Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Our Ref: PFD-1217773

Dr Karen Henderson
HM Assistant Coroner, Surrey
HM Coroner's Court
Station Approach
Woking GU22 7AP

21 May 2020

Dear Dr Henderson

Thank you for your letter of 20 April 2020 to Matt Hancock about the death of Theo Benjamin Young. I am replying as Minister with responsibility for patient safety and maternity.

Firstly, I would like to say how deeply sorry I am for the tragic death of baby Theo and for the failings in care detailed in your report. That Theo's death could have been avoided is extremely distressing and I offer my most heartfelt condolences to his parents and all those affected by his death. I am determined that we do all we can to learn from Theo's death to ensure the safety of health services and prevent such deaths from occurring again.

Your report raises important matters of concern in relation to the conduct by the Healthcare Safety Investigation Branch (HSIB) of investigations under its Maternity Investigation Programme, and specifically the investigation carried out into Theo's death.

It may be helpful if I explain that HSIB was established in April 2017 to conduct independent investigations of serious patient safety incidents in NHS-funded care across England, with a specific focus on system-wide learning and improvement. In 2018, HSIB's remit expanded to include the investigation of maternity incidents under qualifying criteria set out in legislation[1].

HSIB has dual accountability. HSIB reports to NHS England and NHS Improvement (NHSEI) on operational issues and to the Department of Health and Social Care on performance. Quarterly accountability meetings, that I chair bi-annually, monitor progress and review performance against agreed key performance indicators for HSIB's national and maternity investigation programmes.

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/702938/NHS_Trust_Development_Authority__HSIB__Directions_2018.pdf

In relation to HSIB's important work on the Maternity Investigation Programme, I am aware that investigation processes, such as obtaining family approval and accessing medical records, have affected the overall timescales, causing a backlog of reports. However, HSIB is taking measures to improve performance, including the adaptation of some investigation processes and additional support from clinical advisors and I am advised the backlog is reducing.

My officials, together with NHSEI, have considered the concerns in your report carefully and assurance has been sought from HSIB of the processes in place for maternity investigations, as well as its conduct of the investigation into the death of Theo Young.

I agree with you that it is vitally important that learnings are identified and shared as quickly as possible. As HSIB has explained in its response to your report, it recognises the vital importance of rapid learning, with opportunities within the investigation process for Trusts to identify and address immediate safety risks. For example:

- NHS trusts are advised to complete rapid 72-hour reviews to enable the identification and mitigation of immediate safety risks;

- HSIB investigators escalate immediate safety risks where they are identified to senior Trust management and seek assurance that they are addressed; and,

- HSIB investigators provide regular written updates on investigations to Heads of Midwifery. In addition, roundtable reviews and quarterly thematic reviews are held with Trusts that have active HSIB investigations to share learning from HSIB's wider Maternity Investigation Programme.

HSIB advises that its investigation into Theo's death provided the Surrey and Sussex Healthcare NHS Trust with opportunities to identify and address immediate safety risks in its maternity services.

You may also wish to note that NHS Trusts are expected to identify learnings in cases of stillbirth or neonatal death through use of the National Perinatal Mortality Review Tool.

As accepted by HSIB, the length of time it took to conclude the investigation into Theo Young's death exceeded the expected timeframe. I note that this was one of the first investigations conducted by HSIB under its Maternity Investigation Programme. Since then, HSIB has made changes to its investigation methodology and processes to enable them to share early learning with Trusts.

HSIB has also confirmed that, through ongoing communication with the Trust, it provided opportunities for safety information to be shared and acted upon as the investigation into Theo's death progressed.

In relation to the quality of the investigation by HSIB of Theo's death, HSIB advises that this was conducted in line with the statutory Directions and disputes that inaccuracies were due to error on its part.

I am advised that HSIB's investigation into the death of Theo Young made six recommendations to the Surrey and Sussex Healthcare NHS Trust and I expect the Trust to take the necessary action to ensure these are addressed, as well as reflect on the findings of your investigation.

Finally, I wish to take the opportunity to emphasise the important work underway nationally to improve the safety of maternity services.

The Government's Maternity Ambition is to halve the 2010 rate of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring during or soon after birth by 2025. The ambition also includes reducing the rate of pre-terms births from eight to six per cent. The NHS Long-Term Plan includes new measures to improve safety, quality and continuity of care that will help achieve our Maternity Ambition. This includes every maternity service in the NHS in England actively implementing elements of the Saving Babies' Lives Care Bundle which comprises key aspects of care such as, reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; effective fetal monitoring during labour and reducing preterm birth.

I hope this reply is helpful. Thank you for bringing these concerns to my attention.

NADINE DORRIES