Independent Investigation into East Kent Maternity Services

In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care. Dr Kirkup yesterday (19 October 2022) published his report of the investigation, *Reading the signals: Maternity and neonatal services in East Kent – the report of the independent investigation*.

The report is summarised below, along with NHS Providers press statement. We would encourage trust colleagues to read the report in full but if you have any comments about the report or this briefing, please contact Ferelith Gaze, head of policy and public affairs, (ferelith.gaze@nhsproviders.org).

Background

From 2010 onwards, a number of reviews raised concerns about maternity services at East Kent Hospitals University NHS Foundation Trust. In 2020, the inquest into the death of Harry Richford set out various reports and concerns to the coroner. On 13 February 2020, the then health minister, Nadine Dorries, confirmed in Parliament that NHSE/I had commissioned Dr Bill Kirkup CBE to undertake an independent investigation into maternity and neonatal services at the trust. The terms of reference were published on 11 March 2021.

The report

The investigation reviewed 202 cases where the families involved asked to participate and where their care fell within the scope of the investigation. The results of these case reviews draw on evidence from family listening sessions, clinical records and interviews with clinical staff and others. The investigation spans the period from 2009 – when foundation trust status was achieved – to the end of 2020.

The report comprises an open letter followed by:

- Chapter 1, setting out what the investigation found, missed opportunities to put things right, underlying failures that led to harm, and key themes that must be addressed in the response to these failures.
- Chapters 2 to 5, setting out the evidence behind the investigation's findings
- Chapter 6, drawing out the lessons with recommendations both for East Kent and nationwide
- Appendices setting out the terms of reference for the investigation, how it conducted its work and the investigation team

Illustrative cases are presented throughout the report, including but not limited to:

- A mother who was sent home and asked to wait before returning to hospital whose baby was stillborn
- A mother who experienced a traumatic birth and surgical injury, but who was made to feel ignored, marginalised and disparaged followed by a lack of transparency about what had happened and a failure to report and investigate a serious incident. The experience has meant she will never have a second child
- The death of Amber Bennington who died at nine days old following clinical mismanagement of her delivery
- The death of a baby from overwhelming streptococcal infection, whose treatment was delayed following his mother's concerns for one of her twins being dismissed and a trainee seeing no grounds for concern despite signs of an infection
- The death of a baby born with signs of brain damage following a labour known to be high risk, where no formal assessment of the risk to mother and baby of a home birth was made, the trust having advised against delivery in a midwifery-led unit
- A mother who reported reduced fetal movements, and who was sent home without discussion of the risks of delaying being induced. When she attended again to report no fetal movement for six hours, no heartbeat was found
- A baby left with significant brain damage following a delayed emergency caesarean section
- A mother who did not receive the advised preventive treatment to manage her raised risk of venous thromboembolism after an elective caesarean section, and subsequently died
- A mother who chose to follow the VBAC (vaginal birth after caesarean) pathway, but whose request for a caesarean section after experiencing excessive pain and a labour which did not progress, was initially denied. After four hours, her baby was found to have died and her uterus ruptured

In his letter to the secretary of state and the NHS chief executive, Dr Kirkup explains that the primary purpose of the report is to set out the truth for the sake of the families involved so that maternity services in East Kent can begin to meet the standards expected nationally for the sake of those to come. He also notes that events at East Kent were not one-off, isolated, failures and that maternity services have been the subject of more significant policy initiatives than any other service since his 2015 Morecambe Bay investigation report. Without tackling these issues differently, he expects there to be more in the future.

With this in mind, detailed changes to practice and management are not set out in the report. The focus instead is on four areas of action: identifying poorly performing units, giving care with compassion and kindness, teamworking with a common purpose, and responding to challenge with honesty. He also highlights the importance of using meaningful, risk-sensitive outcome measures in maternity services to identify results that are genuine outliers.

Chapter 1: Missed opportunities at East Kent – our Investigation findings

The maternity services in two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020 were examined. The investigation found a clear pattern wherein, over this period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor, both as care was given and in the aftermath of injuries and deaths.

The investigation found that the individual and collective behaviours of those providing the services were visible to senior managers and the trust board in a series of reports throughout the period and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively and eight clear separate opportunities were identified when that could have happened. The investigation's assessment of the clinical outcomes found that:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the [investigation team] panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.
- The panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

These numbers are understood to be minimum estimates of the frequency of harm over the period, and are based on the 202 volunteered cases.

Findings

The report recognises that most mothers and babies are healthy, but where things start to go wrong, problems can rapidly escalate. The investigation identified problems in:

- What happened to women and babies under the care of the maternity units within the two hospitals
- The trust's response, including at trust board level, with a lack of learning and undue assurance taken from the fact that the great majority of births in East Kent ended with no damage to either mother or baby
- The trust's engagement with regulators, including the Care Quality Commission (CQC), and the actions and responses of the regulators, commissioners and the NHS, regionally and nationally

The investigation questions how statistics are used to manage maternity services and believes that it should be possible for:

- individual trusts to monitor and assess whether they have a problem;
- the NHS regionally and nationally to identify trusts whose safety performance makes them outliers; and
- the regulators to differentiate the services provided more quickly and reliably.

What happened to women and babies

The investigation found that no single clinical shortcoming explains the outcomes of the cases examined, and the pattern of repeated poor outcomes should not be attributed to individual clinical error. Shortcomings in physical infrastructure, and workforce and resource shortages, were not found to be causative or sufficient to justify, explain or excuse the experience of the families. The geography, location and demographics of the hospitals were factors but again, should not have been regarded as explaining or justifying the service provided. Instead, the investigation found that the origins of the harm lie in failures of teamworking, professionalism, compassion and listening:

- *Failures of teamworking:* The investigation found gross failures of teamworking across the trust's maternity services, including dysfunctional working between and within professional groups, bullying, lack of mutual trust, and disregard for other points of view.

- *Failures of professionalism:* The investigation found clear and repeated failures, including staff being disrespectful to women. The investigation also found that midwives who were not part of the favoured in-group at WHH were sometimes assigned to the highest-risk mothers and challenged to achieve delivery with no intervention. This report describes this as a downright dangerous practice.

- *Failures of compassion:* The investigation heard many examples of uncompassionate care, including women's questions and concerns being dismissed, dealt with brusquely, ignored or disbelieved. This applied during their care and in the aftermath of injury and death.

- *Failures of listening:* The investigation found that in some cases, failure to listen contributed to an adverse clinical outcome. In others, it was part of a pattern of dismissing what was being said, which contributed significantly to the poor experience of families.

Failures after safety incidents

The investigation found that dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage. The report describes staff who failed to show compassion, denied responsibility or that anything untoward had occurred, and at times blamed mothers for what had happened. Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families. Safety investigations, if conducted, were not undertaken in a way, to identify learning. The investigation found that where the nature of the safety incident meant that incidents could not be minimised, a junior obstetrician or midwife was often blamed.

Failure in the trust's response, including at trust board level

The investigation found that problems within teams were known but bullying and divisive behaviours were not effectively addressed.

The investigation also found that the trust board missed opportunities to identify the scale and nature of the problems and put them right. Although action plans were put in place they under-estimated the recurring pattern of failure, often attributing blame to individuals or individual clinical error. Repeated staff turnover exacerbated the tendency to treat problems as a one-off.

The actions of the regulators

The investigation found that the trust was faced with a bewildering array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and

clearly enough to ensure that real improvement followed. The report adds that it seems the plethora of regulators and others served to deflect the trust into managing those relationships as a priority. Tensions within the roles of regulators and professional bodies were also identified. When regulators did seek to help, these interventions did not secure the necessary improvements.

Missed opportunities

The most significant missed opportunities since 2009 were:

1. In 2010, an internal review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of a shortage of oxygen. Recommendations were made regarding clinical practice, adherence to guidelines and review processes but no evidence was found that these recommendations were followed up.

2. From 2013, the clinical commissioning groups (CCGs) in East Kent raised concerns about the trust, including its maternity services, with NHSE and with the trust. They failed to gain traction with either and approached CQC, which subsequently inspected the trust in 2014.

3. In 2014, CQC rated the trust Inadequate overall, identifying a divide between senior management and frontline staff, governance and assurance processes that did not reflect reality, very poor staff engagement, poor reporting and investigation of safety incidents, and limited use of clinical audit. Maternity services were rated as "Requires Improvement". The report describes the reaction of the trust as defensive saying when action plans were drawn up, they were of poor quality and not effectively followed up.

4. In 2014/15, the new head of midwifery undertook a review, working alongside the trust's HR department, and found considerable evidence of a dysfunctional and frightening work environment. Those individuals identified as central to the issues were set to be relocated or suspended, but following their collective letter of grievance, the trust withdraw support from the review process. The head of midwifery was advised against disclosure by the Royal College of Midwives in the interests of patient safety. No further efforts were made to address the persistent bullying culture.

5. In May 2015, the head of midwifery at the trust noted the similarity of issues and lessons identified within the Morecambe Bay maternity services report and sought to raise similar

issues of concern with the trust leadership. The trust commissioned a report later in 2015 and found that it "was not another Morecambe Bay".

6. In February 2016, a Royal College of Obstetricians and Gynaecologists report made serious criticisms of the maternity services in East Kent.

7. On 9 November 2017, baby Harry Richford died in the neonatal unit at WHH, seven days after he was delivered at QEQM. Many of the same issues cited in previous inspections, reviews and reports appear again in Harry's case, the clinical management of his delivery, the care given to his mother, and the treatment of his family after his death.

8. In 2018, it became evident to the Healthcare Safety Investigation Branch (HSIB) that East Kent maternity services were an outlier because of the rate of occurrence of safety incidents resulting in serious harm. HSIB experienced difficulties in its dealings with the trust, including problems obtaining information, staff attendance at interviews, and support for the process from the trust's senior leadership team. HSIB's concerns increased over the course of 2018 and it sought a meeting with the trust's senior leadership team.

Where accountability lies

The report states that had any of the above opportunities been grasped, there would undoubtedly have been benefits in terms of avoiding death, disability and other harm, and in terms of the mental wellbeing of many families. However, the report authors are also clear that the issues here were systemic throughout the organisation and do not lie at the door of individual clinicians.

The report is clear that a series of failings at board level meant opportunities to identify and rectify failures were missed.

Key areas for action

Recent years have seen investigations including into maternity services in Morecambe Bay in 2015, in Shrewsbury and Telford in 2021/22, the East Kent investigation commissioned in 2020, and latterly Nottingham. To avoid adding multiple, overlapping recommendations which do not lead to sustainable improvement, this investigation identifies a limited number of key themes and recommendations. The investigation is also concerned to avoid the assumption that East Kent will be the last maternity service facing these issues. It therefore identifies four key areas for action that it believes must be addressed by all trusts and nationally.

Key Action Area 1: Monitoring safety performance – finding signals among noise

The report finds that a mechanism is needed to give early warning of problems before they cause significant harm. The aim must be for:

- every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time;
- the NHS to monitor the safety performance of every trust; and
- neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.

The mechanism must be nationally standardised and is not optional. It will be based on:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into "league tables".

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The investigation found frequent instances of a distressing and harmful lack of professionalism and compassion. Too often, well-founded concerns were dismissed or ignored.

A particular area of concern was the telephone advice given to mothers to stay at home if they were not adjudged to be in established labour. The investigation also found a pattern of poor behaviours by some obstetric consultants, particularly at QEQM. When addressing consultants' behaviour, the report found that the trust's actions were weaker than when dealing with midwives.

The report is concerned not to detract from the importance of employment protection, but at the same time questions the fact that behaviour which seriously threatens patient safety cannot be robustly addressed.

The report finds that there is a pressing need to understand better gross lapses of professionalism, compassion and willingness to listen, including their prevalence, the underlying causes, how they can be changed.

Key Action Area 3: Flawed teamworking – pulling in different directions

The report finds that teamworking in East Kent maternity services was dysfunctional. Many staff described "toxic", "stressful" working environments and poor relationships both within and between

professional groups. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

No systematic policy in East Kent maternity services was found of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. However, the way in which "normal birth" was described and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve.

The report authors believe that insufficient attention has been given nationally to the language that is used around "normality" and in the presentation of information among both maternity staff and mothers. The investigation is aware that some recent steps have been taken to improve this, but considers these insufficient to remove the risk of misunderstanding and misinterpretation.

The report found that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made with the best intentions may have unintended consequences. More generally, it believes that it is time to think about a better concept of teamwork for maternity services – one that establishes a common purpose across, as well as within, each professional discipline.

Key Action Area 4: Organisational behaviour – looking good while doing badly

The investigation found that during the period under review, the trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

The investigation describes an unhelpful pattern of hiring and firing, initiated by NHSE, at leadership levels, including with regard to the roles of chief executive and chair. It states that while the practice may never have been an explicit policy, it has become institutionalised. The appointments that were made led the trust, and NHSE, to believe that things were changing when in fact the underlying shortcomings remained and created a flawed model based on "heroic leadership".

The report considers the problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services. It cites a legal duty of truthfulness placed on public bodies has been proposed as one of the responses to the Hillsborough disaster.

Chapter 2: The Panel's assessment of the clinical care provided

All the cases were graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) scoring system, which defines four levels of suboptimal care based on their relevance to the outcome.[1] The degree of harm in each case was also determined.[2]

The Panel's findings regarding suboptimal care and associated outcomes for all cases mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases reviewed (48%)
- In 69 of these 97 cases, the outcome would have reasonably been expected to be different
- In 28 of these 97 cases, it might have been different

In relation to baby deaths, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 45 of the 65 cases of baby deaths (69.2%)
- In 33 of these 45 cases, the outcome would have reasonably been expected to be different
- In 12 of these 45 cases, it might have been different

In relation to cases of injury to babies, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 12 of the 17 cases of brain damage (70.6%)
- In 9 of these 12 cases, the outcome would have reasonably been expected to be different
- In three cases, it might have been different

In respect of cases involving maternal injuries and deaths, the Panel's findings mean that:

- Had care been given to nationally recognised standards, the outcome could have been different in 23 of 32 such cases (71.9%)
- In 15 of these 23 cases, the outcome would have reasonably been expected to be different
- In eight cases, it might have been different

[1] Level 0 – No suboptimal care; Level 1 – Suboptimal care, but different management would have made no difference to the outcome; Level 2 – Suboptimal care, in which different management might have made a difference to the outcome; Level 3 – Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome.

[2] Degrees of harm being: none, minimum, moderate, severe, death.

The Panel found that, in a few cases, there was suboptimal care that did not lead to a poor outcome or which led to an outcome that could have been much worse. These are examples of suboptimal care that went unnoticed, which by chance did not result in a poor outcome. They are described as being "narrow escapes" rather than "near misses".

The Panel also found an overriding tendency of midwives and doctors to disregard the views of women. This is despite the concerns they were raising matching the avoidable factors identified by the investigation.

Chapter 3: The wider experience of the families

Summary

This chapter describes the wider experiences of the families beyond the clinical outcomes and identifies six common themes:

1. Not being listened to or consulted with
2. Encountering a lack of kindness and compassion
3. Being conscious of unprofessional conduct or poor working relationships compromising their care
4. Feeling excluded during and immediately after a serious event
5. Feeling ignored, marginalised or disparaged after a serious event
6. Being forced to live with an incomplete or inaccurate narrative

The Panel found a deep impact on the wellbeing of families that continues to this day, sometimes many years after the birth.

Findings

The Panel undertook family listening sessions where women and their families shared their knowledge, experience and perceptions of the care they received. This was correlated with clinical notes in each case and where necessary, relevant staff were interviewed. Trauma-informed counselling was offered to the families, and in total more than a quarter attended.

The Panel found a number of overarching themes that characterise the experience of the participating families. The behaviours identified are believed to have been detrimental to the quality and safety of the care given to women, and to their overall experience. We would encourage all trusts to read the table of themes and indicative behaviours included within the full report.

Conclusions, including consequences and impact on wellbeing

These families attribute the following consequences to the events they experienced and the actions of clinicians and other trust staff:

- Not knowing if things might have been different; living with "what ifs"
- Feelings of guilt and responsibility for what happened
- Changes in personal beliefs about healthcare
- Mistrust of clinicians, institutions and the wider health system
- Feeling forced into a position where they sought legal advice to find out what had happened
- Loss of personal confidence
- Heightened emotions, including anger, rage and shame
- Self-blame for not raising concerns more forcefully or speaking up enough
- Panic attacks
- Not wanting more children or being frightened at the prospect of having another baby
- Needing to move away from the area or avoid being in proximity to the hospital
- Relationship difficulties, including some that have ended in separation, and difficulties with intimacy.

The report also highlights the additional guilt that many families have come to feel for not speaking up, when they have seen more recent cases come to light.

The Panel found that in addition to failures in clinical care, additional harm was caused by the behaviours and attitudes of those responsible for communicating with and supporting them after the event. It is the Panel's view that aspects of the families' experiences have been so damaging as to have had a profound and lasting effect on their health and wellbeing.

Chapter 4: What we have heard from staff and others

Summary

Alongside listening to families, the investigation has conducted interviews with 112 current and former staff at East Kent Trust and with others whose work brought them into contact with the trust's maternity and neonatal services. This chapter describes what was heard, rather than indicating the Panel's own thinking and conclusions.

Findings

Between October 2021 and June 2022, the Panel met with 90 members of trust staff, including midwives, neonatal nurses, obstetricians, neonatologists, paediatricians and other clinicians, as well as members of the Board, the Executive and other managers. It also interviewed 22 individuals who had been in contact with the trust from the CQC, HSIB, NHSE/I and CCGs.

The Panel's write up focuses on what it heard about the problems and challenges facing the trust. The Panel also notes that it heard about positive aspects, including efforts made to improve the culture and service, the initiatives to support better performance and outcomes, and the commitment of the majority of staff to do their best for their patients. However, the Panel is conscious that some wished to put a positive light on subsequent improvements in services, but this view was not generally borne out by other evidence.

Trust merger

The trust was previously three separate trusts: the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust. The three merged in 1999 following a local review of services.

The merger is described as having pitched the three original trusts against each other, for example, in reducing the number of maternity units from three to two. It was noted in 2014 by the CQC that the trust still behaved like three separate organisations. As part of its achieving foundation trust status, the then regulator Monitor required fewer management groups, which left senior clinicians feeling they did not have a voice and in 2011 a reorganisation moved a number of unrelated specialties (including women's health) into a single division. This was said to have displaced focus and leadership from maternity services. In 2018, the trust's directorates became clinically-led care groups with the intention of the clinicians delivering services being supported by their managers. The trust was described to the Panel as a "challenged" organisation typical of a cohort of trusts where there were significant performance and operational challenges, but where the underlying problem was really one of culture.

Staff views

Based on its interviews, the Panel describes:

- Poor staff morale
- Lack of staff engagement and leadership
- Staff behaviours that needed addressing including poor relationships between professional groups, difficulty challenging poor behaviour, bullying, racial discrimination and lack of diversity

Organisational issues

Culture of denial and resistance to changes

Many staff, and others, spoke about a culture of denial at the trust and a resistance to change.

Culture of blame and handling complaints

The Panel heard from a number of people about a "blame culture" when things went wrong. When a learning opportunity was identified, it felt like a punishment. When things went wrong, there was no opportunity to debrief; the response was reactive rather than proactive.

External factors or problems as the staff saw them

The issues cited as external factors or problems were:

- Facilities and infrastructure which were not fit for use
- Geography which made maintaining staffing levels and service quality a challenge
- Staffing shortages and difficulties in recruiting
- Leadership which, at a board level, struggled with the size, complexity and diversity of the trust, and where there was toxic culture and unhealthy tension between managers and clinicians, who had different priorities
- Changes at board and senior management level where there were prolonged periods of instability with regular senior staff turnover
- Clinical leadership with difficulty attracting clinical leaders as well as resistance by clinicians to being led, and a lack of a midwifery voice at board level
- Financial Special Measures which had a significant adverse impact on the transformation and improvement agenda and on innovation
- Governance which suffered from a disconnect between ward and board and poor information flows, and a lack of robust structures and processes
- Response to the Royal College of Obstetricians and Gynaecologists report which didn't see an organisational approach to tackling the problems identified
- Risk management was disjointed, under-utilised and under-resourced, as well as lacking ownership and leadership, and suffering the impact of wider cultural issues

The Panel also sets out the trust's relationships with involved bodies:

- Regulators and commissioners were numerous and created the potential for confusion in their roles, with relationships between the trust and these bodies also challenging

- Clinical Commissioning Groups in the area did things differently, making it hard to respond, and from the CCG perspective relationships were very challenging
- Care Quality Commission and the trust had significantly different views about the trust's performance, and had a very difficult relationship
- Healthcare Safety Investigation Branch saw the trust was an outlier in its referral rate and struggled to get the engagement and support of the trust's leadership team
- Nursing and Midwifery Council whose involvement varied according to the referrals received, and noted these are not always indicative of the degree of problems faced
- General Medical Council which had not received feedback on issues within the maternity services at the trust
- Local Supervising Authority which audited the trust between 2012 and 2016, and identified a number of issues including in relation to adherence to standards, learning from incidents, governance and transparency
- NHS England/NHS Improvement which became concerned about the trust in 2019 following concerns were raised by HSIB and which then undertook extensive scrutiny of and involvement with the trust
- Improvement initiatives and programmes began to have an impact from 2018, initially with the BESTT programme, but the multiplicity of recommendations and ongoing prevalence of issues was also notable

Chapter 5: How the trust acted and the engagement of regulators

Summary

This chapter gives an account of how the trust considered maternity and neonatal services and engaged with regulators and others. This chapter sets out how the trust conducted itself as reflected in its own documents and is not an expression of the investigation's findings.

Findings

The first indication of awareness of concerns about maternity services within the trust came at the Board meeting on 24 September 2010, where the Medical Director gave an overview of a recent SUI within maternity. Over subsequent years, reviews were undertaken by the trust and external bodies, and concerns were raised by a number of individuals and organisations. Changes were made to the configuration of its maternity units and plans developed, but concerns continued that these were not being embedded and that cultural issues persisted.

The chapter expands on the findings of the reviews and further concerns mentioned earlier in this briefing, namely those by the trust, by Monitor, the CQC, following the Morecambe Bay investigation and RCOG. It also sets out the interactions between the trust, regulators and HSIB, as well as board oversight of maternity services over the period of the investigation.

Harry Richford

This chapter also sets out in detail the circumstances surrounding the birth and death of Harry Richford in November 2017, the subsequent investigation and its considerable flaws, and the findings of the coroner. The coroner's report identified the following failures in Harry's care:

- Harry was hyperstimulated by an excessive use of Syntocinon over a period of approximately ten hours.
- The CTG reading became pathological by 2am and Harry should have been delivered within 30 minutes, not 92 minutes later.
- The delivery itself was a difficult one. It should have been carried out by the consultant who should have attended considerably earlier than [they] did.
- The locum on duty that night was relatively inexperienced. [They] were not properly assessed, if at all and should not have been put in the position of being in charge unsupervised.
- There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.
- There was a failure in not requesting consultant [paediatrician] support earlier enough during the resuscitation attempts.
- There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the result that control was lost.

The coroner also issued a regulation 28 report – a report requiring action to prevent future deaths. This detailed 19 concerns identified during the inquest and the coroner's recommendations as to how they could be addressed to prevent future deaths. The recommendations included:

- Action to ensure proper review and assessment of locums and a reminder that it is the supervising consultant's responsibility to ensure the locum under their supervision is competent and experienced
- A review of trust processes to ensure clarity around the actions required in the event of an obstetric concern or emergency developing
- A review of procedures to ensure staff understand the circumstances where consultant attendance is required

- Training and learning, including simulation training, covering neonatal resuscitation
- Cross-site paediatric working between QEQM and WHH
- Addressing confusion among staff regarding the guidelines and policies that apply to them, by reviewing staff awareness of governing clinical and operational guidance
- An audit of the quality of record keeping and documentation, as the record keeping on the obstetric unit was substantially substandard
- A review of trust policies to ensure that the outcomes of independent reports are shared with trust staff so that important learning takes place to prevent any future deaths.

Harry's death was not raised in any detail with the trust board until late 2019, months before the inquest began and almost two years after Harry died. The report finds that it was only in the aftermath of the coroner's findings and the regulation 28 report that the trust took meaningful action in response to the failings identified in the Richford case. The trust established a Learning and Review Committee (LRC) with separate workstreams to look at the myriad issues, as well as previous investigations such as the RCOG report, the Richford Root Cause Analysis and the HSIB report. The LRC reported to the board on its implementation of recommendations and actions, and all actions were completed by June 2020, when the LRC became the Maternity Improvement Committee.

Over the course of 2020, the board made assurances to the public of its commitment to listening to patients and their families, that the trust was making significant changes to its maternity services, and that it was working with the national bodies to make the necessary improvements.

Chapter 6: Areas for action

The investigation has not sought to identify multiple detailed recommendations. It takes those recommendations and the resulting policy initiatives as a given. Instead, it identifies four broad areas for action, based on its findings but with much wider applicability.

Key Action Area 1: Monitoring safe performance – finding signals among noise

The problem	The future
• A dearth of useful information on the outcome of maternity services • How information and data are used, and the false assurances that are drawn	• Effective monitoring of outcomes, with benefits including identification of scope to improve effectiveness and address safety problems, and early identification of warning signs / outliers

	• Requirement 1: generation of measures that are meaningful; risk adjustable; available; and timely • Requirement 2: the use of sound, statistically based approaches to detecting the signal among the noise, and presenting this graphically to show not only the level of variation but also the significant trends and outliers • The approach must be national, and it must be mandatory

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The problem	The future
• Failure to listen directly affects patient safety because vital information is ignored • If role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards • Patterns of unprofessional behaviour, lack of compassion and failure to listen are normalised and difficult to correct	• Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised • Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels • Reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable • The importance of listening to patients must be re-established as a vital part of clinical practice

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

Key Action Area 3: Flawed teamworking – pulling in different directions

The problem	The future
• In almost every failed maternity service to date, flawed teamworking has been a significant finding, often at the heart of the problems • The divergence of objectives of different groups • Poor morale among obstetric trainees is a common feature	• A stronger basis for teamworking in maternity and neonatal services, based on an integrated service and workforce with common goals, and a shared understanding of the individual and unique contribution of each team member in achieving them • National guidance on of different care pathways must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives • Teams who train together work better together – there are opportunities at every stage of training to increase understanding of others' roles and responsibilities, and to become used to working with other disciplines and the contributions they make • Re-evaluation of the changed patterns of working and training for junior doctors, and in particular how the unintended consequences of fragmentation of work and lack of support can be avoided or mitigated

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with

reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

Key Action Area 4: Organisational behaviour – looking good while doing badly

The problem	The future
• The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation. This can lead to denial, deflection, concealment and aggressive responses to challenge, rather than learning, improvement and compassion • Pursuit of decisive action in the face of difficulties, with changes to leadership being one of the few levers available to NHSE – this halts steps towards recovery and creates an incentive to be less frank about emerging problems	• The balance of incentives for organisations needs to be changed. The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment • Legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open • A review of the regulatory approach to failing organisations by NHSE to identify alternatives to the "heroic leadership" model, including the provision of support to trusts in difficulties and incentives for organisations to ask for help rather than conceal problems

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

East Kent Hospitals University NHS Foundation Trust

The report states that the new leadership of the trust are already aware that there are deep-seated and longstanding problems of organisational culture in their maternity units. They will know what assistance they can commission from external bodies, including NHSE, and must receive full support. They must work in partnership with families who wish to contribute, and report publicly on their

approach and its progress. We expect that staff will want to give their full engagement and cooperation, having seen the harm that resulted from previous behaviour that had become normalised.

In making its recommendations, the report is clear that the first step in the process of restoration is for all those concerned to accept the reality of what has happened. The damage caused to families is incalculable, and their courage in coming forward to ensure this came to light is exemplary, but it should not have been necessary. This must be acknowledged without further delay. Only then can the trust embark on trying to make amends.

Recommendation 5

- The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Press statement

NHS Providers responds to report on East Kent maternity services

Responding to the report of the independent investigation led by Dr Bill Kirkup into maternity and neonatal services in East Kent, NHS Providers' interim chief executive, Saffron Cordery, said:

"Dr Kirkup's findings are harrowing. It is clear in the cases investigated here that women, their babies and families did not receive the safe, compassionate care they should have done.

"As Dr Kirkup notes, there have been many other recent investigations and reports into maternity services, and the parallels in each are clear.

"This sensitive, insightful report seeks a different approach to avoiding any more families facing the same devastating failures of care. Dr Kirkup's focus on behaviours as the driving factor is the right one, and we welcome his insistence on the need for honesty, openness and compassion throughout the NHS.

"We welcome too his recognition of maternity and neonatal services as being delivered as part of a wider system. Where failures are collective, reflection and improvement must also be collective.

"Some of the problems identified are more common in maternity and neonatal services, some exist in the NHS more widely particularly with regard to the need to invest in and staff the workforce appropriately. From NHS wards and boardrooms to national regulators and the government, there must be an absolute commitment to developing a safety culture throughout the NHS.

"Across the country and across its services, the NHS delivers high quality care every day and night. But as this report makes clear, this is not an experience shared consistently by everyone. It is essential that we both build on the good care within the NHS and learn from the experiences of those in this report and its predecessors.

"There must be openness and support throughout the system to listen to where there is the potential for harm, and commitment to continually learning from mistakes and building on strengths."

Annex: Terms of reference

In February 2020, Dr Bill Kirkup was appointed by NHSE/I to chair the independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at East Kent University Hospitals NHS Foundation Trust during the period since 2009 (when the Trust came into being) drawing upon the methodology followed in the Morecambe Bay investigation. This was confirmed in parliament. The minister at the time, Nadine Dorries, also announced that the Chief Midwifery Officer, Jacqueline Dunkley-Bent, had sent an independent clinical support team to the Trust to provide assurances that all possible measures were being taken.

The investigation considered four issues in particular:

1. What happened at the time, in individual cases, independently assessed by the investigation.
2. In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the trust respond and seek to learn lessons?
3. How did the trust respond to signals that there were problems with maternity services more generally, including in external reports?
4. The trust's engagement with regulators including the CQC. How did the trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

The investigation considered those cases where there was:

1. A preventable or avoidable death;

2. Concern that the death may have been preventable or avoidable;
3. A damaging outcome for the baby or mother;
4. Reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong.

The investigation was tasked with providing an independent assessment of what happened with East Kent Maternity and Neonatal Services and identifying lessons and conclusions. This was to include:

a. Determining the systems and processes adopted by the trust to monitor compliance and deliver quality improvement within the maternity and neonatal care pathway.
b. Evaluating the trust's approach to risk management and implementing lessons learnt.
c. Assessing the governance arrangements to oversee the delivery of these services from ward to board.

In doing so, the investigation committed to focusing on the experience of the families affected, providing them with an opportunity to be heard and to shape the key lines of enquiry. It also focused on the actions, systems and processes of the trust (with reference to clinical standards for maternity and neonatal care during the period). It would also consider the relevant processes, actions and the responses of regulators, commissioners and the wider system.

The investigation would then draw conclusions as to the adequacy of the actions taken at the time by the trust and the wider system. Taking account of improvements and changes made, the investigation aimed to provide lessons helpful to East Kent and nationally in order to improve maternity services across the country. It committed to agreeing with NHSE/I steps to help ensure that the lessons identified are understood and acted upon.

The full terms of reference, including the protocols and methodology used by the investigation, are set out in the report and on its website: https://iiekms.org.uk/terms-of-reference/.