Department of Health

From Jackie Doyle Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

39 Victoria St
London
SW1H 0EU

020 7210 4850

Ms Alison Mutch OBE
HM Senior Coroner Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Our reference: PFD 1122493

25 April 2018

Dear Ms Mutch,

Thank you for your letter of 1 March to the Secretary of State for Health and Social Care about the death of George Edward French-Russell. I am responding as Minister with responsibility for maternity care.

Your report raises several areas of concern which are operational and for the NHS Trusts involved to address.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care.

My officials have made enquiries and I am assured the East Midlands Ambulance Service NHS Trust and the Stockport NHS Foundation Trust are taking steps to make improvements in response to this tragic death. I understand the Trusts are responding to you with details of the action taken and I will not repeat that information here. However, I am encouraged that both organisations are working together to share learning from this incident.

You may wish to be aware that the National Institute for Health and Clinical Excellence (NICE) published a guideline on Preterm labour and birth[1] in November 2015. The guideline covers the care of women at increased risk of,

[1] https://www.nice.org.uk/guidance/ng25

or with, symptoms and signs of preterm labour (before 37 weeks) and women having a planned preterm birth.

This guidance recommends that women presenting with symptoms of preterm labour should be offered a clinical assessment (NG25, 1.7.2 *Diagnosing preterm labour for women with intact membranes*), which regrettably, does not appear to have been offered in this case.

You may be interested to know that NICE is currently developing a guideline on Intrapartum care for high risk women, which is expected to be published in March 2019. The guideline will be considering the optimal mode of birth (emergency caesarean section or continuation of labour) for women with breeching presenting in the first or second stage of labour.

The death of a baby is a devastating tragedy and we must do all we can to make the NHS the safest place in the world to give birth.

In November 2017, we launched *Safer Maternity Care: progress and next steps*[2], which set out progress against the delivery of the national maternity ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth by 2025. To make sure progress is made quickly, we also set out an expectation of a 20 percent reduction by 2020.

Safer Maternity Care sets out a number of steps to make sure we are doing all we can to prevent serious incidents in maternity services. This includes developing the role of the Healthcare Safety Investigation Branch[3] (HSIB) to standardise investigations of cases of severe brain injury, intrapartum stillbirths, early neonatal deaths and maternal deaths in England so that the NHS learns as quickly as possible from what went wrong and shares this learning as widely as possible to prevent future tragedies.

As well as providing comprehensive final reports for each case it investigates, the HSIB will publish themed reports drawing together overarching themes and points of learning from multiple investigations and making appropriate recommendations for system bodies to act on these findings.

---

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

[3] https://www.hsib.org.uk/

Department of Health

The new investigative approach will begin in a single region from April 2018 and will continue to roll out to all areas of England by April 2019. When fully rolled out, the HSIB will investigate around 1,000 cases a year with the expectation that the learning from investigations will spur system improvements leading to fewer deaths and injuries in the future.

I am aware that the HSIB has responded to you to advise that, as this incident occurred before its establishment on 1 April 2017, it does not meet the criteria for investigation. Nevertheless, the information provided will assist the HSIB develop a wider picture of safety issues in the NHS and help inform future investigations.

I hope this offers assurance that we are committed to learning from deaths and taking action to prevent future tragedies in maternity care.

Thank you for bringing the circumstances of George's death to our attention.

JACKIE DOYLE-PRICE