



## Re: Your request made under the Freedom of Information Act 2000

Could I have the following maternity department data for each year from 2014 - present, broken down by year and by individual hospital please.

1) The number of adverse events in each maternity unit.

	Doncaster Royal Infirmary	Bassetlaw Hospital	Montagu Hospital	Retford Hospital	External to DBH	Off Site (Community Clinic)	Patient's Own Home	Total
2014	603	280	2	10	3	1	5	904
2015	1065	470	4	6	36	17		1598
2016	870	398	2	6	13	5		1294
2017	782	305		2	23	15		1127
2018	752	322		1	14	16		1105
2019	733	284	3	4	5	11		1040
2020	1010	168			11	10		1199
2021	118	63			1	4		186
Total	5933	2290	11	29	106	79	5	8453

a) How many adverse events resulted in harm/injury, whether that was minor, moderate or severe. (Babies and mothers separately). Specify nature of harm if possible.

# **Babies**

#### **Doncaster Royal Infirmary**

	Low	Moderate	Severe
2014			
2015			
2016	16	2	
2017	9	1	2
2018	26	1	5
2019	11	1	3
2020	11	2	
2021			
<b>Grand Total</b>	73	7	10

#### Nature of harm as below

Access, admission, transfer, discharge other	2
Apgars <6 at 5 mins	1
Baby born with an unexpected weight below the 10th Centile	10
Birth trauma to baby - Fracture	1
Birth trauma to baby - marked bruising	7
Birth trauma to baby - scalpel injury	6
Collision with an object	1
Communication failure outside of immediate team	1
Cord pH <7.15	4
Delay / difficulty in obtaining clinical assistance	1
Delay getting treatment / being seen	1
Delay/failure in acting on complication of treatment	1
Diagnosis wrong/incorrect	1
Diagnosis images / specimens inadequate / incomplete	1
Failed instrumental delivery	2
Failure / insufficient / incomplete monitoring	1
Failure to act on adverse test results or images	2



Failure/delay to order correct tests, images etc  Fall from a low bed  Implementation & on-going monitoring/review - other  Injury from dirty sharps  Intrauterine death  2 Missed / Delayed Newborn Screening  Missed diagnosis Ruptured uterus  1 Shoulder dystocia  1 Simple complication of treatment  1 Surgical Wound  1 Treatment plan not followed  1 Treatment/procedure failed  1 Treatment/procedure inappropriate/wrong  1 Tripped on hazard / object (wire, cable, stool)  Unexpected admission to Neo-Natal Unit  Unexpected re-admission or re-attendance  1 Unintended injury in the course of operation or clinical task  1 Unplanned admission / transfer to specialist care unit  7	Failure/delay in receipt/transport of specimens, images etc	1
Implementation & on-going monitoring/review - other  Injury from dirty sharps  Intrauterine death  Intrauterine death  Inspect of Delayed Newborn Screening  Missed diagnosis Ruptured uterus  Inspect of Shoulder dystocia  Inspect omplication of treatment  Insurgical Wound  Intreatment plan not followed  Intreatment/procedure failed  Intreatment/procedure inappropriate/wrong  Intripped on hazard / object (wire, cable, stool)  Interpected admission to Neo-Natal Unit  Unexpected re-admission or re-attendance  Interpect of the review - other other of the stool of	Failure/delay to order correct tests, images etc	1
Injury from dirty sharps  Intrauterine death  Missed / Delayed Newborn Screening  Missed diagnosis Ruptured uterus  Shoulder dystocia  Simple complication of treatment  Surgical Wound  Treatment plan not followed  Treatment/procedure failed  Treatment/procedure inappropriate/wrong  Tripped on hazard / object (wire, cable, stool)  Unexpected admission to Neo-Natal Unit  Unexpected re-admission or re-attendance  1 Unintended injury in the course of operation or clinical task  1	Fall from a low bed	1
Intrauterine death 2 Missed / Delayed Newborn Screening 3 Missed diagnosis Ruptured uterus 1 Shoulder dystocia 1 Simple complication of treatment 1 Surgical Wound 1 Treatment plan not followed 2 Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Implementation & on-going monitoring/review - other	1
Missed / Delayed Newborn Screening 3  Missed diagnosis Ruptured uterus 1  Shoulder dystocia 1  Simple complication of treatment 1  Surgical Wound 1  Treatment plan not followed 2  Treatment/procedure failed 1  Treatment/procedure inappropriate/wrong 1  Tripped on hazard / object (wire, cable, stool) 1  Unexpected admission to Neo-Natal Unit 18  Unexpected re-admission or re-attendance 1  Unintended injury in the course of operation or clinical task 1	Injury from dirty sharps	1
Missed diagnosis Ruptured uterus 1 Shoulder dystocia 1 Simple complication of treatment 1 Surgical Wound 1 Treatment plan not followed 2 Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Intrauterine death	2
Shoulder dystocia 1 Simple complication of treatment 1 Surgical Wound 1 Treatment plan not followed 2 Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Missed / Delayed Newborn Screening	3
Simple complication of treatment 1 Surgical Wound 1 Treatment plan not followed 2 Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Missed diagnosis Ruptured uterus	1
Surgical Wound 1 Treatment plan not followed 2 Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Shoulder dystocia	1
Treatment plan not followed 2  Treatment/procedure failed 1  Treatment/procedure inappropriate/wrong 1  Tripped on hazard / object (wire, cable, stool) 1  Unexpected admission to Neo-Natal Unit 18  Unexpected re-admission or re-attendance 1  Unintended injury in the course of operation or clinical task 1	Simple complication of treatment	1
Treatment/procedure failed 1 Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Surgical Wound	1
Treatment/procedure inappropriate/wrong 1 Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Treatment plan not followed	2
Tripped on hazard / object (wire, cable, stool) 1 Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Treatment/procedure failed	1
Unexpected admission to Neo-Natal Unit 18 Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Treatment/procedure inappropriate/wrong	1
Unexpected re-admission or re-attendance 1 Unintended injury in the course of operation or clinical task 1	Tripped on hazard / object (wire, cable, stool)	1
Unintended injury in the course of operation or clinical task 1	Unexpected admission to Neo-Natal Unit	18
·	Unexpected re-admission or re-attendance	1
Unplanned admission / transfer to specialist care unit 7	Unintended injury in the course of operation or clinical task	1
	Unplanned admission / transfer to specialist care unit	7

## Bassetlaw Hospital

	Low	Moderate	Severe
2014			
2015	2		
2016	2	2	1
2017	6	2	1
2018	12		1
2019	8	2	
2020			
2021			
<b>Grand Total</b>	30	6	3

#### Nature of harm as below

Apgars <6 at 5 mins	2
Baby born with an unexpected weight below the 10th Centile	1
Birth trauma to baby - Fracture	4
Birth trauma to baby - marked bruising	5
Birth trauma to baby - scalpel injury	2
Cord pH <7.15	1
Delay or failure to follow up / missed appointment	1
Delay/failure in acting on complication of treatment	1
Failure / insufficient / incomplete monitoring	1
Fall from a low bed	1
Labour or delivery - other Missed / Delayed Newborn Screening	1
Test results / reports failure/delay to receive	1
Third or fourth degree tears	1
Treatment/procedure inappropriate/wrong	2
Unexpected admission to Neo-Natal Unit	10
Unintended injury in the course of operation or clinical task	1
Unplanned admission / transfer to specialist care unit	2
Verbal abuse or disruption	1

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

# **Mothers**

## **Doncaster Royal Infirmary**

	,	,	
	Low	Moderate	Severe
2014	76	9	5
2015	110	6	2
2016	67	15	4
2017	49	5	2
2018	92	2	3
2019	82	8	4
2020	119	7	1
2021	13	2	1
<b>Grand Total</b>	608	54	22

Nature of harm list is extensive.

# **Bassetlaw Hospital**

	Low	Moderate	Severe
2014	42	3	
2015	51	1	5
2016	48	10	1
2017	32	1	
2018	51	4	1
2019	32	5	
2020	13	4	
2021	9	4	1
<b>Grand Total</b>	278	32	8

Nature of harm list is extensive.

b) How many adverse events resulted in death. (babies and mothers separately)

# **Babies**

# **Doncaster Royal Infirmary**

	Death
2014	
2015	1
2016	1
2017	
2018	1
2019	
2020	2
2021	
<b>Grand Total</b>	5



**NHS Foundation Trust** 

Our Ref: 385/2021 January 2021

Bassetlaw Hospital

Dassetiavv	riospitai
	Death
2014	
2015	
2016	
2017	
2018	2
2019	1
2020	
2021	
<b>Grand Total</b>	3

## Mothers

## **Doncaster Royal Infirmary**

	Death
2014	
2015	
2016	
2017	
2018	
2019	1
2020	
2021	
<b>Grand Total</b>	1

# **Bassetlaw Hospital**

	Death
2014	
2015	
2016	
2017	
2018	1
2019	
2020	
2021	
<b>Grand Total</b>	1

c) How many adverse events that resulted in harm or death were deemed to have been avoidable, potentially avoidable, or it was found that different management of care could have changed the outcome.

Maternal deaths: 1 potentially avoidable, 1 unavoidable

2) The total number of serious incidents on each unit.

	Doncaster Royal Infirmary	Bassetlaw Hospital	External to DBH	Off Site (Community Clinic)	Total
2014	2		1		3
2015	4	5		1	10
2016	5	1			6
2017	2	1			3
2018	5	4		1	10
2019	5				5
2020	3	2			5
2021	0	2			2
Total	26	15	1	2	44



3) The total number of stillbirths on each maternity unit.

	Doncaster Royal Infirmary	Bassetlaw Hospital	Outside of maternity	Total
2014				
2015	13	6	1	20
2016	18	3		21
2017	12	3		15
2018	10	3		13
2019	9	3		12
2020	12	1		13
2021	1			1
Total	29	8		38

a) The total number of stillbirths on each maternity unit that were investigated as a serious incident and/or by the HSIB.

	Doncaster Royal Infirmary	Bassetlaw Hospital	Outside of maternity	Total
2014	1		ĺ	1
2015	2	3	1	6
2016	2	1		3
2017				0
2018	1	1		2
2019	1			1
2020	2			2
2021	1			1
Total	10	5	1	16

b) The total number of stillbirths on each maternity unit that were deemed to be avoidable, potentially avoidable, or it was found that different management of care could have changed the outcome.

	Doncaster Royal Infirmary	Bassetlaw Hospital	Outside of maternity	Total
2014	1			1
2015	2	3		5
2016	2			2
2017				0
2018		1		1
2019	1			1
2020	2			2
2021	1 (HSIB)			1
Total	9	4	0	13

4) The total number of neonatal deaths on each maternity unit.

	Doncaster Royal Infirmary	Bassetlaw Hospital	External to DBH	Total
2014			1	1
2015		1	1	2
2016	1			1
2017	1			1
2018	2	1		3
2019	3	2		5
2020	3			3
Total	10	4	2	16



a) The total number of neonatal deaths on each maternity unit that were investigated as a serious incident and/or by the HSIB.

2014 - Serious Incident

2018 - Serious Incident

2019 - HSIB

2020 - Serious Incident / HSIB

b) The total number of neonatal deaths for each maternity unit that were avoidable, potentially avoidable, or it was found that different management of care could have changed the outcome.

2014- Avoidable

2018 - Avoidable

2019 - Unavoidable

2020- HSIB currently being investigated no care deficits highlighted on initial review

5) The number of babies and mothers who were injured or came to harm in the units (minor, moderate and severe). Specify nature of harm if possible.

Maternal injury includes 3<sup>rd</sup> and 4<sup>th</sup> degree tears, injury from falls, and injury from unknown cause. This data has been pulled of datix web and will include injury+harm+mother+baby

	Doncaster Royal Infirmary	Bassetlaw Hospital	Retford Hospital	External to DBH	Off Site (Community Clinic)	Total
2014	70	37	3			110
2015	85	42		3	2	132
2016	81	45				126
2017	50	27	1	1		79
2018	97	61		1	1	160
2019	83	38		2	1	124
2020	103	11			1	115
2021	15	12				27
Total	584	273	4	7	5	873

a) In relation to 5a - how many were investigated as serious incidents and/or by the HSIB. (we have not included IUFD or NND info to this data as recorded above)

	HSIB	Serious Incident
2014		
2015		3
2016		3
2017		3
2018		6
2019	2	4
2020	2	1
2021		
Total	4	20

2019 - Both HSIB cases were none SI

2020 - 1 HSIB is included in the SI data

b) In relation to 5a - how many cases were deemed to have been avoidable, potentially avoidable or it was found that different management of care could have changed the outcome.

14 of the above were avoidable 6 were investigated and deemed unavoidable



6) The number of 'never events' on each unit.

#### 3 never events - 2 on DRI site (both retained tampon/swabs) 1 at BDGH (retained tampon)

7) The number of emergency transfers of mothers or babies from each unit to other hospitals and where they were transferred to.

This data will include a transfer out of our trust, the data of transferring between our units is not captured

	Transferred to another hospital
2014	
2015	
2016	11
2017	77
2018	73
2019	62
2020	39
2021	
Total	262

8) The total number of babies born on each unit.

	Doncaster Royal Infirmary	Bassetlaw General Hospital	Total
2014			
2015	3510	1609	5122
2016	3479	1608	5094
2017	3335	1550	4886
2018	3289	1490	4781
2019	3306	1419	4728
2020	3823	537	4365
2021			

The above data has been pulled from K2 electronic notes and the datix web system. Serious incidents and brain injuries have been deep dived all other data has not.