Ministry of Justice

Lord (David) Wolfson of Tredegar, QC
Parliamentary Under-Secretary of State

Lord Hunt of Kings Heath
House of Lords
London
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22 November 2021

Dear Lord Hunt,

PRISONS AND PROBATION OMBUDSMAN (PPO) INVESTIGATION INTO THE DEATH OF BABY A – HEALTH RESPONSE AND PARTNERSHIP APPROACH

I undertook to write to you following the recent Committee debate on amendments 212 and 213 to the Police, Crime, Sentencing and Courts Bill (PCSC) regarding the response we had received from NHS England and NHS Improvement (NHSE/I) to the PPO's investigation into the tragic death of Baby A at HMP Bronzefield.

This was a tragic event and I am determined that contracted providers, the Ministry of Justice (MoJ), HM Prison and Probation Service (HMPPS), and NHSE/I work together to prevent this happening again. Minister Atkins recently met with Minister Keegan, Minister of State for Care and Mental Health in the Department for Health and Social Care (DHSC), to discuss our departments' ongoing commitment to a partnership approach to reforming the care and support available to pregnant women in prisons, and the learning from the Baby A incident and investigations specifically.

We implemented a range of immediate steps locally with the private sector operator, Sodexo, at HMP Bronzefield, prior to the PPO investigation, to safeguard women and children. These included a review of commissioning arrangements for maternity services at HMP Bronzefield, in consultation with NHSE/I, and an investment of £120,000 for an improved maternity service at the prison concerned to be delivered by Ashford and St Peter's Hospitals NHS Trust.

The eighteen recommendations made by the PPO have been accepted. Additionally, NHSE/I and HMPPS have provided the PPO with a joint action plan which sets out the steps we have taken locally, and nationally where appropriate, to address the recommendations and ensure holistic improvements in the care we are providing to pregnant women. In partnership, NHSE/I and HMPPS established a project management approach to implementation, which assures progress against key deliverables arising from the report. The Project Board meets monthly and is overseen by an Executive Director level SRO in HMPPS and equivalent in NHSE/I.

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The health recommendations from the PPO report have been reviewed and included in the NHS E/I national learning process through the National Specialised Commissioning, Health & Justice Delivery Group. NHSE/I regional Directors have been asked to share the recommendations and lessons learned with local health and justice commissioners and heads of healthcare, who in turn have been asked to share at their Local Women's Prison Partnership Boards and local quality and governance groups. There will be a system to ensure that learnings are discussed, and assurances sought regarding implementation. A review of progress with a paper to the delivery group will take place in early 2022. Healthcare staff are also key partners in multidisciplinary working groups which prisons have been required to put in place to oversee implementation of the recommendations from the PPO report and the new MoJ/HMPPS policy on Pregnancy, Mother and Baby Units and Maternal Separation from Children up to the Age of Two in Women's Prison. They report progress bi-weekly to the Prison Group Director.

More widely, NHSE/I and HMPPS have jointly commissioned a National Women's Prisons Health and Social Care Review Group which is independently chaired. This was convened in January 2021 to undertake a 15-month review that will aim to improve the health and well-being of women in prison, including maternal care for women in prison. The outcomes of the review, including recommendations for implementation, will be reported in Spring 2022.

As part of the review, NHSE/I have also convened a national multi-agency women's estate Perinatal Services Group, which reports to the National Women's Prison Health and Social Care Review Group. This will support the needs of pregnant women and mothers and their babies in custody, share learning and best practice, and identify learning from serious incidents where features of perinatal care have been identified. This sub-group will deliver improved, coordinated and collaboratively commissioned services for Perinatal Mental Health Pathways and Perinatal physical health pathways to clinically support pregnant women, women separated from their babies and women who have lost babies and children. This follows a 2019 review which included the development of a perinatal mental health service specification. This specification has been in place across the female estate since February 2021, despite experiencing some mobilisation delays due to the COVID-19 pandemic.

In addition, NHSE/I are developing a national maternity and post-natal service specification for regional NHSE/I Health and Justice Commissioners, which is being shaped in consultation with women with lived experience. This specification will ensure that pregnant women who either experience all or part of their pregnancy in secure environments can expect and receive high quality, consistent and respectful care during their pregnancy. The service specification is intended to support an increased awareness around the needs of and services available to pregnant women in custody and will be available for roll out nationally by spring 2022.

On 20 September MoJ published a new policy on Pregnancy, Mother and Baby Units and Maternal Separation from Children up to the Age of Two in Women's Prison. The new policy forms an important part of our organisational response to the learning from the Baby A investigation. NHSE/I were consulted throughout the review to produce the new policy, and MoJ utilised the review structure to undertake further consultation with NHSE/I following the PPO investigations, to ensure national learning was addressed where appropriate. We have launched a detailed implementation strategy for our new policy which includes a range of joint initiatives that will help us deliver whole system change.

I hope this provides assurance on the response we have received from NHSE/I regarding the death of Baby B, and our partnership approach to reforming care systems for pregnant women to prevent future tragedies. I will be placing a copy of this letter in the House of Lords Library.

Yours sincerely,

LORD (DAVID) WOLFSON
OF TREDEGAR, QC