NHS England

Professor Fiona J Wilcox
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22 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Elton Michael Deutekom who died on 12 January 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 December 2024 concerning the death of Elton Michael Deutekom on 12 January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Elton's parents and family. NHS England are keen to assure the family and the Coroner that the concerns raised about Elton's care have been listened to and reflected upon.

My response to your Report focuses on the areas of concern raised by the Coroner that sit within NHS England's national policy and programme remit. Your Report raises a number of concerns specific to Chelsea and Westminster Hospital and it is appropriate that Chelsea and Westminster NHS Foundation Trust, who I note you have also sent your Report to, respond to you on these matters. I wish to assure you that the National Medical Examiner, who you have also addressed your Report to, has reviewed your Report and has input into my response.

I respond to each of your concerns relevant to NHS England in turn below.

That newly qualified midwives should have more supervision whilst they are managing women in labour (concern no.5)

NHS providers, under the NHS Standard Contract, are required to ensure that all midwives meet the necessary qualifications, competencies, and receive adequate supervision, including preceptorship and oversight.

For newly qualified midwives, it is for NHS providers to design preceptorship programmes aligned with NHS England's National Preceptorship Framework, tailored to local service configurations. These programmes, recommended in the first year post-registration, provide structured support, protected learning time, and access to experienced preceptors (teachers or instructors) to develop autonomous practice and ensure safe, high-quality care. During preceptorship, newly qualified midwives are recommended to have supernumerary status for a minimum of four weeks (150 hours) across the year, typically allocated at the start of rotations or clinical placements. This means that they are not allocated personal caseloads or included in staffing numbers

during this period. Any additional training needs identified should prompt individualised support plans at the provider's discretion.

NHS providers should ensure that all midwives (including those post-preceptorship) have access to clinical supervision through the A-EQUIP (**A**dvocating and **E**ducating for **QU**ality **I**m**P**rovement) model, delivered by Professional Midwifery Advocates (PMAs). PMAs provide structured support and guidance, enhancing care quality and workforce well-being. NHS England's A-EQUIP operational guidance prompts providers to consider how and what type of support will be put in place to enable midwives to seek immediate support, engage in proactive planning, mitigate risks, address midwifery learning and development needs, and create opportunities to discuss the woman's birth experience and choices. Additionally, 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.

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

The Maternity and Neonatal Programme cannot comment on the local practice and guidance for reviewing CTGs in this case, but provider trusts are expected to deliver care in line with NICE guidance. In addition, the Saving Babies Lives Care Bundle v3 does include guidance for fetal monitoring during labour, including an hourly holistic review of cardiotocograph (CTG) monitoring at the bedside with the woman.

This review should include not just analysis of the CTG, but also consideration of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction and previous caesarean section; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour, and should lead to escalation if indicated.

While central monitoring systems can be a useful additional tool, when there are additional staff available to observe them, the holistic review is more than just a categorisation of the CTG and requires a discussion between the midwife caring for the woman and another midwife or doctor.

Trusts should be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTGs in relation to the clinical situation and escalate accordingly when concerns arise, or risks develop.

That in some hospitals the Medical Examiners do not have access to obstetric records when reviewing deaths (concern no.7)

At the time of these events, NHS trusts were implementing the medical examiner system on a non-statutory basis and were not yet reviewing all deaths. The government decided in April 2024 that, from 9 September 2024, the Death Certification Reforms would come into force, including the statutory medical examiner system.

Since this date, it has been a requirement that all deaths in England and Wales are independently reviewed without exception, either by a medical examiner or a coroner.

Part of medical examiners' role is to consider whether referral to the coroner is required, and to ensure more consistent referral of appropriate cases where the cause of death cannot be established, or the Notification of Deaths Regulations 2019 apply for other reasons. For all other cases, upon receiving a Medical Certificate of Cause of Death (MCCD) from an attending practitioner, medical examiners are under a statutory duty to scrutinise the cause of death; consider the information provided by the attending practitioner; make whatever enquiries they consider necessary; and confirm the cause of death by signing off the MCCD.

The Access to Health Records Act 1990 (AHRA) has been amended to establish the statutory right of medical examiners to access health records of deceased patients, to enable them to make whatever enquiries they consider necessary. Attending practitioners are now required by the Medical Certificate of Cause of Death Regulations 2024 to make the deceased person's relevant health records available to the medical examiner.

In some neonatal cases, medical examiners may consider the maternal patient records are relevant. Unless the mother is also deceased and her death is undergoing scrutiny by the same medical examiner, the specific medical examiner's right of access to these records under the Access to Health Records Act 1990 would not apply. If this is not the case, the usual information governance principles for living patients would apply to access to the maternal patient records (for example, obtaining consent from the living patient or establishing another legal basis).

That neonatologists in other hospitals may not be appropriately reporting deaths to the coroner (concern no.9)

The new national medical examiner (ME) system was introduced on 9 September 2024 and all Medical Certificates of Cause of Death (MCCDs), including for neonatal deaths not investigated by a coroner, are reviewed by a medical examiner to ensure that the MCCD is completed accurately, that concerns of family members are taken into account following the death of a baby, and that deaths are appropriately reported to the coroner when indicated. This process was not in place in 2022 when the death of Elton occurred.

In addition, the British Association of Perinatal Medicine is currently developing a framework for the governance of neonatal mortality. This will be available later this year and will provide specific guidance on good practice following a neonatal death. The working group includes neonatologists, neonatal nurses, pathologists, medical examiners and a representative of the Chief Coroner's office. We would be happy to share the document with the Coroner once it is available.

Regional Review

My regional Clinical Quality & Patient Safety colleagues for the region of London have also reviewed your Report and are engaging with relevant regional and system colleagues for the appropriate oversight.

London has a strong record regarding preceptorship. In summer 2022, the London CapitalMidwife Programme refreshed its 2019 CapitalMidwife Preceptorship Framework, collaborating with local, regional and national stakeholders across clinical practice, education and leadership. This work informed the development of the National Preceptorship Framework. By January 2023, all London maternity units had achieved the CapitalMidwife Preceptorship Framework Quality Mark requiring only minor adjustments to align with the national standard introduced later that year and referenced above.

In January 2024, London's regional Maternity Team also established a six-weekly, multiagency and multidisciplinary Perinatal Quality, Safety, and Surveillance Group to improve safety and service user experience through person-centred care, a safety culture, and continuous learning. Outputs are escalated to regional and national quality and safety groups as required.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Elton, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director