The Leeds Teaching Hospitals
NHS Trust

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Chief Medical Officer
[redacted]
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Date: 26 August 2025

Mr Oliver Longstaff
Area Coroner
West Yorkshire (Eastern)
Coroner's Office and Court
Merchant Gate, Burgage Square,
Wakefield
WF1 2TS

Dear Mr Longstaff

INQUEST TOUCHING THE DEATH OF BENJAMIN FINCH ARNOLD (Deceased)

I refer to your correspondence of 3rd June 2025, regarding the inquest touching the death of Benjamin Arnold Finch and the Regulation 28 Reports to Prevent Future Deaths in respect of this case.

I can confirm that the contents of your Regulation 28 Reports have been shared with the relevant staff to enable us to provide you with a comprehensive response.

In your reports you highlight that your matters of concern were as follows:

(1) The evidence at the inquest disclosed an ambiguity as to whether the SJUH maternity unit, officially a "Level 1" centre, was operating outside the parameters of that classification. That ambiguity was demonstrated by a witness (whose evidence was admitted in writing under R23 due to her poor health) who described it as a "Level 2" unit, and by a witness in person who described it as a "Level 1 and a half" unit, which last classification does not exist.

(2) The inquest heard oral evidence of amendments and updates to the LTHT risk register in the light of Benjamin's death. The purpose of including this issue as a matter of concern in this report is to give LTHT the opportunity to describe those amendments and updates in a detailed written response so that they may be fully understood.

We have considered the contents of your reports very carefully and our response is set out below.

1. Status of the Neonatal Unit at St James's University Hospital (SJUH)

SJUH is part of the Yorkshire & Humber Neonatal Operational Delivery Network (ODN), which comprises 19 hospitals across a geographical area extending from York to Chesterfield (north to south) and from Grimsby to the Pennines (east to west). The network includes a dedicated neonatal transport service – Embrace – responsible for transferring babies between hospitals. Within the network, four hospitals deliver most of the region's neonatal intensive care and are often referred to as Level 3 centres. Leeds General Infirmary (LGI) is one of these designated intensive care units. Several other hospitals within the network provide High Dependency care and are designated as Local Neonatal Units (LNUs) and often referred to as Level 2 centres. A smaller number are designated as Special Care Units (SCUs), focusing primarily on special care provision. These are often referred to as Level 1 centres.

SJUH is currently designated as a SCU i.e. a Level 1 centre but with added service specifications which have been agreed with the network. It is therefore termed as a "Special Care Unit plus" (SCU+), indicating that it operates under agreed service specification variations with the network. This includes delivery of non-invasive respiratory support and use of central lines. The delivery criteria are set as that of a SCU i.e. delivery at >32 weeks gestation only and >34 weeks gestation if multiple pregnancy.

The Trust is currently seeking formal redesignation of the SJUH unit as a LNU/Level 2 centre, in line with the national NHS England Neonatal Critical Care Service Specification. SJUH meets the required staffing levels and care standards for LNU/Level 2 designation, as set out in the NHS specification and based on recommendations from the British Association of Perinatal Medicine (BAPM).

To prevent any possible misunderstandings, staff at SJUH have been reminded of the unit's designation and the criteria it follows. Ongoing education and training on this topic will continue.

2. LTHT Risk Register

The Trust welcomes the opportunity to provide a comprehensive account of the amendments made to the risk register following Benjamin's death. The Trust's risk register is a core tool used across Clinical Service Units (CSUs) to identify, assess, and manage risks to patient safety and service delivery. The risk specific to neonatal services was recorded on the Trust's Datix system on 28 January 2014 and has remained under continuous review by both the CSU and the Trust's Risk Management Committee (RMC).

As of 15 November 2018, prior to Benjamin's death [redacted] the risk was scored at 8 and described as:

"Risk to service sustainability for neonatal services due to delayed centralisation of maternity and neonatal services resulting in increase in transfers between sites, short notice reduction in service provision, difficulty in covering staffing rotas and changes in protocols to mitigate risk."

Subsequently and particularly during 2022, pressures on service provision increased significantly due to a 50% reduction in the number of registrars available to contribute to the on-call rotas. In response, the Trust took the decision to reduce the number of cots at the LGI to mitigate this risk. While this aimed to stabilise staffing, it also had potential consequences for families and babies across the Yorkshire and Humber region. Several actions were initiated, including re-writing of training rotas, improved support for Advanced Nurse Practitioners (ANPs) through pay and banding enhancements, and Executive Director-approved variation orders for payment. There was a recognised need for additional investment in the consultant workforce, particularly while services continued to operate at both the SJUH and LGI sites.

At the time, these developments were also the subject of a serious incident investigation related to Benjamin's death, including a review of the service and cover provided at SJUH.

Clinical protocols were adjusted with the unit functioning as a SCU while all intensive care (ICU) and high dependency (HDU) activity was centralised to the L43 unit at LGI. The Trust introduced a joint maternity and neonatal clinical dashboard, reviewed at the Maternity Services Clinical Governance Forum, which helped monitor incidents and inform decision-making. Daily safety huddles between neonatal and maternity teams were introduced to proactively plan for high-risk births, alongside consultant-led cover where junior doctor gaps occurred. A protocol was also implemented to transfer sick neonates born at SJUH to LGI.

In view of the increased risk, the risk score was increased from 8 to 16 and on 22/11/2022 the risk description was updated to read as follows:

"Risk to service sustainability for neonatal services due to delayed centralisation of maternity and neonatal services resulting in increase in transfers between sites, short notice reduction in service provision, difficulty in covering staffing rotas and changes in protocols to mitigate risk. This is registered on the BtLW Programme Corporate Risk Register – Hospitals of the Future Project due to the risk that it will not be able to deliver its stated objectives and benefits, including recommendations from the statutory public consultation and commissioner requirements relating to the centralisation of maternity and neonatal services on one site…"

In efforts to mitigate the risks, in 2023, three new consultants were appointed (two in post, one pending), which improved staffing levels, although these gains were partially offset by reduced hours among existing consultants. A business case was submitted to increase the consultant workforce to 18 whole-time equivalents (WTE). This would enable the development of a dedicated weekend rota at SJUH and allow for 24-hour resident consultant cover at LGI, in accordance with the recommendations of BAPM. Despite recruitment progress, staffing levels remained insufficient, and the risk score remained unchanged at 16.

The risk description was updated again on 13 July 2023, to reflect the implications of cross-site working and weekend cover to:

"Risk to service sustainability for neonatal services due to delayed centralisation of maternity and neonatal services resulting in increase in transfers between sites, short notice reduction in service provision, difficultly in covering staffing rotas and changes in protocols to mitigate risk. The lack of centralisation has led to the necessity of cross city working for the consultant team meaning at weekends there is only one consultant available for cover for both units. This is against standards set out by BAPM (British Association of Perinatal Medicine). This is registered on the BtLW Programme Corporate Risk Register – Hospitals of the Future Project due to the risk that it will not be able to deliver its stated objectives and benefits, including recommendations from the statutory public consultation and commissioner requirements relating to the centralisation of maternity and neonatal services on one site, resulting in increases in transfers between sites, short notice reductions in service provision, and difficulties in covering staff rotas and changes in protocols to mitigate risks."

Throughout 2024, the approved business case supported the staged recruitment of consultants and ANPs. As of February 2024, recruitment was underway for an additional 2.7 WTE consultants, with a goal of reducing this requirement to 1 WTE from April onwards. By March 2024, 1.7 WTE had been appointed, along with two new ACPs scheduled to start in February and June 2024 respectively. Despite these efforts, full consultant recruitment was not achieved, and the risk remained active on the register.

In February 2025, it was agreed that centralisation of maternity and neonatal services would be placed on the Risk Management Committee (RMC) agenda for March. A review, led by the Children's and Women's Clinical Service Units, considered the Secretary of State's decisions on new hospital infrastructure alongside the Care Quality Commission (CQC) recommendations from recent inspections.

In March 2025, the RMC noted the alignment of this risk to Corporate Risk CRR07, which pertains to the delivery of the new hospital programme. The centralisation of services continued to be delayed, partly due to dependencies on national decisions and infrastructure investment. CQC inspections in late 2024 and early 2025 highlighted specific concerns regarding neonatal service designations and staffing at both LGI and SJUH. A Trust-wide review of the risk description, mitigation measures, and planning was agreed and included in the Trust's neonatal improvement plan.

In June 2025, the RMC received an update following the January 2025 CQC inspection. A new Executive-led group was established to review the neonatal care model and ensure safe, sustainable services at both sites, including appropriate clinical staffing. The Children's CSU committed to a full review of the risk, working alongside Specialist Commissioners and the ODN to clarify controls, identify ongoing gaps, and develop further mitigation strategies.

In light of the above mitigations, the risk score is currently 12 and on 23 July 2025, the risk description was updated to reflect the current concerns to:

"Risk to service sustainability for neonatal services due to delayed centralisation of maternity and neonatal services resulting in increase in transfers between sites, short

notice reduction in service provision, difficultly in covering staffing rotas and changes in protocols to mitigate risk. The lack of centralisation has led to the necessity of cross city working for the consultant team meaning at weekends there is only one consultant available for cover for both units. This is against standards set out by BAPM (British Association of Perinatal Medicine). At a recent inquest following an SUI at SJUH, the coroner raised as a matter of concern the delay in centralisation. As the medical workforce become more junior and less experienced due to changes in training, medical staff report feeling exposed and isolated at SJUH. Changes in the designation of SJUH to ensure tighter adherence to SCBU status has led to capacity concerns at LGI NNU."

As can be seen, the neonatal services risk register remains an active and evolving document. It is reviewed and updated regularly as part of the Trust's commitment to robust risk governance. Controls, mitigations, and scores are continually evaluated in response to workforce changes, infrastructure development, service reconfiguration, and external regulatory input.

We continue to work in close partnership with the ODN and Specialist Commissioners to support a co-ordinated, regionally consistent, and clinically safe model of neonatal care. The Trust remains committed to integrating learning from this case and implementing the recommendations from the Prevention of Future Deaths reports into our strategic plans to ensure the highest standards of care for neonates and their families.

Should you require any further information or documentation, we would be pleased to provide it.

Thank you for bringing these important matters to our attention.

Kind regards

Yours sincerely

Dr Magnus Harrison
Chief Medical Officer