DEATH OF AMANDA COX AT ROYAL INFIRMARY OF EDINBURGH 10/12/18

STATEMENT FROM NHS LOTHIAN ON THE ACTIONS TAKEN AND LESSONS LEARNT

We are so sorry that Mrs Cox died in our care and extend our sincere condolences to her family.

1. BACKGROUND

Following the tragic death of Amanda Cox in the Royal Infirmary of Edinburgh (RIE) in December 2018, NHS Lothian immediately instigated a Serious Adverse Event (SAE) Investigation.

2. THE SAE REVIEW PROCESS

2.1 The Clinical Review Team

The multi disciplinary Clinical Review Team was led by a senior NHS Lothian Obstetrician and the Clinical Director for Obstetrics and Neonatal services in Lothian and included an External Obstetric consultant Reviewer as well as a consultant Neurologist.

The Review team looked at the whole of Amanda Cox's care, starting with her antenatal management through to her transfer to the RIE, her management pre and post delivery of her baby and up to the point when she was found unresponsive in a stairwell at the other end of the hospital.

2.2 Facilities Directorate Review

In tandem with the clinical review process, the NHS Lothian Facilities Directorate also undertook an immediate review along with Consort/Engie (PFI partners).This review focused on security, signage, and access to non public areas within the hospital and CCTV coverage.

2.3 The SAE Report and Action Plan

Following the conclusion of their investigations, the two Review teams made a series of recommendations which formed the Improvement Action plan in the final SAE Investigation Report (see attached)

3. IMPROVEMENT ACTIONS TAKEN BY NHS LOTHIAN

3.1 CLINICAL MANAGEMENT ACTIONS

3.1.1 Development of national guidance on the management of headache in Pregnancy and the development of national pathways for the management of women with complex obstetric care needs

NHS Lothian shared the outcome and lessons from this SAE with Scottish Government colleagues working on the implementation of '*The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland 2017',* as the findings of the review related to the work of two sub-groups of 'Best Start' - the Maternal Medicine Expert Group and the national Neurology Expert Working group. These groups have been progressing work to develop agreed, Scotland wide pathways and toolkits to improve outcomes for women and to guide professionals in the management of women who need additional specialist input during pregnancy (see update Statement from Scottish Government colleagues, May 2020),

3.1.2 Local Service Improvement work between Obstetrics and Neurology in Lothian to support improved local guidance

Leads for Neurology services and Obstetrics in Lothian have been meeting (and continue to meet) to look at the the management of epilepsy and headache specifically and to develop local referral criteria and assessment, investigation and escalation processes. This work links to and is being informed by the national work referred to above in 3.1.1.
The Headache pathway has been agreed by Lothian clincians and is in use. It is available on the intranet. It will be reviewed and updated if necessary when the national work is complete.
As highlighted in the SAE report as a contributing 'Organisational factor', Neurology services and Obstetric services in NHS Lothian have for a long time been located on different hospital sites, which has added to the challenges of referral between the specialties and obtaining emergency reviews.

The move of the Department of Neurosciences from the Western General Hospital to the RIE campus, which took place in May- July 2020 has made a significant impact on joint working, ease of referral and ease of access to expert neurological assessment. This means individual patienst can be reviewed more timeously and that joint working around neurological conditions such as epilepsy during pregnancy are enhanced.

3.1.3 Improving Continuity of Obstetric Care

The SAE investigation highlighted the need to maximise continuity of Obstetric care for women with complex pregnancies, to avoid them being seen by multiple different consultants. This has now been addressed by putting in place continuity of obstetric consultant to lead daily ward rounds and provide ward cover for the week. This has been in place since January 2020. In addition to this a senior obstetric trainee doctor has been allocated to supporting care on the wards. Junior trainee doctors' shifts have been reorganised to provide continuity of shifts rather than single shifts only. This significantly improves communication and continuity of patient care as well as patient safety. The SAE review also noted that mothers being cared for on the post natal ward whose baby is in the Neonatal unit are encouraged to go and be with their babies whenever they wish, which is line with good practice. This can however lead to them missing the post natal Consultant ward round and not being seen themselves, as happened in this case. New procedures have been put in place to ensure women return from the Neonatal unit for the post natal ward round, or stay in the post natal ward until they have been seen by medical staff.

3.2 FACILITIES, SITE AND SECURITY ACTIONS

The main actions are summarised here

3.2.1 Controlling access to non public areas

Following on from the Facilities review, all stairwells in the RIE now have tensile barriers and 'talking signs' advising against unauthorised access.

The locks on all Plant rooms have now been changed to access controlled, to prevent doors being left unlocked.

Voice activated warning signs have also been installed in the stairwells in RIE.

These are checked by Equans on a regular basis and checks are also undertaken by the NHS Lothian Facilities team.

3.2.2 Signage

Revised ward signage is now in place on the hospital first floor, to prevent confusion about the sequencing of numbered wards. This followed a review, involving the expertise of an external signage supplier. This work was completed in 2020 with further amnedmnets in September 2021.

The signage within the Neonatal unit itself has also been improved, to make it clearer which way to go out of the Unit in order to get back to the post natal ward. The Fire Exit doors out of the Neonatal unit have also had enhanced signage put up, instructing people that they are fire exit doors only and must not be used for any other purpose.

3.2.3 Enhanced CCTV coverage

The investigation highlighted that the relatively small number of CCTV cameras on the RIE site made it difficult to identify where a patient might have gone within the building itself.

A full review of CCTV coverage and security has resulted in an agreed action plan to install around 60 more cameras across the hospital, with a focus on covering stairwells, corridors and Fire doors. This work was commissioned by service change order 200. .

There is a CCTV camera at the Entrance/Exit to the Neonatal Unit which captures all movement in and out.

The doors are controlled by a swipe card security system and video link buzzer to a staffed desk in the Neonatal Unit. To get into the Unit, staff use their ID swipe cards and the security system records each person's use of their card. Parents and Visitors to the Unit require to ring the video link buzzer to gain admittance.

Exit from the Unit is through the same Entrance/Exit door - the doors are opened by a push button by the door which allows people to leave. There is no specific 'log' of people leaving the Unit by this route, but the video camera at the door captures all movement in and out.

Fire Exit doors
In this particular case, the issue was that Patient AC left the Neonatal Unit by going through a Fire Door by mistake (which was marked as a Fire Exit only). The Fire Door signage has now been made even clearer, to prevent anyone making a similar mistake. Signage within the Unit itself directs people more clearly to the proper Exit/ Entrance and back to the Maternity Ward area.

The Fire Doors are alarmed to the RIE Site Security service (provided by EQUANs) and if the doors are opened, the video camera at the door records who has activated them. The Engie Security Control Room is manned 24/7 and monitors this and all other site CCTV.

3.3.4 Review of Missing persons /search protocols

The RIE Site Management team, Facilities and Consort/ Engie carried out a review of the RIE Missing Persons protocols, in conjunction with the Site Security protocol and Facilities protocols and these were updated in 2019. A further update was made in June 2021 and the link to the policy is here: https://policyonline.nhslothian.scot/Policies/Document/Acute_Partnership_Agreement.pdf