



39 Victoria Street London SW1H 0EU

Our Ref: PFD - 1401273

Alison Mutch
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

29th July 2022

Dear Ms Mutch,

Thank you for your letter of 6 April 2022 about the death of Oliver Lindsay. I am replying as Minister with responsibility for Primary Care and Patient Safety.

Firstly, I would like to say how deeply sorry I was to read the circumstances of Oliver Lindsey's death and I offer my most heartfelt condolences to his family. We must do all we can to ensure such failings in care do not occur again. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, my officials made enquiries with NHS England and NHS Improvement, as well as the Care Quality Commission.

You may wish to know that since this incident occurred, NHSEI (in collaboration with national maternity and neonatal partner organisations including Royal Colleges, Neonatal Critical Care CRG, HSIB, NMC and NHS Resolution) have published on 17th December 2020 a framework to address known variation in training and competency assessment to ensure that training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service – this is the Core Competency Framework¹. There are 8 priority areas, which are also are set out in Safety Action 8 of the Maternity Incentive Scheme².

Included in the core competency modules is training for maternity staff on implementation of the Saving Babies Lives Care Bundle Version 2, which includes monitoring fetal growth restriction, with links to the national e-learning for health training modules. Full implementation of the Care bundle is expected of all maternity care providers, and this is monitored via Safety Action 6 of the Maternity Incentive Scheme.

¹ https://www.england.nhs.uk/wp-content/uploads/2020/12/core-competency-framework.pdf

² https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fresolution.nhs.uk%2Fwp-content%2Fuploads%2F2020%2F02%2FMaternity-Incentive-Scheme-year-three-guidance.docx&wdOrigin=BROWSELINK

Element 2 of the Saving Babies Lives' Care Bundle Version 2: *Risk assessment and management of babies at risk of fetal growth restriction*, seeks to identify all babies at risk. The element recognises that there is a range of expert opinions on some interventions and allows flexibility in the choice of pathways. It therefore advocates personalised, safe care and choice for all women.

My officials have informed me that NHSEI are in the process of updating the Care Bundle and have service user representation on their related Steering Group. It is expected that the maternity systems should be ready to implement this on publication later this year. As part of the review the intention is to update the Care Bundle with the latest evidence based research including RCOG Green Top Guidance for management of Fetal Growth Restriction (FGR) (which is to be published imminently) and information for women and pregnant people which will seek to address the issues raised from your report in relation to risks associated with FGR.

With regard to the health and care system, you may wish to know that since the NHS Long Term Plan was published, the NHS has made significant progress in making maternity care safer and more personalised in England. According to the Office for National Statistics, the stillbirth rate in 2020 has reduced to 3.8 per 1000 births, and the neonatal mortality rate, for births at 24 weeks gestation and above, has reduced to 1.3 per 1000 live births. This is ahead of our 20% reduction target from 2010 levels, at 25.2% and 36% respectively. This has been achieved in large part through implementation of the initiatives set out in the Long Term Plan, including rollout of the Saving Babies' Lives Care Bundle (including new preterm birth clinics), providing continuity of carer, and investment in additional neonatal nurses.

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

Yours sincerely,



JAMES MORRIS MP
PARLIAMENTARY UNDER SECRETARY OF STATE FOR PRIMARY CARE AND
PATIENT SAFETY