From: minh alexander <REDACTED>
Subject: HSIB and the death of Baby Theo Benjamin Young Coroner's PFD 0094 2020
Date: 24 April 2023 at 08:38:06 BST
To: REDACTED
Cc: REDACTED

BY EMAIL

Professor Ted Baker
Chair of Healthcare Safety Investigation Branch

24 April 2023

Dear Ted,

Forgive me for writing again so soon.

I realised there was a matter that I had omitted from my information request,

May I please re-submit my information request as follows:

Request for information

May I ask:

1) What data is HSIB collating on investigation timeliness beyond the overall six month completion date?

In particular, is HSIB tracking how soon it is interviewing and statements from clinical staff involved in maternity safety incidents?

Please provide the details of data that is collated on maternity investigation timeliness.

2) Did HSIB receive complaints about the conduct of its officers with respect to the case of baby Theo Young, with regards to the relationship with Surrey and Sussex Healthcare NHS Trust and/or with regards to the Coroner's inquest and Office?

3) Have any of HSIB's formal letters of concern to NHS Trusts, arising from maternity safety invesigations, raised issues of unauthorised changes to medical records/ tampering with medical records?

If HSIB has identified any such issues, how many NHS trusts did this relate to?

Did HSIB consider that any such alterations to medical records were unlawful or were likely to be unlawful?

Best wishes,

Minh

Dr Minh Alexander

From: Minh Alexander < REDACTED >
Subject: HSIB and the death of Baby Theo Benjamin Young Coroner's PFD 0094 2020
Date: 23 April 2023 at 12:53:31 BST
To: REDACTED
Cc: REDACTED

BY EMAIL

Professor Ted Baker
Chair of Healthcare Safety Investigation Branch

23 April 2023

Dear Ted,

HSIB and the death of Baby Theo Benjamin Young Coroner's PFD 0094 2020

I write to enquire seek clarity about a matter that arose from the Coroner's criticism of HSIB's actions in this case.

The coroner criticised the fact that HSIB instructed the NHS trust not to conduct its own local investigation of baby Theo Young's death, and that then HSIB breached its six month investigation timescale by a factor of three, taking eighteen months, producing a final report that was sub-standard, during which time further deaths could have occurred.

The coroner issued a Prevention of Future Deaths report which focussed solely on HSIB's failings:

https://www.judiciary.uk/prevention-of-future-death-reports/theo-young/

"The MATTERS OF CONCERN are in relation to the role of the HSIB in their conduct, investigation and conclusion:

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.

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.

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."

The coroner added in the PFD notice that she had other concerns about HSIB:

"Other matters were brought to the attention of the court outside of PFD matters which raise considerable concern as to the role and actions of HSIB which I will deal with in a letter to them in due course and will be shared with other relevant bodies."

The NHS trust's response to the Coroner agreed with the issues about the investigation of baby Theo Young's death:

"In the Regulation 28 Report you raised specific concerns regarding the role of HSIB in their conduct, investigation and conclusion. We agree that the requirement of HSIB not to undertake our own investigation could have prevented the timely undertaking of remedial action. In fact, as we have described, the Trust did formulate and complete an action plan long before the HSIB report was finalised. If we had not done this and instead waited for more than a year for the final report then potentially more babies could have been at risk. Our concern would be the potential response of other organisations to a request like this from HSIB. In addition, the request from HSIB for the Trust not to collect statements from the staff involved in the incident seems wrong in our view. It is self-evident that compiling contemporaneous records of what happened will be more accurate than relying on individual memories of the incident some months later."

Keith Conradi the then HSIB Chief Investigator responded to the Coroner's PFD and did not appear to accept the Coroner's criticism that HSIB had instructed the trust not to conduct a local investigation. Mr Conradi cited the fact that:

"It is HSIB policy that all NHS trusts are advised to complete 72-hour reports for cases that are referred as eligible for investigation"

and he asserted to the coroner that the trust carried out a 72 hour review but declined to share the findings with HSIB.

Mr Conradi also drew the Coroner's attention to HSIB's processes for periodically liaising with NHS trusts during its investigations to share information, although this did not directly address some of the concerns raised, such as the trust's point about staff statements not being taken soon after an incident whilst recollections are fresh.

Clearly there was a conflict between the trust's claims and HSIB's claims, and I note that the coroner had some undisclosed concerns about HSIB.

When HSIB was approached by the Health Service Journal for an article which was published on 21 May 2020, HSIB commented:

"We have now improved and taken on board feedback about our processes, which has led to more rapid investigation times".

Request for information

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2) Did HSIB receive complaints about the conduct of its officers with respect to the case of baby Theo Young, with regards to the relationship with Surrey and Sussex Healthcare NHS Trust and/or with regards to the Coroner's inquest and Office?

Please disclose if this was so, and the broad details.

Many thanks and best wishes,

Minh

Dr Minh Alexander

Cc Dr Rosie Benneyworth Interim Chief Investigator HSIB