Shropshire Telford & Wrekin Defend Our NHS
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A Tragedy in Maternity Care: Who knew? Why did they keep quiet?

Shropshire, Telford and Wrekin Defend Our NHS spoke this morning to Richard Stanton, father of Kate Stanton Davies. Kate was born in March 2009. She died when she was just six hours old, and her death was avoidable.

Richard said to us*, 'It's time to ask some big questions here. Who knew this was happening? Why did they choose to keep quiet about babies and mothers dying? How do we know this won't just happen again, in another service, with other people harmed?'*

Those are absolutely legitimate questions.

The avoidable deaths and harm identified by Donna Ockenden and team[1] represent a tragedy of monumental proportions. Failures of basic care have created loss, pain, and ongoing grief for many, many families.

The failures cover every aspect of maternity care: a lack of kindness and compassion, poor assessment of risk, failure to escalate concerns appropriately, poor management of labour with a repeated failure to learn from poor outcomes, traumatic births via forceps delivery where obstetricians failed to follow guidelines, and bereavement care that was at times inadequate, inappropriate or non-existent. There are even examples of mothers being blamed for the deaths of their babies.

The repeated failure of SaTH's maternity leaders to learn from mistakes in care is brutally clear. This is a story of negligence *and* arrogance. They were unable to accept they'd got it wrong.

This review took place only because parents fought for it. Without Rhiannon Davies and Richard Stanton, without Kayleigh Griffiths and Colin Griffiths, babies and mothers would still be dying avoidably at SaTH and the public would be none the wiser.

It is inconceivable that deaths and harm on this scale could take place without SaTH leaders and the leaders of the wider NHS in Shropshire also knowing. The documentary evidence confirms this. In Defend Our NHS, we are well aware of the failures within SaTH. There is evidence of a wider failure too.

Gill George, Chair of Shropshire, Telford and Wrekin Defend Our NHS, said:

What happened here is one of those 'everybody knew but nobody said' situations. The NHS has a structure that is meant to protect the public – but we believe NHS leaders in our patch chose to remain silent while babies and mothers continued to die. It's a silence that cost lives. There must now be some honesty and accountability about this.

[1] Ockenden Report. 10 December 2020. https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockenden-report.pdf

CCGs

Both our CCGs, Shropshire and Telford and Wrekin, have known for years of serious concerns. Board minutes from April 2013 – the very first formal Board meeting of Telford and Wrekin CCG – confirm this.

Defend Our NHS has been assured by our CCGs that they actively monitored perinatal mortality for SaTH from 2013 onwards, that they have been provided with regular data by SaTH, that maternity has been discussed regularly at monthly 'CQRM meetings', and that the CCGs have commissioned specific reviews of maternity, including reviews of specific serious incidents as well as broader reviews of the quality of SaTH's maternity service. The CCGs established a maternity specific CQRM in 2017 to allow a specific focus on this service area.

This confirms very clearly that they were aware of avoidable deaths and harm. They didn't tell the public though. They also failed to insist on the learning and safety that could have stopped the deaths. Why? Who took the decisions here?

The CQC

The CQC, the NHS regulators, inspected SaTH in 2014 and reported on their findings in 2015. They gave the maternity service an almost entirely clean bill of health.

At the time, SaTH's perinatal mortality figures were well above average. The inquest into the death of Kate Stanton Davies had reached deeply concerning findings. This was a service in desperate trouble. It is also genuinely unlikely that the CQC inspection team had not been told by the CCGs of specific and serious concerns about maternity.

What happened? Was the inspection team negligent? Or did they choose to look the other way?

NHS England

We know from the minutes of CCG Board meetings that the regional NHS England team knew of the concerns about SaTH's maternity service way back in 2013. They were alerted by the CCGs. NHS England subsequently chaired monthly 'Quality Surveillance Group' meetings where maternity safety were discussed.

We've heard rumours that the regional NHS England team actively prevented an effective system response to SaTH's maternity safety issues.

At <u>best</u>, NHS England knew of avoidable harm and deaths, failed to inform the public, and failed to take effective action to stop the ongoing harm. These are shocking omissions.

Was there active denial of known problems?

At SaTH, this may well have been the case. **Simon Wright**, SaTH's Chief Executive at the time, had an apparent strategy of offering reassurance to anyone who raised concerns about maternity care. He was joined in this by Director of Nursing, Midwifery and Quality Deirdre Fowler. Both of them seem to have publicly downplayed the scale of an escalating maternity crisis.

In August 2018, as the press covered the rising number of cases considered by the Ockenden Review, Simon Wright described the reports as '*untrue*' and '*misleading*'. He said this was *'scaremongering'*. He added, *'This will cause unnecessary anxiety amongst women going through one of the most important times of their life and I would like to assure them that our maternity services are a safe environment with dedicated caring staff'.*

His comments were inaccurate.

Adam Gornall, Clinical Director for Maternity, assured a Board meeting of 25th October 2018 that *'overall harm at SaTH is lower than average'*. Asked about the Ockenden Review, considering at least 100 cases at the time, he was dismissive*: 'Media coverage means that inevitably people come forward and they just want to ask questions'*.

It's a shockingly inadequate response given the extent of failure in the service he ran. At the time, the CQC had already taken urgent enforcement action on maternity safety.

Either the Clinical Director for Maternity and SaTH's Chief Executive didn't know what was happening in SaTH's maternity service – or they chose to mislead. Neither is acceptable.

Our **CCGs** also seem to have been part of the problem here. **David Evans** is probably the most powerful man in the local NHS. He leads both our CCGs, Shropshire and Telford and Wrekin. He is set to be appointed the leader of the new organisation that will be created when the CCGs merge in April 2021.

In December 2019, David Evans gave his view of the Ockenden Review to a Joint HOSC meeting. He said, *'The Trust delivers about 5,000 babies a year, or thereabouts. The media reports have been talking about going back over 40 years. Now of course I'm definitely not trying to say we shouldn't learn because definitely we should learn. But actually, if you take the number of cases that have been talked about over a 40-year period* ***it's relatively small in real terms*** *compared to the number of births.'* [our emphasis]

The CCGs have a responsibility to ensure the quality of the health services they commission for us. They had failed to ensure maternity safety from 2013 onwards. Even when it was clear that the crisis in maternity care at SaTH was exceptionally serious, the instinct from the leader of our CCGs was to downplay and reassure. It was an extraordinary comment from Mr Evans.

The story here is one of failure by SaTH, and by the NHS 'system' in our area. Gill George concluded:

'It's time for some accountability. Babies and women were let down by SaTH – and by the wider NHS system that was responsible for keeping maternity care safe. The public has a right to know why local and regional NHS leaders kept quiet, and why their failure led to ongoing harm and deaths.'

The Defend Our NHS submission to the Ockenden Review is attached. This includes more information on the fundamental issues of regulation and accountability touched on here.

For further information, please contact Gill George on 07900 411 769 or by email: gill@gillgeorge.net