

FINAL OVERARCHING SUMMARY REPORT

CONTEXT

1. The Morecambe Bay Investigation (MBI) was established by the Secretary of State for Health in September 2013, following concerns over serious incidents in maternity services at Furness General Hospital. Covering the period from January 2004 to June 2013, the findings from the report were published in March 2015 and concluded that “...the maternity unit at FGH was dysfunctional and that serious failures of clinical care led to unnecessary deaths of mothers and babies”.
2. The report made a total of 44 recommendations – 18 specifically for University Hospitals of Morecambe Bay (UHMB), 26 for the wider NHS and other organisations.
3. The first recommendation of the MBI Report was:

“The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring to light and the previous failures to act. This should begin immediately with the response to this Report.”
4. Following the publication of the MBI Report, UHMB has sought to fully embed the learning that has emanated from this, working with a wide variety of partners and stakeholders.
5. Whilst the MBI Report highlighted many failings at an individual, organisational and system level, it left unanswered questions for some of the families. As one of the key lessons was for openness, transparency and candour, this has meant close liaison with these families to understand any residual concerns and issues and to work jointly with them to ensure that they were addressed.
6. This report shares the work undertaken with one of those families, James and Hoa Titcombe, to fully and openly review the circumstances and events that led to the tragic, and avoidable, loss of their son Joshua. In the words of James:

“Following Joshua's loss, it was important to me that the truth about the circumstances that led to his death were understood and acknowledged by the trust and the staff involved and that we could be confident that all possible lessons had been learned. The only way we felt that this could be achieved is

if a proper process of investigation of the events leading up to Joshua's death was undertaken".

7. Specifically, work undertaken with the Titcombes has entailed:
 - Comprehensive Incident Investigation Report
 - Formal response to questions raised by the family
 - Review of staff accountability (internally and externally)

COMPREHENSIVE INCIDENT INVESTIGATION REPORT

8. The Comprehensive Incident Investigation Report was commissioned to examine all aspects of care provided by the Trust to Hoa and Joshua Titcombe, in order to determine whether the care provided was appropriate and delivered to a high enough standard. Further, it was to determine whether there were any breaches of care standards by any clinical staff and to identify the root cause of any such breach. It also considered whether professional standards were maintained by the clinical staff involved in the care of Hoa and Joshua.
9. The report was undertaken by an expert panel of a Consultant Obstetrician, Consultant Neonatologist and Lead Midwife from Central Manchester Foundation Trust, a strategic maternity partner for UHMB. It was undertaken through a retrospective review of available clinical documentation/notes and interviews with the family, current and former employees.
10. The report highlights that the lack of timely escalation to a Paediatrician created a chain of events and missed opportunities, which would probably have altered the outcome in this case. The key conclusions from the Comprehensive Incident Investigation were:

"There were care failings in this case both through a lack of knowledge of individual staff members but also a lack of basic clinical care for mother and baby. There was a failure to recognise deviations from normal (and indeed to monitor for such) and some clinical failings appeared to be secondary to a general complacency in the care offered in the post-natal period with almost a complete lack of documentation from many staff members after the birth. There was no apparent midwifery leadership on the wards and the care was fragmented and haphazard with staff members unsure of what aspects of patient care each were responsible for. There are also concerns that observations may not have been taken in a timely or appropriate manner."
11. The report includes 22 key findings (9 Care Delivery Problems, 9 Service Delivery Problems and 4 Incidental Findings) and addresses these through 18 recommendations. The report acknowledges that due to the time lapse, and the many changes already made at UHMB since the incident, that many of these will already be in place.

12. The report highlights many missed opportunities in the care provided to Hoa and Joshua:
- Delayed (and inadequate) maternal assessment of Hoa after delivery
 - Failure to appropriately document reason for administering antibiotics to Hoa
 - Failure to undertake full reassessment of Joshua in view of risk factors (prolonged spontaneous rupture of membranes (SRM), maternal pyrexia)
 - Failure to escalate concerns/risks to Paediatrician at early stage for a neonatal review of Joshua
 - Failure to formally handover care of Hoa and Joshua
 - Failure to undertake (and document) observations on Hoa and Joshua
13. The Trust fully accepts the findings of the review and acknowledges that:
- Thorough observations of Joshua should have led to a neonatal review by the Consultant Paediatrician at an early stage, including commencement of antibiotics and admission to Neonatal Intensive Care. Had this happened, the Trust accepts the view of the consultant neonatologist who carried out the review, that Joshua would have almost certainly survived had he received antibiotics which should have happened by no later than 10am on the day of Joshua's birth.
 - When Hoa called for help at around 2.30am on 28th October 2008, because of concern about Joshua's breathing, it was 'highly improbable that there were normal neonatal observations present' at this time. This is at odds with the statement from the midwife responsible for Joshua's care at this time who maintained that detailed observations were taken and that all Joshua's observations were normal. Whilst there are no records of any of the observations taken of Joshua at the time, (as Joshua's yellow observation chart has been lost), the Trust acknowledges that this is not a credible version of events based upon the expert view.
 - The standard of care Hoa received following her collapse was not safe, and that the outcome for Hoa was due to the fortuitous use of a broad spectrum antibiotic, rather than the proper and careful assessment and monitoring that should have taken place.
14. Whilst each of the 18 recommendations within the report have now been addressed by UHMB in the period since 2009, it is evident that if the case had been investigated in a timely, comprehensive, open and robust way, such fundamental lessons could have been learnt and actioned much sooner. 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.

15. This is especially true for the recommendations in relation to:
- Improving knowledge and skills of staff in monitoring and caring for a compromised neonate, recognising deteriorating patients
 - Robust shift and patient handover (including the SBAR communications framework)
 - Multi-disciplinary team working and care management
 - Early escalation to Paediatricians
 - Observations, record-keeping and documentation
 - Use of Maternity Early Warning Scores (MEWS)
 - Guidelines for managing maternal and neonatal sepsis
16. The themes addressed by these recommendations were apparent in other serious incidents that continued to occur at the maternity unit at FGH for a number of years after Joshua's death.

FORMAL RESPONSE TO QUESTIONS RAISED BY THE FAMILY

17. The way that UHMB initially responded to the incident and dealt with the family in the years leading up to the MBI Report created a sense of distrust and dishonesty, perpetuated through a perceived lack of acceptance of the failings and ownership of the issues by the Trust.
18. UHMB acknowledges that it did not carry out a full investigation in a timely manner following Joshua's death, and the Comprehensive Incident Investigation has only taken place eight years later. This passage of time has created issues arising from missing and inconsistent data, which are incongruent with personal recollections of the events.
19. A separate review was therefore undertaken to address a series of questions that were posed by the family, connected to (but separate from) the Comprehensive Incident Investigation. This was undertaken through examining a significant volume of evidence, which allowed UHMB to draw some conclusions based on the information available. Against each of these questions, a professional judgement was provided by the Executive Chief Nurse based on current standards and expectations, but subject to the limitations of the information available. Learning against each of these questions has also been captured.
20. Although it was not possible to provide definitive answers to some of the questions due to absent or missing documentation and differing recollections of events, the review found nothing that cast doubt on the events as described consistently by Hoa and James since 2008.
21. As identified previously, there has been considerable change within Maternity Services at UHMB since 2009. Much of the learning within the report directly addresses the recommendations resulting from the Comprehensive Incident Investigation.

22. The most fundamental learning is about how the Trust responds to patient safety incidents. If such an incident were to occur again, a thorough and efficient investigation would now be commenced within 24 hours through a Rapid Review process. This would ensure that all staff involved in the incident would provide a clear and contemporaneous account allied to gathering additional relevant information (including documentation).
23. In addition, to the Rapid Review, the Trust would also commission an external, independent review alongside its internal processes. This would utilise external expertise – the benefit of the expert Obstetrician, Neonatologist and Midwife in the Comprehensive Incident Investigation has already been acknowledged and will be used in the future.
24. Further learning is about how the Trust would ensure involvement of the family throughout the investigation, both through face-to-face discussions and with written updates (under the duty of candour and the Trust's wider commitment to transparency).
25. The key reflection for the Trust is therefore about responding to incidents of this nature in an open, transparent way that allows findings and lessons learnt to be shared more widely. It is important that the Trust's systems and processes are developed to routinely support both families and staff, giving them an opportunity to meet, share reflections and learning, understand the impact of the incident on each other and to apologise for any failings (please see para 36 below).
26. It seems evident that if such a family-centred approach had been commenced from the outset, a joint understanding of what happened and led to the tragic circumstances would have been established. This would have led to joint ownership of the learning, and a more compassionate outcome for the family through them obtaining the answers to their questions.
27. The approach latterly developed with the family in this case sets out a model for adoption more widely across the system.

REVIEW OF STAFF ACCOUNTABILITY (INTERNALLY AND EXTERNALLY)

28. A consistent theme through both previous reports is the Trust's acknowledgement that matters should have been investigated more thoroughly, openly and transparently much earlier. This clearly links into this third element too, as any failings at an individual or team level could have been addressed by appropriate development and performance interventions.
29. The failure of the established processes at that time have led to unsatisfactory and prolonged outcomes for all, most importantly for the family who have failed to see how employees involved have reflected on the circumstances,

learnt from their experiences, accepted their contribution and the impact on the family, and been held to account for their actions.

30. A robust review into the incident, as was done only retrospectively with the Comprehensive Incident Investigation, would have identified recommendations at an individual employee level at an earlier point. Midwives and wider team members would then have been supported in the development of their clinical knowledge, safe practice and professional conduct, improving safety and quality on the unit.
31. This would have been supplemented by robust assurance through the Supervisors of Midwives framework, ensuring that the appropriate competencies were being maintained and that safe services were provided.
32. In addition, any fundamental failings in practice or conduct would have been subject to internal performance processes, with early escalation to regulatory bodies (as required).
33. Internal systems and processes have changed significantly since 2009 – whilst the emphasis is on learning and improvement, this has to balance with personal accountability.
34. It is evident that if such a learning, human factors-based approach had been taken from the outset, appropriate developmental and performance interventions would have been taken that would more appropriately have held people and teams to account for their individual and collective actions.
35. The findings from both the Comprehensive Incident Investigation and the questions raised by the family highlight some fundamental inconsistencies with evidence/statements provided previously, that do not stand the rigour of such close scrutiny. A more contemporaneous and thorough investigation would have identified this at the time and provided opportunity for appropriate action to have been taken at that point.
36. Following the conclusion of an NMC process, which led to a disciplinary sanction being applied to a midwife, a facilitated meeting was held with the family and members of the Trust (including the midwife). The circumstances of the meeting were unique, allowing individuals to meet and share reflections, to demonstrate understanding and acknowledgement of the failures in care and the consequences for the family. The family took great comfort from the midwife demonstrating how she would carry the learning with her always. The key learning is that where there is openness, reflection and learning, it is possible for there to be forgiveness and a positive outcome.

CONCLUSION

37. Following the publication of the MBI Report in 2015, UHMB apologised unreservedly to the families of those who suffered as a result of poor care in the maternity unit at Furness General Hospital between 2004 and 2013,

accepting and acknowledging the criticisms and accepting its recommendations without reservation.

38. Since the report, UHMB has worked hard with stakeholders, service users and members of the public to address each of its recommendations in full, with good progress – we remain on track to deliver the remaining recommendation on time, which is to improve the physical environment in the Labour Suite at FGH by December 2017.
39. For UHMB, the MBI Report was about more than simply addressing the recommendations, but was about the continued development of a patient-centred and safety-focussed organisation in a sustainable way, built around core values.
40. The approach taken jointly with the family demonstrates our acceptance of the MBI findings and our commitment to continue working with the families to improve services and to provide the answers that they need.
41. The further work we have done should indeed have been carried out much earlier in order that the learning could have taken place sooner.
42. What is striking in this review is the commitment of all parties to come together in a process of truth and reconciliation which we would wish to adopt going forward.
43. Sharing stories like Joshua's can play an important part in this learning process. It is important that UHMB makes best use of its 'organisational memory'. Many positive changes have been made at Furness General Hospital's maternity unit and these need to be consolidated and sustained. We are determined that the learning following Joshua's death will continue to play an important part in the ongoing development of Maternity Services and patient safety right across the Trust. Other maternity units can also learn more from the missed opportunities, reflections and powerful lessons from Morecambe Bay.