HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

22 May 2020

HEALTHCARE SAFETY INVESTIGATION BRANCH
HSIB, A1
Cody Technology Park
Farnborough
Hampshire

Dr Karen Henderson
HM Assistant Coroner for Surrey
Station Approach
Woking
Surrey GU22 7AP

Dear Dr Henderson,

RE: Matters of Concern regarding HSIB in *The Inquest Touching the Death of Theo Benjamin Young: A Regulation 28 Report – Action to Prevent Future Deaths*

Thank you for your report *The Inquest Touching the Death of Theo Benjamin Young: A Regulation 28 Report – Action to Prevent Future Deaths* which I received from your office by email on 20 April.

Within it you have raised several Matters of Concern pertaining to the Healthcare Safety Investigation Branch (HSIB), requesting that we provide a response to you that contains details of action taken or proposed to be taken, setting out the timetable for such action, or explanation of why no action is proposed.

I appreciate the opportunity for HSIB to respond to your concerns and explain our processes for addressing safety risks identified during HSIB maternity investigations, both in general and with respect to our investigation into the neonatal death of baby Theo. We have thoroughly reviewed all our records and evidence collected by our investigation team during the investigation, providing a comprehensive explanation and clarification for each of the three concerns you have raised.

Matter of Concern 1

"The HSIB specifically requested the Trust not to undertake their own investigation effectively preventing the recognition of causes of concern and therefore being unable to undertake any immediate and necessary remedial action at the earliest opportunity to prevent future deaths".

HSIB response

HSIB places utmost importance on the need to ensure that rapid learning takes place for cases that fall within the eligibility criteria of HSIB's maternity investigation programme. There are several stages throughout HSIB investigations where the opportunity for identifying and addressing safety risks is provided to trusts, and these were implemented during the investigation of baby Theo's death.

1. It is HSIB policy that all NHS trusts are advised to complete 72-hour reports for cases that are referred as eligible for investigation. The purpose of this is to ensure that trusts can readily identify immediate safety concerns and take necessary actions while they await the commencement and outcome of HSIB's more in-depth reviews. Trusts are not mandated to share their 72-hour reports, but many share them with HSIB voluntarily.

This enables HSIB to compare the Trust's and our investigation's early findings so that any areas for concern may be highlighted. With respect to baby Theo's investigation, the Surrey and Sussex Healthcare NHS Trust ('SaSH Trust') undertook a 72-hour review, but they declined to share this review with HSIB. Following ongoing engagement with the senior management team at SaSH Trust, they now share their 72-hour reports with HSIB on request.

2. To further support trusts with rapidly addressing safety risks in their maternity services, HSIB investigators also immediately escalate any safety concerns uncovered during the investigation process to the Head of Midwifery and Clinical Director. This case was discussed at our clinical panel at the outset of the investigation, which identified key lines of enquiry, but the panel did not identify any preliminary findings which suggested an immediate risk to patient safety. Through our regular engagement processes, we ensure that prompt actions are taken by trusts in response to any matters raised through early escalation. Fortnightly written updates are sent to all Trust Heads of Midwifery to provide updates on the progress of HSIB's local investigations and to seek support with addressing any barriers to progress. These fortnightly updates are specific to each local trust and detail the progress of all investigations relating to that trust.

3. HSIB held a roundtable review with SaSH Trust on 10 January 2019 which included a discussion of baby Theo's case. A summary letter was sent to the Head of Midwifery on the same day and outlined HSIB's concerns relating to staffing, escalation, interpretation services and debriefing.

4. Quarterly thematic reviews are also held with each trust where there are active investigations to share learning accruing from HSIB's maternity investigations across the country, alongside identifying themes for each organisation where there are particular areas of concern. HSIB held quarterly review meetings with SaSH Trust on 10 May 2019, 6 September 2019 and 6 December 2019.

Through these processes, HSIB provided sufficient, appropriate and timely information to support SaSH Trust's early learning activity from baby Theo's death.

In terms of the role of HSIB's maternity investigations, the DHSC Safer Maternity Report 2017 referenced HSIB maternity investigations, stating that,

"These investigations will be the primary and, as far as possible, the only investigation of the individual case and may be informed if appropriate by tools that local providers will be using such as the Standardised Perinatal Mortality Review Tool for perinatal deaths. This will ensure consistency for all 'Each Baby Counts' cases nationally and avoid duplication and unnecessary complexity for families."

Matter of Concern 2

"HSIB indicated to the Trust at the outset that their investigation would take approximately six months which is highly likely to delay the introduction of any immediate necessary measures by the Trust to prevent further deaths".

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HSIB response

The timescale to produce HSIB reports is set in paragraph 4(1) of the HSIB Maternity Directions 2018[1] as follows:

> *HSIB must, within a reasonable period of time, produce a report on the matters set out in sub-paragraph 3(2) and, as far as reasonably practicable, such period should not exceed six months from the date on which the qualifying maternity case in question was referred to it*

The timeline in this particular case is set out below:

25/05/18	Incident date
12/06/18	Referral date
9/10/18	Draft report submitted for QA
15/02/19	Date draft report shared with trust
28/02/19	Trust response returned
8/03/19	Shared with the family and amendments made
08/03/19-17/05/19	Reviewed with family on three separate occasions, and shared with members of staff, further comments addressed
17/05/19	Final Trust amendments received and actioned
28/06/19	Final report completed and signed off

This report did exceed our target timescale; however, HSIB communicated regularly with SaSH Trust and the family during the investigation process and provided the Trust with relevant safety information. This is a standard process in our investigations as detailed in the response above and enables trusts to introduce any immediately necessary measures to prevent future deaths before the sharing of our report.

This was one of the first investigations of the HSIB Maternity Programme and many of the processes and systems had yet to mature. The HSIB has taken on board the feedback and is assured that the continuous development since this investigation has led to more rapid investigation times whilst maintaining the quality and communication with trusts and families.

[1] The National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) (Additional Investigatory Functions in respect of Maternity Cases) 2018

Matter of Concern 3

"The initial draft report contained factual errors and inaccuracies requiring considerable input by the Trust to resolve. The final report is insufficiently detailed and was completed 18 months after the death, during which time further deaths could have resulted".

HSIB response

HSIB consider that the report provides detailed reflection of the investigation that was undertaken. Evidence was collated from the medical records, Trust guidelines and policies and interviews with the family and staff (as outlined as requirements in paragraph 3 (3) of the HSIB Maternity Directions 2018).

The final report established the facts, having reviewed the sequence of events and contributory factors that led to the outcome for this baby, taking into consideration specific concerns raised by the family. The final report had six safety recommendations which were aligned to current best practice. HSIB were able to make these recommendations based on the information provided during the investigation.

HSIB's quality assurance process involves sharing the draft investigation report with the Trust and family for their comment on factual accuracy. With regard to baby Theo's death, SaSH Trust made seven references to content being 'factually incorrect'. Following HSIB's review of the investigation evidence, only two of SaSH Trust's factual accuracy submissions were found to be correct and these were due to information not being made available by the Trust to the investigation team at the time.

A draft version of the report was shared with SaSH Trust 8 months after referral. The Trust returned the draft 13 days later with suggested amendments. Between 08/03/19 and 17/05/19 (10 weeks) the Trust continued to review the report and returned further amendments on 17/05/19. The final version of the HSIB investigation report was shared with the family and SaSH Trust 14 months after Theo's death, not 18 months as stated. The ongoing communication processes between HSIB and the Trust during that time were designed to ensure that opportunities for identifying and addressing safety risks were not missed. Since this investigation, the HSIB are not aware of cases with similar themes repeated within this Trust.

I trust this response provides you with explanations and assurance about HSIB's investigation and report production processes, and our commitment to reducing patient safety risk in NHS maternity services.

Your sincerely

[REDACTED]
Chief Investigator

[REDACTED]
PA to [REDACTED] [REDACTED] | [REDACTED]