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

James Titcombe
November 2013
Joshua’s Story

March 2008 in Normandy – Pregnant with Joshua.

Rest of pregnancy normal
The Days Before the Birth…..

- Monday 20\textsuperscript{th} October, my wife and I were feeling poorly, we had headaches, sore throats - tired and ill.

- Saturday night (25\textsuperscript{th} October), at about 9pm – waters break.

- Over the next 2 days, we visited the maternity unit twice, each time were told to return home and wait for the contractions to start.

- Contractions start around 5am on Monday 27\textsuperscript{th} October…
The Birth

On Monday 27th October we went to hospital at about 6.30am. At 7.38am, Joshua was born.
However.....

Soon after the birth - at around 8am, my wife collapsed with a very high temperature which we later learned was caused by an infection.

At this time we were alone in the birth room and I went for help....
Does the NHS learn when things go wrong?
A case study

CONFIDENTIAL ENQUIRY INTO INTRAPARTUM RELATED DEATHS

NHS West Midlands – Oct 2010
Perinatal Institute Study – 2010 Methodology

- Look at all normally formed, labour or delivery related stillbirths in 2008/09
- 25 cases of perinatal death included in the review
- 16 stillbirths and 9 early neonatal
- 15 maternity units
- Carried out full Confidential Inquiry review of the 25 cases and compared the findings to the unit level reviews
What the study found:

<table>
<thead>
<tr>
<th>Category of substandard care</th>
<th>No. of concerns identified by the panel review</th>
<th>No. of concerns identified by the unit review</th>
<th>% of panel concerns identified by unit review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor antenatal risk assessment / plan</td>
<td>11</td>
<td>2</td>
<td>18%</td>
</tr>
<tr>
<td>Poor antenatal recognition of IUGR</td>
<td>9</td>
<td>1</td>
<td>11%</td>
</tr>
<tr>
<td>Poor management plan for labour</td>
<td>6</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Poor interpretation of the CTG</td>
<td>17</td>
<td>3</td>
<td>18%</td>
</tr>
<tr>
<td>Inappropriate use of oxytocin</td>
<td>5</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Delay in management and / or care</td>
<td>15</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Failure to escalate / obtain senior input</td>
<td>23</td>
<td>9</td>
<td>39%</td>
</tr>
<tr>
<td>Substandard neonatal resuscitation</td>
<td>17</td>
<td>3</td>
<td>18%</td>
</tr>
<tr>
<td>Poor postnatal support</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lack of follow up / future plan</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate record keeping</td>
<td>21</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total number concerns raised</strong></td>
<td><strong>140</strong></td>
<td><strong>33</strong></td>
<td><strong>24%</strong></td>
</tr>
</tbody>
</table>
Some Facts:

- According to a 2011 study by The Lancet, the UK has one of the worst records for stillbirths ranking 33rd out of 35 high-income nations.

- In 2011-12, more than £550m was paid out in negligence claims relating to maternity care in the UK.

- Yet we are only taking 24% of the possible learning from unexpected perinatal deaths?
Back to Joshua’s Story….

- My wife was eventually given fluids and antibiotics & recovered but we were told ‘Joshua was ok’

- Repeated low temp

- Laboured breathing, lethargic and not feeding.
Joshua’s collapse

- Joshua remained in the care of the postnatal ward until 25 hours following his birth.

- At this time, Joshua had never been seen by a paediatrician.

- 25 hours after his birth, my wife spotted Joshua collapsed in his cot, blue with bubbles of saliva around his mouth.

- She called a midwife for help and Joshua was taken away. His battle for life then started.
Intensive care

- Joshua was initially transferred to Manchester where he spent a night. Here he was diagnosed with overwhelming infection to his lungs (pneumococcus), the same organism found in my wife.

- He was then transferred to Newcastle where he was placed on ECMO.
Joshua’s death

- Up until 3rd November, Joshua was doing very well on ECMO.
- On the night of 3rd November, attempted to wean Joshua from ECMO.
- At the latter stages of weaning, Joshua began to bleed from his left lung.
- On the 5th November 2008, around midday we were told that Joshua’s bleeding was too severe and it was time to turn off the ECMO machine.
- Died at 12.15 that day
What happened next…

- Around a month after Joshua’s death we were told all records of his observation prior to his collapse had ‘gone missing’
- Told Joshua’s death was a ‘one off’ but learned over time this wasn’t true
- Report into 2008 maternity deaths ‘hidden’ by trust
- Various investigations but ultimately…
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.
Seven steps to patient safety
The full reference guide
Second print August 2004

Stages of RCA

Fishbone diagram

- Task factors
- Equipment and resource factors
- Working conditions and environmental factors
- Individual factors

Latent organisational factors

- Communication factors
- Education and training factors
- Team and social factors
- Patient factors

Problem or factor to be explored
So why are lessons often not learned?

- Excellent guidance for incident investigation exist – eg 7 steps to patient safety published in 2004 – but this is very rarely followed

- No enforced standards in clinical incident investigation – Not looked at by regulators during inspections (currently!) – big variation from trust to trust

- Too often organisations respond to incidents in legalistic and defensive way – culture of denial

- Lack of training/expertise in principles of patient safety and incident investigation
Don Berwick's Challenge

“The NHS must place the quality of patient care, especially patient safety, above all other aims” – Don Berwick
Not unless…

1) We have candour when mistakes happen and all medical errors are openly acknowledged

2) All mistakes/serious incidents are properly investigated (enforceable standards are needed)

3) Action plans which address the root cause & are audited - the same mistake causing preventable harm twice should be regarded as a ‘never event’ in the NHS

In the Perinatal Institute case study the ‘learning’ ratio was just 24% (max). Raising this ratio across all incidents in the NHS is an urgent priority
Baby
JOSHUA
TITCOMBE
27.10.2008 - 5.11.2008
Our Little Fighter
Always Remembered
References


http://www.nwemail.co.uk/news/significant-risks-to-fgh-mums-and-babies-1.922870?referrerPath=home/2.3320