The Children's Trust
For children with brain injury

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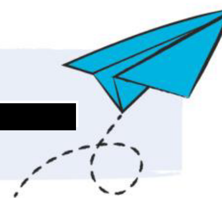

8th July 2022

Private and Confidential

Dr Karen Henderson
HM Assistant Coroner
Surrey Coroner's Court
Station Approach
Woking
GU22 7AP

Dear Dr Henderson,

We are writing to set out our formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013, dated 15 May 2022, which was issued following the inquest into the death of Connor Wellsted.

We would like to begin by, once again, extending our deepest condolences and sincere apologies to Connor's family. Our charity exists to help children like Connor live their best life possible and so it is the deepest regret of our senior leadership team and board of trustees that we failed to do so. We know this has been an extremely difficult time for Connor's family, including his foster carers, and that they have had to wait a long time for answers. Whilst no words can ever bring Connor back, we hope that this response illustrates how very seriously we take the family's loss and the rigour with which we have taken actions from the lessons learnt to ensure that something like this can never happen again.

We have put in place extensive measures and improvements over the last five years, and we are confident that these measures are robust and effective. Concerns raised in the regulation 28 report, with regards to the prevention of future deaths, relate to issues we have addressed during the significant passage of time since Connor's death, as heard in evidence at the inquest. The coroner has not raised any concerns about the adequacy of the measures we have put in place. Nevertheless, in the first section of this response we set out the actions we have already taken and summarise the evidence heard at the inquest about the changes implemented from the lessons learnt.

Aside from the concerns directly linked to preventing future deaths, the coroner has included other concerns in her report which deal with our immediate response to Connor's death, the subsequent internal investigation and questions of transparency and probity. We take these other concerns extremely seriously and the second section of this report sets out our response to these concerns as well as the actions we are taking.

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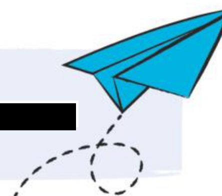

1.0 Action to Prevent Future Deaths

This section sets out in detail the actions we had already taken, prior to the inquest, to prevent future deaths and which were outlined in the evidence before the coroner at the inquest. Whilst we are never complacent and always look to improve our processes and controls, we believe the steps we have taken are robust. We have, for example, undertaken external benchmarking of our sleep monitoring practices to assure ourselves of this. It should also be noted that our services have been inspected and rated five times by the Care Quality Commission (CQC) and Ofsted Care since Connor's death with the following outcomes:

- CQC January 2018 and March 2020 – "Outstanding" on both occasions.
- Ofsted Care January 2020 and August 2021 – "Outstanding" and "Good" respectively. At the time of writing, we are awaiting the rating following Ofsted's most recent inspection of our care services in May 2022.

Concern
1.1 The cot "The cot Connor's [*sic*] was allocated was nine years old, used infrequently and had not had a yearly servicing for the previous five years. There was no guidance or clarity as to how the padded boards/cot bumper should have been placed around the wooden frame of the cot in circumstances whereby the foster parents did not wish the cot to be padded. It is likely the padded board (1m long, 40 cm wide with a soft side and a rigid side) was inappropriately and inaccurately placed on the wooden frame of the cot and as its top edge was without Velcro it could not have been attached to the cot leaving it loose with the result that it dislodged entrapping Connor across his neck."
Response
Type of cot During the course of the inquest into Connor's death, the coroner heard evidence from the former director of clinical services (chief nurse), and the current medical director of The Children's Trust, in respect of the measures we have implemented to ensure the safety of sleeping equipment. We stopped using the specific type of cot allocated to Connor in October 2017. All our bed supports and sleeping systems are assessed and recommended by qualified practitioners. During December 2020 - February 2022 we undertook an audit of all of our existing beds against the children's bed standard, BS EN 50637:2017, which came into force in August 2020 for beds sold after that date. Although the standard does not apply retrospectively to beds already in use, we took the opportunity following our audit to replace twenty junior beds, eight adult beds and three cots. We introduced two new bed models conforming to BS EN 50637:2017; the 'Linet Tom 2 Cot' and 'Accora

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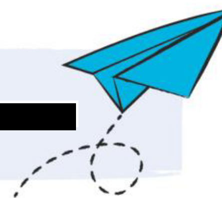

Floorbed'. The new beds have built in cot sides and padding, integral to the bed rather than separate bumpers.

Servicing and maintenance, governance and record keeping
We have contracts in place with two UK-based, bio-medical engineering repair and maintenance companies who carry out regular inspections of medical equipment and devices and undertake repairs and preventive maintenance. Our estates compliance team monitors a number of KPIs on a monthly basis to provide assurance that beds and other clinical assets have been serviced in line with the relevant servicing schedule. Compliance has averaged 99% over the last quarter.

We acknowledge that our record-keeping around the servicing of beds at the time of Connor's death was not robust. However, as detailed in the learning statement presented by our current medical director at the inquest and in this report, in the last five years we have made significant improvements.

We commissioned Croydon Healthcare Services to undertake an external review of all our clinical assets inventory and service and maintenance data in January 2019 and entered into a medical equipment maintenance service level agreement with Croydon Healthcare Services in February 2019. Around the same time, we established a new, clinical assets working party meeting, chaired by the director of clinical services, with responsibility for developing and monitoring effective governance arrangements, policies and procedures for the safe deployment of all medical devices. In May 2020 we appointed a dedicated clinical assets lead, responsible for maintaining the clinical assets register and coordinating and overseeing servicing and maintenance in line with statutory requirements and manufacturers' guidance.

In October 2020, we transferred our Excel-based clinical assets register and maintenance records to a new centralised system, "CATi". As part of this project, we completed a "desk-top bed audit" followed by a physical inspection and a validation of service history data. A bed condition report was completed and reviewed by the Clinical Governance & Safeguarding Committee.

Our Internal Audit team completed a "Clinical Assets Lifecycle Management" audit in September 2021 which found there to be good processes and controls in place around the tagging, recording, servicing and maintenance of beds and other medical equipment. The report made a few recommendations to further improve controls, including more centralised record keeping around training and a more robust process for staying up to date with changes in regulations and standards in relation to medical devices. The implementation of management actions from internal audits is monitored by our Audit & Risk Committee.

Policies, procedures, training and guidance for staff
As detailed in the evidence of our current medical director at the inquest, as part of the learning following Connor's death, we have updated our Medical Devices and Equipment Policy and keep this under review to ensure it is aligned with current regulations and best practice.

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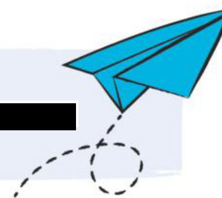

Specialist equipment such as adapted beds, sleep systems, moving and handling devices and seating must be risk assessed by a qualified registered professional before use.

Staff are trained in the appropriate use of clinical assets in a number of ways including through our existing clinical competencies assessments and moving and handling training programmes; as part of "therapy training days" and "in practice learning". Nursing and care staff are also required to familiarise themselves with individual care plans which contain guidance, including photographs, on the use of specific clinical assets assigned to each child or young person.

When new equipment is purchased or introduced, the clinical asset lead and clinical education team will check whether training is adequately covered by existing programmes. If it is felt that additional training is needed, the clinical asset lead will arrange for a representative of the manufacturer to provide training either directly to nursing and care staff and therapists or on a "train the trainer" basis.

It is mandatory for nursing and care staff to carry out and to document checks on beds, cots, bumpers and other equipment twice in every 24-hour period, once during the day shift and once during the night shift. Compliance is monitored through quarterly audits. For the quarter ending January 2022, compliance was assessed as 98.8% (and 98.1% for the previous quarter).

Should equipment be identified as faulty, staff are required to report it immediately to the facilities helpdesk using our "Top Desk" reporting system, accessible via our intranet. The equipment in question will immediately be taken out of service for repair or replacement. Larger items will be clearly tagged to state they are "out of use" and moved out of the child or young person's room, as applicable.

Concern

1.2 Monitoring of Connor during the night

"Connor had no regular or direct visual supervision during the night (other than to open the door of his room to check if there was a smell) despite the request of his foster parent to check in circumstances whereby in other parts of the Trust regular visual inspection was the norm."

Response

Overnight monitoring policy

As detailed in the evidence of our medical director at the inquest, following Connor's death, our sleep monitoring procedures were reviewed and revised immediately, to ensure the safety and wellbeing of the children in our care during sleep.

In accordance with our current Sleep Monitoring Policy, a mandatory risk assessment is completed when each child or young person is first admitted to our service and is reviewed and updated regularly to reflect changing needs. The risk assessment is completed by a qualified nurse and identifies the nature, frequency and extent of monitoring required when a child is sleeping, in consultation with their

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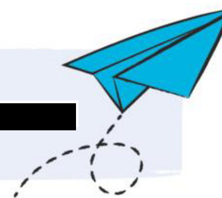

allocated doctor. In assessing the risk to each child, nurses and doctors will take into account clinical presentation, for example a child may be more susceptible to sudden death following an acquired brain injury if they have co-morbidities. Where a child or young person is assessed as being at greater risk, for example, if they experience seizures and apnoea or have respiratory conditions requiring the administration of oxygen, monitoring would be more frequent and would include measures beyond visual surveillance such as monitoring heart rate and oxygen saturation levels.

Our clinical protocols and guidelines outline when to initiate continuous vital signs monitoring, should there be a deterioration in clinical presentation and set out other escalation practices such as administering oxygen, changing the settings on a ventilator, or calling for an ambulance. The care plan, which is informed by the risk assessment, is written in collaboration with the parents/ carers of the child, who must also sign it to show their agreement with its provisions.

Our current Sleep Monitoring Policy is due for review in July 2022, in line with our standard policy review cycle. Two changes we will be making to the policy will be to expand its scope and to rename it the 'Frequency of Monitoring Policy and Procedure.' These changes will ensure that we incorporate the required monitoring practice over a 24-hour period and not just whilst a child or young person is asleep overnight.

Visual Surveillance
As outlined in the Sleep Monitoring Policy, the minimum required level of visual surveillance includes entering the bedroom and physically observing and assessing a child to ensure they are sleeping soundly, are not tangled in any bedding, are comfortable and not in distress. If a parent or carer would prefer that a medically stable child should not be disturbed overnight then this is risk assessed and, as a minimum, an audio-visual monitor would be used to allow remote observation. The frequency of monitoring overnight is clearly documented in every child's care plan and must be signed by the parent/carer and a registered nurse.

Reviewing and agreeing the care plan with families/ carers
We have reviewed our process for developing and agreeing each child's care plan, including sleeping arrangements and overnight monitoring. Whilst we will always consider the wishes of families, we must always use our professional skill and judgement, informed by a child/ young person risk assessment, to determine what we believe to be in his/ her best interests. Our Sleep Monitoring Policy clearly states the minimum standards for surveillance. We have recently benchmarked our sleep monitoring practice at The Children's Trust against that of similar organisations and have found it to be more robust, both in terms of the frequency and nature of checks undertaken.

Record keeping
We acknowledge that at the time of Connor's death, we did not have robust record-keeping in place to evidence overnight monitoring checks. We have addressed this by introducing a 24-hour sleep monitoring chart that must be completed for each child every day. The chart documents the time

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periods during which a child is awake and asleep (day and night), when visual surveillance checks are performed and the exact positioning of a child or young person in their cot/bed. The chart is part of a large A3 Nursing and Care 24-hour evaluation document. It must be countersigned by the shift lead or a registered nurse. A laminated guide for completing the 24-hour evaluation chart which incorporates sleep monitoring and equipment safety checks is displayed at the nurses' station on each house.

Compliance monitoring

Compliance with the Sleep Monitoring Policy is assessed through quarterly audits by nursing and care staff of a selection of clinical records. The audits look for evidence of i) risk assessments having been ely, ii) control measures identified to manage the risks having been incorporated iii) those control measures having been adhered to and documented in the 24- t. The most recent audits in September 2021 and January 2022, respectively 8.1% compliance, respectively.

2.0 Other Concerns Raised by the Coroner

igation by the Children's Trust, Tadworth

"The police and the coroner's service attending the Trust shortly after being informed of Connor's death nformed of the circumstances of his death. The scene had not been preserved. They were not told of the position Connor was found, that he had been dead for some time (likely hours) or that the padded board was initially found across his neck and that it required force by either one or two nurses for it to be pushed down to be removed.

Connor's death was sudden and unexpected, and the senior management of the Trust (chief nurse and medical director) were concerned at the time the role the padded board may have played in Connor's death. However, they did not keep a copy of Connor's medical records, nor did they undertake their own initial internal enquiries, or info relevant statutory bodies of their concerns. Furthermore, they arguably misled the CQC as to the circumstances of Connor's death. Likewise, the pathologist who undertook the autopsy on Connor was not informed of the circumstances of his death thereby preventing a forensic post-mortem to have taken place to establish the role the cot bumper may have played in his death. In addition, the Trust engaged an expert opinion from a forensic pathologist without fully informing him of the position the cot bumper may have played in Connor's death. The Trust undertook several Serious Investigation reports, the first of which was six months after Connor's death. These reports did not acknowledge or address the role the cot bumper may have played in Connor's death despite evidence from multiple witnesses indicating it was likely to be significant."

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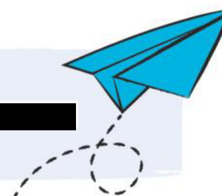

Response

Information provided to the police and coroner's service

We willingly complied with all external investigations that took place and also carried out our own detailed review. The evidence before the coroner at the inquest was that the police officer attending the scene following Connor's death had been informed of the position in which the cot bumper had been found. This was reflected in the contemporaneous notes taken by the officer in their police-issued pocket notebook. The officer in question gave evidence at the inquest that he had been informed of the positioning of the bumper.

has been the only unexpected death in our organisation's 38-year history. At the miliar with the correct procedure to follow and allowed the coroner's officer to l records with them without making a copy. It was our understanding that a copy of Connor's medical records which included notes on the exact position in which the cot bumper had d subsequent events was to be provided, by the Coroner's Office, to the pathologist who undertook the autopsy on Connor. These records as well as a copy of the transcribed recording of the adjourned inquest in April 2018 were also provided to the forensic pathologist that we instructed to ion and to assist the court. Copies of the letters of instruction sent to the forensic vided to the coroner. The medical records handed over to the coroner's officer 24-hour Continuous Evaluation" which states the following in the entries on the morning of Connor's death, at 08:40 and 09:05 respectively: *"Child was seen with head down to his chest and a cot bumper against the chest area."* and "…*together we opened the cot side and removed cot bumper which was under his neck*".

In terms of the assertion that we did not communicate the time of death to the police or Coroner's Office, the pathologist's post-mortem report states on page two of eight, under the heading "clinical history", "..*he appeared to have been dead for some time and therefore no CPR was attempted*". The witness statement submitted by the former medical director and provided to the coroner's service stated; "*Appearances were consistent with death having occurred at least one or two hours earlier*." and the police notes also state "*Dr stated that Connor had been deceased for well over an hour".*

However, we accept that we could have more explicitly highlighted the potential role of the cot bumper by preparing a report of initial findings to be made available to the pathologist, Coroner's Office and police. We should also have provided more detail about the circumstances of Connor's death, in particular the position he was found in relative to the cot bumper, to the consultant paediatrician at Sheffield Children's Hospital, who conducted the child death review.

Failure to preserve the scene

Our nursing and care staff are taught to urgently undertake a clinical assessment of any child or young person who they discover in an unresponsive or deteriorating medical state. We train staff in basic life support (BLS) in line with the Resuscitation Council UK's national guidelines, 2021; to assess a patient's

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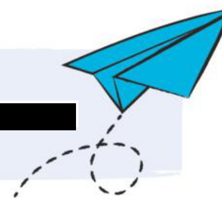

airway, check for breathing, and check circulation. Accordingly, when our staff first found Connor unresponsive in his cot, they moved him into a horizontal, supine position in order to assess his vital signs. The police then performed their own independent physical examination. All of Connor's equipment remained in the room with him, and the room (including the bed and bumpers) remained sealed until the findings of the post-mortem were released.

Our Basic Life Support (BLS) training follows the Resuscitation Council UK guidelines and is mandatory for all nursing and care staff. Shift leaders and senior nurses also attend an enhanced BLS+ training annually which is designed to increase knowledge, skills and confidence in managing medical [redacted]er emphasises and builds upon the Resuscitation Council UK guidelines taught in [redacted]anced simulations and training around escalation of care and management of [redacted]more relevant to our service. Additionally, the training covers how to call for help, [redacted]n, using call bells, dialling 999 and at what point each might be appropriate. Each [redacted]nds with a mandatory assessment of skills.

At the inquest, the coroner heard evidence that in order to ensure all staff members are aware of the [redacted]ke in the event of an unexpected death, we have incorporated additional content i[redacted]basic life support training that all staff must receive on induction as well as a r[redacted]date.

In addition to this, we have reviewed The Royal College of Pathologists guidelines on 'Sudden u[redacted]th in infancy and childhood: Multi-agency guidelines for care and investigation,' 2016, and guidance produced by the Surrey Child Death Review Partnership. We are further developing a clear protocol and training for our nursing and medical staff in the event of an unexpected child death. We accept that our training has historically focussed on basic life support and actively assessing and supporting children who we do not anticipate will die unexpectedly. Whilst our staff will continue to receive their basic life support training, we will have clear guidelines on processes and actions to be taken in the event of a sudden unexpected death. We are also planning to expand our existing simulation training beyond medical emergencies and basic life support, to cover unexpected deaths.

Record keeping

All of Connor's (original) medical records were sent on 17th May 2017 with the coroner's assistant to inform the post-mortem. We omitted to make copies of these notes and they were not returned until after the post-mortem was completed, six months later. It was not until this time that our internal investigation could commence. We acknowledge that it was a mistake not to make copies of the medical notes.

Our internal investigation

Regrettably, and as detailed in evidence at the inquest, we were unable to undertake an internal investigation until the medical records had been returned from the Coroner's Office. They were returned on 28th November 2017, over six months later. Our initial internal investigation did not examine the issue of the cot bumper as we had been informed by the Coroner's Office that the post-

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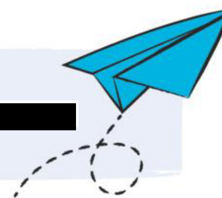

mortem investigation had concluded that the cause of Connor's death was undetermined but most likely to have been natural causes.

We accept that we should have thoroughly examined the potential role of the cot bumper in our initial investigation. With hindsight we were too quick to rule the bumper out based on the post-mortem findings. Our learnings here are reflected in the updates we have since made to our "Incident Reporting and Investigation, including Duty of Candour Policy".

Notification to statutory bodies

[redacted]or's death, The Care Quality Commission (CQC) was the only regulator of the [redacted] Connor was receiving at The Children's Trust. More recently, our entire site at [redacted]been designated a "children's home" bringing our rehabilitation service in scope [redacted]es Regulations as well, which are regulated by Ofsted.

Our former head of nursing and care formally notified the CQC of Connor's death via their online statutory notification system on the 17th May 2017, the day of Connor's death. The notification clearly [redacted]e was found in, the position of the cot bumper 'across his chest area' and the [redacted]essment performed. In this notification we did incorrectly advise that Connor had [redacted]5 minutes overnight. However, once the medical notes were returned from the [redacted]ovember 2017 and we could begin our investigation, we realised our error. We contacted the CQC on 29th November 2017 explaining the sleep monitoring arrangements that had in [redacted]e for Connor. The CQC has confirmed they have a record of this call and have provided us with the transcript.

We accept that, had we made a copy of Connor's clinical notes prior to them leaving our site with the coroner's officer, we would have had more factual information to provide within our CQC notification on the day of his death. This learning is reflected in our protocol we 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' and current statutory guidance.

Connor was commissioned for a placement at The Children's Trust but resided permanently in Sheffield. Following his death, notification was made to his local teams, and the former medical director at The Children's Trust provided information to the consultant paediatrician at Sheffield Children's Hospital, who conducted a child death review and produced a formal report, dated 25th May 2017. On 16th November 2017 a 'multi-agency case discussion following unexpected child death' was held in Sheffield, chaired by the designated doctor for child deaths.

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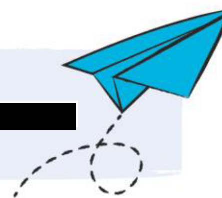

Concern
2.2 Senior Management, The Children's Trust, Tadworth "The current senior management team have not acknowledged there was a lack of transparency and openness as to how Connor died, or that the Trust did not properly investigate his death or inform the relevant statutory bodies of the circumstances of his death giving rise to concern of an ongoing lack of insight that institutional learning around serious incidents has not been accepted by the Trust. As a consequence, there is a need to introduce and develop robust clinical governance processes and [redacted]e public and supervisory statutory bodies that they will be informed of any future [redacted]ey will be investigated with openness, candour and transparency."
Response
[redacted]urse, saddened by the coroner's finding that we were said to have lacked transparency and openness around Connor's death. However, we are also an organisation that is committed to listening and responding to all feedback, even when it is difficult to hear. [redacted]er's finding that we did not properly investigate the circumstances of Connor's [redacted]uld have highlighted the potential role of the cot bumper more explicitly to the pathologist via the Coroner's Office. However, these oversights were as a result of a lack of experience in responding to and investigating an unexpected child death, rather than from any intention to mislead. The coroner heard evidence from the former director of clinical services, the former medical director and the current medical director. The evidence of our current medical director intended to provide the court with further information in respect of the changes implemented following our internal investigations and wider learning across The Children's Trust. Both our current medical director a[redacted]former director clinical services offered their unreserved apologies to the family in respect of Connor's tragic death and the conduct of our subsequent investigations. Our senior leadership team, with the full involvement of our board of trustees, has established a learning action group (overseen by our Clinical Governance & Safeguarding Committee) dedicated to developing new processes and systems that will address the coroner's concerns and will build upon the improvements we have been making over the last five years. We want to reassure Connor's family, and others, that we will do everything we can to ensure that something like this cannot happen again.

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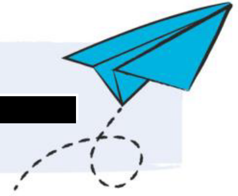

We hope that we have provided you with robust assurance that we have already taken steps to address the issues of concern in your report and that we are continuing to take action to strengthen the quality and safety of care we provide to children and young people.

Signed on behalf of the senior leadership team and board of trustees of The Children's Trust:

____

Chief Executive

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Chair of Trustees

The Children's Trust is accredited by CHKS with ISO 9001 certification (for organisational and clinical management systems), inspected and rated 'Outstanding' by Care Quality Commission and rated a 'Good Provider' by Ofsted Care (for residential houses).
Registered charity number: 288018. A company limited by guarantee; registered in England and Wales with registered number 1757875.

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