The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

20 JAN 2015

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Your ref: JL/tmp

Date: 14th January 2015

Ms. J Lake LL.M
Senior Coroner for Norfolk
69 – 75 Thorpe Road
Norwich
Norfolk
NR1 1UA

Dear Ms. Lake,

Re: Regulation 28 report following the Inquest into the death of Jackson Terry Sellers Mitchell

Thank you for your letter of the 8th January 2015, which was received yesterday, requesting an immediate response to your Regulation 28 Report following the Inquest into the death of Jackson Terry Sellers Mitchell. I understand that you sent this report to the former Chief Executive on the 27th October 2014 but unfortunately we have been unable to find any record of its receipt in the organisation, hence our unfortunate lack of response. I apologise that this failure to respond has occurred and I would like to offer you my assurance that this matter was acted upon at the time by the clinical team involved and continues to be monitored by the Trust.

I have as a matter of urgency contacted all the relevant clinical staff and have requested an immediate update on the actions that were undertaken following the death of baby Jackson and have asked them to appraise me in detail of what has been done to ensure learning for the neonatal team within this Trust and across the wider NHS.

An internal review took place within the Trust using a root cause analysis approach and I understand that this was presented at the Inquest. The report concluded with an action plan that focused on training and learning for staff at a local level and at a broader Network level.

This action plan has since been followed up and expanded upon. Locally the learning from the internal investigation and the outcome from the Inquest were discussed and shared at the paediatric governance meetings. A new X-ray review checklist was introduced which requires that all X-rays undertaken have to be reviewed and signed by a senior clinician. This includes those X-rays which are taken to check on the position of lines and tubes. This will ensure that it will always be a senior clinician that approves the position of lines.

The learning from this incident was incorporated into the Regional Skills Day that took place on the 8th October 2014 and will be addressed again this year at the next Skills Day, which is due to take place on the 13th October 2015.

In advance of any work that is being done nationally, the regional guidelines for umbilical venous catheterisation are currently being revised by [redacted] at the Norfolk and Norwich University Hospital and a draft set of guidelines has been circulated to all the paediatric teams in the region for consultation and comment. Once those comments have all been reviewed and any amendments made, these guidelines will be subject to ratification and will be implemented throughout the region. In the interim, practice here at King's Lynn is already in accordance with these new recommendations.

Nationally, [redacted] the Patient Safety Lead for Maternity and the Newborn at NHS England, convened a meeting in October last year in conjunction with the British Association of Perinatal Medicine (BAPM) to discuss the formation of a small group to review current practice and formulate new national guidance. The group is intending to review the literature on the matter and utilise the clinical experience of clinicians who have experienced difficulties with using venous lines, to produce a Framework for practice for all central venous lines. The clinical aspect of this work will be led by BAPM but NHS England will support by providing any relevant safety facts and by assisting with the dissemination of the Framework once completed. I understand that the working group will also incorporate a person with a link to the National Institute for Health and Care Excellence so that the Institute is fully aware of the recommendations of the working group. The working group will submit their report and recommendations to the membership of BAPM for comment before the final Framework is published and circulated. This is unlikely to occur before autumn 2015.

I hope that I am able to assure you that this matter is under significant review locally, regionally and nationally and will ultimately result in a new Framework for practice that will support healthcare professionals in managing this difficult area of care and treatment. It is hoped that this will ensure that the entire NHS learns from this tragic event and will improve the care and management of such vulnerable babies in the future.

May I apologise once again for our failure to provide you with a more timely response.

Yours sincerely,

[redacted]

Dorothy Hosein
Chief Executive