquest to explain that it is her job to assure the Coroner that the incident won't happen again, but also acknowledge how difficult it must be for the family to hear this.

The Trust was set to hold a significant stakeholder event on 10 July 2024, aimed at engaging with the local community and hearing the experiences of bereaved families, in order to develop meaningful discussion about how the Trust can continue to improve its maternity and neonatal services.

Supporting staff through the claims and inquest process

Sian Brown – Partner in the Specialist Maternity Division at Browne Jacobson

Sian draws on her extensive experience of guiding NHS staff through complex and high-value maternity claims and inquests to provide her insights on the support that can be provided throughout this process.

Sian acknowledged that whilst we try our best to keep cases out of court, the claims and inquest process can still be lengthy and difficult. She emphasised the importance of having an open conversation about the impact it can have on staff so that we can all learn from experiences. She provided examples of the support that can be provided from a legal perspective:

- As lawyers, we need to be mindful of the language we use and the impact of our communications, such as sending a letter to a clinician's home address after they have left the Trust.
- Regularity of contact should be tailored to individual preferences; some staff may want frequent updates, while others may prefer less or minimal contact.
- Ensure staff have access to documents and records related to the case.
- Provide protected time for staff to review these documents and avoid last-minute preparations. Whilst we recognise that it's easier said than done on the shop floor, staff should not be preparing for an inquest the night before.
- Encourage staff to discuss concerns. We would much rather know and have honest conversations before the inquest.
- Talk staff through what to expect on the day, including the various roles, how evidence is given and what sort of questions might be asked. Provide practical details like where to park.
- Conduct a debrief after the hearing or inquest to discuss and reflect on what happened. Team dynamics can play out in evidence and these teams have to go back to working together the next day, so it is important to try and reconnect and bring teams back together.

Useful Resources

Our Maternity Services Resources Hub is a unique facility which provides resources and training materials to help maternity services improve and follow best practice. The Hub provides advice and support in relation to the legal workforce and regulatory issues that may arise.

You can also find our mock inquest training course and inquest guides and resources via the Hub, which provide invaluable practical advice and tools for governance and risk, complaints, family liaison and in-house legal teams who are involved in the in-house process in preparing for a coronial investigation.

- Mock inquest training
- Series of mock inquest films
- Guide to coroners' inquest process for clinical witnesses
- Guide for clinical witnesses writing coroner's inquest statements
- Guide to preparing and delivering a prevention of future deaths report

We were also fortunate to be joined on the call by Sangita Bodalia, Head of Early Notification (Legal) at NHS Resolution, who signposted delegates to a range of available resources on their website, including:

- Support for NHS trusts or member organisations
- Support for families or carers
- Early Notification Scheme animation on Vimeo
- Watch how to prepare for an inquest

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Discussion

Delegates had the opportunity to share their own reflections and feedback, including:

- The benefits of staff attending post-incident briefings/reviews, as they are often able to provide more context and detail than what is documented in the records, particularly in emergency situations.
- Involving staff from the outset helps to promote a more supportive, open and transparent culture.
- Inviting agency, bank and students to briefings/reviews to ensure they are aware of, and involved in, these processes as well.
- Delegates affirmed that regular check-ins and buddy systems are effective for maintaining support throughout investigations, even if there are no updates to share.
- It can be helpful to link staff to a peer who has previously been involved in an inquest or claims process and can offer practical guidance and support.
- Ensuring effective support is in place for senior clinicians, who can still find investigations, inquests and claims stressful but there isn't always an awareness or appreciation that they need support too.

Key takeaways

- Promote a non-blame culture focused on learning from incidents to prevent recurrence.
- Create a safe environment where staff feel encouraged to raise concerns without fear of reprisal.
- Offer protected time for staff to prepare for hearings and ensure they are provided with a copy of the relevant notes and records.
- Utilise available resources to support staff through the inquest and claims process.
- Conduct post-hearing debriefs to reflect on experiences and rebuild team relationships.
- Acknowledge and encourage open conversations about the emotional toll that an incident and investigatory processes can have on staff and provide ongoing support with periodic check-ins.
- Ensure there is clear and compassionate communication with both staff and families when incidents occur and throughout any investigation process.

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