The Morecambe Bay NHS tragedy: creating a culture of learning in the NHS

James Titcombe

"To err is human, **to cover up is unforgivable**, and to fail to learn is inexcusable"

3rd March 2015

Furness General Hospital – 2004 – 2013:

> “Lethal mix” of failures that “we have no doubt, led to the unnecessary deaths of mothers and babies”

> “Our findings are stark, and catalogue a series of failures at almost every level – from the maternity unit to those responsible for regulating and monitoring the Trust.”

20 instances of significant or major failures of care at FGH

Relating to 3 maternal deaths and 16 babies deaths

11 babies and 1 mother would have survived with different care

March 2008 in Normandy – pregnant with Joshua

Rest of pregnancy normal

Waters broke three weeks early after week of feeling poorly

Joshua born two days later (October 2008)

What happened next…

- Hoa collapse / treatment – Joshua:
  - Repeated low temp
  - Breathing rapidly
  - Mucousy
  - Lethargic
  - Reluctant to feed
  - Reassured ok
  - No referral to paediatric
  - Found collapsed at 24 hour of age

ECMO

- Died nine days later – 5 Nov 2008
- Consequence of untreated infection

What happened next…

- Nov 5th 2008 – Joshua died
- Advised no inquest – ‘pursue complaint’
- 14th Nov 2008 - Letter to hospital with chronology
- + 1 month – advised by hospital observation records ‘lost’
- Trust investigation (no interviews with staff) + LSA investigation
- Both investigations flawed
- Complaint to PHSO – ‘no worthwhile outcome’
- Feb 2010 – approach Coroner again
- March 2010 – Coroner opens inquest
- Jan 2011 – JT received Fielding report –sends to CQC
- June 2011 – Inquest takes place – 10 failings, ‘collusion’ & rule 48
- Sept 2011 – CQC publish inspection report
- Feb 12 – Monitor publish critical reports – 119 unaddressed risks

FOR HEALTHCARE LEADERS
HSJ
HEALTH SERVICE JOURNAL

MIKE BIRTWISTLE

The government has gambled on the new drug pricing scheme

University Hospitals of Morecambe Bay Foundation Trust

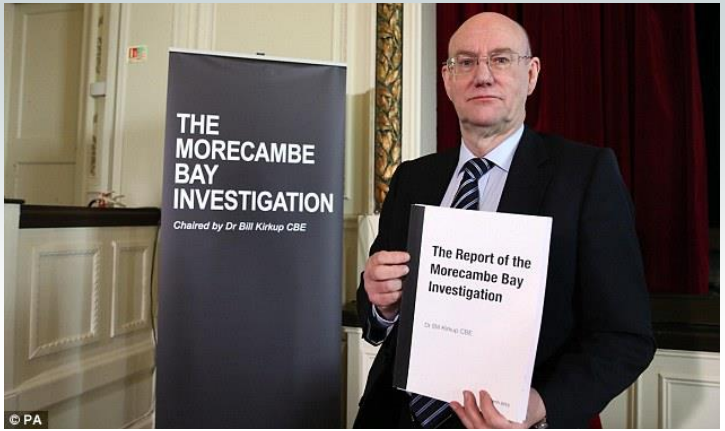
Mothers and babies still at 'significant' risk at Morecambe Bay

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.

What happened next…

- CQC commission GT report
- Jan 2013 – Families meet and launch MBIA
- Feb 2013 – UK Gov commit to inquiry – becomes Kirkup report
- June 2013 – GT report published
- Jan 2013 – Feb 2014 – PHSO publish 4 reports – 1 not upheld
- March 2015 – Morecambe Bay Investigation Report Published

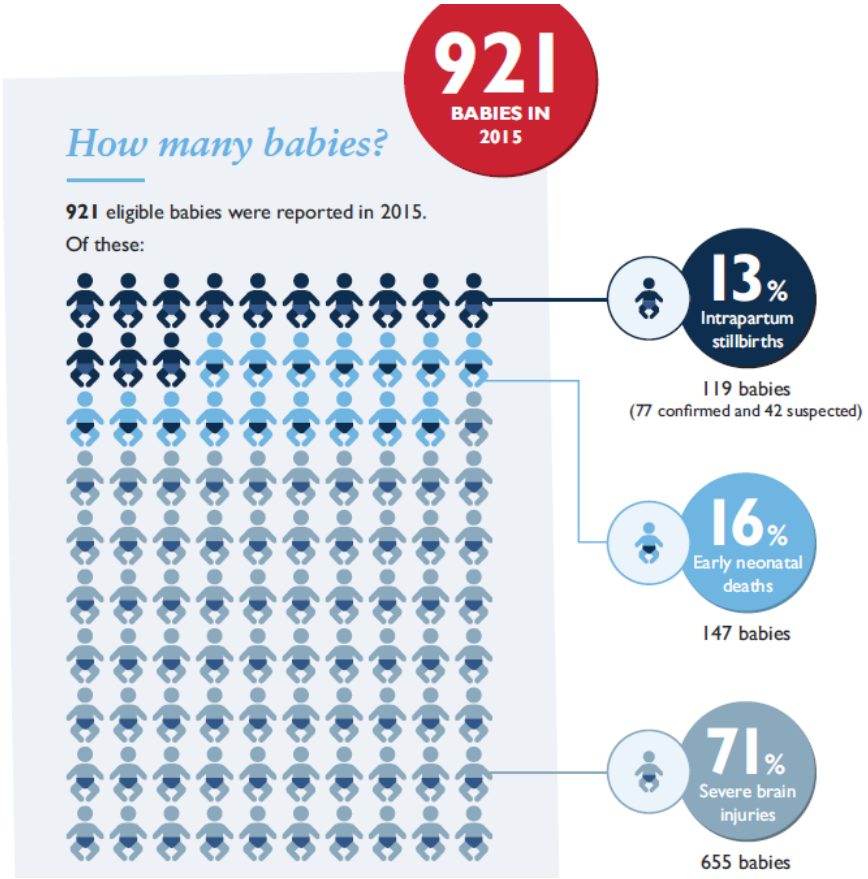


"….errors occur in every healthcare system. What is inexcusable, however, is the repeated failure to examine adverse events properly, to be open and honest with those who suffered, and to learn so as to prevent recurrence. Yet this is what happened consistently over the whole period 2004–12."

Isolated local failure at "…one small maternity unit" ?

We have observed a high number of investigations that show a lack of skill and expertise in the methodology used; that do not identify the underlying systems issues that led to the incident; or that leave the reader with unanswered questions. There was also limited evidence that patients and families were engaged in the process, or that clinical and other staff were sufficiently involved.

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)

“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 27

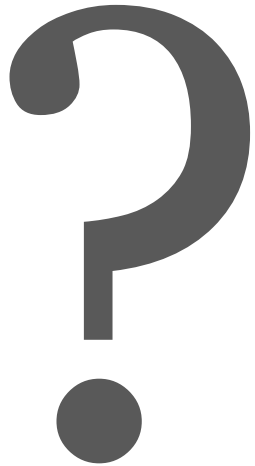
Professional regulatory bodies should clarify and reinforce the duty of professional staff to **report concerns about clinical services**, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a **lapse from professional standards**. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.

115 Members of staff in the NHS who cover up or do not report a sentinel event may be subject to disciplinary action by their employer or by their professional body.

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 Infirmary1984–1995

Learning from Bristol

“Healthcare has to choose between Safety & Fear”

“Learning from error, rather than seeking blame, must be the priority in order to improve safety and quality.”

-Ian Kennedy 2001

“The NHS has developed a widespread culture more of **fear** and compliance, than of learning, innovation and enthusiastic participation in improvement.”

- Francis Report

“**Fear** is toxic to both safety and improvement”

- Don Berwick 2013

“Staff described a bullying and blame culture… Staff found it difficult to raise concerns or challenge poor performance and behaviours. Staff did not always report incidents; where these were discussed the blame culture prevented an open discussion to encourage learning and improvements to patient safety.”

http://www.cqc.org.uk/location/RRK15/reports

"I'll Datix You…"

Examples from Sellafield:

1. Incident reporting scheme and free Ipads!
2. ‘Human Performance awards’

- Healthcare Safety Investigation Branch (HSIB)
- Linked to drive to improve local investigations (must involve families)
- Medical Examiners (2018)
- National Guardian role
- EAG recommendation – process to help resolve ‘historical’ unresolved cases
- EAG recommendation ‘Just Culture Taskforce’

A conversation in a flower shop

"….investigation that was carried out was rudimentary, protective of the midwife involved, and failed to identify the shortcomings in practice and approach."

"If a proper investigation had been done in 2004, it would not only have reduced the likelihood of unnecessary loss of babies and mothers, it could have corrected the poor risk assessment and unsafe practice at an early stage…"

- Dr Kirkup: process ‘glacially slow’
- 6 cases re Joshua
- 4 completed in 2016
- 2 hearings no action (process described as ‘deficient’ by PSA)
- 1 hearing – 9 month suspension
- 1 hearing – stuck off
- 2 cases ongoing

- High quality initial investigation essential
- Process must support ‘just culture’ – don’t punish human error but focus on risks to public
- Clearer rules around deferment of regulatory action
- Prioritisation of cases which involve allegations of covering up and dishonesty
- Changes needed in how families are involved and supported
- An open culture of learning and improvement

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