As promised, I am now providing a further update on the progress that has been made both in the expanded Terms of Reference and in appointing the remaining members of the Oversight Panel. In my last update I said having reflected on the views expressed to me by families and maternity and neonatal experts, I had taken the view that the scope of the clinical review of cases needed to be widened. Today I am releasing the expanded draft Terms of Reference {hyperlink} to parents and staff so that their views can be fully considered by the Oversight Panel before the Terms of Reference are finalised. A dedicated email address has been set up for this purpose and I would be grateful if views could be emailed to Review.SwanseaBayUHB@bevanbrittan.com by 10th May 2024. If you would welcome any support on how to give your feedback or want to discuss the Terms of Reference then Llais (the independent patient advocate body) are available to offer this support and can be contacted on

E : maternityexperience@llaiscymru.org
T: 01639 683490

I am also very pleased that following a robust interview process the following individuals have accepted appointments to the Oversight Panel:

- <redacted s40(2)> PEEPS HIE (Hypoxic Ischaemic Encephalopathy).

- <redacted s40(2)>, Consultant Obstetrician and Gynaecologist Kent Surrey & Sussex Patient Safety Collaborative. Brighton & Sussex University Hospitals NHS Trust.

- <redacted s40(2)> - Consultant Neonatologist, Chair of the Scottish perinatal network significant adverse event review group and the NHSE maternity and neonatal outcomes group.

- <redacted s40(2)>, Executive Clinical Nursing / Maternity Patient Safety Leader with over 15 years Executive Director Board Level Experience.

Those from a clinical background are all recognised experts in their respective fields and have all confirmed that they have no previous affiliation with the Health Board. <redacted s40(2)> of PEEPS HIE has agreed to join the Oversight Panel, bringing with her, her lived experience of HIE following the birth of her daughter Heidi in March 2015. The charity is focussed on raising awareness and support, ensuring the parent voice is heard.

Set out below is a biography for each member of the Oversight Panel which I hope provides reassurance to the families at the heart of this Review that over the coming months the Oversight Panel, which I chair, have the background and experience to provide the necessary scrutiny of the Review to ensure it delivers to its Terms of Reference and provide the answers that are sought.

Finally a flowchart can be accessed here {hyperlink} to illustrate and explain the structure of the Review.

Margaret Bowron KC.

<redacted s40(2)>, PEEPS H.I.E:

<redacted s40(2)> PEEPS HIE are a national charity who support anyone within the UK affected by a Hypoxic Ischaemic Encephalopathy event (H.I.E event). Peeps was set up in 2018 by <redacted s40(2)> and <redacted s40(2)>. The name came from friends who affectionately referred to their daughter <redacted s40(2)> as "<redacted s40(2)>". <redacted s40(2)> birth in March 2015 was complicated by an H.I.E event following which <redacted s40(2)> and <redacted s40(2)> felt there was a gap in support and awareness.

The Charity prides itself on collaboration, working together, supporting, sharing ideas, signposting with likeminded individuals and groups, to offer as much help and information as possible to those who may need it, raise awareness, and ensure the parent voice is heard.

Here are some of the people and organisations PEEPS HIE have worked with to date:

Baby Loss Awareness Alliance

Campaign for Safer Births

Council for Disabled Children

Little Journey

NHS Resolution Early Notification Maternity Voices Advisory Group

North West Neonatal Operational Delivery Network

Pregnancy & Baby Charities Network

Spoons Charity

Stick 'n' Step Charity

The Ockenden Independent Review into Maternity Services at the Nottingham University Hospitals NHS Trust

The team behind Peeps can be viewed here:
https://www.peeps-hie.org/meet-the-team/

<redacted s40(2)>:

<redacted s40(2)> I am the National Speciality Advisor for the Maternity and Neonatal Programme in NHS England. I have been working at national level since 2016 and have gained experience working with a range of stakeholders across the whole of the perinatal system. I have led and supported programmes of work that cover the development of the new national maternity early warning score tool and the national culture and leadership programme.

Previously I was the Director of the Patient Safety Collaborative in the KSS Academic Health Science Network for two years. Prior to this I have worked in a regional capacity on quality improvement for a number of years. From 2010 to 2014 I was the Associate Medical Director for Quality and Innovation at Brighton and Sussex University Hospitals NHS Trust. I have been working in the field of clinical effectiveness and quality improvement for over 25 years, and specifically within safety and quality for the last 15 years.

I am a clinician at heart and I have been a Consultant Obstetrician and Gynaecologist at University Hospitals Sussex in Brighton since 2003. I am one of several obstetricians providing high risk intrapartum care.

<redacted s40(2)>:

<redacted s40(2)> <redacted s40(2)> is a consultant neonatologist with 23 years' experience in NHS Lothian Edinburgh and previously Addenbrooke's hospital Cambridge and UCLH London. She has been a clinical director of obstetric and neonatal services in NHS England and Scotland and a neonatal network lead. <redacted s40(2)> has developed a body of experience in external service and safety reviews, perinatal adverse event review, management and improvement and is chairing the NHS England "reading the signals" maternity and neonatal outcomes group. She chairs the Scottish perinatal network adverse event review group following publication of the maternity and neonatal (perinatal) adverse event review process: guidance 2021. <redacted s40(2)> is a neonatal assessor for MBRRACE-UK confidential enquiries and is part of the NI DOH SAI redesign development group. Her specialty clinical interest is perinatal palliative care and is co-chairing the BAPM perinatal palliative care working group. <redacted s40(2)> co-wrote the stillbirth and neonatal death pathways for the Scottish National Bereavement Care Pathway. She is a tutor for the Effective Communication for Health (EC4H) training programme and is a trained mediator.

<redacted s40(2)>:

<redacted s40(2)> I am an Executive Clinical Nursing / Maternity Patient Safety Leader with over 15 years Executive Director Board Level Experience. This includes working for Providers, Commissioners, two Acute Trusts, a London Teaching Hospital and a recent national role for Patient Safety. I was also a Director Lead for the Early Notification Scheme (ENS) in maternity and the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. Previously I was the President of Royal College of Nursing (RCN) from July 2021 to December 2022.

I have significant experience of working at international, national and regional level within acute and community settings. My experience spans the fields of nursing, midwifery, education, governance, clinical risk and also on major change and reconfiguration initiatives. I hold a PhD and a Master's degree in Management and Social Care and have also achieved a Bachelor's degree along with a Higher Education Teaching qualification.

I have published a range of learning resources for maternity, just and learning culture and emergency care. I have also published a book in 2016 named "Effective Leadership – A Cure for the NHS?" and have contributed to a chapter dealing with Patient Safety for the "Clinical Negligence 6th Edition" which was published in 2023 (Powers & Barton).