Department of Health & Social Care

From Nadine Dorries MP
Parliamentary Under Secretary of State for Patient Safety, Suicide Prevention and Mental Health

39 Victoria Street
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[redacted]

Our Reference: PFD-1204212

Mr Christopher Sutton-Mattocks
HM Assistant Coroner, North East Kent
HM Coroner's Office
2nd Floor
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25 March 2020

Dear Mr Sutton-Mattocks

I am writing in response to the Prevention of Future Deaths report dated 3 February 2020, sent to Matt Hancock about the death of Harry Richford. I have been asked to reply as Minister with responsibility for patient safety.

Let me start by saying how deeply sorry I am for the failings in care highlighted in your report. That Harry's death was avoidable is extremely distressing and I offer my most heartfelt sympathies to Mr and Mrs Richford and all those affected by his death. We must do all we can to learn from such tragic incidents to ensure the safety of health services and prevent future deaths.

The circumstances you set out in your report are clearly unacceptable and I want to outline the action taken by health regulators and system partners to scrutinise and support the safety of maternity services at the East Kent Hospitals University NHS Foundation Trust. As I told Parliament on 13 February 2020[1], we all want and need to know that maternity services at East Kent Hospitals are safe and of the highest standard.

Key partners within the health system have acted to identify the problems in the Trust's maternity services and put in place support to address them.

In February, the Care Quality Commission (CQC) conducted an unannounced inspection of the Trust's maternity services, after which it wrote to the Trust with an overview of its findings and sought assurance on matters relating to triage, day care and medical staffing. The full report of the CQC's inspection will be published in due course. However, I want to assure you that the CQC continues to be in close contact with the Trust and will take regulatory action if it decides that it is necessary. You have issued your report to the CQC and I expect the CQC to provide further detail on its actions.

[1] https://hansard.parliament.uk/

The Healthcare Safety Investigation Branch (HSIB) identified a number of safety concerns through its conduct of maternity investigations at East Kent Hospitals as part of its national maternity investigation programme. These include concerns similar to those described in your report, such as the availability of skilled staff (particularly out of hours) and access to neonatal resuscitation equipment but also failings in leadership and governance.

It is clear from the work of HSIB and the CQC that there are a range of issues to address. NHS England and NHS Improvement (NHSEI) have put in place an intensive programme of support at the Trust. This includes:

- Support from the regional medical director to address concerns in relation to senior medical oversight;
- Support from the regional chief nurse to assist the Trust to prioritise and focus the Trust's maternity improvement plan to address the safety risks identified;
- Reviewing the effectiveness of clinical governance and executive leadership;
- Ensuring the Trust is taking the learning from all historical cases and disseminating that learning throughout the Trust; and,
- Independent clinical support working within the Trust to deliver immediate improvements in care as well as supporting the Trust to put in place robust and comprehensive processes to ensure high standards of care in the long term.

I am advised that the Trust Board is taking these matters very seriously and has welcomed the national support being provided. I expect the Trust to set out in its response to your report the actions it is taking to address the important safety risks you have outlined.

I am aware that the Trust has taken a number of actions already such as the recruitment of several specialist midwives and new, regular safety huddles to anticipate and discuss emerging problems in care. CTGs (cardiotocographs used to measure fetal heart rate) are now double checked to ensure any sign of fetal distress receives the appropriate clinical response.

Of great importance when things go wrong in care is that the NHS engages sensitively and meaningfully with bereaved families and does all it can to identify what went wrong so that future deaths are prevented. NHS trusts are expected to follow national guidance on learning from deaths[2][3] and are mandated to report the number of avoidable deaths in their care and the learnings they have taken from them. It is deeply concerning to read in your report that the Trust recorded Harry's death as 'expected' and no notification was sent to the coroner. I am advised that the Trust has developed its approach to engaging with families when unexpected deaths occur and to involve families in the investigation of these

[2] https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/

[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

incidents. The Trust must continue to strengthen its processes to learn from deaths and develop an open, learning culture for the safety of its patients.

It is essential that close scrutiny continues and I am advised that the CQC, NHS England and NHS Improvement and other system partners will oversee progress and will take further intervention measures where necessary. I expect to be regularly updated.

Finally, it is critical that all the necessary learnings are identified for East Kent Hospitals but also that they are shared nationally to benefit maternity services across the country. NHS England and NHS Improvement have commissioned an independent review into maternity services at East Kent Hospitals, to be led by Dr Bill Kirkup, who led the inquiry into maternity services at Morecambe Bay. The review will look in great detail at the safety and quality of the Trust's maternity services. The terms of reference and scope of the investigation are to be determined and will be made public in due course.

Once more, I would like to express my deepest sympathies to the family of Harry Richford, and to the patients and families of all those affected by the events at East Kent Hospitals. I hope this reply is helpful.

Yours, Nadine

NADINE DORRIES