NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

FAO the Senior Coroner,
Professor Fiona Wilcox
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By Email

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24 January 2025

Dear Senior Coroner, Professor Wilcox,

Inquest touching the death of Baby Elton Deutekom – Response to Prevention of Future Deaths Report issued 02 December 2024

I am the Chief Executive Officer writing on behalf of the Chelsea and Westminster Hospital NHS Foundation Trust, in response to the Regulation 28 report issued by the court on 02 December 2024, in relation to the death of Master Elton Deutekom, on 12 January 2022. We thank the Senior Coroner for bringing these concerns to the Trust's attention and aim to address these, with this response.

Firstly, on behalf of the Trust, I offer my sincere condolences to Elton's parents and family. We wish to reassure them that care and service delivery problems identified both after his death and during the inquest process have been reflected upon and learned from.

The Trust has also had sight of NHS England's PFD response when making this response.

I address each of the evidentiary points raised and thereafter the Matters of Concern, below:

- The Trust accepts and has continued to reflect upon the factual findings in relation to evidentiary points 1-3 which are broadly in line with the findings of the external Healthcare Safety Investigation Branch ("HSIB") investigation that followed shortly after Elton's death following direct referral from the Trust. The Trust sought to address these findings immediately following receipt of their investigation report, and the changes implemented are set out further under the relevant Matters of Concern below.

- In respect of evidentiary point 4, the neonatal consultant who obtains consent for the post mortem is expected to provide the discharge summary to the Pathologist and/or complete a post mortem request form, in addition to speaking to them to highlight any relevant clinical information. We recognised that in this instance, on reviewing the summary there was no mention of the abruption. The consultant responsible is not able to confirm that the information relating to the abruption was subsequently passed on to the pathologist. The Trust apologises for this oversight and has taken this learning back to the Neonatal team to ensure all information identified at the time of the birth is provided as part of highlighting relevant clinical information.

- In respect of evidentiary point 5, the Coroner notes, "*Issues in relation to management of labour that may have contributed to the death and thus render the death as reportable to the coroner under the Notification of Deaths Regulations (the Regulations) were noted on 17th January 2022 on a Datix report, in statements gathered in January and February 2022 and at the Perinatal Mortality Review meeting in early March 2022. On 11th April 2022, HSIB advised Chelsea and Westminster to report the death to the coroner based on issues they identified in relation to management of Elton's mother's labour. Despite this the death went unreported until 17th June 2022.*"

  The Trust confirms that immediately following on from this death, the neonatologists felt able to establish a Medical Cause of Death and did not consider this was a matter that ought to be referred to the Coroner. Despite this, a referral was repeatedly explored, re-assessed and considered with the input of the wider medical team and Medical Examiners throughout January 2022 and all considered this did not meet the requirements for referral. The matter was again re-considered during the multi-disciplinary Perinatal Mortality Report Tool meeting in March 2022, and the conclusion was it did not meet criteria for referral. A timely referral to HSIB was made following Elton's death as part of the Trust's usual processes.

  The Trust has been advised by HSIB following the inquest, that the letter dated 11 April 2022 and disclosed during the inquest process, was incorrectly dated and was not sent to the Trust until 11 June 2022. This letter advised the Trust to again consider whether a referral to the Coroner ought to be made.

  This advice was followed, and within a week, the neonatal team contacted the Coroner on 17 June 2022 and again on 22 June 2022. The Court opined that this did not fall in their jurisdiction and the Neonatal team clarified that this was a neonatal death rather than a stillbirth. A pre-investigation hearing was arranged for 16 July 2022, whereby the Trust clinicians attended and re-confirmed this position. An inquest was then opened, and the Trust has engaged throughout.

- In respect of point 6, the Regulation 28 report states, "*Explanation from the hospital was sought as to why the death was not reported in line with Regulations and a letter was received from the Lead for Neonatal mortality. This provided no clear explanation to many of the questions raised and demonstrated a lack of understanding of the Regulations and the obligation they place upon doctors to report deaths to coroners, and that these legal obligations continue after the death may have been registered as natural.*"

  This point was raised prior to the inquest and the Trust prepared a letter in response (enclosed with this letter for ease of reference). During the inquest the Trust prepared a further written response from the neonatal team to assist the court. The Trust has responded to all requests and every effort has been made to ensure that the reporting systems and criteria have been set out. The Trust is seeking clarity on this point for the future, and is eager to adopt any relevant guidance in the framework for the governance of neonatal mortality, currently being developed by the British Association of Perinatal Medicine.

- In respect of evidentiary point 7, the Trust denies that statements and handwritten documentation by nursing staff were not disclosed, but appreciates that there was difficulty in establishing this position during the inquest, for which we apologise. A detailed timeline under Matter of Concern 2 is set out in respect of this point.

- In respect of evidentiary point 8, this is addressed in detail under Matter of Concern 3. For clarity, paper records were written up into the electronic record from handwritten notes recorded during the

emergent situation in line with Trust policy. Assistance was given in the context of mentoring, as the midwife was in the first year of her preceptorship programme. The paper note which had been captured during the emergent delivery, was discarded once it had been accurately transcribed into the electronic record. The Trust denies any suggestion that this was a "cover up" and wishes to reassure Elton's family of the same.

- In respect of evidentiary point 9, this is also addressed under Matter of Concern 2, but the Trust accepts there was confusion during another inquest as to what disclosure had been made and when, in the context of a lengthy investigation with voluminous documentation. As soon as this was identified in the inquest, the Trust legal team took immediate steps to ensure the parties had all received the documentation and re-disclosed the records to address any disparities. There was no intention by the Organisation or its employees to prevent disclosure of full records at any time. The Trust feels that this had been adequately addressed in that inquest, and therefore this was not contextually relevant to Elton's inquest.

- The Trust has addressed evidentiary points 10 and 11 under Matter of Concern 7. Medical Examiners for the Trust now have full access to maternal and baby notes when reviewing deaths and will review them, in accordance with appropriate consent.

Matters of Concern

In respect of the Matters of Concern to be addressed in the Regulation 28 Report, the Trust confirms:

1. ***That Chelsea and Westminster Hospital are not appropriately referring neonatal deaths to coroner- either late or not at all, and this raises the possibly that lessons may not be learned from the investigation of these deaths that may save the lives of others.***

The Trust is confident that it meets its obligations in respect of referring neonatal deaths to the Coroner.

All deaths are now required to be reviewed under statutory duty of the Medical Examiner, therefore all neonatal deaths are reviewed. The Medical Examiners have confirmed that they have full access to maternal/obstetric notes as part of the review process and will access them when appropriate consent has been obtained with regard to maternal records.

Please find enclosed the Trust's "Medical Examiner Process flowchart", which also sets out how the Medical Examiners assess each neonatal death.

The Neonatal team liaise with the Medical Examiners and maternity teams in the event of a neonatal death and referrals are made appropriately and according to existing criteria.

Furthermore, all neonatal deaths are reviewed by a large multi-disciplinary team including external attendees and the Child Death Overview Panel within 6 weeks, using the national Perinatal Mortality Review Tool. This is the standard process for learning from neonatal deaths that has been in place since 2018.

It has been reiterated to staff in the service and to the wider leadership team of the Trust that any concerns held with regard to circumstances surrounding a death, should prompt a referral to the Coroner.

2. *That Chelsea and Westminster Hospital may not be complying with the duty of candour to disclose evidence relevant to a death to the coroner until forced to by court directions made in public, which thus raises the same concern as above.*

The Trust takes seriously its obligations in respect of both Duty of Candour and disclosure, and endeavours to engage with and assist the court in all matters.

It is denied that the court was not provided with the evidence it required when requested. As set out below, the Trust has confirmed that disclosure was made at the times requested prior to inquest, on 16 May 2023. Emails confirming this fact are enclosed for the attention of the Coroner. Despite this, the Trust appreciates that there were difficulties in establishing what had been disclosed and when during the hearing, and has fed this back internally.

The Trust understands that the documents in question were a statement from the Obstetric Registrar and a statement from the Labour Ward Co-Ordinator, as well as a paper handover note that was used during live evidence in the course of the inquest.

The Trust's external and internal legal team have each reviewed notes of previous court attendances and confirm that in a Pre-Inquest Review Hearing on 14 March 2023, the relevant incident statements were discussed and it was requested they be disclosed to the Coroner to assess whether the family ought to see them.

The Trust records demonstrate that the Trust sent documentation to its external solicitor who provided disclosure to the Court, on 16 May 2023.

The Trust is reviewing its internal legal and governance processes to ensure clear records of disclosure are maintained so that we may provide assurance should the need arise in future.

3. ***That following neonatal deaths assistance is given to midwifery staff as to how to write records in retrospect and contemporaneous handwritten notes are destroyed possibly reducing the accuracy of the records and thus risking that lessons may not be learned that may save the lives of others.***

The Trust has clear policies in place for record-keeping, and in respect of maternity and/or nursing notes, these remain in line with the ***NMC Code, Professional standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates***.

The Trust reviewed the record-keeping as part of the response to the HSIB investigation and following receipt of this Regulation 28 report and confirms that:

Notes were recorded in retrospect in this matter due to the emergent nature of the delivery. This is a practice used throughout the NHS. They were recorded in line with the Trust's Maternity Clinical Record Keeping Policy and the relevant ***NMC Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, October 2018 – Standards Relevant to Record Keeping,*** in place at the time of Elton's death.

The Practice Development Midwife acted as a preceptor for the junior Midwife involved and assisted in demonstrating proper record keeping, as per Preceptorship policy and the NMC Principles for Preceptorship, which is the expected and recommended standard. This is also in line with NHS England's National Preceptorship Framework.

Paragraph 1.4 of the NMC Principles for Preceptorship (point 3, page 10) states, *"Preceptorship is tailored to the individual nurse, midwife and nursing associate preceptee's new role and the health or care setting. It seeks to recognise and support the needs of the preceptee to promote their confidence in their professional healthcare role. In effective preceptorship models, preceptees: are provided with the appropriate resources to enable them to develop confidence as newly registered nurses, midwives and nursing associates*

- *Are supported according to their individual learning needs*
- *Are supported by a nominated preceptor*
- *Have opportunities for reflection and feedback to support their approach to preparing for revalidation…'*

4. That the labour ward is understaffed.

The Trust has addressed the staffing gaps with an ongoing recruitment and retention programme.

This staffing gap was accepted by the Trust at the time of the HSIB investigation and during the inquest process.

Enclosed and set out below is the 2021 Birthrate Plus report (the Birthrate Plus staffing tool is the validated tool for the calculation of the maternity workforce and is based on activity, acuity and complexity data), which is part of requirements of the NHS Resolution Maternity Incentive Scheme. The Trust has been compliant with this Scheme for the past 5 years and are on track to submit compliance in Year 6.

This report demonstrates on page 15 that the gap in staffing on the Chelsea Hospital site in May 2021 was: 10.95 whole time equivalent (WTE) midwives and 9.2 in specialist and management.

Overall comparison of Birthrate Plus wte to current funded wte (tables 9a & b)

CHELSEA & WESTMINSTER HOSPITAL	**RMs**	**MSWs**	**Bands 3 - 7**
Current Total Clinical	173.11	17.83	203.64
Contribution from Specialist MWs	12.70		
Total Current Funded	**185.81**	**17.83**	**203.64**
BR+ Clinical wte			**214.59**
Skill Mix Adjustment (90/10)	193.13	21.46	
Variance +/-	-7.32	-3.63	-10.95
	Birthrate Plus	Current	**Variance**
Additional Specialist & Management wte	23.60	14.40	-9.20
OVERALL TOTAL VARIANCE	238.19	218.04	-20.15
(Postnatal Band 3 - Band 8)			

Overall comparison C&W Table 9a

Following this case, the Trust received 21 WTE from the national funding and then the business case for investment was approved in December 2022, for funding over 4 phases as we recruited to the posts.

The Maternity service will be fully recruited to Phase 3 by March 2025. Following this, the Trust Executive Management Board and Finance Investment Committee will receive a business case for phase 4 (on the Chelsea Site the equates to 1 WTE clinical midwife and 1 WTE specialist and management), in addition to any proposed further investment following the Birth Rate Plus Review in April 2025. This will be to ensure we are at near-full capacity in terms of staffing. This funding has meant that the Maternity Unit has been able to lift the staffing in areas to improve safety, having put in a night site safety coordinator on the Chelsea site. This was identified as learning within the Trust's Action Plans. The Maternity team continue to use the NHSE funding for the preceptorship support midwife.

The Maternity team have also proactively undertaken the "3 year birth rate plus assessment" and have just received the draft which will go to Executive Management Board (EMB) in February for review and ask for investment if required.

The Trust has addressed the staffing gaps with its ongoing recruitment and retention programme. Given the national position regarding midwifery vacancies, the Trust has invested in the workforce and worked collaboratively across North West London undertaking domestic and international recruitment, in addition to supporting the service in continuing to recruit to turnover any maternity leave posts. Shift fill rates within the maternity service are reviewed monthly and on the Chelsea Hospital site range from 98-100% of shifts filled to the expected staffing levels, the service utilize temporary staffing to ensure safe staffing levels. All temporary staff complete an orientation and either complete local mandatory training or approved external training.

5. **That newly qualified midwives should have more supervision whilst they are managing women in labour.**

Since Elton's death, new framework was published in March 2023 regarding supervision of newly qualified midwives whilst managing women in labour.

The initial preceptorship programme began in January 2022 and was in line with national recommendations at that time.

Please find enclosed the Capital Midwife Preceptorship Framework that was in place at the time of the incident. The framework stipulated that new starters should have "*one week (or equivalent) of supernumerary time at the start of each rotation*"; it did not specify what this meant in hours or whether this was pro rata for part-time staff members.

After completing a gap analysis and implementing any outstanding actions in March 2021, both hospital sites were awarded the CapitalMidwife Preceptorship quality mark, which was uniformly achieved across London by January 2023.

The new midwifery preceptorship framework published by NHSE in March 2023 was implemented at the Trust by September 2023 and remains in place. This current framework stipulates that all preceptees should have supernumerary status for a minimum of 150 hours over a 12-month period, which usually means 75 hours at the start of each new rotation/area. The programme also strengthens the provision of protected time for preceptee/preceptor progress meetings and any additional support required.

The Trust has investigated the levels of clinical support given to preceptee midwives and confirms that in practice, a Practice Development Midwife is allocated for clinical support, though this has been affected by staffing as posts are presently not fully recruited to.

In the context of clinical oversight during labour care, NHS Resolution's Maternity Incentive Scheme outlines ten maternity safety actions, among which Safety Action 5 requires that the labour ward coordinator should remain supernumerary to ensure oversight of all birth-related activities and enhance patient safety. The Trust is fully compliant with this standard.

6. *That there is no regular review system for CTGs on the central CTG monitoring board.*

This was accepted following on from the HSIB report and as a direct result of the recommendations, the Trust updated the current Intrapartum Fetal Monitoring Guideline to confirm that all CTG's must be confirmed at a patient's bedside. This is in line with the NICE Guidance and the Saving Babies Lives Care Bundle v3 that says a holistic review should take place hourly. The holistic review incorporates a categorisation of the CTG and requires a discussion between the midwife caring for the woman/birthing person and another midwife or doctor, which cannot be achieved at the central CTG monitoring screen, the outcome of this holistic review is discussed with the woman/birthing person. The CTG central monitoring screen can be a useful tool in supporting MDT discussions and teaching of fetal wellbeing. The service has seen significant improvement in the compliance with the hourly holistic review and submitted compliance with this intervention as part of SBLv3 which is part of the national Maternity Incentive Scheme.

The Trust has provided further learning through a Fetal Monitoring Study day from 2023 onwards the service has maintained compliance with over 90% of staff having undertaken and passed a fetal wellbeing study day annually since the introduction of this study day alongside weekly drop in session to review cases. The case of Baby Elton was presented at each study day in 2024, including discussions around central monitoring. The Trust has ensured further refreshers and training through six separate newsletters surrounding "Fresh Eyes CTG Reviews" since Baby Elton's death, which has seen improved practice. This has been undertaken alongside a Fetal Monitoring Campaign through posters on the Maternity Units and through emails.

7. *That in some hospitals the Medical Examiners do not have access to obstetric records when reviewing deaths.*

At the time of Elton's death, maternal/obstetric notes were not readily available and were requested by the Medical Examiners; however they now have access, within standard information governance processes. The Trust is unaware whether there is a wider concern but confirms that in respect of this Trust, no concern remains.

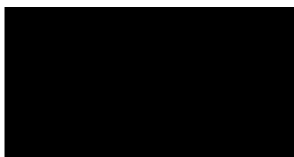
8. *That the neonatologists at Chelsea and Westminster are not passing sufficient and appropriate information to the pathologists when consented post-mortem examinations occur such that the cause of death found by the pathologist may be inaccurate.*

In this instance on reviewing the summary there was not a mention of the abruption. The consultant responsible is not able to confirm that the information relating to the abruption was passed on to the pathologist. This appears to be an individual oversight and has been fed back to the clinician involved.

The neonatal consultant who obtains consent for the post mortem provides the baby's discharge summary to the Pathologist and / or completes a post mortem request form, in addition to speaking to them to highlight any relevant clinical information.

May I once again extend my sincere condolences to Elton's family. I trust that the information provided has delivered assurance that the concerns raised have been addressed.

Yours sincerely



Chief Executive

Enclosures:

1. Letter from Trust regarding referral to Coroner 201124
2. Neonatal contact with the Coroner – June 2022
3. Initial letter regarding late death referral - 13 November 2024
4. Letter from Trust regarding referral to Coroner - 20 November 2024
5. ME Flowchart - 24 October 2024
6. Disclosure to court in May 2023
7. NMC Code
8. Clinical Record-Keeping Policy
9. Maternity Clinical Record-Keeping Policy
10. CW Birthrate Plus Report 2021
11. CapitalMidwife Preceptorship Framework 2019
12. Intrapartum Fetal Monitoring Guidelines October 2024
13. Fetal Monitoring Campaign
14. Fresh Eyes Newsletters