Joshua's Story

Learning from Morecambe Bay

BABY LIFELINE
The Mother and Baby Charity

East Midlands Perinatal Conference

James Titcombe

Feb 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
- Various investigations but ultimately…

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."

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."

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

SOCIETY

Nurses' watchdog spent £250,000 on 'cover-up'

By Paul Gallagher
HEALTH CORRESPONDENT

Almost £250,000 was spent by the regulatory body for nurses trying to cover up how much information it held on a grieving father it had been monitoring for nearly a decade.

The revelation provoked outrage among nurses who called last night for an explanation from the Nursing and Midwifery Council (NMC).

It came after the NMC followed what James Titcombe said in public and on social media sites about his fight for an investigation into the death of his nine-day-old son, Joshua, from a treatable infection in 2008. The NMC reported the information it found about his speaking engagements and social media use internally.

Mr Titcombe had been seeking answers over the avoidable death of his son at the hands of so-called "musketeer midwives".

After he requested what information the regulator held on him under the Data Protection Act, the NMC's chief executive, Jackie Smith, authorised a team of lawyers to work on how much information the regulator could block from documents it was forced to hand over. Mr Titcombe (*pictured*) was sent heavily redacted NMC documents last month. Some A4 size reports had all but 10 words removed, while others were left with incomplete sentences.

Mr Titcombe made a Freedom of Information request to find out the legal costs. The NMC wrote to him this week. "I am sorry you do not feel we have been transparent in the way we handled your data subject access request," it said.

"We engaged the law firm Fieldfisher to help us deal with your request and the estimated cost of their work is £239,871.85 (including VAT)."

The NMC said that it could deal with most requests internally, but that Mr Titcombe's was "particularly complex". A spokesman said: "Handling the request in this way has incurred a significant cost, however, we believe that the approach taken was the best way of ensuring a full response."

Outrage Nurses' reaction

Social media reaction from nurses and health professionals

@PDarbyshire Who will start the 'Not in our name' campaign? Every nurse in UK I hope.

@mrsverypicky I am highly embarrassed the NMC, which I was registered with from 1983-2016 acted this way. Not what fees are for.

@MatSilk ... there are clear principles they should have applied to this before considering legal, and at that cost.

@Isabelsauntie this is outrageous and not what I expect my fees to be spent on.

@EyesNurse interesting use of mine and 1000s of others £120 registration fee.

@grahamjsutton This deserves wide circulation particularly among nurses, whose (compulsory) registration fees are funding NMC's paranoia & abuse of power

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

http://www.drphilhammond.com/blog/2013/10/05/private-eye/medicine-balls-private-eye-issue-1350/

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!

A conversation in a flower shop

PKM/CE

17 October 2008

Mr I Y Hussein
Clinical Lead in Obstetrics & Gynaecology
FGH

Dear Ibrahim Veeren

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.

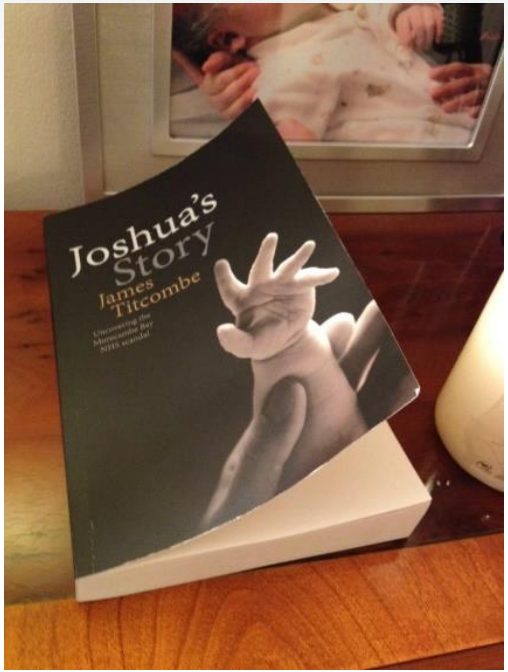
I don't think one can defend in any court of law when you have not heard the fetal heart with the Doppler and explaining that the fetal heart is normal but we are unable to pick it up because of the positioning. I am all for having a normal natural childbirth but not at any cost.

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…"

Since 2015….


Joshua's Story
James Titcombe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7:19
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THAN TWO WEEKS AFTER IT WAS PLANNED
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News story

New ambition to halve rate of stillbirths and infant deaths

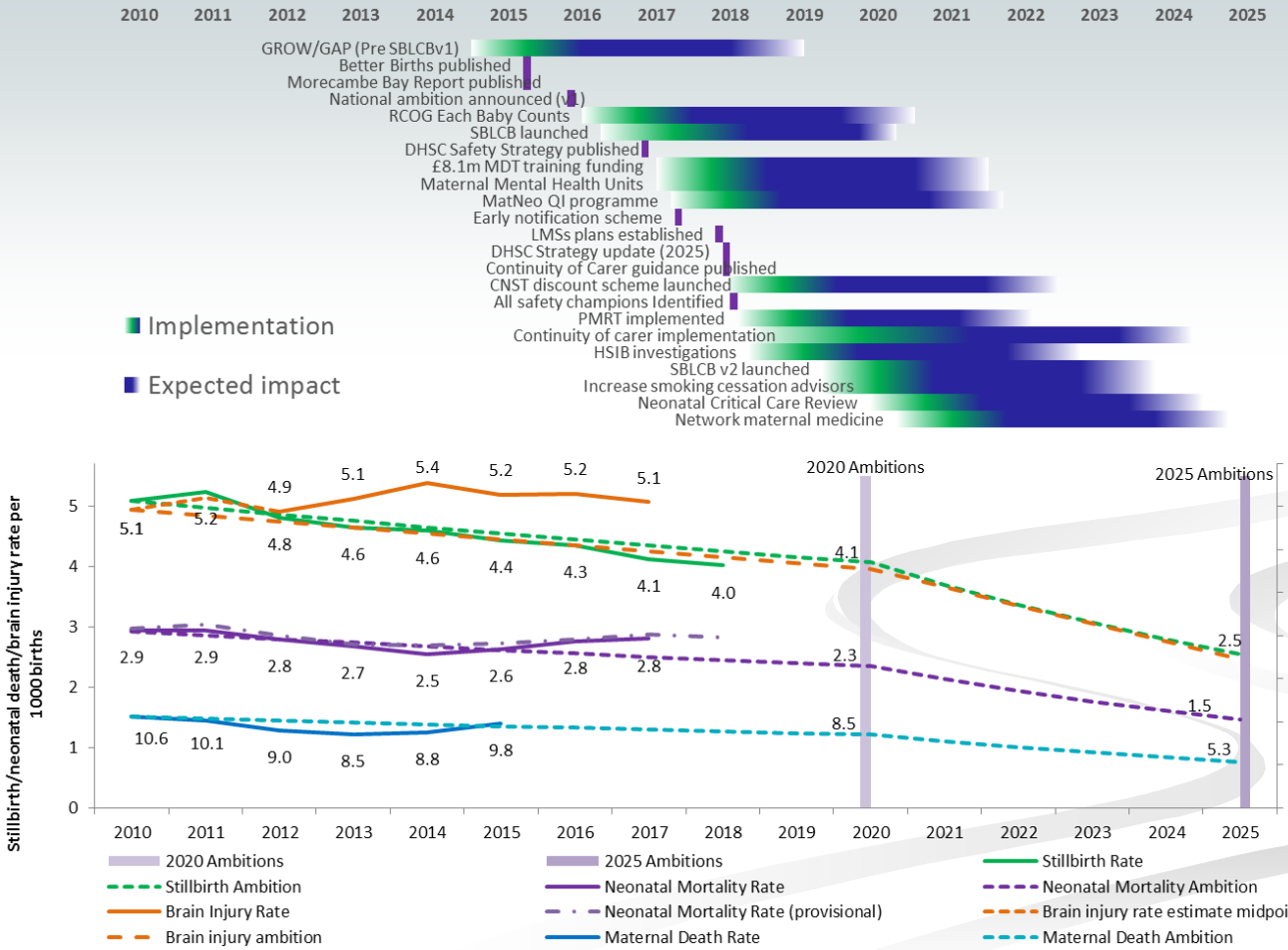
Government announces new commitment to ensure England is one of the safest places in the world to have a baby.

Published 13 November 2015
From: Department of Health and Social Care and The Rt Hon Jeremy Hunt MP

HSIB HEALTHCARE SAFETY INVESTIGATION BRANCH

Maternity investigations

Part of a national action plan to improve maternity care.


2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
GROW/GAP (Pre SBLCBv1)
Better Births published
Morecambe Bay Report published
National ambition announced (v1)
RCOG Each Baby Counts
SBLCB launched
DHSC Safety Strategy published
£8.1m MDT training funding
Maternal Mental Health Units
MatNeo QI programme
Early notification scheme
LMSs plans established
DHSC Strategy update (2025)
Continuity of Carer guidance published
CNST discount scheme launched
All safety champions Identified
PMRT implemented
Continuity of carer implementation
HSIB investigations
SBLCB v2 launched
Increase smoking cessation advisors
Neonatal Critical Care Review
Network maternal medicine
Implementation
Expected impact
Stillbirth/neonatal death/brain injury rate per 1000 births
UK Maternal mortality rate per 100,000 maternities
2020 Ambitions
2025 Ambitions
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2020 Ambitions
2025 Ambitions
Stillbirth Rate
Stillbirth Ambition
Neonatal Mortality Rate
Neonatal Mortality Ambition
Brain Injury Rate
Neonatal Mortality Rate (provisional)
Brain injury rate estimate midpoint
Brain injury ambition
Maternal Death Rate
Maternal Death Ambition

Where are we today?

- 2018 (ONS data) stillbirth rate 4.0 per 1000 births (5.1 in 2010)
- Little change in neonatal and infant deaths over same period
- Several important Morecambe Bay Investigation recommendations not yet implemented
- Leaked interim Ockenden report into Shrewsbury and Telford (Nov 2019)
- Independent Inquiry (Kirkup 2) into maternity services at East Kent (Feb 2020)
- ‘Mind the Gap’ (2018) – significant variation in multi-professional training from trust to trust – 2016 training fund disbanded
- HSIB Maternity Investigations only confirmed until 2021


SOUTH
LAKES
BIRTH
CENTRE

Further information:

‘Mind the Gap report’ – available here

Information about Baby Lifeline Training Courses – available here

Information about the Baby Lifeline & Independent maternity safety campaign – available here

Twitter @JamesTitcombe
@babylifeline