Joshua's Story

HPA
HARMED PATIENTS ALLIANCE

Just Culture Across Industries:
Continuing to learn from each other

- November 2020

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)

Joshua –

Shortly after his birth on 27 October 2008 at Furness General Hospital

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

Joshua

- Born 27th October 2008
- Collapsed at 24h of age
- Died on 5th November

What happened next…

- No Inquest ‘natural causes’
- Missing records
- A ‘one off’?
- Fielding report
- July 2011 – Inquest….

Inquest Verdict

- Failure to listen to and understand the family's concerns;
- Failure to record fully or at all many of the factors which, taken together, might have led to a greater degree of suspicion or a referral to a paediatrician; Failure by some staff still to recognise that the standard of record keeping was unacceptable;
- Failure to understand a basic medical fact that a low temperature or a failure to maintain a temperature could be a sign of infection in a neonate;
- Failure to monitor the signs of infection in Joshua;
- Absence of continuity of care before and during the birth;
- The treatment of the protocol on Prolonged Rupture of the Membranes as a rigid formula and not as a tool to make a considered diagnosis and (if necessary) to get a doctor to attend;
- Mrs Titcombe and Joshua were treated as unrelated individuals. No thought was given to how, if something was affecting Hoa, it might also affect Joshua. Failure to think of them laterally and holistically as a mother and baby.
- Failure by all staff to acknowledge that the midwives were working as a separate team and that there was no integration between the midwifery and paediatric teams;
- Failure to identify that the unit was short staffed on that day;
- Inadequate, or no, training for midwives on the post-natal ward to carry out the observations that the SCBU nurses had done.

FOR HEALTHCARE LEADERS

HSJ

HEALTH SERVICE JOURNAL

MIKE BIRTWISTLE

The government has gambled on the new drug pricing scheme

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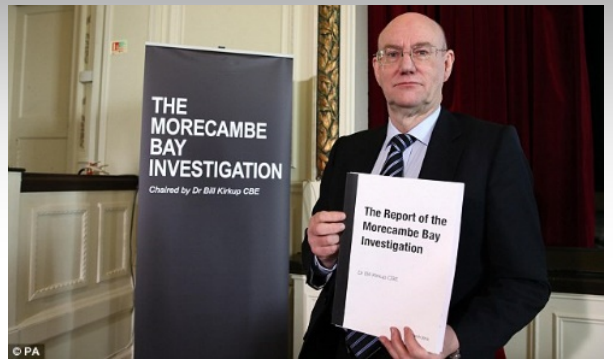
2012/2013 - Campaigning with other families for an inquiry…..

Kirkup report – March 2015



"lethal mix" of failures 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."

Reconciliation 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
- 2nd Review of supervisory investigation (SHA/NMC) – 2010
- 1st 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– 2014
- Morecambe Bay Investigation 2015
- 4 times NMC hearings – 2016
- **Final external investigation report commissioned by Morecambe Bay - 2016**
- Final NMC hearing finished in 2017
- PSA report published in May 2018

False assurance…

"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)

J R Soc Med OnlineFirst, published on October 30, 2014 as doi:10.1177/0141076814555939

The Royal Society of Medicine

Essay

Journal of the Royal Society of Medicine; 0(0) 1–5
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Learning from failure: the need for independent safety investigation in healthcare

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"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

Learning from other sectors

Examples from Sellafield:

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

"I'll Datix You…"

A conversation in a flower shop

PKM/CE

17 October 2008

Mr I Y Hussein
Clinical Lead in Obstetrics & Gynaecology
FGH

Dear Ibrahim Veerus

Re: - Complaint – Liza Brady – Simon Davey

I was on call for the weekend when we had the unfortunate intra-partum death on 5 September, the baby of Simon Davey and Liza Brady. I was not directly involved with their antenatal management and during their intra-partum period, during my rounds both in person and on the telephone, I was not informed of any undue concern regarding the progress.

After going through the complaint made by the father, I have grave concerns about the management of this particular lady. In the third paragraph they have indicated about the intravenous cannula for iv access and epidural. In the answer given by the staff, regarding epidural, if it is true, is not acceptable and completely un-scientific. Obviously this lady was known to have both clinically and ultrasonographically, a large baby and as a prophylactic measure, an IV cannula for access is a good obstetrics and midwifery practice as they are likely to have a PPH.

In the fourth paragraph, according to the father, it seems that Dr Surrey had taken 15-20 mins to attend and as soon as he entered the room he did not examine Liza or make any decision regarding possible Caesarean section. I have asked this question to Dr Surray as this was one of the main complaints to me after the unfortunate incident. Dr Surray replied that when he entered the room he was told by the attending midwife that the head had come down and everything was fine and normal and he does not have to interfere or intervene at this stage. Obviously he waited outside in the nursing station.

My main concern is that trying to make every labour and delivery as normal and natural and not thinking laterally the possible complications.

Obviously this baby has died sometime in the second stage.

It is not possible for the baby to die within five minutes because of shoulder dystosia.

I don't think one can defend in any court of law when you have not heard the fetal heart with the Doppler and explaining that the fetal heart is normal but we are unable to pick it up because of the positioning. I am all for having a normal natural childbirth but not at any cost.

This has happened in our unit in the past and I am sure if we don't take appropriate precautions and positive steps, I am sure that this is going to happen again in future.

"….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…have reduced the likelihood of unnecessary loss of babies and mothers… could have corrected the poor risk assessment and unsafe practice at an early stage…"

Impact on us

- Shock, guilt, trauma
- Broken trust, grief, anger
- Mental health – PTSD
- Relationships, marriage, children, parents
- Career
- Complicated grief
- Prolonged over 10 year period of ongoing processes that forced us to relive what happened to Joshua whilst seeking answers

What does good look like?

"In the aftermath of our loss, we needed healthcare to fully acknowledge and thoroughly understand our experience of what had happened to our children and the impact it had on us. We needed answers to all of the questions that we had, that were important to us, and we needed those regardless of whether anyone else felt our question relevant or important. We needed staff to be supported to give us honest accounts of their actions and their reflections. We needed a collaborative approach to reach a truthful and evidence-based explanation of events. We needed help and support to understand what all the processes were that were happening and how to engage with them. We needed the system to learn and to see meaningful change, but we also needed the system to help us heal, recover, and restore our trust. Meaningful engagement coming from a place of care could have provided that."

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'Restorative healing after healthcare harm'

www.harmedpatientsalliance.org.uk

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