Department of Health & Social Care

From Helen Whately MP
Minister of State for Social Care
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[redacted]

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Dr Karen Henderson
HM Assistant Coroner for Surrey
HM Coroner's Court Surrey
Station Approach
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19 January 2023

Dear Dr Henderson,

Thank you for your letter of 15th May 2022 about the death of Connor Samuel Timothy Wellsted. I am replying as the Minister responsible for Social Care, and I thank you for additional time allowed.

Firstly, I would like to say how saddened I was to read of the circumstances of Connor's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, Departmental officials have made enquiries with NHS England as well as the relevant regulator in this instance, the Care Quality Commission. I am further advised that the Children's Trust have also provided a detailed response to your report.

I am sorry that Connor was not provided the care that he needed to him safe. The Children's Trust's have now updated their Medical Devices and Equipment Policy and staff are now trained in the appropriate use of clinical assets, including padded cots. It is also now mandatory for nursing and care staff at the Trust to carry out checks on equipment twice within a 24-hour period. They have also updated their Sleep Monitoring Policy and a mandatory risk assessment, co-signed by the parent, is completed when a child or young person is admitted to the Trust. The policy mandates visual monitoring of the patient and that a 24-hour sleep monitoring chart must be completed, indicating when a visual inspection was performed.

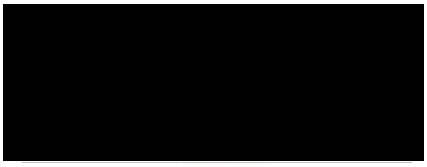
I understand the Trust have developed their policies and protocols for responding to medical emergencies and sudden unexpected deaths, including updating the sudden death policy to include the need to preserve the scene and quarantine equipment. They have also undertaken to ensure any future investigations into unexpected deaths are conducted with honesty, openness and full transparency, in a timely manner and in accordance with statutory guidance and best practice. The Senior Leadership Team and Board of Trustees understand their statutory duties and the role they are expected to play in the investigation of any future sudden unexpected deaths, exhibiting openness, transparency and probity while promoting an open and clear learning culture at all levels for dealing with serious incidents.

In addition to this, NHS England have made sure that all relevant policy teams who are responsible for policy setting and transformation in areas such as Specialised Commissioning and the Children and Young people Programme were aware of your report and the concerns raised. They have also met with representatives from a variety of teams to ensure they are aware of the guidance: 'Bed rails: Management and Safe Use'.[1]

Further, the Children's Trust learnings are being reflected in the protocol they are developing in line with the Royal College of Pathologists guidance: 'Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation'[2] and current statutory guidance. The CQC have advised that such learnings were evident at their subsequent comprehensive inspections of the Trust. The CQC have also confirmed that all statutory notifications received by the CQC from the Children's Trust since 2018 have been followed up with appropriate and robust investigation reports, complete with details of actions taken and improvements made.

Finally, I am aware that the Trust's senior leadership team has established a learning action group that is dedicated to developing new processes and systems that will address your concerns and will build upon the improvements the Trust has made over the last five years.

Yours sincerely,



HELEN WHATELY

[1] https://www.gov.uk/guidance/bed-rails-management-and-safe-use
[2] https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf