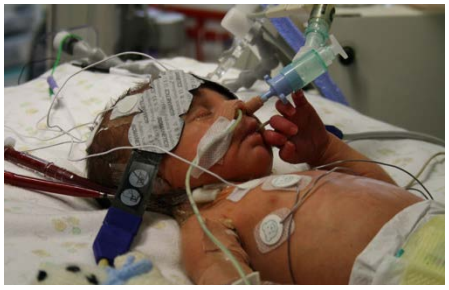
Patient Safety Culture

Where do we stand?

James Titcombe, OBE, recently addressed a group of staff at the hospital. He spoke about the failures associated with the investigation of his son, Joshua's death nine days after his birth in November 2008 at the Furness General Hospital, one of the University Hospitals of Morecambe Bay NHS Foundation Trust.

He gave a moving account of the sequence of events starting with his wife's collapse from pneumococcal sepsis soon after the delivery of Joshua, followed by his son's rapid deterioration over the subsequent 24 hours. Joshua was transferred to Manchester, then Newcastle where he was supported by an Extra Corporeal Membrane Oxygenator, but later succumbed to complications.*



James Titcombe is in Australia at the invitation of The Victorian Managed Insurance Authority (VMIA) and Dr Carmel Crock, Director of the Emergency Department arranged his visit to the hospital. James was previously a project manager in the nuclear industry, but now works full time in patient safety. Only through his tireless energy and campaigning has he now got the answers he and his wife needed about his son's death.

Since 2008 there have been dozens of organisational investigations into Morcombe Bay at an estimated cost of over £6m. Eventually a definitive investigation was carried out by the UK government under the Chairmanship of Dr Bill Kirkland. Covering the period from January 2004 to June 2013, the report concludes the maternity unit at FGH was dysfunctional and that serious failures of clinical care led to unnecessary deaths of mothers and babies. Compelling evidence was discovered of dishonesty, inadequately trained staff, a dysfunctional 'them and us' culture between midwives and doctors, "lost" records, collusion between witnesses, non-objective internal and external reviews, suppression of reports, mutual reassurances between organisations and more.

The Kirkland Investigation report details 20 instances of significant failures of care in the maternity unit which may have contributed to the deaths of 3 mothers and 16 babies. Different clinical care in these cases would have been expected to prevent the death of 1 mother and 11 babies. The report makes 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.

Of great concern is that the recommendations of the Kirkland report mirror those of the enquiry 16 years previously into the 2001 Bristol paediatric heart surgery enquiry which resulted from the campaigning by anaesthetist, Dr Stephen Bolson.

James described how new and changed patient safety organisational structures have been put in place in the NHS and how some organisations have been disbanded. There is more emphasis on establishing ***just*** local hospital cultures and open, transparent behaviour when investigating adverse incidents and near-miss events. An investigation by a truly independent external organisation is important for serious incidents.

James eventually met face-to-face with the midwife responsible for the care of his son Joshua. Although it was a very emotional and difficult meeting, he was pleased to report that the midwife had learned from the incident, was still employed in the maternity unit and is now a forceful campaigner for a just, open and honest work culture.

James writes in the Health Service Journal that

> "A climate of fear will prevent people from reporting, and serves to drive issues underground. Everyone in healthcare needs to understand the negative effect on patient safety that comes from punishing those who make genuine mistakes."

* Images are from The Telegraph