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Exclusive: Dozens more maternity failings exposed at scandal hit trust

By Shaun Lintern | 31 August 2018

At least 60 separate cases of baby or mother deaths identified at west Midlands trust

Families not satisfied that Shrewsbury and Telford Hospital Trust's review will be objective

Scale of problems "could put Morecambe Bay in the shade"

Dozens more cases of poor care have been uncovered at a hospital's maternity service, which is already under investigation for failing 23 families, *HSJ* has learned.

At least 60 separate cases including baby deaths, brain injuries, and at least four deaths of mothers, have now been identified at the Shrewsbury and Telford Hospitals Trust.

The scale of the incidents has led to claims the trust's problems could exceed the failings found at the University Hospitals of Morecambe Bay Foundation Trust, where an independent government inquiry in 2015 identified the avoidable deaths of 11 babies and one mother.

Following the launch of a government probe into concerns at the Shropshire trust in 2017, more families have come forward with concerns spanning a total of 19 years.

The latest deaths happened in December 2017 when a mother and two babies died in unrelated incidents.

One source close to issues at the trust said: “The scale of this could put Morecambe Bay into the shade.”

HSJ has learned there are multiple separate investigations into maternity care at the trust, including an internal review being led by the trust itself – which families say cannot be trusted to be objective.

They have called on health and social care secretary Matt Hancock to widen the terms of reference for the independent inquiry ordered by his predecessor, Jeremy Hunt, in 2017.

Senior midwife Donna Ockenden was appointed to review 23 cases of alleged poor care last year but families believe she should now be allowed to expand her work to consider the emerging concerns.

Rhiannon Davies, whose daughter Kate died in 2009, said: “What’s so difficult about what’s coming out is that things have been and continue to be far worse than even we knew.

“Compounding this pain is the fact I now know acres of learning from avoidable deaths existed before Kate. Unlike what I was led to believe in 2009 Kate was not the first avoidable death at the trust. Yet no one bothered to learn and so sealed her fate – and mine, and that causes me almost unbearable pain.”

She added: “There are lots more cases now and all that learning could be lost because things will be missed. That is unacceptable. We are talking about avoidable deaths; the health secretary needs to step in.”

Kayleigh Griffiths, whose daughter Pippa died in 2016 after midwives ignored signs of a serious infection, added: “What we want is for all of it to come under the Ockenden review, otherwise things will be missed and there will be no learning. We trust Donna Ockenden to do a good job but the trust is not open to change. There are going to be more cases as families are coming forward.”

The parents of Kate Stanton-Davies and Pippa Griffiths wrote to Jeremy Hunt in 2016 highlighting the 23 cases of poor care they were aware of which directly led to Mr Hunt commissioning the Ockenden review.

NHS Improvement and the Department of Health and Social Care initially declined to widen the Ockenden review but following *HSJ*’s representations agreed tonight to allow the Ockenden review to consider additional cases.

A spokesman for the DHSC said: “We take patient safety concerns extremely seriously. We have asked NHS Improvement to investigate whether further cases at Shrewsbury and Telford Trust

should be considered as part of the Ockenden review, as well as assurance that the trust has taken steps to improve maternity services since these issues came to light in 2016.”

Separately, *HSJ* has learned, the Care Quality Commission has threatened the trust with a formal warning amid multiple safety concerns it has about the trust.

Multiple reviews into care failings

Since 2017, Shrewsbury and Telford Hospital Trust has had six separate reviews commissioned into its maternity services with at least 60 cases identified. These include:

- The Ockenden Review commissioned by Jeremy Hunt to examine 23 cases. Three further families have been identified by the review team according to NHS Improvement documents seen by *HSJ*.
- An internal “legacy review” by the trust has identified 40 cases, of which the trust said 12 had potential for further learning.
- A Royal College of Obstetricians and Gynaecologists review published in July 2017 which found perinatal mortality rates were above average compared with similar trusts and that despite deaths in 2013 and 2014 there was no “evidence of action plans and resulting changes in practice.” The trust paid for an addendum to the review based solely on representations from the trust. It said all recommendations from the earlier report had been implemented.
- Separate reviews have been commissioned into the deaths of a mother and two babies in December last year.

Dr Kathy McLean, medical director at NHS Improvement, said: “Our independent review will consider everything it can to ensure Shrewsbury and Telford Hospital Trust is equipped to learn from the previous failings in its maternity and neonatal services.

”This includes continuing to examine the 23 historical investigations identified in April 2017 as well as investigations that have been highlighted since then.

“Working with CQC and others we will ensure the trust has the right support in place to continue to improve its services for patients.”

Jo Banks, director of the women and children’s care group at the trust, said the multiple reviews gave the trust the “best opportunity to look at all the care we provide to learn and improve”.

She said the trust's use of the RCOG was important to allow independent experts to review its services and since then improvements had been made "with pace and focus".

She added the additional cases over a 19 year period "were not included in the secretary of state's review to ensure a robust process and complete transparency.

"We are committed to the continuous improvement of safety in our maternity services and were recently praised by NHS Resolution for meeting all 10 targets in its maternity incentive scheme."

HSJ can also reveal that the trust's former head of midwifery Cathy Smith, who was heavily criticised by the report into the death of baby Kate Stanton-Davies, has been disciplined by the trust for gross misconduct.

A review by expert Debbie Graham called into question her professional judgement and said her inaction meant lessons from baby Kate's death were not learned.

Ms Smith was given a final written warning earlier this year by the trust, which commissioned an independent expert to oversee the disciplinary case.

She is still employed at the trust overseeing its patient safety partnership with Virginia Mason Hospitals in Seattle.