Maternity and Newborn Safety Investigations (MNSI)

This factsheet is about the Maternity and Newborn Safety Investigations (MNSI) process at University Hospital Southampton NHS Foundation Trust. When a baby dies during or after birth, or when a woman dies during or after pregnancy or birth, the MNSI team conducts a maternity safety investigation and produces a report.

We understand that this is a very difficult time for your family. This factsheet includes information about how we can support you during this time.

The MNSI report will help us to understand what happened during your care with us. You will receive more information from the MNSI team directly. If you have any further questions or concerns, please contact us or speak to your MNSI contact.

What is the Maternity and Newborn Safety Investigations (MNSI) programme?

The MNSI programme conducts independent maternity safety investigations in NHS-funded care across England. The aim of these investigations is to help improve patient safety and to reduce harm. The MNSI team is made up of a number of individuals, including midwives and doctors, who have diverse experience of healthcare and other safety-critical industries.

Examples of maternity safety events that are referred to the MNSI programme include term babies (babies who are born after 37 weeks) born following labour, who have one of the outcomes below:

- early neonatal death (when babies are born alive but die before they are seven days old)
- intrapartum stillbirth (when babies are thought to be alive at the start of labour but are born with no signs of life)
- a potential severe brain injury which is diagnosed in the first seven days of life

The MNSI programme also investigates direct or indirect deaths of pregnant women or women who have died within 42 days of giving birth.

What does an MNSI maternity investigation involve?

We have included an overview of what happens, and what each organisation will do, following a maternity safety event where the outcome was not as expected in the table on the next page.

To help make it as clear as possible, we have divided the information into three stages:

- what happens immediately after a maternity safety event occurs
- what happens during an MNSI investigation
- what happens after an MNSI investigation

Immediately after a maternity safety event occurs	
What UHS will do	**What the MNSI team will do**
A member of our maternity team will talk to you about your care soon after the event (at an appropriate time). They will then confirm your conversation in writing and explain what will happen next. As part of a national action plan to ensure safe maternity care, we will then make a referral about your care to the MNSI team. To allow us to do this, we will ask you for your permission to pass on your contact details to the MNSI team. This is so that they can contact you to explain what they would like to do and to discuss your wishes. If you do not agree to the MNSI team contacting you, we will inform you as to whether there will be a local review of care. In the meantime, we will try our best to answer any immediate questions you have. If we are unable to answer them at the time, we will arrange an appointment to answer your questions later. We will also carry out a local review of the maternity event to identify any immediate learning that may improve the safety of others. We can inform you of the outcome of this review if you wish. You can access our birth reflections service. This is a midwife-led listening and debriefing service which provides you with an opportunity to: • reflect on your birth experience • explore the care you received For more information about this, including how to access the service, please scan the QR code below: We will provide you with information about support organisations if you would like us to.	Once you have confirmed you are happy to be contacted by the MNSI team, a member of their team will contact you to introduce themselves, explain their process and give you information about what happens next. If you wish for the MNSI team to proceed with an investigation, they will start their investigation by asking you for your permission to access the relevant medical records. The MNSI team will then explain what the aim of the investigation is and give you information to help you understand the process. They will also give you information about support organisations if you would like them to.

During an MNSI investigation	
What UHS will do	**What the MNSI team will do**
After you have been contacted by the MNSI team and you have agreed that you are happy for your and/or your baby's medical records to be accessed, we will upload your medical records to a secure MNSI portal. We will then continue to support the MNSI team's investigation, including arranging interviews with staff who were involved in your care. We will offer you a follow-up appointment with your lead obstetric consultant or consultant midwife around six to eight weeks after the event (this can be sooner if you wish) to: • discuss your and/or your baby's care • answer any questions you may have based on the information available at the time	A member of the MNSI team will: • discuss with you how they would like to gain your thoughts and experiences • give you written information in a format that works best for you • discuss with you how you would like to be kept updated MNSI investigators will then interview the key members of staff who were involved in your care. They may also seek independent clinical advice. An MNSI investigator will let you know how long this will take and describe what the investigation report will look like.
After an MNSI investigation	
What UHS will do	**What the MNSI team will do**
We will receive a draft report from the MNSI team to check for factual accuracy before receiving the final report. We will then contact you to ask if you would like to take part in a three-way meeting with us and the MNSI team. The purpose of this meeting will be to: • answer any further questions you may have • explain what we will be doing or have already done as a result of any recommendations or findings from the MNSI team's investigation	The MNSI team will share their draft investigation report with you and ask you to check that it is factually accurate. The MNSI team will then finalise their report and share it with you. The report will be anonymised (any information that is personal to you and would identify you as an individual will be removed) and will not apportion (assign) blame or liability. The MNSI team will then contact you to ask if you would like to take part in a meeting including them and UHS to discuss the report and any next steps. Finally, the MNSI team will ask you to give feedback about their investigation process.

Contact us

If you have any questions or concerns about this investigation, please speak to your MNSI contact or contact us.

Division C risk and governance team
Email: **DivCGov@uhs.nhs.uk**

Useful links

www.mnsi.org.uk

www.mnsi.org.uk/for-families/investigation-overview-for-families

If you are a patient at one of our hospitals and need this document translated, or in another format such as easy read, large print, Braille or audio, please telephone **0800 484 0135** or email **patientsupporthub@uhs.nhs.uk**

For help preparing for your visit, arranging an interpreter or accessing the hospital, please visit **www.uhs.nhs.uk/additionalsupport**

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