Ms Penelope Schofield
Senior Coroner
County Records Office
HM Coroners Office
Orchard Street
Chichester
West Sussex
PO19 1DD

NHS Sussex
Wicker House
High Street
Worthing
BN11 1DJ

Tel: [redacted]
E-mail: [redacted]
Website: www.sussex.ics.nhs.uk

21 June 2024

Dear Madam

I write in response to your Regulation 28 report and your covering letter dated 26.04.2024, setting out your concerns after hearing evidence at the Inquest touching on the death of Orlando Nova Davis.

I wish to begin by extending my sincere condolences to Orlando's family. This must have been an extremely difficult time for them, and I hope that my response provides them and you with assurances that NHS Sussex Integrated Care Board has taken action to address the issues set out in your Regulation 28 report.

HM Coroner's concerns

The matters of concern are that;

> *Orlando was caused an irreversible brain injury when his mother suffered a seizure having developed hyponatremia during her labour. The concern is that the midwifes (in the community and in the hospital, who had cared for Orlando's mother) were completely unaware of this potential condition developing in birthing women.*
>
> *In this case due to Orlando developing a tachycardia during labour Orlando's mothers was actively encouraged to take in more fluid yet there was no accurate record kept of either input or output of fluid. Again, when in hospital further fluids were given intravenously with no recognition of any potential risk of hyponatremia developing by the midwives or the Doctor on duty.*

Our Response

NHS Sussex Integrated Care Board ('the ICB') is the lead commissioner for maternity services provided by University Hospitals Sussex NHS Foundation Trust ("UHSx") and East Sussex Healthcare NHS Trust ("ESHT"). NHS Sussex ICB works in partnership with Surrey

Heartlands ICB and with Kent and Medway ICB who are the lead commissioners for the maternity services provided by Surrey and Sussex NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust who also provide some maternity services for parts of Sussex.

As part of our commissioning role, we seek assurance about the quality and delivery of the maternity services provided and we work together with our partners, including service user representatives and including those where other ICBs are the lead commissioners, to share learning and to make improvements for the people of Sussex.

We also have a Local Maternity & Neonatal system (LMNS). The purpose of the LMNS, is stated below:

'As the maternity arm of NHS Sussex, Sussex LMNS oversees perinatal clinical quality with the ICB quality and contracting teams, playing a key role in quality oversight, ensuring integrated oversight and action'.(Sussex LMNS Perinatal Quality Surveillance Operating Model, (1st approved April 2022))

We seek to disseminate any learning from the reports and the recommendations from any maternity investigation as widely as we can across Sussex maternity practitioners. We have a clinical shared learning forum for maternity investigations where reported serious incidents and actions are discussed. This is a monthly meeting which brings together clinicians from the perinatal multi-disciplinary team across the LMNS.

HSIB attended the learning forum in September 2022, and confirmed from investigations they had undertaken nationally, that the improvement areas being progressed regarding awareness and education around hyponatraemia, were being targeted appropriately.

There are two particular issues that arise from HM Coroners concerns regarding the care of [redacted] and Orlando Nova Davis during labour. The first is regarding the failure of the midwives to monitor fluid balance and to record the fluids accurately during labour in the community and in Hospital, although we are advised by UHSx that the guidance at the time did not require accurate monitoring of fluid balance during labour, and the second is the lack of knowledge and education amongst both doctors and midwives in relation to the rare complication of hyponatraemia in labour.

We can confirm that by November 2022, both Trusts, UHSx and ESHT, had put in place policies with regards fluid management and hyponatraemia in labour. Training and education related to the accuracy of fluid management and the risk of hyponatraemia in labour, has also been developed and has been delivered at both Trusts.

Both Trusts are also auditing compliance with the completion of fluid balance charts, and we have requested another audit is completed before the end of the year. A leaflet has been developed advising mothers about fluid intake in early labour. The leaflet has been published by UHSx and a publication is being considered by ESHT for inclusion on their website.

NHS Sussex continues to oversee further improvements, including further fluid balance audits covering all birth settings and being shared with NHS Sussex following completion, through its perinatal quality surveillance arrangements.

In order to enable the learning to be shared more widely with other Integrated Care Systems, our work on hyponatraemia and fluid balance in labour was shared with the Regional Maternity Team at NHS England in 2022, as part of the perinatal quality surveillance processes, put in place following the Ockenden Review.

I hope that we have provided you and Orlando's family with some assurance that NHS Sussex ICB has taken steps to address the concerns outlined in your report and that we are continuing to take action to prioritise patient safety in our maternity departments.

Thank you for raising this matter with me and please contact me if I can be of any further assistance.

Yours sincerely,

[redacted]

[redacted]

Chief Nursing Officer

On behalf of NHS Sussex