NHS
Surrey and Sussex Healthcare
NHS Trust

Please reply to:
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8th July 2020

By email to:
Dr Karen Henderson
HM Assistant Coroner for Surrey
Dr Karen Henderson HM Assistant Coroner for Surrey
Station Approach
Woking
GU22 7AP

Dear Dr Henderson,

Response to Regulation 28 Report – The Inquest Touching the Death of Theo Benjamin Young on 29.05.2018 from Surrey & Sussex Healthcare NHS Trust

The Trust has received the Regulation 28 Report following the Inquest Touching the Death of Theo Benjamin Young. In this report you rightfully detailed eight failures in the care we provided to Theo and his mother during her labour for which we are truly sorry. We respectfully note that in the report you reported no matters of concern pertaining to the Trust and we also note that in the Inquest you concluded that you had heard considerable evidence on actions already taken by the Trust regarding preventing future deaths. You were satisfied that the Trust took this extremely seriously and commended the Trust for having independently taken steps to change practice following Theo's death.

In order to assure all stakeholders, the Trust sets out here the specific actions that have been taken to minimise the risk of similar failings happening in the future:

In recognition of the effect staffing ratios and skill mix have on safety, we have increased midwifery staffing numbers by 10 full time equivalents and undertake a six monthly Board level review of midwifery staffing. We have instituted a daily review of staff allocation throughout the maternity department by the delivery suite co-ordinator and manager on call to ensure safe allocation and redeployment of staff.

In recognition of the failings regarding CTG monitoring and interpretation we have completed the following:

All staff involved in the care of women in the maternity department complete a CTG online training package and an annual competency assessment. All new starters will complete this before caring for women in labour and all staff will repeat this training and competency assessment on an annual basis. We have reviewed the 'fresh eyes' approach to review fetal and maternal observations during labour so that independent review of CTG traces is a routine part of care. All staff are clear that if a satisfactory CTG trace cannot be obtained then fetal scalp electrodes are to be used and if this proves not possible then immediate escalation to the senior obstetric team is expected. The Trust has also recruited a Senior Lead Midwife whose role is to ensure daily monitoring and oversight of care on the labour ward.

Since these actions were put in place, our Maternity Department was inspected by the Care Quality Commission and in January 2019 was rated 'Outstanding'. The department has also been awarded compliance with the Maternity CNST incentive scheme last year which includes the provision of assurance in regard to the Saving Babies Lives Care Bundle

In the Regulation 28 Report you raised specific concerns regarding the role of HSIB in their conduct, investigation and conclusion. We agree that the requirement of HSIB not to undertake our own investigation could have prevented the timely undertaking of remedial action. In fact, as we have described, the Trust did formulate and complete an action plan long before the HSIB report was finalised. If we had not done this and instead waited for more than a year for the final report then potentially more babies could have been at risk. Our concern would be the potential response of other organisations to a request like this from HSIB. In addition, the request from HSIB for the Trust not to collect statements from the staff involved in the incident seems wrong in our view. It is self-evident that compiling contemporaneous records of what happened will be more accurate than relying on individual memories of the incident some months later.

The Trust acknowledges that the timeline of HSIB investigations has improved since their investigation into the death of Theo Benjamin Young.

Safety of our patients remains the Trust's paramount focus and being open, honest and transparent are crucial factors in being an organisation that learns from incidents. We have shared this response with NHS England and the Care Quality Commission.

Yours sincerely

[redacted]

Michael Wilson CBE
Chief Executive