

# James Titcombe

Human Factors in Healthcare Forum, 6 June 2017

# **Joshua's Story**

## **- Learning from Morecambe Bay**

**June 2017**

**James Titcombe**



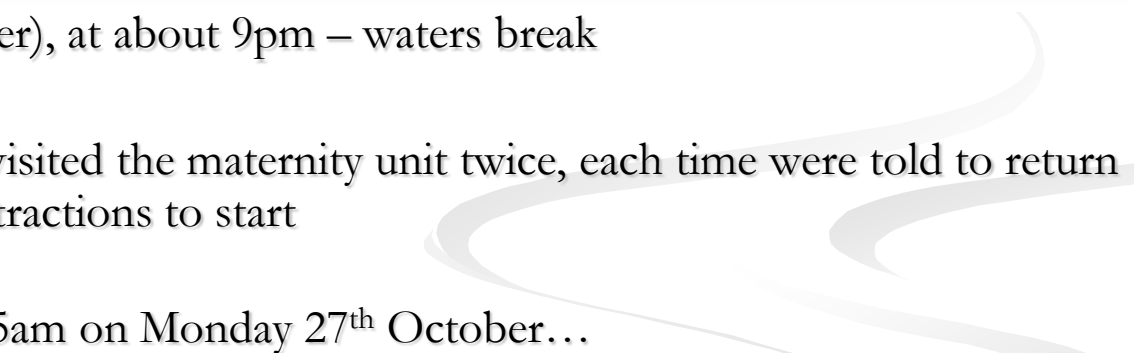
# Joshua's Story

March 2008 in Normandy – Pregnant with Joshua

Rest of pregnancy normal



## The Days Before the Birth.....

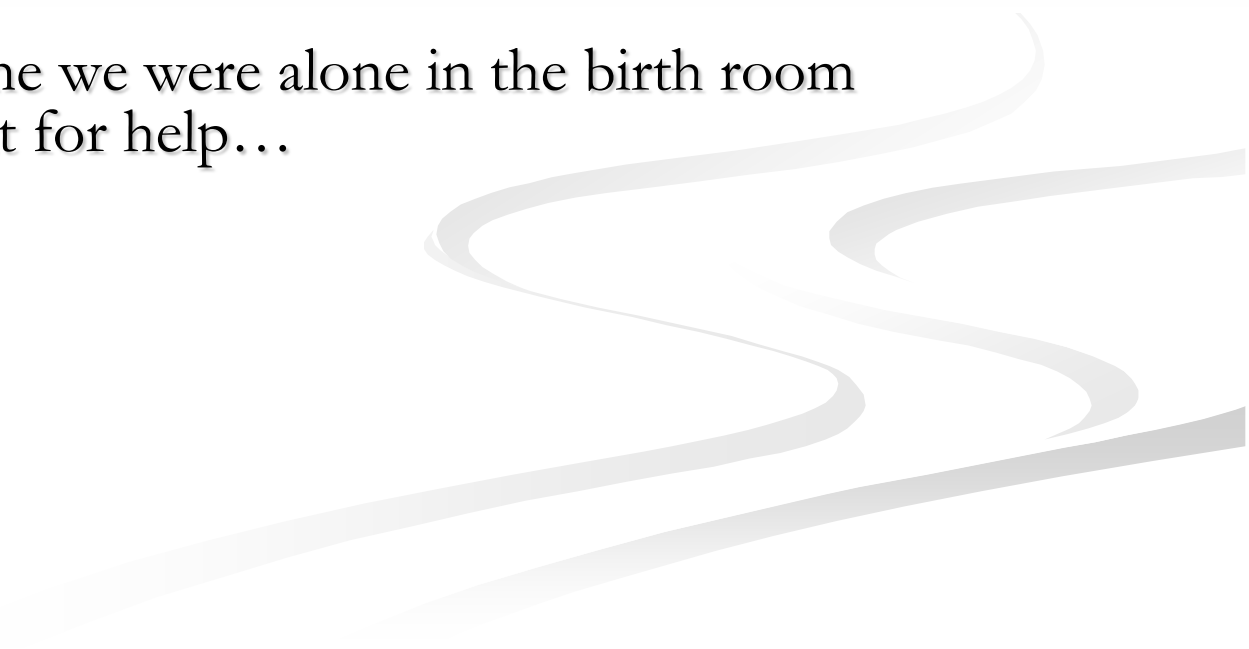
- Monday 20<sup>th</sup> October, my wife and I were feeling poorly, we had headaches, sore throats - tired and ill
  - Saturday night (25<sup>th</sup> October), at about 9pm – waters break
  - Over the next 2 days, we visited the maternity unit twice, each time were told to return home and wait for the contractions to start
  - Contractions start around 5am on Monday 27<sup>th</sup> October...
- 

## The Birth

On Monday 27<sup>th</sup> October we went to hospital at about 6.30am. At 7.38am, Joshua was born.



## However.....

- Soon after the birth - at around 8am, my wife collapsed with a very high temperature which we later learned was caused by an infection
  - At this time we were alone in the birth room and I went for help...
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- The bottom right portion of the slide features several overlapping, wavy, light gray lines that create a sense of movement and depth, extending from the right edge towards the center.



- My wife was eventually given fluids and antibiotics & recovered but we were told 'Joshua was ok'
- Repeated low temp
- Laboured breathing, lethargic and not feeding

# Intensive care



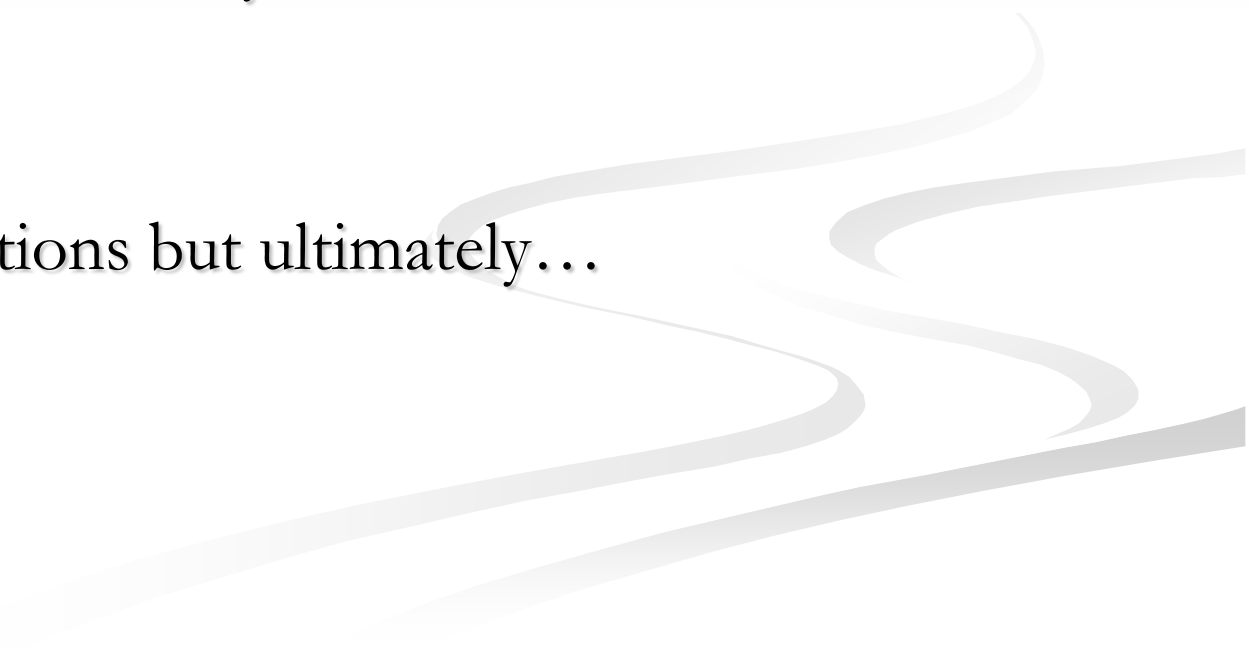
- Joshua was initially transferred to Manchester where he spent a night. Here he was diagnosed with overwhelming infection to his lungs (pneumococcus), the same organism found in my wife
- He was then transferred to Newcastle where he was placed on ECMO



## Joshua's death

- Up until 3<sup>rd</sup> November, Joshua was doing very well on ECMO
- On the night of 3<sup>rd</sup> November, attempted to wean Joshua from ECMO
- At the latter stages of weaning, Joshua began to bleed from his left lung
- On the 5<sup>th</sup> November 2008, around midday we were told that Joshua's bleeding was too severe and it was time to turn off the ECMO machine
- Died at 12.15 that day

# What happened next...

- No Inquest 'natural causes'
  - Missing records/dishonesty
  - A 'one off'?
  - Fielding report
  - Various investigations but ultimately...
- 
- A decorative graphic consisting of several thick, light gray, wavy lines that flow from the right side of the slide towards the left, partially overlapping the bottom right corner of the text area.

FOR HEALTHCARE LEADERS

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University Hospitals of Morecambe Bay Foundation Trust


## Mothers and babies still at 'significant' risk at Morecambe Bay

7 FEBRUARY, 2012

**PERFORMANCE:** The safety of mothers and babies at the foundation's Furness General Hospital remains at "significant risk", according to a new independent review commissioned by foundation trust regulator Monitor.

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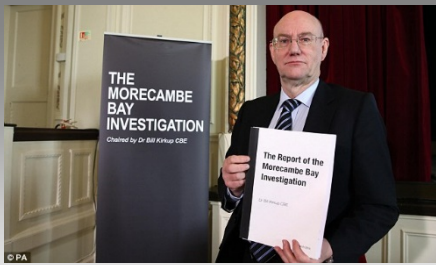
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2012/2013 - Campaigning with other families for an inquiry.....



## Kirkup report – March 2015

“Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth ‘at any cost’; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.”

“...these factors comprised a **lethal mix** that, we have no doubt, led to the unnecessary deaths of mothers and babies.”



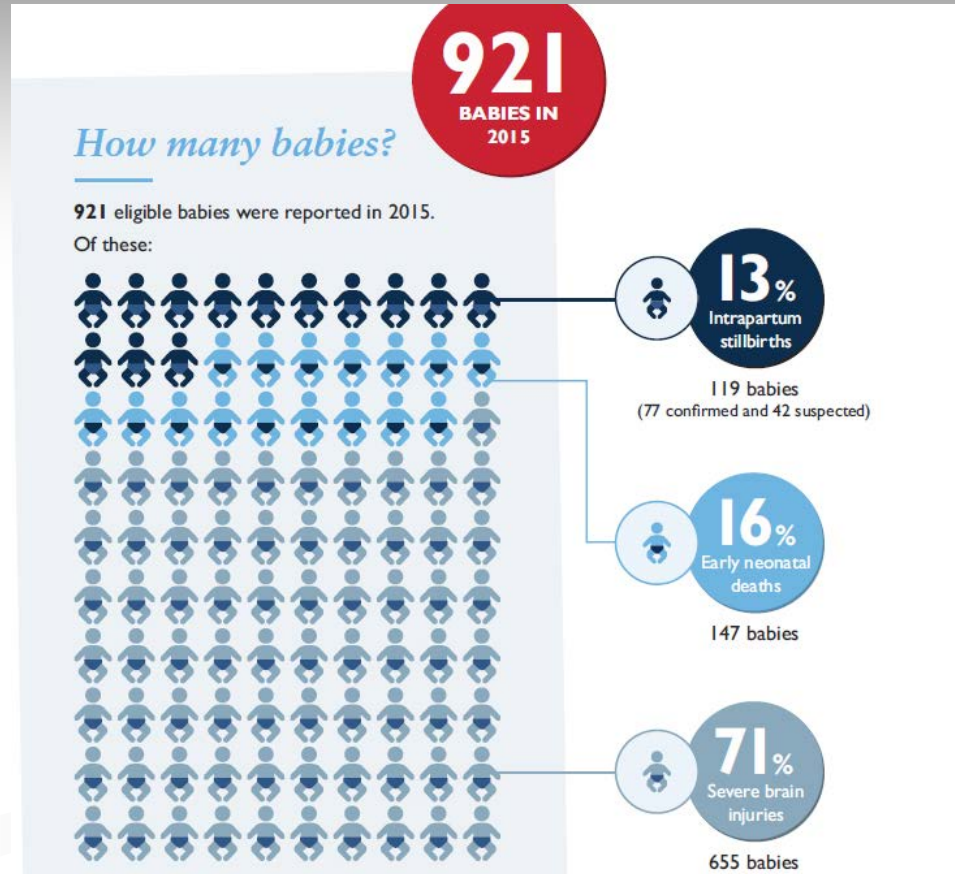
“...errors occur in every healthcare system. What is inexcusable, however, is **the repeated failure to examine adverse events properly**, to be open and honest with those who suffered, and to learn so as to prevent recurrence. Yet this is what happened consistently over the whole period 2004–12.”

One off, isolated failures?

# Each Baby Counts



Royal College of  
Obstetricians &  
Gynaecologists



# 599 local reviews had been carried out

## Of these:

- **48%** used no specific tools or methodology
- Only **7%** used an external expert
- Only **25%** invited the parents to be involved in the process
- **39%** of the reviews contain no recommendations (or solely focused on an individual)

# Kirkup Recommendation 23

“Clear standards should be drawn up for incident reporting and investigation...

...to include a requirement that investigation of these incidents be subject to a **standardised** process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff.”

- 112 *All sentinel events should be subject to a form of structured analysis in the trust where they occur, which takes into account not only the conduct of individuals, but also the wider contributing factors within the organisation which may have given rise to the event.*



# Kirkup Recommendation 31

The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a **fundamental review of the NHS complaints system is required.**

- 36 Complaints should be dealt with swiftly and thoroughly, keeping the patient (and carer) informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be established to assist patients (and carers).

?



# Kennedy Report: 2001



The Report of the Public Inquiry into  
children's heart surgery at  
the Bristol Royal Infirmary 1984–1995

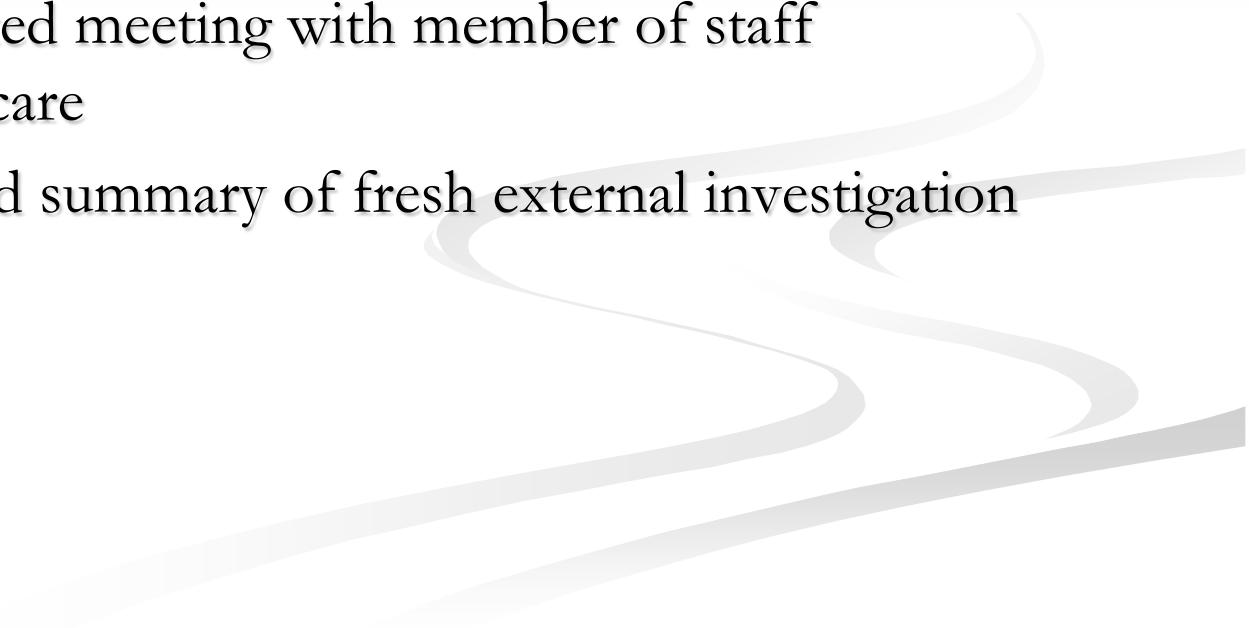
Learning from Bristol

# Culture change at Morecambe Bay

## Kirkup Report – March 2015:

“When the dysfunctional nature of the maternity services became obvious, in 2008, the Trust’s response was **flawed and inadequate**, and categorised for some years by instances of the same **denial** and **cover-up** that was evident in the maternity unit. At the time, the Trust was strongly focused on achieving Foundation Trust status, which both diverted capacity to manage day to day and surely fostered reluctance to disclose anything that may have jeopardised the bid.”

# Recent work at Morecambe Bay

- 2016 – commissioned fully external review of Joshua's case
  - October 16 – facilitated meeting with member of staff involved in Joshua's care
  - Nov 2016 – published summary of fresh external investigation into Joshua's case
- 

18 recommendations within the report have now been addressed...



However...

“In reality, many of changes needed to meet the recommendations of the review were not meaningfully implemented until 2012/13, some five years after Joshua’s death. Had this happened earlier, this would have led to better clinical outcomes for others.”

The Kirkup investigation confirmed 6 babies died because of this delay

# Investigations relating to Joshua's case since 2009

- Trust RCA internal – 2009
- Trust 'external investigation' - 2009
- LSA Supervisory Investigation Report – 2009
- Review of supervisory investigation – 2010
- 2<sup>nd</sup> Review of supervisory investigation (SHA/NMC) – 2010
- 1<sup>st</sup> PHSO consideration & refusal to investigate Joshua's case – 2010
- 2010 – Fielding report (hidden)
- **Joshua's Inquest – 2011**
- Investigation by Cumbria Police (5\* expert reports ) 2011 – 2015
- PHSO refusal to investigate supervisory system/appeal/legal challenge – final agreement to investigate & report (2013)
- Grant Thornton report into CQC failures
- 4 other PHSO reports (collusion/NMC Shit/trust response/offensive correspondence – 2014
- Morecambe Bay Investigation 2015
- 4 times NMC hearings – 2016
- **Final external investigation report commissioned by Morecambe Bay - 2016**
- 1 NMC investigation ongoing
- PSA confirmed investigation of NMC to start June 2017.....

## Private Eye – Issue 1350

The Coroner was eventually persuaded to open an inquest which was held in 2011 and exposed a cover up at the Trust. Monitor eventually investigated the Trust in 2011. The CQC eventually investigated the Trust in 2012. Grant Thornton was commissioned to investigate the CQC in 2013 and delivered a scathing verdict of another cover up. The Ombudsman is currently formally investigating the LSA and the Trust. The Police are formally investigating the Trust. The DoH have commissioned an independent inquiry led by Bill Kirkup to investigate the Trust, the LSA, the CQC and the Ombudsman. **Still James waits to find out how and why his son died.**“

– May 2013



# Assurance is never enough...

“Around 1,200 babies are delivered safe and well at Furness General Hospital every year. Latest statistics show that Furness General Hospital and the trust as a whole are among the safest places in England to have a baby - Our trust has fewer still births and neonatal deaths than the national average.” **Tony Halsall - 15th January 2010**

“Our apologies cannot lessen the pain and suffering of Joshua’s parents, however, we would like to reassure the public that we have taken all the steps we can to minimise the risk of this happening again.” – **Tony Halsall June 2011**

“...all of these organisations failed to work together effectively and to communicate effectively, and the result was **mutual reassurance** concerning the Trust that was based on no substance.” – **Kirkup Report March 2015**

**Persistent questioning and deep inquiry are vital for learning!**

# Healthcare Safety Investigation Branch (HSIB)



“The NHS currently has no consistent approach to investigating and learning from safety issues”

----PASC Report --- HSIB Expert Advisory Group --- HSIB!!!

# HSIB Advisory Group Recommendations

## **INDEPENDENCE, ENGAGEMENT AND LEARNING**

1. Must be independent in structure and operation
2. Investigations must be to understand causes of harm, to support improvement, not to apportion blame
3. Patients, families and staff must be active, supported participants

## **SYSTEM-WIDE INVESTIGATION AND IMPROVEMENT**

4. Must be empowered to investigate safety incidents anywhere across the entire healthcare system
5. Investigations must be led by experts in safety investigation and HSIB should provide leadership to the whole system on investigation
6. Investigation reports must explain causes of incidents and make recommendations
7. Reports must be public documents and recipients must publish responses

## **JUST CULTURE: TRUST, HONESTY AND FAIRNESS**

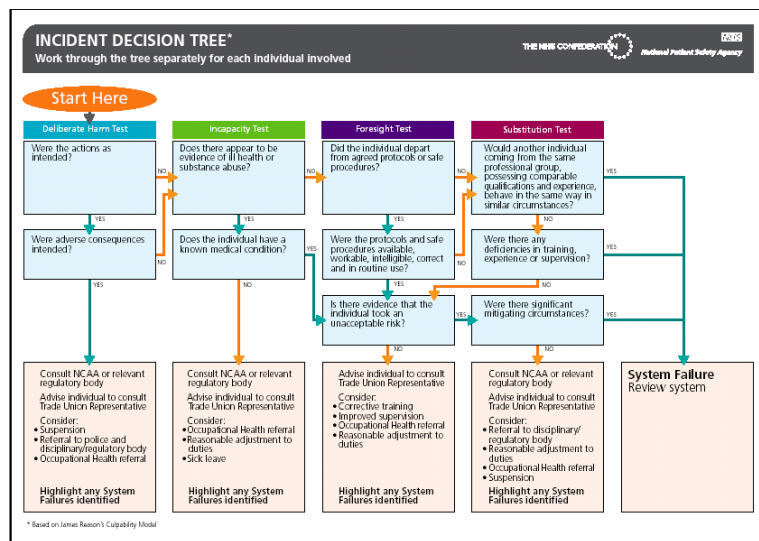
8. Must promote creation of a 'just' safety culture
9. Must provide families and patients with all relevant information from an investigation about their care while protecting all information from use by other bodies or for other purposes
10. Information must be provided to investigators honestly and openly. Where evidence shows wrongdoing, negligence or unlawful activity the relevant body must be informed.

## **FURTHER ACTIONS REQUIRED ACROSS THE HEALTHCARE SYSTEM**

11. Recommend a 'Just Culture' Task Force be established to make further recommendations about moving healthcare to a just culture
12. Recommend a programme of capacity building and improvement of safety investigation
13. Recommend a process to provide truth, justice and reconciliation in relation to unresolved cases

# Just culture....

“...a shared set of values in which healthcare professionals trust the process of safety investigation; and are assured that any actions, omissions or decisions that reflect the conduct of a reasonable person under the same circumstances will not be subject to inappropriate or punitive sanctions.”



# Learning from other sectors



## Examples from Sellafield:

1. Incident reporting scheme and free iPads!
2. 'Human Performance awards'

# Final thoughts



“The first event that should have triggered concern..... However, the investigation that was carried out was rudimentary, protective of the midwife involved, and failed to identify the shortcomings in practice and approach.....

“Had an effective multidisciplinary investigation been carried out, it is likely that the early stages of dysfunctional relationships and inappropriate risk assessment would have been identified and could have been addressed.”