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15 December 2017

[redacted]

By email
[redacted]

Dear [redacted]

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

We refer to your email of 17 November 2017 in which you requested information under the FOI Act from Monitor and the NHS Trust Development Authority. Since 1 April 2016, Monitor and the NHS Trust Development Authority have been operating as part of an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor and the TDA.

Your request

You made the following request:

" i) What are/is the Occurrences/Statistics of new born babies switches at birth in the UK , especially in recent years

ii) under the current safeguards put in place by The NHS can it be ruled out the possibility of baby switches happening ?"

Decision

NHS Improvement holds information in relation to your request and has decided to release that information.

Question 1

A search of the National Reporting and Learning System (NRLS) was carried out on 28th November 2017 of all incidents reported as occurring between 1st January 2011 and 31st December 2015, uploaded to the NRLS by 26 November 2017. A search of the Strategic Executive Information System (StEIS) of all incidents reported as occurring from 20th May

2015 was also run. We searched for the expression ‘baby switch’ and related terms including misspellings.

In summary no patient safety incidents were reported to the NRLS or StEIS where a baby was switched and sent home with the wrong parents or was labelled with the name of a baby born to other parents. We have found 3 incidents which have some relevance to your enquiry and in case it is of assistance we have provided the descriptions of these incidents (with personal information redacted) in the table below.

IN05 Incident Category - Free Text	**IN07 Description of what happened**
Documentation (including records, identification) other	Baby taken back to a mother in Bay 3 identified by the mother as wrong baby , baby then wheeled to mother opposite who called back the member of staff to say this was also not her baby .
Miscellaneous	Error noted on e - records 36 hours of age for a set of 23 week twins who do not yet have first names , referred to on eRecord as baby 1 and baby 2 . Baby 1 hospital number and location are assigned to Baby 2 and vice versa . It appears the babies were assigned correctly initially as the details on the case notes front sheets and stickers are correct . The names on eRecord would appear to have subsequently been switched so that baby 1 has the [initials] number previously allocated to baby 2 and vice versa . This has resulted in confusion about which baby lab results belong to and the need to repeat crossmatch samples from both babies . .

Labour - other	Incident report on probable switching of twins identity and also error on [initials] . Twin 1 was cephalic and weighed 2.4kg , (twin 2 was breech and weighed 2.7kg - born by emergency C / S. However , (mother was adamant that the twins ankle labels must have been switched as ' larger baby ' was labelled twin 1 , (and ' smaller baby ' twin 2 . When babies were weighed on [number] , (twin 1 gained weight , (whilst twin 2 lost 16% weight while both on same feeding regime , (and one baby had not visibly lost significantly more weight than the other . Blood tests showed normal renal function which made 16% weight loss clinically unfeasible . Error could have occured with incorrect lablels placed on twins , (or incorrect data entry , (or incorrect initial birth weight . Also twins on [initials] were incorrectly entered as both " Twin 2 [name] " , (which may have lead to confusion and incorrect specimens sent for the wrong baby . This was subsequently corrected . .

Question 2

The standard practice is to label all babies with two wristbands (both placed around the ankles) immediately after birth and mother and baby are kept together throughout the postnatal stay. Where they need to be separated for either maternal or neonatal care reasons, labels are checked prior to separation. All babies have their labels checked daily whilst in hospital.

The likelihood of two babies without any labels, at the same time, is extremely remote.

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