Health Education East of England
[redacted]
2-4 Victoria House
Capital Park Fulbourn
Cambridge
CB21 5XB

23 SEP 2015

STRICTLY PRIVATE AND CONFIDENTIAL

Mr Tom Osborne,
HM Senior Coroner for Bedfordshire and Luton
Coroner's Office
The Court House
Woburn Street
Ampthill, Bedfordshire
MK45 2HX

Date: 22 September 2015

Dear Mr Osborne

Re: **Baby Casey Paul Garrett (Deceased)**
Response to Regulation 28: Report to Prevent Future Deaths to Health Education England

Please find below the response of Health Education England following the inquest into the death of Baby Casey Paul Garrett and the Regulation 28 Report which you issued on 3rd August 2015.

Your concerns were set out in the Regulation 28 Report as follows:

"My concern was regarding the clinical learning environment, in that a Student Midwife was working with a Midwife and witnessed / carried out entirely inappropriate midwifery care which led to this infant's death, including insufficient foetal monitoring, misinterpretation of a CTG trace and the failure to escalate the level of care when there was a "deviation from the norm".

The MATTERS OF CONCERN are as follows:-

1. The incident raises questions about the suitability of Bedford Hospital NHS Trust being used as a clinical learning environment for Student Midwives – this needs an urgent review in the interests of safety of mothers and babies to avoid similar deaths in the future.

Response of Health Education England

Health Education England (HEE) exists for one specific purpose; to support the delivery of excellent healthcare and health improvements to the patient and English public by ensuring that our workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.

Health Education England is organised into 13 Local Education and Training boards. The University of Bedfordshire and the Bedford Hospital NHS Trust at which the student was on placement fall within the geography of Health Education East of England (HEEoE) therefore all actions and monitoring are overseen by HEEoE.

Following the incident, a full internal investigation was completed by Bedford Hospital NHS Trust and the University of Bedfordshire into the suitability of the learning environment. It was established that the events that had led to the tragic death of Baby Casey Paul Garrett did not reflect any wider issues with the supervision and education of midwifery students at Bedford Hospital. Analysis of current supervision and capacity indicates in excess of a 2:1 ratio of mentors to students, all of whom have undertaken a recent mentorship programme.

The investigation also confirmed that the placement was audited in July 2015 and at that time fully complied with NMC standards. In addition to the requirement that each student has a named mentor, HEEoE also require all students to have regular visits by academic staff throughout their placement and are allocated a personal tutor from the university for the duration of their programme.

However, additional work is now underway to ensure that the maternity unit continues to further enhance its clinical learning environment. For example the Deputy Director of Nursing, is holding Open Access Events for student midwives and has arranged Listening

Events to capture ongoing opportunities for further development of the learning environment

Triangulation

HEE is responsible for education and training across many healthcare professions and disciplines. Of particular relevance is training of doctors specialising in Obstetrics and Gynaecology which also takes place at Bedford Hospital. Through our quality management processes we have consistently found Bedford Hospital to provide excellent training and supervision of trainee doctors in the maternity department and of Obstetrics and Gynaecology registrars in particular.

In considering Clinical Learning Environments HEE also triangulates our evidence and impressions with others assuring quality including the Care Quality Commission, Clinical Commissioning Groups and through information shared at the Quality Surveillance Group. This triangulation supports the use of this department at Bedford Hospital as a Clinical Learning Environment.

HEEoE, since being notified of the incident has been working closely with Bedford Hospital NHS Trust and the University of Bedfordshire to provide input to the development of an appropriate action plan (see attached).

A summary of the actions to be taken forward is outlined below.

Summary of actions

Raising Concerns

An initial review of the learning environment has identified that whilst students are allocated a trained mentor and a personal tutor and visited by a link lecturer during their time on placement, further work should be undertaken to enhance each student's confidence and staff's response to raising concerns. Action will therefore be undertaken by Bedford Hospital NHS Trust to develop local leadership and to facilitate a positive reaction to students raising concerns. At the same time the University of Bedfordshire will develop their teaching and further emphasise the professional responsibility of students in this area.

Placement suitability

The placement was audited in July 2015. The University will quality check all active placement audits to ensure consistency of approach and progress on action plans.

On-going placement evaluation and monitoring

Each placement is formally reviewed every 12 months, in accordance with the NMC standards.

Every student completes a post placement evaluation. University of Bedfordshire and HEEoE will monitor these carefully and implement any necessary remedial actions. This will be achieved through increased link-lecturer involvement within the placement area, sharing of student feedback and joint action with Bedford Hospital NHS Trust.

Student supervision

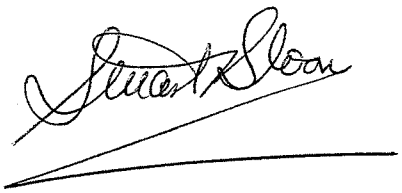
Whilst the feedback on the midwifery learning environment from students is very positive overall, it is recognised there remain further opportunities for improvement in the supervision of students. Bedfordshire Hospital NHS Trust is therefore implementing a number of steps to support workforce development and to enhance the learning culture within the midwifery team. The Director of Nursing will establish a student forum with free access to the senior nursing team. The University of Bedfordshire will revisit its mentorship programme and mentor education to further enhance the support given to midwifery students. Please see attached action plan developed by the University of Bedfordshire and Bedford Hospital NHS Trust in response to the investigation.

Bedford Hospital NHS Trust is working with the Bedfordshire Clinical Commissioning Group and the University of Bedfordshire to review all serious incidents, as well as their gap analysis from the recent Morecombe Bay Investigation (DH 2015).

Health Education East of England will continue to work with both the University of Bedfordshire and Bedford Hospital NHS Trust to ensure the above actions and the attached action plan are delivered. Through the Quality Improvement and Performance Framework, we will continue to dedicate resources and support to ensure the learning from this incident is shared and adopted across all of the commissioned programmes and learning environments within our provider Trusts.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours Sincerely,



[redacted]

Chairman

[redacted]