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27 March 2017

[redacted]

By email

[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **27 February 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority, as part of the integrated organisation known as NHS Improvement.

Your request

You made the following request:

Under the Freedom of Information Act,

Could you please disclose from information you hold from the NRLS:

a) The number of birth-related traumas that have resulted in an infant brain injury from 1/1/2015 1/1/2017 in England and Wales - giving a month by month breakdown and name of hospital where incident occurred.

b) The nature of the injury - ie bleed on brain, brain haemorrhage, ischemic or hypoxic - whether surgery was required and the number of deaths.

c) Details of the cause of the injury - ie forceps delivery, stuck in birth canal

d) The number of compensation claims and where necessary the individual amounts paid out - along with details of the individual case

Interpretation of the term 'birth trauma'

For the purposes of this analysis the term 'birth trauma' has been interpreted to mean any physical wound or injury to an infant during the birth process. Analysis therefore excludes patient safety reports where it was evident that antenatal (prior to the onset of labour) or postnatal (the period following delivery) injury had occurred e.g. antenatal haemorrhage leading to hypoxic brain injury or postnatal collapse leading to hypoxia.

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Decision

NHS Improvement holds some of the information that you have requested and can provide full data for part a) of your request only. We are not able to provide all of the data requested in parts b) and c) as the National Reporting and Learning System (NRLS) does not systematically record details about the outcome of brain injury related birth traumas. Implementation of post birth interventions to reduce babies risk of brain injury (e.g. therapeutic hypothermia or 'cooling') and other factors mean that outcomes will frequently only become apparent much later and often several years after the event.

Please note that the NRLS only contains information about those cases of birth trauma that have been reported as patient safety incidents and not necessarily all that have occurred.

For part d) of your request, we do not hold this information and can advise that the NHS Litigation Authority would be the organisation to contact in this regard.

The information we hold on birth-related traumas is from the NRLS. By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

A search of the NRLS was carried out on 15 March 2017 of all incidents reported as occurring between 1 January 2015 to 31 December 2016, uploaded to the NRLS by 13 March 2017 and where the free text description of the incident contained 'Infant brain injuries'-related terms including misspellings. Whilst we have chosen key word searches in good faith as most likely to identify requested incidents we cannot guarantee that there are not additional relevant incidents that an alternative keyword search strategy might have found.

I can inform you that as a result of this search, 242 patient safety incident reports were identified that contained the selected search terms relating to 'infant brain injury'. These incidents were clinically reviewed to determine relevance to your request and following review we can advise that nine reports have been identified as relevant.

Please see table 1 below which provides a breakdown of the incidents by month and name of the hospital where incident occurred.

Response to question a): the number of birth-related traumas that have resulted in an infant brain injury from 1/1/2015 1/1/2017 in England and Wales - giving a month by month breakdown and name of hospital where incident occurred.

Table 1: Relevant incidents by month and hospital

Incident	Month	Year	Hospital
1	May	2015	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS TRUST
2	March	2016	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
3	April	2016	EAST SUSSEX HEALTHCARE NHS TRUST
4	May	2016	THE ROTHERHAM NHS FOUNDATION TRUST
5	June	2016	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
6	June	2016	TAUNTON AND SOMERSET NHS FOUNDATION TRUST
7	July	2016	UNIVERSITY HOSPITALS SOUTHAMPTON NHS FOUNDATION TRUST
8	September	2016	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
9	October	2016	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

Response to question b): The nature of the injury - ie bleed on brain, brain haemorrhage, ischemic or hypoxic - whether surgery was required and the number of deaths.

The nature of the injuries was:

- five incidents stated the nature of the injury as hypoxic brain injury
- one incident described brain injury as a result of a significant and rare in utero fetal/maternal haemorrhage. Timing of the bleed was uncertain
- one incident described brain injury due to likely metabolic cause
- two incidents referred to abnormal neurology/encephalopathy (this can be any level of altered brain function – mild to severe) but where the exact nature was unspecified

Please note that the need for surgery was not detailed in any reports, and that where an outcome was recorded, four neonatal deaths were reported.

Response to question c): details of the cause of the injury - ie forceps delivery, stuck in birth canal:

- There were no cases where the incident report stated that the brain injury described was as a result of mechanical trauma (e.g. forceps) or where babies whose delivery was delayed due to obstructed labour.
- The cause of the injury was unclear in eight of the nine cases where the baby was delivered unexpectedly in poor condition. In four of these cases the baby was found to have significant underlying morbidity.
- In one case the cause was asserted by an outside source as being due to delayed delivery.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement