Official Journal of the Irish Medical Organisation

Ir Med J; April 2022; Vol 115; No. 4; P575

April 29th, 2022

The Ockenden Report into Maternity and Neonatal Services at Shrewsbury and Telford Hospitals, UK

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The Report by Donna Ockenden[1] into the maternity and neonatal services at the Shrewsbury and Telford Hospitals Trust, was published on March 30th, 2022. The review had commenced its work in 2017. It is the largest report of its kind in the NHS's history. The printed version weighs 1.25 Kg. It has made 15 recommendations for immediate action by all hospitals nationally, and 66 actions specifically for the Trust. Many related to staffing levels, training, and communication with families.

The review was mounted on foot of adverse reports about the standards of maternity and neonatal care being provided by the Trust to mothers and their babies over a 20-year period 2000-2019. The initial impetus for the investigation was the repeated concerns expressed by the parents of babies Kate Davis (2009) and Pippa Griffiths (2016), both of whom died shortly after birth. The families wanted to understand what happened to them and why. They wanted to ensure that their efforts to seek the facts would make a difference to the safety of maternity care.

Over time the reservations about the perinatal services being provided by the Trust gathered momentum within the community. Ultimately 1,486 families were included in the Report, their case notes being scrutinised by a team of 60 clinicians.

On the other hand, only 98 members of staff (including both past and present) agreed to contribute to the review. The Report expresses disappointment at this low number as it lessens the understanding about what was happening at the Trust. The two reasons given by the staff for non-participation was that they were advised by the managers of the Trust not to take part. The second reason was a concern about the possible police investigation at the Trust. Although the review committee gave assurances around confidentiality, the staff remained apprehensive.

The headline findings of the Report are concerning. It found that 201 babies and 9 mothers may have survived if better care had been provided to them. There were also concerns about 94 babies who suffered brain injuries. The current CEO of the Trust said that words will never be enough for the unacceptable and avoidable failings. She added that many positive changes have been made in the delivery of care. There is now a senior doctor on the labour ward 24/7.

The maternity services in the Trust were based on a hub and spoke model. It consisted of a single consultant led unit which was originally sited at the Royal Shrewsbury Hospital which subsequently transferred to the Royal Hospital, Telford in 2014. There were five midwifery led units (MLUs) in the surrounding area. In 2009, for example, there were 3,871 births in the consultant led unit and 1,280 births in the MLUs. By 2020, three of the MLUs had closed with the remaining two delivering just 239 babies.

The Report tried to be balanced. It recognised that it was reviewing a maternity and neonatal service over a long period of time. It appreciated that when a hospital is being investigated there is a tendency to view all its activities through a negative prism. Throughout the Report the narrative provides examples of good care as well as the cases of poor care. As pointed out by Knight and Stanford[2], pregnancy, labour and birth are never predictable, and events can rapidly escalate into life threatening emergencies requiring a rapid and appropriate response. They added that the great strides in perinatal care can only be maintained by deploying sufficient skilled staff, multidisciplinary care, and a focus on patient safety.

For the most part the criticism levelled at the Trust's perinatal services are about how the commonly encountered problems of maternal and infant care were managed. This is exemplified by the two index cases. Baby Kate died shortly after birth in an MLU. Her mother had been worried about reduced fetal movements. There were subsequent issues during the labour and the conduct of the neonatal resuscitation. Baby Pippa died the day after a home birth. The cause of death was GBS meningitis. During the preceding night the mother had contacted the midwifery staff on a number of occasions because she was worried about the baby's breathing, feeding, and other symptoms. Insufficient action was taken.

There were examples of substandard management of fetal growth retardation (FGR). This included inconsistent taking of measurements, incorrect plotting on the growth chart, and indecision about triggering further management. The other commonly encountered clinical scenarios where care was insufficient included – gestational diabetes, hypertension in pregnancy, and multiple births. The review team identified a failure to follow national clinical guidelines.

The inpatient antenatal care came under considerable scrutiny. It is pointed out that 12% of all pregnant women are admitted to an antenatal ward during the pregnancy. The criticisms included the lack of structured ward rounds, consultant supervision, handovers, and delays in transfer to the labour ward.

The review noted the Trust's low caesarean section rate of 14% compared with the UK national figure 23% at the time. It states that this was a misleading and counterproductive target considering the high rates of perinatal complications including birth asphyxia that were being experienced.

The timely escalation of care was found to be deficient in some cases. This is an item that comes up repeatedly in reviews of this type. Escalation often requires someone who is both experienced and assertive with leadership qualities. It is difficult to get right. A unit can end up under-calling or over-calling. It is better to over-call in that it does not do any harm apart from triggering additional senior reviews. Under-calling, on the other hand, can result in the delay of treatment leading to an adverse outcome. Escalation works best when there is good teamwork and a mutual respect for everyone's roles.

There were a number of cases where the newborn life support algorithm was not followed correctly. This was particularly the case where cardiac compressions were commenced before establishing lung inflation. If the airway is not first established, the cardiac compressions will not be effective. The Trust was a late adopter of CO2 detectors. This led to multiple extubations and re-intubations due to uncertainty about the tube placement. On the other hand, there were many examples of good neonatal management. The neonatologists gave a high level of neonatal input both during the day and out of hours. In addition, they had pointed out their concerns about the high incidence of birth asphyxia, the lack of IUGR recognition, and trauma secondary to instrumental delivery. In summary, the Report found no evidence of systemic poor neonatal practice, lack of care, or compassion in the neonatal service.

The Report is critical of the decision of the Trust to continue acting as a tertiary unit for many years after it had been re-designated a local neonatal unit (level 2). This designation directed that unit should transfer all cases less than 27 weeks gestation to the tertiary centre and should only undertake short-term intensive care in more mature infants. There were a number of cases where a diaphragmatic hernia was delivered and stabilised locally rather than in the tertiary centre. The review pointed out that at least 85% of births less than 27 weeks gestation within a network should be delivered in the tertiary centre.

There were similar reservations about the management of complex pregnancies. There were examples of being overly confident. There was a reluctance to transfer antenatal cases. In summary the review felt that the perinatal services, in some instances, had been operating beyond their designated scope.

Considerable sections of the Report are reserved for the examination of the Trust's responses to adverse events. The review group states that it failed to investigate, failed to learn, failed to improve. As a consequence, it failed to safeguard mothers and their babies. The reviews of cases with an adverse outcome were cursory, non-multidisciplinary, and did not identify the principal cause of the problem. It was found that there was a down-playing of serious incidents to a local methodology exercise. As a result, the true scale of serious events that occurred in the Trust went unknown until the Ockenden review was undertaken. There were inconsistent responses to complaints. In some cases, there was a lack of preparedness for follow-up briefings. Complaints were responded to with inaccurate information including omissions of relevant information.

This Report represents a detailed analysis of the sequence of events that can happen when clinical care goes wrong. Many of the Report's findings are generic and could be applied to any branch of medicine. If adverse, unexpected, and unpredicted outcomes are not properly investigated, lessons will not be learned, and the error is likely to occur again. Units should continually benchmark their outcomes in relation to national[3], and where necessary, international standards. When a hospital's data set indicates that the complication rates are above the normal range, a more in-depth review should be triggered. Persistent variation in clinical care statistics is often the bellwether of a bigger systemic problem.

References:

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3. Thornton J. Ockenden report a 'watershed moment'. Lancet 2022;399:1371