HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

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HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) MATERNITY INVESTIGATIONS

Trust Introduction Pack

INTRODUCTION AND BACKGROUND TO HSIB

The Healthcare Safety Investigation Branch (HSIB) was established by an expert advisory group following recommendations from a government inquiry into clinical incident investigations. HSIB became operational on 1 April 2017. Our purpose is to conduct effective investigations, and by sharing what we learn, improve patient safety, raise standards, and support learning across the healthcare system in England.

We are funded by the Department of Health and Social Care and hosted by NHS Improvement. We are independent of both, and of other NHS organisations and the Care Quality Commission (CQC).

HSIB national investigations are carried out by our experienced team, led by a chief investigator. The team have specialist skills and expertise, and come from different investigation backgrounds including health, aviation and the military. Our investigators oversee the process from start to finish, and work closely with key people and organisations throughout the investigation. HSIB also work with independent subject matter experts to gain critical and distinct perspectives during investigations.

MATERNITY INVESTIGATIONS BACKGROUND

In November 2017 the Health Secretary launched further initiatives to improve safety in maternity care in the form of The Maternity Strategy, Next Steps 2017. This led to the setting up of the Maternity Investigation Team at HSIB which began operating in April 2018.

We will conduct quality maternity investigations for all incidents that fit the criteria of the Each Baby Counts* programme and also any maternal deaths within 42 days of birth. This will not include suicide or homicide.

Our maternity investigations will replace the Trust investigations in these cases. If the incident meets the criteria of a Serious Incident (SI) in accordance with the Serious Incident Framework (2015) the Trust is still responsible for the Duty of Candor, 72 hour report and reporting to the Strategic Executive Information System (StEIS).

In addition, the incident should be reported to Each Baby Counts and NHS Resolution – Early Notification Scheme where required. Where cases meet the criteria for reporting to the Perinatal Mortality Review Tool (PMRT), this will be completed by the trust and HSIB once the investigation is complete. We will work with women and their families, the maternity teams who care for them and the risk and safety teams at the trust.

OUR HSIB MATERNITY TEAM

The HSIB team includes multi-disciplinary professionals who all have investigation experience. This expertise is being further developed through our tailored investigation training programme. The wider maternity investigation team includes clinical experts in obstetrics, neonatology, anaesthetics and midwives. As with all our investigations, we bring in specific subject matter experts when needed.

THE INVESTIGATIONS

Why is HSIB carrying out maternity Investigations?

We were instructed by parliament to carry out maternity investigations as part of a national strategy to improve maternity safety.

What is the criteria for a maternity investigation?

These investigations may be classified as a Serious Incident (SI) but the type of classification is not the defining factor.

Our criteria includes:

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6) days of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- Was therapeutically cooled (active cooling only); or
- Had decreased central tone and was comatose, and had seizures of any kind.

In line with our directions we do not investigate neonatal cases where the mother has not laboured. For example, a caesarean section which was performed before the mother had started contracting or ruptured her membranes.

* www.rcog.org.uk/eachbabycounts

Maternal deaths: Direct or indirect maternal deaths (during labour or within forty two days of the end of pregnancy).

Direct deaths include those resulting from obstetric complications of the pregnant state (pregnancy, labour and postpartum), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

Indirect deaths include those from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

We may investigate some maternal deaths which do not entirely fit within the two above categories. For example coincidental may be investigated following discussion with MBRRACE.

Our directions exclude the investigation of cases where suicide or homicide was the cause of death.

Host organisations should continue to investigate SI maternity events outside the specified criteria.

How are maternity incident referrals made to HSIB?

Referrals from all NHS trusts are made via the Maternity Investigation Database and Support System (MIDAS), the details and instructions for the use of this system will be provided by HSIB. It is recommended that three members of staff are registered to use this portal.

How is a maternity investigation undertaken?

The investigators work in partnership with the host Trust to understand the clinical environment, explore staff perception of events by conducting interviews, reviewing patient notes and by considering all other relevant evidence. Our investigators will conduct thorough, independent and impartial investigations. We also work with clinical advisors and subject matter advisors within particular specialisms as required for the case to make sure we produce a factual and accurate investigation. We aim to complete the investigations within a reasonable timeframe not exceeding six months in accordance with our Directions. However where possible we would be aiming to achieve our investigations in line with the current incident investigation framework.

How families are involved in HSIB investigations?

We involve the family throughout the investigation. Once a referral has been made, the Trust will provide the family with some initial information explaining who we are and what will happen next. HSIB investigators will contact the family to assess how they want to be involved.

Are individual staff required to engage with HSIB investigation?

Yes, individual staff are obliged, as per their professional code of conduct, to engage in an investigation. If staff are asked to attend an interview they are welcome to bring someone for support. Staff interviews help establish the facts about the incident. Supporting staff is a priority. We make sure staff are fully informed of their legal obligations, the legal environment in which HSIB operates, and how this aligns with their professional responsibilities within an investigation.

Who has ownership of recommendations?

Safety recommendations made in HSIB reports are discussed and agreed with those responsible for implementing them, prior to being placed in the final report. The report will also contain HSIB findings that relate to issues identified that do not directly contribute to the investigation findings. Our reports will also reflect immediate actions taken to provide safer care and highlight where innovative and proactive approaches have led to improvements in maternity services.

How wider learning is shared?

HSIB analyse the findings of the investigation reports and safety recommendations to identify any recurring themes. We may then use our national teams to investigate these themes further. We share the recommendations with regulators who can monitor implementation as part of their regulatory inspections.

Can we comment on the final report before it's published?

We will send you a copy of the draft investigation report initially for the Trust to comment on for factual accuracy and ask you to share with staff involved in the incident, prior to sharing with the family. We will then share the working draft report with the family for comment. We will ask the Trust to coordinate comments from themselves and the staff involved, and share requested changes by both the Trust and the family with all parties involved.

Who sees the final report?

The final reports are anonymised and shared with you, the staff involved, the family and other relevant organisations. In addition, key areas of learning will be published on our website.

Do providers still complete the Perinatal Mortality Review Tool (PMRT), if the incident is referred to HSIB?

Yes. The Perinatal Mortality Review Tool (PMRT) remains the responsibility of the Trust, who register the baby on the system at the time of the incident, however it will be completed jointly with HSIB on completion of the investigation.

The Trust will also be responsible for providing data for other portals, such as the Each Baby Counts, NHS Resolution, MBRRACE and StEIS if an SI.

When a referral is made to HSIB, there are specific actions required of the Trust. The actions are detailed on the ***'What to do now?'*** card in the Trust information pack. Reference to this card is included in the electronic immediate response received by the Trust on completion of the referral. It is essential for certain evidence to be collected to facilitate a complete and thorough investigation and these actions make certain this occurs.

FIND OUT MORE

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