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Ms Charlotte Keighley H M Assistant Coroner for West Yorkshire (Western Coroner Area) H M Coroner's Office City Courts The Tyrls BRADFORD West Yorkshire BD1 1LA

Dear Ms Keighley

INQUEST TOUCHING UPON THE DEATH OF ALFIE HINTON

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 2 December 2024, which you sent following the inquest touching the death of Alfie Hinton.

Firstly, I wish to convey my sincere condolences to Alfie's parents and family for the loss of Alfie.

In advance of the Inquest, the Trust's response to this case was as follows:

- We reported the case to the Healthcare Safety Investigation Branch ('HSIB') on 16 May 2019 in order that it may undertake an independent investigation into the circumstances of the case and to identify learning and propose any safety recommendations;
- With knowledge that the HSIB could take up to nine months (at the time) to provide a report to support learning, we undertook our own concurrent, internal investigation in case any more urgent actions were required and we produced an Action Plan as part of that process.
- On receipt of the HSIB report in December 2019, we accepted its recommendations in full and made revisions to the Action Plan in response, and implemented the same;
- We carefully considered the independent expert report which the Coroner had obtained from Professor Draycott, Consultant Obstetrician and also accepted his recommendations in full.

In the Regulation 28 report you have raised the following concerns:

1) During the course of the Inquest, I could find no evidence of how or if the maternal risks were assessed following her admission, nor how the level of risk posed by the level of bile acids was communicated to those tasked with prioritising those patients awaiting induction of labour and therefore the allocation of staffing and resources. This is further reflected in the 39 minute delay in CTG monitoring and the fact that at the point Bradycardia was noted, the initial assumption from staff was that there was an issue with the monitoring equipment, there being little awareness of the risks already present, which contributed to delays in expediting delivery. These facts gives rise to concerns in respect of the way in which information is gathered and shared within the Maternity Unit

and in particular how risk is recorded and communicated between all of those involved in providing intrapartum care.

2) During the course of the Inquest, I heard evidence about the difficulties in communication between the Consultant Obstetrician and Consultant Anaesthetist, with delays being caused by several attempts being made at siting spinal anaesthetic, against the advice of the Obstetrician and the wishes of the patient, causing distress to staff and patient alike. I heard no evidence of any policy that provided direction or guidance in circumstances such as this. This gives rise to concerns in respect of communication, ongoing risk assessment and an absence of local policy in respect of the approach to be taken in such time critical situations.

Please be reassured that the Board are taking the receipt of a Regulation 28 very seriously and understand the importance of providing safe patient care. In response to these outstanding concerns and on receipt of the Regulation 28 PFD, the executive team have led a further review to assist me with compiling this response, comprising:



The clinical leads and other senior personnel from the various directorates have also been fully involved in this review to support this response.

In response

Concern 1:

The review has confirmed that it is the admitting obstetric consultant's responsibility to determine the clinical condition of the patient and the risks posed by any clinical condition/diagnosis to both mother and the unborn baby and to implement a management plan which accords with those assessed risks.

The admitting obstetric consultant would need to determine whether the unborn baby needed to be delivered more urgently by way of caesarean section or whether it was appropriate to proceed to induction of labour ("IOL") (or other mode of delivery). The decision making around IOL is supported by the Trust's guideline 'Induction of labour (incorporating management of pre-labour spontaneous rupture of labour at term)' [pages 1488 - 1509 of the Inquest bundle].

In Mrs Hinton's case, on 08.05.19, it was promptly recognised by the admitting Consultant Obstetrician that her bile acids were very significantly elevated and that she was suffering from Obstetric Cholestasis.

The Trust had in place at the time a guideline to support the diagnosis and management of Obstetric Cholestasis ('Obstetric Cholestasis (Intrahepatic cholestasis of pregnancy)') [pages 1576 – 1588 of the Inquest bundle]. Mrs Hinton's bile acid level put her in the 'Severe ICP' category, indicating that there existed a still birth risk that was higher than the background risk.

In Mrs Hinton's case, following diagnosis, it was recognised that treatment needed to be initiated in the form of Ursodeoxycholic Acid (UDCA), with definitive treatment ultimately being delivery of the baby. It was not considered necessary to treat the case as an emergency and thereby proceed to caesarean section at that time; a view that is supported by HSIB and **Exercise**. At the point of admission, the Consultant Obstetrician had hoped that IOL would be able to commence the

following morning (09.05.19) if circumstances (both ward activity and acuity) permitted, following two doses of steroids which were to occur 12 hours apart according to guideline.

As to the specific issue of how risk factors are communicated, every expectant mother admitted to the maternity unit would be **under the care of an obstetric consultant and/or midwife** and those clinicians would bear responsibility for knowing the patient's history and presentation and to review and complete the patient's record, which would contain all such information.

Furthermore, in evidence to the Inquest it was explained that each patient is subject to a structured **discussion at handover** between day shift and night shift teams (and so twice per day), including details of the patient, the reason for their admission, their diagnosis (where applicable), comorbidities, and proposed plan for care and delivery, including whether that is by way of planned caesarean section, induction of labour or any other mode of delivery, so that the whole team are aware of the position.

In addition to handover, where the patient is subject to consultant led care, the obstetric consultants hold **twice daily ward rounds**, which is typically attended by the Consultant, junior doctors, Labour Ward Coordinator, allocated midwife and the obstetric anaesthetist (when available or where necessary). Each patient is discussed at this multi-disciplinary ward round in further detail to the information handed over at the morning or evening handovers, specifically addressing the reason for IOL and urgency.

The Labour Ward Coordinator has responsibility for the oversight of all expectant mothers and is responsible for managing the workload of all members of the midwifery team and prioritising clinical activities. The obstetricians also have responsibility for reviewing the patient, their results etc and advising on priority. Priority for IOL is an MDT decision.

The Labour Ward Coordinator reassesses the full unit 4-hourly and (amongst other information) records the available staffing resource, patient numbers and acuity. At the time of this case, this information was recorded within the '**National Patient Safety Agency Intrapartum Score Card**'; a national tool used in these circumstances.

In addition, as given in evidence at the Inquest, the Labour Ward at the time held an **Induction of Labour Diary**, which would detail all patients planned for IOL. The Labour Ward Coordinator would make an assessment of activity and acuity of the unit (at least 4-hourly as above) based on the Score Card data and make a decision as to whether any additional patients at home (details of whom would be included in the Induction of Labour Diary), could be invited into the unit to prepare them for induction/section.

In terms of the communication of each patient's clinical condition and as an aid to prioritisation, the Labour Ward Coordinator's office also held a **whiteboard**, on which all patients were detailed, which was a further tool to assist with prioritisation.

The **patient's clinical records** are also central to communicating details of the clinical condition as between clinicians. It is noted that in Mrs Hinton's case:

- at the head of the handwritten midwifery records (pages 743, 745, 747, 749, 751, 753, 756, 759, 761, 763 of the inquest bundle) each page is clearly marked at the head of the page as "Antenatal risks present √" and "↑ Bile Acids";
- 2. the specific value of bile acids is also recorded on the 'SBAR Maternity Handover' records at pages 775 and 776 of the inquest bundle, to which the allocated midwife would refer and complete;
- 3. the specific value of bile acids is also recorded within the clinical record at page 756;

- 4. the specific value of bile acids is also recorded within the SystmOne records at page 957; and
- the specific value of bile acids would also be held within the Clinical Biochemistry records to which the whole team had access (page 867 of the inquest bundle) – the admission value of 149 umol/L (which dropped dramatically to 35 umol/L by 10.05.19 – page 877 and 6 umol/L by 11.05.19 – page 883).

In effect at the time of this case was the Trust Guideline 'Handover of Care on Site – Maternity Unit Maternity Services' which details expectations regarding handover of patients between clinicians and necessary communications and records surrounding this process. The guideline applies to all maternity staff and in the following situations:

- At midwife and multidisciplinary handover at change of shift
- Midwife to doctor on ward round/raising concerns
- From midwife to midwife at change of shift
- Midwife to midwife from/to antenatal/postnatal ward to labour ward staff
- Midwifery and nursing staff on transfer to/from ICU/HDU, theatre and general ward.

Included is the SBAR (Situation, Background, Assessment, Recommendation) communication tool which is fully embedded and utilised as an effective means of transfer of clinical information as between health professionals and is included and completed within the patient's record [pages 770-776 of the Inquest bundle].

We also observe at this stage that LW Coordinator, BB, gave evidence to the inquest to the effect that she was fully aware of Mrs Hinton and her clinical condition throughout the day shift of 09.05.19 and that she was communicating with the Obstetric Consultant with regards to patient acuity on the unit to determine the point at which it was safe to offer Mrs Hinton IOL, which was agreed shortly after 18:00 hours on 09.05.19.

The Coroner's independent expert, **Sector 1** provides evidence that "There was delay commencing the IOL related to unit level activity. This is a common issue in current practice across the UK and I consider that it was reasonable to have delayed the IOL until the unit could accommodate Mrs Hinton".

It was however explained in evidence that as a result of the events in this case and in response to the Healthcare Safety Investigation Branch ('HSIB') independent investigation into the circumstances of this case, the Trust has developed and implemented an **Induction of Labour Prioritisation Proforma**, to highlight risks and associated priority of women attending for induction of labour. The Trust supplied the Coroner with the proforma and this details the following guidance:

- "Women who are booked for induction of labour must be added to the IOL diary by the Labour Ward Coordinator. As much information as possible should be provided. Women who are booked for stat/urgent induction of labour must have the following -: The decision for induction of labour must be discussed with the consultant on call. The decision made and who discussed with must be clearly documented in the obstetric notes. Exceptions being induction for postdates (term+7-10) or pre-labour rupture of membranes at term. (Induction of Labour Guideline)
- A maximum of 3 inductions (2x CLC and 1x MLC) per day can be booked through the Induction suite. Any further inductions must be discussed with the labour ward co-ordinator.
- Patients awaiting induction who are residing on ward 21 must be prioritised.
- A multidisciplinary discussion should take place before or after the ward round on the Labour Ward. The prioritisation form should be completed at this time. The initials of all team members who are part of this discussion should be written in the column at the applicable time. An order should then be made and the order number added to the number column. The

multidisciplinary review will take place at each ward round or Doctors handover. If a woman declines to come in at the time arranged this should be documented in the multidisciplinary discussion documentation box. Any woman in these circumstances should remain on the list. Any delay in admission should also be added to this box. Prioritisation of the women, who are booked for induction of labour, will be carried out in terms of risk. Women who are inpatients and also outpatients should be prioritised during this discussion.

- Any delays in induction due to clinical activity should be discussed and agreed with the labour ward coordinator and consultant.
- Any delays longer than two hours are considered to be a red flag and an Adverse Events Form should be completed fully and submitted. This should contain the details of the lady who has been delayed. Full explanations should be given to the women by both a Doctor and a Senior Midwife.
- Completed copies of the form will be left in the LW Managers office and will be available to support decision making and provide information in Governance reviews."

Process - Induction of Labour Management

In order to provide you with further assurance as to the current process, and visually present the process to aid understanding, we have set out a 'process map' which details:

- 1. how patients who are to undergo IOL are managed within the maternity unit at Airedale;
- 2. how the activity and acuity is assessed, monitored and managed each day, including joint working with other units within the region;
- 3. the various safeguards in place to ensure escalation and prevent avoidable delays in patients proceeding to IOL; and
- 4. the process of prioritisation of all patients by appropriate methodology and MDT assessment.

We provide the policies/procedures and guidelines which inform this process map to evidence the clearly defined structures and systems in place at the Trust today.

Please see Appendix 1 – Process Map – Induction of Labour

To draw out a few specific points of relevance to your concern:

- I can advise that the Obstetric Cholestasis Guideline has been further updated to reflect the updated RCOG green topped guideline. This included guidance on the timing of delivery relating to the specific level of the bile acid results. The guideline states diagnosis of severe ICP would prompt delivery between 35-36 weeks. Diagnosis of severe ICP after 36 weeks would require immediate senior obstetric review and Induction of Labour and the guideline now makes this clear.
- 2. The prioritisation process and proforma formalises the process of patient management and priority according to individualised patient risk and provides a living record of priority to evidence why one patient is scored above another. It reflects MDT agreement as to priority.
- 3. The development of the Trust's RAG rating system for IOL based on identified risk factors will support the standardisation of prioritisation of IOL cases and will further strengthen this process and provide objective support for determining priority, although, ultimately, the clinical expertise of the MDT will take precedence and such tools can only be considered to be supportive of clinical decision making.

Concern 2:

Policy / Guideline

In effect at the time of this case, the Trust's '*Anaesthesia for Category 1 Lower Segment Caesarean Section (LCSC) guideline*' (2016) [pages 1589 – 1596 of the inquest bundle] advised that the anaesthetist has overall responsibility to decide on the method of anaesthesia.

The relevant section states:

"The decision for the type of anaesthesia rests with the obstetric anaesthetist, who will assess risk factors in the mother such as a known or predicted difficult airway, or morbid obesity. The safety of the mother is paramount. While general anaesthesia is usually the fastest method to anaesthetise a Category 1 caesarean section; it is associated with increased maternal morbidity and mortality. There is also evidence (level 3) to suggest general anaesthesia may increase the incidence of adverse neonatal outcomes. If a regional anaesthetic is attempted, it may be appropriate to perform a 'rapid sequence spinal'. This consists of a no-touch spinal technique, consideration of omission of the spinal opioid, limiting spinal attempts and allowing the start of surgery before full establishment of the spinal block. Oxygen should continue to be given during preparation for and insertion of the spinal anaesthetic. The anaesthetist needs to maintain situational awareness, so that if there is any delay in establishing adequate regional anaesthesia (and providing there is no contraindication to general anaesthesia), then conversion to general anaesthesia should be undertaken. Conversely, if the risk of general anaesthesia is considered to be high, the anaesthetist would be justified in further attempts at spinal anaesthesia while awaiting the arrival of experienced help."

The Guideline was revised post Alfie's case (March 2020 and again in October 2023) and the relevant sections (taken from the version created in October 2023) state:

"When a decision is made to perform a category 1 LSCS, the operating surgeon should inform the obstetric anaesthetist as soon as possible, so that they can assess the patient and prepare for anaesthesia with minimal delay. **Clear communication is required between the operating surgeon and the anaesthetist to convey the degree of urgency of the caesarean.** The obstetrician should state the required timeframe for delivery, so that *an informed decision can be made about the feasibility of attempting regional anaesthesia.* The mother and her partner should also be kept fully informed of the situation as this will be a very stressful situation for them."

"The decision for the type of anaesthesia rests with the obstetric anaesthetist, who will assess risk factors in the mother such as a known or predicted difficult airway, or morbid obesity. The safety of the mother is paramount. Whilst general anaesthesia is usually the fastest method to anaesthetise a Category 1 caesarean section, it is associated with increased maternal morbidity and mortality. There is also evidence (level 3) to suggest general anaesthesia may increase the incidence of adverse neonatal outcomes.

If an **effective epidural** is in situ, it may be feasible to top this up and different regimes can be used for this purpose. If **spinal anaesthesia** is attempted oxygen should be administered during preparation for and insertion of the spinal anaesthetic. The anaesthetist must maintain **situational awareness** so that if there is any delay in establishing adequate regional anaesthesia (and providing there is no contra-indication to general anaesthesia), then conversion to general anaesthesia should be undertaken. Conversely, if the risk of general anaesthesia is considered to be high, the anaesthetist would be justified in further attempts at spinal anaesthesia while awaiting the arrival of experienced help." The Guideline was further strengthened for the Trust (November 2024) and the relevant sections confirm:

"When a decision is made to perform a category 1 LSCS, the operating surgeon should inform the obstetric anaesthetist as soon as possible, so that they can assess the patient and prepare for anaesthesia with minimal delay. Clear communication is required between the operating surgeon and the anaesthetist to convey the degree of urgency of the caesarean. The obstetrician should state the required timeframe for delivery, so that an informed decision can be made about the feasibility of attempting regional anaesthesia. The mother and her partner should also be kept fully informed of the situation as this will be a very stressful situation for them.

If the mother requests a general anaesthetic, then this should be done unless there are important safety reasons not to."

"The decision for the type of anaesthesia rests with the obstetric anaesthetist, who will assess risk factors in the mother such as a known or predicted difficult airway, or morbid obesity. The safety of the mother is paramount. Whilst general anaesthesia is usually the fastest method to anaesthetise a Category 1 caesarean section, it is associated with increased maternal morbidity and mortality. There is also evidence (level 3) to suggest general anaesthesia may increase the incidence of adverse neonatal outcomes.

If an **effective epidural** is in situ, it may be feasible to top this up and different regimes can be used for this purpose. If **spinal anaesthesia** is attempted oxygen should be administered during preparation for and insertion of the spinal anaesthetic. The anaesthetist must maintain **situational awareness** so that if there is any delay in establishing adequate regional anaesthesia, i.e if spinal is not achieved within a 5 minutes from the initiation of the procedure (and providing there is no contra-indication to general anaesthesia), then conversion to general anaesthesia should be undertaken. A multi-disciplinary discussion will take place at 5 minutes from the initiation of the spinal to re-assess the situation and consider conversion to general anaesthetic. Conversely, if the risk of general anaesthesia is considered to be high, the anaesthetist would be justified in further attempts at spinal anaesthesia while awaiting the arrival of experienced help, but this must include a multi-disciplinary risk assessment of the clinical situation."

In order to bring about this change in process, the senior leads for obstetrics and anaesthetics agreed that if spinal anaesthesia is not successfully sited after 5 minutes of the initiation of the procedure, a general anaesthetic should be commenced, provided there are no contraindications.

The Trust considers this to be an important mechanism to ensure that, as a matter of policy, an MDT discussion takes place at 5 minutes from attempting to site spinal anaesthesia and that the anaesthetists should covert to general anaesthesia at this point. This should prevent anaesthetists from proceeding with additional attempts at spinal anaesthesia where there is MDT disagreement, thereby avoiding the delays which occurred in this case. This 5 minute interval is identified as an appropriate timescale in consideration of the NICE Decision to Delivery Interval ("DDI") of 30 minutes in Category 1 caesarean section (Clinical Guideline CG132).

The Trust has further strengthened the Guideline to confirm that where a intrapartum sentinel event occurs, general anaesthesia should be undertaken unless there are important safety concerns; it details the steps to be taken to achieve intra-uterine fetal resuscitation in the case of fetal distress; to clarify the roles and responsibilities as between the specialist disciplines and the steps to be taken if further spinal anaesthesia is to be considered post the five-minute review.

Process – Category 1 Caesarean Section / Fetal Bradycardia

In order to provide you with further assurance as to the current process, and visually present the process to aid understanding, we have set out a 'process map' which outlines:

- 1. the management in respect of fetal bradycardia from the point it is first detected;
- 2. the steps taken to declaring the need for a Category 1 lower caesarean section;
- 3. the steps taken thereafter including:
 - a. transfer to theatre
 - b. MDT CTG re-assessment (and plan of care thereafter)
 - c. decision making regarding anaesthetic choice including roles and responsibilities
 - d. the process for achieving effective anaesthesia and
 - e. the process for abandoning spinal anaesthesia in favour of general anaesthesia including clarity as to the decision makers; and
- 4. an indicative timeline in consideration of the DDI of 30 minutes, per the NICE guideline.

We provide the policies/procedures and guidelines which inform this process map to evidence the clearly defined structures and systems in place at the Trust.

Please see Appendix 2 – Process Map – Category 1 Caesarean Section / Fetal Bradycardia

Communication and Culture

As an organisation, the Trust made the same observations as the Coroner as to the concerns regarding communication breakdown as between the obstetric and anaesthetic teams in theatre, which the Trust considers to be at the heart of the difficulties encountered in theatre. Ahead of this Inquest, we acknowledged that these difficulties had led to avoidable delay.

As part of an organic development in health practice but also designed specifically to address the issues which occurred in this present case, particularly focussed on culture, leadership, team working and compliance with national standards, the Trust undertook the following:

- As explained in evidence to the Inquest, the Trust has radically developed its training programme to an MDT model (between anaesthetists, obstetricians and midwives) which has been fully embedded, strengthened and follows a globally accepted, evidence-based human factors approach, known by the acronym **PROMPT (Practical Obstetric Multi Professional Training)** www.promptmaternity.org, which has been in effect at the Trust since January 2021.
- 2. The Trust is fully compliant with the Maternity Incentive Scheme, as operated by NHS Resolution on behalf of the Department of Health and Social Care. As part of this assurance programme, the Trust has had to evidence the implementation of a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns. There are ten standardised safety actions in the scheme which have been agreed by senior (external) clinicians to help drive improvements in maternity, with a significant element of the actions targeting safety and culture. (Maternity Incentive Scheme NHS Resolution)
- 3. As explained in evidence to the Inquest, the Trust has embedded SIMS training real life Simulation Based Training which is based on obstetric emergencies and scenarios. This is a learning tool used to improve team working in emergency procedures. The SIMS training includes learning from scenarios, incidents, case reviews, patients' experience and themes and trends across the service to improve learning and reflection. This facilitates constructive feedback to aid teams working together, learning from scenarios and dynamic integration into current themes on the maternity unit.

- 4. **GMC Professional Behaviours and Patient Safety Programme** the Trust entered into an agreement with the GMC to pilot a scheme designed to help organisations develop culture change and address unprofessional behaviours in clinical practice and to engender just and fair culture.
- 5. Perinatal Culture Leadership programme the Trust attended the Perinatal Culture Leadership Training programme in 2024. The Perinatal Quadrumvirate consists of Midwifery, Obstetrics, Neonates and Operational Management. The programme has consisted of understanding behaviours and cultures. 360-degree feedback and coaching was included within the programme. A SCORE Survey was completed in April 2024 and the report received in the Trust in October 2024. Teams are currently drilling down into the feedback and producing an action plan. Updates are presented to Quality and Safety Committee, Trust Board and Safety Champions.
- 6. As explained in evidence to the Inquest, the Trust has developed a programme of **Human Factor and Ergonomics Training Workshops**, led by a Consultant Anaesthetist, which focuses on systems issues within healthcare and how human behaviours influence outcome and can be modified through systems changes to achieve better clinical outcomes (the principles of such training are explained at <u>Human factors | NHS England | Workforce,</u> <u>training and education</u>).
- 7. **Compassionate and Inclusive Leadership with Accountability** leaders across the organisation participated in this multiprofessional programme led by HealthSkills.
- 8. The **external review of maternity services** the purpose of which was to provide external review of the service in order to provide external assurance and opinion, identify areas of good practice and provide any recommendations for improvement. The methodology firstly included a tabletop review of Trust self-assessment against CQC's key lines of enquiry ('KLOE'), minutes from governance meetings, TOR, completed RCA's and consultant job plans. This was then followed up by a two-day on-site visit which included discussions with members of the team. It was followed by a report incorporating findings and recommendations, which are subject to a specific project of implementation, many recommendations having already been implemented.
- 9. The Trust was an early adopter of transitioning to Learn from Patient Safety Events ('LFPSE') and the Patient Safety Incident Response Framework ('PSIRF') to improve learning and safety culture, moving away from root cause analysis which is much less effective in complex health systems.
- 10. As provided in evidence to the Inquest, the Maternity Department has introduced (issued May 2023) a guideline 'Maternity Escalation of Clinical Concerns Maternity Services', which is designed to empower all staff members to raise clinical concerns and have agreed escalation processes in place. It incorporates the escalation toolkit provided by RCOG (2022) as part of their 'Each Baby Counts: Learn + Support' guidance (Each Baby Counts: Learn & Support | RCOG)
- 11. As explained in evidence to the Inquest, **clinical incident reporting** is an embedded mechanism highlighting themes of clinical adverse events, in real time. The Division have weekly meetings to discuss any AEF's completed. This assists with early identification of themes, quality and safety and performance concerns and triggers for any immediate action and learning. This AEF reporting process has the wider Trust oversight.
- 12. As explained in evidence to the Inquest, **Quality Safety Summits** have been introduced across all disciplines in the Trust. This has assisted with wider learning across all disciplines particularly when cases have required input from other specialities. This has assisted as a mechanism to improve wider learning and ongoing quality and safety improvements. Maternity contributes to this process given the complexities of women accessing the services and the requirements for multi-disciplinary engagement.

In summary, the organisation aims to meet the challenges around workplace culture and MDT collaboration head on and has undertaken an extensive programme of work to address and validate this area and will continue to do so.

As you will appreciate, this is an ongoing challenge for all NHS organisations and we have positioned ourselves to take on that challenge and benchmark the Trust against other organisations by working in partnership with other healthcare providers, and to engage with our regulators to ensure compliance and best practice.

I hope that this response addresses the concerns which you have raised and explains why the Trust has chosen to take the steps it has. I thank you for bringing these issues to our attention which we take very seriously.

Yours sincerely



Chief Executive Airedale NHS Foundation Trust