Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

[redacted]

www.cqc.org.uk

HM Coroner's Office
[redacted]
Records Office
Orchard Street
Chichester
West Sussex
PO19 1DD
[redacted]

9 March 2023 (resent on 13 March 2023)

Care Quality Commission

[redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Teegan Marie Barnard

Thank you for sending CQC a copy of the prevention of future death report issued following the death of Teegan Marie Barnard.

CQC has contacted the provider University Hospitals Sussex NHS Foundation Trust to request written confirmation and evidence of the action they have taken to date following this death and any additional action they intend to take in response to the prevention of future death report.

We note the legal requirement upon the following individuals and organisations to respond to your report within 56 days:

1 [redacted], Chief Executive U. Hospitals Sussex NHS Foundation Trust
2 [redacted], Medical Director, St Richards Hospital, Chichester
3 Chief Executive NHS England
4 Chief Executive Health Education England
5 Chief Executive CQC

We are responding as directed.

Having received your report, the CQC took steps to request information and seek assurance from the Trust regarding the concerns within the report. University Sussex

Hospital NHS Trust have provided the following documents which CQC have reviewed:

1. Maternity Improvement Plan - 23.1.23 incl Ockenden (DRAFT)
2. CNST MIS_SafetyAction_2023_V9_UHSussex 31012023
3. Local Requirements for HSIB Investigations Standard Operating Procedure
3 Safety Action 8 compliance with multi-professional training
4. Integrated UHS Learning from Deaths Annual Report
4 Summary Hospital - level Mortality Indicator (SHMI) report January 2022-December 2022.
5 Quality Mortality Earlier Intervention report
6 Letter from trust dated 16 February 2023 outlining action taken prevention of future death report.

We have also reviewed the following documents:

1.) Summing up and conclusion from HM Coroner
2.) Reg 28 Coroner evidence BARNARD - 6. Full Inquest Additional 1
3.) Reg 28 Evidence from Coroner BARNARD - 3. Full Inquest Exhibits Medical Records.
4.) Regulation 28 report.
5.) Reg 28 Evidence form Coroner BARNARD - 1. Full Inquest Statements

Over the last 18 months, CQC have discharged its regulatory function through enhanced monitoring, engagement and inspection of maternity services at each main hospital site.

For ease we will set out all the inspections undertaken in the last 13 months.

Royal Sussex County Hospital, Brighton

- 28 September - 04 October 2021
    - Maternity rated inadequate

Link to report: https://api.cqc.org.uk/public/v1/reports/65b10d86-462c-4f8d-b6de-907e7356cf15?20211223171918

- 26 and 27 April 2022 (follow up inspection to check compliance against warning notice issued following above inspection)
    - Maternity – inspected but not rated

Link to report : https://api.cqc.org.uk/public/v1/reports/c55b73a3-3d17-4e31-833e-59556e80cc95?20220729070335

Princess Royal Hospital, Haywards Heath

- 28 September – 04 October 2021
    - Maternity rated inadequate

Link to report: https://api.cqc.org.uk/public/v1/reports/300ee9ab-0ee2-4035-aa37-0d5b851b47cc?20211223171918

- 26 and 27 April 2022
    - Maternity – inspected but not rated (follow up inspection to check compliance against warning notice issued following above inspection)

Link to report: https://api.cqc.org.uk/public/v1/reports/d5a15938-fa30-45b4-bb35-2eeab72fc3b2?20220729070335

St Richards Hospital, Chichester

- 28 September – 4 October 2021
    - Maternity rated requires improvement.

Link to report: https://api.cqc.org.uk/public/v1/reports/19c41cd3-3d04-4476-b809-a23a81d695c0?20211223171918

- 26 - 27 April 2022
    - Maternity – inspected but not rated inspected but not rated (follow up inspection to check compliance against warning notice issued following above inspection)

Link to report: https://api.cqc.org.uk/public/v1/reports/81170a7a-3725-4a88-a459-6eef3de0b385?20220729070335

Worthing Hospital

- 28 September – 04 October 2021
    - Maternity rated requires improvement.

Link to report: https://api.cqc.org.uk/public/v1/reports/9a45b0c0-8332-4635-8bb0-5e66defae1a6?20211223171918

- 26 and 27 April 2022
    - Maternity – inspected but not rated (follow up inspection to check compliance against warning notice issued following above inspection)

Link to report: https://api.cqc.org.uk/public/v1/reports/e8ede713-1a80-40e0-8687-37b3344c4522?20220729070335

A Trust wide Well Led inspection was undertaken on 4 and 5 October 2022.The report is still undergoing quality assurances processes and will be published on our website in due course.

CQC note the concerns outlined in section 5 of the Regulation 28 report.

Action CQC intends to take is to agree with the Trust regular engagement meetings to monitor and have oversight of the following:

1.) Request and monitor staff training compliance with emergency life support training and the management of deteriorating patients.
2.) Review audits undertaken by University Sussex Hospital NHS Trust in the management of deteriorating patients and compliance against the Trust's policies.
3.) Completion of actions from HSIB reports.
4.) Progress against actions outlined in the Maternity Safety Support Program.
5.) Monitor progress against Trust's action plans in response to CQC inspections.
6.) Monitor Summary Hospital-level Mortality Indicators for the Trust.

The time frame for completion is within the next three months to establish agreed frequency to meet with the Trust.

Additional actions CQC propose to take (for completion within the same timescale) are:

1.) Monitor the Trust's progress and compliance in implementing the national medical examiner system by April 2023.
2.) Seek confirmation that the Trust have an established process for the isolation of any medical equipment involved when an event happens when equipment may be involved.
3.) Information sharing and collaborative working with HSIB.
4.) CQC will request information from the Trust which demonstrates compliance with Regulation 20: Duty of Candour.

If CQC deems insufficient progress has been made by the Trust or if there is risk to service users, CQC will consider discharging its regulatory functions.

Should you require further information from CQC, please contact us.

[redacted]

Thank you in advance for your assistance.

Yours sincerely

[redacted]

Deputy Director (Interim)
Acute Hospitals South East