From: Derek [REDACTED]

Date: 17 August 2018 at 21:43:04 BST

To: "Carroll, Emma" <REDACTED>

Cc: Tom Richford [and other addressees, addresses REDACTED]

Subject: Re: MRR1-5502219816

Emma, further to your email earlier it has prompted me to understand the regulations by which you work and I would like to share the following with you as I seek to understand more.

The regulation that would apply in our case would I believe be **Health and Social Care Act Regulation 12**

"The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm."

I would say that the Trust were in breach in the following ways –

- CTG scans were misinterpreted in April 2017 leading to the death of a neonate. 6 months later Sarah and Harry's CTG's were said to be misinterpreted by the midwives (3 of them) on the maternity ward but the ST3 doctor was said to be correct. This led to the care plan not being carried out. The RCA concluded that the ST3 doctor was correct. Later investigation from the Trusts independent advisor shows that the midwives were correct and the ST3 doctor was incorrect. **This would indicate that CTG scans are still not being read correctly even by the consultants that carried out the RCA. This is a Trust responsibility and led to unsafe care.**

- The overnight registrar was a locum doctor from an agency. He had never worked for the Trust before other than the previous two nights before Harry's case. It has been established and admitted that this doctor was not assessed by the Trust in any way and further admitted that no one clinical even saw his CV before he was allowed to operate as the onsite lead of O&G overnight. **This recruitment process allowed an unassessed doctor to carry out operations that, under ROCG rule 8 he was not entitled to do. This lack of basic care in recruitment was the responsibility of the Trust and led to unsafe care.**

- The resuscitation was poor in very many ways. The Trust's own independent review suggests that the resuscitation was so poor because there were too many inexperienced staff in place who were incapable of maintaining an airway and following basic resuscitation procedures. **This would indicate that the staff rostering, the responsibility of the Trust was substandard and that inadequate checks had been done leading to unsafe care.**

Clearly you will have looked carefully at all of these issues so I am somewhat concerned that you have concluded that the care offered by the Trust was safe and that all of the failings were individuals. Interestingly the RCA concludes that there are no individual failings just System failings. Imagine how it makes us all feel when the Trust say there are no individual failings and the CQC say it is all individual failings?

I have taken the opportunity to copy in Mr Ted Baker as I wish to highlight this case as one that I feel needs a second look.

Regards Derek

Fri 17/08/2018 16:21

Carroll, Emma [REDACTED]

Dear Mr Richford,

MRR1-5502219816

I wanted to email you with an update regarding our review of the specific incident involving the death of your Grandson, Harry.

We have held three management meetings to discuss the information shared by yourself and the trust, including the RCA, both independent reviews, the trust's action plan and additional information requested from the trust. We have not received confirmation from the senior coroner as to whether they will be progressing with an investigation. However, I have requested CQC are made an interested party which means we will receive the final Coroner's report.

After an extensive review, we do not believe there has been a breach in regulation. The concerns raised in this incident are centred on an individual's decision or error. The criminal offences CQC can prosecute against only apply to registered person failures. I understand from your emails, the GMC are using their powers to investigate this.

I understand the family may be disappointed at our decision, however the information you have provided will be used to plan future inspections at the trust and the trust's progress against their action plan in relation to this will be reviewed at our engagement meetings.

There has been recent inspection activity at the trust. You can sign up to get an email alert on East Kent University Hospitals NHS Foundation Trust at www.cqc.org.uk/content/our-email-alerts. If you subscribe to an alert, we will send you one email when we have inspected the service and another when we publish the resulting report.

Kind Regards Emma Carroll

Inspector

Care Quality Commission- South East Acute Hospitals Directorate

By post to:
CQC South
Citygate
Gallowgate Newcastle Upon Tyne NE1 4P