THIS Institute, Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK

director@Thisinstitute.cam.ac.uk

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# Learning from maternity service failures at East Kent Hospitals

## Preventing these recurring tragedies requires a highly coordinated system level response

Mary Dixon-Woods *director*

The report into failings in maternity and neonatal services in East Kent Hospitals University NHS Foundation Trust is the latest in a horrifying series of investigations into maternity care.[1] Led by Bill Kirkup, it yet again bears painful witness to the anguish of families. The outcomes in half (97) of the 202 cases reviewed would have differed had care been given to nationally agreed standards. Many of the deaths (45 of 64) and brain injuries (12 of 17) in babies could have been avoided, as could most maternal deaths and injuries (23 of 32). Beyond these grimly countable outcomes, women and their partners experienced multiple indignities, and families who sought understanding and redress were often exposed to further trauma.

## Multifactorial and cumulative

The failings at East Kent have much in common with other high profile disasters in healthcare and beyond: the origins are multifactorial and cumulative, arise from a complex tangle of behaviours and systems in dysfunctional settings, and evade detection and effective action over long periods, often extending to years.[2] It is, however, organisational and institutional failure to tackle unacceptable practices and behaviours over more than a decade that is an especially egregious feature of East Kent.

One important problem was that unprofessional behaviours by some consultant obstetricians were not tackled. Some consultants did not attend labour ward rounds, review women in labour, draw up care plans, or attend the hospital on request when they were on call. Although the Royal College of Obstetricians and Gynaecologists identified such behaviours as a major problem in its 2016 report on the trust, it seems they may have played a role in the death of baby Harry Richford in 2017.

The trust seems to have been supine in dealing with the problem, apparently believing that it would probably lose at an employment tribunal if it took disciplinary action against consultants. It is unclear whether this perception is grounded in evidence. In addition, the General Medical Council declined to initiate fitness-to-practise proceedings in 2020 on the grounds that its role did not extend to "lower-level behavioural issues, or cultural issues, or attitudinal issues," indicating a surprising ambiguity about what counts as reasonable concern. Regulators and national agencies need to work together to review employment and case law, contracts, and national standards to produce clear integrated guidance on how to deal with such matters within the current complex ecosystem of local and national bodies.

A second problem was that bullying, harassment, and discrimination were endemic at East Kent, with words such as "horrible" and "sickening" used to describe the culture. Management systems, including human resources (HR) processes, seem to have been seriously defective in dealing with the nature and scale of the challenges. For example, bullying and harassment policies at the trust—in a possible misinterpretation of the Advisory, Conciliation and Arbitration Service (ACAS) guidance—required the people raising concerns to speak with the subject of the complaint informally. This was a deeply misguided approach, since the trust comprehensively failed to ensure that it was safe to do so.

Particularly disturbing is the evidence of racial abuse detailed in the report, with the trust rated one of the worst in the country for workplace diversity and attitudes towards cultural difference. Again, HR processes seem to have been unfit for purpose. One midwife of minority ethnicity made three complaints to HR, but each time was told they were over-reacting.[1] Concerns about management making offensive jokes connected to race were minimised, put down to staff trying to be humorous.

The systems that might have supported psychological safety, including people feeling safe voicing concerns, were weak or absent.[3] Staff were deterred from speaking up for fear of retaliation (which in some instances seemed to be justified). They were then perversely blamed for their lack of courage, with trust leadership responding to anonymous concerns in 2014-15 by saying nothing could be done "if no one is brave enough to put their name on these letters." It is in fact possible to investigate anonymously raised concerns. But it is also the case that the guidance on how best to do so could be much improved, with ACAS likely to be the right body to take this forward.

A 2014 investigation concluded that the trust's bullying problem was so bad that one of the units should be shut down because of the risk to women. But diagnoses are useless unless effective treatment follows—and that requires leadership commitment and sound systems,[4] both of which were lacking at East Kent. The confusions and conflicts inherent in the multiple roles of some external bodies again seem to have played a part in inhibiting action.

## System failure

At its most fundamental, East Kent was a system failure. The organisation's weaknesses in tackling poor conduct, behaviour, and culture arose from defects in its leadership and management (especially HR processes), but the wider context was also important. When the trust was clearly unable to handle the situation—or even properly recognise that it was happening—there was no effective mechanism

to take over. In some cases, bodies that might have supported action may have made things worse.

The chillingly recurrent discovery of the same failings in report after report in maternity care and elsewhere represents an unforgivable forgetting of painful lessons.[5] Stopping another repeat will require a system level, highly coordinated response that deals with the overlaps and underlaps of the multiplicity of bodies and confusions about their authority and responsibilities[6]—as well as vastly improved management systems in NHS organisations, buttressed by clear, authoritative external standards and guidance. It will also require sound, evidence based approaches to improvement that genuinely involve staff and patients.[7]

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