

# **Reading the signals**

## Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

Dr Bill Kirkup CBE

HC 681



Return to an Address of the Honourable the House of Commons  
dated 19 October 2022 for

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# Open letter to the Secretary of State for Health and Social Care and Deputy Prime Minister and to the Chief Executive of the NHS

The death of a baby is a devastating loss for any family. As one bereaved mother put it, *“When your baby dies, it’s like someone has shut the curtains on life, and everything moves from colour to darkness.”* How much more difficult must it be if the death need not have happened? If similar deaths had occurred previously but had been ignored? If the circumstances of your baby’s death were not examined openly and honestly, leaving the inevitability of future recurrence hanging in the air?

The Panel investigating East Kent maternity services heard the harrowing accounts of far too many families to whom all of this had happened, and more. If it was hard for us to listen to, we could not imagine how much harder it was for those families to relive, although the effects on those who were giving us their accounts were often all too clear. The primary reason for this Report is to set out the truth of what happened, for their sake, and so that maternity services in East Kent can begin to meet the standards expected nationally, for the sake of those to come.

But this alone is not enough. It is too late to pretend that this is just another one-off, isolated failure, a freak event that *“will never happen again”*. Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

For that reason, this Report is somewhat different to the usual when it comes to recommendations. I have not sought to identify detailed changes of policy directed at specific areas of either practice or management. I do not think that making policy on the basis of extreme examples is necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. More significantly, this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967–69, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.

This Report identifies four areas for action. The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty. None of these are easy or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change. Nor do I pretend to have the answers to how best they should be tackled: they require a broader-based approach by a wide range of experienced experts. But unless these difficult

areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems.

Above all, we must become serious about measuring outcomes in maternity services. There are obvious difficulties, given that pregnancy and childbirth are physiological in most cases and poor outcomes less common, but this must not become an excuse. Meaningful, risk-sensitive outcome measures can be found, as they have been in other specialties. They can be used, not to generate meaningless league tables, but to identify results that are genuine outliers. Only in this way can we hope to detect the next unit that begins to veer off the rails before widespread harm has been caused, and before it has had to be identified by families who have suffered unnecessarily. There is work under way in the NHS but it needs further support and direction and the approach must be mandatory, not optional. I am ready to discuss and explain further how this can best be done.

But if we are to break the cycle of endlessly repeating supposedly one-off catastrophic failures, all four areas must be addressed. There are very difficult and uncomfortable issues here, but we cannot in all conscience pretend that “it will not happen again” unless we are serious about tackling them.

My thanks are due to everyone who assisted with this Investigation, including NHS and Trust staff, and it would not have been possible without an incomparable Panel, Advisers and Secretariat. Most of all, however, thanks are due to the families, some of whom made the Investigation happen in the first place and all of whom helped us understand the reality, often at great personal cost to themselves. We owe it to them to listen and learn, not only for East Kent but for NHS services elsewhere.

A handwritten signature in black ink that reads "Bill Kirkup". The signature is written in a cursive, slightly slanted style.

**Dr Bill Kirkup CBE**

October 2022

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

## Introduction

**1.1** The Panel has examined 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, in accordance with our Terms of Reference. Responsibility for these services lay with East Kent Hospitals University NHS Foundation Trust (the Trust).

**1.2** We have found a clear pattern. Over that 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.

**1.3** The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, 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. We identify here eight clear separate opportunities when that could and should have happened.

**1.4** It is therefore only right that in our Report we indicate where, in our judgement, accountability lies for missing the opportunities to bring about real improvement in the clinical outcomes and in the wider experience of families in East Kent.

**1.5** The consequences of not grasping these opportunities are stark. Our assessment of the clinical outcomes, set out in Chapter 2, shows 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 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.

**1.6** We have no doubt that these numbers are minimum estimates of the frequency of harm over the period. We made no attempt to review other records or to contact families who did not volunteer themselves. It was our judgement that we had enough evidence based on the existing 202 cases to identify the problems and their causes, and we did not wish to delay publication of our findings.

**1.7** Nor was the harm restricted to physical damage. Chapter 3 sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

**1.8** This chapter sets out what we have found in East Kent maternity services, and how the Trust failed to read the signals and missed the opportunities to put things right. We know that this will make for painful reading for families affected but also for the Trust, for regulators and for the wider NHS. But unless this is stated and acknowledged, history in East Kent and nationally suggests that there is a real danger that our Investigation will become yet another missed opportunity, not only in East Kent but elsewhere.

**1.9** As well as setting out what happened, we identify here the underlying failures that led to the harm we found, as well as some key themes that must be addressed in the response to the failures in East Kent. This chapter also explains the missed signals and where accountability lies. The evidence behind our findings is laid out in Chapters 2 to 5; in Chapter 6, we draw out the lessons with recommendations both for East Kent and for national application.

## Our findings

**1.10** There is a crucial truth about maternity and neonatal services which distinguishes them from other services provided at hospitals. It is in the nature of childbirth that most mothers are healthy, and, thankfully, their babies will be too. But so much hangs on what happens in the minority of cases where things start to go wrong, because problems can very rapidly escalate to a devastatingly bad outcome.

**1.11** We listened carefully to the families who have participated in our Investigation, and we listened equally carefully to staff at the Trust and in other relevant organisations. As a result, we identified problems at every level within the services:

- 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, and whether the Trust sought to learn lessons
- 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.

Running through each one of these layers has been a failure to recognise and acknowledge the scale and nature of the problem.

**1.12** We have found that the Trust wrongly took comfort from the fact that the great majority of births in East Kent ended with no damage to either mother or baby.

**1.13** This failure reflects badly, not only on practice within East Kent maternity services, but on how statistics are used to manage maternity services across the country as a whole. We believe that it should be possible for individual trusts to monitor and assess whether they have a problem; that it should be possible for the NHS regionally and nationally to identify trusts whose safety performance makes them outliers; and that it should be possible for the regulators to differentiate the services provided more quickly and reliably. We set this out in our first key area for action, to be addressed below and in Chapter 6.

**1.14** More immediately, the Trust should acknowledge the full extent and nature of the problems which have endured over the period. It has not yet done this in full. We have found that its failure to do so explains why the action that has been taken has not been sustained and has not had the impact needed.

## **What happened to women and babies**

**1.15** Chapter 2 gives details of our assessment as to whether the cases within our Investigation involved suboptimal care. We used the approach of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), now commonly referred to as CESDI scores.

**1.16** In these cases, we have not found that a single clinical shortcoming explains the outcomes. Nor should the pattern of repeated poor outcomes be attributed to individual clinical error, although clearly a failure to learn in the aftermath of obvious safety incidents has contributed to this repetition.

**1.17** Although there are shortcomings in the physical infrastructure at both hospitals, and there have been periods of staffing and resource shortages, we have not found that these played a causative role in what happened. While these factors require attention, and are rightly the subject of national consideration, they do not justify, explain or excuse the experience of the families using East Kent maternity services as revealed by our Investigation.

**1.18** Similarly, the geography of East Kent, its coastal location, the demographics of its population and the distance between the two hospitals are factors, but they should not have been regarded as explaining or justifying the service provided. We have found evidence of these factors fuelling what is sometimes referred to as a “victim mentality”. Those who should have provided leadership have been tempted to regard themselves as victims of geography, recruitment difficulties and a neglected estate.

**1.19** Rather, we have found that the origins of the harm we have identified and set out in this Report lie in failures of teamworking, professionalism, compassion and listening.

## ***Failures of teamworking***

**1.20** Teamworking is crucial to modern healthcare. Poor teamworking may result from a lack of respect for other staff and a lack of mutual trust, with insufficient credence given to the views of others. Failure to work effectively together leads directly to poor care and jeopardises patient safety. In maternity services, it leads to staff failing to escalate clinical concerns promptly or appropriately. As a result, necessary assessments and interventions are either done by the wrong people with the wrong skillsets or are not done at all. In both cases, the risks to safety are obvious.

**1.21** We found gross failures of teamworking across the Trust’s maternity services. There has been a series of problems between the midwives, obstetricians, paediatricians and other professionals involved in maternity and neonatal services in East Kent. Some staff have acted as if they were responsible for separate fiefdoms, cultivating a culture of tribalism. There have also been problems within obstetrics and within midwifery, with factionalism, lack of mutual trust, and disregard for other points of view.

**1.22** We found clear instances where poor teamwork hindered the ability to recognise developing problems, and escalation and intervention were delayed. The dysfunctional working we have found between and within professional groups has been fundamental to the suboptimal care provided in both hospitals.

**1.23** Poor teamworking was raised as a prominent feature by many of those we interviewed. Some obstetricians had *“challenging personalities ... big egos ... huge egos”*. Midwives showed *“cliquey behaviour”* and there was an in-group, *“the A-team”*. This behaviour was displayed *“in front of women”*. One clinician told us that *“many times we could have done better ... the culture in obstetrics and the relationship with midwifery were poor”*. An external assessor with wide experience of the NHS said that the Trust had *“the worst culture I’ve ever seen”*. Another, from a different organisation, had *“not encountered such behaviour anywhere else”*.

**1.24** We have found divisions among the midwives which at times included bullying to such an extent that the maternity services were not safe. We also found that some obstetric consultants expected junior staff and locum doctors to manage clinical problems themselves, discouraged escalation, and on occasion refused to attend out of hours. This, too, put patient safety at significant risk. We have found that midwives and obstetricians did not always share common goals, and that this damaged the safety of patient care. One mother, who asked a paediatrician why her baby had died, was told that *“if you want to look for blame, you should be looking at the obstetricians not me”*.

### **Failures of professionalism**

**1.25** Professionalism means putting the needs of mothers and babies first, not the needs of staff. It means not being disrespectful and not disparaging other staff in front of women, who lose confidence in services as a result and may make poorly informed decisions about their care. It means not blaming women when something has gone wrong, and it means making decisions on who is best placed to care for an individual based on their clinical need, not on who belongs to which staff clique.

**1.26** We found clear and repeated failures to uphold these principles. Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families. A family member heard a consultant describe the unit they were in as *“unsafe”* to a colleague in the corridor, which was hardly the way to raise any legitimate concerns they may have had.

**1.27** Others sought to deflect responsibility when something had gone wrong. A staff member visited a mother the day after a significant problem with her baby had been missed at birth. The mother remembers that the staff member did not ask how her baby was, but said: *“[Y]ou do remember I was handing over, don’t you?”* Another woman, whose baby had died, was told: *“It’s God’s will; God only takes the babies that he wants to take.”*

**1.28** In other cases, women themselves were blamed for their own misfortune. A woman admitted to hospital to stabilise her type 1 diabetes pointed out to antenatal ward staff that they were not adjusting her insulin correctly. She was told that *“we’re midwives not nurses and we don’t deal with diabetes ... it’s not our issue and you don’t fit in our box”*.

**1.29** We heard 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 was a downright dangerous practice.

### **Failures of compassion**

**1.30** Technical competence alone is not sufficient for good care, if it is delivered without compassion and kindness. Uncompassionate care can be devastating for the wellbeing and mental health of the recipients. It can cost women the care that they need and it can affect their peace of mind, sometimes in extremely fraught situations that involve the loss, or potential loss, of their baby’s or their own life or health.

**1.31** We heard many examples of uncompassionate care that shocked us. A woman who asked for additional information on her condition during an antenatal check was dismissively told to look on Google. A mother who was anxious about her baby's clavicle, fractured during a difficult delivery, was told that "*collar bones break all the time because they are built to do that to get them out easier*". Another, who asked why an additional attempt at forceps delivery was to be made, was brusquely told that it was "*in case of death*". Women who pointed out that their spinal or epidural analgesia was not effective and they were in pain were ignored or disbelieved; one told us that "*they didn't listen ... they carried on, obviously, to cut me open. I could feel it all.*"

**1.32** The effects of many further examples of lack of compassion are considered in detail in Chapter 3.

### **Failures to listen**

**1.33** Good care must involve listening and responding appropriately. Women know what they are experiencing at that moment in a way that a clinical attendant cannot. Failing to listen – or, worse, telling someone that they must be wrong – is disrespectful and dangerous. A wise physician, William Osler, encouraged clinicians over 100 years ago to "*listen to the patient, [they are] telling you the diagnosis*". Ignoring or discounting what a patient says means discarding clinical information that may make the difference between a good outcome and a disaster.

**1.34** We have found that there have been repeated failures to listen to the families involved, as exemplified in Illustrative Case A.

### **Illustrative Case A**

A's second pregnancy progressed normally to term, when she reported a loss of clear fluid and suspected that her waters had broken spontaneously. No fluid could be seen on examination, and she was sent home with a view to inducing labour a week later. After four days, however, she telephoned the hospital to say that she was experiencing contractions and her baby's movements had reduced markedly over the previous day. As her contractions were deemed not yet frequent enough to indicate established labour, she was asked to wait at home despite her concern over her baby's movements. When she attended the following day with more frequent contractions, her baby's heartbeat could not be found, and she gave birth to a stillborn baby.

**1.35** In some cases, we have found that this failure to listen contributed to the clinical outcome. In others, it was part of a pattern of dismissing what was being said, which contributed significantly to the poor experience of the families within our Investigation, as Chapter 3 sets out. Aspects of the families' experiences have been extremely damaging and have had a significant effect on the outcome for them.

### **Failures after safety incidents**

**1.36** We found that the same patterns of dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage. Although some staff were caring and sympathetic, and this was recognised and welcomed by families, others were not. Sadly, but naturally, the poor responses are the ones that remain in families' memories. In a number of cases, the dysfunctional relationships between

the staff involved were all too visible to the families themselves. This was such a common feature that we have concluded that it was part of the culture at QEQM and WHH.

**1.37** Time after time, we heard that staff not only failed to show compassion, they also denied responsibility for what had happened, or even that anything untoward had occurred. Similarly, we have found instances where the mother was blamed for what had happened.

**1.38** Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families about what had happened. Safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning. The instinct was to minimise what had happened and to provide false reassurance, rather than to acknowledge errors openly and to learn from them. Where the nature of the safety incident made this impossible, a junior obstetrician or midwife was often found who could be blamed.

**1.39** The following example (Illustrative Case B) illustrates a number of features we have found repeated many times, and the harm to wellbeing that can result from a failure to listen and to respond compassionately. It also shows that multiple failures may coexist in the same case.

### Illustrative Case B

*“We feel lucky that we have our daughter and grandson; other people weren’t as lucky as us. But we are where we are by a whole string of luck rather than by good planning and good care.” (B’s mother)*

B was pregnant for the first time and chose care in her local Midwifery-Led Unit (MLU). She had a good relationship with the midwife she saw. The midwife told B how lucky she was to be fit and healthy, and B trusted her advice, although she had scans which showed excessive growth of her baby that was not investigated or followed up. At 39 weeks pregnant, B developed two significant complications of pregnancy: pre-eclampsia and obstetric cholestasis (a liver condition). A doctor recommended induction of labour and noted the risk of a postpartum haemorrhage and the need for tests of her disordered liver function and blood clotting. The blood-clotting results were lost until after her baby was born.

Despite the risk factors, B was monitored only intermittently in labour, and she received varying advice from different professionals about the likelihood of requiring a caesarean section, which unsettled her. Progress was slow, and the next day her cervix stopped dilating at 7cm. B’s baby was born by caesarean section, apparently uneventfully, although the need for extra stitching to control blood loss from the uterine incision was recorded.

Afterwards, B and her family were placed in a recovery room, where they remained alone for over two hours, undisturbed by staff who should have carried out postoperative checks. After this time, B’s family were alarmed by blood emerging from under the blanket and realised to their great distress that she was bleeding very heavily. They raised the alarm, and staff implemented the hospital’s protocol for massive postpartum haemorrhage.

B was taken to theatre while her mother and other family members were left with the new baby, waiting anxiously and tearfully for news in a four-bedded bay, separated from other mothers and babies only by curtains. After some time, their request to be moved to a side room was granted. In theatre, B was thought to be bleeding because of an atonic uterus – this is when the uterus has not contracted effectively after the birth –

and a device called a Bakri balloon was placed in the uterus and inflated to reduce the bleeding by compression. B was then transferred to the intensive care unit.

Meanwhile, the family remained with the baby, who now needed feeding. B's mother asked for assistance: *"I asked for milk, and this was the thing that was really quite upsetting at the time, the baby needing feeding, and I was told that 'we encourage breastfeeding here and if you want milk you have to go to ASDA, it's up the road'."* After she insisted, some milk was brought, but the irritation of staff was obvious, she said, and no advice was given on feeding under the circumstances. Some staff were subsequently helpful, but others made the family feel that they were being a nuisance.

During the night, family members saw the consultant obstetrician again, who explained that B was still bleeding and would need to return once again to theatre. The family recall the consultant saying, *"you're really lucky because I've phoned a friend' and this rings a bell, because I thought, oh no, we're going 50/50 next and then we're going to ask the audience. I couldn't believe [they were] saying it."*

The "friend" was a consultant gynaecological oncologist who carried out an exploratory operation. They found that there was an extensive collection of blood in the broad ligament (alongside the uterus). The bleeding was from a tear in the cervix extending into the upper vagina, which must have occurred at the time of either the caesarean section or the insertion of the Bakri balloon. The consultant tied off blood vessels in the pelvis, including the internal iliac artery, a major artery, and evacuated the blood. This stopped the bleeding, but B required extensive blood transfusion.

B's subsequent recovery was steady, but her mother remembers being severely reprimanded by midwives for taking the baby to the intensive care unit to bond with B, and the lack of contact and monitoring when B returned to the ward after several days. B felt that she would be just as well off at home, but was told that she shouldn't leave, because she was *"like a broken car that we've fixed up and if you leave you might just break down again"*. B realises that it was the doctor's way of trying to explain things, but she found it very insensitive and has not been able to forget what they said. *"In that moment, when I wasn't really being looked after, was I just going to break down, was I just going to die?"*

After they sent a letter of complaint, B and her mother were told that the unit was safe, with mortality rates below the national average, and that B's care would be reviewed because there was a good governance system for reviewing cases. B's family asked for the review to be shared with them but were told: *"It doesn't happen like that; the team sit round and read through the notes to check that the haemorrhage was managed correctly."* They also asked if the review would consider whether the haemorrhage could have been avoided and were told that it would not. Later, they found out that the case had not been recorded as a serious incident because the haemorrhage had been managed correctly and it was not an unexpected admission to intensive care. *"Nothing seemed to ring true"* to B and her mother.

B and her family found the lack of care and compassion to be the most distressing feature. *"The whole thing was 'you're lucky, you've got a baby, you're alive, you didn't die, your baby didn't die; you need to brush yourself down, get on with it and go on and have another baby'; it was really insensitive to the problems."*

B was advised to go and see the midwife to talk through her birthing story. She understood that this would be a therapeutic exercise that would help her understand what had happened. However, the midwife read her notes and said: *"I don't know why you're here, you're really lucky, you're alive, your baby's alive."* There was no recognition

of B's obvious guilt over feeling upset about what had happened when her baby had survived. She received only reinforcement that she should feel lucky to be alive. The impact on her mental wellbeing was not considered.

B had another appointment with her consultant. They told her that they fully expected to see her in a few months, because "you've still got everything, you can still have a baby, we'll look after you". But the experience has left B terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

*"It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn't be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I've always wanted a second baby and I will never do that, ever, and no one appreciates that side to it."*

**This case illustrates clear problems of teamworking, professionalism, lack of compassion and failure to listen. B was made to feel ignored, marginalised and disparaged after the event. Also striking are the lack of frankness about what had happened and the failure to report and investigate a serious incident.**

## Failure in the Trust's response, including at Trust Board level

**1.40** In specific instances where things have gone wrong, the Trust has found it easier to attribute the causes to individual clinical error, usually on the part of more junior staff, or to difficulties with locum medical staff. But we have found that these are symptoms of the problems, not the root causes. This has been combined with the disposition to minimise problems, so it is unsurprising that the Trust has given the appearance of covering up the scale and systematic nature of those problems.

**1.41** The problems among the midwifery staff and the obstetric staff were known but not successfully addressed. The failure to confront these issues further damaged efforts to improve maternity services and exposed critical weaknesses in the Human Resources (HR) function. When bullying and divisive behaviours among midwives were challenged, the staff involved began a grievance procedure, following which, it appears to us, the Head of Midwifery was obliged to leave and not speak out. The bullying and divisive behaviours were not addressed.

**1.42** One critical weakness was the lack of control that could be exercised in relation to consultants. We have found that experience in East Kent demonstrates the problems that occur when some consultants stubbornly refuse to change unacceptable behaviour. In these circumstances, the mechanisms that trusts are able to deploy to address such behaviour, either through professional regulation or HR processes, may prove frustratingly ineffective.

**1.43** It seems to us that the Trust was disposed to replace staff in key managerial roles who identified and challenged poor behaviour. The staff who remained were those who either personified the poor culture or were prepared to live with it rather than question it.

**1.44** We have found that the Trust Board itself missed several opportunities to properly identify the scale and nature of the problems and to put them right. These opportunities are described later in this chapter.

**1.45** The Trust Board was faced with other challenges. Some of these concerned other hospital services, particularly the Accident and Emergency department, and the failure to meet targets. But those other challenges, though considerable, do not constitute a good enough reason for failing to put right the way in which maternity and neonatal services were operating.

**1.46** The Trust Board did endorse a succession of action plans. It was said to us that “*if there is one thing East Kent can do it’s write an action plan*”. But these plans and the way in which the Trust Board engaged with them masked the true scale and nature of the problems. Instead, the plans supported an imagined world where there were fewer problems, and where the plans associated with newly appointed staff were deemed to be sufficient despite the previous recurring pattern of failure. Individuals were lauded only to fall out of favour, sometimes quite quickly.

**1.47** The repeated turnover of staff at many levels, including Chief Executive, served to encourage this cycle; each time it was believed that this time things really would get better. Looking at cases to the end of 2020, we have not seen evidence to convince us that this cycle has ended.

**1.48** Treating problems as limited one-off issues susceptible to being picked off by the latest action plan or new manager, rather than acknowledging their full extent and nature, has got in the way of confronting the issues head-on. Where issues have been brought into public focus by the efforts of families or through the media, too often the Trust has focused on reputation management, reducing liability through litigation and a “them and us” approach. Again, this has got in the way of patient safety and learning.

## The actions of the regulators

**1.49** We have reviewed how the Trust engaged with the regulators and others and how those organisations handled the signs of problems with maternity services in East Kent.

**1.50** We have 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.

**1.51** In practice, there was no shortage of regulatory and other bodies holding relevant information. The list includes:

- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- Local Supervising Authority (LSA; previously performing the role of supervision of midwives)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Midwives (RCM)
- NHS England (NHSE)/NHS Improvement (NHSI) (merged from April 2019 as NHSE&I; NHSE again from July 2022)
- Care Quality Commission (CQC)
- Healthcare Safety Investigation Branch (HSIB)
- Clinical Commissioning Groups (CCGs)
- Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS)

**1.52** Looked at individually, a case can be made that the distinctive role of each organisation should have added positively to identifying and addressing the problems. However, standing back from that detail, it is hard to avoid the impression that, in practice, the plethora of regulators and others served to deflect the Trust into managing those relationships and away from its own responsibility.

**1.53** The task of regulators was made more difficult by the extent to which problems were denied; this denial ran right through the Trust, from clinical staff to Trust Board level. Even five years on, the Panel has been told that “*we were not as bad as people were saying we were [in 2015/16]*” and that “*it only takes one case [baby Harry Richford] to trigger an investigation*”. A critical RCOG report in 2016 (see paragraphs 1.97–1.102) was based on “*hearsay and uncorroborated comments*”. Legitimate challenge by the CQC was “*always met with anger and defensiveness*”.

**1.54** There are inherent tensions in the roles of regulators and professional bodies, both individually and collectively. The RCM, for example, combines three functions: that of promoting quality maternity services and professional standards; that of advising and commissioning legal representation for individual members subject to disciplinary and professional processes; and that of a representative body for its membership. We found that these functions became entangled when the RCM was involved in problems relating to midwife behaviour in East Kent, and it was not possible to tell in what capacity it was operating at any one time, fuelling the perception that these problems were too difficult for the Trust to resolve.

**1.55** The actions of the regulators and others are set out in Chapter 5.

**1.56** We have found that NHSE&I did seek to help bring about improvements in the Trust. We have heard that a Quality Surveillance Group was established at least as early as April 2014. This followed identification of concerns by the CCGs (see paragraphs 1.75–1.81). As with the other regulators, we have found that the intervention of NHSE&I and its predecessors failed to secure the necessary improvements in the services provided.

## Missed opportunities

### Illustrative Case C

**1.57** A young mother (C) arrived at the hospital having had a healthy pregnancy. She had been told by a community midwife that the slowing down of her baby’s movements was not a reason for concern. Following a scan late on in the pregnancy, C was further reassured that there were no underlying problems with her baby.

**1.58** When C went into labour late in the evening, she was told to wait until her contractions were stronger and more frequent before travelling to the hospital. She felt discouraged and waited until the following afternoon, despite the altered movements of her baby. On arrival, she vomited in the corridor, often a sign of a rapidly progressing labour. The first midwife on the scene could not tell how dilated C’s cervix was and brought in another midwife.

**1.59** The standard method for checking a baby’s heartbeat is by using what is known as a doppler. The staff present followed this practice but detected C’s heartbeat instead. The midwife left for a break and another one was brought in from the labour ward. The new midwife spotted that the baby’s own heartbeat was not recovering quickly enough after the contractions. The first midwife was called back and, following discussions, C was taken to the labour ward.

**1.60** C wanted to push but had been told not to do so. But now she was told to push and the baby was delivered with forceps without additional pain relief. C remembers seeing her baby in the resuscitation cot in the corner of the room. She felt euphoric at having given birth but also concerned by what she saw. She assumed that her baby would be resuscitated and that she would be able to hold the baby at any moment. She remembers being told that her baby was breathing before then seeing her baby being taken away to the neonatal intensive care unit.

**1.61** C was left in the room with her family – her parents and partner. No member of staff stayed with them or joined them, and they were not told what was happening. C remembers that she was bleeding profusely and that her father left the room in order to ask whether somebody could attend, only to be told that *“they are all in the staffroom having a cup of tea to recover from the shock”*.

**1.62** When the consultant obstetrician arrived, C remembers being told that her baby was being cooled on a life support machine, because of the effects of a lack of oxygen. She was also told that the baby had too much acid in her blood as a result of distress in labour. And then the awful news. Her baby might not survive, or might survive with brain damage.

**1.63** For a time, as any parent would, C and her partner were hopeful that their baby would indeed recover. C was expressing milk for her newborn child, who was well grown and had appeared healthy.

**1.64** In the coming days, C and her partner would see the effects of their baby’s organs shutting down. They stayed up all night with their baby not knowing when the baby’s last breath would be. The baby passed away in C’s arms the following afternoon.

**1.65** Some months later the family had a meeting with the Head of Midwifery and with the head of the MLU. They remembered being told that *“many many mistakes had been made”*; their baby’s death could have been prevented had delivery been only a matter of hours earlier. In response to a question, C was told that ten babies had died since her baby.

**1.66** As well as the Trust admitting negligence, C recalls being told that if the family wanted to take any legal action the hospital would be supportive. C and her partner considered carefully what to do and came to their decision. They would pursue the case in order to highlight the issue higher up in the NHS, with the aim of preventing similar outcomes in the future.

**1.67** Concern about the death of baby Harry Richford in November 2017 precipitated our Independent Investigation. But this is not Harry Richford; it is baby Amber Bennington, who was born seven years earlier, in August 2010, and who died nine days later.

**1.68** There are similarities between the two cases. One is that the Panel has found that in both cases different clinical management would have been expected to have made a difference to the outcome.

**1.69** Another similarity is that both families have wanted their experience to be considered in order that the services be improved. The fact that it took the experience of Sarah and Tom Richford, seven years after the experience of Lucy and David Bennington, to bring East Kent maternity services into national focus suggests that the issues are deep and entrenched, and that the Trust has not been ready to look for signs of problems.

**1.70** It is clear that concerns have arisen throughout the period since 2009 when the Trust was constituted, and that numerous opportunities have been missed to rectify the situation that had developed. It is likely that the sooner this was tackled, the more straightforward it

would have been, before problematic attitudes and behaviour, and dysfunctional teamworking, became embedded. Yet each of these opportunities was missed in one way or another, and the consequences continued. The most significant are set out here.

### **Missed Opportunity 1: Internal review and report, 2010**

**1.71** On 24 September 2010, Dr Neil Martin, the Trust's Medical Director, gave a presentation to the Board on a recent serious untoward incident within maternity services. He also reported that the Trust's internal monitoring process had highlighted an increase in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. An internal review was being undertaken and external midwifery support had immediately been put in place at WHH due to a concern about a decrease in the skill mix at the unit.

**1.72** The review examined the antepartum management of 91 babies who had an unexplained admission to the neonatal intensive care and special care baby units within East Kent between January and September 2010. In 40% of the cases examined, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to be a factor that was relevant to the outcome. Of the 91 cases reviewed, there were 16 perinatal deaths; significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the report described as "long-term handicap"; significant suboptimal care was identified in three of those cases.

**1.73** More broadly, the 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. The review identified a number of themes, many of which are recurring issues in the inspections that took place and in the reports and findings published between 2010 and 2020. The main themes were poor identification of fetal growth restriction, failure to diagnose labour leading to inadequate fetal monitoring, incorrect intermittent fetal monitoring, poor practice of continuous fetal monitoring with failure to correctly identify pathological traces and escalate concerns, and failure to follow guidelines.

**1.74** The outcome of the review was to move the standalone midwifery units at Canterbury and Dover and to locate them alongside the obstetric units at Margate and Ashford. Recommendations were made to remind staff to practise within guidelines, to improve diagnosis of labour in low-risk settings, to improve standards in fetal monitoring, to review clinical guidance and resuscitation arrangements where meconium is present, to review the process by which medical staff of all grades learn from adverse events, and to review the process of escalating concerns about the progress of labour to more senior staff on call. We could find no evidence that these recommendations were followed up.

### **Missed Opportunity 2: Clinical Commissioning Group reporting to NHS England from spring 2013**

**1.75** The CCGs were created and commenced oversight from 1 April 2013. From the very outset, East Kent CCGs raised concerns about the Trust, including concerns about maternity services; they included these concerns in monthly written reports to NHSE. For example, in the June 2013 Quality Report to NHSE, the CCGs noted:

*There is concern about the number of Serious Incidents (SIs) relating to maternity services at the Trust. Prior to April 2013 there were five SIs relating to maternity still open and in April 2013, two more were logged.<sup>1</sup>*

**1.76** These concerns were repeated in the August 2013 Quality Report to NHSE:

*The quality group and the Kent and Medway Quality Surveillance Group have both expressed concerns in relation to the number of serious incidents and the severity and trends within serious incidents related to maternity services within East Kent. Site visits have already taken place to both maternity units and further work with the trust and members of the quality surveillance group will now be taking place to further explore these issues.<sup>2</sup>*

**1.77** The Panel heard that the CCGs were “met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge” – “you took a deep breath to have the conversations before you picked up the phone or you met with them”.

**1.78** Another interviewee said:

*The Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 ... they would say it in public meetings, “we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be” ... they would narrate it ... over and over to try and make it become fact ... you then had NHSE saying, “yeah we haven’t really got any specific issue” ... and then you had us [CCGs] ... shouting, “... they’re not financially stable, their leadership is falling apart ... they’re not a cohesive leadership team ... they’re not safe from a clinical and patient safety perspective ... there are many gaps, and then they’ve got big cultural issues, huge cultural issues ...”*

**1.79** These differences between the Trust and the CCGs were recognised by a member of the Trust Board and the Executive, who spoke of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

**1.80** The CCGs found it difficult to gain recognition of their concerns within NHSE. It is not clear whether this was because the CCGs were able to bring fresh eyes to bear on the situation, or whether there had been rapid deterioration, but the existence of problems identified in 2010 makes rapid deterioration an unlikely explanation.

**1.81** Having failed to gain traction with NHSE, the CCGs approached the CQC, and the Panel heard that it was this engagement that contributed to the CQC inspection in 2014. In the meantime, however, both the Trust and NHSE failed to accept that the CCGs had grounds for concern – another missed opportunity to recognise and address what was happening.

### **Missed Opportunity 3: Care Quality Commission report and governance issues, 2014**

**1.82** The CQC inspected the Trust over six visits in March 2014 and published its findings on 13 August 2014. The overall rating for the Trust was “Inadequate”, with findings that the Trust was “Inadequate” in the domains of providing safe care and being well led, and a finding of “Requires Improvement” for effective and responsive services. Again, there are significant similarities between some of the CQC findings and those in previous and subsequent reviews.

**1.83** Key findings from the CQC included the 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. The CQC noted an unusually high number of staff raising concerns about safety directly with its inspectors.

**1.84** Maternity services were given a less stringent rating: “Requires Improvement”. Unfortunately, this implied that problems in maternity care were not as bad as elsewhere, not only downplaying the very significant problems that had existed for several years, but also deflecting attention to those areas seen as higher priorities.

**1.85** The reaction of the Trust was again one of defensiveness and disbelief, and we found that there was a very tense and difficult relationship between the Trust and regulators throughout. One former member of the Board and Executive told us that a decision had been taken by the Trust to “*fight the regulators*”. We heard that the Trust reacted very badly to the CQC report, sending back hundreds of minor challenges, including grammatical and spelling issues, rather than addressing its substance. Despite issues being flagged as poor by the CQC during its inspections and reported back to the Trust each day, there was still disbelief when the report came in. Six months were spent quibbling over it, and when action plans were drawn up, they were of poor quality and not effectively followed up. This was another significant missed opportunity.

#### **Missed Opportunity 4: Bullying and inappropriate behaviour within the Trust and maternity services, 2014/15**

**1.86** Bullying and harassment have been prevalent features in the Trust’s maternity services over a prolonged period, as reported by many staff with whom we spoke. Staff surveys confirmed that staff felt disengaged, and reports of bullying and harassment were numerous. Some interviewees were explicit that the effects of this behaviour put the safety of care at risk.

**1.87** This issue came to a head in 2014/15, initially when the Trust’s Chief Nurse received an anonymous letter:

*I work on maternity at the William Harvey. I’m ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people ... Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It’s ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity ... you need to know that at times the unit is [an] awful place to be.*

**1.88** In response to this and to other evidence of staff unhappiness, the new Head of Midwifery undertook a review, working alongside the Trust’s HR department. In all, 110 staff were interviewed. There were consistent reports from over half of these staff of abrupt and sarcastic senior staff, junior staff being shouted at and humiliated in front of others, staff feeling intimidated and undermined in front of patients, alleged racism, and a daunting and frightening work environment.

**1.89** The Head of Midwifery decided, with HR, that some senior midwives who were repeatedly identified as central to the issues should be relocated or suspended pending further action. A collective letter of grievance with 49 signatories was subsequently submitted via the RCM, alleging failures of process in the review. It is notable that this letter admitted that the unit was “*dysfunctional*”.

**1.90** We heard that, as a result, the Trust withdrew support from the review process and from the Head of Midwifery. Consequently, she resigned from her post in August 2015. She requested advice from the RCM on whistleblowing about the culture of bullying and intimidation prevalent in the unit and was advised against disclosure in the interests of patient safety because of the

risk this posed to her future career prospects. It is notable that the RCM was already aware of the dysfunctional behaviours at the Trust.

**1.91** The Panel heard of no further efforts to address the bullying behaviour, which, we heard, persisted. This was another significant missed opportunity.

### **Missed Opportunity 5: The Report of the Morecambe Bay Investigation, 2015**

**1.92** The report into the serious failings in Morecambe Bay maternity services was published in early 2015. It identified, among other issues, failings of poor working relationships and dysfunctional teamworking, failures of risk assessment and planning, and failure to investigate properly and learn from safety incidents. All of these features were already evident in East Kent maternity services.

**1.93** In May 2015, the Head of Midwifery at the East Kent Trust had already noted the similarity of issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership. She was not heeded.

**1.94** When we interviewed staff in 2021/22, some told us that they still believed the comparison to be misplaced. The Trust had commissioned a report later in 2015 specifically addressing this question; it found that the East Kent Trust “*was not another Morecambe Bay*”.

**1.95** Given what the Trust knew about its own services at this point, this is an extraordinary conclusion; we can only suppose that it reflects the pattern of false assurance and defensiveness that characterised much of the Trust’s behaviour.

**1.96** The Morecambe Bay report included a message for other trusts in 2015:

*It is vital that the lessons, now plain to see, are learnt and acted upon, not least by other Trusts, which must not believe that “it could not happen here”. If those lessons are not acted upon, we are destined sooner or later to add again to the roll of names [of dishonoured trusts].<sup>3</sup>*

### **Missed Opportunity 6: Report of the Royal College of Obstetricians and Gynaecologists, 2016**

**1.97** In 2015, concerned about accumulated evidence on the working culture in maternity services, the Medical Director, Dr Paul Stevens, commissioned a review by the RCOG. He specifically identified for review the poor relationship between obstetricians and midwives, compliance with clinical standards, poor governance and response to safety incidents, supervision of trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite.

**1.98** The RCOG review reported in February 2016 and made serious criticisms of the maternity services in East Kent. Among other things, the report was critical of the lack of engagement of obstetricians in drawing up guidelines, which were of poor quality as a result. Safety incident investigations were inadequate and failed to identify areas where obstetric practice could be improved. Some consultant obstetricians at QEQM consistently failed to attend labour ward rounds, review women in labour, or draw up care plans; they also refused to attend when asked to when on call out of hours. Although these consultants were clearly contravening their duties to the Trust and to their profession, the RCOG review found that “*this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants*”.<sup>4</sup>

**1.99** As a result of these appalling patterns of behaviour, trainees were under pressure to cope with clinical issues they were not competent to deal with unsupported, and midwives felt that there was no point in escalating emerging urgent clinical concerns. In addition, both groups of staff had given up reporting concerns about unacceptable behaviour, as no action was taken. Educational supervision of trainees was inconsistent, posts were often filled by locums, and morale was poor.

**1.100** In keeping with the familiar pattern of defensiveness, the Trust told the RCOG that it would not respond to the report in light of an anticipated CQC inspection. When this occurred, the RCOG report was not shared with the CQC. Within the Trust, the RCOG review report was not widely distributed and was dismissively described as *“a load of rubbish”* by some senior obstetricians. A meeting of the Trust Quality Committee heard that *“initial information from the recent [RCOG] Maternity Review report is clear – the Trust does not have an unsafe maternity service but there is improvement work to do around how the service is run in some areas”*.

**1.101** There was, however, sufficient pressure that maternity services were recognised as presenting an “extreme” risk, with potential harm to both pregnant women and neonates, in the Corporate Risk Register in June 2016. The resulting action plan, heavily process-oriented, was subsequently merged with a general improvement plan in response to the national Maternity Transformation Programme, diluting it and losing some of the specific elements prompted by the RCOG report. Fewer than a quarter of the action points had been completed when the risk was removed from the Register in 2019.

**1.102** Most obviously, at no time was there an explicit plan documented or actioned to address the identified failure of some consultants to fulfil their professional duties. We heard that it was a *“difficult area”*, that *“quiet words”* were had, that two consultants had moved on or retired, and that another had a modified job plan that excluded overnight labour ward cover. While we recognise the constraints, and will comment elsewhere on them, the failure to tackle this explicitly or visibly has left echoes in the unit that still persist. This was another significant missed opportunity.

## **Missed Opportunity 7: The death of baby Harry Richford**

**1.103** Baby Harry Richford died on 9 November 2017 in the neonatal unit at WHH in Ashford, seven days after he was delivered at QEQM in Margate. The cause of death was recorded as hypoxic ischaemic encephalopathy (HIE).

**1.104** Many of the same red flags that had shown themselves in the litany of previous inspections, reviews and reports appear again in baby Harry’s case. Not only does this apply to the clinical care given to his mother, Sarah Richford, it is also evident in the way that the whole family were treated after his death. The patient safety issues echoed the problems that had been highlighted first in the Trust’s internal review of 2010 and most recently again in the RCOG report, published 18 months before Sarah attended QEQM.

**1.105** Sarah witnessed conflict and disagreement between the obstetric and midwifery teams about the way that oxytocin was being used to augment her labour. Midwives were concerned about changes to the continuous heart trace of the baby, but the obstetric team disagreed.

**1.106** Obstetric cover on the labour ward was provided by a locum specialist registrar, whose knowledge and experience had not been assessed by a Trust consultant. When there was disagreement over Sarah’s care plan, neither the locum registrar nor the midwifery team escalated this to the consultant on call, contrary to guidelines. Sarah was not reviewed by an obstetric consultant during either the 1pm or 6pm assessment rounds, contrary to unit protocols.

**1.107** There were further features of concern over the baby's condition coming up to delivery, and the locum registrar undertook to expedite delivery, either by forceps delivery or, if this was not possible, by a caesarean section. It appears that the locum registrar discussed this by telephone with the consultant on call, who agreed with the plan but did not attend, although it was likely to present challenges to an inexperienced obstetrician.

**1.108** After an unsuccessful attempted forceps delivery, a caesarean section was undertaken. Unsurprisingly, in view of the descent of the baby's head, this proved very difficult; several attempts were made to dislodge the head from the pelvis, including by applying pressure vaginally. The consultant on call was contacted by telephone and offered advice but was still not in attendance.

**1.109** There were major difficulties in resuscitating baby Harry after delivery, including delay in establishing an airway, together with delay in escalating concerns to a consultant paediatrician on call.

**1.110** In keeping with the familiar pattern of downplaying problems and seeking to avoid external scrutiny, the Trust classified baby Harry's death as "expected" on the basis that he was admitted to the neonatal unit at WHH with severe HIE, and therefore death was not an unexpected outcome. For that reason, the Trust initially refused to refer baby Harry's death to the coroner for investigation. There were errors in the data sent to the national audit, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

**1.111** Baby Harry's family faced great difficulty in finding out what had gone wrong, although they were sure that something had, and they began to distrust any information they received from the Trust. The weeks, months and years that followed baby Harry's death involved sustained efforts by his family to seek understanding and truth about what had happened during his delivery. Their efforts included referring the case to HSIB and to the CQC for investigation and pressing to have a full inquest into the circumstances of his death.

**1.112** This pattern of behaviour by the Trust, clearly evident in this case, recurred in many others that we examined. It included denying that anything had gone amiss, minimising adverse features, finding reasons to treat deaths and other catastrophic outcomes as expected, and omitting key details in accounts given to families as well as to official bodies. Although we did not find evidence that there was a conscious conspiracy, the effect of these behaviours was to cover up the truth.

**1.113** Even had none of the previous failings been known – and they were – baby Harry's death should surely have been a catalyst for immediate change. In fact, it required public remonstrance by a coroner over two years later, precipitated by the persistence, diligence and courage of baby Harry's family, to reveal an organisation that did not accept its own failings, considered itself above scrutiny or accountability, and consistently rejected the opportunity to learn when things went wrong.

## **Missed Opportunity 8: Engagement with the Healthcare Safety Investigation Branch from 2018**

**1.114** HSIB was established in 2017 in response to widespread concern that the NHS was not learning consistently from safety incidents. Its brief is to carry out independent investigations into safety incidents, focusing on systems and processes, to identify learning. In light of previous issues, most obviously at Morecambe Bay, HSIB was given a special brief to look at all maternity incidents that fulfilled certain harm criteria. In 2018, it became evident that East Kent

maternity services were an outlier because of the rate of occurrence of safety incidents resulting in serious harm.

**1.115** From the outset, 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 found this to contrast sharply with the response of other trusts in the region, which generally welcomed the opportunity to have "fresh eyes" on any problems. The East Kent Trust, on the other hand, challenged HSIB's right to carry out investigations and its credentials to act as what the Trust saw as another regulator.

**1.116** HSIB's concerns increased over the course of 2018, particularly over failures to escalate clinical concerns, unsupported junior obstetric staff, the use and supervision of locum doctors, management of reduced fetal movement, neonatal resuscitation, and fetal monitoring and its interpretation. In light of its "*grave concerns*", HSIB sought a meeting with the Trust's senior leadership team, which took place in June 2019.

**1.117** The accounts of that meeting that we heard from more than one source left us shocked, given the extent of the problems at the Trust that by then had been evident for almost ten years. The HSIB team was not made welcome but was left waiting in a corridor for an extended period. Senior executives greeted them in an "*incredibly aggressive*" manner, saying "*I don't know why you are here*" and telling HSIB that its recommendations were "*not needed*". The tone of the meeting was one of defensiveness and aggression, and there was a "*heated discussion*" about a maternal death.

**1.118** Although relationships between the Trust and HSIB became more cordial, we heard that the Trust did not achieve the same level of acceptance and learning evident in other trusts that HSIB deals with. This is the most recent in this long series of missed opportunities.

## Where accountability lies

**1.119** This section has highlighted our findings and set out the series of missed opportunities that has characterised the whole period since the establishment of the Trust in 2009. Any one of these was a chance to rectify a situation that had clearly gone very wrong and was continuing to deteriorate. Had any of these opportunities been grasped, there would undoubtedly have been benefits in terms of death, disability and other harm avoided, and in terms of the mental wellbeing of many families who were disregarded, belittled and blamed.

**1.120** We do not blame, or identify, those who have made honest clinical errors. Clinicians should not have to live in fear of clinical error and its aftermath; it is an inescapable accompaniment to practice everywhere. The fundamental point is to recognise and report error, so that it can be investigated and learned from. The route to improved maternity services would be fatally undermined if individuals, be they midwives or consultants, were deterred from reporting, or from entering practice, by the fear that honest clinical errors would result in public or professional vilification.

**1.121** We have found that repeated problems were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and they reflect a persistent failure to look and learn. They concerned both hospitals and continued throughout the period we have investigated. They included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

**1.122** Each of these problems has been visible to the senior management of the Trust. In these circumstances, while it is right that this report should be clear about those systemic issues and how they have been evident through the organisation, we have concluded that accountability lies with the successive Trust Boards and the successive Chief Executives and Chairs. They had the information that there were serious failings, and they were in a position to act; but they ignored the warning signs and strenuously challenged repeated attempts to point out problems. This encouraged the belief that all was well, or at least near enough to be acceptable. They were wrong.

## Key areas for action

**1.123** It is a privilege to have been asked to investigate maternity and neonatal services in East Kent. But, in doing so, we are faced with a reality of national as well as local significance.

**1.124** This Investigation is simply the latest to focus on failings in an individual NHS trust. The list is now a long one, going back at least as far as the 1960s. As the Health Foundation has pointed out, most people think of the inquiry into failures of care at Ely Hospital in Cardiff in 1967 as the first NHS inquiry.

**1.125** The period since then has been punctuated by reviews into local circumstances: for example, the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, published in 2013. With maternity services alone, the spotlight has been shone on Morecambe Bay in 2015, on Shrewsbury and Telford in 2021/22, East Kent, with this Investigation commissioned in 2020, and now Nottingham.

**1.126** The pattern is now sadly familiar: detailed investigation, lengthy reports, earnest and well-intentioned recommendations – all part of a collective conviction that this must be the last such moment of failure, with the lessons leading to improvement, not just locally but nationally. Experience shows that the aspirations are not matched by sustained improvement. Significant harm then follows, with almost always patients and families the first to raise the alarm.

**1.127** In investigating East Kent maternity services and their missed opportunities, we have become all too aware that a conventional report, with multiple recommendations, overlapping with recommendations from other inquiries, other periods and other sources, is unlikely to break free of this pattern.

**1.128** For this reason, we have set ourselves the objective of identifying a more limited number of key themes and recommendations, and of not confusing the already difficult – if not impossible – task of making sense of those that already exist.

**1.129** Within this approach, we want to tackle head-on the fundamental issue affecting maternity services that this succession of reviews creates. The frequency with which supposedly one-off outliers keep cropping up despite previous investigations and reports makes it, in our view, unsafe to suppose that East Kent is the last one that will be identified. The answer cannot be to hope that individual reviews and multiple recommendations prevent recurrences elsewhere. If that approach were the right one, it would have worked by now. It hasn't.

**1.130** We have identified four key areas for action that we believe must be addressed.

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

**1.131** We have come to the view that something more reliable needs to be put in place, not only in East Kent but also elsewhere and nationally, 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; for the NHS to monitor the safety performance of every trust; and for 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.

**1.132** We are clear that such a mechanism can be developed in order to spot the relevant signals. In Chapter 6, we recommend how this should be done. This is not a toolkit, because it must be nationally standardised, and it 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”.

**1.133** In essence, it is clear that in East Kent the Trust too often treated the concerns expressed by families as “noise” when they were in fact an accurate signal of real problems. One example is how the family of baby Harry Richford was treated, particularly when they sought answers to legitimate questions. But that is not the only such example. The accounts we have heard from families show persuasively that the Trust’s mindset was too often to be defensive and to minimise problems; and that this mindset was itself a barrier to learning.

**1.134** The Trust also took false reassurance from national statistics that appeared to suggest that the number of baby deaths was no higher than in other trusts, underlining the shortcomings of available information. This was very clear from the accounts we have heard from the Trust’s staff. For example, a senior clinician accepted that the Richford case was tragic and avoidable but added that, *“however, when you look at the figures it was only in 2017 that [East Kent] were slightly outside average Trust behaviour”*.

**1.135** Chapter 5 describes how the Trust sought to monitor its performance. By contrast, we have identified a more reliable approach that would utilise the available statistics in the way suggested in Chapter 6, for the use of clinical teams, trusts, regulators and the public, as well as listening to what women and their families say – treating that too as a likely signal, not as noise.

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

**1.136** The frequent instances we have found of a distressing and harmful lack of professionalism and compassion are of great concern to us. Of course, we are aware that the majority of clinical staff do not behave like this; but, equally, it would be wrong to imagine that these behaviours are confined to East Kent’s maternity services.

**1.137** This is not a finding of technical incompetence. But the experience shared vividly with us by families and often confirmed by staff accounts has demonstrated that technical competence is not enough. In any clinical situation, not least the stressful circumstances of giving birth, there is an equal need for staff to behave professionally and to show empathy. The evidence of staff

not showing kindness or compassion and not listening or being honest has been both harrowing and compelling.

**1.138** Part of a professional approach is explaining what is happening or has happened honestly and openly – at the time, whenever possible, and certainly afterwards. But what we have found is that, too often, the response has been based on personal and institutional defensiveness, on blame shifting and punishment.

**1.139** We have found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members. In fact, in a significant number of cases, the Panel has found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, when they questioned their care, and when they challenged the decisions that were made. Too often, their well-founded concerns were dismissed or ignored altogether.

**1.140** 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. It is foolhardy to disregard the woman's voice, especially if she has experience of previous labour, and we saw evidence of distressing births before the mother's arrival in the maternity unit as a result. But it is dangerous when the caller has also reported other problems such as altered movements by the baby, and we saw examples of babies lost as a consequence of such advice.

**1.141** We have also found a pattern of particularly stubborn and entrenched poor behaviours by some obstetric consultants, particularly at QEQM. We are clear that this has been damaging, not just to team relationships but also to the safety of women and their babies.

**1.142** Some consultants did not attend when requested, although they were on call, and they did not attend scheduled labour ward rounds. They discouraged both junior staff and midwives from calling them at night, leading most staff to conclude that they just had to get on with it without the advice or presence of consultants when those consultants were on call. These concerns were known to the Trust, having been clearly identified in the RCOG report of 2016 and confirmed subsequently by the Trust itself in an audit conducted in April and May 2016. The RCOG did not immediately offer to be involved in how these problems might be resolved, and was rebuffed by the Trust on offering to revisit six months later.

**1.143** We note that, in seeking to overcome the reluctance of some consultants to attend when on call, the Trust's actions were weaker than when dealing with midwives. This difference was evident to staff, who put it to us in these terms: *"Nurses would potentially be disciplined ... doctors would be asked to reflect on what happened."*

**1.144** It is apparent to us that this reflects a much wider difficulty. Any trust seeking to address problematic behaviour by consultants will face significant constraints. Employers effectively have no sanctions short of dismissal against a consultant who defies them, and experience suggests that if employers do act, or if a consultant claims constructive dismissal, the employers are very likely to lose at an employment tribunal. In such situations, external support for trusts is often unhelpful, while defence organisations mobilise their full resources in support of their member. When the GMC was belatedly informed of the unacceptable consultant behaviour in East Kent, it decided that no fitness to practise proceedings were required, and confirmed to us later that it was not able to address *"lower-level behavioural issues, or cultural issues, or attitudinal issues"*. Without wishing to detract from the importance of employment protection, it cannot be right that behaviour which seriously threatens patient safety cannot be robustly addressed.

**1.145** There is a pressing need to understand better the gross lapses of professionalism, compassion and willingness to listen that these events illustrate, including their prevalence, the underlying causes, and – most importantly – how they can be changed. Unless we address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively and safely, the problems evident in East Kent will recur elsewhere.

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

**1.146** We have found that teamworking in East Kent maternity services was dysfunctional. This was clear in the accounts we have heard from families and was consistently supported by the evidence of the staff interviews and available records. Many staff described “toxic”, “stressful” working environments. Arguments between staff were played out in front of families just at the time when truly effective teamwork was required and just when families needed to see that teamwork at work.

**1.147** Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

**1.148** In sometimes suggesting that the relationships between midwives and obstetricians and neonatologists were satisfactory, staff revealed the limitations in their concept of teamworking. This was, at most, a concept of each discipline doing its own job to an acceptable standard, but within rigidly demarcated and sometimes conflicting roles. In part, this resulted from an inflexible interpretation of a wider maternity debate, positioning midwives as the defenders of women against intervention and obstetricians as the inflictors of over-medicalised models of care.

**1.149** This is no basis for effective teamworking in maternity services. Midwives and obstetricians each bring a unique set of skills and experience to maternity care. They should contribute to maternity care as equal and valued partners. But it is inconceivable that they might have objectives that differ. There is not a separate role to promote “normal” birth or to reduce caesarean sections, or to be the “guardians of normality”, any more than there is a separate role to promote safety. A team that does not share a common purpose is not a team.

**1.150** We have not found any systematic policy in East Kent maternity services of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. Those we interviewed were careful to say that there was no such policy. We have found, however, that the way in which “normal birth” was spoken about and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve. On some occasions, this pressure of expectation seemed to contribute to staff decisions not to escalate concerns or to intervene, decisions that were otherwise inexplicable.

**1.151** One particular example is the Vaginal Birth After Caesarean (VBAC) Clinic, which started at QEQM in 2005 and was operational across the Trust by 2007. The inherent expectation of the clinic was clearly the promotion of VBAC, and it certainly operated in that way. While VBAC is a welcome and appropriate plan for some women, the benefits must be weighed against the risks, particularly of uterine rupture, taking into account any adverse factors. There were clear examples of women who were at high risk from VBAC where we could find no evidence that these risks were discussed, or that a decision which placed a woman at high risk was communicated to her or flagged to inform her future care. Such decisions need to be taken carefully, free from inherent prejudice about the “best” method of delivery.

**1.152** We believe that insufficient attention has been given nationally to the language that is used around “normality” and to the presentation of information, or to the expectations that both can create among both maternity staff and mothers. Language and information that are helpful in the majority of cases can have disastrous consequences when labour does not progress physiologically. We are aware that some recent steps have been taken to improve this, but these are insufficient in our view to remove the risk of misunderstanding and misinterpretation.

**1.153** Trainees in all disciplines contribute significantly to the work of maternity teams, providing care while gaining experience. For this to be effective, they need to feel supported, both by their peers and by senior staff, and they also need to take part in supervised learning. We found that clinicians in training did not feel supported; they felt isolated, exposed and vulnerable, and they sometimes worked unsupervised in complex situations beyond their experience. This applied equally to midwives and obstetricians, as well as to paediatricians in some cases.

**1.154** We found that bullying and harassment were frequently reported, working relationships with other disciplines did not feel comfortable, and more senior staff could be undermining and unhelpful. There were shortages of junior medical staff and posts often had to be filled by locums, further impeding the development of teamworking. New staff were made to feel unwelcome, were excluded from cliques, and were given challenging cases and expected to manage them without support.

**1.155** In part, this can be related to national changes in the training of junior medical staff brought about by the need to reduce working hours and compress training. While both of these have welcome consequences, principally in reducing fatigue and unjustifiably extended training, they also have unwelcome consequences. Shift working reduces continuity of care and increases the likelihood of information loss or error at handovers. The loss of the former “firm” system, in which junior medical staff were part of a stable clinical unit headed by one or more consultants, has reduced the feeling of belonging for staff, as well as the opportunity for staff to develop trust and knowledge of colleagues’ capabilities. It is important that we find ways to counter these unwelcome features and improve the sense of belonging among staff.

**1.156** A more longstanding difficulty is the separation of early training into different clinical disciplines, when staff’s future ability to work in teams in a mutually supportive way will be crucial. Staff who work together should train together from the outset, at least in part, and not just in rehearsing emergency drills (which is the most common form of joint training claimed).

**1.157** We believe that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made for good reasons have had unintended consequences. More generally, we believe 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**

**1.158** Throughout the period we have investigated, it was clear that the Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

**1.159** With families, this was evident in the way in which their concerns were dismissed. Where there were complaints, too often the Trust’s instinct was to manage those complaints rather than to consider what was being said as feedback and learning.

**1.160** With regulators and others, we have found that too much effort was consumed in seeking to challenge and undermine any scrutiny. For example, it is revealing that when the CQC report became available in 2014, the Trust *“went through every line, every word of [it] and came up with hundreds of challenges to the report, grammatical, spelling ... rather than actually going to the essence of the report and seeing ‘what do we do’”*, as a member of staff put it to us.

**1.161** Unfortunately, these problems are far from restricted to East Kent. Indeed, reputation management could be said to be the default response of any organisation that is challenged publicly. When the end result is that patient safety is being damaged, unrecognised and uncorrected, however, it is especially problematic. At present, the benefits of inappropriate and aggressive reputation management outweigh the meagre risks to an organisation of behaving in this way. This balance must be addressed.

**1.162** We have found at Chief Executive, Chair and other levels a pattern of hiring and firing, initiated by NHSE. The practice may never have been an explicit policy, but it has become institutionalised. In response to difficult problems, pressure is placed on a trust’s Chair to replace the Chief Executive, and/or to stand down themselves.

**1.163** There may be organisations in which the frequent and short-term appointment of key staff proves effective. It is clear that this approach was not just ineffective in East Kent, but wholly counterproductive. These decisions appear to us to have been made separately from any question of accountability: the effect was simply to rotate in a new face and rotate out the previous incumbent elsewhere.

**1.164** In practice, the appointments that were made led the Trust, and NHSE, to believe that things were changing when in fact the underlying shortcomings remained. This approach also led to the term of the then Chief Executive being cut short in 2017, when some of our interviewees suggested that improvements were beginning to be made.

**1.165** We are conscious of the damage caused by the succession of appointments as Chief Executive, Chair and Head of Midwifery, but also in other posts. Enthusiasm for the newly appointed individuals created unrealistic expectations that only fuelled criticism when those expectations were not met; this was described to us as a flawed model based on *“heroic leadership”*. NHSE and the Trust have not yet been able to break free of this unproductive cycle.

**1.166** 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. A legal duty of truthfulness placed on public bodies has been proposed as one of the responses to the Hillsborough disaster. It seems that NHS regulation alone is unable to curtail the denial, deflection and concealment that all too often become subsequently clear, and more stringent measures are overdue.

## Conclusion

**1.167** The Independent Investigation into East Kent Maternity Services has been a challenge to carry out, and at times difficult, but the Panel has never once doubted that it has been so very much more challenging, difficult and personally demanding for the families without whom it would not have been possible.

**1.168** We have set out in this chapter the stark findings of deep problems at every level in the Trust, from labour ward clinicians to the Board and external relationships. We have summarised the shocking consequences for the lives of women, babies and families, their health and their wellbeing. We have identified the significant missed opportunities stretching back to 2010 to prevent the continuing toll. We have introduced the four areas for action that we believe are essential to correct the underlying problems in East Kent and elsewhere, and to prevent recurrence. These are considered further in Chapter 6, with a route to taking action in each area.

**1.169** Our lasting gratitude goes to the families who put aside for a while the cares they should not have had to bear, to help us to understand the events, and to make the Investigation happen in the first place. We all owe them our undertaking to make things better. It is essential that the findings of this Report are heard, and the necessary actions heeded, around the NHS as in East Kent.



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

This chapter explains that, had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases the Panel assessed (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%).

In the 25 cases involving injury to babies, 17 involved brain damage. This included hypoxic ischaemic encephalopathy (HIE, a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain) and/or cerebral palsy attributable to perinatal hypoxia (insufficient oxygen). Had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%), had care been given to nationally recognised standards, the outcome could have been different.

The Panel has not been able to detect any discernible improvement in outcomes as evidenced by cases over the period within our assessment (2009 to 2020). Our assessment has also indicated that the outcomes and patterns of suboptimal care concerned both the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM) and the William Harvey Hospital in Ashford (WHH).

## Introduction

**2.1** We have conducted a review of each of the 202 cases where the families involved asked to participate in this Independent Investigation, and where their care by the maternity and neonatal services of East Kent Hospitals University NHS Foundation Trust (the Trust) fell within the scope of the Investigation's Terms of Reference. This chapter describes the review undertaken, our sources of evidence and its results.

**2.2** We have reviewed 202 cases, identified using our Terms of Reference and via families who had approached us to participate in the Investigation. In focusing on reviewing what happened in these participating cases, we have had the benefit of richer sources of evidence than we would have had by looking at, for example, clinical records in isolation. Specifically, our review draws upon the following three sources of evidence:

- **Family listening sessions:** In the great majority of the participating cases (189 out of 202), the family was prepared to relive their often traumatic experience for the benefit of this Investigation. In a minority of cases (13), the family wanted their experience to be heard without going through the distressing process of retelling what had happened. In these cases, the Panel focused on the information available in the clinical notes. We wish to place on record our thanks to each and every family, regardless of the decision they took on this point. The family listening sessions have provided a wealth

of evidence, expressed in a compelling way and creating a clear and vivid picture of what happened. In many cases the family listening sessions have included the husband or partner. Where they were present for the birth, their account as witnesses to what happened has proved to be invaluable, often including details which go beyond those available from other sources. In addition, the accounts of husbands and partners are testament to their own personal experiences as events unfolded; they are considered further in Chapter 3.

- **The clinical records:** We have had full access to the records we needed to conduct our review of the 202 cases. We would like to thank the team in the Trust who have made this possible in a full and timely fashion. In every case where the participating families have themselves been given documents, they have been ready and generous in making these available to the Investigation.
- **Interviews with clinical staff and others:** Chapter 4 sets out what we heard more generally from the staff at the Trust, past and present, and from others whose role has shed light on the maternity and neonatal services provided. In conducting our clinical review, we were able to invite to case-specific interviews the staff involved, including midwives, doctors and managers, where we judged that it would be helpful to do so. We are pleased to report that in every such case the person involved agreed to participate. This too has provided a very rich vein of evidence, largely confirming what the families witnessed and were able to recall in their accounts. Some of those interviewed provided additional documents which have helped to complete the picture.

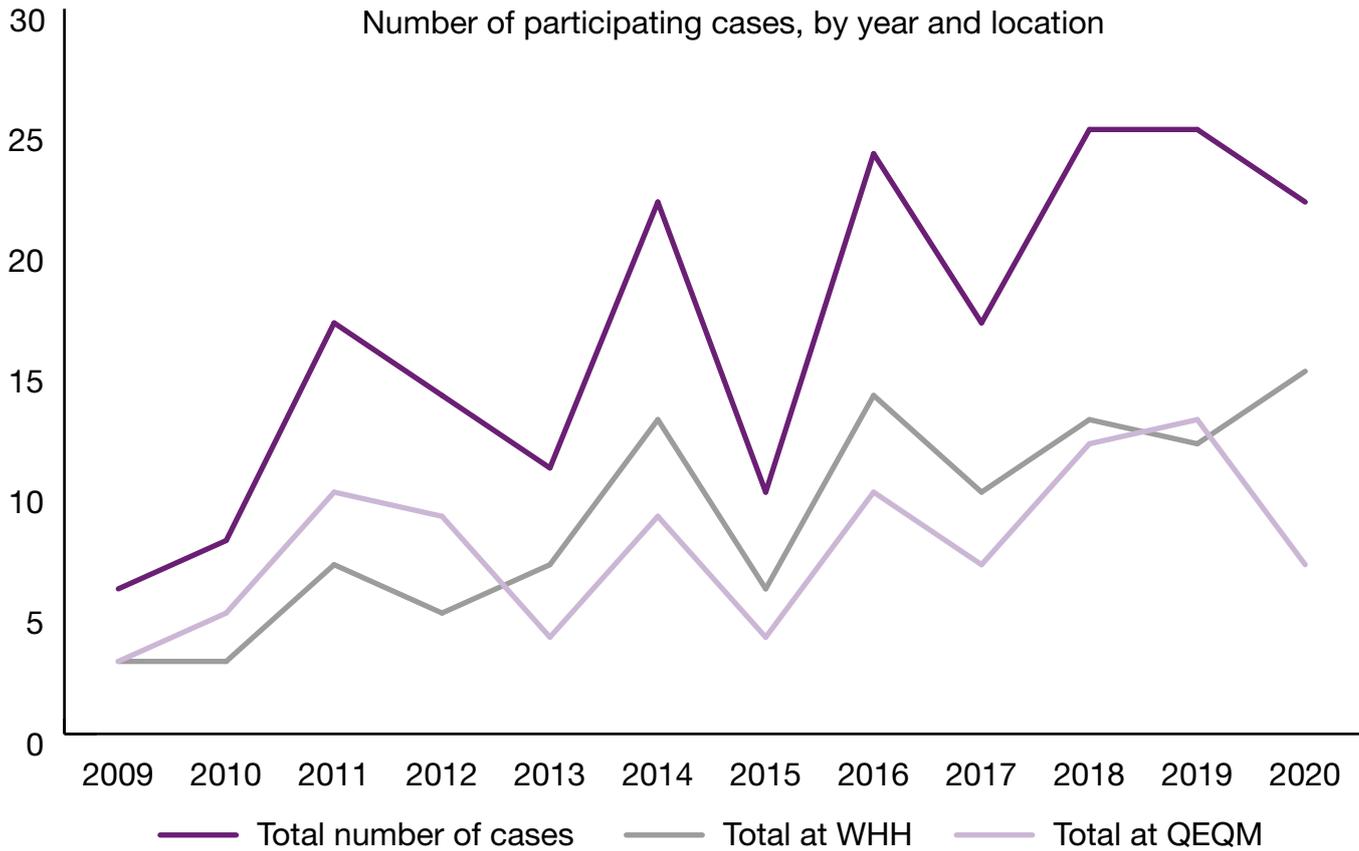
**2.3** Drawing upon these sources of evidence, this chapter explains how the clinical review was conducted. It also sets out its results, both in terms of the grading of suboptimal care (using the standardised scoring system developed for the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)) and the associated harm in each case (adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm). A fuller description of our process of clinical assessment is given in Appendix B.

**2.4** Alongside the clinical review, the Investigation has witnessed the wider range of harm which followed from the experience of the participating families. That wider experience, described in Chapter 3, is no less significant than the clinical outcomes.

## Clinical review and grading of cases

**2.5** The Investigation spans the period from 2009 – when the Trust achieved foundation status, so acquiring a new degree of autonomy and financial independence – to the end of 2020. A number of women came forward whose pregnancies fell outside the timeline set out in the Terms of Reference or whose approach to the Investigation came after we had completed this phase of our work. The Panel considered information about these cases, for background, but they do not feature within the grading of cases.

**2.6** Figure 1 does not show the total number of births in the Trust or indicate where the births relate to suboptimal care or a poor outcome. It does show how the participating cases span the period covered by the Investigation.



**Figure 1: Cases reported to the Investigation by year and location**

**2.7** With the consent of the families involved, we carried out a thorough review of the clinical records of each woman and baby's care by the Trust's maternity services, adopting a systematic approach (as described in Appendix B). In addition to the clinical records, the Trust provided other documentation such as complaints correspondence, investigation reports and exchanges with GPs.

**2.8** The Panel reviewed the records primarily to identify the presence of suboptimal care that might have led to a poor outcome in the period of pregnancy up to labour (antenatal), from the onset of labour through to delivery of the placenta (intrapartum) and in the hours and days after delivery (postnatal for mother; neonatal for baby).

**2.9** The Panel came together to consider the evidence contained in the clinical records, with our understanding enhanced by what we had learned from the other sources of evidence. As a result, the assessment of each case reflects the judgement of the Panel collectively.

**2.10** All the cases were graded using the CESDI scoring system previously used in *The Report of the Morecambe Bay Investigation*, published in March 2015. This defines four levels of suboptimal care based on their relevance to the outcome (see Table 1).

**Table 1: CESDI scoring system**

Level of suboptimal care	Relevance to the outcome
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

**2.11** In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case, using a classification adapted from the NHS NRLS definitions of degrees of harm (see Table 2).\*

**Table 2: Degrees of harm**

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including HIE and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

\* Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

## What the numbers tell us

### Suboptimal care and associated outcomes: summary of the Panel's findings

**Table 3: Degree of suboptimal care, Trust-wide**

Suboptimal care	Relevance to the outcome	No. of cases Trust-wide	No. as a percentage
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome	69	34.2%
Level 2	Suboptimal care, in which different management might have made a difference to the outcome	28	13.9%
Level 1	Suboptimal care, but different management would have made no difference to the outcome	54	26.7%
Level 0	No suboptimal care	51	25.2%
Total		202	100%

**2.12** The Panel's findings, set out in Table 3, 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.**

**2.13** The Panel found no differences to the outcomes or occurrence of suboptimal care over the time period covered by the Investigation (2009 to 2020). That is to say, we have not been able to detect any discernible reduction in suboptimal care or adverse outcomes over time, as evidenced by the cases we have assessed. Our assessment has also indicated that the outcomes found and patterns of suboptimal care concerned both QEQM and WHH.

**2.14** Table 4 gives a breakdown of the range of outcomes in the assessed cases.

**Table 4: Outcomes as reviewed by the Panel**

Outcome	Total number of cases
Baby death (stillbirth or neonatal death)	65
Baby sustaining hypoxic or other injury during labour or birth	25
Maternal death	4
Injury to mother	28
Other physical harm (psychological harm is considered separately in Chapter 3)	32
No death or injury	48
Total	202

**2.15** In relation to baby deaths, drawing upon our assessment of suboptimal care and the breakdown of outcomes, 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.**

**2.16** In relation to cases of injury to babies, drawing upon its assessment of suboptimal care and the breakdown of outcomes, 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%), including HIE and/or cerebral palsy attributable to perinatal hypoxia.**
- **In 9 of these 12 cases, the outcome would have reasonably been expected to be different.**
  - **In three cases, it might have been different.**

**2.17** In respect of cases involving maternal injuries and deaths, drawing upon its assessment of suboptimal care and the breakdown of outcomes, 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.**

### ***Illustrative cases of suboptimal care***

**2.18** The findings set out above are stark. But the impact of suboptimal care, while suggested by these findings, goes beyond mere numbers and can best be conveyed through a series of illustrative cases. These are just a few of the examples the Panel has studied, but serve to highlight some of the points that arose in many further cases. The first set comprises three examples of neonatal death (Illustrative Cases D, E and F) and one of antepartum stillbirth (Illustrative Case G).

#### **Illustrative Case D**

D's pregnancy was uneventful and she went into spontaneous labour around her due date. Progress was slow, and her baby developed signs of oxygen shortage. After significant delay in recognising the need for urgent delivery, an inexperienced locum doctor attempted an instrumental delivery, which was difficult and hazardous as the baby's head remained high. When this failed, D's baby was delivered by emergency caesarean section, with considerable damage and bleeding. The baby was in poor condition at birth. Resuscitation was inexpertly carried out, with significant delay in establishing an airway, and he died after a few days due to severe hypoxic brain damage.

## Illustrative Case E

E gave birth to twins after an uncomplicated pregnancy and induced labour. After a few hours, she reported that the first twin's breathing was laboured and noisy, only to be told by a midwife that "*he's not grunting, he's singing*". His temperature later dropped, suggestive of infection, and a medical assessment was requested. A middle-grade paediatric trainee attended two hours later but saw no grounds for concern, and significant further delay ensued before a consultant neonatologist initiated investigation and treatment for neonatal sepsis. The delay proved too much, however, and despite transfer to a specialist centre, the baby died of overwhelming streptococcal infection.

## Illustrative Case F

F's first child was born by caesarean section following lack of progress after full dilation of her cervix. When she became pregnant again, F was keen to have a vaginal birth with as little intervention as possible. At her first meeting with her consultant, F and her partner were deeply disappointed to be advised that she should give birth in an obstetric unit, where she could be monitored effectively in view of the risk of uterine rupture.

The couple deferred their decision, but as F's due date approached, they decided they wanted their baby to be born in a midwifery-led unit alongside an obstetric unit, with a doula present. They were aware that this was against recommendations because of F's high-risk status. The couple met with the consultant midwife at the Vaginal Birth After Caesarean (VBAC) Clinic, who refused to book F for delivery in the midwife-led unit on the grounds of safety. When the couple resisted the recommendation of delivery in the hospital's obstetric unit, the midwife suggested that in that case they should consider a home birth.

The couple remained very averse to the obstetric unit, and a plan was drawn up with midwifery staff for a home birth. Despite the obvious risks, which had already been regarded as sufficient to close off the option of birth in a midwifery-led unit, no formal assessment of the risk to mother and baby of a home birth was made. Neither was any consideration given to allowing F to give birth in a midwifery-led unit as an exception to protocol.

F went into labour a few days after her due date and her contractions soon became strong. After some time, progress in labour slowed and F was transferred by ambulance to the nearest hospital obstetric unit. Once there, concerns about the baby's heart rate resulted in F being taken to theatre for an emergency caesarean section. Baby F was born with signs of brain damage and required specialist care. She died soon after.

### **Illustrative Case G**

G progressed fairly uneventfully in her second pregnancy up to 36 weeks, when an ultrasound scan showed an excess of amniotic fluid around her baby. At 38 weeks, she reported reduced fetal movements, and although the baby's heart rate record (cardiotocography or CTG) showed no adverse features, she had a second episode of reduced movements two days later. A repeat ultrasound scan showed marked levelling off of the baby's growth. G recalls induction of labour being discussed in general terms, but felt concerned about the risk of cord prolapse, which she had been told was raised because of the excess amniotic fluid. There is no record of discussion of the risk of continuing with the pregnancy in light of the adverse findings of reduced growth, reduced fetal movements and excess amniotic fluid. Despite these obvious adverse factors putting her baby at risk, G was sent home with an appointment to return at 41 weeks. Two days before term, she attended again, having felt no fetal movements for a period of six hours. No heartbeat could be found.

**2.19** The second set of illustrative cases comprises examples of HIE (Illustrative Case H) and maternal injury (Illustrative Case J).

### **Illustrative Case H**

H experienced reduced fetal movements and attended QEQM. The CTG showed very abnormal features from the start and was seen by an obstetrician who recognised its nature but who was about to start another caesarean section. This situation should have been escalated immediately to the consultant on call but was not. In all, it took 70 minutes before the decision that an emergency caesarean section would be necessary was confirmed, the need for which should have been obvious to clinicians from the outset. Meanwhile, the baby's heartbeat had slowed significantly, and was undetectable as the caesarean section was about to commence. The baby was in very poor condition at birth, with profound hypoxia. There was delay in establishing an airway because the correct tube for intubation was not immediately available, but after eight minutes pulse and respiration had become established. The baby was cooled and transferred to WHH for neonatal intensive care. He suffered further problems related to severe HIE and has been left with significant brain damage.

### **Illustrative Case J**

At 41 weeks, J attended for a booked induction of labour. Progress was slow in labour, and a caesarean section was undertaken. The baby was delivered in good condition, but there was significant bleeding from J's uterus because the incision had extended into the uterine artery on one side. The surgeon was inexperienced, and did not recognise the dangerous nature of the situation at first or the need to escalate to consultant level immediately. In trying to control the bleeding, a stitch was wrongly placed around the ureter on that side, jeopardising kidney function. J required emergency intervention by a urologist to conserve kidney function and by an interventional radiologist to embolise (create a blood clot in) the uterine artery to control bleeding. She recovered after a difficult postoperative course, including the need later to remove part of the placenta from her uterus, but was left with prolonged pain.

**2.20** The final set of illustrative cases in this section comprises examples of maternal death (Illustrative Case K) and intrapartum stillbirth (Illustrative Case L).

### Illustrative Case K

K was booked for an elective caesarean section. She had previously had an emergency caesarean section following a complicated pregnancy, and was at raised risk of venous thromboembolism, blood clots that may travel to the lungs and cause pulmonary embolism (a serious emergency). K's raised risk was not identified before the elective caesarean section, but it was noted on medical assessment on the first postoperative day, with an instruction that she should have ten days of preventive treatment with an anticoagulant. This was not acted upon, and K had no preventive treatment after the first postoperative day. Her discharge notification incorrectly stated that thromboembolism prevention was not required. Three weeks after the caesarean section, K collapsed at home and subsequently died from extensive pulmonary embolism.

### Illustrative Case L

L, an older mother with a raised body mass index (BMI), was in her sixth pregnancy. Her last pregnancy had ended with an emergency caesarean section after prolonged spontaneous rupture of the membranes, with sepsis. As was routine, she was referred to the VBAC Clinic to discuss having a vaginal birth. There is no record that any of the additional risk factors particular to L were recognised or discussed with her, and she chose to follow the VBAC pathway. At two days post term, she had an induction of labour with a prostaglandin pessary. L reported excessive pain from the outset, which was unresponsive to tramadol and pethidine administered without an obstetric assessment. After four hours, labour was not progressing and she was still reporting excessive pain. She asked for a caesarean section, but her request was denied. After another four hours, a trace of the baby's heart was attempted (monitoring had been only intermittent despite the risk factors), but no heartbeat could be detected, and the death of her baby was confirmed. A consultant discussed the intended mode of delivery and offered a caesarean section, without apparently recognising the implications of the intrapartum death and L's severe pain. At caesarean section, three hours later, her uterus was found to be ruptured and her abdomen full of blood. L recovered after a difficult postoperative course.

## Narrow escapes

**2.21** 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. We do not consider these to be "near misses", things that were prevented from happening because they were identified in time and action taken; rather, they are examples of suboptimal care that went unnoticed, which purely by chance did not result in a poor or even grave outcome for the woman concerned. They are "narrow escapes". As such, they too have informed our view about the Trust's failure to ensure the provision of safe care to families. This point is exemplified by the following illustrative case, an example of a maternal injury considered by the Panel to be a narrow escape.

## Illustrative Case M

When M's labour began, at 41 weeks in her first pregnancy, she went to hospital where her cervix was found to be almost fully dilated. She was pleased to be able to use the birthing pool, and soon began pushing. After about two and a half hours, her cervix was confirmed as fully dilated. However, there was no progress apparent and she began to become exhausted. She was transferred to obstetric care. Three hours after confirmation of the second stage of labour – which should not normally last for more than two hours in a first pregnancy – a plan was made to allow a further hour for the baby's head to descend. An epidural was then set up, and a further hour “*allowed for descent*”. After five hours of confirmed second stage labour, with the baby's head in a transverse position and still not descended into the pelvis, a trial of instrumental delivery was undertaken. There was no descent of the baby's head with four pulls on the forceps, and a caesarean section was undertaken after six hours of confirmed second stage labour. The mother suffered perineal damage from the attempted instrumental delivery, but fortunately her baby remained in good condition.

### Failure to listen to parents

**2.22** In assessing cases, it has been striking how the avoidable factors we identified match many of the issues of concern that families themselves brought to our attention in the listening sessions we held with them. It is clear to the Panel that women had raised many of these concerns with their doctors and midwives while they were receiving their care. This is an important point, not least because it emphasises the role of women themselves in achieving a good outcome.

**2.23** An overriding theme to have come from the listening sessions is the tendency of midwives and doctors to disregard the views of women. In fact, in a significant number of cases, the Panel found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, their concerns often dismissed or ignored altogether. In at least some of these cases, the Panel was able to draw a connection between that failure to listen and an adverse outcome.

**2.24** The illustrative cases below provide examples of this theme. They describe the circumstances surrounding an antepartum stillbirth (Illustrative Case N) and a failure of neonatal diagnosis (Illustrative Case O). These are further examples of what the Panel found to be a failure to listen to women or other family members that contributed to an adverse clinical outcome.

## Illustrative Case N

N's first pregnancy progressed normally until 37 weeks, when she reported abdominal pain and altered movements by her baby. She was admitted to hospital for observation. She was not in labour, and intermittent CTG recordings of her baby's heart were within normal limits. A blood test indicative of infection was noted in her records but was not followed up, and she was allowed home the following day with no further arrangements or follow-up scheduled other than a routine appointment in two weeks. When she attended at 39 weeks, N reported reduced movements again, and her baby's heart was not heard. A stillborn baby was delivered the following day. Subsequent post-mortem examination confirmed the presence of an acute infection of the membranes inside the uterus.

## Illustrative Case O

Baby O was very quiet and lethargic, and hadn't fed since he was born. Just after 11pm, about three hours after delivery, he started to vomit and O called for help and asked for clean bedding. By 1am, he still hadn't fed and vomited again. O called for help again and told the midwives that something was wrong, that her baby hadn't fed and was vomiting green bile. She was told this was normal, and no checks were done or further enquiries made. In the morning, O told the nurse that she was really concerned, that her baby had been sick all night and still hadn't fed. This was at the change of shift and the sister who came on duty raised the alarm. Doctors attended immediately and inspected the sheets, removed the baby's nappy and asked whether he had passed a stool, which he had not. He was then transferred to the Intensive Therapy Unit. Baby O had been born with no anorectal canal and complete intestinal obstruction. It had taken 14 hours from his birth to identify this condition, rather than it being picked up by the midwife at the newborn check or later in response to the mother's concerns about his bilious vomiting. During this time, baby O's condition had deteriorated significantly because his developing electrolyte imbalance had not been corrected with intravenous fluids and attempted feeding had continued. He required specialist surgery at another hospital and prolonged follow-up.

## Conclusion

**2.25** This chapter has set out the Panel's assessment of the clinical outcomes experienced by the women and their families who contributed to our Investigation, and the extent to which these outcomes could have been different in the absence of suboptimal care. It shows that, in nearly half of the cases assessed by the Panel, the outcome could have been different had care been given to the standards expected nationally.

**2.26** The findings on clinical outcomes are stark. But the issues go wider and deeper than the clinical practice evident in the cases we have assessed. In other cases, including the 54 where the assessment of suboptimal care was at Level 1 and different management would have made no difference to the clinical outcome (see Table 3), or in the 48 cases where the Panel found that there had been no injury to the mother or baby (see Table 4), the care provided fell short of expected standards of service. We repeatedly heard that women's confidence in their care, and in the Trust more widely, was lost because of poor communication, a failure to engage and an unwillingness to involve women in decisions about their care.

**2.27** In particular, an overriding theme, raised with us time and time again, is the failure of the Trust's staff to take notice of women when they raised concerns, when they questioned their care, and when they challenged the decisions that were made about their care. This is considered in more detail in Chapter 3, along with other aspects of the families' experience.



# Chapter 3: The wider experience of the families

*“You go to hospital to trust people, because your life is in their hands, and you never expect one of your family members or you to be let down by the system like that; it’s really scary.”*

*“The experience has affected all of our family but particularly myself and [my daughter] ... she is my baby and I cannot do anything to take her pain [of her lost baby] away.”*

*“We want to move forward and actually live our lives a little bit. We don’t want this to be our lives ... we want to move on. It’s difficult; you’re stuck. You lose whatever you do. We feel like we’re not doing H justice or we’re not doing ourselves justice. Whatever you do, you can’t win.”*

This chapter describes the wider experiences of the families beyond the clinical outcomes described in Chapter 2. It 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.

Illustrative cases show how these themes featured in individual situations. These are just a few of the many accounts that we heard. The Panel has been struck by the extent to which there has been a deep impact on the wellbeing of families that continues to this day, sometimes many years after the birth. This is described towards the end of the chapter.

## Introduction

**3.1** In this chapter, we set out what we learned from the families we spoke to about what was important to them while they were under the care of East Kent Hospitals University NHS Foundation Trust (the Trust); how they felt they were treated by the midwives, doctors and others who looked after them; and in what ways they felt let down. It should be said that, among the stories of individual and systemic failures, there were also examples of good care by individuals, as well as compassion and kindness.

**3.2** Our starting point for the Investigation, and a core principle underpinning our work, was an acknowledgement that the experiences of women and their families were key to our gaining an understanding of what was happening in the Trust's maternity services during the period under scrutiny.

**3.3** Equally important was the Panel's undertaking to carry out an expert clinical review of what had happened in each case, including selected interviews with staff. The Panel's meetings with families, referred to as family listening sessions and described below, provided the contextual information and a sense of families' own experiences. Both these were invaluable to the Panel in its later review of individual clinical notes and its ability to make broader judgements about women's clinical care and any consequences.

## How we engaged

### Family listening sessions

**3.4** The women and their families were a primary source of evidence. In family listening sessions with Panel members, they shared their knowledge, experience and perceptions of the care they received, often providing poignant and moving descriptions of their treatment by those responsible for their care, in whom they had placed their trust. This process was sometimes difficult and painful and we are indebted to them for their courage and willingness to engage fully with the Investigation. Their accounts tell us much about the Trust's culture and organisational values throughout the period under scrutiny, as practised rather than espoused: in other words, the gap between what the Trust said it did and what it actually did. We believe that this gap itself contributed to the poor outcomes experienced by the women and their families who participated in our Investigation.

**3.5** It is important to acknowledge the experiences of the husbands and partners whose contributions, in themselves, have been invaluable. Not only have they had to deal with their own sense of pain and personal loss, but they have also had to provide ongoing care and support to their wives and partners, many of whom continue to have difficulties. In addition, some of our couples have experienced relationship difficulties – particularly around intimacy – greater than those that might be expected following a normal pregnancy and birth, and continue to do so.

**3.6** Every family was given the opportunity to meet members of the Panel in a family listening session, either by video (an imperative in the early months of the Investigation because of the Covid-19 pandemic) or, if they wished and it was possible, in person. Our early reservations about using video for such sensitive encounters were soon allayed, as the benefits of allowing people to contribute from the safety and security of their own homes became apparent and, without exception, they spoke freely and candidly about what had happened to them.

**3.7** We were also careful to correlate what we heard in family listening sessions with what was recorded in the clinical notes in each case and, where necessary, to interview relevant staff about the events.

### Trauma-informed counselling

**3.8** Mindful of the additional anxiety and distress that might be caused to them by having to recount and possibly relive their experiences, we offered each family the opportunity to attend a session with an expert counsellor.

**3.9** Like many who have experienced trauma, our women and families frequently described a sense of not being able to cope or to live their lives as they had before because of what had happened to them. The aim of our counselling was to support families as well as possible after they had relived their experiences with the Panel, seeking to increase their personal confidence in making decisions about how to manage the impact of the harm done to them. The counselling was the start of this process for some, while others were further on in their journey. For all, it was an opportunity to reflect and take stock.

**3.10** We were struck by how many families took up the offer of counselling as a result of participating in a family listening session. We believe this, in itself, is a sign that these families had experienced a significant effect on their wellbeing. In total, 54 families (more than a quarter) attended counselling sessions, some more than once. In some cases, families were signposted to other counselling services for further suitable support.

## Themes and behaviours

**3.11** Putting aside issues relating to the technical aspects of clinical care, which are covered in Chapter 2, there are a number of overarching themes that characterise the experience of the participating families. This is particularly concerning, given that the cases span an 11-year period up to as recently as 2020. It suggests that the themes are symptomatic of deep-rooted and endemic cultural problems across the Trust, which continue to hamper staff and compromise the safety of maternity services.

**3.12** Although there are overlaps across the range of themes in this context, they can be grouped into those that feature in the period up to and immediately after birth, and those that relate to families' experiences after a poor outcome.

**3.13** From our analysis, each theme can be characterised by particular indicative behaviours. We believe these have been detrimental to the quality and safety of the care given to women, and to the overall experience of them and their families (see Table 5).

**Table 5: Themes arising from family listening sessions**

Theme: experience of women and their families	Indicative behaviours of staff
1. Not being listened to or consulted with	<ul style="list-style-type: none"> <li>• Not listening to women’s concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation</li> <li>• Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care</li> <li>• Failing to keep accurate notes about what women themselves were saying and how they were feeling</li> </ul>
2. Encountering a lack of kindness and compassion	<ul style="list-style-type: none"> <li>• Showing a basic lack of kindness, care and understanding to women and their families</li> <li>• Making unkind or insensitive comments to women and their partners</li> <li>• Showing an indifference to women’s pain</li> <li>• Failing to ensure or preserve women’s dignity or provide for their basic needs</li> <li>• Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event</li> <li>• Putting pressure on families to consent to a post-mortem examination</li> </ul>
3. Being conscious of unprofessional conduct or poor working relationships compromising their care	<ul style="list-style-type: none"> <li>• Making rude, inappropriate or offensive comments to women and their partners</li> <li>• Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care</li> <li>• Disagreements between individuals in the same or different professional groups about women’s care, including giving mixed messages</li> <li>• Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services</li> <li>• Shifting the blame for a poor outcome onto colleagues</li> </ul>
4. Feeling excluded during and immediately after a serious event	<ul style="list-style-type: none"> <li>• Not being told what was happening, or what had happened, when things went wrong</li> <li>• Leaving family members waiting and anxious for news</li> </ul>

Theme: experience of women and their families	Indicative behaviours of staff
5. Feeling ignored, marginalised or disparaged after a serious event	<ul style="list-style-type: none"> <li>• A collective failure to be open and honest or to comply with the duty of candour</li> <li>• A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints</li> <li>• A tendency for the Trust to fail to take responsibility for errors or to show accountability</li> <li>• A failure to provide adequate follow-up support, including appropriate counselling</li> </ul>
6. Being forced to live with an incomplete or inaccurate narrative	<ul style="list-style-type: none"> <li>• Blaming women and families, or making them feel to blame, for what had happened to their baby</li> <li>• Not giving women and their families answers or reasons for why things had gone wrong</li> </ul>

**3.14** Each of these themes is considered in turn in the following pages. We have included a selection of illustrative cases and direct quotations from families relating to each theme, to add weight to our findings and because they speak for themselves.

**3.15** It was common for families to experience behaviours spanning the range of the themes we identified, which had an additional and cumulative impact on them. A more in-depth illustrative case is included later in the chapter to demonstrate this.

### Theme 1: Not being listened to or consulted with

**3.16** As in previous investigations into maternity services, we have found strong evidence at East Kent maternity services of a failure to listen to women and their families.

**3.17** We saw in Chapter 2 that not listening to women and their partners risks there being a poor clinical outcome, with the Panel finding examples of a clear link between a failure by clinical staff to take notice of women's concerns and the poor outcome they experienced. However, this recurring theme emerged from our review not just as one that had potential clinical consequences, but as one that had a broader and deeper impact on the families concerned.

**3.18** Not being listened to or not feeling that they were involved in decisions about their care undermined women's confidence in those providing that care and caused them to feel uncared for and, in some cases, unsafe. This was particularly the case when the woman was aware that she was high risk or had been told by a doctor that her pregnancy was considered to be high risk.

**3.19** This "not being listened to" took several forms. We saw a pattern of women, particularly first-time mothers, being made to feel patronised and demeaned when their concerns were dismissed as overreactions and unnecessary anxieties based on "first-time nerves". There were women whose concerns about the wellbeing of their unborn babies were ignored; and women on their second or later pregnancies whose personal knowledge, experience and understanding of their own bodies informed their convictions that something was wrong, but whose concerns were either ignored or dismissed. There were also women whose legitimate concerns about their newborn babies were not taken seriously.

**Indicative behaviour: Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation**

**3.20** We heard about:

- Women's feelings or concerns about their symptoms being dismissed:
  - *"A lot of it was that no one listened, every time I went to hospital. If they had, it might have been a very different outcome."*
  - *"I know I haven't had a baby before but this is my body and I know what's going on, and this doesn't feel right, this doesn't feel safe. I was expecting to be in pain, I'm not stupid, but this feels unsafe, this amount of pain; and being told, 'you've never had a baby before, I don't know what you expected'."*
  - *"I was saying 'look, I'm really swollen', but they didn't listen, they didn't take on board the things I was pointing out."*
- Women's concerns about reduced fetal movements being ignored:
  - *"I just wish so hard that when I went and said she was not moving the way she should be, that if they'd listened to me seriously ..."*
  - *"I had gone into day care with reduced movements; having had babies before, I knew that was a big no-no and I was shocked really, the whole approach was very dismissive, I felt like I was wasting their time for being there."*
  - *"The last thing I wanted was to be sat at the hospital, when I already had a three-year-old at home. I wasn't there to waste their time. I was there because I thought something was genuinely wrong. Even if there was nothing wrong, and I was just being neurotic, they still could have done things to support you rather than just be completely dismissive ... There were so many things that could have been different, that would have helped me feel like I wasn't going completely mad and maybe prevented the outcome."*
- Women's assertions that they were in labour or that their waters had broken being dismissed:
  - *"My waters went at 18 weeks and I went to [the hospital] and told them and the whole time I was there, they just told me that they hadn't gone and I was like 'I think they have' but they didn't believe me at all; I think it was that night that they did a scan, and it came back that my waters had gone, so quite a distressing time, and all I was told was 'it's not too late to have an abortion if you want to'; the whole day, the whole night, that's all they kept offering me."*
  - *"My waters broke when I came out of the shower and I mentioned it to the nurse, and she was quite dismissive of it, thinking it was just water from the shower dripping off my body ... and I don't feel that anything was picked up then; obviously now, looking back, that was really key, for me to be monitored after that particular time."*
  - *"I was in a side room on a bed waiting for obs, but as I stood up, there was this big gush, you know, like water, and they told me I'd weed myself; and I said, look, I have not weed myself, I'm so sure this is my waters gone, I would know if I'd weed myself ... again, I'm still being dismissed."*

- Women's concerns about the progress of their labour or the delivery of their baby being dismissed:
  - *"No one was trying to make the situation any better, apart from telling me that I was doing it wrong, and I wasn't doing enough to get the baby out ... I didn't feel supported by anyone in the room or that anyone really cared when I was telling them 'my body is telling me this isn't going to happen'."*
- Women's concerns about their newborn babies being disregarded:
  - *"I felt everyone was quite patronising and playing it down and we were trying to tell them that something was wrong ... We could see the deterioration. We never saw the same midwife. When he didn't open his eyes, I spoke to two midwives, one said to the other 'first-time parents'."*

**Indicative behaviour: Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care**

### 3.21 We heard about:

- Women being left frightened or uncertain because of a failure to communicate with them effectively:
  - *"We weren't really told much but I was told that sepsis is the main killer of babies and as a new mum I was petrified."*
  - *"No-one was telling me what was actually going on, they were just telling me what they were doing. They weren't explaining things. I was clueless."*
  - *"Although they tell you things, they don't tell you things how you need to hear them."*
  - *"Every time I tried to sit up, I was physically forced back, to lie back down. I was having flashes in my brain of old films about mental hospitals and things where people are forced to lie down and strapped in, and that's what it felt like especially with all the wires."*
- A failure by doctors and midwives to explain risks and ensure that women were fully informed, including when seeking consent:
  - *"Nobody talked through the risks of a VBAC [vaginal birth after caesarean]. Had I known, I would not have put my baby at risk and would have elected for a C-section ... there was no discussion about any risks associated with VBAC induced pregnancies, or the fact that I was an older mum and overweight."*
- Women feeling patronised and that they were not getting answers to their questions:
  - *"Because of my age, I was 19, I think that made her feel she could get away with not explaining things to me; it was like she thought I was stupid and she knew better."*
  - *"She didn't give me any answers, which I think is a massive thing. If she had just explained her thought process, it would have helped so much."*
  - *"Above all, no matter how old you are, you should be listened to."*
  - *"My midwife wasn't interested in talking to me ... she would just say just speak to your doctor or have you had a look on Google; but you want reassurance."*

- A reluctance of staff to discuss women's birth plans or to try to comply with their wishes:
  - *"I got the impression that the decision was made there and then, anything I thought was pretty silly because she's the nurse and she knows better than me, because I'm just the mother; I came out thinking that I was banging my head against a brick wall, she just wasn't listening."*
  - *"It was a battle to be heard from day one, it was 'I'm the clinician, I'll make the clinical decision'."*
  - *"I didn't think they could do things to you after you said 'no', but they did. It makes me scared to give birth in future; it makes me feel like I would end up giving birth at home with no one there because I'm so scared of midwives just doing what they want and not having my best interests and not listening."*
  - *"When I asked about alternatives to induction, I was met with 'if you don't get induced and if anything happens, it'll be your fault'."*
  - *"It very much felt like it was something being done to you, and not something we were involved with. 'This is what has to happen, and because it has to happen it doesn't matter what you think. This is what the list says we need to do.'"*
- Women feeling pressured about the mode of delivery:
  - *"The sister just looked at her and she said 'that's a swear word in my ward; we don't talk about C-sections in this ward, you'll be alright, you will be able to push this baby out'."*
  - *"It felt a little bit like the choices were out of my hands; as a patient, you know nothing and they know everything."*
  - *"I can't explain it, but I had this feeling that I wanted the babies to be delivered and I wanted a C-section; I asked the staff and was told we don't do C-sections because the mother is uncomfortable, it's not about the mother."*
  - *"They threatened me, it felt like, with a caesarean. 'If you can't be bothered to deliver this baby on your own, we'll have to do a caesarean. Is that really what you want out of this situation?' As if I was somehow being lazy, or just not doing what I needed to do."*
  - *"At one point, X said to her, 'hang on, why are you going to try forceps now when we've just agreed to a C-section? My wife has said she doesn't want forceps, she would much prefer a C-section.' Maybe we were being naïve that we had some sort of a say in this. She turned around and really snapped back and told [him] off saying, 'I'm the clinician, I'll make the clinical decision', and then stormed out."*
- Women being poorly communicated with and browbeaten to give consent in emergency situations:
  - *"That ultimatum on the operating table with someone stood over you with a scalpel in one hand was just like something from a horror film. It was so scary. These women who had been treating me, by this point I thought that they would do anything to me without consent."*
  - *"The doctors were rushing around, using words that made X anxious and she couldn't understand what they were saying. They wanted her to sign papers to say that she was happy to go to theatre, but she didn't understand what was happening or what she was signing. She was crying and shaking."*

- *“The doctor turned around to me and went ‘you need to start thinking about your baby’. I wanted to know what was going to happen. I didn’t know if they were planning for me to have a caesarean. I didn’t know what I was signing for. I signed the form because I didn’t want them to think I wasn’t thinking about my baby.”*
- *“I remember one of the midwives saying do you understand what’s going on? And I just said, C-section ... they didn’t ask if it was ok to use forceps ... and that’s what they did. I didn’t understand why they did it without asking ... I felt violated.”*

**Indicative behaviour: Failing to keep accurate notes about what women themselves were saying and how they were feeling**

**3.22** We heard about:

- Women’s concerns that their notes were inaccurate, with important aspects of their care missed out or incorrectly recorded:
  - *“So many times throughout the pregnancy I said I’m worried about this, I’m concerned about that, I’m not feeling great, but my notes just seem to say ‘mother was happy’.”*
  - *“They haven’t written any epidural request, any caesarean request, any help request. Nothing. They just did their own thing.”*
  - *“He [the consultant] went through my notes and said there is nothing in here that tells me about that [dysphasia]; and there was nothing in there that told him that her collarbone had broken and that we’d had an x ray – in her maternity notes – the slightly alarming thing for me is that, whatever happened, it hasn’t been recorded in the notes. To me, that’s alarming and it means that something’s wrong.”*

**3.23** It is the Panel’s estimation that, in a significant proportion of cases, this failure by midwives and doctors to listen to what women were telling them was a feature of the care experienced.

**3.24** Overall, we found “not being listened to” to be part of a broader tendency of clinical staff to fail to engage women in the management of their care.

## **Theme 2: Encountering a lack of kindness and compassion**

**3.25** The Nursing and Midwifery Council publishes professional standards which govern the activities and behaviours of nurses and midwives. Its first standard is *“treat people with kindness, respect and compassion”*.<sup>1</sup> Similarly, the General Medical Council publishes professional standards that govern the activities and behaviours of doctors. It states: *“You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.”*<sup>2</sup>

**3.26** The public might expect that kindness and empathy would characterise maternity and neonatal services anyway, without reliance upon a professional standard. Given the long-standing existence of professional standards set by regulatory bodies and the legitimate expectations of patients and their families, it is all the more concerning that lack of kindness and empathy features so heavily in our families’ accounts. We heard about behaviours of both midwives and doctors that fell some way short of those expected standards and legitimate expectations. In fact, in a majority of cases, families described aspects of their care that they felt were the result of unkindness and a lack of compassion and empathy.

## Indicative behaviour: Showing a basic lack of kindness, care and understanding to women and their families

### 3.27 We heard about:

- Women and families who felt uncared for and unwanted by doctors and midwives:
  - *“They are meant to be there for you ... I was a first-time mum; I was worried and I didn’t know how it all worked. It was unbelievable how I was treated.”*
  - *“There were so many failures that it’s hard to sum up ... It wasn’t even the physical medical things that happened ... it was the treatment from the people, the way we were treated, the way we were spoken to, with no human decency whatsoever, no bedside manner, no consistency, no continuity of care, the list goes on and on. And I think that is the culture, that is the culture there. It is this conveyor belt, where they are so immune to it, they forget that the women are even there.”*
  - *“If they had just cared, it would have made the blow a little less; a bit of support, a hug, just something, but there was nothing. It was really hard.”*
  - *“I came away from the experience very scared and humiliated. That’s what I took away from the experience of childbirth.”*
  - *“The care for my son was second to none. The care for me was diabolical.”*
  - *“I’m a carer and if I had acted like some of the midwives I would have been taken into the office and disciplined.”*
  - *“It just felt like a really lonely and traumatic experience, which I feel like maybe if it had been a more experienced midwife or someone else there, that I would have got that reassurance and encouragement that is really important when you’re having a baby, let alone in traumatic circumstances.”*
  - *“I felt like I was a nuisance.”*
- An apparent lack of awareness or a failure to take account of pre-existing mental health conditions or personal histories which made women particularly vulnerable to feelings of fear or anxiety:
  - *“The feelings are so similar to the sexual abuse but this time I’m left with a physical disfigurement as well as the mental side of it.”*
  - *“They were going to do an internal; I am a survivor of childhood sexual abuse and it was a male midwife and a male doctor; it’s making me sweat just thinking about it ... it was horrible.”*
  - *“I used to suffer with mental health issues ... that was in my notes with my first pregnancy and it went on my notes for my second but my community midwife, who I have to say has been amazing afterwards, she did take it off my notes at one of my appointments and that’s concerning for me actually now, looking back ... I did bring it up with [name], one of the midwives at the hospital, she did go away and speak to a doctor, who she said said to her, just put her on Sertraline ... and I don’t want to go back on tablets, I spent a long time coming off tablets.”*
- The needs of family members not being met, and in particular a tendency to leave people waiting, knowing that something has gone wrong but not being given any information:
  - *“X was taken back to theatre and I went to the ward to find the rest of the family and the new baby. They had been told to wait in a four-bedded bay; they were standing*

*in the space where X's bed would have been, huddled together and crying behind the curtains, surrounded by the three other women in that ward and their babies."*

- *"No one said anything to me ... I think at that point it probably would have been better if I had been told, look, there is something serious, given I could have probably switched into a more supportive role ... I always look back and feel quite guilty that at that time I wasn't supportive enough and actually I was sitting there and I was just questioning everything and thinking well maybe I'm just being overly worried here and there is nothing. I would probably have preferred to have known at that point"* [the reflections of a woman's partner recalling the moment he realised that their baby was ill; it was several hours later that they were told the gravity of the situation].
- Women or their partners calling for help and feeling ignored when no one came:
  - *"Within minutes, I began to feel very unwell and began shaking violently and vomiting. We pressed the emergency buzzer, but no one came. X [her partner] then went out into the corridor to try to find someone to help, but could not find anyone, so was left to deal with the situation alone."*

### **Indicative behaviour: Making unkind or insensitive comments to women and their partners**

#### **3.28** We heard about:

- Women and family members feeling patronised, being ignored or "told off", or being subject to hurtful remarks:
  - *"Some parents just aren't supposed to have children"* [a woman recalling the comments of a doctor].
  - *"I was told at one point it was because I was fat. It wasn't even beating around the bush, saying 'because of your weight' or anything like that: it was 'well, because you're fat, that's how it is and we have to do different things'."*
- Women feeling that they were unimportant and too much trouble:
  - *"She said sorry for your loss, but our baby was dead and there were other babies who were still living that she needed to attend to."*
  - *"We have more important people on this ward, you are not the only one who is in need at this point"* [a woman recalling the comments of a midwife made to her while she was waiting for a blood transfusion].
  - *"They would make me feel terrible ... every time I went, they would make me feel like I shouldn't be there."*

### **Indicative behaviour: Showing an indifference to women's pain**

#### **3.29** We heard about:

- Women in acute pain feeling ignored and being left without appropriate pain relief, their pain sometimes being dismissed:
  - *"I wanted to die, I was in so much pain."*

- *“The pain was horrific pain but the midwives who examined me said I was fine. I was in so much pain that I couldn’t place my feet flat on the floor, but they just told me I was doing well. I felt like nobody was listening to me and they couldn’t be bothered.”*
- *“She said ‘you’ll have to wait, I’m busy, I’ve got other things to do’; and I waited two hours, I spent two hours crying in pain before I rang the bell again because I was too scared, in case she started having a go at me again.”*
- *“People give birth in Africa in mud huts without pain relief”* [a woman recalling the comments of a midwife made to her during her labour].
- *“I still have nightmares to this day, of feeling that pain so vividly.”*
- Women feeling pain because of a failed epidural or spinal,\* or one that was wearing off:
  - *“He came and did these manual evacuations; my spinal had started to wear off a bit and he was going up with his hand right into my uterus and pulling out all the clots it was the most painful thing I’ve ever experienced in my whole life ... he was looking at me and said to me, Oh, is that painful? And I was like, yeah, your hand’s right up there, my spinal’s wearing off and I’ve just had surgery ... He didn’t seem to have any feeling ... The midwife said to me oh my God, they were looking horrified; they couldn’t hide their looks”* [a woman describing how a registrar proceeded with manual evacuation of placental tissue as her spinal was starting to wear off].
  - *“I lay down on the table and they started to do the cold spray, straight away I could feel it ... I kept saying I can feel this ... they didn’t listen to me, I said this about four or five times to the team, I can feel this, it’s not right. They didn’t listen ... They carried on, obviously, to cut me open. I could feel it all. My left side was slightly numb, I could feel everything on my right side. I felt the knife going in; I started to get hot and I could feel the blood draining from my face. I started to really panic and remember trying to push them off me ... I felt everything from there on, it was just an absolute nightmare.”*

**Indicative behaviour: Failing to ensure or preserve women’s dignity or provide for their basic needs**

**3.30** We heard about:

- Women not being able to be accommodated in the labour ward:
  - *“I was told we have no beds and you’ll need to wait in the day care waiting area; I had a really bad feeling at that point and burst into tears ... nobody reassured me, I felt like there was no sympathy or empathy expressed by anyone. I was told sorry, that’s the only place we’ve got for you, so I sat out there all day. That’s basically where I sat for the rest of my time, until I had my daughter at about 4.00 in the afternoon ... from 7.00 in the morning, I had been looked at, assessed once ... they asked my partner to hold her so she didn’t fall to the floor, because I was standing up. There were no midwives around, they had to go and find somebody ... I had to ask for blankets ... there was no dignity, I had to ask somebody to cover me up.”*

\* “Epidural” and “spinal” refer to forms of pain relief often used in labour or for obstetric procedures, involving an injection of anaesthetic around the nerve roots.

- Women's distress at their dignity not being preserved, for example by them being left for long periods in soiled bedding or in ward areas which did not provide for their privacy:
  - *"My blood was up the walls, on the ceiling; my sheets weren't changed."*
  - *"I know that doctors and midwives need to come and go, but the door was left open quite a few times, which was not very nice; there was no privacy – I think everyone in that hospital saw me in that bed. That was awful."*

**Indicative behaviour: Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event**

**3.31** We heard about:

- The impact of the limitations of the two hospitals' premises on women who had just lost their babies, which meant they were placed in wards among other mothers with their newborns or had to carry their babies' bodies to other areas:
  - *"It is soul destroying to hear the cries of healthy babies being born knowing that your baby will be born silent."*
  - *"Spending about 24 hours on the labour ward listening to other babies crying was hell on earth."*
  - *"It didn't make it easy for us; having to come out and see lots of happiness and we were going through the worst point ever."*
  - *"As I stepped outside, one of the mums from the nursery next door came up to me and said 'oh, how's he doing', and I looked at her and said 'he's dead'. That should never have happened, for her."*
  - *"They were walking the same way we were going, turning around, staring. That will haunt me for the rest of my life because they knew I was carrying a baby that was not here. They were just watching me the entire time, walk through the corridor. She said to her husband, as I passed them, 'she's carrying a dead baby'. It was awful."*

**Indicative behaviour: Putting pressure on families to consent to a post-mortem examination**

**3.32** We heard about:

- Newly bereaved parents feeling under pressure to consent to a post-mortem examination of their infant:
  - *"The pressure is unreal, for everything. Hours after we delivered him, they're there, 'do you want a post-mortem?'. This is stuff that I have never even thought to have done, and you're bombarding me with these questions."*
  - *"They wanted to know if we were happy for them to do a post-mortem and we were like, no, we don't want to have one, we don't want it to happen ... but they were like, ok, but it will really help other parents if you have one, and we were like, please do not ask, we do not want one ... and the next day, they asked us again, and we said we've already decided, do not ask us again, we do not want one, and we had to be quite firm ... that was quite hard because we felt they were pushing us into it."*

## Illustrative Case P

At 29 weeks pregnant, P began to feel unwell with abdominal pains. She called maternity day care and was told to attend for observation and cardiotocography (monitoring of the baby's heartbeat). She told the midwife it felt like she was having contractions but the midwife was dismissive, saying it would be a urine infection and the doctor would give her antibiotics and send her home. P believed the midwife, despite her concerns.

Two hours later, P noticed that she was bleeding and, on examination, was found to be in labour. Baby P was delivered by caesarean section. After initially making good progress, the baby developed a severe infection and his condition worsened.

After ten days, a doctor informed P and her partner that treatment had failed and nothing further could be done.

*"[They were] so blasé, [they] got the ultrasound scan and literally just said yes, that's infected, that's infected, his brain's covered in this, his heart's covered in that; I'll come back at ten o'clock when I've done my rounds and take the tubes out."*

Afterwards, P sat with her dead baby in her arms with the other parents in the room listening to her *"howl from her soul"*.

## Illustrative Case Q

At 17 weeks pregnant and bleeding heavily, Q was told to attend the maternity department. The person on reception was busy making arrangements to deliver a cake and made her wait. Placenta praevia was diagnosed and Q required an overnight stay.

Afterwards, at home, the bleeding resumed and Q found herself back in hospital. Suffering from a headache and feeling extremely thirsty, she called the midwife, who – in front of all those in the ward – said, *"Aren't you the woman who's going to have an abortion?"* Q was distraught: she had been told when she was first admitted that the viability of her pregnancy might be in question because of the heavy bleeding, but nobody had told her that she was at that stage.

A few hours later a consultant attended, who told her there had been a mistake, the midwife should not have spoken to her in that way and she had no need to worry. On her fifth day in hospital, Q was discharged and told to reschedule her 20-week scan, due in two weeks, because she was high priority. However, when she tried to bring the appointment forward, she was told this could not be done.

For the next three weeks, Q stayed at home, bleeding and suffering from headaches, scared of being a nuisance. She finally returned to the hospital and a scan revealed the presence of two large haematomas. After a week in hospital, she haemorrhaged and woke in theatre to confusion and panic. A consultant was present but there was no anaesthetist and there was a delay in obtaining the blood necessary for a transfusion.

Q's baby had not survived and she required a hysterectomy to control the bleeding; the consultant told her that, in their 30-year career, they had never had to perform one in such circumstances. The midwives told Q's husband: *"We're not set up for this, we haven't got the procedures."*

**3.33** What the Panel has learned from its interviews with Trust staff is described in Chapter 4, so will not be covered here. However, we found evidence that the prevalent culture in the Trust has tolerated and fostered the unkind, uncompassionate and intolerant behaviours sometimes experienced by women and their families.

### Theme 3: Being conscious of unprofessional conduct or poor working relationships compromising their care

**3.34** Team conflicts pose a potential threat to the quality of relationships and communication between patients and staff, as well as to the quality of care. They can also make patients feel unsafe when they perceive that staff are not communicating with each other or working as a team. It is therefore unsurprising that a lack of teamwork and a failure to share information featured in the family listening sessions as matters of concern to the women and families who spoke to us.

**3.35** We heard accounts of unprofessional conduct that were alarming to women and their families because they undermined their confidence in the doctors and midwives looking after them and, in some cases, made them question the safety of their care. For one family, these concerns were compounded by the comments of a consultant, overheard in a patient area, who was discussing with a colleague how unsafe the unit was and how they had reported it to senior management but had given up trying to raise it.

#### Indicative behaviour: Making rude, inappropriate or offensive comments to women and their partners

**3.36** We heard about:

- Women or their partners being on the receiving end of inappropriate and unprofessional comments, which they found hurtful or offensive:
  - *“She’s making the wrong call here, and it’s going to be your wife’s fault when it all goes wrong”* [a woman’s husband recalling the comments of a midwife].
  - *“[They’re] all over the place because [they’ve] just come back from a cruise”* [a woman recalling the comments of a consultant about a colleague].
  - *“Is she normally this dramatic with pain?”* [a woman’s husband recalling the comments of a consultant].
  - *“I don’t have time for this. I have to get to Canterbury and the parking is bad”* [a woman recalling the comments of a consultant made during a consultation].
  - *“Under no circumstances can you leave this room. If you do, you are putting your unborn child at risk ... on your head be it”* [a woman recalling the comments of a consultant].

#### Indicative behaviour: Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care

**3.37** We heard about:

- Midwives complaining about doctors and other midwives behind their backs:
  - In one case, midwives referred to a consultant as having a *“God complex”*.

- Midwives ignoring the advice of doctors and taking contrary action:
  - *“I don’t agree with that, this is what we’re going to do”* [a woman recalling the comments of a midwife made after a consultant had explained their plan for her care and left the room].
- Doctors showing disregard for their midwife colleagues:
  - *“[They] told the midwives off in front of me.”*
- Doctors disagreeing within earshot of women and their families:
  - *“Don’t you dare argue this with a patient, this isn’t appropriate or professional”* [a woman recalling comments made by a consultant to a colleague, disagreeing about a baby’s transfer to the bereavement suite].
- Women being told “on the quiet” that their care had been substandard and they shouldn’t accept it:
  - *“There are things that should have been done differently. If you were a member of my family, I would not be happy with the care that you’ve had”* [a woman recalling the comments of a midwife after a bladder injury during a caesarean section].

**3.38** In some cases, these behaviours reflected poor working relationships within and across professional groups. This theme is picked up below in reference to teamworking and information sharing, and in Chapter 4 on what we heard from staff. In any event, the impact of such behaviours on the women who witnessed them was such that they featured heavily in their accounts of what they experienced at the Trust. This laid bare for the Panel the extent and pervasive nature of the poor behaviours and teamworking in both maternity units, which the senior team failed to address with any degree of success.

**Indicative behaviour: Disagreements between individuals in the same or different professional groups about women’s care, including giving mixed messages**

**3.39** We heard about:

- Doctors and midwives contradicting each other or disagreeing in the presence of women, which caused the women anxiety and made them lose confidence in their care:
  - *“I’m not dealing with this, I’m not going to be here while you do this”* [a woman recalling the comments of a midwife made to two consultants who were about to break her waters].
  - *“Women and their families are set up for misunderstanding. You’re on the back foot and need to reinterpret what you’ve been told.”*
  - *“In hindsight, it’s easy to see there was a bit of a tug-of-war between the midwives and the registrar.”*
  - *“The consultant came to see me and said that they wanted to keep me in overnight, and the midwife sent me home about an hour later. And the consultant had written in my notes that they wanted to keep me in overnight and the midwife sent me home, and there were no notes after that to say why. I had no explanation. They just sent me home.”*

**Indicative behaviour: Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services**

**3.40** We heard about:

- Failures to provide sufficient information at handover, or to document information in the notes at shift change alerting staff to a possible risk to mother or baby, resulting in poor continuity of care and compromising safety:
  - *“The shift changes were shocking, there was no communication between teams; the new team didn’t have a clue what we had been through during the previous three days.”*
  - *“Communication seemed to be the biggest issue on that day ... the night shift didn’t hand over all the details ... there was the potential there to record some things that would have made it an amber alert but it was ten hours before we finally got those antibiotics, which in my opinion was too late.”*
- A failure to pass on information to colleagues and teams, including to the delivery ward or community midwives, resulting in upsetting interventions by staff following the death of an infant:
  - *“Calm down everyone, you’re going to have a baby today”* [a woman recalling the comments of a midwife made in the delivery suite prior to the planned delivery of her stillborn baby].
  - *“There’s no loop, no one communicated properly ... they didn’t even think to tell my midwife that my baby had died, it took me to do everything ... [they] signed me up for groups for after I’d had R, being a young mum, and I got letters in the post from them inviting me to mums’ groups, because nobody told them that my son had died.”*

**Indicative behaviour: Shifting the blame for a poor outcome onto colleagues**

**3.41** We heard about:

- Doctors and midwives trying to abdicate responsibility to others or shift the blame when things had gone wrong:
  - *“You could feel this cultural thing going on, where the consultants were saying ‘no, no, no, it’s the midwives’ and the midwives were saying ‘no, it’s not us’; and immediately, we got this little window into what was actually going on there.”*
  - *“We got taken to this tiny little box room and she just kept saying the whole time, ‘as long as you know, it is not our fault. It is no-one’s fault. It is just one of those things.’”*

## Illustrative Case R

R was pregnant with twins. At her 20-week scan, slight ventriculomegaly (enlargement of the ventricles of the brain) was apparent in twin one, and this had become severe by her 24-week scan.

The consultant told R and her partner there was a 95% chance that twin one would be severely disabled, and it was likely that the other baby would be as well. The consultant also told the couple that they were being unfair on their older children by continuing the pregnancy and that termination of the entire pregnancy was recommended, as it was not viable.

Even though they believed it was no one's decision but their own, the couple felt they would be going against medical advice if they chose to continue with the pregnancy. They were referred to King's College Hospital in London where the range of possible outcomes was discussed, including a positive outcome. They were also told that selective termination of just one twin was an option; this had not been communicated to them before.

The couple moved areas and within a few weeks R had her first appointment at the local hospital. The perinatal and obstetrics and gynaecology consultants advised her that there was a possibility of complications, but that this wasn't guaranteed and every baby should be given a chance. The couple felt that they were being treated as intelligent people who were competent to make their own decisions.

The following week, R had a bleed and was admitted. After a month as an inpatient, she delivered two baby girls by caesarean section. Although one required resuscitation, the twins were both well and continue to thrive.

## Illustrative Case S

Towards the end of an uneventful pregnancy, S developed a rash on her body, the cause of which could not be determined, and a decision was made for labour to be induced. The date was set and, early that morning, she called the hospital to check that she should come in. She was told that there were no beds available and to call back later.

Around 20 minutes later, S's waters broke; she called the hospital again and was advised to go to a neighbouring clinic to be checked. From the clinic, she was sent to hospital for additional monitoring, where it was confirmed that the baby's heart rate was slow, but she was wrongly told this was not a cause for concern.

S was sent home to allow labour to develop. That evening, having not felt her baby move for a while, she called the hospital again and was told to attend. She arrived as the night shift changeover was taking place. She was checked and found to be having contractions, but her labour was not progressing. S was attended by a student midwife, who applied Prostin gel to speed up her labour, and arranged for a birthing pool. The student midwife told S that it was likely she would end up having a caesarean section as her waters had broken more than 24 hours previously and her labour was not progressing.

Soon after, S was attended by a different midwife, who disagreed that a caesarean section would be necessary. S was given an epidural and labour augmented with Syntocinon; however, she felt very unwell as a result, and was shaking and vomiting.

The day shift ended, and S's care was handed over to a senior midwife, who told her that she had been left in a "ridiculous" situation and that she shouldn't have been kept on a drip, which clearly wasn't working as she was still in the same state of labour as she had been that morning, but was now exhausted and unwell.

Because labour was not progressing, a decision was made that delivery should be by caesarean section. S's epidural was topped up in preparation, but she felt very unwell again. No one seemed concerned or acknowledged that this was the second episode of these symptoms. One of the surgical team said: *"It happens, sometimes people are sick."*

## Theme 4: Feeling excluded during and immediately after a serious event

**3.42** In several cases, women became aware that something was going wrong in the course of their care, either as it was happening or shortly afterwards. They described a lack of compassion and a sense of being excluded as events unfolded or in the immediate aftermath. Sometimes, this failure to inform and consult them about a deteriorating situation extended to the woman's partner and other family members, who were left waiting for long periods in a state of ignorance and growing anxiety and fear.

### Indicative behaviour: Not being told what was happening, or what had happened, when things went wrong

**3.43** We heard about:

- Women and their partners or family members not being informed what was happening as events were unfolding:
  - *"No one talked to me at all through the operation ... I had the spinal block and no one told me what was happening. I was asking questions constantly ... I was trying to make sure that I stayed conscious so I could remember everything, and no one told me what was going on. I kept on peeking up and they kept on telling me to lie down. I just saw them covered in blood, up to their elbows covered in blood, having conversations about me saying, 'oh that's bad, that's bad, that's bad', but not telling me what was going on ... I was 100% sure I was going to die."*
  - *"My daughter went one way, my wife went the other, and I was left on my own, not knowing if my wife was alive or my daughter was going to be alive at the end of the day."*
  - *"I was just left for so long to my own devices. When the doctor came in, it was like no one wanted to tell me that he had died. They waited for me to go down to ultrasound, but by this point I knew something was up. I used to find [his heartbeat] at home on my own so I knew something wasn't right, but nobody was telling me."*

### Indicative behaviour: Leaving family members waiting and anxious for news

**3.44** We heard about:

- Women and their partners or family members not being informed after a serious event about what had happened:

- *“When I came around in recovery, I kept saying to them, ‘where is he, where’s my baby’. Nobody would look at me, nobody would tell me anything. It was only when X came in and I saw his face that I knew he was gone. They knew there and then that things had been done badly, because they wouldn’t even look at me.”*
- *“What was really strange, and what I really didn’t understand, is that no one was really willing to tell me anything, to explain to me what happened. They were really vague, and you would get different versions depending on what doctor you spoke to.”*

## Illustrative Case T

T had had three previous caesarean sections and knew what to expect, but her reception at the hospital unsettled her. She and her partner found the surgeon arrogant, rude and unreceptive to questions, though the anaesthetist was more reassuring.

T was given pain relief and a screen was put up, but no one provided any explanation about the procedure and T wasn’t even aware when it had started. Then, as the baby was delivered, a midwife leaned over and said: *“I’m really sorry the paediatrician is not here yet, but he will be here.”* T didn’t know what to make of that.

The infant was born translucent, pale and white. He was taken away and T knew that something was wrong. She asked what was going on and what had happened, but was not given any information other than that it was a *“freak of nature”*, an *“accident”*.

It was nearly an hour before T was able to hold her baby. When he was put into her arms, she was shocked at his pallor. He was then taken for a blood transfusion. T asked for information and was told that the clinicians had cut through the placenta; she knew there had been a ten-minute gap between knife to skin and the baby being delivered, and felt panic at the thought that he had been without oxygen for ten minutes.

The hospital staff said they had performed a computerised tomography (CT) scan and the baby’s brain was fine, but T was worried about the possibility of brain damage. She kept asking if he was OK and was told that he had been given a CT scan which had come back clear. She later found out from her notes that he had received a cranial ultrasound, not a CT scan. After discharge, T contacted the hospital to inform them that her baby was *“juddery”* and his eyes weren’t right; she was told *“boys are lazy”*.

At the two-month check-up, T asked whether the ultrasound would definitely have detected damage and was told by the sonographer that this was not necessarily so. With a great deal of effort, T managed to secure a magnetic resonance imaging scan for her baby. The couple were informed on the telephone that their baby had suffered a cerebral infarction. They attended the William Harvey Hospital in Ashford (WHH) to see the scan and were shocked at the very large area of baby T’s brain that had been affected. They asked how extensive the damage was and were told *“work it out yourself”*. The hospital has never provided an account of what happened.

## Theme 5: Feeling ignored, marginalised or disparaged after a serious event

**3.45** As well as their frustration and anger about not being informed as events unfolded, families described a range of experiences of the Trust’s investigations process that followed. Some felt that the process had been reasonably open and fair, while others felt deeply distressed and aggrieved by it. Sometimes, where there had been a very serious adverse outcome, families lacked information about what to expect and what processes should and would be

followed, including how they would be involved. In general, there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place.

**3.46** We also heard about the downgrading of incidents without proper explanation, and families' concerns about deaths that should have been reported to the coroner but were not.

**3.47** It is clear to the Panel that this failure to engage with women and their families after a serious event – or to do so in a manner that did not take into account either their distress or their concerns about their care, or to provide appropriate and timely support – caused them additional harm. These types of responses, illustrated by the indicative behaviours for this theme, made it harder for women and their families to work towards regaining a sense of being able to cope or to return to the kind of lives they had prior to what happened to them.

**Indicative behaviour: A collective failure to be open and honest or to comply with the duty of candour**

**3.48** At the time of writing this Report, it has been confirmed that, for some women, the Trust's failings have contributed to or caused the poor outcome experienced by them or their baby. In a few cases, this has been as a result of the Trust's own investigation; in others, it has followed a coroner's inquest or the interventions of a third party such as the Healthcare Safety Investigation Branch. However, there are many families who remain in the dark and who seek long overdue answers to their questions, as well as confirmation that any lessons learned have resulted in improvements.

**3.49** We heard about:

- Failures to explain to women or their families what had happened or to apologise, and families being "fobbed off" when they sought answers to their questions:
  - *"When things go wrong, people should talk about it and learn. Nobody thought I was in labour, nobody said they had made a mistake, and these are the consequences."*
  - *"Although it was seven years ago for us, it is still burning in our hearts because we haven't had answers."*
  - *"WHH shut down to us, they were more concerned about us taking legal action than actually wanting to learn from A's death."*
  - *"We've heard lots of people say they knew the hospital was an unsafe place and the culture was wrong. When we complained about the basic things, like the cleaning of condemned mattresses, [senior nurse] said she was surprised, because the CQC [Care Quality Commission] were due and everywhere had been painted. It was like, we've done the painting, and it's all ok; like the Queen's coming to visit so we've done a bit of decorating."*
  - *"People think that we are on a witch hunt for the surgeon, but we are not that sort of family. We understand that things go wrong, but we are having a problem because they could have seen it from a different view."*

**Indicative behaviour: A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints**

**3.50** We heard about:

- A poor complaints process, with responses to complaints sometimes not being received, defensiveness and a “pick and choose” approach to what was covered in complaint responses:
  - *“If it’s a small company, you can go to the boss to complain that this has been terrible ... With something as big as the NHS, you’re fighting a losing battle.”*
  - *“I had made suggestions in my complaint, and I had made it clear how wonderful the people were that had helped me. My complaint wasn’t about the fact that this was maybe an error or a faulty device, my complaint was about the lying and blaming me and covering it up. That’s what’s really upset me about it.”*
  - *“We wrote a measured complaint after some time, we didn’t do it in raw emotion, we waited, and I think it was quite clear what we wanted out of it in terms of an apology and to know that things were going to improve and not just ignored or brushed under the carpet ... it took three attempts to send that letter in before someone replied to us and in the end it took me writing to the CEO of the hospital Trust, just to get a reaction and acknowledge that we’d written the complaint ... they went on to investigate it ... and it took another six months before we had our meeting.”*

**Indicative behaviour: A tendency for the Trust to fail to take responsibility for errors or to show accountability**

**3.51** We heard about:

- A failure by the Trust to undertake robust investigations or to involve families:
  - *“People are investigating things by looking at the notes and we’re the ones who were with her, who could hear what she was saying and all the texts on her phone saying no one’s listening to me, everyone’s acting like it’s normal to feel like this.”*
- Delays in completing internal investigations, a defensive approach, and a reluctance to involve families, keep them informed of progress or report back to them, sometimes resulting in them fearing a cover-up:
  - *“It was literally like cloak and daggers, going round, trying to find out information and getting stuff from nurses who had put it by for us, who had photocopied things to try and give us the information we needed. We were getting no support from the management about anything at all.”*
  - *“Every time at the hospital, it always seems like one person is covering up for the next; they are a team and they work together, but they shouldn’t cover up when children are dying.”*
  - *“Their attitude was ‘we made a mistake, but it wasn’t that bad, and it won’t happen again’.”*
- The ongoing concerns and experiences of women being consistently ignored and invalidated after the event:

- *“They did their investigation ... I don’t know whether it’s ironic, but we got their response back, it was not good enough, I mean the response took over three months, but we got a response back the day before the Coroner’s court, but it was very very short, it was almost like bullet points, and we were like this is not good enough, straight away. So then we did a timeline, we did every question possible and the potential answers and we sent it to them ... so we are now waiting to see the response from that.”*
- A failure to demonstrate that the Trust has learned from serious incidents:
  - *“I just want to put things right for mums and babies. I just want to see things get better. Without accountability you can’t hold them to their promises and that’s why we’re here. I know people will promise you anything to get rid of you, but we really do need to get the accountability in order to get improvements – I don’t want differences, I don’t want changes, we want improvements.”*
  - *“What I can’t accept is that you refuse – you actively go out of your way to try and avoid learning from the situation, you actively try to cover it up, and that ultimately means it will happen again. That is something that I find unacceptable.”*

**Indicative behaviour: A failure to provide adequate follow-up support, including appropriate counselling**

**3.52** We heard about:

- Inconsistencies in the referral process to the Birth Afterthoughts service; when families were referred, they often found it unhelpful or even detrimental to their recovery:
  - *“That appointment was more hurtful than anything else. The lady was trying her best but she didn’t have all the notes, some of the notes were in the wrong order. There were notes that contradicted each other ... we just came out and cried.”*
  - *“I asked for Birth Afterthoughts and was told that wasn’t suitable because I had a complaint in process.”*
- Poor and sporadic access to and quality of counselling for the mother, with non-existent provision for fathers; many families have resorted to sourcing counselling themselves:
  - *“There was no care, no support, it was very lonely.”*
  - *“I just left there and thought this was the biggest waste of time ever. Because you don’t really want to go back to that hospital anyway when something like that has recently happened, and to go there and they can’t even get your name right or the baby’s name right, or how far along you were in your pregnancy, it was insulting.”*
  - *“It [the follow-up] was really, really bad. It was terrible. When they answered the phone, they didn’t want to help, they didn’t want to know anything about it.”*
  - *“For my counselling after it, I put myself forward for the doctor ... I didn’t even really know I needed anything, and then I got myself in a really bad state one day and thought about harming myself and then I realised I needed help.”*
- Failures of the bereavement service to provide an adequate and supportive response:
  - *“We asked to see the bereavement counsellor, and she refused to see us because we weren’t having a funeral, she was like, well, there’s nothing I can do for you.”*

- *“I wanted to get some counselling, but the waiting times were months and months for those ... I had a bereavement counsellor but because it was covid times, it was all over the phone and it was quite distanced and it was a very lonely time. I didn’t really find the bereavement [counselling] terribly helpful ... in the end it felt I was left to my own devices.”*

**3.53** Not being listened to, not being extended kindness and compassion, and feeling ignored or marginalised when accessing healthcare may leave patients who have uneventful care feeling insignificant and invisible. In those circumstances, it is not uncommon for patients to rationalise their responses as being the result of service pressures and to accept and normalise them.

**3.54** However, when these responses occur after events that are traumatic, frightening or have a poor outcome, as was the case for families in our Investigation, there is an expectation that staff will do all they can to minimise any impact and will act with compassion and insight. When this does not happen, the impact is greater. We heard this in the accounts given by the women and their families, and saw it in their visible distress months and years after their experiences. They were left questioning why they were treated in such a manner and feeling diminished, powerless and even worthless, adding a layer of harm to what was already for many an almost unbearable event.

**3.55** In common with other investigations, the trigger for regulatory scrutiny and the commissioning of this Independent Investigation came from individual families who had been failed by the Trust. It was their persistence and determination to get to the truth that has led us to where we are now. It is disappointing that families continue to have to do this to substitute for ineffective safety monitoring by trusts and regulators.

## **Theme 6: Being forced to live with an incomplete or inaccurate narrative**

**3.56** Many women were not party to the whole of their own or their baby’s experience, due to being sedated, not being in the same room as their baby or simply being too unwell to remember parts of what happened. In the absence of full and frank information from Trust staff, this left a space that was filled by women and families trying to make sense of what had happened and how and why it had happened.

**3.57** Being left with so many questions about events that they were unable to answer naturally led women and families to seek answers from the Trust. These answers were not always forthcoming, were only partial, or in some cases were misleading. We heard of internal investigations failing to get to grips with what had happened, so that no meaningful explanation could be provided. This led to families resorting to working through and trying to make sense of clinical notes in order to piece together what had happened, or to get answers to their questions. In doing so, they often found that how they had felt at the time and what they had been telling the doctors and midwives were not reflected in their notes, adding to their frustration and anxiety.

**3.58** In addition, being blamed by individual doctors or midwives for aspects of events, or being made to feel to blame for what had happened to their baby and being unable to challenge hierarchical systems and individuals with professional knowledge, left our families living with “what ifs”. This inevitably meant that they were forced to construct an uncertain or incomplete narrative about what had happened, due to the lack of facts, their sense of responsibility for events or simply the uncertainty with which they were left.

### Indicative behaviour: Blaming women and families, or making them feel to blame, for what had happened to their baby

#### 3.59 We heard about:

- Women and their partners being made to feel to blame and living with the guilt of believing that they were in some way responsible for the outcome or should have done more:
  - *“A member of staff said to me ‘is there anything that you think you could have done better?’, which stuck with me for months and months afterwards, I felt so guilty.”*
  - *“As I’m sitting here talking about what other humans could have done more, I still also feel myself that I could have done more as his mother, and I’m sure his dad feels the same, but this is what you’re left with.”*
  - *“To cover it up, to cover herself rather than try to stop it happening again, by blaming mums, I think this is something that happens. I think this is an ingrained thing, and that does cause damage, psychological damage. I am still upset now talking about it, but my son is okay.”*
  - *“The problems are ingrained, not listening to anyone and blaming the most vulnerable people at the most vulnerable time. They need to be doing the opposite of that. They need to be listening to the mums. They need to take accountability even if it’s human error. I would forgive anyone for a mistake, but lying and blaming is unforgiveable.”*

### Indicative behaviour: Not giving women and their families answers or reasons for why things had gone wrong

#### 3.60 We heard about:

- Families being left convinced that their baby’s death or injury was the result of failures in care because of the lack of information and attention provided by the Trust in the days, weeks and months after the death:
  - *“My opinion will always be that F died because somebody didn’t do their job properly; and that’s fine if you work in Sainsbury’s but when it comes to a family’s life; it has affected me, my husband, our son ... it’s devastating and it can’t be undone, it’s what we just have to live with.”*
  - *“What’s caused the suffering, and what is dangerous, is the lies and the falsifying the notes and blaming me to cover up for the human error or the device, and that being seen, when you make a complaint, as acceptable. I think that covering up and that blaming is really dangerous because we do not know what really happened.”*

**3.61** The consequences for the families are profound. Living with a narrative that they know to be untrue or partially untrue, or never knowing for certain if things might have been different, has fractured their trust in healthcare professionals, often challenging previously held beliefs about who is trustworthy and who is not. Having these previous beliefs challenged, as well as feeling unable to construct a true explanation about a major event in their own lives – even when they may have been present – has undermined their confidence in their abilities, strengths and decision making.

**3.62** We saw that this has often led to major changes in how families viewed themselves and others, and their ability to manage their lives. They were generally less trusting and confident in the ability of others to have their best interests at heart, even those closest to them. This additional harm has added to their grief, loss, physical disability or change in circumstances, with some families also experiencing major financial difficulties. In these circumstances, their ability to regain their capacity to cope has been severely hindered.

### Illustrative Case U

Two weeks after her due date, U was booked in for an induction. Despite a sweep and two doses of Prostin, progress was slow, and U and her partner felt neglected as staff were busy with other patients. One midwife refused to carry out an internal examination of U that evening, even though one was overdue, and no examination took place before a second dose of Prostin was administered.

During the night, U woke in intense pain and experiencing contractions. As her contractions became more frequent and stronger, she asked again whether she would be examined but was made to feel like she was making a fuss. In the morning, U mentioned the pain she was experiencing and that her contractions were getting shorter. Then the contractions suddenly stopped and she experienced reduced fetal movement. The midwives said that her baby would be sleeping.

On the induction ward, U was monitored and there was still very little fetal activity. A midwife said she should stay on the trace for another ten minutes for a “sleep trace”. The monitor started to sound an alarm, and within minutes an emergency caesarean section was performed and baby U was delivered covered in meconium and requiring resuscitation. She was cooled straight away and had several seizures. Fortunately, she did not sustain any long-term damage.

U and her partner were informed that there had been a meeting about the event, but they were denied any details. Subsequently, they requested the minutes of the meeting but were told that these could not be found. They believe there was an investigation but the outcome was not shared with them. They queried the care provided on the evening prior to baby U’s delivery when the midwife refused to examine U, and the failure to properly monitor her to identify that the infant was in distress. However, they received no answers and no explanation of why the baby was born in such poor condition.

The couple indicated their intention to complain and asked to be put in touch with the Head of Midwifery; however, the hospital failed to contact them. Then, feeling that they had done all they could to obtain answers to their questions, they instructed a solicitor. The Trust called into question U’s account of events because it did not correlate with what was recorded in her notes. The couple were told that their legal claim could not succeed because their baby had survived without lasting damage. They agreed to mediation at the request of the Trust. However, on the day before the mediation, the Trust submitted additional paperwork and refused to be bound by the mediation’s outcome, leaving the couple without any determination and a hefty fee. They are left not knowing what happened and believing that the hospital is hiding something from them.

### Many of the cases included all the above themes

**3.63** Illustrative Case V is representative of many accounts we heard, in that it describes how one family experienced failures in care and poor behaviours of staff that cut across the range of themes we have identified. It is necessarily more detailed than the others in this chapter and, for that reason, all the more powerful.

## Illustrative Case V

When V became pregnant, she was told that she was at high risk, so she was surprised that each time she attended for an appointment, she saw a different doctor. She experienced swelling in her face, feet and fingers, and breathlessness, headaches and tiredness. All of these symptoms and the extent to which she was struggling were dismissed as due to her weight.

*“I felt like I was going to these appointments and was just being churned through a mill. I would sometimes sit for way past an hour past my slot time, to be measured and weighed and just told yes, just carry on, we’ll see you in four weeks. And I thought, you’ve not asked anything about what went on since the last appointment; I was saying things like ‘I’m really swollen’, but they didn’t listen, they didn’t take on board the things I was pointing out ... I was just told, no, you’re just fat.”*

Near to her due date, V had an appointment with a new junior doctor, who told her that she had too much fluid, and that if she were to go into labour she was at risk of the fluid “gushing out of her”, possibly resulting in an accident to the umbilical cord. This alarmed her, and she worried that all she could do was ring for an ambulance if her waters broke.

By the time of her final consultant appointment, V was suffering from symphysis pubis dysfunction; her pelvis was extremely painful and she had difficulty walking. She told the consultant that she felt sure she would need a caesarean section, particularly given that her scans were showing her baby to be large. She was told that she should have no concerns about a natural birth and all would be fine.

*“And again, I felt like, in that appointment, I was churned out, they didn’t have any time for my questions. That was my very last appointment with a consultant, and I was just totally disregarded. I really don’t even know why we bothered going, because everything that I was worried about, it was just ‘you’ll be fine, mother nature will take care of you’.”*

V’s anxiety was compounded by her midwife, who told her that “it was not midwife territory” and “they’re not interested in having you under consultant care”. She told V that she too had raised concerns with the consultant, which were dismissed.

At 41 weeks pregnant, V was very unwell. Feeling “fobbed off” by the hospital, she went to see her GP, who sent her straight there, giving her a letter to take with her stressing the urgency of the situation due to her evident pre-eclampsia.

*“I got there, and it was just the same as usual; it was the same ‘well, this is how it is at the end of your pregnancy, you’re not going to feel your best’. And I thought, there’s not feeling your best, and there’s feeling horrendous. One of the things that I really want to be highlighted is that there were so many times throughout the pregnancy when I said I’m worried about this, I’m concerned about that, I’m not feeling great, but my notes just seem to say ‘mother was happy’. And I wasn’t happy.”*

The hospital consultant confirmed that V’s baby needed to be delivered in light of her pre-eclampsia. However, there was no room for her that day, nor the next, which was a Friday, so she would have to come back on Monday because they did not induce women over the weekend. The consultant organised for her to have a sweep and she was told that, if that brought on labour, she should go straight back to the hospital because a woman in labour could not be turned away. Her labour began that weekend.

*“I had to go with ‘there’s no room at the inn’ and go home after the sweep, and I felt again that they were just not taking it seriously. I went home and I did go into labour*

*over the weekend. We went in on the Sunday morning, I think at a time that wasn't ideal, it was the changeover of the shift, and they actually said when we got there, 'oh, we've had such a long night'; and we were a bit apologetic. And I said, 'well I've had a long night too, we've not really had any sleep'. My contractions had started on and off and then really picked up in the early hours of Sunday morning, and they were like 'well, they're not that strong' and started to play it down immediately."*

V was told by a midwife that she was not in labour because her contractions were mild and subsiding, and that she should go home and come back the next day, Monday, for her booked induction. The midwife asserted that, in her excitement to give birth, she was reading too much into the pains, which were not the real thing. V asked if she was going to be examined by the consultant, whom she had seen at the desk when she arrived and who had said she could stay if her cervix was dilated, but was told by the midwife that she did not need to be subjected to *"unnecessary poking and prodding"*. The midwife said: *"I can 100% guarantee that you're not dilated."*

*"We were leaving, even though I was in pain, because we were not wanted there."*

V went to bed. Later that day, she noticed that her abdomen had softened and dropped and there was no resistance or kicking back when she pressed it. She rang the hospital and explained that she hadn't felt her baby move for around six hours. The person on the telephone told her to come in and then hung up. On arrival, V, her partner and her mother were put in a room with other people. Looking back, she wonders whether it might have been better to place them in an empty room, given that she had told the hospital that her baby wasn't moving.

All the curtains were open as staff tried to find a heartbeat. Everyone was staring at them. When no heartbeat could be found, V became upset and the family were moved to another room for a scan. After what seemed like a long wait, a junior doctor arrived; the doctor wouldn't talk to them, look at them or give them any information, merely saying, *"well, give us a chance"* when they asked what was happening. Even though no heartbeat had been found, V was in a state of disbelief that something could be wrong.

*"After a really long time, I'm guessing close to an hour, an obstetrician turned up and [they] scanned me. Again, there was no conversation. And then [they] said, 'you have to be very brave, because your baby has passed away, there's no heartbeat, your baby has died'. Everyone was crying but I said to [them] straight away, 'how did this happen, I was here this morning and you said everything was fine and I should go home'. And then [they] left the room, and I didn't see [them] again for six years until I was in a courtroom with [them]."*

Having been told that there was no heartbeat, V was given a pessary to commence labour. She was told that as her cervix was already 5cm dilated, it would probably happen quite quickly.

*"It's not really one of those things that you can measure because I know that people can go from zero to five centimetres in no time at all, but it plays on my mind that maybe if [the consultant] had just examined me in the morning, I would have been enough dilated to have stayed. And even if the outcome had been the same, that I'd have been left in that room all day on a monitor and he still died, I'd have felt that I was in the right place. Instead, we have all these 'what if' questions, which now we just have to live with and it's difficult to move past that."*

V's labour was traumatic and began with a failure in communication that was most distressing for the family.

*“When they came in, one of them said, ‘calm down everyone, you’re going to have a baby today’ and they hadn’t been told. Then she had a bit of her own meltdown because she felt so silly, and we ended up feeling sorry for her. It was such a mess. Sometimes, I think I don’t know what difference it would have made, for her coming and saying sorry for your loss, let’s help you, but at the same time, the two of them came in like a parade, like happy, happy, it was just awful.”*

V spent 18 hours trying to deliver her infant because the hospital did not initially agree to a caesarean section. At one point, she lost consciousness – a terrifying experience for her partner. Finally, a caesarean section was carried out to deliver the stillborn baby. The surgeon told them that the baby shouldn’t have died, that he was a good size and healthy and they should take matters further.

*“I had just delivered a stillborn baby and I was already being told, this isn’t right, something has gone wrong here. But we knew it, we knew it anyway, because we’d been to all these appointments, but nothing was put in place.”*

Afterwards, V had to stay in hospital for a while. Being on the ward with no baby was particularly difficult, but it was during those few days that the couple experienced a growing awareness that things had gone wrong. The comments of one particular doctor stand out for them.

*“[They] said to us ‘we can manage this in other pregnancies, we can give you a small dose of aspirin every single day and your pre-eclampsia will be managed; this won’t happen to you again, and I’m sorry it happened to you this time’. And then [they were] swept out of the room so quickly, as if we shouldn’t have been told that, because until then, pre-eclampsia just hadn’t been mentioned.”*

Then, when V had returned home, she was telephoned by her midwife; her recollection of what the midwife said is as follows:

*“I shouldn’t say this to you, but I think we’re friends now, you need to get a lawyer ... they’re covering things up and I shouldn’t tell you this and I don’t really want to talk about it anymore.”*

The couple pursued a legal claim, but no fault in V’s care could be proved – not least because of the emphasis placed on her clinical notes, which the couple believe do not give an accurate picture of her condition or care. They are left with the belief that the management of V’s pregnancy was *“a mess from start to finish”*. They remain particularly upset that the hospital made an error regarding the gestation of their baby, whose post-mortem examination confirmed that he was far more advanced than had been recorded. Despite telling the hospital that her dates did not match theirs, V was left to go overdue, her baby *“fighting on for an extra two weeks”* before he died.

Over the last eight years, V and her partner have asked hundreds of questions about what went wrong and have still not had answers. They were told that nothing went wrong; it was one of those things. They have never received an apology.

## Conclusions, including consequences and impact on wellbeing

**3.64** The Panel has considered carefully the evidence provided through the family listening sessions, alongside the information obtained from reviewing clinical notes and other documentary sources. In doing so, it has identified a range of repercussions for women and their families. 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.

**3.65** We would also like to highlight the additional guilt that many families have come to feel for not speaking up, when they have seen more recent cases come to light. We are absolutely clear that no family should feel that way: it is not up to families to correct the deficiencies of a Trust that has shown itself consistently incapable of learning.

**3.66** Losing a baby or sustaining a life-changing injury during childbirth as a result of failures in clinical care has an emotional and psychological effect that most people would find hard to contemplate. However, the Panel is in no doubt that, on top of this, these women and their families experienced behaviours from clinical staff which failed to meet the standards required of them and rightly expected by the families.

**3.67** We found that the impact on the wellbeing of women and their families was often compounded by the additional harm caused by the behaviours and attitudes of those responsible for communicating with and supporting them after the event. This included the doctors and midwives who had been directly involved in their care, as well as others who were acting on behalf of the Trust in a different capacity, such as those responsible for leading internal safety investigations or managing complaints.

**3.68** This additional harm served only to worsen and magnify the families’ sense of pain, anger and injustice and hinder their ability to come to terms with what had happened to them and begin to live their lives fully again. The Panel is in no doubt that this could have been avoided had the initial response of the Trust and its staff been open and compassionate, with a focus on including and supporting women and their families.

## Illustrative Case W

W sustained a life-threatening surgical injury, either during a caesarean section or afterwards during a procedure to stem heavy bleeding. After her discharge from hospital, she met with her consultant. They told her that they fully expected to see her in a few months, because “*you’ve still got everything, you can still have a baby, we’ll look after you*”. But the experience has left W terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

*“It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn’t be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I’ve always wanted a second baby and I will never do that, ever, and no one appreciates that side to it.”*

**3.69** In this chapter we have described the wider experiences of the families, setting out and providing evidence for the themes we have identified and the behaviours that are indicative of those themes. These experiences provide further evidence of care and treatment that fell short of what might reasonably be expected, and that in some cases contributed to the poor outcomes many families suffered.

**3.70** In addition, we have made clear our finding that women and their families have suffered additional harm as a result of the behaviours and attitudes of the health professionals who were responsible for their care, as well as others at the Trust with whom they had interactions after the events. For some, this has had an impact on their wellbeing which continues to affect their lives today. 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

Alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at East Kent Hospitals University NHS Foundation Trust (the Trust) and with others whose work brought them into contact with the Trust's maternity and neonatal services. This has been a key part of the Investigation. It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking and conclusions.

## Introduction

**4.1** Between October 2021 and June 2022, the Investigation Panel met with 90 different 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. The Panel met five of those people twice.

**4.2** In addition, the Investigation interviewed 22 individuals who did not work at the Trust but whose role brought them into contact with the Trust in connection with the provision of maternity care, such as representatives from the Care Quality Commission (CQC), the Healthcare Safety Investigation Branch (HSIB), Clinical Commissioning Groups (CCGs) and NHS England/NHS Improvement (NHSE&I).

**4.3** This chapter reflects what the Panel was told by those it interviewed. It does not contain the Panel's commentary or assessment of any of the information provided by staff and others except where explicitly stated, but it does focus on what the Panel heard about the problems and challenges facing the Trust. That is not to say that the Panel did not hear about positive aspects – the 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.

**4.4** In particular, the Panel was conscious that many interviewees understandably wished to put a positive light on subsequent improvements in services, but we found that this view was not generally borne out by other evidence.

## History and structure

**4.5** Many staff with whom the Panel met raised the fact that the Trust was previously three separate trusts: the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust. The three trusts merged in 1999 following a local review of services, "Tomorrow's Healthcare", and the resulting trust became one of the largest hospital trusts in the country at that time. The long-term outcome of the Tomorrow's Healthcare review on maternity

services was to focus obstetrics at Ashford's William Harvey Hospital (WHH) and Margate's Queen Elizabeth The Queen Mother Hospital (QEQM).

**4.6** Each hospital had an obstetric unit. WHH had a Level 3 neonatal intensive care unit, which is suitable for all babies who do not require very specialised regional or national specialist care. QEQM had a Level 1 special care unit, suitable for low dependency care of babies born after 32 weeks of pregnancy. Dover and Canterbury hospitals operated standalone Midwifery-Led Units (MLUs) in the former obstetric units (later relocated alongside the obstetric units in WHH and QEQM).

## What we heard from staff

**4.7** The Tomorrow's Healthcare review was described by one clinician as *"a bruising period"* and by another as *"a very traumatic process, as it basically pitched all three Trusts against each other"*. The clinician told us:

*[It was a] challenge to integrate the whole of the maternity services which were so divided before, and especially during, the Tomorrow's Healthcare consultations, and to bring some order to the whole Trust. It took years, not months, to bring understanding that they would have two units and it was no longer possible to have three.*

**4.8** The Panel heard about the challenges that merging the trusts brought. One member of the medical leadership team said: *"Moving from three relatively small organisations to one large organisation meant there was a lot to do in terms of healing rivalries, managing the communities and to some extent the staff."* Although effort was put in to build an *"East Kent focus"* across the Trust, many people reported that the hospitals remained quite separate, and in 2014 a CQC inspection report noted that the Trust still behaved like three separate organisations.

**4.9** The Panel was told that the Trust *"had never really coped with the merger"* and that *"the merger is highly relevant to what goes on in the Trust day-to-day"*:

*They were supposed to be one team but in reality that wasn't the case. Even the guidelines were different for each site until recently.*

**4.10** When the Trust became a Foundation Trust, the internal structure was relatively flat and involved clinical directorates; this, it was said, allowed people to participate in decision making. The application for foundation status resulted in Monitor\* insisting on fewer management groups, which, the Panel heard, left senior staff (especially clinicians) feeling that they did not have a voice and were excluded from Trust business. The Trust moved the individual directorates into four (*"massive"*) divisions in 2011 as part of a reorganisation. The Women's Health directorate was rolled up in the Specialist Services division with renal, dermatology, cancer services and paediatrics – *"specialities that had nothing to do with each other, but that was the structure of the Trust at the time"*. The Panel heard:

- *"It felt like [women's services] were being put with other odds and ends – the elsewhere 'unfileable'."*
- *"... the voice of maternity services was diluted within that Division."*

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\* Monitor was an executive non-departmental public body of the Department of Health, responsible between 2004 and 2016 for ensuring that healthcare provision in NHS England was financially effective.

**4.11** One Trust Board member commented that “*staff in maternity felt they were always the poor neighbour to cancer*”, and an obstetric consultant told the Panel that the Specialist Services division had far too wide a remit and resulted in people at divisional level taking their eyes off the ball in terms of maternity services. The Panel heard that the new director leads had little understanding of midwifery and maternity services, and “*the maternity unit was in disarray with few plans for the future*”.

**4.12** In 2018, soon after the arrival of a new Chief Executive Officer (CEO), the Trust changed from directorates to clinically led care groups. This was intended as a move from a management-driven structure, in which clinicians supported managers, to one in which the clinicians delivering the services would be supported by their managers. There were initially seven care groups, but the Women’s and Children’s Health group was later split in two and there became eight. This was considered a positive development.

**4.13** 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.

### Poor staff morale

**4.14** A member of staff who had been with the Trust for 20 years described the first ten years as “*generally good*”, but they resigned more recently due to a “*toxic culture*”. Working at the Trust during the reference period of the Investigation was said to be “*challenging*”.

**4.15** One band 7 midwife<sup>†</sup> who had been at the Trust during the same period described the peaks and troughs: “*times when I felt positive and times when I felt rock bottom. It has always been that way at East Kent, good times and bad times.*” When they were going through a trough, when morale was low, people might not work as well as a team or they might be short-tempered. Those were the times when this midwife felt that teamworking was not good.

**4.16** In 2014, following the CQC report, the executive team was described as “*demoralised and not working as a team*”. In the year that followed:

*An awful lot of work took place to try and engage and improve the morale of staff, trying to bring together management and clinical staff. That was probably the biggest problem the organisation had, that there was this disconnect between the hierarchy of management and clinicians.*

**4.17** The Panel heard about a “*really bad period of time*” when there was a big change in managers and people didn’t have the experience to manage correctly or appropriately. This resulted in lots of disciplinary issues, and it affected morale because people were nervous and they weren’t “*nice*” to each other: “*It had a knock-on effect, like dropping a pebble in the water.*” We were told:

*Everybody wants to get it right and everybody wants to give quality care. Nobody wants to cause any harm to people. When it does go wrong it has a massive effect on people’s wellbeing and morale. There was definitely a lack of understanding between divisional and Trust levels of management and what goes on on the shop floor. That lack of understanding would sometimes have a negative effect on things.*

<sup>†</sup> Band 7 is a senior grade of midwife or nurse, still generally with clinical responsibilities.

**4.18** One director attributed the causes of staff disenchantment across all sites to the Foundation Trust status requiring financial savings and the close scrutiny under which the Trust operated. Decisions taken by the Trust to improve efficiency and clinical systems were aimed at improving patient safety and clinical services but resulted in staff earning less money. Some staff expressed that they were unhappy with the new arrangements.

**4.19** A member of staff decided to leave the Trust because it was “*trying to do too many things in too many places*”, not only from a workforce perspective but also from a financial perspective. Their view was that the models of care that were operating were not sustainable, and the cultural difficulties persisted:

*[S]ome people were trying to deliver services that were really hard for them to deliver, and consequently, their behaviours and interpersonal relationships struggled and were damaged by that.*

**4.20** The Panel was told how perceived poor performance by people in senior positions negatively impacted staff morale, but that there had been more recent initiatives such as regular safety huddles that aimed to help develop and strengthen relationships between different disciplines and in all areas of maternity services.

**4.21** One midwife, who had often raised concerns around consultant decision making, was told in relation to a poorly performing doctor that having “*someone was better than no-one*”. Those aspects were described as “*very challenging and demoralising*”.

**4.22** This same point was echoed by a member of the medical team, who commented that, for the Trust, “*having bad clinicians is better than having no clinicians*”. They remembered a clinical member of the Trust Executive saying that a clinician who had been investigated by the General Medical Council (GMC) was “*just about good enough and that was all that could be expected at East Kent*”. The message given was that mediocre was acceptable, which was a depressing standard for clinicians to aspire to.

**4.23** A senior obstetrician told the Panel that the staff were fundamentally good people who were placed in an impossible position because of the pressures of the roles they were asked to perform.

**4.24** A member of staff told the Panel that the Trust and maternity services had a bad reputation and that there was a bad news story every week, which had a profound impact on morale:

*It was hard to watch the media reports and see the Trust criticised. Staff morale was low and there were shockwaves among the staff. It was difficult for pregnant women to come into the hospital having seen the media reports. They would ask if they would be safe delivering there ... There was support, but the shockwaves that affected the shop floor weren't noticed.*

**4.25** One midwife working at the Trust throughout the Covid-19 pandemic noted that morale seemed worse at the time because of bullying and the questioning of practice in a “*personal and aggressive way that wasn't justified*”.

**4.26** Another midwife, in commenting on the behaviour of senior midwives, told the Panel:

*[S]enior midwives often came across as lazy, or they were just attending the ward to complete their hours.*

**4.27** Band 7 midwives told the Panel that they were held accountable for what other midwives were doing, when there should have been a level of individual accountability (they were “*getting the blame from everywhere*”). The band 7 group of midwives also felt very demoralised due to the scrutiny of maternity services.

**4.28** Concerns about accountability were raised by another midwife in connection with the lack of personal professional responsibility on the part of some members of the midwifery team. This was attributed to low morale and poor management:

*There has to be some accountability. Since the loss of supervision, there are no consequences for people not acting correctly.*

## Engagement and leadership

**4.29** The biggest obstacle to implementing change – in particular the improvement plans in response to the 2014 CQC report and the Royal College of Obstetricians and Gynaecologists (RCOG) report in 2016 (see Chapter 1) – was the lack of staff engagement with the process. The Trust was described as reactive and not “*terribly forward-looking*” in changing the culture around staff engagement.

**4.30** One Board and Executive member, commenting on the change to a managerially led divisional structure in 2011, told the Panel:

*It would be unfair to say that was responsible for poor medical engagement because the poor medical engagement was there already, but it didn't help.*

**4.31** The Trust had poor medical engagement, the obstetrics and gynaecology department was described as “*dysfunctional*”, and poor behaviour and leadership by consultants adversely impacted patient care and safety. However, the Panel was told that, since 2018, there has been a change of emphasis within the Trust, with more clinicians prepared to step into clinical lead roles.

**4.32** Another Board and Executive member found the Trust a very despondent place for all staff. Consultant engagement scores were very low and the culture came across as very negative. There was a historical lack of clinical leadership and of clinicians feeling accountable for what they did. The same Board and Executive member identified several dangers around the way in which clinical effort was focused, including the divisional structure and the need to turn the Trust from a managerial approach to a clinically led culture. This was described as a “*colossal*” piece of work, which lasted from 2018 well into 2019 and required the appointment of new clinical leaders, particularly in maternity services.

**4.33** The Panel was told that consultants did not engage in clinical audit or clinical guideline development because there was no time written into their job plans for it. For the same reason, we were told, areas where one would expect consultants to lead – the development of clinical guidelines, conducting maternal death and perinatal investigations, and leading on perinatal meetings – were all led by midwives.

**4.34** A lot of time was spent on incidents and complaints, with governance midwives being recruited to manage these alongside the consultant with responsibility for risk management and clinical governance. There was a lack of engagement from obstetricians on clinical governance and updating guidelines, “*leaving [the consultant] to do a lot of the work*”.

**4.35** One consultant noted a difficulty in getting clinicians at QEQM to be part of an investigation into a neonatal incident, and told the Panel that this remains a challenge. The Panel heard that there was a greater focus on midwifery than on obstetrics, and that there was an expectation that engagement in serious incidents was the responsibility of midwifery rather than obstetrics.

**4.36** The Panel heard that Women's and Children's Health, as part of the Specialist Services division, had two and a half days a year devoted to learning and considering incidents, complaints and feedback, including positive news. However, the Panel also heard that doctors never attended the meetings; only nurses and healthcare professionals attended (although this began to change later).

**4.37** The Panel was told that there were "about three" cultural change programmes at the Trust that failed because of a lack of direction and leadership, and that the Trust paid lip service to cultural change but this was not sufficient. There was not enough commitment or engagement from leaders of the organisation.

**4.38** Professor James Walker, the Clinical Director of Maternity Investigation at HSIB, commented:

*They don't really have consultant supervision to try and support the service. Now whether that is because they haven't enough, or they don't have enough people interested or whatever, I don't know, but it took us a long time to get the obstetricians involved [with HSIB investigations]. Even now, we get the lead obstetrician there or the lead paediatrician comes in – I am not sure how much our messages are getting down into the shop floor. In other hospitals we present back, and we've got consultants, students, registrars, and student midwives in the room, and that is where these hospitals really take ownership of problems. It's interesting because people will then talk about the cases and the obstetricians and midwives will then realise the problems the others have, and that helps to move forward for solutions.*

## Staff behaviour and bullying

### *Relationships between professions*

**4.39** A senior clinician with a regulatory and oversight organisation told the Panel that East Kent maternity services had the worst culture they had seen in their long experience of working in hospitals with inappropriate cultures, and a "terrible culture between the medics and the midwives". Staff were not supportive or encouraging to each other and there was "a bullying culture"; "freedom to speak up at the Trust was not good". They said:

*People's standards weren't what they should have been, and they didn't know what good looked like.*

**4.40** The relationship between midwives and doctors was described by one senior midwife as "cordial", and concern about difficulties with working relationships at the Trust featured prominently during staff interviews and was an issue raised across different levels of seniority.

**4.41** The Chief Executive of the Nursing and Midwifery Council (NMC), Andrea Sutcliffe, told the Panel that "the relationship between midwives and obstetricians is absolutely critical".

**4.42** Contrasting views were expressed about teamworking. Some said that teamworking between obstetricians and midwives had always been good. Nevertheless, the Panel was

repeatedly told of poor teamwork, particularly between different professions. The senior consultant obstetricians were described by one senior manager as *“extraordinarily challenging in their behaviours, lack of communication and teamwork”*:

*Their behaviour was appalling, and they had no respect for their colleagues. Consultants did and do still refer to midwifery staff as “lazy fucking cunts”.<sup>‡</sup> They take no responsibility for their actions and blame colleagues for any challenges and failings ... such a rancorous, hostile environment creates a service ripe for error, risk and lapses in safety.*

**4.43** A senior member of the Executive noted the *“dysfunctional relationships within specialities”* and that, within maternity services, there were issues with obstetricians and midwives working together. A senior manager observed that *“doctors and midwives sat apart in meetings ... and clearly did not respect one another”*.

**4.44** Doctors were said to have been overpowering in a lot of situations and women’s voices were discounted as a result. It took one midwife a very long time to feel confident enough to speak up to doctors because they came across as quite intimidating. The same midwife felt that the situation later improved, although women were still not always empowered by doctors. This point was echoed by another midwife to whom the Panel spoke. They described ineffective communication and discussions that were *“quite hierarchical ... Ultimately, decisions come from the top, rather than because staff communicate well and listen to each other.”*

**4.45** A senior midwife spoke about the fact that many of the consultants working at QEQM are longstanding members of staff and have a more *“traditional”* model of working when they are on call overnight, and that because there are a few layers between midwives and the consultant (mostly filled by junior doctors), midwives can find it hard to reach a consultant at times. In contrast, the obstetric team had a greater opportunity for contact with consultants.

**4.46** The Panel heard that there were set patterns for doing things and that it was difficult to introduce new ideas from elsewhere. A midwife at QEQM who had worked at the Trust for over 20 years told the Panel that they felt like *“an outsider”* for quite a few years. Students who came through the unit would be the trained midwives of the future; similarly, trainee doctors would often return as consultants once they had completed their training. The team was considered to be *“like a family”* and their strengths and weaknesses were well known.

**4.47** The dynamics of the team affected decision making; this was recognised as *“not a safe way to practise”*. There was no multi-disciplinary team learning and there was very much a *“divide between disciplines”*. The Panel was told that the obstetricians had *“huddles”*, but these were a *“tick box exercise with no real value”*. One midwife commented that the relationship with the obstetricians could be challenging and it had a big impact on how midwives felt about their work. Some of the consultants were very unhappy about being questioned and would become stubborn and unwilling to back down. Another midwife mentioned that junior doctors felt *“bullied”* by the midwives, and the relationship with the obstetricians wasn’t very good.

**4.48** A midwife who had been with the Trust for a lengthy period told the Panel that the lead clinician for obstetrics faced *“massive challenges”* with relatively little support, that there were some *“big egos”* among the obstetric consultants, and that to try to bring about change with these strong personalities present was very challenging. They also said that poor communication was a significant theme and spoke about how everyone knew that it would be a difficult day if a particular clinician was on duty.

<sup>‡</sup> The Panel deprecates the use of language that is disrespectful to other staff and demeaning to women; it is included here only to underline the extreme lack of respect and professionalism among some Trust staff.

**4.49** Some consultant obstetricians were described as “*a bit dictatorial*”, and, while a lot of the team had gone on the “Human Factors” course to try to improve things, there was a cultural expectation of hierarchy. The hierarchy disempowered staff from speaking up and the Panel heard that it was hard to voice opinions without them being taken the wrong way.

**4.50** A midwife said:

- *“... the culture just continued. A lot of work with human factors was done but it never really seemed to translate into the management team.”*
- *“Years ago, the matrons used to go round and talked to all the staff first thing in the morning when they came on duty. They used to go and speak to the women to see if they’ve got any problems. A lot of complaints could also be addressed at that level before they got bigger. The management team now go to their office and don’t speak to anyone.”*

**4.51** One midwife commented that the Trust seemed to have forgotten the Human Factors principles in the past few years and that professional challenge was perceived as criticism. A consultant told the Panel: *“The Trust thinks if you send someone on a three-day training course in human factors, that their personality will change forever but that’s not going to happen.”* Another clinician expressed having limited confidence in the behaviour and competence of certain obstetricians.

**4.52** A midwife spoke of the “*fear of speaking up*”. Instead of consulting staff and discussing how issues could be improved, staff were told what to do and viewed as “*negative*” if they proposed any alternatives:

*Staff feel they don’t have a voice, that nothing will change and that if they don’t agree with instructions from above, they will be ostracised. Staff are desperate to get on with everybody at work which means that they say and do things that they don’t agree with. It hinders their ability to speak up when things aren’t as they should be.*

**4.53** The Panel heard examples of this behaviour, such as a staff member feeling as though they weren’t very good if they asked for a short break after ten hours of work instead of carrying on like the rest of the team, or a midwife admitting that they didn’t feel confident suturing a woman and facing a response like *“she’s been a midwife for years. What’s her problem?”*

**4.54** The Panel was told of an occasion when a midwife had sought to explain to a consultant the adverse impact of the consultant’s late arrival on the operation of the clinic and associated services, in response to which the consultant wagged a finger in the midwife’s face and said: *“I am a consultant, and you can’t tell me what to do.”* The midwife was astounded that colleagues could speak and act in this way, but this kind of behaviour was described as “*relentless*”.

**4.55** The Panel heard about conflict over patient management plans and midwives “*bracing*” themselves to discuss these cases. There were suggestions of pressure put on midwives to accept women into the low-risk pathway when they had not been risk assessed or they were outside the guidelines, and consultants challenging any resistance to this approach.

**4.56** One member of staff told the Panel that many families had complained about staff arguing among themselves in front of women over whether to call for support and assistance from a more senior clinician, including in life-threatening situations.

**4.57** Another midwife commented that, in the past, although members of the multi-disciplinary team were supposedly working towards the same goal, it felt as though they were on “*parallel tracks*” rather than on the same path. However, they thought that this was less the case more recently. The introduction of a preventive measure for rhesus disease was cited as an example of good collaborative working between midwives and obstetricians. The Panel was told that, in the recent past, “*it was definitely not a case of them and us*” and that things had improved, but there was still some way to go. The Panel was told that the change process had been aided by new staff thinking differently, having more enthusiasm and providing a lead for others to follow. A more recently appointed obstetrician had been particularly interested in leading on multi-disciplinary working.

**4.58** The Panel heard contrasting views about multi-disciplinary working. On the one hand, we were told that the relationship between multi-disciplinary teams was positive; relationships with the neonatal team had “*always been good*” and anaesthetists were “*a great support to the labour ward*”. One senior member of staff suggested that the relationship between neonatology and obstetrics had always been good at QEQM, with communication between the teams if there were problems. The Panel was told of the recent appointment of obstetricians who had trained at East Kent maternity services and knew the units.

**4.59** However, the Panel also heard numerous contrary accounts. It was said that there had always been friction between anaesthetists and other specialties: on one occasion a “*massive argument*” took place between an anaesthetist and a doctor in the middle of the corridor on the labour ward. We heard accounts of problems between midwives, obstetricians and neonatologists; neonatal provision at QEQM was not as “*supportive, available or accessible*” as it was at WHH. The obstetricians were described as “*challenging*” but nothing was done to address challenging behaviour.

**4.60** The Panel heard that one perinatal meeting ended with a dreadful conversation and arguments with a senior midwife, who became very upset and went on sick leave. The issue was never addressed. We were also told that there were ongoing issues with communication between paediatricians and maternity services on the Kingsgate Ward; midwives were not listened to and were not taken seriously when concerns were raised. Paediatricians were also said to be slow to attend.

### **Challenging poor consultant behaviour**

**4.61** The Panel heard from a number of people about poor consultant behaviour and the difficulties in challenging consultants and addressing their behaviour. It was felt that the poor behaviour of consultants was dealt with very differently compared with the poor behaviour of midwives.

**4.62** The Trust was said to have done little to change the poor working culture; instead, it tolerated bad behaviour, especially in relation to those who had been with the Trust for a long time or held a senior position. In 2019, a formal complaint was made about bullying at WHH; at that time, one consultant was known for making midwives cry in front of others, often at handovers. However, the Panel heard that nothing really happened when bad behaviour was reported. Some staff did not have faith in the Trust to make improvements.

**4.63** Staff observed that the consultants who had worked there longer had a louder voice than the newer consultants, who struggled to find their way. When efforts were made to tackle poor behaviour, people backed away from the situation, or didn't report it in the first place. Consultants' poor behaviour was dismissed as “*just the way they were*”. Staff reported being

heckled, shouted at and having things thrown at them: *“it was accepted and allowed to happen, that was the way we worked”*.

**4.64** The Panel heard that staff were not empowered to challenge consultants’ bad behaviour. The Panel heard instances of extremely poor behaviour from consultant obstetricians; one became rude and very personal with another member of staff who had tried to generate discussion in a large meeting around the findings of the Morecambe Bay report. No one intervened, although it became evident afterwards that there were people in the room who recognised that the behaviour had been unacceptable. This incident was one of the issues that prompted the Medical Director to invite the RCOG to conduct a review.

**4.65** The Panel was told about clinical and behavioural concerns raised by one consultant about another, which they thought would be investigated by the Trust. The only feedback provided was that there was a communication issue and there would be training:

- *“After this there was reluctance for people to raise issues or make comments if they were asked further because of the way the process was done.”*
- *“If people get away with bad behaviour, they’re going to keep doing it.”*

**4.66** Some midwives told the Panel that when they raised issues with their line manager, they would not hear about the outcome. The Panel heard that midwives often talked to each other about raising issues but questioned whether anything really changed. The person involved might be told off and improve for a few weeks, but then they would slip back into old habits. Behaviour was also explained away as *“it’s the way they are”*.

**4.67** The lead CCG for maternity services pointed out that Medical Directors generally lacked the tools to be able to handle intransigent consultants. As an example, in 2020, there was a discussion with the Trust’s new Chief Medical Officer about an anonymous survey to identify problem consultants (whom people did not feel able to challenge and with whom they could not escalate issues). Although the problem consultants were known, no one was willing to raise a concern formally. The CCG also noticed a difference in the way in which nurses and doctors were treated in connection with serious incidents – nurses would potentially be disciplined, while doctors were merely asked to reflect (see “Culture of blame and handling complaints”, paragraphs 4.154–4.168).

## **Midwifery culture**

**4.68** The Panel heard about a lack of professional respect for midwives from the MLU and the community, and that their professional judgement was disregarded and dismissed in front of women.

**4.69** The Panel was informed that there were several “freedom to speak up” issues raised from the maternity department at WHH. The issues related to bullying and behaviour. The Panel heard from one midwife that *“once that individual had the impact of their behaviour pointed out, they reflected and modified it. It just needed someone to point it out to them. There haven’t been any further concerns raised about the individuals’ behaviour.”* However, other midwives told us that bullying persisted and remained prevalent. There were also issues raised around rostering and equipment.

**4.70** The Panel heard that, since 2012, the Trust had had a Medical Director for Governance and Patient Safety and two band 7 nurses as Freedom to Speak Up Guardians, although the latter had not had protected time to fulfil these roles. Only recently had the Trust appointed its

first full-time Freedom to Speak Up Guardian. A predominant theme at patient safety speak-ups was behaviour – not so much bullying as poor leadership and a reluctance or lack of skills to actively listen to what staff were saying. Poor behaviours existed “*at all levels of the organisation from top to bottom*” and the Panel heard that it was “*challenging when it is senior people who are bullying*”.

**4.71** The Panel heard that there was discussion within the Trust on whether there was enough documented information to take people through a disciplinary process. However, although the Trust received a lot of information, staff were rarely prepared to put it in writing. We were told: “*The Trust sometimes moves the problem around but actually it’s about six months later and there are reports from the other site around the same issue.*”

**4.72** The origin of different cliques of maternity staff was said to have dated back to the closure of the Canterbury site, when staff were moved to WHH and QEQM: “*In both hospitals, there were two circles of core staff that had been at William Harvey/QEQM and then the Canterbury staff. They didn’t get on well together.*”

**4.73** A midwife who had worked at various sites and in various roles across the Trust told the Panel that the staff working at WHH had a reputation for being outspoken, and that allegations of bullying – in particular, more senior nurses treating junior staff with little respect – had circled the site for many years and had not been dealt with effectively. QEQM was considered to be friendlier, with less staff turnover and better working relationships, and new staff found it easier to settle in; it was suggested that this might be due to QEQM being a quieter site.

**4.74** Staff told the Panel that “*senior midwives*” at WHH had a tendency to form “*cliques*” and that this could come across as threatening to more junior members of staff. They also told us that support workers had raised complaints about being treated unfairly compared with other groups of employees within the maternity unit. They indicated that, while there had been an improvement latterly at WHH in the way in which staff communicated with each other and mothers, it remained a concern. The Panel also heard that management “*cover themselves*” so that action would not be taken if the friend of a band 7 midwife did something wrong. One midwife was told expressly not to enter details of an incident on Datix (patient safety incident reporting software) as the band 7 midwife involved “*just forgot*” to take the required action.

**4.75** One midwife described difficulties with the coordinator culture at WHH, with coordinators not listening to other team members or doing things in a set way. They were described as “*unhelpful and not hands-on*”, and they did not have the confidence of certain members of staff.

**4.76** The Panel was told about midwives shouting and screaming at each other. A band 7 midwife spoke about witnessing a loud argument between a unit coordinator and a ward clerk, which prompted the band 7 midwife to close the doors around the ward to prevent women and families from hearing the argument. Afterwards, the band 7 midwife felt “*terrified by the way the coordinator spoke to [them] about having done this*”.

**4.77** The Panel heard that a supervisory session for midwives was carried out at WHH and one of the questions asked was “*what is a good day for you*”. The response from one midwife was “*getting to the car, across the car park, at the end of the day without bursting into tears*”.

**4.78** The Panel heard that student midwives did not feel valued by more senior staff members. Many student midwives did not feel welcomed and heard more senior members of the midwifery team gossiping about them. Another member of staff observed “*quite sharp questioning*” at WHH during handovers, which left staff feeling uncomfortable and feeling that they were being

judged rather than supported. The handover was described as a “*blood bath*”, with one member of staff telling the Panel that it was “*terrifying as [a] student*” and reporting being told off for showing a baby to the grandparents in the corridor, or for using someone else’s cup. The band 7 midwives were described as “*quite fierce*”:

*As someone who was quite new to the profession, you would second guess yourself quite often to make sure you weren’t using someone’s cup or sitting in someone’s seat.*

**4.79** The culture of the Trust was also described as follows:

*[There was] favouritism and some people are not treated fairly within midwifery ... there were [senior midwives] put in place who were bullies and they reported people who perhaps shouldn’t have been and others perhaps who shouldn’t be in the job.*

**4.80** More than one midwife identified challenges with internal recruitment: namely, that promotions were predictable and the same people would always be promoted. People with friends higher up in the maternity unit were said to get jobs before they had even been interviewed. Regarding senior management culture, we were told:

*[[I]f you’re friends with someone, you’ll get the job. It has been the case for quite a while that preferred candidates are coached for job interviews.*

**4.81** One midwife said that they did not apply for positions as they knew they would not be chosen. Another staff member had withdrawn from an application as their face didn’t fit:

*At East Kent, if your face fits, you’ll get the job.*

## **Bullying**

**4.82** The Panel was told that there were large numbers of staff who complained of bullying, harassment or discrimination. A member of the HR team commented on the high levels of bullying and harassment:

*There were other issues but that was the most troubling because of the duty of care to the workforce and their perception of what it was like to work in that environment.*

The same person told us that nobody got to grips with the situation or wanted to tackle it.

**4.83** A member of the Executive told the Panel that the problem of bullying was “*well distributed*” across the organisation, and that it was not any worse in maternity than elsewhere. However, the Panel also heard:

*[P]eople outside maternity would probably not have been aware of the bullying culture within midwifery and [the] difficulty with performance of obstetricians. There was a cloud of secrecy as staff members were involved in the disciplinary processes. It wasn’t openly discussed. They had to deal with individuals confidentially and professionally.*

**4.84** The Trust was said to be occupied with firefighting visible issues, such as the difficulties with the Accident and Emergency department (A&E), but did not address the underlying problem of the culture of the organisation, including bullying, harassment and discrimination. One midwife commented that the focus was on the little things to make it look good from the outside.

**4.85** While complaints of bullying were often made by midwives, it should be noted that staff also spoke of bullying behaviours towards consultants and among members of the Executive. One consultant told the Panel that they were bullied by a senior midwife in the special care baby unit and by senior nurses. The Panel further heard of poor behaviours of non-executive directors at the Trust Quality and Safety Committee: *“The behaviour of the non-executive directors was appalling, rude, bullying. It was shameful.”* Sessions with registrars had been introduced to enable junior doctors to report concerns; these were then fed back to consultants to determine what needed to be done.

**4.86** A CCG staff member told the Panel that, through quality visits, they had picked up on *“quite unpleasant”* bullying. One senior member of Trust staff described maternity services as *“a vipers’ nest”*, and another expressed the belief that the deaths of some babies could have been prevented had there not been a bullying culture within maternity services.

**4.87** A midwife told the Panel that staff were not given any individual or constructive feedback to improve the results of the staff surveys. Band 7 midwives had occasional study days, annual supervisory reviews and either irregular appraisals or no appraisals at all. However, nothing was mentioned to identify that any improvement was needed in this area and the Panel heard that issues of bullying had not been raised as part of the appraisal process. In 2010, approximately 80% of staff had no appraisal at all.

**4.88** The bullying culture at WHH was described as *“horrible”* and *“sickening”* and as persisting indefinitely. Between 2010 and 2012, an anonymous complaint was made to the Chief Nurse by junior midwives at WHH stating that the band 7 midwives were bullying them, forming cliques, excluding the junior midwives and creating a hostile *“in or out”* group dynamic. No one was named in the complaint. The Head of Midwifery wrote to all midwives across the Trust, urging them to speak to the Head of Midwifery directly. The Panel heard that one midwife left the Trust because of bullying.

**4.89** The Panel heard that repeated concerns were raised about some staff members’ behaviour, but no action was taken in response. The Panel also heard that, in some cases, allegations of racial abuse were made against individuals, but there was no resolution and there was no structured way of dealing with allegations. Bullying and harassment policies required that an opportunity be provided for people to speak to each other in an informal way, to try to encourage them to understand the other person’s position. However, the inability of certain staff to communicate respectfully with each other was such an issue that they could not safely work on the same shift.

**4.90** One midwife commented that bullying was a mindset. They told the Panel:

*[[If people bully you, you’re part of that relationship ... there were people that I dreaded to work with, and I knew they would be short or cross ... but I just had to carry on doing the work ... you have to focus on the people that you’re caring for – sometimes, the management or whatever is happening in our sort of profession may be harrowing – there’s no staff, it’s difficult, there’s ... problems between managers and things that you have to really put into the background and try and focus on the care.*

**4.91** In 2014, an internal investigation into bullying began, carried out jointly by the then Head of Midwifery and the HR department. As a result of information obtained from the investigation, the Head of Midwifery was sufficiently concerned to recommend that the unit at WHH should be closed because of the risk to women.

**4.92** The bullying was described as occurring more at WHH, where *“there were a lot of cliques”,* and where, *“as a junior midwife, you would hand over and you’d be berated ... and put down. I remember ... one time saying this lady’s been in second stage for two hours and the band 7 said, ‘she’ll end up in ITU and it’ll all be due to you’.”* The environment was described as *“toxic”,* and it was commented that *“Labour Ward and Post-Natal are high risk and high pressured enough without feeling scared to hand over”.* Cliques were prevalent in management and on the shop floor within midwifery. The Panel heard that, if a friendship group of midwives was on the same shift, the most difficult cases were delegated and shorter breaks given to the midwives outside the group. The Panel was told: *“It would depend on what mood the co-ordinators or some of the midwives were in on that day as to what you got ... If your face fitted you did really well.”* The existence of cliques was also an issue at QEQM, where one junior midwife noted that the culture in maternity services was *“hostile at times”.*

**4.93** The Panel heard that the repercussion of making a complaint at WHH was to be given extra work. One midwife described feeling unable to tell the truth around the time of the 2014/15 investigation because, if they did, they would be bullied themselves. The midwife felt that they had no choice but to give a character reference to a band 7 midwife accused of bullying, although, really, they were *“dying to tell the truth”.*

**4.94** The Panel was told that a number of anonymous letters were sent prior to the 2014/15 investigation but that the response from leadership at the time was that they would not do anything about it *“if no one is brave enough to put their name on these letters”.* Another senior midwife told the Panel that there was no recognition of, insight into or acknowledgement of the issue of bullying from obstetricians or midwives, and that people in senior positions did not respond appropriately to the situation.

**4.95** A midwife at QEQM described a culture of *“playing the bullying card”,* and *“if you say something that I don’t like then I will accuse you of bullying me”.* In their view, this tactic put a halt to managing challenging situations, while attempts to introduce positive change were met with the response that *“you are picking on me”.*

**4.96** In 2015, a collective grievance was raised by staff about the manner in which the 2014 internal investigation into bullying had been conducted. However, the grievance about the investigation process accepted the existence of serious bullying and dysfunctional behaviour within maternity services at WHH. The grievance also referred to the fact that:

*An absence of senior support for staff at this present time has exacerbated an already difficult situation, as a result of which we believe there is a significant risk to our health and wellbeing, the patients we care for and the service as a whole.*

**4.97** The Panel was told that the Royal College of Midwives (RCM) represented some of the midwives who were subject to the investigation into bullying and that the RCM assisted with lodging a collective grievance.

**4.98** A representative of the RCM told the Panel that the RCM had known before the collective grievance that there were challenging issues around midwifery leadership in the Trust at both WHH and QEQM. There were two big units operating without sufficient overall strategic leadership or strong management on either site. Cultural issues of bullying, harassment and poor staff engagement had been identified by RCM members, as well as being raised with the CQC.

**4.99** The Head of Midwifery in 2014/15 told the Panel that they regretted going to the RCM for support with whistleblowing because the RCM advised them to resign and move on; if not, the RCM said that they would be unemployable in a senior position, and they should protect themselves. They told the Panel that it was really hard making the decision as they did not want to leave women vulnerable. However, they had been told by the RCM that whistleblowing was not in the public interest and they had to think of their career.

**4.100** The Panel heard from Robert Eames, who worked as Associate Director of HR between 2014 and 2015, that “[the Head of Midwifery] *wasn’t part of the problem. I think [they] had a good go at trying to fix the cultural piece and the behaviours, but the team lashed out at [them].*”

**4.101** A number of midwives told the Panel that 2014/15 was a very difficult and strange time in midwifery. One midwife thought that the bullying stopped when certain midwives were suspended. However, the Panel also heard that some obstetricians and some neonatologists did not think the correct midwives were suspended. Other midwives told us that the bullying persisted after 2016.

**4.102** Some staff did not perceive the behaviours as bullying; the band 7 midwives were “*good at their jobs; they were just a bit fierce and a bit scary. If you had a problem, you could take one aside and talk to them ... they were strong, dominant women, commanding a unit.*” A midwife at WHH considered that band 7 midwives were often a target for accusations of bullying, because the nature of the role meant that they often had to tell staff to do things differently.

### ***Lack of diversity and racial discrimination***

**4.103** The Panel was told that the Trust had been rated one of the worst in the country for workplace diversity and attitudes towards cultural difference. The QEQM midwifery unit was described by one member of staff as being “*often seen as a white-led midwifery unit*” that would benefit from having more people from different cultural backgrounds.

**4.104** Complaints of discrimination were sometimes based on race. A member of the Executive recognised racial inequality in East Kent and the existence of racial tensions, which probably contributed to bullying in parts of the Trust. One midwife from an ethnic minority background had been to HR three times; however, on each occasion the complaint was reduced to an overreaction. On one occasion, a midwife was discriminated against when a coordinator, at a woman’s request, would not permit the woman to be looked after “*by anybody except an ‘English’ midwife*”. Concerns were also raised about management making offensive comments or jokes connected to race; however, these concerns were minimised and put down to staff just trying to be humorous. The Panel heard more than once that instances of personally offensive behaviour by consultants and midwives were not treated seriously.

**4.105** Concern was expressed that the Trust’s attitude and lack of diversity were having an impact on patients as well as on staff. It was said that, at WHH, women who could not speak English or who were from different ethnic backgrounds were treated differently, as though they were at fault.

**4.106** However, contrasting views were also expressed to the Panel. One senior member of staff from an ethnic minority background described not only being made to feel welcome but being positively favoured due to their heritage. Another member of staff told the Panel that they had not experienced any prejudice as a person from an ethnic minority background and felt happy when called to work at QEQM.

## Consultant rotas and availability

**4.107** Consultants identified challenges arising from the on-call rota. Prior to 2020, consultants would arrive around 8am and stay until 5pm or 6pm and then be on call from home. They covered other duties including gynaecology as well, limiting their presence on the labour ward.

**4.108** One midwife told the Panel that the process for escalating a clinical issue was very clearly to the Senior House Officer (SHO; a junior doctor), then to the registrar, and then to the consultant, in that order:

*I didn't escalate directly to the consultant because that wasn't the culture ... the issue was that consultants were at home in the night and so it was difficult to call them about a pathological CTG [cardiotocograph; a trace of fetal heart rate] if the registrar was busy with a case in theatre.*

**4.109** One consultant told the Panel that they escalated issues around lack of consultant availability, but that the process of trying to get these resolved took a long time because of the way in which consultants were treated (or needed to be treated). There was a lack of support provided to the junior doctors, and the Panel heard that “East Kent did not feel like a consultant-led service”.

**4.110** A midwife told the Panel that, in 2016, after the RCOG report had been submitted, the consultants at WHH made a noticeable effort to be more visible and accessible while on call.

**4.111** A junior doctor recalled that “consultants would point-blank refuse to come into the hospital after hours and would put other staff under intense pressure as a result”.

**4.112** The Panel was told about one occasion when a woman who was 35 weeks pregnant and thought her waters had broken attended QEQM. The woman needed a speculum examination; however, the SHO hadn't been trained on how to do it. Although the consultant was called, they did not attend and the SHO sought advice from YouTube on how to do the procedure.

**4.113** There was a reluctance among junior doctors and midwives to raise the issue – people did not want to complain about a consultant or be named as the person who had brought up the issue. A Trust Board member supported this view and told the Panel that it was very hard for their clinical leaders to call out bad behaviour in a way that was effective.

**4.114** However, the Panel was also told by an obstetric consultant that, more recently, adverse publicity had resulted in consultants either being contacted more frequently, perhaps in circumstances where trainees could do what was necessary, or themselves being too cautious.

## The separate operation of the WHH and QEQM sites

**4.115** The Panel was told by a number of staff that, although the merger of the three different trusts to create the East Kent Trust occurred over 20 years ago, the Trust continued to operate as if there were three separate hospitals that ran independently of each other.

**4.116** The Panel heard that staff in the Trust had never come to terms with the merger:

*Ashford is still taking it hard, and Canterbury doesn't understand why they aren't the centre of the world. It is deep rooted.*

**4.117** More than one member of staff spoke about the Canterbury-centred nature of the Trust, which was an issue that needed addressing:

*[The Trust] was run like three completely separate units, and nobody had really tried to merge it in any way. Canterbury was full of the great and the good consultant-wise, and they sort of looked down at Margate and Ashford and everybody knew that as well. The inter relationships were really difficult.*

**4.118** The Panel heard that there was no cross-site teamworking or shared learning. The sites “always ran distinctly, even down to different working policies”.

**4.119** There was also a perceived inequality and an “us and them” culture between the two sites at Ashford (WHH) and Margate (QEQM). One member of staff told the Panel that, although QEQM was quite big, “it always felt like it was a bit of an afterthought”.

**4.120** One member of the Executive commented:

*[P]eople working in Margate don't feel massively connected on a day-to-day basis with what's happening in the William Harvey maternity and neonatal service. This should not be underestimated. It's not an excuse for people not engaging and not following national guidance but it is a factor that cannot be ignored ... There is an element of clinical isolation at Margate whereby you don't get an opportunity to see how things are done elsewhere and there isn't much interchange ... However, you can also flip this round, and Margate has been able to find their own solutions to problems, and they are committed to their population who they live with and understand (whereas at William Harvey the atmosphere is not quite so embedded in the locale as Margate). When this works well it can be very powerful and a force of great good. But by the same token when it's not quite right you can get quite a long way from what is best practice.*

**4.121** One experienced midwife told the Panel that there had always been a very different working pattern at the two sites, and this impacted on the midwives and on patient care. At QEQM, the consultants were not on the labour ward after handover; this also had an impact on the junior doctors, on their teaching and on the support available. Further, at WHH, regular ward rounds were conducted with the obstetricians; however, this was not the case at QEQM. Some staff at QEQM did not do ward rounds at all, although one midwife suggested that this had subsequently improved.

**4.122** Another difference relates to the treatment of families following the loss of a baby. We heard that, for a number of years, the consultants at WHH have been speaking with families at around 6 to 8 weeks following the loss of a baby of 12 weeks' or more gestation, so that the family could understand what happened and to discuss how the family would be looked after in their next pregnancy. However, the Panel heard that the doctors at QEQM have resisted this practice.

## Training

**4.123** A member of the Executive spoke of their concern that an organisational development programme was not introduced when the Trust was going through restructuring; instead, the restructure focused on moving people without developing them.

**4.124** A senior clinician recognised that there were challenges in gaining experience and competence in neonatal intubation and in maintaining neonatal resuscitation skills as a general paediatrician at QEQM. Each consultant performed intubation of extreme premature babies approximately once a year, and there were not many other intubations during the year. This posed a risk of consultants gradually becoming deskilled over time, and there was a need to ensure that all staff were up to date with neonatal life support training.

**4.125** The Panel was told that a simulation training programme to teach resuscitation techniques was introduced following the inquest into the death of baby Harry Richford. Consultants across the whole team participated in the simulation and the Panel was told there was a neonatal simulation held jointly with midwifery every other week.

**4.126** The Panel also heard that there had been a robust in-house teaching programme for neonatology and paediatrics for some time. Other basic skills taught include airway skills on mannequins, resuscitation, non-labour emergencies in neonates and communication with midwives.

**4.127** The Panel heard that, more recently, staff grade doctors who came from abroad, or trainees without experience working in the UK, were trained and rotated to the neonatal unit at WHH for experience; this also applied to non-trainee grades who lacked confidence in their skills.

**4.128** Many midwives spoke about a lack of support during their training or when they first started in their roles and a lack of mentorship. One midwife who was appointed into a coordinator role had to teach herself the leadership skills needed to maintain a safe service:

*[S]ome band 5 midwives don't have professional resilience because they've not been taught how to develop it. It's a big jump from being a student to becoming a band 5 midwife.*

## Organisational issues

### Culture of denial and resistance to change

**4.129** The Panel heard about the “*sense of optimism*” in the Trust as it achieved Foundation Trust status in 2009. The Dr Foster Hospital Guide named the Trust as Overall Trust of the Year and Foundation Trust of the Year in England in 2010; however, this appeared to be a double-edged sword. One member of staff said that the Dr Foster recognition was:

*... a bad thing and a major error. Complacency started to come in ... There were things the Board believed that were not true ... [P]eople had got into the wrong frame of mind. It was great to get awards if you were doing well, but not if it gave false assurance, and things were melting down behind the scenes.*

**4.130** One consultant felt that senior managers became arrogant as a result of the 2010 award and “*shot down other people's suggestions for further improvement as a result*”. A senior member of the management team described the Trust as:

*... riding on the Dr Foster's award and felt itself to be quite above everything else ... the Dr Foster's award was held up to every criticism.*

**4.131** Many staff, and others, spoke about a culture of denial at the Trust and a resistance to change. The Panel was told that, following the 2014 CQC inspection and report (which resulted in the imposition of Quality Special Measures), the reaction of the Trust was one of real defensiveness.

**4.132** A member of the Executive who joined the Trust after the CQC report commented that the Board was “*potentially in denial about the organisation*”, which served to reinforce the disconnect between the Board and the wards. One manager told the Panel:

*[T]he organisation was utterly floored and did not recognise the report. People were traumatised.*

**4.133** There was quite a strong feeling from Board members that the Trust was a victim, that “everyone was against them”, and that “things weren’t as bad as this”. Another senior manager commented:

*[T]he Trust board were in complete denial and were shocked, angry and hurt. They disagreed with just about every point in the report.*

**4.134** The Trust went through the CQC reports:

- The Trust came up with “hundreds of challenges to the report, including grammatical/spelling issues ... rather than getting to the essence of the report or discussing what to do”.
- “It was not for nothing that the Trust was rated inadequate, yet they responded by sending back comments about commas and semi-colons, losing sight of the problem.”

**4.135** We heard that the Trust did not use its staff surveys to identify issues, and that there were some very bad staff surveys that fed into the CQC report. The staff survey results in 2014 gave an indication of bullying; however, these results were not a one-off and bullying had been a common theme in previous surveys. We heard that “the trust central teams were in denial” and it seemed that they were not “systematically reviewing anything on a regular basis”.

**4.136** Interviewees confirmed that staff survey results at the Trust were never very good. A member of the HR team told the Panel that, whenever they tried to discuss the results, “they weren’t necessarily what people wanted to see and hear. We were told there were lots of reasons why the results were invalid.” They told us that there was no desire on the part of the Board or the executives to think about the survey results and what they were telling the Trust:

*This desire to give a rosy view was unhelpful ... it was unhelpful to patients too because it doesn’t provide a full picture of what is really going on in an organisation and the potential risks and issues.*

**4.137** In 2014/15, the then new Head of Midwifery identified cultural issues within maternity services; they described their reaction to East Kent maternity services to the Panel as being “the next Morecambe Bay”. One senior midwife told the Panel that staff were really shocked by this as they did not see the similarity: “things were being said that were very untrue”. The Panel also heard that East Kent was “equal to or worse than Morecambe Bay”, but:

*[T]here was no recognition, insight or acknowledgment from the obstetricians or the midwives into any of the issues identified in the 2014 [CQC] report.*

**4.138** One clinician told the Panel that they did not recognise some of the issues that were highlighted in either the CQC or the RCOG report. A senior midwife remembered the RCOG report being dismissed by a senior consultant obstetrician as a “load of rubbish”. The midwife commented to the Panel that Trust obstetricians did not like the light being shone on them in that way.

**4.139** Another clinician couldn’t recall the RCOG report being widely discussed, and they were not made aware of the report’s key findings or recommendations. Similarly, a junior doctor told the Panel that the report was not formally discussed with junior doctors. Another consultant told

the Panel that they believed the issue raised by the RCOG report around consultant availability was limited to just two consultants, one of whom left the Trust.

**4.140** In 2018, the Trust's maternity services were rated by the CQC as "Requires Improvement", although reference was made to the introduction of multi-disciplinary training as a step in the right direction. We heard that the Board took reassurance from that, notwithstanding the lack of effective audit and quality assurance systems that was identified by the CQC.

**4.141** Professor Walker, the Clinical Director of Maternity Investigation at HSIB, spoke of the initial defensiveness of the Trust in 2018 and of a lack of opportunity to engage with staff outside a small number of senior Trust staff. There was a meeting in the summer of 2019 between HSIB and members of the Trust's Executive, at which there was a lot of aggression and pushback by the Trust. Professor Walker told those present in the meeting: "[L]ook, you've got a major problem at this hospital, which is going to escalate, and you'll hit the press by the end of 2019."

**4.142** Another HSIB officer told the Panel: "There was denial in the Trust about the enormity of the underlying problems."

**4.143** The relationship with HSIB was described by a member of the Board and Executive as difficult. So too was the transition from a process whereby the Trust conducted investigations itself, with the benefit of having a relationship with the family involved, to outsourcing the process to HSIB. They commented that the HSIB process felt very impersonal, and people were defensive.

**4.144** This defensiveness was echoed by another member of the Board, who described being "blind-sided" by HSIB's serious concerns in about 2019 that East Kent maternity services were at the top of the list for total body cooling (therapeutic hypothermia) and feeling disappointed that the Trust had not engaged appropriately with HSIB on the issue. There was an internal report to the Board in December 2019 addressing HSIB's concerns and citing improvements in certain areas (such as staff recognition of clinical deterioration or changes in the escalation process), although no evidence was provided and "frankly the Board was not assured that what they were doing was enough".

**4.145** A non-clinical member of the Board felt that the relationship with HSIB was not proactive and detected a reluctance within the Trust's clinical team to accept what HSIB was saying.

**4.146** The Panel heard from Nick Hulme, a Trust Governor, that, even as recently as 2020, at Council of Governors meetings it was regularly highlighted that it was "not fair" that East Kent scored lower down the lists of trusts, given the large size of the Trust and that it had "a lot of comorbidities". Mr Hulme told the Panel that governors were told to "ignore the press" because they had "an agenda". Mr Hulme also told the Panel that he had been actively dissuaded from speaking to the Panel by a member of the Board, who told him that he "would not add value".

**4.147** Mr Hulme also told the Panel about an attitude within the Trust of "well, as long as we're not bottom, that's alright". There was no ambition to be anything other than "bang average", and the focus was on "get to good". The Panel also heard from a Board member of a "culture of failure for five or six years", with the Board being described in around 2017/18 as "very fragile and brittle":

*There were few people left in the Trust who knew what success looked like or who had experienced working in an organisation that was functioning effectively. It wouldn't be straightforward to change that.*

**4.148** The Panel heard of clinical leads who were resistant to change and reluctant to look outside the organisation or to be open to other ways of working. One manager was used to organisations seeking fresh eyes on incidents or complaints, but this was always resisted at the Trust.

**4.149** The Panel was told that concerns about maternity services were raised with the executive team by the divisional management and by other functions within the Trust, such as clinical governance and patient safety, legal and HR, but nothing happened.

**4.150** The Panel heard that the practice of the Trust was to discourage the reporting of screening issues to Public Health England, despite it being national policy to do so, and that a screening coordinator was reprimanded for involving Public Health England in a serious incident and was told not to report issues externally. The Panel heard that the culture in the past was to keep things in-house, but that this had improved more recently.

**4.151** One consultant midwife sometimes found East Kent maternity services slow to adopt new national recommendations, for example about identifying women at risk of restricted fetal growth. They told the Panel that they would approach the governance team, maternity leadership and the obstetricians about making the recommended changes, but those approached would often produce counterarguments relating to equipment or resources for why the recommendations could not be implemented.

**4.152** A member of staff who had rejoined the Trust in 2019 recognised positive changes that had occurred and noted that morale and staffing had improved. However, there was still a reluctance within the Trust to adopt new research and guidelines.

**4.153** The Panel was told that, even in 2020, obstetricians and paediatricians had a focus on process rather than on outcomes. That included some of the work of the Birthing Excellence: Success Through Teamwork (BESTT) programme:

*For example, they would try to decide whether a day or a day and a half of training per month was needed, instead of identifying the outcomes they needed to achieve and then basing the training requirement on those.*

## **Culture of blame and handling complaints**

**4.154** The Panel heard from a number of people about a “blame culture” when things went wrong:

- *“Feedback was almost like a blame game where someone was at fault and had done something wrong, rather than giving feedback on how to improve when something happens.”*
- *“Raising complaints at the William Harvey was difficult as individual staff would feel blamed for mistakes.”*
- *“Ashford [WHH] is odd and the culture there is weird. They are less likely to support each other, and more likely to blame.”*
- *“Staff are less supported now by senior management than they have ever been, and there is a culture of blame and recrimination.”*
- *“There was often feedback, but it was not given in as supportive a manner as it could have been ... You were only called to see your supervisor if you had done something wrong ... I am open to scrutiny if there are lessons to be learnt but that doesn't mean you're a bad midwife or that you did it on purpose.”*

- “[Consultants] *take no responsibility for their actions and blame colleagues for any challenges and failings.*”
- “*One particular paediatrician would often blame obstetricians for any deaths or serious incidents that arose.*”
- “*Historically there was a lot of jumping to conclusions and finger-pointing, whereas [more recently] there’s recognition that things aren’t black and white – that they can be complex, and you shouldn’t jump to conclusions.*”

**4.155** A midwife told the Panel of an incident when they were called before an obstetrician after a baby had become grey and floppy in recovery, and the obstetrician seemingly accused the midwife of doing something wrong (“*that baby was screaming and fine in theatre, what happened?*”). There was a similar account from another midwife where there was a poor outcome:

*[T]he consultant stormed onto the ward the next day and demanded to know what I had done to produce this outcome.*

**4.156** A band 7 midwife told the Panel of the “*punitive approach*” to dealing with issues:

*[T]here’s a lot of fear among staff about making mistakes and being told off, and this hinders their ability to learn.*

**4.157** The same member of staff told the Panel that there was “*no celebration*” of anything that was done well, and communication was not transparent. When a learning opportunity was identified, it felt like a punishment; the approach at the Trust’s maternity services was “*not healthy*”.

**4.158** The Panel heard from a senior midwife about the difference in the treatment of midwives and doctors. Whenever there was a root cause analysis investigation, there were often outcomes for midwives such as referrals for supervision or reflection, or formal HR processes. However, for doctors, there would simply be an informal conversation:

*This was why the midwives felt that there was a blame culture and that things were inequitable.*

**4.159** A separate senior midwife made the same point and described how issues raised with doctors wouldn’t go any further and there wasn’t any challenge to difficult obstetricians, whereas with midwives the outcomes were very structured, with a pathway and supervision.

**4.160** We heard that a lot of disciplinary action was taken and that, at one disciplinary hearing, the Chair said: “*I don’t know why this has got this far. How did it get to this?*” When a midwife was referred to the NMC, the case manager came back and said: “*I’ve looked at everything and I don’t know why she was referred.*” We were told:

*There was a knee-jerk reaction to punish people and it created a very unpleasant environment.*

**4.161** Others commented that, when things went wrong, there was no opportunity to debrief; the response was reactive rather than proactive. The Panel was told of a culture of blaming junior staff or locum doctors for whatever problems occurred within the Trust.

**4.162** The Panel heard that some issues could escalate quite quickly, and that staff seemed to act on rumours rather than facts. A midwife could quickly be on an action plan after raising a

simple issue that they were not sure about, when “[it] *didn’t need to go that far*”. The Panel was told that midwives were hindered by fear: they worried about what people thought and said about them, and about things being done in the background that they were not aware of.

**4.163** The Panel was told about a focus on documentation, and that this could distract from giving actual care, noticing when things deviated from the norm, or recognising when issues needed to be escalated. The Panel heard that midwives were sometimes too scared to press the emergency buzzer in case they were wrong, or to tell a more senior staff member on duty that they were unsure about a situation. This fear related to delivery suite coordinators and obstetricians as well as band 6 and 7 midwives.

**4.164** There were approximately five to ten complaints each month about maternity services, mainly about communication and relationships. They covered:

*... things like the fact that people didn’t feel involved in the decisions that were being made and hadn’t been provided with sufficient information.*

**4.165** We heard that a high proportion of complaints about maternity services concerned the midwives’ attitude towards and communication with younger women, who felt that things weren’t always explained well or that they weren’t listened to, helped with breastfeeding or given information about their baby. Other common themes reported to the Panel included pain relief and whether or not a caesarean section should have taken place.

**4.166** A senior midwife commented that inappropriate staff behaviour was the most prevalent “*human factor*” at the Trust, and that it was not limited to midwives; complaints were also made against healthcare assistants, obstetricians and ultrasound staff. They commented that “*complaints as a result of poor behaviour impacted staff across the board*”.

**4.167** The Panel was told that the obstetrics and gynaecology department had a “fix it” clinic every other Friday morning, where a consultant and specialist nurse would meet with women who were unhappy with their treatment and care. There was a six-month waiting list for the clinic, but the women “*had the opportunity to get stuff off their chest and try to sort something out*”.

**4.168** The Panel was told that Trust staff had later come to see the importance of standing back and thinking about what the family’s needs were in situations where complaints were made, and the need for staff to take time to talk things through with the family, to listen to them, to understand what was important to them and how they were feeling, and then to respond to that, rather than assuming that they knew what was important.

## External factors or problems as the staff saw them

### Facilities and infrastructure

**4.169** Infrastructure was cited as an issue for many services in the Trust. One member of the Board and the executive team talked about the estate:

*[It is] profoundly challenging – it is difficult to attract clinicians and to provide good modern services.*

**4.170** Another Board member commented:

*The maternity estate is tired, poor, and needs replacing and totally modernising. But it's not just maternity – the entire estate needs this.*

**4.171** Some members of staff talked about QEQM as “*falling apart*” and not “*fit for use*”. The Panel heard about the challenges presented by the size of the rooms and the lack of resuscitation trolleys on the ward.

**4.172** We heard that theatre access was identified as a problem at QEQM: there is only a single theatre in the labour ward and, if there were a second emergency, it could take up to 30 minutes to organise and start operating in the main theatre.

**4.173** One midwife referred to the “*struggle with the footprint of both the acute labour wards*”. The MLUs were new, but the majority of women were giving birth in environments that were not fit for purpose. Another senior midwife described the dated estate as a “*big problem*”.

**4.174** A member of staff who worked in the MLU at WHH commented on the difficulty presented by having the MLU on a different floor of the hospital from the labour and postnatal wards:

*The team felt disjointed ... The perception was that you didn't matter. It was difficult to keep the woman at the centre when you're juggling politics between two areas.*

**4.175** One consultant commented:

*[A] lot of the labour beds have only 30% of space recommended by national guidance. This meant that if a baby was born in poor condition, midwives would have to run down the corridor to consultants as there was no space to treat the baby by the bedside.*

**4.176** The Panel heard that WHH would struggle to meet guidance recommendations that each labour bed should have a bath available.

**4.177** We heard that there was only one toilet for staff across the whole unit at WHH, so if someone was working on the Folkestone Ward (which provided care for antenatal and postnatal admissions), they had to tell the other midwives that they were leaving the ward to go to the toilet. One midwife told the Panel: “*I feel like we're not well looked after as midwives.*”

**4.178** The Panel heard that requests for a second obstetric theatre at WHH were declined because maternity services did not generate as much money as other departments.

**4.179** The Panel was told by many interviewees that one of the problems at QEQM was that the resuscitation trolleys were outside the delivery rooms, and there were several cases where a baby was taken out of the room but their mother would hear things going on in the corridor that related to their baby, which was very distressing. The response of the Trust was that it couldn't do anything about it because, in its view, it was the nature of the Trust estate.

**4.180** The Panel also heard from Mr Hulme, a Trust Governor, who commented:

*[Y]es, the estate is in a mess and absolutely needs to be improved; they are awful but ... it is not impossible to do really good care just because the buildings are rubbish.*

## Geography

**4.181** Some people who spoke to the Panel mentioned the challenges presented by East Kent's geography:

- *“The geographical location of the hospitals on two different sites is also a difficulty, as staffing levels and service quality need to be maintained across both sites.”*
- *“You can’t change the geography of the organisation. The challenge is how to ensure the right support is in there, given the geography.”*

**4.182** A director observed:

*[O]ne of the challenges for East Kent staff is that there are few alternative employment opportunities. A nurse working in Margate would have to commute eighty miles, e.g., to Medway [and back], if they wanted to work at another NHS trust. Professionals who train at Canterbury Christchurch University, e.g., radiographers and nurses, gain their practical experience in the Trust and then [are] likely [to] come to work for the organisation too ... staff tended to be inward-looking in their view as a result.*

**4.183** The Panel also heard comments that it is difficult to build strong organisational connections and shared values across separate sites. Some staff expressed doubt as to whether the Trust would be viable over the long term with two or three sites.

**4.184** An experienced consultant told the Panel that the geography made the Trust difficult to work at:

*[W]hen an incident does occur, managers become torn between multiple sites and must choose carefully where they spend their time.*

**4.185** The Panel was told by an experienced midwife of occasions when the labour ward at QEQM was closed due to safety reasons, requiring attendance at other sites. As the nearest labour ward is 30 miles away and women are often reluctant to travel to other sites, unplanned home births could result. Women were not routinely told that there was a risk of the labour ward being full before they entered the hospital or that being transferred to a different trust was a possibility. This was particularly a problem at Thanet, where many people do not have their own transport and therefore there was little possibility of reaching another trust in time to give birth safely.

**4.186** A member of the Board and Executive described how the maternity case mix at the Trust changed between 2007 and 2015:

*[T]here was more complexity, higher teenage pregnancies, higher than usual problems with smoking, obesity, and diabetes – all the social determinants of health. East Kent has both affluent areas and also a lot of deprived areas, particularly coastal areas. From a midwifery point of view there was a lot of complexity that people were managing. The Trust was tracking c-section [caesarean section] rates and intervention rates and they were tracking slightly higher than the national norm.*

## Staffing

**4.187** A number of people to whom the Panel spoke commented on the difficulty of recruiting staff to the Trust, particularly at Margate:

- *“QEQM was always a difficult site to recruit to, on the extreme southeast of the country and a coastal community.”*
- *“Margate is the furthest place from London where people want to go and settle, and finding staff is not easy.”*

- *“One thing about the geography was that it was almost impossible to recruit staff to go to Margate, so the only staff they had were people who lived there, and they had been there a very long time. If you don’t get any turnover, then that brings about an issue.”*
- *“The biggest issue was staffing. Just prior to 2009 there was a large investment (almost £4M) into nursing and midwifery because the staffing levels were not safe. However, recruitment was a challenge given the geography of East Kent (coastal areas at one end of the country), and there was difficulty in recruiting both midwives and obstetricians, and the Trust was more reliant than it wanted to be on locums.”*

**4.188** One senior consultant described QEQM’s middle grade medical staffing situation in 2012 as “dire”. However, we heard that, by the end of 2013, QEQM had a full set of middle grades and there was active recruitment of staff from abroad.

**4.189** The picture presented to the Panel in some interviews was that, up to 2015/16, there were quite a few experienced middle grade doctors who had been at the Trust for a long time; and that from 2015/16 to 2019, there were a lot of rota gaps and there was a time when more than 50% of the rota was covered by locum doctors. Some consultant obstetricians told us that they were always worried when working with someone they had not met before and that they gave careful consideration to whether locums could be left unsupervised. These issues were escalated to the divisional Medical Director, but it was not felt that they were taken seriously enough by the Trust. We were told:

*It was difficult to maintain quality with locums. This is not a problem unique to East Kent but the thing that set them apart was the scale of it – 40-50% of the shifts ... Trying to secure locums at short notice was an endless task.*

**4.190** A senior midwife described how the CQC’s intervention in 2014 and the adverse publicity facing the Trust caused difficulties in recruiting staff. They described the workforce as stable and structured prior to 2016, but after this there was a need to use significant numbers of locum doctors, which had a negative impact. The quality of some of the locums was described as “troubling” but it was “a case of having that locum or nobody”.

**4.191** We heard that the Trust was spending about £17 million per annum in 2018 on locum doctors and agency staff, which was, according to one Board member, “bad for patient safety and continuity”. The Panel heard that there were constant challenges in keeping staff up to date.

**4.192** The Trust was described by a regulator as “not a Trust that attracts quality staff from elsewhere”, and a midwife told the Panel that trainees did not want to come to East Kent as it is too far out of London.

**4.193** The Panel was told that a benchmarking exercise within midwifery in 2020 had established that numbers of staff within the Trust’s midwifery unit were too low. A review of resources in the same period had established a need for specialists in mental health and heart monitoring, more core midwives, an additional community midwife, a Deputy Director of Midwifery, and two senior band 7 nurses to focus on patient experience and digitisation.

## Leadership

**4.194** The Panel was told that, following the achievement of Foundation Trust status in 2009, the period from then until 2014 was one of relative stability, and that at Board level things felt strong. However, one Board and Executive member reflected that staff morale was adversely affected by the impact of 5–6% efficiency savings year on year; the Board failed to recognise

this development, even though the signs were there in the staff survey results, which showed that stress and bullying increased during this period.

**4.195** A non-executive director told the Panel that the Trust was “*too large, complex and diverse for the ability of the executive team*”:

*It was just out of their league. It was just too big. The span and complexity was too large for them ... They weren't even firefighting. They were just on the ropes being punched the whole time.*

**4.196** It was said that individuals were doing the best they could; however, the system was letting them down. The lack of senior leadership training and senior leadership models was an issue. Also, we were told that the problems in maternity were:

*... symptomatic of an organisation that is outwith the competence of the executive team.*

**4.197** One director during the period described the Board as:

*... very dysfunctional; it was not united. They did not work well together, and they were very separate ... The chairman and the chief exec were pretty much not talking to each other.*

**4.198** It was commented that the quality of non-executive directors on the Board was variable and that they did not always provide the right kind of challenge. One member of staff described the non-executive directors as “*weak*”:

*[T]hey didn't know what they were doing and didn't have enough challenge. They didn't know the data. Your non-execs are there to hold the executive to account in the right way and I didn't think that was happening enough.*

**4.199** The Panel heard about “*really awful reporting to the board*”:

*There was no challenge or testing at executive level, and that's partly what got them into the mess that they got into ... Nobody really knew what the truth was about a problem.*

**4.200** A non-executive director with experience of both public and private sector boards commented that the Trust was just going through the motions.

**4.201** The Panel also heard about communication breakdown between non-executive directors and the Executive Board. One non-executive director first became aware of issues in maternity services the day before a news story was about to break on the BBC website. On another occasion, the same person first learned of an issue after seeing the front page of a newspaper. It transpired that the Executive had known about this for a month but had not thought it appropriate to tell the non-executive directors.

**4.202** Senior management were described as lacking people skills. One member of the Executive was described as a “*threatening*” presence throughout the Trust; the Panel heard that “*staff did not feel supported by [them]*”. Another member of the Trust Executive was described as “*overwhelmed*”, with a tendency to talk at people rather than engaging fully.

**4.203** The Panel was told of a toxic culture and unhealthy tension between managers and clinicians, who had different priorities. The managers were quite wary of powerful clinicians:

*[I]t led to a really unhealthy tension where people just tiptoed around the issues.*

**4.204** Of the culture, it was said:

*[T]hey're [senior managers] really frightened of these people [consultants].*

### Changes at Board and senior management level

**4.205** After the 2014 CQC report, the Trust lost its Chair, the Chief Executive, one of the joint Chief Operating Officers, the Director of Nursing and the Director of Finance. This heralded the start of a long period of instability at Board and senior management level which had:

*... [a] tremendous impact ... Everything got put on hold because key people were not in post.*

**4.206** Since 2014, there have been three Chief Executives of the Trust, four Chairs of the Board, three Chief Nurses and four Heads of Midwifery (referred to since 2018 as Directors of Midwifery). A number of members of Trust staff identified that the level of turnover in key senior positions had had a detrimental impact on the effectiveness of the Board and Executive during this period. It was also said to comprise a disproportionate amount of the Council of Governors' work.

**4.207** One member of the Board and Executive described the Chief Executive post as "undoable" and a case of "how long is the next one going to last". One Head of Midwifery was asked by a senior colleague on taking up their post, "how long are you going to stay?".

**4.208** The result of so many changes within the management structure was that "people didn't have much confidence in the management team".

**4.209** The Panel was told how tough it was to maintain momentum while losing people and continually having to develop new relationships; of the damaging impact of the constant changes of senior leaders; and how initiatives were regularly implemented and then abandoned with the next change of leader.

**4.210** The Panel was told that the departure of the Chief Executive in 2017 was "catastrophic" and that "the visible loss of leadership had major consequences for the Trust": "conflict and difficult relationships" abounded and remained a problem for two years.

**4.211** One senior midwife described how, every time someone new came in, the journey would start again, with new leaders wanting to know everything that had happened and changing priorities. It was a case of "that's not important, this is now important". The BESTT Maternity Transformation Programme that was launched in 2017 was cited as an example of a programme that had been owned by the staff but was now "shelved" and "just another example of not seeing something through".

**4.212** Another senior midwife said:

*[T]he goalposts were being moved quite a lot because there were new Heads of Midwifery coming in.*

**4.213** And another member of staff said, in reference to the six different Heads of Midwifery throughout the period of the Investigation:

*[A] new incumbent would bring new ideas and then things would change again with the next person. It felt as though we were always trying to catch up.*

**4.214** The Panel heard that, both in the immediate aftermath of the 2014 CQC report and since, there had been a high turnover of non-executive directors, with some leaving because they had come to the end of their tenure but others leaving due to frustration or because the pressure of reputational issues was too much. Some non-executive directors chose to move on before the end of their term because they did not want to be associated with what was happening at the Trust.

**4.215** We heard about the dangers of “hero leaders” who were expected to single-handedly reverse the fortunes of an organisation, only to be quickly and repeatedly replaced when they inevitably failed. We also heard of the need for a strong leadership team with a long-term strategic vision beyond the next two to three years.

**4.216** Commenting on a whole series of changes of leadership, Professor Ted Baker, former Chief Inspector of Hospitals at the CQC, observed that stability and support from external parts of the system such as NHSE&I and the CCGs are required in order to turn a trust round from special measures:

*If you look at East Kent ... there has been a whole series of changes of leadership and none of the leaders have stayed very long. That kind of chopping and changing leadership and people who go in to lead an organisation like that and have a two-year horizon in terms of what they want to achieve, are never going to drive the change you want. There's a history in some of these trusts that don't make progress, that when we find real problems – put them in special measures – the leadership changes and a new hero leader is brought in, whoever they may be, and they are going to sort it out. And two years later they have failed, and they move on quietly and someone else comes in. The misconception is: one, it's not one person, it has to be a team; two, it's not a hero leader, it's someone who is thoughtful and who is going to drive cultural change; and three, they need support, however good they are, from the external part of the system – NHSE&I, CCGs or ICSs [integrated care systems] now. They need to support them because taking a trust that is in special measures, that is inadequate and has really serious issues and turning it into a really good trust, is a huge job and a formidable challenge. It's not one person's job, and it's not something anyone can achieve easily.*

**4.217** Professor Walker, who had significant experience of investigating maternity incidents at the Trust with HSIB, offered this insight:

*There were continued problems and with continued themes, which in fact have continued to this day ... A lot of big hitters come into East Kent to try and solve a problem, and in fact they make the problems worse because they obligate the Trust to spend a lot of money and time building structure, while not necessarily solving the problem on the shop floor. And so, the same problems on the shop floor, lack of support, lack of escalation, are still going on ... The appointment of a CTG midwife or a lead person in this, or having a committee in that, doesn't solve these problems ... A lot of the oversight groups spend their time trying to be reassured by what's going on, rather than finding out whether something is improving. They want people to say, “we've got this committee, we're looking at that, this is our report, this was our graph”, and everyone nods and says, “well, that's really good” and “let's move on” without looking to see whether things have changed ... What East Kent told us is that although there was leadership there, they weren't in touch with what was going on ... and they tended to believe what they were told.*

**4.218** The Panel was also told of a lack of stability within key clinical roles and that members of the Executive did not act as a single cohesive team providing a tier of support below the Chief

Executive. The size of the Trust, the portfolios of those working there and the expectations were said to be huge and potentially unworkable.

**4.219** One experienced midwife told the Panel that they saw the situation deteriorate around 2015/16:

*[T]here seemed to be a flurry of appointments made of people who had very little experience and it appeared almost as if they were trying to eradicate all previous managers and senior people from the team ... They were appointing people with no background experience and their lack of experience was reflected in what was happening on the shop floor unfortunately.*

**4.220** The Panel heard:

*[T]he long history of reports of deep cultural issues in East Kent maternity services was related to instability in the leadership team. Other contributory factors were the fact that the two sites worked separately rather than together as one trust, and the large geographical spread of the trust. In 2018 there was more stability in the leadership, and it felt as though a shift in culture led to people working well together ... staff took more ownership of what was happening. There were obstetrics and midwifery leads for all pieces of work and if the focus of a project was on one site, then the other site had shadow leads for obstetrics and midwifery.*

## Clinical leadership

**4.221** The Panel heard that doctors were not engaged in the management of the Trust, and a senior member of the Executive spoke of the difficulty in attracting good leaders as well as in having a body of consultants who were unwilling to be led.

**4.222** Another member of the Executive highlighted several dangers related to the way in which the clinical effort was focused at East Kent maternity services – there was a historical lack of clinical leadership and “*it was much more controlling and quite negative*”:

*There is a culture of politically aware bureaucrats versus clinicians who don't have the leadership skills.*

**4.223** The Panel was told of a reluctance on the part of staff within obstetrics to take on leadership roles, and that the midwives and obstetricians held their meetings in silos with very few multi-disciplinary meetings. One midwife described a Clinical Director within the obstetric team as like a “*lone ranger*”.

**4.224** The Panel was told that consultants' views were not included in decision making, and without good clinical leadership in women's services, it was hard to get voices heard. It was noted that clinicians did not feel accountable for what they did, which led to consultants not being there when they were supposed to be.

**4.225** One consultant told the Panel that they had told the RCOG that three colleagues should be sacked because “*they didn't have the same work ethic and responsibility*”.

**4.226** Leadership within midwifery was described at times as resistant to challenge and favouring the status quo, which was a source of frustration. The Panel heard from senior midwives that there was a perception that the views of midwives were blocked and not

escalated appropriately due to “gatekeeping”. It was frustrating that midwifery did not have a voice at Board level.

**4.227** The Panel heard positive comments about the leadership of midwifery more recently, with improvement in effective leadership, visibility and openness to challenge.

## Financial Special Measures

**4.228** The Panel heard that, immediately after exiting CQC special measures, and perhaps as a result of spending on the improvements required, the Trust was placed in Financial Special Measures by Monitor.

**4.229** A Board member described the impact of being placed in Financial Special Measures in 2017 as like coming out of Quality Special Measures on a Tuesday and going into Financial Special Measures on a Wednesday. A number of Board and Executive members told the Panel that going straight into Financial Special Measures was not helpful. One said:

*The organisation came out of special measures, and the next day they went into financial special measures, which was massively unhelpful and not necessary. It gave the organisation no time to take its breath ... This didn't directly lead to the problems within maternity services, but it is part of the context and the people who would have been doing work on maternity services were responding to financial special measures and all of the effort that required. Had the organisation been given time to breathe it may be that there would have been more focus on maternity issues.*

**4.230** The Panel was told about the significant impact that Financial Special Measures had on the transformation and improvement agenda, and on innovation; the Trust became very financially focused and operationally led. One member of the Board and Executive described the organisation as “controlling” and stated that, because of the problems with the finances and the buildings:

*[P]eople couldn't see a way out. It felt very negative. Staff were not utterly disengaged but they were very despondent.*

**4.231** A member of the Board and Executive made the following points:

- The Trust has been in deficit since at least 2016 and the deficit target has been missed every year since 2017.
- The Trust has been aiming to make 4–5% efficiency savings each year (£30 million) and has sought to do this in a way that does not affect clinical services, for example by making structural changes that produce a saving on VAT.
- However, there have also been some cost efficiencies in clinical areas.

## Governance

**4.232** Members of the Executive spoke of the disconnect between ward and Board and of communication issues. One told the Panel:

*It didn't help to have a disparate multi-site Trust. It didn't help that there were issues with medical engagement and a lot of turnover in the Board. It didn't help to have a bunch of people who, when the divisional structure came in, got put into roles without any development. One of the recurring themes in CQC inspections around the country is the*

*middleman, through whom nothing filters down or goes back up. Where organisations work well, the communication is great from ward to Board and Board to ward. It comes back to the multi-site structure – people need to walk around to see what’s going on. It is not enough to be in an office and do it by video link.*

**4.233** One member of the Board and Executive was aware, even before they joined the Trust, of the fact that the views of management were not shared by the staff. Another described sitting aghast as they listened to feedback provided by ward colleagues and feeling like they were not part of the same organisation. The executive team did not listen enough to what people were saying, and they did not talk to those on the ground. One senior executive observed:

*[There was a] significantly different view between the board and the staff about the purpose of the organisation.*

**4.234** One clinician felt that certain sites were underrepresented within the Trust’s governance structure, with QEQM being under greater pressure because of recruitment issues and a lack of capacity for staff to participate in governance. Well-staffed sites, by comparison, had more time to focus on non-clinical issues.

**4.235** The Panel was told by a Board member that the governance structures within the Trust were not sufficiently robust to allow assurance from ward to Board, and that the Board did not give consideration to this issue or to what it could do differently. Another member of the Board described the governance arrangements in 2018 as:

*... like being in a car, when you move the gear lever, and nothing happens. The governance from board to trust and from ward to board had broken down and needed to be fixed.*

**4.236** Consistent with this observation, the Trust was described by regulators as an organisation that did not actively look for problems and issues to solve; rather, it waited for them to be pointed out. They suggested that the Trust needed to be problem sensing rather than comfort seeking in its approach.

**4.237** A senior midwife told the Panel that maintaining compliance, receiving feedback and implementing lessons learned were some of the key priorities that were not always addressed. It appeared to them that sometimes the Trust was waiting for an incident to happen, rather than utilising the vast amount of patient safety incident data available to predict incidents.

**4.238** A senior manager described governance within maternity services as:

*... frightening, but they had normalised it and couldn’t see there were issues ... The leadership within maternity did not mix at all. Staff days and learning within the nursing teams was not embedded. It was very narrow in the way that it operated and didn’t invite people in.*

**4.239** A senior manager told the Panel that the Board “*tended to deny there were problems and suppress discussions*”. After the 2014 CQC report, Board committees were split so that the Quality and Safety Committee included nursing and medical staff but did not include divisional directors; this impacted the quality of the conversation and the decision making.

**4.240** The Panel was told that the Executive had difficulty accepting the findings of the initial CQC review and “*spent about six months quibbling over what was in the report*”. It was said at the time of the report that “*there was nothing of significance coming out of women’s services*”.

One senior member of staff thought the Trust did not understand how much time was needed to take the actions forward.

**4.241** Former Board members told the Panel that, between 2016 and 2018, maternity services featured very little in Board discussions and should have had a higher priority. The priority issues for the Trust in 2018 were described by a member of the Board as: safety, governance and finance – “*the core business of a hospital*” – but with specific focus on A&E (which was the worst in the country); cancer services (which were the fifth worst); and the response to treatment time (the Trust had the second longest waiting list in the country). It was accepted that maternity services did not consistently appear in governance sessions and that issues became diluted; their significance was not recognised as they were reported up through the chain and repeatedly summarised.

**4.242** The Panel was told that the Board was looking for patterns and themes, but the mechanisms were not in place to identify them. It was recognised that clinical governance required improvement because the Trust did not have information flowing up and down the organisation between the point of care and the Board.

**4.243** In terms of the Trust’s recognition of the wider significance of individual events, Professor Walker told the Panel:

*They didn’t link [two maternal deaths] together ... They just saw them both as really unusual things that happened out of the blue ... [HSIB] tried to get across, yes there is a reason for it. It’s the systemic failure ... These were all, what used to be termed under old parlance, “latent errors” – errors waiting [to happen] ... It was almost like a journey of realisation for them that these things were repeated in the same way. The problem they tended to do was they blamed individuals. They blamed the locum, for instance, for the problems, instead of saying, “well, the locum only has a limitation in their ability and knowledge of the hospital”. What supervision or assessment did you make of that individual? Or did they just turn up on the night of their on call, without any orientation or anything like that? ... The Trust had to think about the systems approach and the preparation and making sure everything is in the right place. So that took quite a long time, really, for them to be convinced of that. Initially they kept on seeing them all as one-off events.*

**4.244** A Board and Executive member commented that the information flow seemed to be there but noted that the relative performance of the Trust was not known by the Board and that they were not aware that it was “*the worst performing*” trust in the country. They also told the Panel that the Board was concerned about whether it had sufficient information, which led to overcompensation by diving too much into the detail on issues, rather than standing back to understand what the information was telling them.

**4.245** One Board member was aware before joining the Trust that it was one of the – if not the – “*most challenged trusts in the United Kingdom*”:

*My initial impression was that there was a very severe problem with governance throughout the trust, throughout the three hospitals, and that was split into two groups. There was a structural problem and there was a deep-seated cultural problem. The structural problem was that the Board only met every two months, and this is a Board with five hospital sites with some of the most challenging performances in the country and quite clearly that was nowhere near enough ... But there appeared to be no recognition of what was needed*

*for a Board. There was no ownership of [Board] papers. The papers were often late. To be honest with you on closer questioning they could be inaccurate. They could be incomplete.*

**4.246** A different Board and Executive member expressed the belief that there remained issues around serious incident reporting and the level of visibility the system provided. They told the Panel that they became aware of baby Harry Richford's death only when they saw the first draft of the root cause analysis report in March 2018 and read it "*with mounting horror*". They told the Panel:

*[O]ne of the reasons it was so difficult was that obstetrics is largely a well-specialty. They were dealing with people who were well, and it can take time to pick up where things were not quite right. If activity or behaviour starts to become normalised, it needs someone to forcibly point it out, and that was part of the problem.*

**4.247** The Harry Richford case was not formally considered by the Board until late 2019, prior to the inquest into his death. In response to the inquest, the Panel was told that different workstreams were set up, including a prevention of future deaths workstream, to which the action plan relating to what happened in Harry's case was added. The neonatal resuscitation process was reviewed, as was the 21-point Prevention of Future Deaths report and the 2016 RCOG report (which included the issue of consultant presence on the labour ward).

**4.248** Mr Hulme, a Trust Governor, was struck by the fact that there was no external benchmarking of serious incidents; the only information provided was the number and type of serious incidents. He found it was very difficult to unpick whether the Trust was improving over time or not. There was no focus on repeated serious incidents. Mr Hulme said:

*That does not show a learning organisation if you're not tracking the number of times that a serious incident has happened ... Apparently there was no way ... of looking at SIs [serious incidents] adjusted for comorbidities, for the size of the Trust and see whether, as a trust, we're not just resting on our laurels and assuming that we've always got to have 50 SIs per quarter, and that's just what it is.*

**4.249** It was suggested that the Trust invest in a different methodology for looking at serious incidents, but "*that did not land well*" and an invitation to consider alternatives at a different trust was never taken up.

**4.250** The Panel heard of concerns from midwives about how the organisation learned. Although HSIB reports were emailed, they were often not looked at or read. Although there had been improvements with the current risk team, there was no strong pathway for feeding back the learning from incidents. One midwife spoke of new guidelines being introduced in response to incidents but no one explaining why:

*Staff aren't involved in improvement plans and yet they know what went wrong. They know how it could be fixed but they weren't invited to comment.*

**4.251** One member of staff described the Trust's learning from incidents as "*formulaic*", a "*pray and spray*" approach with "*fingers being crossed, and a policy updated*".

**4.252** There was criticism of the divisional structure, which created an extra tier of management. The structure of the divisions was described to the Panel as follows:

*Each [division] was led by a divisional director. They had a doctor as a clinical lead as well, and the relationships almost without exception, between the doctor and the manager,*

*were not good ... The divisional directors and doctors just didn't understand about working together.*

**4.253** An experienced midwife recalled when a divisional leader came to a supervisors' meeting and said: *"I'll be perfectly honest with you, I don't actually know what you do."* A senior midwife told the Panel the same thing: that the appointed divisional leaders had very little understanding of maternity services and the difficulties midwives face.

**4.254** Another senior midwife reported that a divisional leader did not assist the midwifery team in implementing new recommendations following the public consultation on maternity services in 2011, and that the *"potential for improvement had been lost"*.

**4.255** The Panel heard similar comments from Board members and managers:

- *"[O]ne of the challenges that East Kent has had with its divisional structure and then its care group structure, is that a lot of responsibility has been delegated to those divisions/groups but the Trust has not always had the process in place to provide central oversight of their effectiveness."*
- *"There was this centralised but non-integrated board approach, and then below them they had what they called autonomous divisions and these divisions genuinely believed that they didn't have any accountability, so this wasn't just maternity. There were issues with each of the divisions."*

**4.256** Midwives informed the Panel of concerns around clinical governance and said that they had written to divisional management to highlight that there was only one midwife within governance, while the number of reportable incidents in maternity services was higher than in many other specialties. They told the Panel that the governance role was much too big for just one person, that complaints were not dealt with well, and that there was a lot of pushback from consultants.

**4.257** Senior midwives told the Panel that governance had not been an integral part of maternity services and that it had not been a golden thread running through the division, as it should have been. They indicated that, because governance was performed for the whole of the specialist division (of which maternity services were just a part), the ownership of governance was not felt strongly within maternity services; there were a lot of gaps and not a lot of reporting. The Panel heard that Women's and Children's Health *"didn't have a fair place at the table"*. More recently, the placement of governance within maternity services was an improvement.

**4.258** The same point was made by a director:

*[T]he golden thread lacked breadth and depth. It was obvious that there was no way that a good or a bad point would be taken from the top and worked down through the trust and spread across so that there could be learning or replication of good practice. The Women's and Children's Division was the same as the others, urgent care was the same, it wasn't specifically a maternity issue.*

**4.259** Maternity services were described as more insular than other services within the Trust, and the reporting culture was not as strong or as open as it was in other services. One midwife commented that debriefing and governance were not things that East Kent maternity services did very well. One anaesthetist commented that obstetricians and midwives often had to be requested for the debriefing process; for some, the debriefing was not very important and could

wait. A difference in approach between midwives and doctors was also noted, with midwives reporting more incidents and very little incident reporting from doctors.

**4.260** One Executive member expressed concern about risk-rating issues with Datix; however, the Board was not receptive to the suggestion that the Head of Midwifery should report directly to the Board as an additional route of escalation. The Board was also dismissive of introducing a non-executive director for women's health to whom people could speak if they weren't being heard. It was therefore felt that there were issues incapable of resolution or of being escalated upwards.

**4.261** A midwife told the Panel that one of the barriers to reporting was the time needed to complete the details required in Datix, and that if someone were an hour late leaving their shift then it would be quite likely that they wouldn't report an incident, even though it should be recorded. It was also said that it remained common not to escalate issues through reporting, including through Datix reports.

**4.262** The Panel was also told that governance was compromised by recruitment problems and constantly changing leadership.

### **Response to the Royal College of Obstetricians and Gynaecologists report**

**4.263** The RCOG review was commissioned in 2015 because of concerns about the culture of maternity services, clinical standards and quality, particularly at QEQM. A senior manager told the Panel that they knew there were issues: “[W]e needed something brutal to help them to change.”

**4.264** A senior representative of the CCGs at the time told the Panel that the momentum for bringing in the RCOG came internally from the Medical Director within the Trust, who felt that it would be more credible to the obstetricians, particularly in QEQM, if they heard from their own professional group.

**4.265** A senior midwife told us that the description of the behaviour of obstetricians within the RCOG report was accurate and said that the response to the report was not appropriate and that obstetricians did not engage with it. An Executive member similarly described the themes in the report as accurate and recalled a meeting being called with the whole executive team because the feeling was that the report was not being accepted:

*The report's findings never resulted in an organisational approach to tackling the problem ... Efforts to improve the O&G [obstetrics and gynaecology] service were confounded by poor and unstable midwifery leadership and disengaged clinicians.*

**4.266** The Executive was asked to help get consultants to engage with the report. The Panel was told by a Board member that the main focus of the Board in relation to maternity services and its response to the 2016 RCOG report was the implementation of the BESTT programme in 2017 (which was described by one midwife as simply “papering over cracks”) and Human Factors training. Although the programme was considered a response to the RCOG report, it was built around the national agenda with specific areas of focus, and those involved in developing the BESTT programme were not provided with a copy of the RCOG report as it was considered “outside of the scope of the project”. RCOG recommendations were incorporated into a later phase of the BESTT programme in 2020 following the Harry Richford inquest.

**4.267** The Panel was told that the RCOG report was never shared with the Trust Quality and Safety Committee, and that programmes such as the BESTT programme:

*... seemed to indicate that matters were improving but it only involved recently appointed obstetricians and not the long-standing recidivists who were not going to change.*

**4.268** Other Board and Executive members told the Panel that the response to the RCOG report was merged into one improvement plan together with the actions in response to the CQC report and the Local Supervising Authority (LSA). They told us that, with hindsight, this might have meant that there was insufficient focus on maternity and neonatal services. The improvement plan was signed off by the Executive, scrutinised by the Improvement Board, and reviewed monthly by the CCGs (with respect to maternity services and obstetrics). However, it was felt that maternity services were never given any financial support and had to work within existing budgets. One Executive member considered the action plans in response to the RCOG report to be more a “tick box” exercise compared with the response to the CQC investigation. People only began taking it seriously with the triangulation of other reports.

**4.269** Nobody in the Trust had been able to produce evidence of how the RCOG recommendations had been implemented and completed, and there had been no action plan endorsed at Board level to rectify the situation.

**4.270** The response to the RCOG report was described by one non-executive director as follows:

*At that point, the hairs were going up on the back of my neck really quickly now. I’m just thinking, “oh my word”.*

**4.271** The culture of the obstetrics and gynaecology service was put on the risk register by the governance and patient safety team, in response to what they believed was contained within the RCOG report, although the Panel heard that they were not permitted to read the report and were later asked to remove the obstetrics and gynaecology service from the risk register.

**4.272** A consultant who was involved in a review of the RCOG report in 2019 found that the action plan drawn up in response was incomplete and that fewer than 25% of the actions were robust and signed off. The consultant did not know why this was the case and could only speculate that either it was not considered important or there was no time to carry out the work properly.

**4.273** A Board and Executive member spoke about how they had more recently sought to identify the actions taken by the Trust in response to the RCOG report but could not find a comprehensive response, or evidence for decisions that had been taken, or evidence of the monitoring of those decisions. They suggested that, because of this failure, the absence of a central repository for recording information and the numerous changes of personnel, a lot of the work done at the time the RCOG report was provided had been lost. They told the Panel that it was not until five years after the RCOG report that there was an action plan in place to cover the recommendations it made.

**4.274** The Panel heard that the RCOG had no further involvement after the report had been written. It was believed that the Trust did not contact the RCOG after 2016.

**4.275** Despite the RCOG report having been provided in early 2016 and containing a number of complaints about consultants failing to respond to requests for assistance from junior colleagues, the Panel was told that the report was not provided to the GMC until 2020, some four years later. The Panel was also told that the GMC decided, following review, that the complaints did not require “fitness to practise” proceedings.

**4.276** In addition, the Panel was told that the RCOG report was not provided to the CQC until it was presented as part of information supplied prior to the May 2018 inspection.

**4.277** Following the RCOG report, it was recognised by a member of the Board and Executive that it was significant that the Chief Nurse at the CCGs had written to the Trust to say that they were concerned about the quality of the serious incident investigations.

## Risk management

**4.278** The Panel was told that part of the risk management strategy around 2012 involved making divisions responsible for their risks:

*This gave management teams a broader range of responsibility, though clinicians saw risk as remaining the responsibility of trust management.*

**4.279** One midwife felt that people within the Trust didn't understand risk when the midwife joined in 2013, although this improved subsequently because the governance and risk obstetrician and midwife brought risk to the fore.

**4.280** The Panel heard that there was one risk register for QEQM and another for WHH, and that issues on the risk registers did not necessarily come to the attention of the Risk Management Committee. The Panel heard that there was a monthly risk group meeting that lasted two hours. Corporate risks were reviewed at each meeting. Each care group had a risk register, but, depending on how many risks were on the register for each care group, it wasn't always possible to review every risk without extra time being allocated. Some maternity issues raised at the risk group – such as reading CTGs and resourcing – *“did not get the air time they needed to provide assurance for the board”*. However, there was acknowledgement from the Board about the importance of managing risk.

**4.281** The risk register was sometimes updated to reflect the barriers to making changes, but it was *“underutilised and a bit hidden. It was all a bit of a mystery.”* One senior member of staff thought that the care groups did not understand what the risk register was for, how it could be used or how it could help. The Panel heard that some staff were unfamiliar with the risk register or completely unaware of it.

**4.282** A number of safety management concerns were identified to the Panel, including:

- A lack of progress with the CQC recommendations
- The risk register being frequently out of date
- Out-of-date policy documents
- An insufficient budget
- A lack of action relating to the quality improvement programme.

**4.283** One member of staff was shocked by the things band 7 midwives at WHH had to say about patient safety, such as *“what's that got to do with us?”*, and that one patient safety lead was not open to challenge.

**4.284** The Panel heard that perinatal morbidity and mortality meetings had always taken place at the Trust and provided an opportunity for reflection and learning. The meetings were Trust-wide until around 2006/07, when they became local. We heard that QEQM had monthly meetings to discuss patients and that these meetings were attended by middle grade doctors,

neonatology consultants, midwives and obstetricians. The obstetricians also held their own discussions that did not necessarily involve paediatricians.

**4.285** Staff perceived the discussions at these meetings differently. Some considered the meetings at QEQM to be open, with challenges to practice on both sides. However, others spoke of clashes between members of staff, with one particular paediatrician often blaming obstetricians for any deaths or serious incidents.

**4.286** The Panel was told that handovers (between off-going shifts and on-coming shifts) were identified as an area of risk, as were delays in communication and issues with communication between disciplines. A consultant expressed frustration at the absence at either site of a multi-disciplinary team for high-risk pregnancies.

**4.287** One staff member who had experience of working in another trust commented on the communication issues in East Kent maternity services. Their experience elsewhere was that communication was open and transparent and staff were kept in the loop about investigations and learning from them; however, it was not like that at East Kent maternity services, where the staff member knew only what happened during their shift and was not kept informed about the wider picture.

**4.288** One midwife told the Panel that, although there were systems in place for midwives to learn from adverse outcomes (risk meetings and perinatal meetings), in reality they did not go to them. However, midwives had statutory study days, and these were well attended.

**4.289** A consultant told the Panel that there had been improvement more recently:

*Historically there was a lot of jumping to conclusions and finger-pointing, whereas now, there's recognition that things aren't black and white – that they can be complex, and you shouldn't jump to conclusions ... Before, people were told what to do rather than why things should be done. They came up with "quick reflex action points", rather than reflecting and agreeing a collaborative approach about how to address the issue ... Some changes didn't work as they were just reflex responses at the time. For example, following a case of uterine rupture during induction, one action was that all inductions should have 3 hourly CTGs in the lead-up to labour. However, in this case, there were lots of signs that other things were going on with the woman, such as poor pain control. The introduction of 3-hourly CTGs was more like a tick box exercise instead of doing holistic risk assessment continuously during the woman's induction and labour. In high risk cases of induction of labour, pain or uterine activity should immediately trigger the application of the CTG to monitor foetal wellbeing. By doing 3-hourly CTGs on everyone, they are taking their eye off the ball, instead of risk assessing the woman holistically every time they look at her. They need to unravel things and reflect on what the thought process was behind the action. They need to risk assess each woman.*

## Regulators and commissioners

**4.290** A large number of organisations have been involved in supervision and regulation of NHS services: the GMC, the RCM, the RCOG, the NMC, the LSA, the CQC, HSIB, NHSE&I, CCGs and the Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS). The Panel heard about the potential for confusion that this has caused, as well as the inability of the supervisory and regulatory bodies to bring about significant change over prolonged periods. We were told:

*It isn't always helpful for individuals to have to deal with different organisations and the landscape is so confusing when you have a complaint about something significant that happened in your life. It is very difficult to pursue that.*

**4.291** Members of the Board and Executive described a very challenging relationship between the Trust and its regulators and commissioners. One told us that a decision had been taken by the Trust to “*fight the regulators*”, although this was a fight that could not be won and was a waste of resource and energy. The Panel was told separately that the Trust had considered taking legal action in response to the 2014 CQC report.

**4.292** One member of staff expressed the following perception:

*[T]he priorities of the regulators might not always be aligned with what is best for the patients. The regulators have their own set of challenges. They are balancing the politics and the requirements that are placed on them, along with the need to regulate organisations.*

**4.293** Managers within the Trust talked about how it was impossible to meet all of the regulators' expectations, but they said that nobody discussed whether this situation should be exposed:

*[It] might not be the regulators' intention that they are not aligned, but they don't get to hear the things that they need to hear. People don't always get rewarded by being honest.*

## Clinical Commissioning Groups

**4.294** A member of the Trust's Board and Executive commented that the four CCGs there had been in Kent all did things differently, making it hard to respond. The relationships were difficult:

*[T]hey weren't all pulling in the same direction, and they were very focussed around money.*

**4.295** The Panel was told that, from the very beginning of the work of the CCGs (April 2013), the CCGs raised and escalated significant concerns about the Trust to NHS England (NHSE). Maternity cases were raised as an issue at every Quality and Compliance Steering Group, from the very first one in 2013, and within the CCGs' written escalatory reports to NHSE every single month. However:

- The CCGs' professional challenge “*was met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge*”.
- “[Y]ou took a deep breath to have the conversations before you picked up the phone or you met with them.”

**4.296** A then newly appointed member of the Executive told the Panel of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

**4.297** The CCGs were escalating issues long before the CQC report in 2014; however, they found it difficult to gain recognition of their concerns. It was suggested to the Panel that the very people to whom the CCGs were escalating their concerns, particularly around maternity services, were the individuals who had previously commissioned those services. This meant that they didn't have fresh eyes, nor the same sense of the need for action. We were told:

*[W]e were escalating to people who had obviously done the same role as us, and had worked with the provider, and accepted that practice ... accepted that that was safe and hadn't escalated it, and now we were coming in saying that the same thing wasn't acceptable, so it was quite difficult politically to manage that situation ... we weren't getting anywhere through repeated escalation ... the lady who led the bomb-shell CQC inspection ... was instrumental in getting everybody on the same page.*

**4.298** Another CCG officer told the Panel that the key issue in 2013 was trying to get people to believe the CCGs' concerns. They couldn't be sure whether the problems at the Trust had been there for some time but had not been picked up (and the CCGs were able to identify them because they had the benefit of fresh eyes), or whether there had been a rapid deterioration just before the CCGs took over commissioning. They commented:

*[S]ome days you almost felt like you were going mad because ... it just felt like people would not listen ... we continually raised concerns at meetings like the Quality Surveillance Group.*

**4.299** The Panel was told that "getting everyone on the same page" was crucial because, prior to the CQC inspection and report in 2014, some people were saying that the Trust wasn't as bad as the CCGs were saying, and it was crucial for the commissioning of recovery plans for there to be a common understanding. We were told:

*[T]he Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 ... they would say it in public meetings, "we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be" ... they would narrate it ... over and over to try and make it become fact ... you then had NHSE saying, "yeah we haven't really got any specific issue" ... and then you had us ... shouting, "... they're not financially stable, their leadership is falling apart ... they're not a cohesive leadership team ... they're not safe from a clinical and patient safety perspective ... there are many gaps, and then they've got big cultural issues, huge cultural issues around their geographical base".*

**4.300** However, the Panel was told that, even after the 2014 CQC report was published, there was no acceptance at Board level that it was accurate until there were major changes at Executive level in the Trust. The appointments of new members of the Executive contributed to a more collaborative relationship.

**4.301** We heard that one of the things that the CCGs identified from the start in 2013 was that the Trust had a very high turnover of senior leaders in midwifery and lacked a Board lead for paediatrics. The Board lead for midwifery (the Chief Nurse) didn't have midwifery experience. The CCGs tried to work on these issues with NHSE.

**4.302** Another Trust-wide issue that the CCGs identified through maternity services was the Trust's approach to serious incidents and learning: how it learned from incidents, near misses and when things went wrong. The Trust's approach was described to us as very tokenistic and it did not use nationally recognised practice or national templates. The CCGs had a battle with the Trust over everything surrounding this issue; the Trust did not identify learning, root causes or relevant systemic contributory factors. There was also evidence of a blame culture that focused much more on midwifery than on obstetrics, and there was an expectation that engagement in serious incidents was more the responsibility of midwifery than obstetrics. However, we also heard that the CCGs believed that, although early reports were not very good

and poor recommendations were made, progress was made later and the quality of reports started to improve.

**4.303** A senior member of staff from the East Kent CCGs in 2018 told the Panel that their wider concerns about the Trust were in connection with:

- A large number of Never Events (safety incidents defined nationally as those that should never occur)
- A lack of learning from incidents and a failure to implement actions identified
- Cultural aspects such as a lack of challenge around serious incidents
- Long waits in A&E and poor-quality care
- Failures to follow up patients
- Concerns around medication doses
- Safeguarding and issues around security
- Infection control
- Poor communication with GPs
- A lack of proper processes for the supervision of staff
- Poor Friends and Family Test (patient experience) results
- Concern about the ability of the Trust to sustain a safe Intensive Therapy Unit service.

**4.304** The Panel heard that there were also overarching issues around leadership and the ability of leadership to get to grips with the concerns, culture (particularly in relation to staff not feeling able to challenge) and learning (much of what was happening had occurred previously and there was a failure to learn and to implement actions to prevent the same mistakes from happening again).

**4.305** A senior member of the CCG told the Panel that the CCG was concerned, as a commissioner, that the Board wasn't as informed as it could have been on some of the quality issues; there was awareness at committee level, but not once issues were escalated to Board level. This did seem to improve a bit as time went on; this appeared to be partly as a result of changes in leadership. There was also a worry about the number of issues that the leadership team was dealing with and its ability to get a grip on all the concerns: for example, the Medical Director, who had to contend with a challenged organisation across three sites, was also the Director of Infection Prevention and Control, and the CCGs had significant concerns about infection control.

**4.306** The Panel was told that, at the end of 2019, the CCGs reported that the Board's oversight of maternity services had been poor, but that the situation had started to change; however, there was more external scrutiny happening at this time, so this may have been a factor in the improvement. The new Chief Nurse and a new Head of Governance, both of whom started around June 2019, seemed to make concerns more visible. Within maternity services there was an increase in serious incident reporting, which the CCGs believed was evidence of an improved safety culture (people were more willing to report incidents), there were better systems and training around CTG monitoring, and there were better induction processes for locum doctors. These actions, together with the work of the new Director of Midwifery, provided the CCG with assurance that things were progressing.

**4.307** The CCGs raised concerns about leadership (including leadership capacity) with the Trust through discussions with the Medical Director and the Chief Nurse, in system oversight meetings and in the Quality Surveillance Group (QSG).

**4.308** CCG officers observed that WHH was hampered by recruitment difficulties and that the midwives and consultants were committed to doing their best for the women using maternity services (“*they’re good people, they’ve got good intentions*”), but the system did not support them – the scale of the challenges at the Trust was so big, and the churn in leadership didn’t help. The CCGs’ view was that there was also a tendency to seek to resolve problems by appointing new leaders and, when they failed, to see those leaders as the problem rather than the underlying issues.

## Care Quality Commission

**4.309** The Panel heard:

*[T]he relationship with CQC and the Trust was absolutely dreadful.*

**4.310** The 2014 CQC report identified a significant difference between the Board’s perception of how well the Trust was doing and what the CQC found on the ground, including the frustration of staff who described bullying behaviours and a fear of speaking out about things that were problematic. A senior CQC staff member who met with the Panel spoke of the importance of the freedom to speak up as part of a strong, positive safety culture that needed to be embraced more.

**4.311** A senior CQC staff member also commented that maternity services and the Trust in general had been stuck at “Requires Improvement” since 2014/15 and that the basic underpinning drivers of quality were not being addressed sufficiently to move the Trust forward to what would be regarded as “Good”. It was suggested that this was partly due to the failure to develop a model of care for the large geographical area of East Kent, which is relatively remote from major population centres, and the absence of a long-term strategic plan.

**4.312** We heard that, following the CQC report in 2014, the Trust Chief Executive had monthly meetings with Monitor that focused on Trust finances, the performance of A&E and the improvement plan. An Improvement Director was appointed.

**4.313** There was a CQC inspection of children’s and young people’s services at the end of 2018. This raised significant concerns, and the Trust was rated “Inadequate” overall. The CQC issued a Section 64 letter (under the Health and Social Care Act 2008, this requires trusts to provide specific documents and information) as the information provided by the Trust didn’t answer the CQC’s questions. The CQC was not assured and issued urgent conditions.

## Healthcare Safety Investigation Branch

**4.314** The first HSIB maternity investigation involving the Trust was in April 2018. We were told:

*The Trust was quickly branded an outlier as its referral rates were markedly higher than the trusts in the rest of the region.*

**4.315** We heard that HSIB had difficulties with its day-to-day operational relationship with the Trust. These included issues such as information requests, staff attending for interview, staff giving their consent to attend for interview and difficulty in getting support with this from the Trust’s senior leadership team. The Panel heard that the HSIB team had a “*very difficult reception from East Kent*”, despite its efforts to build good relationships: “*engaging with the governance team at East Kent would be difficult*”. This contrasted with other trusts. Consequently, HSIB investigations were delayed because the relationship wasn’t good from the outset. However, an HSIB investigator said that, when they were able to engage with more junior staff, these staff were open and honest.

**4.316** In 2018, engagement between HSIB and the Trust included preliminary recommendations from an HSIB review of ten ongoing HSIB investigations, visits to the Trust in October and November (including a presentation on HSIB's work) and a round-table meeting with the Trust in December. The meeting in December identified emerging patient safety themes, including neonatal resuscitation, documentation processes and escalation during care; these were followed up in a letter to the Trust. However, it was clear that the Trust *“did not want to engage with HSIB at all”*.

**4.317** The Panel heard that obstetricians did not attend any meetings with HSIB, although they were invited to do so. One HSIB investigator's assessment was that the obstetricians didn't want to engage in such discussions, rather than that they were excluded from doing so:

*In 2018, obstetricians didn't see incidents – especially those involving midwifery – as anything to do with them.*

**4.318** The Panel was told by officers within HSIB that, by the end of 2018 (following seven or eight months of input), HSIB was identifying themes associated with maternity incidents and it had concerns about East Kent maternity services. Its concerns included: failures of escalation; unsupported junior staff; problems with locum doctors and a lack of proper supervision and assessment; the level of neonatal deaths at QEQM; neonatal resuscitation; CTG interpretation; triage, management of reduced fetal movement and ultrasonography; and the home birth and midwifery-led care environment, including fetal monitoring. We heard that HSIB was confident that it had identified the right themes:

*[B]ut [HSIB] knew that they weren't being received very well at the Trust. The Trust was irritated with HSIB. It was as though the Trust thought that HSIB wasn't a regulator and what right did it have to be in the organisation, doing investigations and asking questions? East Kent wouldn't engage. By contrast, in other trusts, HSIB were being received openly, with a view to having a fresh set of eyes on the challenges.*

**4.319** There were several recurring themes in the cases that HSIB saw:

- **Escalation:** Recognising women and babies who were deteriorating, reporting this to more senior staff, and those more senior staff responding appropriately; there were also frequent problems with locum staff and how they were recruited.
- **Triage:** Particularly in relation to documentation. At times there was no record that calls from patients were made, who was taking the calls or what advice was being given to patients.
- **Neonatal resuscitation:** Concerns around the geography of the work (e.g. the location of resuscitation trolleys) and the impact on families (rather than concerns about the particular skills of individuals). There was no resuscitation trolley in A&E.

**4.320** These issues kept appearing, which indicated to HSIB that sustained change was not happening in response to issues being raised. As time passed, HSIB formed the view that these were longstanding issues. HSIB had three main concerns with East Kent maternity services:

- A high number of referrals in comparison with other trusts – the numbers dropped after the first year and the Trust saw this as an improvement, but when HSIB triangulated this with other information, it was clear that cases just weren't being referred
- Recurring themes – indicating that lessons were not being learned
- Patient safety concerns.

**4.321** By early 2019, there was still no improvement in the Trust’s engagement with HSIB, so matters were escalated to HSIB’s senior maternity team and the CQC. The Panel heard:

*[N]o changes were being made at East Kent. The Trust had still not returned HSIB’s initial roundtable letter, and the same patient safety themes were continuing to harm patients.*

**4.322** There was a meeting between HSIB and the Trust’s senior leadership team, including clinical leadership, in June 2019; the meeting was described as “very difficult”. By this time, the HSIB team had “grave concerns”. The HSIB team were not made to feel welcome by the Trust (they were kept waiting for 45 minutes in a corridor) and were greeted in an “incredibly aggressive” manner by the Trust representatives, with one commenting that “I don’t know why you are here” and that HSIB’s recommendations were “not needed”.

**4.323** There was a “heated discussion” about one of the maternal death cases. There was denial in the Trust about the enormity of the underlying problems and HSIB was not seeing evidence that actions were being taken to change things. An HSIB investigator noted: “It felt like the issues were being given lip service.”

**4.324** As a reflection of the level of concern within HSIB about the performance of East Kent maternity services, a letter was issued to the Trust CEO in August 2019 by Sandy Lewis, Associate Director of the Maternity Programme at HSIB. This was considered a highly unusual step. The letter stated:

*Given the gravity of the concerns raised and the lack of response to the issues raised, I consider that there may be a serious continuing risk to safety within your Trust.*

**4.325** The Panel heard that the Trust’s referral rate was 50% higher than that of other trusts with which HSIB was engaged at that time and HSIB was concerned about the recurrence of issues about which it had already made recommendations. HSIB thought that Trust staff “weren’t hearing them when they made recommendations”.

**4.326** HSIB set up quarterly meetings with the Trust from October 2019 for the purpose of monitoring improvements. At these meetings, overviews of national figures were provided together with common investigation themes. An HSIB investigator said:

*Sadly, these meetings once again highlighted that the patient safety themes at East Kent were not changing.*

**4.327** The approach to maternal and neonatal safety was described as “tick-box”: for example, following the introduction of safety huddles, poor escalation issues continued to arise, and the Trust’s reaction was that it had “already implemented a solution, so nothing more could be done to improve the situation”. However, several Trust staff stressed in their interviews with HSIB that the safety huddles were ineffective, as they were developed by senior leadership who did not understand experiences on the shop floor.

**4.328** The Panel was told that the Trust also struggled with having a safe space where people could discuss concerns.

**4.329** HSIB’s clinical oversight concerns revolved around the lack of engagement between midwives and obstetricians and junior staff:

*The two professional groups don’t function as one team. They are separate. There are, of course, individuals who work well together. The result of this is that the two groups don’t*

*provide effective safety for one another and mothers and babies. The communication between teams often leads to confrontation rather than reasoned discussion. They don't respect one another or have the confidence to challenge one another in a helpful and respectful way.*

**4.330** In addition, a senior HSIB investigator commented:

*The Trust board saw patient safety issues as problems with individual staff, rather than as part of their role to improve systems and learning. Patient harm was seen as the shortcoming of staff on the shop floor. There seems to be a great disconnect between the senior team and general staff.*

**4.331** An HSIB investigator told the Panel that there was a strong culture of “*pushing things under the carpet*” and not listening to staff who raised concerns. We were also told of a striking disconnect between staff on the ground and the management team.

**4.332** The investigator also commented that staff were not good at identifying their own problems. They stated that “*when they do look back they don't seem to be able to see what is glaringly obvious to others*”, and that the Trust had not maintained “*good, open, communicative*” relationships with families who had had bad outcomes, but that more recently this had improved.

**4.333** Reflecting on how investigation reports were communicated to the staff who were required to implement them, a midwife cited the example of HSIB reports; the reports were available in hard copy, on a shared drive and circulated by email, but it was demanding for staff to absorb this information while delivering their roles, and quite a challenge to become aware of all the recommendations. It was difficult for staff to understand the detail and significance of the information without making further enquiries, and there was so much going on that information was not always properly digested. In general, recommendations were not conveyed simply and there were no bite-sized chunks of information for staff to digest.

**4.334** While the number of referrals from East Kent maternity services had begun to decline and HSIB's relationship with the Trust to improve, Professor Walker explained that HSIB was still seeing “*some of the same problems coming through, particularly about support and staffing, their midwife led care services etc*”.

**4.335** The Panel heard that the Trust's 72 hour reports were “*very poor*”; they didn't go into detail and HSIB provided training to help improve the quality. However, the reports remained poor. Initially, the Trust would not share these reports with HSIB. The Trust challenged why HSIB would need them and said that “*they aren't there to help you with your investigation*”.

**4.336** HSIB still saw cases where women presented with symptoms that appeared to be an infection but were sent home without being seen by a senior person, only to return in a more serious state. Professor Walker commented that “*it is about proper assessment, risk assessment, escalation, and things like that ... but to be fair the numbers [became] less than they were*”.

**4.337** The most prominent HSIB themes in 2018/19 were guidance, escalation, fetal monitoring, documentation and birth environments. The themes in 2019/20 were guidance, escalation, fetal monitoring, staffing and general clinical oversight.

**4.338** Professor Walker told the Panel that, in the early years of HSIB (2018/19), it didn't know how to talk to other organisations. For example, HSIB was contacted by the CQC, which

enquired whether HSIB shared the CQC's concerns about the neonatal and paediatric services at the Trust. HSIB didn't know what information it was able to share and was anxious to maintain its independence. However, HSIB recognised that it had a duty to escalate concerns and found a way to do so without sharing case-specific facts.

## Nursing and Midwifery Council

**4.339** The Panel was told by Andrea Sutcliffe, the NMC's Chief Executive, that the NMC's involvement in either an individual case or a cluster of cases was dependent on the referrals that came through, which might be determined by lots of local factors. She told the Panel that, while many referrals might indicate a problem, it could be just as problematic if people weren't making referrals, because they weren't recognising problems and dealing with them. She added that, given the relatively small number of fitness to practise referrals made to the NMC, it was difficult to identify organisations with recurring problems. Referrals were affected by the leadership of organisations, and she thought that one of the issues with East Kent was the high turnover of Chief Nurses throughout the period.

**4.340** Ms Sutcliffe told the Panel that the NMC received some referrals around maternity incidents at East Kent: “[I]t was very much on an individual basis, and our analysis shows that quite a lot of these referrals were coming through from families.” In the case of baby Harry Richford, the family referral included four midwives and the NMC opened cases on a further three midwives as a consequence of that family referral. No referral was made by the Trust. Ms Sutcliffe commented:

*Perhaps we should regard the referral of a practitioner to a regulator by a family as failure of the system. If something has gone wrong, the organisation itself should be dealing with that and doing so in a way that gives confidence to the family that the issues are being addressed appropriately and if there are issues that are to do with fitness to practise of an individual, they should be confident that that individual will get that referral. Whereas what often happens is that we get referrals from families when they've already been let down locally and so we're all compounding loss and distress as a consequence of that.*

**4.341** Ms Sutcliffe told the Panel that:

*If people are scared of the regulator then they're not going to speak up when they should. They're not going to engage with our processes in a meaningful way when they should. One of the things we've been absolutely clear about is making sure that we are improving the fairness of those processes, looking at the context of what is happening and making sure that is fully and properly taken into account.*

**4.342** Ms Sutcliffe stressed the importance of regulators such as the NMC, GMC and CQC working together with trust organisations, to collaborate and share information, and to identify the indicators that might show that there is a problem. She told the Panel that the NMC set up its Employer Liaison Service in 2016 to feed back information to trusts, and to provide insight and support as well as helping in some of the training that they might need.

**4.343** While continuing to stress the difficulties for a regulator of individuals to identify systemic issues (red flags) based on individual referrals, and the difficulties in taking action, Ms Sutcliffe told the Panel:

*[I]t is probably fair to say that all of us, and the NMC is in and amongst that, could undoubtedly have done better in joining the dots earlier ... If I look back and think “what would we want to do differently now” we would want to have better collaboration.*

## General Medical Council

**4.344** A senior GMC interviewee confirmed to the Panel that its focus is on the fitness of individual clinicians to practise. However, it receives significant and comprehensive feedback from approximately 60,000 trainees each year, and there had been no mention within that feedback of any issues with maternity services at the Trust. The fitness to practise data did not point to there being an issue either.

**4.345** The Panel was told that the GMC gains information from its outreach function and the meetings with the Responsible Officer (RO) and Medical Director at trusts; these have been taking place since 2011/12. There are regular meetings to support ROs with fitness to practise issues and revalidation issues. As part of this work, the GMC has sought to address clinical leadership, which, it acknowledges, can be a difficult area for doctors.

**4.346** There are other sources of information, such as revalidation data and surveys of trainee doctors (national training survey data). The GMC established an internal mechanism called the Patient Safety Intelligence Forum that gathers information on organisations and can lead to action such as talking to other organisations, or to instigating enhanced monitoring within the GMC's education functions.

**4.347** We were told that the Trust was regarded within the GMC as a concern in general terms from around 2015, but not maternity services at that time. The longstanding challenges at East Kent were with recruitment and retention, the geography of the sites, and the use of locum doctors. However, the specific concerns about obstetrics and gynaecology were more recent. One GMC interviewee thought that they were not raised until early 2020, when the RO told the GMC about the CQC's and HSIB's involvement.

**4.348** We were told by GMC staff that the fitness to practise data have not been informative because they involve such a small number of referrals. Making better use of the data would depend on linking them with other sources, and the GMC told us that it had put a lot of effort into working more closely with other regulators in terms of data sharing. The interviewee also made the point that the GMC is aware that teamworking issues can have a significant impact on patient care.

**4.349** The Panel heard that information sharing has been challenging for the GMC, and is constrained by its precise legal powers.

**4.350** The Panel also heard of the difficulties in dealing with behavioural issues among doctors, as follows:

*[Within] healthcare regulation and oversight there are a myriad of organisations, and it can lack clarity as to who is doing what, and who is responsible for what ... it can be quite confusing, I think it is confusing for patients, and it can be confusing even amongst regulators – who precisely is doing what, and who is responsible for what? [The GMC is] responsible for individual doctors in terms of their fitness to practise and their revalidation etc., but where you are talking about lower-level behavioural issues, or cultural issues, or attitudinal issues that are not ideal, but you are not going to strike someone off, that can be a little bit tricky as to who is responsible for dealing with that.*

## Local Supervising Authority

**4.351** The Panel heard that when the first Morecambe Bay recommendations were starting to be known, the LSA Midwifery Officer (LSAMO) began a gap analysis against the emerging findings.

This continued throughout the year and included the need to make sure that supervision was clear and complemented the clinical governance processes of trusts.

**4.352** The first audit of the Trust carried out by the LSAMO was in 2012, and yearly thereafter. The Panel was told that the findings and recommendations of each audit were as follows:

- **2012:** The recommendations made by the LSA included better engagement with feedback from women (the Trust was not particularly strong on this at the time), ensuring one-to-one care in labour, and ensuring that meetings were held with individual midwives on an annual basis.
- **2013:** The LSA revised the supervisory audit to make it more specific to the standards and rules. The LSA also sought evidence prior to the audit – moving from a reassurance model to an assurance model. In looking at compliance with Birthrate Plus,<sup>§</sup> and at learning from incidents, there was a theme around disjointed supervision and clinical governance.
- **2014:** There was improved interface between governance and the supervisors of midwives, but there was still a need for more evidence. The LSAMO arranged an away day for the supervisors of midwives that was facilitated by the Trust and was centred on leadership and working towards improvements as a group. Around this time there was a lack of transparency within supervision generally (not limited to East Kent maternity services) and it was difficult to get people to say who had a problem and where the problem was. It was also a challenge to embed openness and transparency, and to share problems and issues so that improvements could be implemented and midwives could be supported in practice – this was what the teamwork was designed to address.
- **2015:** The audit showed that there was improved governance and that the Trust had a clear policy around governance – supervisors were reviewing all serious incidents. They still needed a little more evidence around this, but the situation was starting to improve. The LSA escalated to the lead CCG the need for a much clearer link between supervision and incidents; this escalation became part of the CQC action plan.
- **2016:** This was the final audit. The Trust was partially meeting most of the standards, but there was still work to be done to ensure that every midwife had an annual review and there were still some issues around making sure that governance was strengthened.

**4.353** The Panel was informed that, in 2017, when the LSA ceased supervision, the action plan was handed over to the Trust; the final recommendations and action plan were also shared with the lead CCG.

**4.354** The LSAMO told the Panel that they also provided education for supervisors of midwives and held monthly meetings so that good practice from the LSA's audits could be shared. Representatives of service users attended the meetings to provide information about the experiences of women who had used maternity services; this feedback looked positive for the Trust. However, the Panel heard that the supervisors of midwives would always comment about the birth environment, which was a longstanding issue for East Kent maternity services.

**4.355** In the LSA's view, governance was also an issue. During this period, the Trust failed to achieve Clinical Negligence Scheme for Trusts (CNST) Level 3 (the best level of rating of risk management in a trust). Governance is at the core of a safe service, and a governance review

<sup>§</sup> A tool to estimate the desirable level of midwifery staffing, taking into account the size and complexity of a maternity service.

had recently been completed by the Maternity Improvement Advisor (MIA), although this could have happened earlier, had it been possible to put feet on the ground.

**4.356** The Panel was also informed that a challenge of the LSAMO role was that they supervised a team of people within a trust but they had no formal management control, and the midwives only reported to the LSAMO through the statutory process. Other challenges included the length of time that investigations took and the fact that, although the outcome of any supervision investigation was shared with the trust involved, there was no reciprocal sharing of investigations by that trust, which would have provided greater context.

## NHS England/NHS Improvement

**4.357** A Trust Board and Executive member told the Panel that the Trust did not receive a great deal of support from NHSE&I.

**4.358** Another member of the Trust Board and Executive told the Panel:

*[T]rying to get the commissioners and NHSE&I to understand, as part of the clinical strategy, that the Trust could not continue to do loads of things in three places was a really long road.*

**4.359** We heard from a member of staff of a regulator that, as late as 2018/19, the safety structures within NHSE and NHSI (at that time two separate organisations) did not see the Trust as being a problem.

**4.360** The remainder of this section of the chapter (to paragraph 4.385) records the observations of NHSE&I representatives, including an account of actions undertaken by NHSE and NHSI.

**4.361** NHSE was alerted by HSIB about the lack of senior engagement in 2019. In response, an intelligence-sharing call was convened with NHS Resolution (NHSR), the CQC, HSIB and the CCGs, which identified the following issues:

- NHSR raised concerns about the Trust being an outlier for claims.
- The Richford family were concerned that the Trust wasn't meeting the requirements of NHSR and CNST. A whistle-blower had also raised concerns about adherence to CNST requirements.
- The CQC expressed frustration about the lack of information coming back to them.
- HSIB raised concerns about the number of cases being higher than the national average and about the "scattergun" nature of the response from the Trust, particularly in relation to the Harry Richford case. There was no evidence of lessons being learned and there were issues with the way in which the Trust was managing the relationship with the family.
- NHSE had concerns about reports from HSIB.
- The CCGs had concerns about how difficult it was to get information from the Trust, CTG monitoring, the multiple action plans, changes in Heads of Midwifery, and the Board not being sufficiently focused on maternity services. The lack of Board to ward oversight and the lack of escalation to the Trust Quality and Safety Committee and the Board were continuous themes.

**4.362** A single-item Quality Surveillance Meeting was subsequently held on 10 December 2019 at WHH. HSIB, the CCGs, the CQC, members of the Trust Executive and clinicians from

maternity and paediatrics services attended. HSIB presented its concerns and there was a long presentation from the Trust. We were told by a senior NHSE&I representative that:

*The trust seemed slightly defensive, as though they were trying to pretend there wasn't a problem. It also felt as though they were trying to do so much that they couldn't see the wood for the trees. They seemed to have difficulty honing-in on the issues highlighted by HSIB and on the cases and the learning from them.*

**4.363** After the meeting, there was further discussion among the partners. A senior NHSE&I representative told the Panel:

*They were concerned about the pace of change, given the long history of problems in the Trust. For example, there had been a lack of action following the RCOG report of 2015. There was a lack of assurance about the changes that were needed. They felt concerned about relationships in the leadership, particularly in relation to the medical director and clinical director roles. HSIB indicated that the head of midwifery had engaged well with them but that she was probably the only one. There was no senior involvement in oversight.*

**4.364** There was a concern about reporting lines between the Director of Midwifery and the Chief Nurse:

*There seemed to be a direct relationship between the director of midwifery and the chief executive, but where was the voice of nursing in that?*

**4.365** There were also concerns about whether the Trust was sufficiently focused on the issues that arose from the cases discussed at the meeting, such as escalation, CTG monitoring and fetal distress. It needed to step back and refocus on the key issues. The inquest into the death of baby Harry Richford was due in January 2020 and, as NHSE&I did not feel assured that the Trust had learned from the case, which had happened several years earlier, NHSE&I put some measures in place.

**4.366** NHSE&I instigated the Maternity Safety Support Programme (MSSP) and arranged support from the regional team for the Trust Medical Director, the Chief Nurse and the Head of Midwifery to help them with the governance challenges. Actions and events included the following:

- The inquest took place in January 2020.
- The independent review of maternity services was announced in February.
- NHR sought to recoup funding it had provided for CNST.
- The CQC did an unannounced inspection and produced findings.
- There was a joint relationship visit with the CQC.
- The Chief Midwifery Officer for NHSE&I and the Regional Chief Midwife visited the Trust at the end of January.
- There were meetings with the executive team.
- Additional external support was provided to the Trust, in the form of a former Head of Midwifery, a paediatrician, a neonatologist and an obstetrician.

**4.367** A QSG review meeting was held in February 2020; by that stage, the Trust was “*feeling under siege*”. There was also increasing press attention. NHSE&I set up weekly East Kent huddles involving the GMC, the NMC, Health Education England, NHSI, the CQC and HSIB to share intelligence, help coordinate the number of requests being made of the Trust and allow the

Trust to remain focused on improvement. It specifically asked for an overarching plan that would bring together in one place responses to the RCOG report, work on coroners' cases, the BESTT programme and other relevant issues. It also requested a review of the medical workload, especially in relation to the balance between obstetrics and gynaecology. The Trust was working on an improvement model, but maternity services were just one of the Trust's challenges. It was also dealing with the pandemic and several other issues that had escalated.

**4.368** The Panel heard from NHSE&I that trusts are often defensive under such circumstances, but that East Kent was particularly so. NHSE&I could see the lack of openness around the cases, and the Panel was told that the Board did not seem to be fully aware of the concerns about maternity services. The Trust wasn't open with stakeholders and providers either. We were told:

*It felt like that at all levels. There was a lack of openness with families, through to lack of openness with stakeholders such as the CCG. It felt as though they didn't always get the information they should have done from the Trust.*

**4.369** The Panel was told that the Trust didn't identify problems partly because it didn't know about them and partly because it didn't want to declare them. For example, the Harry Richford case caught the Executive off guard, until it reached escalation point in October 2019. The Panel heard that:

*Initially, when support was offered to the Trust, they were reluctant to accept it and it was as though they were trying to prove that there wasn't a problem. There was an acceptance issue. The region had to check regularly that the support was being used continuously.*

**4.370** In relation to dealing with inappropriate clinician behaviour, NHSE&I supported action in various ways:

*The new medical director was doing a good job and making an impact, but this was [their] first medical director role and [they] needed their help with it. One of the planks of the maternity safety support programme was to help with the relationship issues between midwives and obstetricians.*

**4.371** We heard that NHSE&I also provided support to paediatrics. NHSE&I split the paediatric and maternity leadership to enable maternity services to have enough bandwidth to deal with their issues.

**4.372** Throughout 2020, NHSE&I was concerned about how the Board was obtaining assurance about the experience of families and patients. It also had concerns about the governance of the organisation and some of the approaches to governance during the pandemic. NHSE&I's view was that the Trust had made some improvements, but the pace of change and oversight by non-executive directors were still concerns. Improvement directors were assigned to the organisation, to help with coordination of the various improvement activities, and Board advisers were provided. NHSE&I requested a rapid governance and leadership review of the organisation, which was done in the autumn. A regional director had fortnightly meetings with the organisation to provide enhanced oversight and to keep traction on the improvement programmes.

**4.373** In response to these measures, NHSE&I began to see some improvement in maternity and infection prevention and control issues. The Trust became more open, and we were told that the Medical Director began to contact the regional NHSE&I if there were any issues. The Trust became more receptive to help and support when things went wrong. However, NHSE&I remained concerned about the pace of change. For example, there was a case of maternal

death on New Year's Eve in 2020, and although the Trust reported it immediately, it didn't think that there were any issues of concern. Yet a few days later, NHSE&I received a letter from HSIB that identified several issues of concern:

*It seemed that depth of understanding and the ability to identify issues hadn't embedded yet. They had made a few steps forward, but it was not enough, and the pace of change remained a significant concern.*

**4.374** NHSE&I was concerned about the effectiveness of Board scrutiny, particularly via the Trust Quality and Safety Committee. Ward to Board escalation wasn't really happening:

*On paper, the governance structure looked fit for purpose but under the surface, there were issues with people's understanding of the governance system and escalation. There was no common approach to safety across the organisation and there were issues around clarity of roles – especially between clinical roles at executive level.*

**4.375** The lack of escalation of these issues was attributed by NHSE&I to an ineffective governance mechanism and a lack of openness, which was apparent in incident reports. The culture of openness and learning had not fully embedded in the Trust and a fear of blame partly accounted for that, although NHSE&I had not seen any actual evidence of this.

**4.376** In relation to governance structures and escalation in the Trust, there was concern about the strength of Board papers and the depth of information that went to Board committees:

*Things might have been reported but may not have been in enough depth for oversight and scrutiny.*

**4.377** There was also concern about non-executive directors' scrutiny of papers in the Trust:

*They asked lots of questions but that might have made it difficult to be open when things went wrong.*

**4.378** The Trust had gone through a restructure of care groups and NHSE&I had concerns about the strength of leadership in the maternity care group and concerns about what the different committees did:

*There were a lot of sub-groups in maternity and [we] questioned their effectiveness as an eye into the organisation. Also, the fact that the same people were on different groups didn't necessarily make for a robust process.*

**4.379** A maternity improvement group was set up; NHSE&I told us it had made sure that it included someone from the CCGs and two representatives from NHSE&I to help them gain assurance and to act as critical friends.

**4.380** NHSE&I had several concerns about nursing and midwifery in the Trust, including about nursing leadership on matters such as safeguarding and the Trust's ability to make progress on some of the issues in nursing and midwifery. NHSE&I was also concerned about:

*... the relationship with the director of midwifery and where the executive clinical nursing role fed into that.*

**4.381** Based on many interactions with the Trust, there was a concern about some of the responses of the nursing leadership and its presence in the organisation. NHSE&I provided

support to the leadership, particularly to the Head of Midwifery. The NMC conducted a review to check if nurses and midwives were being referred from East Kent maternity services, and the CQC expressed concerns about midwives.

**4.382** One thing that was heard from staff was the following point:

*[D]espite the challenges, everybody was coming to work every day to do a really good job. There was something about how you balance what are really difficult stories for women, for their families, really difficult incidents, some of them quite historical, with the ability to celebrate the small success and incremental change. It didn't feel as though the Trust had that balance quite right. There was also a need to ensure that staff were briefed in order to support them with tricky conversations or queries from women who may be concerned at the quality of care from adverse media coverage.*

**4.383** The role of the NHSE&I Regional Chief Midwife for the South East was created in April 2020 to offer informal support to the Trust's Head of Midwifery on an ad hoc basis, mainly through the MSSP and meetings with the MIA on a weekly basis. The MIA relationship was key – they were there to support the Head of Midwifery, be a critical friend, and help them develop and work through the improvement plans.

**4.384** The MSSP first went into the Trust as an action arising from the “Single Item” QSG in December 2019. A team went in to carry out a diagnostic assessment and the midwife lead for that team, along with an obstetrician, provided a report. There was also ongoing feedback and support. However, the pandemic hit and the MIA who carried out the diagnostic assessment was called back to their own organisation. Another MIA was sourced, commencing work in April 2020.

**4.385** The feedback to the Regional Chief Midwife about the Trust at that time was that there was improvement although the pace was slow. The principal output from the “Single Item” QSG concerned consultant cover; in response, the Trust was introducing 24-hour support at WHH and improving how cover was provided at QEQM. There was also work around CTG monitoring, and around the aggregated action plan (linking to the Trust's Improvement Director).

## Improvement initiatives and programmes

**4.386** The Panel was told of improvements beginning in 2018 through the BESTT programme, including strengthened governance (midwife governance leads), the appointment of bereavement midwives, improved fetal monitoring, an improved dashboard, and the achievement of 100% one-to-one care.

**4.387** Referring to the BESTT programme, the Panel was told:

*[S]taff really engaged in it and were keen to be part of the change. By 2018, there were improvements in recruitment. People wanted to work at the trust and at interview, applicants were citing BESTT as a reason why they wanted to work in the trust's maternity services. They noted a big improvement in the trust's reputation on the recruitment front, and students who had trained elsewhere wanted to work there. There were significant improvements in staff survey results and staff felt more supported in engaging in improvement activities.*

**4.388** Professor Walker from HSIB told the Panel that one of the problems for trusts is the multiplicity of recommendations that have originated from all over the place, and some of the recommendations disagree with each other:

*They're getting big hammers coming in and there are too many cooks ... The problem is that I'm not sure that their structures and their management structures are in place to encompass that and help the staff achieve that. I'm not sure if some of the changes they've brought in are achieving it ... I wasn't convinced that they were on the right track. There're lots of people doing things and committees doing things and people with oversight of things, but I'm not sure that the people on the ground floor are being encouraged to say, "yes you are good, you can be better, let's see how we can do this" ... I don't think the solutions are difficult. I think they're just fundamental and at grassroots level, like "let's build this up, let's build the teams, let's build their confidence, let's build the team working, the support". It's really from the bottom up that you want it, not from the top down.*

**4.389** An experienced midwife told the Panel:

*You have to ask yourself, why is it that despite feedback after incidents, complaints, legal claims, despite the robust training programmes that you have in place, do behaviours not change? Why are we still seeing the same themes coming up, not just in one Trust but across the country?*

**4.390** The Panel was told by Professor Walker of his reaction to the focus on specific hospital trusts:

*We've got to stop mentioning hospital names ... this is a maternity problem and we've got to take ownership of it throughout the maternity system. That doesn't mean every hospital is bad, but ... I think every hospital has got problems and I think we should be looking at that in a global way ... But I think we need to rethink how we disseminate information, and particularly how we train and implement change.*

This chapter has explained that, alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at the Trust and with others whose work brought them into contact with the Trust's maternity and neonatal services; and that this was a key part of the Investigation. We would like to thank everyone who was interviewed for their willingness to share their experience with the Panel for the purpose of this Investigation.

It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking or conclusions.



# Chapter 5: How the Trust acted and the engagement of regulators

This chapter gives an account of how East Kent Hospitals University NHS Foundation Trust (the Trust) considered maternity and neonatal services and engaged with regulators and others. It draws upon documents and other information that the Investigation has received from the Trust and from organisations and individuals with whom it has engaged.

We refer throughout to the Board of Directors as “the Trust Board” or “the Board”.

This chapter sets out how the Trust conducted itself as reflected in its own documents. Nothing included in this chapter should be taken as expressing the Investigation’s own findings, except where explicitly stated: its findings are set out in Chapter 1 of this Report.

## How the Trust managed maternity and neonatal services

**5.1** The Board of the newly constituted East Kent Hospitals University NHS Foundation Trust met for the first time on 2 March 2009. This was the day it received its authorisation as a Foundation Trust.

**5.2** As a Foundation Trust, the Trust enjoyed greater freedoms than a non-Foundation Trust, including more financial autonomy. The Trust’s Chair and Chief Executive, in their foreword to the 2008/09 Annual Report, said:

*[W]e now have much greater involvement in our decision-making from local people, including patients and staff, through a new 32-strong Council of Governors, mostly elected by a membership that now exceeds 13,000. Being granted Foundation Trust status is recognition of the standards that have been achieved by the organisation through the expertise, hard work and dedication of our staff. We are now awarded greater freedom to govern ourselves in a way that is responsive and flexible to the changing needs of the people we serve, while continuing to ensure that healthcare is provided in a safe, effective and efficient manner.<sup>1</sup>*

**5.3** The Trust Board met for a second time on 27 March 2009. In neither of these inaugural meetings did the Board agenda include consideration of maternity or neonatal services, nor have we seen any reference to them in the papers circulated for those meetings. It is clear from the Annual Report that the Trust was focusing its attention on national priorities, which at that time included waiting times, coronary heart disease and cancer, but not maternity services.

**5.4** From the material seen by the Investigation, the first substantive reference to maternity services at the Trust was at the Board meeting on 28 August 2009. At that meeting, the Deputy Director of Nursing introduced a Serious Untoward Incident (SUI) report. Particular reference was made to the changes in reporting maternity cases to the Strategic Executive Information System (StEIS), which is supposed to capture all serious incidents; this had resulted in an

increase in the number of maternity cases on the system. As a result, it had been agreed with the Eastern and Coastal Kent Primary Care Trust (PCT) that from July 2009 only cases where concerns with practice had been raised would be recorded on StEIS. The meeting also noted that neonatal deaths were being monitored by the Trust's Audit Committee and that no formal report was required by the Board.

## Internal review and report, 2010

**5.5** 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. They reported that the Trust's internal monitoring process had highlighted an increase between April and August 2010 in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. They reported that an internal investigation involving a review of medical notes had commenced to establish the facts, and a formal report of findings would be brought to the Board in October 2010. They added that the PCT would be involved throughout the investigation and external midwifery support was also being sought. The Medical Director went on to report that external midwifery support had immediately been put in place at the William Harvey Hospital in Ashford (WHH) due to a concern regarding a potential decrease in skill mix at this unit, which would unfortunately have an adverse effect on other units. This was intended to be a temporary measure and would be reviewed once the internal investigation had ended. Monitor and the Care Quality Commission (CQC) had also been informed.

**5.6** At its meeting on 27 October 2010, the Trust Board received a confidential interim report. The report stated that *"during Q1 a higher than expected term admission rate to NICU/SCBU [neonatal intensive care unit/special care baby unit] was noted and discussed at the perinatal mortality and morbidity meeting in July. No themes or common factors were identified."* It went on to state that *"concern was raised about midwifery staffing levels at WHH and a 'risk alert' was circulated to midwifery staff"*, and that:

*... a decision was made to enhance midwifery levels at WHH pending the outcome of an internal review and to do so to close the Buckland Hospital [Dover] birthing unit to births to increase staffing levels at WHH. This was communicated as a SUI and both CQC and Monitor informed.*

**5.7** The interim report also stated that it *"does not enable any final conclusions as to the standard of care offered at this stage although a number of trends have emerged which largely reflect recognized risk factors for HIE"*. These were that *"46% of babies were born 'through' meconium stained liquor; 53% of mothers were either overweight or obese; 26% of babies showed signs of growth restriction (birth weight < 10th centile)"* and that *"to date 'no suboptimal' or 'minor suboptimal' care has been recorded in over 85% of cases"*.

**5.8** The 2010 internal review examined the antepartum management of 91 babies who had an unexplained admission to the NICU or SCBU within the Trust between January and September 2010. In 40% of the cases reviewed, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to have been a relevant factor in the outcome. Of the 91 babies reviewed, there were 16 perinatal deaths, and significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the review describes as *"long-term handicap"*, and significant suboptimal care was identified in three of those cases.

**5.9** More broadly, the review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of shortage of oxygen. The report identified a number of themes, many of which are recurring issues in the reports, inspections and findings that took place between 2010 and 2020.

**5.10** The report noted areas of commendable practice, including the prompt and effective response to potential or actual obstetric emergency situations.

**5.11** In summarising its findings, the report addressed staffing issues and recommended an urgent review of midwifery staffing at the WHH site. It noted that midwives faced *“the challenge of caring for more than one high risk labouring woman at any one time”*, and that *“an informal poll of trusts in the South Thames region has revealed that staffing/patient ratios in EKHUFT [the Trust] are amongst the lowest in the region”*.

**5.12** The report also noted that, where the review team identified areas of suboptimal practice, the staff involved received a letter advising them to address that area of their practice, which was copied to their supervisor. While there was a robust arrangement in place within the midwifery profession to learn from incidents and address areas of practice, the report noted that *“arrangements for medical staff are less robust and this will be reviewed”*.

**5.13** The report included recommendations such as reminding staff to practise within guidelines, improving diagnosis of labour in low-risk settings, improving standards in fetal monitoring, reviewing clinical guidance and resuscitation arrangements where meconium is present, reviewing the process by which medical staff of all grades learn from adverse events, and reviewing the process of escalating concerns about the progress of labour to more senior staff on call.

**5.14** The Medical Director introduced the final report of the neonatal admissions review at the Board meeting on 22 December 2010. They highlighted that there were concerns about midwifery and obstetric management and that *“midwifery staffing levels may limit the provision of safe care across obstetric birthing sites in East Kent”*. It should be noted that at this point in time there were four geographically separate maternity units: WHH, the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM), Canterbury and Dover. This is what was deemed unsustainable, hence the relocation of the two standalone Midwifery-Led Units (MLUs) to be located alongside the obstetric units at WHH and QEQM. In response to a question from a non-executive director raising concerns about 40% of cases having suboptimal care, the Medical Director stated that *“this represented 1.9% of total births”* and that the Trust had not been identified as an outlier in national perinatal statistics.

**5.15** The Trust Board was asked to note the recommendation that one standalone MLU remain closed until May 2011 while an urgent review of minimum midwifery staffing levels was carried out. An action plan resulting from this review would be presented to the Board.

**5.16** The Assistant Head of Midwifery and the Clinical Director for Women’s Health presented the action plan at the Trust Board meeting on 28 January 2011. The Clinical Director for Women’s Health emphasised that *“the Trust was operating a safe staff to patient ratio”*. The Board formally noted the action plan.

## Report to Monitor and review of maternity services

**5.17** Monitor was responsible between 2004 and 2016 (when it became part of NHS Improvement (NHSI)) for authorising, monitoring and regulating NHS Foundation Trusts.

In January 2011, Monitor received an update on the maternity serious incident report described above. This stated that, in response to the findings of the report, the Trust was implementing changes to midwifery and obstetric practice. The Trust also recognised potential concerns with activity and midwifery staffing levels at the high-risk obstetric units.

**5.18** The report to Monitor noted that, in view of these concerns, the Trust was carrying out further analysis of midwifery staffing levels at WHH and had embarked upon a review of maternity services across East Kent with the PCT, to be completed by May 2011. Until the outcome of this review was known, the Board had agreed to the closure to births of the MLU in Canterbury, while maintaining daytime services. The Board had also agreed to the reopening to births of the MLU in Dover, which had been closed in September 2010. The Trust maintained that these restrictions enabled the maintenance of enhanced midwifery staffing levels at the high-risk obstetric unit at WHH.

**5.19** At the Trust Board meeting on 28 January 2011, the Medical Director reported that they had recently met with staff from the PCT who were carrying out the review of midwifery staffing levels. They referred to the need to inform the local authority's Health Overview and Scrutiny Committee of progress.

**5.20** There was no further discussion of maternity services at the Trust Board until 24 June 2011, when a review of the configuration of maternity services was discussed. The review stated that it was the Trust's ambition to "provide 1:1 midwifery care in active labour corresponding to a midwife to birth ratio of 1:28 at all birth units in line with 'Safer Childbirth' recommendations".<sup>2</sup> The average ratio at WHH was 1:40, while at QEQM it was 1:35.

**5.21** The options for consultation were discussed at the Board's meeting on 26 August 2011, where the recommendation was made to the Trust Board that:

*[T]he most sustainable option would be to maintain all services except births and step-down postnatal care at both Dover and Canterbury. This will enable a midwife to birth ratio at Queen Elizabeth the Queen Mother hospital (QEQM) and WHH of 1:28 and will enable the QEQM co-located Midwifery Led Unit (MLU) to be opened.*

This was recorded on the leaflet circulated for consultation as "Stop births at Dover and Canterbury centres but retain midwife-led antenatal care, day clinics and postnatal support. Open the new midwife-led service at Margate. Increase staffing levels to provide one-to-one care for all mothers." The Board agreed and consultation commenced on 14 October 2011.

**5.22** After consultation, the preferred option was discussed and agreed at the Trust Board meeting on 27 April 2012. In discussion, the Assistant Head of Midwifery stressed that current services were not unsafe. They said that the driver behind the review was to ensure that services were equitable across the Trust, with all women receiving one-to-one care during labour. The Board agreed to the implementation of the preferred option. Although the issue of equitable provision across the Trust was reasonable and clearly dominated the Trust's response, it overlooked the accumulating evidence that there was more to the safety issues than that – in particular, the longstanding cultural problems subsequently described.

**5.23** The Trust Board returned to the issue of maternity services on 26 October 2012, when they were featured in its regular "Patient Story" item. This focused on a positive story within maternity services at WHH: 24-hour visiting for patients and more male toilets. It was noted that the Trust had successfully recruited all the midwives who had completed their training at WHH.

**5.24** There was no further reference to maternity services until the Trust Board meeting on 30 January 2014, when (under the “Questions from the Public” item) a Trust Governor referred to the Clinical Quality and Patient Safety Report (a Board paper) and the increase in incidents reported to be related to staffing levels. The Governor referred in particular to the Singleton Unit, an MLU at WHH which was fully staffed but reported 18 incidents related to staffing levels. The Chief Nurse agreed to find out the detail behind these incidents and to contact the Governor outside of the Board meeting.

**5.25** The Trust Board returned to this theme at its meeting on 28 February 2014, when (again in the “Questions from the Public” item) it was reported that the trend of an increase in staffing incidents recorded had continued since January; this was due to a combination of sickness levels and maternity leave. The recruitment of 14 midwives was under way and the Trust was working through Human Resources (HR) to understand and address the underlying causes of the sickness levels.

**5.26** The Canterbury and Coastal Clinical Commissioning Group (CCG) noted at its March 2014 Quality Performance Meeting that it was concerned about maternity services at the Trust. The CQC visited the Trust in the same month and rated it “Inadequate”, with maternity services rated as “Requires Improvement”, although the CQC report was not published until 13 August 2014.

**5.27** In April 2014, the Local Supervising Authority (LSA),\* then a designated function of NHS England (NHSE), commissioned a maternal death review, with a panel of clinicians responsible for the care of women during pregnancy and childbirth. The review considered six maternal deaths that occurred in Kent and Medway during the year from April 2012 to March 2013, *“in order to determine whether learning from these tragedies could help improve the future delivery of care”*.<sup>3</sup>

**5.28** Quality Surveillance Groups (QSGs) were established by the NHS Commissioning Board (the predecessor to NHSE) in 2013. The intention was for local QSGs to be engaged in surveillance of quality at a local level, with the help of those closest to the detail and most aware of concerns. The members considered information and intelligence but also took coordinated action to mitigate quality failure. The meetings were chaired by the NHS Commissioning Board Area Director, Nursing Director and Medical Director.

## Care Quality Commission report, 2014

**5.29** The CQC published its findings on 13 August 2014. The overall rating for the Trust was “Inadequate”, with findings that it was inadequate in providing safe care and being well led, and that it required improvement to deliver effective and responsive services. Some of the key findings from the CQC were the following:

- There was a concerning divide between senior management and frontline staff.
- The governance assurance process and the papers received by the Board did not reflect the CQC’s findings on the ground.
- The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years, reflecting behaviours such as bullying and harassment (staff engagement was among the worst 20% when compared with other similar trusts).

\* LSAs were accountable to the Nursing and Midwifery Council (NMC), though their midwifery officers were employed elsewhere, latterly by NHSE. LSAs were responsible for producing supervisory audits of maternity services to ensure the provision of safe and high-quality midwifery care. They ceased to perform this function in 2017.

- Staff had contacted the CQC directly on numerous occasions prior to, during and since their inspections to raise serious concerns about the care being delivered and the culture of the organisation.
- Patient safety incidents were not always identified and reported, and staff use of the incident reporting system varied considerably across the Trust.
- The CQC saw limited evidence of how clinical audit was used to provide and improve patient care and saw examples of where audits had not been undertaken effectively and provided false assurance.
- The CQC found examples of poorly maintained buildings and equipment, and in some cases equipment that was not adequately maintained and was out of date and unsafe.

**5.30** Maternity services were given the rating “Requires Improvement”.

**5.31** The findings of the 2014 CQC report identified a significant difference between the Board’s perception of how well the Trust was doing and the experiences of the staff, who described bullying behaviours and a fear of speaking out about things that were problematic. In response to the report, the reaction of the Trust was one of real defensiveness and disbelief.

**5.32** The improvement plan for the CQC (which embedded maternity services within it) was reported and discussed at Board level. However, the Board rarely dived into the detail of maternity and neonatal services, and its response was more about monitoring progress against the overall improvement plan (of which maternity and neonatal services were just a part).

**5.33** There was a clear disconnect between ward and Board and a perception among midwives that their views were blocked and not escalated appropriately due to “gatekeeping”. Governance structures within the Trust were not sufficiently robust to allow ward to Board assurance, and the Trust was not willing or able to actively look for problems and issues to solve, but rather waited for them to be pointed out. The Trust needed to be problem sensing rather than comfort seeking in its approach.

**5.34** Maternity services featured very little in Board discussions, despite the concerns that had been raised. Maternity services also did not feature consistently within governance sessions, and there was rarely detailed discussion about maternity and neonatal services at Board level. Issues became diluted, and their significance was not recognised as they were reported up through the chain and repeatedly summarised.

**5.35** It remains a concern that a number of themes identified in the 2014 CQC report and in reviews since then have appeared during this Investigation. By way of example:

- At the time of the CQC’s initial investigations, staff commented that they were still unable to raise concerns due to the culture at the Trust. The Investigation has heard repeatedly that there was little or insufficient response when concerns were raised by staff.
- Policies were reported as being out of date long after the CQC’s initial inspection.
- Lack of support with training has been an ongoing issue (for example, staff being told off for asking questions), and some departments have only recently been requested to participate in formalised training.
- Bullying and harassment remain a significant concern of staff, with some stating that they continue to be negatively impacted as a result of raising a complaint. The suppression of dissent or complaints appears to be an ongoing issue.

- The CQC report identified staffing as an issue across all three sites (Ashford, Margate and Canterbury).

## Follow-up to Care Quality Commission inspection, 2014

**5.36** Maternity services were discussed again at the 26 September 2014 Trust Board meeting under the “Patient Story” item. The Chief Nurse presented a report which described the experience of a couple during the birth of their first child. The report highlighted the following issues: privacy and dignity not being maintained; a lack of information provided; unprofessional behaviour of some staff; and poor pain control. Since the concerns had been raised with the Trust, the couple had met with the matron and specific actions had been put in place. The Chief Nurse reported that this was not an isolated incident. Matrons and the Head of Midwifery would undertake improvements across all teams.

**5.37** In discussion, one of the non-executive directors asked for assurance that there was sufficient resource available to embed the actions and learning highlighted in the “Patient Story”. The Chief Nurse stated that staff listening events held following a CQC inspection had enabled staff to discuss their experiences positively. The Chief Nurse added that there were historic cultural and leadership issues which needed to be addressed.

**5.38** In October 2014, the regional QSG received a report on the maternal death review and current maternity risks from the LSA. The report identified the following causes for concern: no regional maternity lead in place, which was impacting on the Trust’s ability to focus on improvement, and a shortage in midwifery leadership.

**5.39** The CCG reported in November 2014 that it was taking action following the CQC inspection. The local CCGs had been meeting with the Trust to gain assurance around both its progress in recruitment and its current birth to midwife ratios. The CCGs were working with the Trust to agree a new approach for holding the Trust to account for the quality of its maternity services, and would be implementing a revised maternity dashboard (a summary of maternity statistics) from the Clinical Network once published.

**5.40** In January 2015, an East Kent Maternity Patient Safety Forum was established, following recommendations from the maternal death review.

## Bullying and inappropriate behaviour within the Trust and maternity services

**5.41** The very significant adverse impact of bullying and harassment, particularly at WHH, was referred to by many staff with whom the Investigation has spoken.

**5.42** The 2013 national NHS staff survey recorded that staff engagement at the Trust was in the lowest 20% nationally. The percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months (at 31% against a national average of 24%) was one of the Trust’s bottom five ranking scores, and it was identified within the survey report as a starting point for local action.

**5.43** The position markedly deteriorated the following year (2014), when the national NHS staff survey recorded that the percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months had increased to 42% (against

a national average of 23%). Overall staff engagement also deteriorated in 2014 and was again in the lowest 20% nationally. The percentage for staff harassment, bullying and abuse was identified again as one of the Trust's bottom five ranking scores, and again the survey report recommended action.

**5.44** The 2014 CQC report published on 13 August 2014 (reflecting CQC inspection visits in March 2014) also identified bullying and harassment within the Trust as a key finding.

**5.45** This Report has already referred (in paragraph 1.87) to an anonymous letter sent to the Chief Nurse on 27 October 2014 from a member of staff within maternity services at WHH, which said:

*I work on maternity at the William Harvey. I'm ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people ... Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It's ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity ... you need to know that at times the unit is an awful place to be.*

**5.46** In response to the issues of bullying and harassment raised within the national NHS staff surveys, the 2014 CQC report, the anonymous letter to the Chief Nurse and the concerns of the newly appointed Head of Midwifery (appointed on 1 July 2014), an investigation, led by the new Head of Midwifery and supported by HR, was opened to find out how it felt to work within the Trust's maternity services.

**5.47** On 19 November 2014, following interviews with 30 staff, an interim report was provided to the Chief Nurse and Director of HR by a member of staff from the HR Business Partner (Specialist Services Division). The interim report included an account of the following behaviours and issues:

- Prickly, sharp, abrupt and sarcastic senior staff
- Instances of staff being shouted at, criticised and humiliated in front of others
- A daunting and unsupportive environment, with one person describing how they were frightened to attend work
- Staff feeling intimidated and undermined in front of patients, resulting in a loss of confidence and time off work with depression
- Allegations of racism.

**5.48** The delivery of the report on 19 November 2014 prompted a meeting later that day between the Head of Midwifery, the Chief Nurse and others, in the course of which the Head of Midwifery was sufficiently concerned to express the view that maternity services at WHH were not safe for patients and should be closed.

**5.49** In the event, maternity services were not closed, and the investigation continued. Some 110 members of staff were interviewed in November and December 2014, and just over half reported that they had experienced unsupportive behaviour while working in the Trust's maternity services.

**5.50** On 6 February 2015, a consultant obstetrician and gynaecologist wrote to the CQC raising concerns. They had previously worked for the Trust but left because of "a downward spiral of staff morale following poor leadership".

**5.51** Following this, the Trust management team received a letter dated 9 February 2015. The Trust has redacted the name of the writer, who stated:

*I am writing to you on behalf of the midwives and their support staff at the William Harvey Hospital. Following a recent Supervisors Surgery staff have expressed their concerns and distress at the current working environment. I felt this needed to be brought to your attention before the situation deteriorates. The unanimous recommendations from the discussion at the supervisory surgery were: that the concerns stated needed to be escalated; that we should ask for a management meeting with the [names redacted] and Human Resources.*

**5.52** The writer made a number of requests in the letter, including: *“Improved communication, where staff are listened to and heard with democratic decisions being made for the greater good rather than being dictated to.”* The Trust responded on 16 February: *“It has been decided to accept your letter as a raising concern and take forward in accordance with the Raising Concerns Policy and Procedure, a copy of which is provided for your information.”*

**5.53** On 29 December 2015, a Report Into Raising Concerns was sent to the relevant maternity staff identified in the letter of 9 February.

**5.54** Further concerns were raised with the CQC on 23 March 2015, when a midwife rang to say that, following an incident at the hospital, which they described as an *“error of judgement”* on their part, they felt that they had been bullied and victimised as a consequence, in contrast to the Trust’s response to more serious incidents involving other staff. They said that they and their colleagues felt there was a culture of bullying at the Trust, that staff were afraid to raise concerns for fear of reprisal, and that such pressures were putting their ability to provide quality care in jeopardy.

**5.55** The midwife said that, following the incident involving themselves, they had been redeployed in a similar role at QEQM; however, they said this was clearly a *“punishment”* for what they had done, even though their actions had not resulted in an SUI. The midwife added that they were in communication with the NMC in relation to their current issues and stated that it had told them that, based on their evidence, the hospital management did not appear to know what it was doing. The NMC can find no communication relating to this matter.

**5.56** In March 2015, the Royal College of Midwives’ Regional Officer lodged a collective grievance on behalf of midwives at the Trust. The Trust has informed us that 51 staff signed this letter on 11 March 2015.

**5.57** While the 2014 CQC inspection mainly focused on bullying and inappropriate behaviours within midwifery, these problems were not limited to that professional group. In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to carry out a review and to report on a number of behavioural and performance issues, which included concerns about relationships between midwives and obstetricians (see paragraphs 5.77–5.98).

## ***The Report of the Morecambe Bay Investigation, 2015***

**5.58** *The Report of the Morecambe Bay Investigation* into serious incidents in the maternity department at the University Hospitals of Morecambe Bay NHS Foundation Trust was published in early 2015. It found that the origin of the problems at the Trust lay in the seriously dysfunctional nature of its maternity service, where the following issues were identified:

- Clinical competence was substandard, with deficient skills and knowledge.
- Working relationships were extremely poor, particularly between different staff groups such as obstetricians, paediatricians and midwives.
- There was a growing move among midwives to pursue normal childbirth “*at any cost*”.<sup>4</sup>
- There were failures of risk assessment and care planning that resulted in inappropriate and unsafe care.
- The response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

**5.59** Of particular concern is the fact that, through the spring of 2015, the Head of Midwifery at the Trust had noted the issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership, but they were not listened to.

**5.60** The Head of Midwifery produced a risk assessment dated 11 May 2015 which stated that “*similarities exist between the dysfunctional elements of the Morecombe Bay O&G [obstetrics and gynaecology] / Maternity Services MDT [multi-disciplinary team] and those within the same department at East Kent Hospitals*”.<sup>5</sup> The risk assessment went on to identify the following areas of risk:

- Poor clinical competence
- Insufficient recognition of risk
- Poor teamworking
- Inadequate clinical governance systems
- Poor-quality investigations – both internal investigations and those undertaken by supervisors of midwives
- Denial of problems
- Rejection of criticism
- Strong group mentality – “*musketees*”
- Distortion of truth
- Model answers
- Disappearance of records
- Conflict of roles.<sup>6</sup>

**5.61** The risk assessment also noted that “*there were several missed opportunities in dealing with the issues at MB [Morecambe Bay] and it is questionable if a similar external review occurred here in EKHUFT [the Trust] Maternity Services whether similar missed opportunities would be uncovered*”.

**5.62** The risk assessment produced by the Head of Midwifery scored the risk at the Trust as “*Extreme Risk – immediate action required*”.

**5.63** The risk assessment was presented at a governance meeting on 12 May 2015, and the Head of Midwifery was due to present their assessment to a wider audience at an away day on 21 May 2015. However, this presentation did not take place.

## Further concerns, 2015

**5.64** Meanwhile, following the April 2015 regional QSG meeting, a conference call was held on 1 May 2015 between relevant stakeholders to discuss a paper that had been presented by the LSA Midwifery Officer (NHSE South). This identified the Trust as an outlier for maternity-related SUIs in 2014/15 and detailed concerns regarding the Trust's maternity performance: namely eight unexpected admissions to the NICU, two unplanned admissions to the Intensive Therapy Unit (ITU), two neonatal deaths and suboptimal care.

**5.65** The intelligence-sharing call agreed that a “deep dive” into maternity services relating to these SUIs should be undertaken by external reviewers. NHSE helped to draw up the Terms of Reference (ToR) for this, and also identified the external clinical reviewers. The Canterbury and Coastal CCG agreed to take the lead. The review was planned to take place before the August CQC visit and the ToR constructed so live learning could take place. A letter from the CCGs to the Trust dated 3 June 2015 confirmed the ToR for an investigation into the management of serious incidents at the Trust.

**5.66** The CCGs informed the June 2015 Kent and Medway QSG that the review was planned to take place during July. However, at the end of July the Trust advised NHSE that the “deep dive” was to be incorporated into a wider review of maternity services by the RCOG.

**5.67** The meeting also heard that there had been seven serious incidents reported in 2015 involving maternity provision at the Trust.

**5.68** On 21 May 2015, at a Closed Board<sup>†</sup> meeting, the Medical Director and the Acting Chief Nurse alerted the Board to cultural issues within obstetrics and gynaecology. A full investigation was taking place. In addition, the Trust was looking formally at serious incidents on StEIS. Early indications were that the situation had not changed.

**5.69** The Thanet and South Kent Coast CCGs produced a report on 10 June 2015 which stated that maternity lessons from serious incident investigations were not being embedded. They also reported that the Deputy Head of Midwifery was currently acting as Head of Midwifery, with external support.

**5.70** On 26 June 2015, at the Trust's Closed Board meeting, the Medical Director (under “Confidential Items”) updated the Board on “*longstanding cultural issues*” in maternity services following concerns raised by staff to the CQC and the subsequent collective grievance (see paragraph 5.56). The situation had improved within maternity services, but further work was required.

**5.71** The Trust had commissioned an external review of obstetrics, as, according to the Closed Board papers, “*mortality rates were above the national average*”. This refers to the work of the RCOG, mentioned above.

**5.72** In addition, a complaint had been received from a patient who had overheard a conversation between obstetricians about the safety of the service. Obstetricians were invited to discuss their concerns and a review of job plans was being undertaken.

**5.73** One of the non-executive directors asked if the issues reported should have been visible through internal governance systems. The Medical Director explained that there had been a

<sup>†</sup> Trusts can hold part of their Board meetings in private. This has generally been referred to as the “Closed” part of the meeting or “Part 2” of the meeting.

long history of cultural issues and leadership gaps within the service, which unfortunately had become normalised. This had been evidenced by the CQC during its visit in 2014.

**5.74** The CQC inspected the Trust in July 2015 and rated it as “Requires Improvement”. In August, the South Kent Coast and Thanet CCGs stated that they were undertaking further scrutiny following the receipt of a 72 hour report in relation to a maternity death SUI.

**5.75** In September 2015, NHSE and NHSI noted that they were following up a perceived lack of pace between the Trust and the four local CCGs in jointly commissioning the RCOG clinical review into maternity services, particularly in agreeing the ToR and initiating a start date.

**5.76** A regional QSG report in October 2015 stated that the Trust had reported a number of maternity serious incidents relating to cardiotocography (CTG) misinterpretations that had resulted in significant harm or death of a baby. The CCGs were not confident that training was effective and were seeking additional assurance.

## Report of the Royal College of Obstetricians and Gynaecologists, 2016

**5.77** The RCOG review was undertaken between 24 and 26 November 2015.

**5.78** It was commissioned in response to concerns about the working culture within women’s services (including relationships between midwives and obstetricians), inconsistent compliance with national standards among obstetricians, poor governance in relation to serious incidents, staffing, education, supervision of obstetric middle grades and trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite. The RCOG reported in February 2016 and made 23 recommendations.

**5.79** The RCOG report included the following findings:

- Major clinical guidelines for maternity did not reflect current evidence-based best practice. The majority of obstetric guidelines were written by midwives with a lack of obstetric engagement in guideline development. Despite the CQC’s recommendation in 2014 that clinical guidelines be updated, the RCOG found that some guidelines had long expired or were inaccurate. The RCOG emphasised that the successful implementation of guidelines required the consultants to take ownership.
- The LSA had in place measures to address the fact that the Trust was the second highest reporter of serious incidents in the area. Recommendations were made for the Trust to provide assurance of safe and effective maternity care services through identification, investigation and learning from the management of serious incidents and effective links with supervisory processes, with evidence of an active learning culture.
- In respect of root cause analysis (RCA) investigations, there was an apparent failure both to address medical practice issues and to make recommendations on issues perceived as not contributing to the outcome. If poor consultant performance was identified during an RCA investigation, the issue would not be reflected in the report’s action plans. There was also a perception by the RCOG assessors that only staff involved in an incident got a copy of the RCA report findings, and there was little evidence of wider learning across the two maternity units.
- At WHH, all obstetric consultants participated actively on the labour ward and consultant attendance for labour ward rounds was in accordance with Trust guidelines,

with consultants staying on site beyond their shift if necessary and attending the unit when requested out of hours. At QEQM, however, there were three to four consultants who consistently failed to follow Trust guidelines. The RCOG found that *“this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants”*.<sup>7</sup> The interviews conducted by the RCOG assessors revealed significant concerns about the failure of these three to four consultants at QEQM to conduct daily labour ward rounds, review women, make plans of care and attend when requested out of hours.

- Obstetric trainees on both sites reported problems with clinical supervision at weekends, while the absence of consultant input at QEQM during weekends caused increased pressure on trainees.
- While there was some evidence of good multi-disciplinary working, there was no evidence of escalation by either doctors or midwives to the consultant in cases of conflicting emergencies, and there was little evidence of the “fresh eyes” approach to managing complex cases.
- The assessors heard that consultant behaviour at meetings was perceived as disrespectful, but it was behaviour that was tolerated by the consultant workforce and not recognised as a problem. Consultants worked in silos and not between sites; consultants did not interact. The assessors felt that the consultant body should be more respectful and supportive of each other as individuals, and that consultants should aspire to work together between the two sites.
- Assessors repeatedly heard that medical and midwifery staff at both sites considered there was no point in reporting safety issues as no action would be taken by the Trust. In addition, “whistle-blowers” were made to feel unsupported by managers and got minimal or no feedback on the concerns raised. The assessors expressed concerns that staff on both sites were no longer raising concerns about unsafe practices, conduct or performance of colleagues that was affecting patient safety or care, because this had been done in the past without satisfactory resolution and had involved the harassment of staff.
- Other weaknesses identified by the RCOG assessors included a lack of engagement in national audits, poor labour ward facilities and environment on both sites, and high midwifery sickness rates across both sites.

**5.80** In addition to a lack of consultant supervision, the RCOG report raised specific concerns about the use of locum registrars. Notably, even as early as around 2009, the Trust was said to be more reliant than it wanted to be on locums. At the time of the RCOG report:

- QEQM was found to be reliant on middle grade locum cover.
- The RCOG found inconsistency in consultant ward rounds on labour wards at both sites, though this was more apparent at QEQM. It also noted vulnerability of the QEQM unit out of hours due to non-attendance and/or reluctance to attend by on-call consultants when requested.
- Obstetric trainees on both sites reported problems with clinical supervision at weekends, including in the daytime, as they covered both obstetrics and gynaecology.
- Only consultants committed to teaching and supervision became educational trainee supervisors, and the RCOG assessors were concerned that this would result in consultants who were not committed to teaching and supervision being on call with middle grade locum doctors, potentially of unknown competence. This in turn would impact on the safety of care in the maternity unit.

**5.81** The Investigation heard that, following submission of the report, the Trust had no further involvement with the RCOG despite the RCOG's attempted follow-ups. The Trust told the RCOG that it was unable to communicate how the recommendations were being taken forward because of an upcoming inspection by the CQC, and it did not respond to the RCOG's subsequent request for follow-up information. The Trust also failed to share the RCOG's report with the CQC.

**5.82** Upon publication of the RCOG report, the Chief Nurse of the CCGs wrote to the Trust to express concern about the quality of the serious incident investigations. Ahead of a QSG intelligence-sharing call on 22 February 2016, it was made clear that the issues were longstanding and that there was a need for positive action. The CCG sent an email to the Acting Chief Nurse at the Trust.

**5.83** A QSG intelligence-sharing call about maternity services took place on 22 February 2016. Following it, the Accountable Officer at South Kent Coast CCG emailed the Chief Nurse at the Trust, stating:

*Having read the report my only non-clinical comment is that it is a really sad read. This is nothing that we didn't already know and were raising through other routes. The issues around consultant behaviour were visible to me when I was commissioning Maternity services. Whatever the outcome, I think there needs to be an understanding that this is very long standing and therefore the necessary change needs to be beyond what has previously been achieved. Obviously this was a theme through CQC and is being tackled in terms of midwifery culture already – but we would need positive assurance that the changes in train are having an impact and further work to capture the issues around consultants.*

**5.84** On 31 March 2016, in internal emails sent between the Medical Director, the Head of Midwifery and the Clinical Lead for Obstetrics, it was suggested that consultant cover on the labour wards exceeded RCOG guidelines at that time. From the Trust's perspective, "safety regarding the Consultant cover is not an issue". Rather, the issue was "engagement of Consultants with ward rounds and also about them being proactive, in a woman's management of care, rather than reactive – this was seen to be more of an issue on the QEQM labour ward site". In what might be perceived as a lacklustre response, the Trust reminded consultants in writing of Trust policy regarding on-call duties on labour wards. The Trust also committed to a two-week audit of consultants on both labour wards; the results identified no significant concerns with regard to consultant attendance or behaviour at WHH, but several concerns at QEQM in relation to consultant non-attendance. The Trust committed to a re-audit within six months.

**5.85** The Investigation heard that findings around a culture of consultants being unwilling to attend were challenged by Trust staff. On publication, the report was dismissed and described as "a load of rubbish" by some senior obstetricians. A number of staff were also unaware of the report altogether.

**5.86** The RCOG report was discussed at a Women's Health Business and Governance meeting on 5 April 2016. However, despite it having been commissioned by the Trust in the first instance, the report was met with resistance, as the following actions demonstrate:

- The Trust informed the RCOG report reviewers of 20 areas of perceived factual inaccuracies, and submitted a narrative pointing out the lack of benchmarking around safety issues and a lack of comment about the workforce.

- Those attending the meeting considered the RCOG's concerns regarding the length of the RCA process but felt the reviewers had not looked at all the medical notes and did not have a full picture.
- One recommendation was dismissed and surprise was expressed that the RCOG had not identified another issue as a strength.
- The draft action plan included circulation of the RCOG e-learning resources to be accessed by all consultants. However, it appears that these resources were only circulated in August 2016, approximately four months after the meeting.

**5.87** On 6 April 2016, the Trust Quality Committee reported that initial information from the recent RCOG report showed that, in the Committee's view, the Trust did not have an unsafe maternity service, but there was improvement work to do around how the service was run in some areas. The Closed part of the Board meeting heard that the Trust was developing an action plan in response to the RCOG recommendations.

**5.88** The view that the unit was not unsafe was restated by the Head of Midwifery at a Quality Committee meeting on 4 May 2016. They advised that when they had joined the Trust there had been leadership concerns; many staff in post were acting rather than substantive; there were many vacant substantive posts; there was poor compliance with audit findings and guidelines; there was a lack of equipment; and there was no progression of maternity services in line with national standards. They set out a list of achievements in the previous year, and a non-executive director congratulated them on leading a transformation from poorly led to well-led midwifery services. The agenda item concluded with the Chair recalling that there had been questions raised at the last meeting about whether this was a safe unit. The Head of Midwifery advised that it was. The meeting was told that, compared with national figures, there were low mortality rates for babies at the Trust.

**5.89** While the Trust challenged the RCOG report and deemed itself not unsafe, it was felt by Thanet CCG in April 2016 that concerns about maternity services met the threshold for NHSE to call a risk summit.

**5.90** An action plan specific to the RCOG report was created in May 2016, with actions to be implemented by the end of October 2016. However, the Panel heard that the RCOG action plan was "*more of a tick box*" in comparison with the CQC investigation. Subsequently, the decision was taken to address the RCOG report within the Trust's general improvement plan. The Panel was told that this meant the response to the RCOG report became diluted and there was insufficient focus on maternity issues.

**5.91** The improvement plan was not implemented completely as there were difficulties in securing the full engagement of those at the Trust. The Panel heard that, had the plan been fully implemented on time, it would have "*done the job*". The improvement plan was then subsumed into the Birthing Excellence: Success Through Teamwork (BESTT) Maternity Transformation Programme in 2017. While it was considered a response to the RCOG report, the BESTT programme was built around a national agenda and some themes from the RCOG review were not included, such as halving the rate of stillbirths.

**5.92** The risk arising from regulatory non-compliance in maternity was recognised as presenting an "extreme" risk, with potential harm to both pregnant women and neonates, and was approved as a risk for the Corporate Risk Register (CRR 26) in June 2016. This risk assessment was based on the report from the RCOG and gaps identified by the LSA. The challenges in embedding a "*mature and developed patient safety culture*" were approved as a separate "moderate" risk for the Corporate Risk Register in February 2017 (CRR 48), for reasons

including that the RCOG improvement plan was not being delivered on time and there was difficulty in gaining engagement among some teams, resulting in delays in prioritising quality transformation and education workstreams. The minutes from the March 2019 Board meeting record that the maternity residual risk score (under CRR 48) had been modified to a lower value following a positive visit from the CQC, and by April 2019 the risks relating to maternity services had been removed completely from the Corporate Risk Register.

**5.93** In 2019, a review of the actions in response to the 2016 RCOG report found that these were incomplete and that fewer than 25% of the actions were robust and signed off. It was not until 2020, following the coroner's findings in respect of the death of baby Harry Richford, that every recommendation had a corresponding action. The RCOG recommendations were then incorporated into the next phase of the BESTT programme, which began in 2020. It was only in January 2020 that the RCOG report was shared with the General Medical Council (GMC).

**5.94** Between publication of the RCOG report in February 2016 and July 2020, just 2 of the 23 recommendations could be evidenced as having been fully met, and only 11 were partially met. The Trust failed to successfully address the issues identified by the report, and any changes that were made were not sufficiently embedded to have any significant impact.

**5.95** In a report produced by the Thanet and South Kent Coast CCGs on 10 August 2016, it is stated that a Trust maternity integrated action plan had been agreed in response to quality and safety issues highlighted in RCOG, LSA, CQC and Public Health England external reports and through performance monitoring. The Trust had also recently reported three SUIs in relation to births of twins and had identified some initial learning. The CCGs were seeking assurance through the Heads of Quality and Maternity meeting that learning and mitigating actions were in place during the investigations into the three SUIs.

**5.96** Staff continued to raise concerns with the CQC. One example is a letter dated 4 August 2016 from a midwife who worked at the Trust from February 2010 until 2016. It is a long letter but highlighted concerns about the way the midwifery unit operated, including roster rules being broken, skill mix, staff not being consulted, requests for training being refused, a lack of equal opportunities in applying for jobs, high turnover of staff and some staff appearing to be uncaring. The writer acknowledged that these issues may appear trivial when viewed individually, but argued that one should take account of the bigger picture.

**5.97** The CQC reinspected some of the Trust's services in September 2016, including maternity services, which it rated as "Requires Improvement" in a report published on 21 December 2016.

**5.98** The Trust discussed the RCOG report at its meeting on 9 December 2016, when the Medical Director noted that the issues identified during that review were being addressed. The Chief Executive Officer (CEO) at the time acknowledged the work that was already under way to address the issues highlighted by the RCOG and proposed that concerns raised about engagement could be addressed outside of the Board meeting (via the Trust Quality Committee). NHSE reported in February 2017 that the Trust had stated that its RCOG action plan was being overseen by the clinical lead.

## The death of baby Harry Richford

**5.99** Harry Richford was born on 2 November 2017 at QEQM. He was the son of Sarah and Tom Richford.

## Harry's delivery

**5.100** Sarah had an uneventful pregnancy and was considered at low risk. She attended hospital two days before her due date when her contractions started but, following an examination, she was told that she could go home. She returned to the hospital later that evening as her contractions were becoming more painful, and she was admitted to the MLU at QEQM.

**5.101** The following morning, 1 November, Sarah was moved to the labour ward for assessment due to lack of progress in labour. She was seen by a registrar, but she did not see a consultant obstetrician while on the labour ward. The CTG, which records fetal heartbeat and contractions, showed decelerations of the baby's heart rate and very frequent contractions suggestive of hyperstimulation of the uterus with Syntocinon, used to accelerate labour. A disagreement took place between the registrar and midwives – in front of Sarah and her family – regarding the appropriate rate of administration of Syntocinon for Sarah.

**5.102** Sarah's care was handed over to a locum registrar who commenced a shift at 8pm on 1 November. Sometime around 2.15am, the locum registrar called the on-call consultant to report on Sarah's case – the cervix was fully dilated just before midnight, and she had started pushing just after 1am. The registrar's intention was to bring Sarah to theatre to attempt instrumental delivery for failure to progress and an atypical CTG. The consultant had not met or examined Sarah and was at home as usual when on call. The consultant said that they had offered to come into the hospital, but the registrar declined; it should be noted, however, that a registrar is not in a position to accept or decline a consultant's decision. The registrar was on their third night of providing locum cover at QEQM. The consultant had not worked with or supervised them previously.

**5.103** Sarah was taken to theatre at about 3am, and the registrar attempted a forceps delivery, but was unable to lock the forceps blades. Sarah had signed a consent form for a caesarean section, and the locum registrar proceeded to a caesarean section. Up until this point, the atmosphere in theatre was *"not calm but being managed"*. The Panel heard that the tension in the room increased, and the atmosphere became panicked and uncomfortable. A more junior trainee doctor was instructed by the registrar to increase the size of the incision in Sarah's uterus but, having never done this before, they were not confident in doing so. The midwife who had been with Sarah since 8.30 the previous evening was instructed to push Harry's head back up the birth canal, something they had done only twice in their midwifery career.

**5.104** Harry was delivered at 3.32am. The Panel heard that the scene in theatre was chaotic and had descended into people shouting at each other. At one stage there were between 20 and 25 people in theatre, but the consultant obstetrician was not yet in attendance. Harry was taken immediately to be resuscitated. The paediatric registrar who attended Harry was a relatively junior doctor and was unable to secure an airway. Harry's father, Tom, was escorted out of theatre, and Sarah asked to be anaesthetised, rather than stay conscious (*"I would rather not be in that room ... because I didn't feel safe"*). There was considerable delay in resuscitating Harry and intubation was not achieved for 28 minutes, when the anaesthetist, after administering a general anaesthetic to Sarah, left her side to assist with the resuscitation. The anaesthetist successfully intubated Harry and he was taken to the SCBU for cooling treatment.

## The days following Harry's birth

**5.105** The consultant obstetrician and the consultant paediatrician on call both spoke to the family after the delivery and told them that Harry was very unwell, and it was likely that he would have cerebral palsy. The consultant obstetrician assured the family that there was going

to be an investigation and told them that they were unhappy with what had happened. The consultant paediatrician told the family that they had looked at the team who had carried out the resuscitation and they had followed protocol. The family recall being told that the paediatric team “*did everything they could*”.

**5.106** Harry was transferred by specialist ambulance to the NICU at WHH. Sarah and Tom followed later that day. They told the Panel that the week that followed was the worst of their lives. It was unclear whether Harry would survive, and he had seizures over the days that followed. Following an MRI scan showing the extent of damage caused to Harry’s brain, Harry died seven days later on 9 November 2017, being held in his parents’ arms for the first time since his birth. The cause of death was recorded as HIE.

## Investigations following Harry’s death

**5.107** The weeks, months and years that followed Harry’s death involved sustained efforts by his family to seek understanding and truth about what happened during his delivery.

**5.108** Harry’s death was recorded as a serious incident, and the Trust conducted an RCA. The family had a number of queries which they addressed to the Trust following Harry’s death, and they believed that the RCA report would answer all their questions. When, after some delays, the report was made available to the family on 8 March 2018, it raised more questions for them than it answered.

**5.109** The Panel heard that the RCA was complex, and more and more issues emerged which required resolution. The magnitude of the investigation was not appreciated by the Trust at the outset, and extensions to the deadline were required.

**5.110** The RCA identified problems relating to Sarah’s and Harry’s care which echoed issues highlighted in the Trust’s internal neonatal admissions review in 2010 and the RCOG report in 2016. These included:

- Delay in diagnosing the onset of labour
- Failure to escalate issues to the obstetric team
- Disagreement and communication issues among midwifery and medical staff
- Escalation issues to obstetric consultant and paediatric consultant
- Incorrect CTG interpretation and classification
- Locum registrar on their third night at the Trust whose level of competency had not been assessed
- Difficulties in resuscitation
- Lack of consultant presence in theatre.

**5.111** The sense from the family was that the RCA investigation and report were inadequate and did not tell the full truth about what happened to Harry or to Sarah. The family identified a number of errors within the RCA report, such as the level of qualification of the locum registrar, a statement that resuscitation had been carried out in accordance with national guidance, and the complete absence of any critical comment about the lack of consultant attendance. The placenta was not sent for pathological examination as it should have been, and it was acknowledged in the RCA report that it should have been sent for histology at delivery (“*especially when there is a poor and unexpected outcome at delivery of a baby*”).<sup>8</sup> Notwithstanding this failing, the RCA included a comment that “*there is no suggestion that a detailed examination of the placenta would have provided any extra information*”.<sup>9</sup>

**5.112** A meeting took place a few days later, on 14 March, between the family and the Trust to discuss the RCA's findings. This meeting appears to have been challenging for all involved (it was described to the Investigation by one member of staff as “a complete car crash” for the Trust). The meeting room furniture was disorganised, requiring the family to rearrange it when they arrived; one of the consultants arrived ten minutes late; and another consultant had to be called to attend from Ashford. There were disagreements among the clinicians within the meeting, and inaccuracies and inconsistencies in the report emerged throughout the meeting (for example, whether there were problems relating to CTGs within the unit). The family's impression was that they were treated poorly by the Trust, spoken to like children, and dismissed when they raised concerns.

**5.113** A critical issue for the family was the Trust's failure to refer Harry's death to the coroner, a concern which was raised by Tom Richford shortly after Harry died. The RCA report addresses this question as follows:

*The coroner was not informed as the cause of death was known to be hypoxia and death occurred later than 24 hours from birth. There was a clear sentinel event coupled with difficulty in resuscitation, this fits clearly with HIE. Again coupled with the MRI findings and the MRI report, there was no uncertainty with regards to causation and the death certificate.<sup>10</sup>*

It should be clear that this is a wholly inadequate reason to evade referral to the coroner, when both mother and baby had been healthy at the onset of labour.

**5.114** During the RCA meeting on 14 March 2018, the family raised their concerns again, and were told that Harry's case did not need to be reported to the coroner because the Trust knew the cause of death was HIE and death was, therefore, considered “expected” because he had been admitted to hospital with severe HIE. The family's natural concern was that the reason for the HIE, and the circumstances that caused it, were not fully understood and required close examination by a coroner. Indeed, the Trust's own internal documents following Harry's delivery identified the outcome as “unexpected”; however, his death was recorded on the death certificate as “expected”.

**5.115** It was only following lengthy discussion at the RCA meeting, during which the Trust representatives finally accepted that Harry's death had been avoidable, that the Trust agreed to speak to the coroner. This action was noted within the RCA report as a recommendation, but it nevertheless took over five weeks, and much contact and follow-up from the family, before the case was referred.

**5.116** This practice of delay and avoiding external scrutiny presented itself again in connection with the Trust's obligation to notify NHS Resolution (NHSR) about Harry's death. Under the early notification scheme, the Trust was required to notify NHSR of the death within 30 days. Following enquiries by the Richford family in 2019, it transpired that the notification was only sent to NHSR on 22 March 2018, one week after the RCA meeting with the family and 123 days after Harry had died.

**5.117** In June and July 2018, the Trust commissioned independent medical reports into the care received by Sarah Richford and the neonatal resuscitation of Harry Richford. Both reports were critical of the treatment provided by the Trust, yet neither report was shared with NHSE or NHSI at the time. Derek Richford, one of Harry's grandfathers, made a complaint to NHSI in December 2018, raising concerns that the Trust was not learning from incidents. The response from the Medical Director was that lessons had been learned by the Trust, and that on receipt

of the report from the Healthcare Safety Investigation Branch (HSIB), which was due in January 2019, the Trust would put in place a further action plan.

**5.118** HSIB is an organisation which acts independently to investigate incidents and develop recommendations to improve patient safety. The Richford family had referred Harry's case to HSIB in April 2018. When HSIB published its report into the care received by Harry and Sarah in January 2019, its findings included:

- The lack of review by a consultant obstetrician during labour
- The use of a CTG interpretation method that was not recommended by the National Institute for Health and Care Excellence
- A failure to meet the requirements of Trust guidance
- Use of a locum registrar without assessing competence or providing appropriate supervision
- The failure of the consultant obstetrician to be present in theatre in accordance with RCOG guidelines and Trust guidelines
- The failure to send the placenta for pathological examination in accordance with Trust policy
- Communication failings between consultants and registrars
- Issues around resuscitation.

**5.119** The Richford family also contacted the CQC regarding Harry's case. The CQC's initial assessment was that the issues related to one doctor who had made a mistake, but there were no systemic issues to investigate. Again through the persistence of the Richford family, the issue was escalated to the CQC's Chief Inspector of Hospitals, and in October 2020 the CQC announced that it was prosecuting the Trust in connection with the care provided to Harry and Sarah Richford. In March 2021, the Trust pleaded guilty to an offence of failing to provide safe care and treatment, resulting in avoidable harm to Harry and Sarah. The Trust was fined £761,170.

**5.120** Overall, the Richford family felt that the information they received from the Trust was not always truthful, and they had to press and fight to be provided with the information they were looking for about what had happened to Harry. An example relates to the incorrect information submitted by the Trust to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), which produces annual perinatal mortality surveillance reports. The MBRRACE-UK form for Harry dated February 2019 confirmed (among other inaccuracies) that the placenta had been sent for histology, that the case had been discussed with a coroner (although this was only done following pressure from the family) and that there was a final, agreed cause of death following the results of the inquest and all investigations. This was incorrect as the inquest did not take place until the following year.

## The inquest

**5.121** The inquest into the death of Harry Richford was held over three weeks in January 2020 before an assistant coroner. In their conclusion, the coroner found that "*Harry Richford's death was contributed to by neglect*". 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.<sup>‡</sup>*
- *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.*

**5.122** 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.

## The Trust’s response

**5.123** The Investigation was told that Harry’s death “*caught the Executive off-guard*”. It 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. This was a significant failure of governance.

**5.124** 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

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<sup>‡</sup> This was the terminology used, although it should be noted that the hyperstimulation is of the uterus not the baby, leading to hypoxia of the baby.

established a Learning and Review Committee (LRC) with separate workstreams to look at the myriad issues emerging from the Harry Richford inquest, as well as previous investigations such as the RCOG report, the Richford RCA 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.

## Subsequent internal and external scrutiny

**5.125** At a QSG meeting on 13 December 2017, the CCG Governing Body's Integrated Quality and Performance Report reported that concerns about maternity safety at the Trust in relation to reporting and escalating incidents had been escalated to the Maternity Performance meeting. The Trust had confirmed that it was providing training and support for staff to change the reporting culture. The Trust had also reported a Never Event within maternity services. This related to an obstetric registrar stitching a vaginal tear using a vaginal tampon, which was then unintentionally left in place after the procedure.

**5.126** On 8 December 2017, the Board reported that, to celebrate the BESTT Maternity Transformation Programme, the Chair of the Maternity National Transformation Board had visited the Trust to discuss its transformation work and achievements. The Board recognised the significant progress made by the maternity team as part of BESTT. It noted key achievements so far: 100% of staff had signed up to attend essential life support in obstetrics training; the number of quality assured trainers had increased from 9 in 2016 to 76; and £33,000 had been put towards ultrasound training so that every woman could have a 36-week scan.

**5.127** The 6 April 2018 Trust Board meeting discussed an item called "Patient Experience Story". The Chief Nurse asked the Board to note that the learning from this experience had resulted in improvements in teamwork and communication. The patient reported a good experience during the birth of her daughter, but she had become unwell afterwards due to a retained placenta and postpartum haemorrhage. The patient observed a lack of communication between the team and herself. There was no leadership in the room and no clear decision making around the bed, with the main issue not being addressed quickly enough. The patient highlighted that her bed covered in her blood being wheeled into the room had been traumatic for her husband.

**5.128** The Trust Chair noted that the story was of a classic postpartum haemorrhage that had been poorly managed. It had changed the way the team shared, learned and addressed mistakes. The learning from the case was that the patient had not felt safe, because the staff were not working together or communicating. It was important for the team to be aware of the finer details. The Head of Midwifery noted that "Human Factors" training (training in human interactions, such as communication and teamwork) was bringing together a cohesive and holistic training approach.

**5.129** The BESTT Maternity Transformation Programme had started in 2017 and had brought about a cultural shift, which the Head of Midwifery hoped would continue as more simulation training took place. One of the non-executive directors asked whether any competency issues were being addressed with staff. The Head of Midwifery noted that individual competency elements were included in the action plan, as well as whole team learning.

**5.130** The Trust Chair highlighted that the patient's story had shown clearly that the clinical team had not worked well together. The Medical Director noted that perinatal blood loss was a key

measure in the National Maternity and Perinatal Audit, and it was an area on which the Trust now performed particularly well.

**5.131** At the Board meeting on 10 August, it was reported that the MBRRACE-UK report on perinatal mortality indicated that the Trust's stillbirth and neonatal mortality rate was above the national average. Investigation had revealed that most of this local variation related to congenital non-survivable conditions.

**5.132** In August 2018, the QSG report stated that, following nine serious incidents being reported in the maternity service, the CCG did not have assurance regarding the safety and quality of maternity services at the Trust.

**5.133** On 6 September, the Board reported that the CQC had identified maternity as "Requires Improvement". The Closed Board meeting noted that an improvement in maternity services had been recognised at WHH due to the transformational work that had taken place.

**5.134** On 4 December 2018, Derek Richford submitted a complaint to the NHSI National Medical Director stating that the Trust was not learning from incidents. NHSI contacted the Trust's Medical Director, who reported that, following the RCA, two independent reviews had been undertaken, by an obstetrician from the Maidstone and Tunbridge Wells Trust and by a paediatrician from the Dartford and Gravesham Trust. They stated that lessons had been learned by the Trust and changes had been made to practice. The HSIB report was due in January 2019 and would contain an assessment, conclusion and recommendations regarding the standard of care received by Sarah and Harry Richford. Following this, the Trust would put in place an action plan. The Trust reported to NHSI that they had told the CCG of this. However, the CCG reported that they only became aware when they declined closure of the RCA due to a number of queries.

**5.135** At the Closed Board meeting on 6 December, it was reported that, further to an outbreak of pseudomonas infection in the NICU, no new cases had been reported but the incident remained open until the origin of the infection had been identified. Further to two maternal deaths, the Medical Director explained that there would be a meeting with HSIB in the coming week to compare the Trust's investigation with the HSIB investigation.

**5.136** In February 2019, NHSI received an email from the Trust's Quality Improvement Director highlighting current key quality concerns. Maternity was not highlighted as a concern. In March, the CCG reported that maternity services were improving under the new leadership model. However, in May 2019, a letter sent to the Accountable Officer for East Kent CCGs by the NHS England and Improvement (NHSE&I) Director of Commissioning Operations following a formal assurance meeting stated:

*There remain some significant and persistent quality failures at EKHUFT, which whilst raised appropriately by the CCGs, you have not managed to get action to achieve sustained improvements in the provider. The performance indicators are poor across EKHUFT across a range of areas including; Cancer Waits, Delayed Cancer Diagnosis, Maternity Services, Mixed Sex Accommodation, Never Events and A&E. The CCG will need to ensure that it is taking clear oversight and leadership in these areas.*

**5.137** The Divisional Director for Women's and Children's Services returned to this theme at the Closed Board meeting on 4 July 2019. They confirmed that, following their report at the last meeting, they would be reviewing all the current referrals to the NMC, currently a total of ten.

**5.138** The Chief Executive commented that, following the discussion at the Board meeting held that morning regarding staff who were under investigation, it was critical the Trust remained resilient as an organisation in supporting those staff and ensuring that the process was undertaken and completed promptly. The Trust needed to be robust in working with external agencies to ensure cases were investigated and closed as promptly as possible.

**5.139** On 13 August 2019, the CEO of HSIB wrote to the CQC to say that HSIB had ongoing concerns around clinical safety for mothers and babies in the Trust and the Trust's response to these concerns, which they felt the CQC needed to be aware of.

**5.140** On 27 August 2019, NHSE&I wrote to the Trust asking for an update on "*The impact of planned changes to improve labour ward senior medical cover*". The Chief Nurse responded on 9 September that the Trust was considering extended consultant presence on the labour ward and a second registrar on shift. It was also reviewing guidelines on consultant out of hours cover or presence, and was sharing guidelines from neighbouring trusts for the clinical team to consider, which included examples of rotas.

**5.141** The CQC wrote to the Trust on 1 October 2019 stating that it was opening a criminal investigation. The Regional NHSE&I Director referred to the letter as "*pretty unusual*". In the same month, in a quality report to the NHSE&I Executive Quality Group, HSIB expressed concerns about senior medical cover on the Trust's labour wards.

**5.142** At the Closed Board meeting on 10 October 2019, the Chief Nurse noted the current position with regard to the NMC and the 12 open cases for Trust staff, only two of whom remained employed with the Trust. There were five additional cases where the Trust was in liaison with the NMC.

**5.143** HSIB returned to its concerns on 12 November, when it reported that the Trust was an outlier for referrals. It raised specific concerns about senior out of hours obstetric cover for the labour wards, escalation and CTG interpretation.

**5.144** This culminated in a round-table discussion on 28 November 2019 about the Trust, where it was noted that there continued to be significant concerns with the lack of evidence that the Trust was learning from incidents in order to improve care. Following this, a report was commissioned by the Clinical Regional Quality Manager at NHSE&I. This was completed on 3 December 2019 and, in its introduction, the report said there was concern that there might be a risk to patient safety because the Trust's maternity services had not provided evidence that they were learning from serious incidents. It said that this related to a number of cases investigated by HSIB.

**5.145** On 28 November, the Secretary of State for Health's Private Office contacted a Director in the Department of Health and Social Care (DHSC), to report that the Secretary of State:

*... has asked about an operational incident at a maternity ward at William Harvey hospital in East Kent and whether we have any background. I'm afraid I don't have any further information but if this rings any bells and you are able to provide a factual briefing to share with the SoS I would be most grateful. We also have the option of putting this on the operational Quad agenda if you think it would be worth raising with Simon Stevens.*

A colleague of the Director replied to say that DHSC was unaware of the incident.

**5.146** On 29 November, the Private Office official shared a briefing from NHSE&I on the issue. They said:

*[T]he SE region have taken the decision this week (Thursday 28 Nov) to convene a single-item QSG looking at maternity services at East Kent University Hospitals. This is because they were made aware by the HSIB that the trust's referral rate of cases for investigation was notably higher per 1000 births than the national average.*

**5.147** NHSE&I also referred to other actions that had been taken. First, HSIB had written to the CQC expressing its concern, which was the first time it had taken this step. In line with the general trend observed at the Trust, HSIB had referenced a specific death in November 2017, which would be subject to an inquest in January 2020. Second, the NHSE&I regional nursing team had led an intelligence-sharing call with system partners (HSIB, the CQC, NHSR and the CCG) to discuss their respective experiences and concerns, which informed the decision to refer the Trust to the QSG. The DHSC Director responded that “NHS should do QSG asap”, and this was relayed by the Private Office to the Secretary of State, who asked whether the QSG meeting was private. A member of the DHSC Director’s team responded on 2 December: “The guidance is clear that the QSG meeting should be conducted in an environment of confidentiality and trust, where members feel able to speak frankly and openly about concerns.” They later confirmed that the meeting had taken place on 10 December.

**5.148** On 7 December 2019, the Trust’s Chief Executive wrote to the Director of Nursing Professional and System Development at NHSE&I:

*Having so many regulators involved is difficult re coordination and perspective. Particularly HSIB who as a new organisation (and not a regulator as such) are confusing regarding their role. They also work more slowly as they are building their staffing and competence. In similar circumstances in the past, one of the regulators taking the lead, setting the tone and coordinating the information requests, has been helpful. (NHSR have also been involved in this one too). I think with Shrewsbury going on and the tragic case of the Richford family, one of who is making contact with all regulators, MPs, the press etc, it would be easy for this current set of concerns, to be inappropriately calibrated. East Kent has recent history of a negative kind, of that there is no doubt. It is after all why I ended up here in the first place. However, I can see that the improvement programme is biting and the new leadership, particularly since [the new Head of Midwifery] arrived, has been having a great effect in maternity. The consultant leadership has also been changed too.*

**5.149** On 12 December 2019, for the “Patient Story” item at the Board meeting, the Chief Nurse introduced Mrs X, who presented her daughter’s experience in maternity services. Her daughter had been admitted for a planned induction and had also been diagnosed with pre-eclampsia, but did not receive the level of attention or pain relief she needed. Staff on the ward did not seem to have considered her additional needs and support requirements.

**5.150** Mrs X stated that she had contacted the Maternity Matron to raise her concerns. The Maternity Matron had taken the time to listen to what she had to say. The Chief Nurse presented feedback to the ward staff in relation to lessons to be learned from this case, while keeping the patient and her family updated on the actions put in place. Mrs X emphasised the importance of staff considering the patient’s perspective and taking into account any pre-existing mental health conditions when delivering care. The Chief Nurse also highlighted that it was vital that staff listened to patients, and drew attention to the importance of having robust handover procedures in place. Patients should have positive experiences while in hospital, and the Chief Nurse was always visible on the wards to allow poor experiences to be raised with them directly.

**5.151** In December 2019, the Medical Director presented a report to the Closed Board meeting to inform the Board, following concerns raised by regulators, about trends in perinatal mortality,

external scrutiny and the actions being taken to mitigate risks to patient safety. Key specific issues included CTG interpretation, medical staffing cover and escalation. The Medical Director reported that actions to address these issues included adoption and rollout of physiology-based CTG interpretation, identification of gaps in medical staff cover and actions to address these, identification of additional support requirements, and provision of daily labour ward safety huddles during the day and out of hours.

**5.152** The Medical Director referred to the RCOG report, which they said had resulted in the Trust adopting the BESTT improvement and transformation programme. The Chief Executive commented that it would be beneficial to review the BESTT programme and whether it had too large a focus and needed to be revised, defining a few specific key areas going forward. The Chief Executive emphasised the need to increase consultant presence on the labour wards, with a minimum requirement to recruit an additional two consultants. There was also a requirement for additional middle grade clinical support. This would, it was claimed, provide additional support for the oversight of locums.

**5.153** On 17 December 2019, the Regional Chief Nurse of NHSE&I wrote to the Trust's Chief Executive, the Medical Director and the Head of Midwifery to follow up the "Single Item" QSG meeting on 10 December. The meeting acknowledged good progress made by the Trust on maternity services but outlined the following areas of concern: medical staffing, leadership, management of care, and learning from a recent coroner's case. NHSE&I listed the support it would like to offer.

**5.154** An Extraordinary Trust Board meeting took place on 30 January 2020, with the single agenda item of maternity. The Trust has told us that it can locate no notes of this meeting, and that it was an informal meeting held to consider and discuss the next steps following the inquest into Harry Richford's death and to consider the setting up of an oversight group, with an external Chair reporting to the Board. This oversight group was subsequently established as the Trust's LRC.

**5.155** The Board met again on 13 February 2020. The Chair reported that the format of this Board meeting would be amended, as the Board recognised and understood that recent media reports on the Trust's maternity services would have raised concerns with East Kent families who were either currently expecting a baby or who had been under the Trust's maternity care in the past. Acknowledging the importance of this issue, half of the Board meeting would be allocated to discussion and questions regarding maternity services. The Chair explained that the Chief Executive and Medical Director would present their respective reports, and time would be allocated to allow them to receive questions from members of the public. The remaining half of the Board meeting would be used to discuss the other agenda items.

**5.156** The Chair extended apologies on behalf of the Board and the Trust to the family of baby Harry Richford for his tragic death and for their heartbreak. Recognising that the Trust had not always provided the right standard of care for every woman and baby in its hospitals, the Trust extended apologies wholeheartedly to those families for whom it could have done things differently. The Chair provided assurance that the Trust had made significant changes to its maternity services in recent years to improve the care of women and their families. The Trust would continue to work to improve its services, ensuring the provision of a high standard of care. It was working with the NHS Maternity Safety Support Programme, which was providing support to the Trust to make rapid and sustainable improvements to its services.

**5.157** In the item "Chief Executive's Report", the Chief Executive expressed heartfelt condolences on behalf of the Trust, themselves and their colleagues to the family of Harry

Richford and to every family that had not received the level of maternity care they deserved. The Chief Executive acknowledged that any death, and particularly that of a baby, was tragic and touched everyone. They assured the public and the Board of the Trust's commitment to listening to feedback from patients and their families regarding any poor care received and their suggestions for improvement. As well as taking into consideration recommendations regarding areas of suggested improvements, the Chief Executive acknowledged the work required with regard to improving the Trust's culture and listening to patients and their families. They would be extending an invitation to the families who had lost a baby to meet them.

**5.158** The Chief Executive reported serious concerns raised in 2014 about inadequate staffing, poor teamwork and inadequate equipment in the Trust's maternity services. This had resulted in the Trust being put into Quality Special Measures. They stated that, since they had been in post as the Trust's Chief Executive, a new maternity senior team had been introduced, with the appointment of a Head of Midwifery and a new leadership team. These changes had resulted in successful improvements to maternity services, as detailed in the Chief Executive's report. The Trust was recruiting six additional consultants as well as middle grade doctors to support the consultants and senior clinicians already in place.

**5.159** The Chief Executive confirmed that the CQC was continuing to monitor and review the Trust's maternity services. The Trust was working closely with NHSE&I to support these ongoing reviews. The Trust was also working closely with HSIB, with quarterly meetings taking place.

**5.160** The Chief Executive stated that an internal review had been put in place. Its aim was to review and confirm the steps implemented to ensure that the Trust moved in the right direction to achieve the necessary improvements in providing excellent standards of care to every mother and baby who used its services.

**5.161** The Medical Director reported that they would be working with external support and would be reviewing all perinatal deaths to identify those that were preventable. The Chief Executive commented that the Trust's staff wished to be associated with a "Trust of excellence", and that all staff were focused and energetic in supporting this improvement programme and would not rest until the Trust, the public and regulators were confident that an excellent standard of care was being provided. The Panel was surprised that the Trust had not been doing all of this before, given how long it had been since very similar problems were first identified.

**5.162** The Medical Director highlighted areas of improvement, which included medical engagement, incident reporting, availability and presence of consultants on the labour wards and escalation. They reported the actions recommended by the family at the inquest into the tragic death of Harry Richford and indicated that there had not been sustained and embedded learning within maternity services. The Trust recognised the importance of embedding learning and the need to make changes. The Medical Director also stated that the independent HSIB review of the Trust's maternity incidents reflected themes evident nationally.

**5.163** Quarterly meetings were being held with HSIB and key recommendations included medical staff engagement, which, according to the Medical Director, had significantly improved. Other key elements included escalation and communication between staff and the two sites. The Medical Director confirmed that the coroner's conclusion had been received; this included 19 recommendations, of which 2 were national recommendations. The Richford family had also submitted 42 recommendations for the coroner to consider, covering six broad areas as detailed in the coroner's report. They also submitted for consideration support for bereaved mothers with regard to accommodation, a dedicated support worker and counselling. The Medical Director highlighted the changes that had been implemented to date in addressing these

recommendations, and concluded by stating that a programme of improvement work had been put in place around learning and support in midwifery, paediatrics and obstetrics. This would be overseen by the internal overview panel, chaired by an external obstetrician.

**5.164** At the Closed Board meeting on the same day, the Medical Director confirmed the completion of the review of all RCAs between 2012 and 2019 in relation to perinatal deaths and identification of any potential avoidable deaths. They reported that 11 deaths had been identified as preventable, with a further 4 potentially preventable. The Chief Executive confirmed that 25 cases had been referred to HSIB, including cases of baby deaths and babies who had recovered after receiving neonatal therapeutic cooling. The Medical Director reported that quarterly meetings continued to be held with HSIB and that update reports from these meetings would be presented to the Trust Quality Committee.

**5.165** The Chief Executive confirmed that an independent review into East Kent maternity services would be undertaken by Dr Bill Kirkup. This would include a review of perinatal deaths to identify any potential avoidable deaths.

**5.166** On 5 March 2020, East Kent maternity services were discussed at a Health Overview and Scrutiny Committee (HOSC) meeting. The Trust's Deputy CEO introduced the item by saying that the Trust had recognised in 2015 that the position in maternity services needed to improve and had commissioned the RCOG to undertake a review. A HOSC member asked why things had gone so wrong despite the RCOG review taking place in 2015. The Medical Director explained that themes from that review had been repeated in subsequent reports, which suggested that any changes made had failed to be embedded.

**5.167** Asked how East Kent residents could be assured that the Trust's Board was adequately monitoring the implementation of best practice, when it had failed to do so in 2015, the Deputy CEO explained that, following the coroner's report, the Trust had established an externally chaired Board (a sub-committee of the main Board) which in turn had seven "task and finish groups", each with their own area of focus. The Chair of the new Board was independent, in order to provide external opinion as well as assurance. The seven workstreams were being overseen by clinicians, which the Trust felt demonstrated a real shift. The Deputy CEO also felt it was important that the Trust accepted the additional clinical support on offer. The Medical Director pointed out that each of those present at the meeting was an East Kent resident and therefore had a vested interest in making the services the best they could be. A consultant said that, as a relatively new employee of the Trust, they felt that the employer was recruiting people with different skillsets in order to build its workforce and that it was being open about the challenges it was facing.

**5.168** A consultant acknowledged that there were lots of things to be done, and they were having to be prioritised. Examples of actions that had been, or were being, taken included:

- Remote fetal monitoring (where consultants could monitor a fetus from any location)
- Further investment in training and development for both technical and non-technical skills
- Implementing controls to ensure increased consultant presence on the wards
- Appointment of three specialist midwives (one specialising in the Better Births agenda and two in fetal wellbeing)
- A piece of work to scope out continuing care and what that meant for women and families in East Kent

- Out of hours safety huddles to ensure ward leads had a strategic view of the service at that time
- Investing in and expanding the Getting It Right First Time programme
- The Chief Nurse holding “floor to Board” meetings to gather intelligence and ensure staff felt listened to.

**5.169** Meanwhile, the RCOG had offered earlier in the year to provide support to the Trust. This culminated in a site visit to the Trust from 11 to 13 March 2020. The proposed output from this was a service development action plan, a governance action plan and a workforce action plan.

**5.170** The Trust Board met again on 12 March 2020, when it received a report from the LRC. The Chief Executive asserted that this provided the Board and the regulators with assurance around transparency and openness, given that the internal review was being externally chaired and led by an independent community representative. The Chair of the LRC reported that they had met with the individual workstream leads and were confident that actions were being taken seriously and implemented. They explained the aim of the LRC in relation to reviewing the Trust’s response to the internal review and whether it had implemented the recommendations from previous historical reports. The LRC would also assess whether the BESTT improvement programme addressed these past and current action plans. The LRC would identify the information needed to assure the Board that the Trust’s maternity and neonatal services were safe, well led and sustainable. It was noted that the actions in relation to how the Trust employed locums were not yet complete, but the LRC was assured that these were being taken forward and were being appropriately prioritised.

**5.171** A non-executive director asked whether there was sufficient engagement, openness, determination and commitment from the Trust’s clinicians to support and embed the improvement programme. The Chair of the LRC assured the Board of this commitment from the workstream clinical leads, who were fully engaged and appreciative of being given protected time to undertake this work.

**5.172** There was further activity in DHSC relating to the publication of an HSIB report, including briefing to ministers on 24 March. The briefing stated that *“the summary report was produced by HSIB at the request of DHSC. It is not a routine report that HSIB would produce or publish under their maternity investigation programme as maternity reports are only shared with the family and trust. The report has been shared with the Trust.”* The briefing continued:

*We have reviewed the contents of the report and do not think there is anything contentious in it or that it highlights issues that have not already been addressed with the Trust that would prevent it from publication. CQC have shared its report with the Trust and the Trust have published the letter from CQC on their website therefore publication of this report, would be consistent with their approach. The terms of reference for the independent review commissioned by NHS England are in the process of being agreed and this report is not dependent on the outcome of the review.*

**5.173** However, in light of the Covid-19 pandemic, DHSC officials advised that publication should be delayed, as it *“may detract media and public scrutiny from the vital work the Trust is doing to respond to the pandemic”*.

**5.174** Ministers were again briefed on 25 March, with a draft response to a Prevention of Future Deaths report from the coroner in relation to Harry Richford. The briefing advised that the ministers' response:

*... highlights the NHSEI and RCOG work on guidelines in relation to locum doctors in maternity services. In addition, the suggested response acknowledges the work undertaken by regulators and other national bodies to scrutinise and support the safety of maternity services at the East Kent Trust; as well as the commissioning by NHSEI of the independent investigation of East Kent maternity services led by Dr Bill Kirkup.*

# Chapter 6: Areas for action

## Introduction

**6.1** Chapter 1 of this Report sets out the findings of the Panel’s Investigation of maternity services at East Kent Hospitals University NHS Foundation Trust (the Trust). It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes – in many cases disastrous. It highlights an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong. It delineates grossly flawed teamworking among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

**6.2** Chapters 2 to 5 provide the evidence to support these findings, gathered through family listening sessions, reviews of clinical records and interviews with managers, staff and others. We have reviewed the emerging findings against a large body of documentation provided to us by organisations with an interest in the Trust during the period under scrutiny.

**6.3** As indicated in Chapter 1, this chapter puts forward an approach that is different from the norm: in particular, we have not sought to identify multiple detailed recommendations. NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations, and we have no desire to add to their burden with further detailed recommendations that would inevitably repeat those made previously, or conflict with them, or both. We take those previous recommendations and the resulting policy initiatives as a given.

**6.4** Instead, we identify four broad areas for action based firmly on our findings but with much wider applicability. None is susceptible to easy analysis or a “quick fix”, but we believe that they must be addressed, because the simple fact is that the traditional approach has not worked: supposedly one-off catastrophic failures have continued to happen, despite assurances that each would be the last. The approach here aims to identify the fundamental problems that underlie these recurrences, however difficult.

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

### The problem

**6.5** There is a dearth of useful information on the outcome of maternity services. This may be a surprising statement, because plenty of data are certainly collected; however, a large majority are process measures of dubious significance, such as caesarean section rates. The minority that are related to outcomes are high level and conceal events susceptible to clinical intervention among a larger, unrelated group, such as perinatal mortality.

**6.6** The unit-level information that is available tends to be presented in the form of “league tables”, based on rankings in some form. These merely serve to conceal the variation between different units, with no indication of whether one or more units at the top or bottom of the rankings are there because they are outliers, or merely through chance. If units are presented only as part of a group, such as the top or bottom ranked 5%, interpretation is even more problematic for an individual unit.

**6.7** The Trust exemplifies all these difficulties. It has used high-level information inappropriately as reassurance, taking comfort from the grouping that at least there were other trusts in the same boat. At times, it has used this false reassurance as a bolster against the plethora of evidence from other sources that there were very significant problems in its maternity services.

## The future

**6.8** There are huge benefits to the effective monitoring of outcomes. Clinicians can see where there is scope to improve effectiveness and address problems of service safety, and evidence from other specialties shows that – perhaps after a little early reluctance – they embrace this enthusiastically, with demonstrable improvement in outcomes and patient safety. Trusts can identify warning signs and take action where necessary, before problems and behaviour become embedded and perhaps intractable. Regulators, including NHS England (NHSE) and the Care Quality Commission (CQC), can identify units that are outliers and investigate appropriately before a trust descends into catastrophic failure. All parties can have a conversation based on relevant shared information about safety performance, rather than what otherwise might become a stand-off based on prejudice and refutation.

**6.9** There are two overall requirements. The first is the generation of measures that are meaningful (that is, related clearly and straightforwardly to outcomes); risk adjustable (that is, they take into account the complexity of work in a unit and its effect on outcomes); and available (that is, they can be garnered from among the array of data already routinely collected, as we have no desire to suggest any data returns additional to the large array currently required). They must also be timely.

**6.10** The second requirement is that the measures are analysed and presented in a way that shows both the effects of the random variation inherent in all measures, and those occurrences and trends that are not attributable to random variation. The random variation is often referred to as “noise”, and the outlying event as the “signal”. There are 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 in the form of statistical process control charts and funnel plots. Useful work on these techniques is already being carried out by NHSE, but it is important that this is extended to clinically relevant outcome measures.

**6.11** Deriving valid measures that meet these requirements is a little more problematic in maternity care than in some specialties because pregnancy and childbirth are physiological in most cases, and poor outcomes are less common. Perhaps this has underlain the lack of progress so far. It is, however, perfectly possible to overcome these problems and generate a suite of outcome measures available for the use of clinicians, units, trusts, regulators and the public. We have resisted the temptation to describe this as a “toolkit” because it is not something optional from which to pick and choose: 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

**6.12** Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care. Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust. Previous experience has shown the danger in assuming that such serious lapses of such a distressing nature are restricted to one trust alone.

**6.13** Failing to meet basic standards of clinical behaviour has obvious effects on colleagues and those receiving care. Unprofessional conduct is disrespectful to colleagues and endangers effective and safe working; it undermines the trust of women. Lack of compassion significantly affects the wellbeing of women, often leading to unnecessary long-term harm. When families are treated unkindly in the aftermath of a safety incident, as is often evident, it compounds and prolongs the harm caused by the event itself. Failure to listen directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored.

**6.14** Because compassion is such an integral part of belonging to any caring profession, it is particularly difficult to comprehend how such failures can come about. Whether or not traits of empathy and compassion form part of the selection or assessment of new entrants, the need to be professional and to listen will surely be emphasised as part of initial education and training. What we saw and heard was that it was when clinicians were exposed to the behaviour of senior colleagues that their standards began to slip. The influence of role models, those whose positions more junior staff would aspire to fill one day, can be significantly greater than classroom teaching. If those role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards.

**6.15** Once such a negative cycle is established, it can prove remarkably persistent because of another feature evident in the Trust's maternity services: normalisation. Behaviour that would otherwise be challenged becomes tolerated, because "that's the way we do things here". In this way, inexorably, patterns of unprofessional behaviour, lack of compassion and failure to listen become accepted and embedded, to an extent that is genuinely shocking when seen through fresh eyes.

**6.16** When such problems are brought to light, perhaps through whistleblowing or external review, they remain difficult to correct. We saw this exemplified in the Trust in the form of the grievance which stopped the investigation of bullying and harassment by midwives in its tracks, and in the failure to address grossly unprofessional conduct on the part of some consultant obstetricians who were refusing to fulfil labour ward responsibilities including attending when on call.

**6.17** The Trust is far from alone in finding great difficulty in addressing unprofessional consultant behaviour. Consultants have, or perceive themselves to have, considerable freedom to act on their own responsibility without taking direction from others. The majority, of course, use this freedom wisely in line with their senior and highly qualified status; but in the minority who act unprofessionally, it serves as a shield to deflect any attempt to correct aberrant behaviour. A trust or its medical director who attempts to intervene has few sanctions available other than dismissal, with the prospect of facing lengthy processes and a likely loss at an employment tribunal against a strong legal defence funded by a protection society. This is such an unequal battle that a consultant subject to challenge is often advised to resign and claim constructive dismissal.

**6.18** This is not to deny that consultants have sometimes been victimised by trusts, or that their employment rights must be protected fairly; nor is this a question of clinical competence. But it remains the case that a stubborn, poorly behaved consultant can cause havoc in a clinical unit that imperils its performance, as well as the wellbeing of staff and patients over a prolonged period. This cannot be right.

## The future

**6.19** 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. Every interaction with a patient, mother and family must be based on kindness and respect. This will not be achieved through well-meaning exhortation in classrooms or by professional leaders, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff.

**6.20** Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels. It must not be something learned during the earlier academic stages of training, only to be forgotten later.

**6.21** There is a need for all staff to acknowledge and accept the authority of those in clinical leadership roles. These are not sinecures to be done for a couple of years on a rotating basis: they are integral to the effective and safe functioning of services. While some clinicians accept this, it is clear that many do not. Those in clinical leadership roles need to have the skills and time to carry them out effectively.

**6.22** 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 existence of such sanctions would itself act as a deterrent to the defiant reactions to challenge exhibited by an unreasonable minority.

**6.23** The importance of listening to patients must be re-established as a vital part of clinical practice. This will require it to be embedded not only in continuous professional development, but also in the academic components of early training. The rapid rise in technical and diagnostic possibilities understandably puts pressure on academic curricula, but this must not be to the detriment of skills such as listening.

## 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

**6.24** Clinical care increasingly depends on effective teamworking by groups of different professionals who bring their own skills and experience to bear in coordination. Nowhere is this more important than in maternity and neonatal services, but nowhere has it proved more problematic. Where it works well, care can be outstanding, but in almost every failed maternity service to date, flawed teamworking has been a significant finding, often at the heart of the problems.

**6.25** Maternity services at the Trust were no exception. The Panel found that there was dysfunctional teamworking both within and across professional groups. The lack of trust and respect between midwives and obstetric staff, and between paediatric and obstetric staff, posed a significant threat to the safety of mothers and their babies. We found many examples of how this caused conflict, made staff feel vulnerable, prevented information from being shared, and encouraged complacency and a lack of accountability. After a safety incident, the most common response was to find somebody to blame for it – often the most junior midwife or doctor involved – preventing important lessons from being learned. The consequences for mothers and their babies were stark.

**6.26** There is one feature of flawed teamworking that is particularly striking in maternity care: the divergence of objectives of different groups. A team that lacks a common purpose will struggle, working in an environment of competing interests which may rapidly descend into conflict, inappropriate hierarchies and power plays. It is evident that there was a struggle for “ownership” of maternity care in the Trust, and it is clear that this also applies elsewhere. Rather than contributing as equal partners, midwives may be encouraged to see themselves as being “there for women”, defending them from the “medicalisation” of maternity care. This polarisation of approach and objectives cannot help but put them in conflict with obstetricians.

**6.27** In this context, the language used around “normal birth” may have significant unintended consequences, raising expectations among women and maternity staff that this is an ideal to be aspired to by all. But it is far from ideal for all, and promoting it unselectively can leave women feeling unfairly that they have failed in some way; in some cases it can expose them to additional risk.

**6.28** Poor morale among obstetric trainees is a common feature and contributed significantly to the problems in the Trust’s maternity services. Trainees felt pressurised, unsupported and

obliged to carry out clinical tasks they were not ready for; unsurprisingly, there were recruitment difficulties and overuse of locum doctors who were not always properly assessed. Necessary changes to doctors' hours and training have had unintended consequences, including fragmenting care and increasing handovers. They have also removed the "firm" system previously in widespread use, which saw teams of staff with one or several consultants who would work together both in routine practice and while providing on-call services, offering support and increasing knowledge of capabilities and ways of working.

## The future

**6.29** We need to find 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. Crucially, this must be based on an explicit understanding of the contribution of different care pathways and when and how they are best offered. National guidance on this must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives.

**6.30** Teams who train together work better together. The most frequent claim of joint training is that it is used in emergency drill training. This is very valuable, but it is not enough. There are opportunities at every stage of training – from undergraduate education onwards – not only to increase understanding of others' roles and responsibilities, but also to become used to working with other disciplines and the contributions they make.

**6.31** We need to re-evaluate 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

**6.32** The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation, as is evident from a great many instances within the NHS and much more widely. Many risk registers will identify reputational damage in several contexts as something to be mitigated. If this were only a single part of a more complete response that was based on identifying failure and learning from it then it might be considered reasonable. But repeated experience says that it is not.

**6.33** On the contrary, the experience of many NHS organisational failures shows that it is the whole basis of the response in many cases. Further, it has clearly led to denial, deflection, concealment and aggressive responses to challenge, in the Trust as elsewhere. Not only does this prevent learning and improvement, it is no way to treat families, who are heartlessly denied the truth about what has happened when something has obviously gone wrong, compounding the harm that they have already suffered. Refusal of scrutiny may extend to the manipulation of information for the CQC, and misrepresenting deaths (for example, as “expected”) to avoid inquests.

**6.34** In the case of NHSE, there is a particular issue evident when a trust is in difficulties with clinical services: naturally, NHSE wishes to take decisive action and to be seen to do so, but its scope for intervention is limited when problems relate to clinical dysfunction. One of the few levers available is the replacement of chief executives and chairs, and we have seen evidence of a pattern of reaching for this lever repeatedly, with questionable consequences. Of course, there are questions of accountability for failing to act, as we have pointed out, and perhaps of competence; however, much more often it seems that neither is the reason, as individuals were simply moved to equivalent posts elsewhere. The only reasonable conclusion is that NHSE is espousing the idea that a fresh face, or faces, will solve the problems that others could not, described to us as the “heroic leadership” model.

**6.35** There are two consequences evident. First, any steps towards recovery will be halted, as staff have to adapt to new ideas and new ways of working. Second, the incentive to be less than frank about emerging problems is intensified, as individuals naturally prefer stability, and having choice over their circumstances of departure.

## The future

**6.36** 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. The current small risk to an organisation does not match the risk of loss of public confidence in one of its vital services.

**6.37** It seems that previous attempts to encourage organisations to change this behaviour by identifying the pernicious, damaging consequences for those harmed have not worked – even when taking into account the duty of candour in relation to individual clinical incidents, typically regarded as satisfied by a single conversation. It is time to introduce legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open. This has previously been outlined in a Public Authority (Accountability) Bill, known colloquially as the “Hillsborough Law”.

**6.38** When families experience harm, the response must be based on compassion and kindness as well as openness and honesty. Healthcare organisations have a lasting duty of care to those affected.

**6.39** A review of the regulatory approach to failing organisations by NHSE would 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. The identification of problems should not be seen as a sign of individual or collective failure, but as a sign of readiness to learn.

## 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

**6.40** For essentially the same reasons, we have not sought to set out a detailed list of things that the Trust must do – and the Trust has had numerous previous action plans that have not worked. Its problems are not susceptible to top-down point by point guidance: they are at once straightforward and deep-rooted. The new leadership of the Trust will read this Report and can see exactly what has gone wrong and what needs to be put right.

**6.41** They are already aware that there are deep-seated and longstanding problems of organisational culture in their maternity units, and they can see spelled out in the words of families and their own staff the nature of the disgraceful behaviour and flawed teamworking that were previously left to fester. 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.

**6.42** The first step in the process of restoration is for all those concerned to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings. 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.**

# Appendix A: Terms of Reference

## Written Ministerial Statement

### **Written statement by Nadine Dorries, former Minister of State, Department of Health and Social Care, 11 March 2021**

*On the 13 February 2020 I confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust).*

*The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).*

*We take the patient safety concerns at East Kent maternity services very seriously. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions.*

*The Terms of Reference have been finalised now the views of the families affected have been taken into account and are published today on the Independent Investigation (Independent Investigation into East Kent Maternity Services: <https://iiekms.org.uk/>) and NHSE website (<https://www.england.nhs.uk/publication/independent-investigation-into-east-kent-maternity-services-terms-of-reference>). The Terms of Reference include the scope and arrangements that are to be put in place to support its functions and confirm the Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020. The terms of reference include the scope and arrangements that are to be put in place and confirm the independent investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020.*

*The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system and will produce a report to be disclosed first to the affected families and then to NHSEI as the commissioning organisation and then to the Department of Health and Social Care prior to publication.*

*The work of the Independent Investigation is expected to complete by the Autumn of 2022 and arrangements will be made for the final report to be presented to the Secretary of State; Ministers will subsequently publish the report to Parliament, and a response will be provided in due course.*

*A copy of the Terms of Reference will be deposited in the Libraries of both Houses.*

# Independent Investigation into East Kent Maternity Services

## Terms of Reference

### Introduction

- 1.** Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust). The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).
- 2.** This is to set out the Terms of Reference for the Independent Investigation, including its scope and the arrangements that are to be put in place to support its functions, detailed in an accompanying Protocol.
- 3.** Dr Bill Kirkup is appointed by NHS E/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.
- 4.** The Independent Investigation was also confirmed in Parliament on 13 February 2020 by Nadine Dorries, Minister of State for Patient Safety, Mental Health and Suicide Prevention. At the same time the Minister 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.

### Scope

- 5.** The Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, by looking in particular at the following four layers:
  - i. What happened at the time, in individual cases, independently assessed by the investigation.
  - ii. 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?
  - iii. How did the Trust respond to signals that there were problems with maternity services more generally, including in external reports?
  - iv. 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?

### Purpose

- 6.** The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions. This includes:
  - 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.

7. The Independent Investigation will 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 Independent Investigation will aim to provide lessons helpful to East Kent but also to share nationally to improve maternity services across the country.
8. The Independent Investigation will focus on the experience of the families affected and the actions, systems and processes of the Trust, (with reference to clinical standards for maternity and neonatal care during the period). The Independent Investigation will listen to the concerns of the affected families, use their experience to shape the key lines of enquiry and provide an opportunity for them to be heard. The Investigation should also consider the processes, actions and the responses of regulators, commissioners and the wider system as they are relevant to the provision of maternity and neonatal services at the Trust.
9. The Independent Investigation will produce a report to be disclosed first to the affected families and then to NHS E/I as the commissioning organisation and to the Department of Health and Social Care prior to publication. The Report will be published and presented to Parliament.
10. The Investigation will agree with NHS E/I steps it might take at the completion of its work to help ensure that the lessons identified are understood and acted upon. These steps might include presentations to NHS groups.

## **Timescale**

11. The Independent Investigation will aim to complete its Terms of Reference by Autumn 2022.

## **Protocol**

### ***Access to documents***

- All relevant NHS organisations, regulators and the Department of Health and Social Care are required and expected to cooperate with the Independent Investigation as is normal, professional practice, including supplying documentation, as and when requested by the Investigation.

### ***Contact with families and the public***

- The Independent Investigation team will be responsible for managing liaison with families whose cases are relevant to the Independent Investigation

### ***Methodology and case review***

- The Independent Investigation will decide how best to deliver its Terms of Reference including by drawing upon:
  - a. the experiences of families affected by maternity services in East Kent and the impact on those families looking as widely as necessary to understand the whole of that experience and impact;
  - b. the medical records of patients;
  - c. the corporate records showing how the Trust discharged its responsibilities for

maternity services, how it communicated and engaged with patients, their families and representatives and with regulators and others over concerns with maternity services;

- d. interviews with those whose work involved maternity services;
  - e. interviews with regulators, NHS England and Improvement, HSIB and others;
  - f. its assessment of what went wrong in individual cases and lessons aimed at ensuring improvements which should be made to maternity services in East Kent and elsewhere.
- In applying its methodology, the Independent Investigation will consider individual cases where there was:
    - i. a preventable or avoidable death;
    - ii. concern that the death may have been preventable or avoidable;
    - iii. a damaging outcome for the baby or mother;
    - iv. 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 Independent Investigation will take account of other relevant work including the following but will be responsible for reaching its own assessment, findings and conclusions:
    - HSIB Reviews
    - The invited review by the RCOG in 2015/16
    - The invited RCPCH review in 2015
    - Perinatal Mortality Review Tool data and reports
    - Intelligence from the CQC/associated reports/recommendations
    - Letters and findings from HM Coroners
    - Each Baby Counts reviews (the Royal College of Obstetricians and Gynaecologists national quality improvement programme)

## Resources and governance

- Resources for the Independent Investigation will be provided by NHS England and NHS Improvement. The Independent Investigation will establish with these resources a team with sufficient expertise and capacity to carry out the work
- The Chair will appoint those with appropriate experience in order to help deliver these terms of reference, including:
  - An expert panel and specialist advisers
  - Secretariat functions
  - Clinical input
  - Legal advice
  - Communication functions
  - Engagement with and support for families
  - Engagement with relevant staff from the Trust
  - Information governance and management

- The Independent Investigation team will keep in regular contact with NHS England and NHS Improvement via the SRO and their team but will not provide a running commentary on the Investigation's findings. Through this contact, NHS England and NHS Improvement will keep in touch with progress of the Independent Investigation, ensure that sufficient resources are available and are being deployed appropriately.
- If the Independent Investigation identifies areas of concern with current patient safety in East Kent Maternity Services, it will contact the Chief Midwifery Officer, Jacqueline Dunkley-Bent in her role described by the Minister in the House of Commons on 13 February 2020.

### **Consent and information governance**

- Specific consent will be sought from the families for their information to be shared with the Independent Investigation team, if initial contact has been via NHS England/Improvement, or the Trust. The Independent Investigation will secure suitable consent from families for their information to be used as part of the investigation.
- The Independent Investigation will have an information handling and privacy policy that will set out the approach the Investigation takes to handling information appropriately and complying with information legislation.

### **Fact checking and opportunity to comment**

- The Independent Investigation will notify individuals and organisations who are referred to in the investigation's conclusions and provide them with an opportunity to respond to any significant criticism proposed for inclusion in its Report.

### **Disclosure**

- The arrangements will include disclosure first to the families and to NHS England, NHS Improvement and the DHSC so that they are aware of the content of the Report to be published.

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1 The trust was placed on the Maternity Safety Support Programme which involves improvement advisors supporting the trust with maternity improvement.



# Appendix B: How the Investigation conducted its work

## The importance of independence

**B.1** National Health Service England/National Health Service Improvement (NHSE&I) commissioned the Independent Investigation into East Kent Maternity Services in February 2020, following concerns raised by families and others about the quality and outcome of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust (the Trust).

**B.2** From the outset, the independence of the Chair and the Panel of experts was considered key to ensuring the credibility of the Investigation and the confidence of any families who would be involved. A guiding principle was that, in search of the truth, the Investigation should go in whichever direction the evidence took it, both to maximise the likelihood that families would be provided with the information they needed to address their questions and concerns, and to ensure that the knowledge and insights gained would be of benefit to the Trust and the wider NHS. In practice, this meant that we would determine the process we would follow to establish the facts, we would speak without fear or favour, and we would not shy away from difficult or contentious issues.

**B.3** Our process was designed to listen to families, to understand their concerns and the reasons why they felt so aggrieved and let down. It was with the families that we first shared messages and updates during the course of the Investigation; and it was with the families that we first shared our findings and recommendations at the conclusion of the Investigation.

**B.4** We did this while maintaining independence and objectivity, which is what the families affected would have wanted and what the public would have expected. We endeavoured to maintain a balanced and proportionate approach, as well as a sustained and high-quality level of engagement with those directly affected, at all times showing sensitivity and understanding.

## How we worked with families

### “Families first” principle

**B.5** The Investigation adopted a “families first” approach. This principle is not defined in statute but forms the basis of many investigations and inquiries: for example, it was included in the Terms of Reference for the Hillsborough Independent Panel formed in 2010 in response to the Hillsborough disaster of 1989, and it was used by the Gosport Independent Panel, which reported in 2018.

**B.6** Not only did the “families first” principle guide our approach to the gathering and scrutiny of evidence, it also informed how we shared our findings. In particular, our intention

from the start was to make sure that families would be the first to hear the conclusions of our Investigation and to have access to the written Report.

**B.7** For the purposes of investigating and reviewing the care families received, access to personal information was needed. To ensure that the Chair and the Panel had the operational independence to determine what lines of enquiry to follow and what evidence to gather and process, Data Controller status was conferred on the investigation team.

## Engagement with families

**B.8** As set out in our Terms of Reference, the Investigation was tasked with looking at individual cases where there had been: a preventable or avoidable death; a concern that the death may have been preventable or avoidable; a damaging outcome for the baby or mother; or 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. Understanding the experiences of the families was a key part of the Investigation process.

**B.9** Early on, informal conversations with families took place to answer any questions they had about the Investigation and to assure them of its independence and determination to get to the truth. We also hoped that this would help build a relationship of trust and confidence and alleviate any concerns the families might have had about participating.

**B.10** On 23 April 2020, we launched the Investigation formally and invited families who wished to share their experience of the maternity and neonatal services at the Trust during the period 2009 to the end of 2020 to contact us. Then, in October 2020, the Panel Chair appealed for other families to come forward if they wished to, mindful that there needed to be a cut-off date for families to be involved. One year later, on 23 April 2021, we stopped accepting new cases to the Investigation, except in exceptional circumstances where the Panel felt that the cases added significantly to the Investigation's findings.

**B.11** The Investigation received approaches from three families who wished their cases to be considered but who, on assessment, were found to be outside the scope of the Terms of Reference. In two other cases, the Panel was not able to review the woman's care because their medical notes were not available. These five cases were therefore not included in the analysis undertaken for the purposes of Chapter 2 of this Report.

## Consent

**B.12** In every case, we obtained the written consent of each family to:

- Access their clinical records and other documentation relating to their case
- Approach relevant organisations that may have held personal data relevant to the Investigation, and for those organisations to share that personal data with the Investigation team
- Use the information we obtained about their case to develop questions or issues for other witnesses or organisations to answer or explore on an anonymised basis
- Include in the Investigation Report personal information about the experiences they shared with us, on an anonymised basis or with their additional consent if the information may be identifiable.

## Family listening sessions

**B.13** Our family listening sessions provided the opportunity for families to meet the Panel and talk about their experience of care at the Trust. We encouraged them to tell us what had happened in full, including the impact on themselves. The sessions took place between January and September 2021, and the majority were conducted via video. Where families preferred to meet the Panel in person, arrangements were made at their convenience. Each session was attended by at least two members of the Panel and one of the specialist advisers to the Panel. The Investigation's family engagement lead also attended.

**B.14** The family listening sessions were deliberately unstructured, with families given free rein to speak as they wished; the Panel asked questions as the need arose in order to clarify or seek further information. Each session was recorded and families were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

**B.15** All the families who contributed to the Investigation through a family listening session were provided with a summary of their spoken account to ensure that it captured the key facts and essence of their experience. The Panel Chair agreed that any comments made by a woman or a family member during their family listening session would not be attributed to them in the Investigation's final Report without their express permission.

**B.16** Families who did not wish to meet with the Panel were given other options: to submit information in writing or to give consent for their records to be looked at without any active participation on their part. A small number took up these offers.

**B.17** Importantly, the family listening sessions included mothers, fathers and in some cases other family members. In preparing our Report, we have referred variously to mothers, women, fathers, partners\* and, on occasion, husbands. In our use of terminology, we hope that we have followed accurately the circumstances of each family and their wishes. We have kept the terms used simple in order to aid the flow of the Report, but we are mindful of the possibility of situations where the term "birthing partner" would be more apt.

## Trauma-informed counselling

**B.18** Mindful of the additional anxiety and distress that might be caused to them by the necessity of having to recount and possibly relive their experiences and share personal details, we offered each family the opportunity to attend a session with an expert counsellor after they had met with the Panel. We selected a professional counsellor with extensive experience of working therapeutically with people who have been harmed during healthcare, with professional knowledge and experience as an academic, and with research expertise in trauma-informed counselling for healthcare harm.

**B.19** Trauma-informed counselling is based on principles intended to "*promote healing and reduce the risk of retraumatisation for vulnerable individuals*".<sup>1</sup> This approach takes account of the events or series of events that contribute to a traumatic reaction and includes the principle that self-referenced trauma is as valid as that which is diagnosed clinically. In other words, despite the narrow medical definition of trauma, if people believe that they have suffered from trauma, they should be accepted as having done so. Given that so many families referred to their experience or aspects of their experience as being traumatic, this approach turned out to be wholly appropriate.

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\* The term 'partners' refers to married and unmarried partners, whether male or female.

**B.20** Our counsellor was able to signpost families to other support, when additional or ongoing support was needed.

## Individual disclosure

**B.21** Because so many of the families had unanswered questions about the care they received or the outcome they experienced, the Investigation Chair undertook to meet with any family who wished to do so after publication of the Investigation Report, to answer any questions that the relevant family may wish to put to the Panel about their individual circumstances.

## How we worked with the Trust

### Clinical records review

**B.22** With the consent of the families involved, as detailed above, and the full cooperation of the Trust, we carried out a thorough review of the clinical records of each woman's and baby's care. This included reviewing original hard copy clinical notes as well as accessing copies of them via a secure online portal.

**B.23** The Panel members worked together to review individual records. They also had ongoing access to the online versions, to continue their work individually.

**B.24** In addition to the clinical records, the Trust provided other documentation, such as complaints correspondence, investigation reports and exchanges with GPs, which helped the Panel build a picture of the woman's or baby's care and the events surrounding it.

### Interviews with Trust Board members, senior managers and staff

**B.25** Members of the Trust Board, the senior management team and staff were selected for interview with the Panel based on their period of employment with the Trust, their position (or positions) during that time, their involvement in governance and patient safety matters, and, in some cases, their involvement in particular cases reviewed by the Panel. Everyone invited was considered by the Panel to be in a position to provide information about the management, delivery and culture of the services under review, at both a service and a corporate level, during the period covered by the Investigation.

**B.26** They were invited by letter to attend an interview with the Panel. The letter explained that the Investigation had conducted listening sessions with a number of affected families and now wanted to hear from past and present Trust staff, and others, who were involved in the delivery, management and/or regulation of maternity and neonatal services at the Trust during the period under scrutiny.

**B.27** We recognised that individuals may wish to be accompanied by a friend, colleague or trade union official, and we offered them the option of bringing one person to support them. However, we were clear that their support person would not be able to answer questions or act in a representative capacity.

**B.28** The interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Each interview was attended by at least two Panel members. In order to facilitate an open dialogue and to meet the Investigation's Terms of Reference, the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

**B.29** In advance of the interviews, individuals were provided with an outline agenda of the themes to be discussed. If they were being invited to discuss a particular case, they were provided with the details in order that they could prepare fully; they were also given access by the Trust to the relevant clinical records.

**B.30** The interviews were recorded and a written summary of the interview was provided to each individual. They were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

## Review of Trust records and other material provided

**B.31** Corporate records were reviewed to understand how the Trust discharged its responsibilities for maternity services and how it communicated and engaged with patients, with their families and representatives, and with regulators.

## How we worked with stakeholders

**B.32** An early task was to identify organisations that might have material pertinent to the matters under investigation or that could inform the work of the Investigation more broadly. These organisations were then contacted in order that the work of the Investigation and its Terms of Reference could be explained; we requested that no documents that might have a bearing on the Investigation should be destroyed.

**B.33** Following on from this early contact, meetings were set up to establish with each organisation whether they had material of interest to the Investigation and to inform them that interviews might be needed with key staff to explore matters arising from our review of that material.

**B.34** While documents were being provided to the Investigation for review, interviews with staff from stakeholder organisations were scheduled.

**B.35** The interview process was similar to that described above. Interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Outline agendas were provided and the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

**B.36** The interviews were recorded and a written summary was provided to each individual. Participants were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

## How we assessed individual cases

**B.37** Having reviewed the evidence gathered from families and Trust staff, the Panel met as a group to consider each case in turn and determine where care was suboptimal when assessed against the standards expected nationally and its relationship with the subsequent outcome. This multi-disciplinary process of assessment was key to the Investigation. The findings were structured according to the validated classification of suboptimal care adopted by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI). Not only did this enable the

Panel to draw evidence-based conclusions about the overall quality and safety of care provided by the maternity and neonatal services at the Trust, but it also allowed us to ascertain the key facts in each case, in order that the Panel could report back to individual families about what had happened in their case.

**B.38** The CESDI scoring system comprises four levels of suboptimal care based on the relationship to the outcome (see Table B1).

**Table B1: CESDI scoring system**

Level of suboptimal care	Relevance to the outcome
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

**B.39** In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case. For this purpose, we used a scoring system adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm (see Table B2).<sup>†</sup>

**Table B2: Degrees of harm**

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including hypoxic ischaemic encephalopathy (HIE) and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

**B.40** The Panel's conclusions drawn from its assessment of cases are set out in Chapter 2 of the Report.

<sup>†</sup> Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

## Organisations contacted by the Investigation

**B.41** The organisations and stakeholders listed in Table B3 were contacted in order to provide evidence or other information in line with the Investigation’s Terms of Reference. A number of these organisations have contributed information and documents to the Investigation, but a proportion of these stakeholders did not have any relevant documents to contribute.

**Table B3: Organisations contacted by the Panel**

Organisation name
Action against Medical Accidents (AvMA)
Birth Trauma Association
Bliss
British Medical Association
Care Quality Commission
Child Death Overview Panel
Department of Health and Social Care
Fairweather Solicitors
General Medical Council
Health and Safety Executive
Health Education England
Healthcare Safety Investigation Branch
Healthwatch
Her Majesty’s Senior Coroner (Mid Kent & Medway, North East Kent, Central & South East Kent)
Kent Community Health NHS Foundation Trust
Kent County Council
Kent Police
Local Maternity System
Maternity Voices Partnership
MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)
Medical Defence Union
Members of Parliament
National Childbirth Trust
National Guardian’s Office
NHS England and NHS Improvement
NHS Kent and Medway Clinical Commissioning Group
NHS Resolution
Nursing and Midwifery Council
Parliamentary and Health Service Ombudsman

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Public Health England

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Royal College of Anaesthetists

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Royal College of Midwives

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Royal College of Nursing

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Royal College of Obstetricians and Gynaecologists

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Royal College of Paediatrics and Child Health

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Sands (Stillbirth and Neonatal Death Charity)

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# Appendix C: The Investigation team

## Panel members

Dr Bill Kirkup CBE (Chair)

Heather Brown (Obstetrics)

Valerie Clare (Midwifery)

Alison Fuller (Clinical Governance)

Helen MacTier (Neonatology)

Denise McDonagh (Data/Information Management)

## Specialist advisers

Nicky Lyon

James Titcombe

## Legal advisers

Innovo Law

## Counselling support

Linda Kenward

## Secretariat

Members of the Secretariat have included:

- Ken Sutton (Secretary to the Investigation)
- Altin Smajli (Deputy Secretary)
- Caroline Allen
- Annette Beckham
- Caroline Browne
- Peter Burgin
- Lynn Cabassi
- John Cairncross
- Ann Ridley



# Endnotes

## Chapter 1

- 1 Clinical Commissioning Groups. Quality Report to National Health Service England. June 2013.
- 2 Clinical Commissioning Groups. Quality Report to National Health Service England. August 2013.
- 3 *The Report of the Morecambe Bay Investigation*. 2015. [www.gov.uk/government/publications/morecambe-bay-investigation-report](http://www.gov.uk/government/publications/morecambe-bay-investigation-report) (accessed 12 July 2022).
- 4 Royal College of Obstetricians and Gynaecologists. Maternity Services Review Report. 2016.

## Chapter 3

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## Appendix B

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