James Titcombe: Can we learn from our mistakes and make genuine improvements in the NHS?

So that's a picture of March 2008 and it's in Normandy in France and apart from being a lot thinner and less grey hair, we're a happy family. That's my daughter Emily and my wife who's pregnant with Joshua. So the pregnancy was fine, it went really well, but on Monday 20 October we were both feeling really poorly: headaches, sore throats and on Saturday night - this was about three weeks before the due date - my wife's waters broke. Over the next couple of days we went to the maternity unit and we were told to come back and wait for the contractions to start and we went into the hospital at 8.30pm and Joshua was born at 7.38am, a perfect healthy little baby boy and we were ecstatic. But soon after the birth, about 8.00am, my wife collapsed, literally collapsed. She had a really high temperature and we later learned that that was an infection, and I'm actually going to leave the story there and finish it at the end of the presentation, because now I just want to talk about this case study.

This was a confidential enquiry done by the Perinatal Institute and I think it's pretty fundamental, and what they did was they looked at normally formed labour and delivery in 2008 to 2009, so one year in the West Midlands they looked at 25 cases and these were all viable births - 16 still births and nine early neonatal deaths across 15 maternity units. They looked at those 25 cases with a full expert panel and they compared the results with what the unit had learned and I think the results are very, very powerful. These are the concerns that the confidential enquiry panel picked up, so 140, compared with the concerns that the unit picked up of 33. So you've got these deaths that were happening and the unit level systems they had to review them had only picked up on 24% of the issues... that's not 24% of the learning, that's the maximum learning... we don't know what the learning was, but it could only be 24%.

So some facts: 2011 this study by The Lancet found that the UK was the 33rd out of 35 high income nations, not good. We spent, in 2011 to 2012, £550 million in negligence claims relating to maternity, yet in this case 24% of the learning points weren't even taken. I think that's quite shocking.

And then I pick up back on my own story. So my wife had collapsed, she eventually was given fluids and antibiotics and recovered, and I asked about Joshua. Well if my wife needs needs antibiotics, what about Joshua? And we were just told he's fine, he's OK. Throughout the next 24 hours he had a low temperature, which I didn't realise but that's a classic sign of neonatal sepsis, nobody picked up on it. Laboured breathing and lethargic, and at one point my wife actually called an emergency bell and said "look, he's not breathing properly". But still nothing was done, he never saw a doctor, and sadly at 24 hours of age he collapsed and that was the first time he'd been seen by a paediatrician. My wife called for help and Joshua was taken away. He was transferred to Manchester where actually at the point when he collapsed the care was fantastic and, you know, the NHS can deliver world class care, we all know that and we should be proud of it. After Manchester he was transferred to Newcastle where he was put on ECMO, and he lived for nine days in total, we were told he was going to survive, but this ECMO which is like a heart and lung machine for babies, he was doing really well until the 3 November and then when they were trying to take him off he started to bleed from

his lung and sadly on 5 November 2008 he died of... well he actually bled to death, which you can imagine was... your world stops.

So what happened after that? Well about a month after Joshua's death we were told all records of his observations in that 24 hour period had gone missing, we were told Joshua's death was a one-off by the trust but over time we learned that wasn't true. The trust actually did a report into the maternity deaths but that report was hidden by the trust, it wasn't shared with the regulators. Ultimately this was the headline in the Health Service Journal in February 2012 (Joshua died in 2008) 'Mothers and babies still at significant risk at Morecombe Bay', and that was only triggered by the inquest we eventually managed to secure for Joshua's case years later.

Why? 2004, this document's been produced - the Seven Steps to Patient Safety - it details an incredible way of learning from mistakes. Suzette Woodward, one of my health heroes, was involved with this, but it's just not followed. So we see we've got documents that say how we can investigate things, but it's not followed. We don't have standards in clinical incident investigations, so the regulators don't go in and audit serious incident reports... and you notice I've put that currently, because I'm really going to try my best to make sure that we do.

Too often organisations respond to incidents in legalistic and defensive ways. How many times do clinical negligence cases get settled three or four years after an event, and you look back at the initial response from the trust and it was defensive? That's no good to anybody. That's the patient safety catastrophe, and there's a lack of training in the principles of patient safety incidents investigation. Don Berwick's challenge is to make sure that the quality of patient care and patient safety is above everything else. No chance, unless we have full honesty when things happen, and medical records going missing is just appalling. All mistakes and serious incidents need to be properly investigated. We need action plans that address the root cause and they're audited, and this is something I'd like people to think about. Another definition of a 'never event' for me is actually any mistake that causes preventable harm happening twice for the same reasons. That to me should never happen.

So the Perinatal Institute case study, the learning ratio if you like, was 24%. I think with everybody that works in the NHS needs to think about their own learning ratio when things go wrong, and we all need to work together to really bring that up, and the reason is because of the photo I showed you at the beginning which was a happy start for a family didn't end up happily. It ended up with a grave and, you know, a son that we don't have any more, and it could have been prevented, and all I ask is everybody to work together to do our best to make sure that that kind of thing doesn't happen again.

Thank you.