HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Safety of maternity services in England, HC 677

Tuesday 3 November 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

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Witnesses

I: James Titcombe OBE, bereaved parent; and Darren Smith, bereaved parent.

II: Helen Vernon, Chief Executive, NHS Resolution; and Dr Pelle Gustafson, Chief Medical Officer, LÖF (Swedish Patient Insurer).

III: Dr Jenny Vaughan, Consultant Neurologist, and Learn not Blame Policy Lead, Doctors' Association UK; and Dr Sonia Macleod, Researcher in Civil Justice Systems, Centre for Socio-Legal Studies, Oxford University.

Examination of witnesses

Witnesses: James Titcombe OBE and Darren Smith.

Chair: Good morning. Welcome to the House of Commons Health and Social Care Select Committee. Today, we have our second evidence session on the safety of NHS maternity units, following the serious issues being investigated at a number of trusts, including Shrewsbury and Telford, East Kent and other places.

In this morning's session, we are particularly looking at how difficult it is to get to the truth when there is an accident or a tragedy, and whether the threat of litigation and the involvement of lawyers has a chilling effect that makes it difficult for doctors, midwives and nurses to be open about things that have gone wrong.

We have some very important witnesses this morning. Dr Sonia Macleod is an expert from Oxford University; Dr Jenny Vaughan is a doctor who has campaigned extensively on these issues; Helen Vernon is the chief executive of NHS Resolution; and from the west coast of Sweden, Dr Pelle Gustafson is the chief medical officer from LÖF, the Swedish organisation responsible for maternity compensation in Sweden. The reason we have invited Dr Gustafson is that Sweden has a neonatal death and injury rate half of that in England. We think there may be some important lessons we can learn from the way the issue is approached in Sweden.

As I mentioned in our first session, but it is important to say it again, nearly 700,000 women give birth on the NHS every year in England, and the vast majority are completely safe. That is very important context for all our discussions. Sadly, it is not the case for every family. We start this morning by hearing from a couple of families where, tragically, the birth was not safe and ended up with a very distressing bereavement in both cases.

Committee member Laura Trott is going to talk to James Titcombe, who lost his son Joshua in 2008. He received an OBE for his campaigning on maternity safety and is probably one of the best-known maternity safety campaigners in the country. Sarah Owen is going to talk to Darren Smith, who lost his son Isaac in 2012. For the purpose of transparency, I should mention that James Titcombe is a trustee of Patient Safety Watch, a patient safety charity that I set up.

Q71 **Laura Trott:** Thank you, Chair. Thank you so much, James, for appearing in front of the Committee today and for all the work that you have done on maternity safety. Can you start by outlining for the Committee what happened in the lead-up to Joshua's tragic death?

James Titcombe: Thank you, Laura, and good morning. These events happened almost exactly 11 years ago to the day. Joshua was our second child, and we were looking forward to him arriving for Christmas-time. In the build-up to when we were expecting him, about three weeks before he was due, my wife and I were feeling very poorly. We had headaches and sore throats. We were not very well. On the Saturday night, my wife shouted at me from the bathroom, "James, my waters have broken." We went to the hospital and explained that we were feeling poorly. We were reassured that it was probably a virus and were sent home.

The next day we went back, were checked over again and sent home. On the Monday morning, Joshua was born. Things went very badly wrong shortly after that. The initial concern was my wife, who suddenly collapsed after the birth. She was given antibiotics and fluids. During the next 24 hours we raised many concerns about Joshua; he was lethargic, he wasn't feeding and he struggled to maintain his temperature. None of those concerns prompted a paediatric review and, 24 hours later, sadly Joshua collapsed with overwhelming sepsis, which was the same infection that had caused my wife to collapse. From that point onwards he had a desperate struggle for life that was very traumatic.

Q72 **Laura Trott:** Why do you think that your concerns were not listened to?

James Titcombe: It is very difficult to know. There was a very poor and dysfunctional relationship in the unit at the time Joshua was born; midwives and doctors were very much separate, and working in silos. There was a culture where people were not talking to each other. It was almost like a turf war between doctors and midwives. Sadly, that request for help and for a paediatric review did not happen. Joshua collapsed and he had nine days of various intensive care. On 5 November 2008, he bled to death because of the injury to his lungs from the untreated infection.

Q73 **Laura Trott:** I am desperately sorry, James. What did you feel was the trust's response to what seems to be a catalogue of errors in your case?

James Titcombe: This was the most shocking thing for me. At the time I was working in the nuclear industry and was very used to a culture where problems are identified and scrutinised. It slowly emerged that the trust was not going to respond openly and honestly to what happened to Joshua. His observation chart went missing. We knew he had a low temperature because we saw the observations, but we were told that his temperatures were normal.

Lots of things happened, and I can only liken it to how perhaps a dodgy second-hand car salesman would try to sell a car that he knew was not fit for purpose. It was all about misrepresenting what happened. Reports were commissioned that showed there were wider problems in the unit that the chief executive buried because he was worried about getting foundation trust status. Individuals covered up. It put me and my family, who were vulnerable and desperate for help and for answers, through an agonising process that went on for years and years of having to fight dishonesty and covering-up. The real tragedy is that during all that time—because eventually there was the Kirkup investigation into what happened at Morecambe Bay—other mothers and babies continued to be at risk from the same problems.

Q74 **Laura Trott:** Absolutely appalling. Do you think things have got better? You have obviously done a huge amount of work in the area subsequent to that. Do you think that things have got better, and do you think the same situation could happen now, or do you think that things have improved and it couldn't?

James Titcombe: There have certainly been some major changes since Morecambe Bay. We now have HSIB and they investigate. If Joshua died tomorrow, HSIB would go in and do an investigation, so, hopefully, we would not go through that whole process.

However, while saying that things have changed, there are very clear signs that things are repeating. When we look at Shrewsbury and Telford and East Kent, and at some of the information that is coming out about those services, it is very similar to issues that we found at Morecambe Bay. It tends to be, yet again, the families involved in the cases who act as the canary in the mine and raise the alarm, rather than the system. There is some progress but a very long way to go before we have truly learnt the lessons from Morecambe Bay.

Q75 **Laura Trott:** You spoke earlier about the disconnect between the midwives and the doctors. One of the things we heard about earlier in this inquiry was the push for normal birth, and that being an issue in maternal safety in some cases. Was that underlying what happened in your case? Were there any indications as to what caused the disconnect?

James Titcombe: I firmly believe it was. From a very early stage, it was clear that there was not the communication that is needed in maternity. Doctors and midwives need to work closely together. Some of the themes from other cases at Morecambe Bay clearly showed that. Dr Kirkup said that the over-zealous pursuit of normal birth ideology at Furness General was a major factor in what happened.

The reaction to the Morecambe Bay report was quite controversial. There was lots of dispute about it, but from all my experience of meeting other parents and talking to staff, I believe that it is an issue that affects maternity safety today. We need to change the very term "normal birth". For me, any birth where a woman and a baby get the appropriate care they need that is safe is the definition of what normal should be in a modern maternity system. I think it is an issue, and it is one that we need to get to grips with.

Laura Trott: Thank you very much, James. We appreciate you coming to the Committee today.

Q76 **Chair:** James, do you think that there are still midwives in NHS maternity units today who are wrongly encouraging mums to have—I won't use the phrase "normal birth"—a standard non-surgical birth, when it would be safer if they had surgery?

James Titcombe: It is an influence that comes into maternity care. I think it comes in through antenatal classes, where the information that people are given is not always as unbiased as it should be. There is a bias sometimes towards the benefits of natural birth.

It is important to say that some women want a birth with minimal intervention, and I am not arguing against that. The important thing is that low risk does not mean no risk. Things can go wrong quickly in maternity services, and, when they do, a safe outcome depends on the multidisciplinary team working effectively together. I am concerned that sometimes the culture in some units does not provide a multidisciplinary approach and I certainly think that the ethos of normal birth can be an influence in that.

Q77 **Chair:** This is a short Select Committee session and you do not have time to explain the whole story, but do you believe that one of the reasons that Joshua died was that the midwives caring for him hesitated for too long before they brought in doctors who might have been able to help deal with a birth that was in difficulty?

James Titcombe: Absolutely. There was a culture of, "We don't need doctors here." The death before Joshua involved an obstetrician who tried to intervene in the birth, and the midwife put her foot in the door to stop the obstetrician coming into the room. It was that kind of culture that led to the breakdown in multiprofessional working at Furness General Hospital and was, I believe, an absolutely crucial factor in what happened to Joshua.

Q78 **Rosie Cooper:** James, in the years since you sadly lost Joshua, you describe some things as having improved and others perhaps staying the same. I was particularly struck by your saying that families are the canary in the mine. You are saying that, even when families vocalise the problems that there are, regulators and senior people in hospitals and medical fields—however that goes—are not listening. After your 11 or 12 years of campaigning, what do you think could help families' and patients' voices be heard before we have a tragedy and before we have to hit the press? What would make people listen?

James Titcombe: That is such a good question, Rosie. The recent Cumberlege "First do no harm" report—not into maternity but related—made a recommendation about a patient safety commissioner, precisely because in that area, with the mesh campaign, there were years and years of families raising the alarm and it not being listened to. That patient safety commissioner recommendation would be one potential solution; it would be somewhere that families could go to ensure that their voices were heard.

Short of that, it is about the regulators, the CQC and the NMC, placing the experience of families at the heart of what they do. We could make all kinds of changes to make that easier. There are barriers, which I am sure will be covered in this session, to do with litigation, defensiveness and a culture where organisations want to diminish things that are obviously going wrong and do not hear what families say. All those changes—ensuring that there is a just culture and that families are truly listened to early on—would make a difference.

Q79 **Rosie Cooper:** Absolutely. In my view, and I hope you share it, patient complaints are actually the measure of what is going on in an organisation. If people only addressed them, we would get rid of these kinds of terrible tragedies.

James Titcombe: I absolutely agree, but even before that, before you get to the point of a complaint, every serious incident needs to be properly investigated, and I have campaigned for that for a long time. That is still a big missing bit. We have HSIB, but there are still a lot of local investigations. Very often, we still ask people in those organisations, who have very little training and are not independent, to investigate terrible and serious incidents, and then we wonder why we do not always get the learning and ensure that truthful learning comes out.

Chair: Thank you, James. Sarah Owen is now going to ask some questions to our second witness this morning, Darren Smith.

Q80 **Sarah Owen:** Thank you, Chair. On behalf of everyone on the Committee, Darren, I am sorry for your loss. Thank you so much for coming to the Committee today. Could you start by sharing your experiences of maternity care with the Committee, please?

Darren Smith: Thank you, Sarah. On 27 July 2012, we had our final scan at 36 weeks plus five days. It all went fine, but as we left the scan room my wife felt a gush. She thought that her waters had broken. In reality, they had not; she was suffering a placental eruption. We were at the hospital and were able to go straight to the maternity A&E. We were in the perfect place for something like that to happen.

Unfortunately, the hospital decided that they would monitor. Although my wife was bleeding a lot, they decided that they would just monitor the situation. We did not know what was really going on. We had heard them mention the words "placental eruption", but other than that we did not know what that meant for us.

They hooked my wife up to heart monitors and she was monitored for about two and a half hours, and our son's heart rate was dropping all the time. They then rushed us in for an emergency C-section. He was born still. He was resuscitated but he had suffered catastrophic brain damage from a lack of oxygen. He was transferred to St Thomas', where he underwent something called brain cooling, which is a treatment to stop further brain damage taking place. Sadly, because of the damage that had been done, he passed away, aged six days.

Separate from that, my wife was still at the original hospital. Her care post birth was not particularly great either. The sort of things that happened there were that just post surgery, having lost a lot of blood, she had to cope with one of the obstetricians in tears in the room with her, obviously upsetting her as well because she did not know what was really going on. She was given medication to stop her producing milk. When she got to St Thomas', they were completely shocked by all of that.

Those are the basics of what happened. We left St Thomas' after six days, with Isaac having passed away, not knowing whether what had happened was correct or not. It just happened that we went back there about a week and a half later to sign the birth certificate and the death certificate, and our consultant at St Thomas' asked for a word. He said that he was going to ask for an initial investigation because the timeline did not seem right. That was the first hint that something was not right in what had happened.

If we fast forward to the results of the negligence case, if they had followed the correct guidance for a placental eruption, he would still be here.

Q81 **Sarah Owen:** I am so sorry, Darren. I know this is incredibly painful, but the Committee is grateful to you for sharing your experiences.

From the moment that your wife started bleeding during the scan through to Isaac's birth—

Darren Smith: Can I correct that? She bled after the scan.

Q82 **Sarah Owen:** From that moment onwards, how informed were you and how involved in the decision-making processes were you and your wife?

Darren Smith: If I am perfectly honest, everyone was so relaxed about what was going on that it did not feel like there was anything significantly wrong. It felt like they were managing the situation. In terms of our involvement, we went along with what they were saying because we thought they knew best.

In reality, and what came out in the inquiries that followed, we were dealing with two junior doctors. They only had one obstetrician on duty at the time, and she was dealing with another patient. There were junior doctors making the decisions, and the first we saw of the obstetrician was once we were having the crash caesarean. The only reason we were even called in for that crash caesarean was the fact that Isaac's heartbeat had dropped so much that it was impossible to tell the difference between the mother and the son's heartbeat. That is the only reason why they went down that route.

Q83 **Sarah Owen:** How do you feel about the trust's response?

Darren Smith: If I am honest, it was appalling. St Thomas' had requested an investigation from North Mid. We received that investigation a couple of months later. It was about three or four pages long and had three recommendations, one of which was that, given the circumstances, they should not have done a C-section and they should have done a natural birth, resulting in a stillbirth.

On the back of that, we wrote a lot of questions and then got to meet the team involved in the case. We were getting very mixed messages. We were told things like, “Well, we don’t have a process and procedure for if there is bleeding,” which seemed bonkers. Nothing seemed to make sense at all. We were getting really mixed messages, so we requested an external inquiry. I have some notes, because of what they specifically said in the external inquiry. They mentioned that, in the future, the panel for the initial inquiry should be more thorough, and that recommendations and lessons based on the proposals would not change anything.

On the back of the external inquiry, we had a load more questions that we went back to the hospital with, and the shutters came down. We heard nothing at all. In a bizarre turn of events for us, about three months later we saw an article saying that North Mid maternity unit had been awarded a patient award by the Nursing and Midwifery Council for 100% satisfaction from patients in July.

That ramped it all up for us. On the back of that, we sent letters, not only to the hospital but to the Nursing and Midwifery Council and everything. This may be coincidence, but obviously from our point of view we think it was all linked; suddenly, we were in touch with the chief executive of the hospital. He got in touch saying that the reason he had not been back in touch since the external inquiry was that he wanted to get the full picture first.

They then redid their internal inquiry, which resulted in more questions. We went to meet the chief exec and a number of the directors to talk through it. Again, that was not a particularly comfortable situation, obviously, and was made worse by one question. We gave a response about the way one of the members of staff had acted, which resulted in two of the directors laughing. That seemed beyond anything you could ever imagine when you are grieving for your child. You want answers.

In reality, the whole process made us realise that we were quite fortunate, in that we could understand what all the inquiries were saying. We could see that they were not right, and we could go back and ask questions. We live in an area of north London where English is not always the first language. You have to wonder what other patients would have done in the same situation. Would they have continued to question it?

The end result was that the final real response we had from the hospital at the time was, “Yes, we made mistakes and there were delays, but chances were that he would have died anyway because it was a placental eruption.” The medical negligence expert witnesses who followed over the years had a very different opinion. They cited 30 or 40 different points that would be identified as negligent issues during our treatment.

Q84 **Sarah Owen:** Was that one of the main factors that contributed to your decision to pursue legal action?

Darren Smith: In reality, the reason we ended up pursuing it was that we wanted an apology. We were in a position where we could ask questions. We could try to make sure that it did not happen to other people, but the messages we were receiving were so mixed that nothing made sense. Their stories were changing all the time. We could not trust what was being said. There was no transparency, so you started to question everything and what they were really hiding throughout the whole course.

Given that the initial external inquiry that we had had done showed that the initial report was wrong, we felt it was the only way we could go about trying to get an apology. Even two years down the line of that medical negligence inquiry, when all the expert witnesses had said, "Yes, he would have survived if they had followed the correct treatment," the apology we then received initially was, "We are sorry for the shortcomings in your care." We are still grieving, because it continued all that time. Every time you get a new report, with a new expert witness, you relive it all again. A simple apology would have been nice.

Q85 **Sarah Owen:** What do you feel needs to change to improve the experiences for other families?

Darren Smith: Once we knew something was wrong, we needed honesty and transparency. You can't grieve your child when all this is going on. It rumbles and rumbles and goes on and on. We both deal with anxiety issues now. My wife suffers from PTSD.

It is about transparency. The whole of the medical negligence process is made to be a battle. It should not be, but it feels, going through that process, that the reality is that, when you get into the medical negligence process, there is nothing about improving the situation. From their side of things, it is about, "What are we going to do to make sure this isn't going to harm us or cause us issues?" That feels completely the wrong way to go about the whole medical negligence process.

There are strange little intricacies that had a major impact for me, personally. In the medical negligence process, you have a primary and a secondary person. What happened happened to Isaac and to my wife, so they were the primary people in the case. As a secondary person, it ended up that I was not even allowed to be called a victim, because of something called dawning consciousness. This may be unique to our case; I don't know. Isaac survived for six days at hospital, but court cases to do with anxiety and mental health issues say that things like PTSD should only be one specific shock incident, and that, as he survived for six days, you should accept that it is going to happen and not suffer any long-term issues as a result. There is that side of it as well, which obviously is not specific to how we can improve the situation, but, for parents going through it, that is something else they should not need to be worrying about. It is a whole set of processes that just extend the pain and suffering.

In reality, would it have been easier not to have gone down that route? For our mental health, yes, but we wanted an apology and we wanted to make sure that it does not happen to other people.

Sarah Owen: Thank you again, Darren, for coming to the Committee. I have seen your fundraising efforts and they are an absolute inspiration.

Chair: It is a privilege for all of us to hear those pieces of evidence. Thank you very much indeed, James and Darren. I do not think any dad could have done more than you have both done for Joshua and Isaac. We really appreciate you joining us this morning.

I am now going to move on to our next panel, but Darren and James are staying with us for a while. I have indicated to them that they are very welcome to chip in if they have further comments to make later on.

Examination of witnesses

Witnesses: Helen Vernon and Dr Gustafson.

Q86 **Chair:** I welcome Helen Vernon, who is chief executive of NHS Resolution, the NHS organisation that has to deal with these very difficult cases, and ultimately decide on the compensation given to families when things have gone wrong.

Dr Pelle Gustafson is the chief medical officer of LÖF, the Swedish patient insurer that deals with maternity cases in Sweden. We are very grateful to both of you for joining us.

First of all, Helen Vernon, can I ask for your reaction to the stories that we heard from James Titcombe and Darren Smith?

Helen Vernon: Good morning, and thank you, Chair, for the opportunity to contribute to this inquiry. What James and Darren both went through is truly awful. I express my admiration to them both for their experience this morning. I have heard James speak powerfully many times, and his story never fails to shock me. What he and Darren have been through is, of course, utterly heartbreaking. No bereaved parent should have to fight for answers in the way they have both had to do.

Very sadly, what they both describe is often what we see in claims. There are issues about how multidisciplinary teams work together, which they both raised, and particularly how they respond to emergency situations. That is something that comes up time and again in the maternity claims that we see. There are issues of leadership and whether or not there is an open culture, and whether the hierarchies in medical teams prevent the escalation of concerns. Again, that is something we see very frequently.

On the issue of transparency and candour, and why people bring claims in the first place, our research has demonstrated that, when something goes wrong, people very much want to prevent the same thing from happening to others. As Darren described, they want to receive a genuine apology or an explanation for the incident, or to trigger a detailed investigation. Often, those investigations are sadly lacking. Sometimes, but not always, they want to receive compensation and to get it rapidly.

Families have often reached the end of the road. They feel that they have not been listened to. They feel that they have no alternative but to seek the help of a lawyer. There are often multiple processes at play. We have incident reporting. We have the investigation and complaints system. We have regulation and professional bodies. Finally, we have the compensation system.

If the response is open and humane and focused on the family right from the off, we find that things are less likely, not more likely, to escalate into litigation. Unfortunately, when they do and a claim finally comes to NHS Resolution, which can be many years down the line, relationships have often broken down and time can have eroded the ability to learn. We are often left with an intractable dispute. In the worst of all worlds—although, thankfully, it happens quite rarely nowadays—families and healthcare staff can be put through the trauma again by having to relive their experience in a courtroom.

Q87 **Chair:** Could I interrupt you for a moment? When I was Health Secretary, I used to have to settle, through you, about two multimillion pound damages claims every week for families whose children were born severely disabled and had to be looked after for the rest of their lives. One of the things that shocked me was that the only way a family could get compensation was to prove that there had been clinical negligence, either by a clinician or by a trust.

Do you think that the fact that you have to prove clinical negligence to get compensation is one of the things that can mean that battlelines are drawn very early, and it is difficult to get the open and transparent resolution that you have been talking about?

Helen Vernon: You are right that there are roughly two cases every week of a multimillion-pound value. What a family going through that process has to prove is that there has been some failure in the care, and that that failure resulted in the outcome that sadly occurred for them.

Q88 **Chair:** For the benefit of the Committee, what is the biggest-ever clinical negligence claim that you have settled? I think it was this year, wasn’t it?

Helen Vernon: It was. It is in the region of £37 million for that single incident. That is the lump sum valuation. There are ongoing care costs that are payable for that person’s life, sadly due to the very serious injury that they suffered.

Q89 **Chair:** If you had a disabled child, it would be only natural that you would want as much financial support as you could possibly get in order to look after that child. If you are advised that the only way you can get that compensation is to go to court and get a lawyer to prove clinical negligence, that is what you are going to do, isn’t it? It makes it very difficult to resolve things in the open and transparent way that you were saying was desirable.

Helen Vernon: There is often a misunderstanding about the number of cases that go to court. We settle around three quarters of cases without them going into court proceedings, although for very serious cases it is necessary for court proceedings to be commenced at some point, so that the court can approve the settlement for the child. It can often be a lengthy process because the court has to be satisfied that the settlement that has been agreed between the parties will provide for the child for the rest of their life. We are talking decades into the future.

The other thing that can slow the process is that it is often very difficult to assess what the needs will be until the child is five, six or seven years old and it is clear what their accommodation, care, educational and equipment requirements will be for the rest of their life. Yes, court involvement is necessary, but it is not always the way in which those cases get resolved. The vast majority are resolved through negotiation and mediation.

Q90 **Chair:** You say that you are settling two multimillion-pound settlements every week. On average, I think it is about five years for these things to be resolved, when they have got to the stage of being resolved through a court.

You obviously have to work within the current legal framework. If you and I had swapped places when I was at the Department of Health, and you had been responsible for the law and wanted to reduce the number of maternity safety incidents, having listened to the stories you have heard from Darren and James, what changes in the law would you want to make our system more just, fairer and quicker?

Helen Vernon: Something that we have tried to do within the existing legal system—

Q91 **Chair:** I am going to cut you short, Helen. I don’t want to know what you are doing within the existing legal system. I want to know what changes in the law you would want.

Helen Vernon: I am describing it because the framework we have set up, if it were enshrined in the law so that it is an alternative way to resolve these cases, might be considered a better way forward for dealing with the multimillion-pound claims. What we are trying to do is take those cases out of the legal system, deal with them sooner and compensate needs in real time so that families do not have to wait, and try to accelerate the liability investigation so that families can get answers sooner and the organisation can be supported to do what it needs to do to pursue a high-quality investigation and ensure that families get the apologies and explanations to which they are entitled.

That is why I describe it as an alternative approach. We are, effectively, removing those cases from litigation and court proceedings. Ultimately, they will have to go to court to approve the settlement, but it is another way of challenging the system, so that cases can be addressed far sooner than has historically been the case. As you say, they come at a very high cost.

Q92 **Rosie Cooper:** We heard from Darren that, after the tragic loss of Isaac, all they initially wanted was the truth and an apology, yet only a small number of qualifying cases for the early notification scheme receive admissions of liability and apology within 18 months. What are the barriers, and what is NHS Resolution doing to address this real and serious problem?

Helen Vernon: It goes back to the system that I was describing, which is, as you say, our early notification scheme for obstetric cerebral palsy. What we tried to do was to break away from the traditional model and to disrupt the somewhat formulaic and lengthy pathway that families have had to go down in order to secure compensation.

Before that scheme was introduced, it would take six and a half years for us to hear about a case. Now that timeframe is four and a half months. The reason is that we can accelerate the investigation of compensation entitlement, make small interim payments to meet needs when they arise, ensure that the trust does the right thing in being open and transparent with the family, and feed learning back to the trust and the wider system at the time when it is most relevant to them.

As you say, like many fundamental changes to how things are done, it has not been without its challenges. One of those has been the eligible cohort that has been reported into the scheme. Like HSIB, we adopted the "each baby counts" definition for eligible cases. That brings around 700 incidents into the scheme.

It is a wide cohort. It is a wide number of cases. It is many more than we would, on average, compensate every year. It lacks specificity as to the core objectives of the scheme, particularly given that only a small number of that 700, which we estimate to be in the region of 10%, have evidence of a confirmed hypoxic brain injury and poor care in the intrapartum period. That cohort is even wider now because of advances that have been made in relation to neonatal cooling. That has led to the pool of reportable incidents widening still further, so we have convened a group of clinical experts to define intrapartum hypoxic brain injury to narrow the pool. A narrower national definition will also enable a more accurate measurement of the rates of brain injury.

In answer to your question, there is a very wide pool of incidents reported, of which only a very small number are cases that will be eligible for compensation entitlement. The number where we have been able to make admissions, now 93, is in the realms that we would expect. As I alluded to earlier, the challenge is causation. While you can establish that something may well have gone wrong with a child's care, you then have to establish that that resulted in the compensable brain injury, and that can take many years to determine—

Q93 **Chair:** Sorry to interrupt, but it is not just avoidability; you have to prove negligence if it is going to get compensation.

Helen Vernon: Exactly, yes.

Q94 **Chair:** That is a very high bar. Even though the doctors and nurses in a case could well accept that it could have been prevented and that the mistake was avoidable, before someone gets compensation you have to prove that a doctor, a nurse or a trust behaved in a negligent way. Is that correct?

Helen Vernon: Yes, that is correct. That is the basis of the existing law. That is the law within which we have to work. We are not able to award compensation when there is no negligence.

Q95 **Rosie Cooper:** Having listened to that, and taking in your last question, Chair, how is NHS Resolution identifying trusts that excel at handling incidents and complaints, and how do they ensure that learning is shared with trusts and other organisations? I do not mean just sending them an email or a letter; I mean outcomes. How do you measure the success of your messages?

Helen Vernon: On the EN scheme, we do that in real time. We employ obstetricians and midwives to work with the trust when incidents are reported to us, to identify evidence of good and poor practice. That is fed back in real time to the organisations, but we also draw it together to create wider learning for the system. We share that very rapidly through a variety of means.

There is aggregated information, which goes back to the trusts on their own risk profiles. We work with the Getting It Right First Time programme to benchmark them against each other's performance. We also publish national reports, publications, videos and conferences to try to hit the mark with frontline clinicians, to ensure that the learning gets back to them and that it is usable and useful for them in their everyday clinical practice.

Q96 **Dr Davies:** Essentially, my main concern is the fact that birth injuries have not improved in recent years. Fundamentally, how would you say that you are looking to address that?

Helen Vernon: We address it in three ways at NHSR. We undertake research, as I have just described. We look at individual cases at micro level, where information needs to get rapidly fed back to the trust, and at a more macro level to see what can be learnt for the system. One of the advantages of a state scheme is that you have all the information in one place. Through our partners, such as the royal colleges, we can get that back to the system as a whole picture of what is happening in maternity services in England.

The second thing is early notification, which I have just described, and completely removing from the process the time lags that can be a barrier to learning, so that we hear about incidents as soon as possible after they happen. As I was describing earlier, learning can go stale if things are left for many years before the opportunity to engage with the organisation and hear from the family arises. We want to accelerate learning and ensure that change happens rapidly, as well as following up with organisations to make sure that changes they promise to make have been implemented.

The third thing is incentivisation. Through our maternity incentive scheme, which we delivered in partnership with the national maternity safety champions, the arm's length bodies and the royal colleges, we have introduced a real financial incentive into the system to support the 10 safety actions—10 key things—that the system feels need to happen in order to improve maternity safety. That has been demonstrated to create greater visibility—

Chair: Helen, I am so sorry, but because we have lots of other witnesses, and this is such an important area, could you keep your answers very brief?

Q97 **Dr Davies:** Helen, you have touched on the reasons why people pursue legal action. Are you content that everything is being done to minimise legal action, using the data that exists?

Helen Vernon: More could be done in the area of transparency and candour. That is something we have long and actively pursued. As I said earlier, if things happened sooner in the process, it would not escalate into legal action in the first place. Absolutely, more needs to be done. We all need to do more in that space.

Q98 **Dean Russell:** James and Darren, thanks for your powerful testimony earlier; it was very moving.

Helen, my question ties into the previous questions. How do the learnings from these awful incidents get fed back into the start of training? It sounds to me like a lot of the challenge is that it waits for an incident to happen and then there is a court case, or whatever, and the learnings could be months if not years later. I understand that they might be reported back to the trust and perhaps shared more broadly, but are they also being shared in the early stages of training for new doctors, nurses and maternity staff?

Helen Vernon: There are two things. First, the royal colleges have a big role to play. The Royal College of Obstetricians has something called "Learn and Support" into which we feed information. It aims to get to obstetricians in training so that they pay attention to the lessons that come out of legal claims and feed them into their everyday practice. There is a route through the royal colleges. The Royal College of Midwives also has a role to play.

The area of training where we are most keen to get involvement is in skills for engaging with families—communication skills. That is something we think is probably lacking in professional training at an early stage. We hear that people have an ingrained belief, for example, that you should not admit liability on a case, and you should not be open with a family because it might result in litigation. That is something we have constantly tried to debunk, to encourage candour, and it could be built far more effectively into clinical training.

Q99 **Dean Russell:** Can I ask briefly about near misses? In the awful cases like those we heard about today the worst possible outcome happened, but I imagine that there may be very many other examples where the ultimate outcome was not the same, but the lead-up to it could have been. Is there monitoring of near misses, once you have found out what the pathway was to those awful cases?

Helen Vernon: It is an interesting question; 50% of the cases we get do not result in a compensation payment, and we only see the tip of the iceberg. Lawyers generally only put forward one in every 10 cases that they see, so there is an awful lot of information that is relevant but does not result in a compensation claim.

Again, we only see the thin end of the wedge. We do not get to see the many incidents or near misses that happen in the NHS that do not come to us as a claim. That is where the role of incident reporting and the work that NHS England and Improvement are doing is extremely important.

Chair: We have a slightly more topical question from Laura Trott.

Q100 **Laura Trott:** Helen, given the increase in stillbirths that we tragically saw in the first lockdown, when cases nearly doubled, is your organisation giving any advice to trusts to try to avoid that occurring in the second lockdown?

Helen Vernon: We have been working very closely with the Department of Health and other arm’s length bodies to monitor the ongoing situation through the pandemic, not least because we need to know if it is going to result in further claims down the line. There has been a lot of publicity around that.

We have highlighted what we see as emerging risk, but of course we only know what we know; we are only able to see the information that is fed through to us, as you have described, from trends that start to appear in the wider safety landscape. We are fully engaged in the conversation about some of the mitigations that can be taken to prevent those things happening. We all see it as an emerging situation.

Q101 **Laura Trott:** What are some of the mitigations that you describe?

Helen Vernon: From our perspective, we have started with some of the information that trusts need about what they need to do to preserve records and to ensure that families are properly informed. Some things that in the heat of the pandemic might be of lesser importance are actually of greater importance because they are fundamental to the delivery of high-quality clinical care. Those are things that we have put on to our website and have shared with the trusts. We have also had a role to play in ensuring that trusts do not see indemnity provision as a barrier to delivering the new and novel healthcare arrangements that have been required to respond to the pandemic.

Q102 **Laura Trott:** Can you explain that to me? What does that mean?

Helen Vernon: We have had to introduce a new scheme, for example, because the scope of our schemes did not respond to taking on independent sector providers to deliver some of the care, and the testing arrangements and that sort of thing. We rapidly launched a new scheme, and then we put out a message to the service that gave reassurance on the indemnity arrangements that were in place to ensure that there were no gaps in cover, to enable trusts to get on with what they needed to do to deliver healthcare.

Q103 **Laura Trott:** Do you think there were some occasions in the last lockdown when trusts did not do what they needed to do because they were worried about litigation?

Helen Vernon: No, I have not seen that at all. We have been very firm in the messaging on that, together with the Department and NHS England and Improvement. We have seen no evidence of that.

Laura Trott: Thank you.

Chair: I turn now to Dr Pelle Gustafson, who joins us this morning from Sweden. First of all, thank you very much for joining us. We really appreciate it.

Dr Gustafson: My pleasure.

Q104 **Chair:** According to the latest data that I have seen, you have a neonatal death rate about half that of England. Roughly speaking, that means that if we had the same safety levels as you have in Sweden, 1,000 more babies would survive every year in England that currently do not. Listening to the evidence that you have heard this morning, what do you think are the main reasons for that difference?

Dr Gustafson: I would like to separate my answer into three parts. First of all, I commend both Darren and James for their work and apologise for the tragic events.

In both answers, I think the key lies in this: first of all, the best injury is an injury that never happens. To address that, you have to do what you can to prevent the injuries from happening. Secondly, if disaster still strikes, you have to have a system that addresses it, and both James and Darren expressed that very clearly.

You have to have some kind of candour and explanation, and then some kind of apology and some kind of compensation. Part of the explanation for the figures in Sweden is that perhaps we have addressed both parts.

Both in training professionals and in supporting them, we give them the tools they need to do a good job. Secondly, we assist them to a higher degree, to address especially what Darren mentioned, which is an apology and knowledge that someone is doing something to prevent it from happening again. Then there is the compensation part. We try to do it much quicker. I can only imagine what it feels like to wait for any kind of answer for six, seven, eight or nine years. It must be absolutely appalling.

Q105 **Chair:** How often do you have litigation in Sweden when you have those kinds of incidents?

Dr Gustafson: Very seldom. From all parts of healthcare, the insurance company receives around 18,000 claims per year, and some 20 to 25 of those claims finally end up in court.

Q106 **Chair:** In order to get compensation does a parent have to prove that a doctor was grossly negligent in that birth?

Dr Gustafson: No. In the insurance-based system, as long as it can be established that care was not given according to best practice, that suffices. In the insurance system, there is no need to prove negligence.

Q107 **Chair:** From the point of view of a doctor or a midwife, it is presumably easier to agree that there was a lapse in care if they are not having to concede that there was gross negligence. They are just able to say, "Look, there was a mistake," and they accept that mistake. Do you think that could be one of the reasons why you have such a low number of claims in court cases compared with the UK?

Dr Gustafson: In my opinion, it has contributed to that fact; yes. It is not dangerous to admit that something did not go as expected.

Q108 **Chair:** Could you explain that a bit more? In terms of professional consequences, if you are a doctor, a midwife or a nurse in Sweden and something goes wrong in a birth in the care of a mother or the care of a child, how do you make it easy for doctors to speak out openly about the situation that they encountered so that you can have a proper learning culture?

Dr Gustafson: Perhaps I should explain that we have separated the supervisory part of an event from the compensation part. It is very easy for someone to say, "Okay, this was not done or handled in the way it should have been according to best practice. Therefore, we are sorry, and we have this insurance solution and can help you to file a claim with them." The bar is lower in Sweden to admit, and the knowledge is there. There are very few doctors or midwives today who fear being prohibited from speaking about it or being unable to practise their profession. It is not so dangerous to admit that something has not gone as expected.

Q109 **Barbara Keeley:** Dr Gustafson, you have heard about the failings of our system and the devastating impact it had on James and Darren. I join in thanking them for talking about what are very painful issues. Clearly, your record in Sweden is very good, but you have some incidents and some claims. What is the Swedish approach to learning from maternity safety incidents?

Dr Gustafson: It is a combined thing. First of all, if we take the Government part, the Swedish Government have put in a substantial amount of money over the last years to improve some parts of healthcare. That is more on the structural side.

As an insurance company, we have constant dialogue with the professional organisations and their members—the Swedish obstetricians, midwives and paediatricians. We continuously feed back information, asking them what they need to avoid this in the future. That could end up, for instance, with a web page on cardiotocogram interpretation. It could be help with education. We feed back a lot of things.

We also work together with Swedish quality registers in providing data, feeding that back continuously. That could be on a national level or at a specific department level. It could also be on an individual level. In that feedback process, we bypass the whole structure; it goes directly to the members of the professional organisations. It is a very direct feedback of information. The content and result of a specific claim is always fed back to the specific department.

Q110 **Barbara Keeley:** What do you think are the key elements of success? You have already mentioned some of them, like it not being dangerous to admit mistakes. What barriers do you see in our UK system, from what you know of it?

Dr Gustafson: I am an expert neither in English law nor in English maternity care, but there are many similarities as well as some differences. The hierarchy in Swedish maternity care among professionals is fairly level. The big hierarchy is between the patient and the family. My picture of your care is that the hierarchies within the profession are much larger, but on the other hand it is much more level with the patient and the family.

The professional hierarchies were a problem 10 or 15 years ago with Swedish maternity care, too. They are definitely lower now. One of the main parts of our project has been to try to disarm the hierarchy by saying that on a national level the midwives and the obstetricians produce best practice. They develop things together; it is not that the midwives do one thing and the obstetricians do another thing. That signal is so important at local level. If they can co-operate at national level, they can co-operate at local level. That is one thing.

A very important part is to trust the professionals. The specific moment when a midwife or an obstetrician makes a decision or does something is the actual moment that separates a potential injury from a definitive injury. We have put trust in the professionals that, if we give them the right tools, we trust that they will fix it and that in common we will follow development. I think those are the two major differences.

Q111 **Barbara Keeley:** Clearly, a change of culture is important. We heard about the issues of culture at the heart of problems like the ones that James talked about at Furness General, where midwives did not even want doctors in the room and prevented them from entering the room, which is astonishing. What factors do you think contributed to the change to a culture of openness and learning in Sweden? I think that is an important lesson for us.

Dr Gustafson: The major thing was to try to make it not dangerous or risky to open up about it, and to remove the obstacles, actual or imagined, that are there. If you feel threatened, perhaps in your professional existence, as well as in your ability to support your family, and it depends on you admitting that something has not gone the way it should go, of course the threshold is much higher. The removal of those obstacles is important.

Chair: Thank you very much indeed, Dr Gustafson. We have much appreciated hearing from you. Thank you very much for sharing your insights. Thank you, too, Helen Vernon, for joining us.

Examination of witnesses

Witnesses: Dr Vaughan and Dr Macleod.

Q112 **Chair:** We move to our third and final panel in this morning's evidence. I welcome Dr Sonia Macleod, who is a researcher in civil justice systems at the Centre for Socio-Legal studies at Oxford University, and Dr Jenny Vaughan, who is a consultant neurologist and the Learn not Blame policy lead for the Doctors' Association UK. Thank you both very much for joining us this morning.

Dr Vaughan, you have looked extensively at these issues. You have heard this morning what happens in Sweden. You have also heard some of the evidence from two dads who had horrific experiences when things went wrong in our system. What do you think are the biggest barriers to a learning culture in the NHS that could bring our neonatal death and disability levels down to Swedish levels?

Dr Vaughan: I was calling a couple of patients from my clinic this morning, but I caught the end of James's evidence and I heard all of Darren's. Again, I express my heartfelt apologies for what happened.

The biggest barrier is the fact that people feel that, if they own up to an error, they are going to be blamed for it. It is our blame culture, which is very toxic. It is very sad, Jeremy, because I am sure that you and the panel remember what happened in 2013. We had the Berwick report and there were all sorts of very powerful recommendations that came out of that. That was in the light of Mid Staffs. Since then, we have to look back and say, "Have we really learned?"

The barriers are all about communication and people feeling that they may be blamed. It creates a very toxic culture. On the frontline, which is the main part that the Doctors' Association represents, we are still working in a resource-poor organisation. There are still opportunities for training that are not always realised. People can still feel very isolated and vulnerable when they are making decisions. We are all human, and with the best will and intention we do not always make the right decisions.

When something happens, the problem is that staff feel that they will be blamed. We need to bring in the work that Aidan Fowler has been responsible for in NHS Improvement, and bring in a just culture where we ensure that anyone showing intention to harm—mortal wounding, intentional harm or wilful and reckless conduct—is taken out. No one is trying to defend anyone committing those sorts of errors. This is not about giving doctors, nurses or midwives a free ride. It is about honest error and how we deal with it. If we do not promote the open culture that Dr Gustafson was talking about, and James and Darren alluded to—they did not get an apology—and get the first investigation right, everything else falls out from that.

I want to mention the work of Leslie Hamilton. I am not an expert in maternity care. I have been involved in the rare cases of doctors who have been accused, and convicted, of criminal gross negligence. In those cases, it was very clear that, because they did not get the first investigation right and the first investigation was all about fixing the blame, everything else that happened after that did not go right. You then expose yourself to the courts and the coroners. That is not necessarily wrong, because some cases have to go there, as we have heard this morning, but not the vast majority of cases. I defended David Sellu from a medical point of view. That case should never have gone near a criminal court. There was a massive outcry from the profession about what happened to Hadiza Bawa-Garba because there were, frankly, so many systemic errors.

What Leslie Hamilton was tasked with doing—as was Norman Williams, whom you tasked, Jeremy; I am sure you remember this—was looking at those cases to try to understand what might reduce the number of cases ending up in a criminal court. What came out of that was a whole raft of recommendations. The most important was getting the first investigation right and ensuring that there was open communication with relatives, that someone in the hospital was with the relatives throughout the process, so that they could tackle the issues that James and Darren raised about poor communication, and an apology for what actually went wrong for the patient. Secondarily, for the member of staff, you look at the investigation from a systems point of view—seniority and systems—and not saying, "How do we fix someone to be the fall guy or girl for this?"

Q113 **Chair:** I remember those issues very well; indeed, you helped Norman

Williams in coming to the conclusions that he came to. You talked about training and resources. They obviously matter, but can I ask you specifically, when it comes to changes in the law, what would help get rid of the blame culture and allow a learning culture to take stronger root?

Dr Vaughan: I hesitate to say this, but I think it is all about changing our system. I think if we wait for the law to change—

Q114 **Chair:** What system changes?

Dr Vaughan: I think we have to accept, whether we can fix it or not, that tort law—the finding of fault—is not the answer for the vast majority of these cases. The changes that need to happen are outlined in Aidan Fowler's just culture and making sure that comes across to the NHS. It is taking out the intentional cases, making sure that they are accountable, and bringing in candour, apology and an open culture. Then you will get back to what we have heard happens in Sweden, where people feel much more confident that, if they speak out and admit their error, they will not be blamed for it.

One of the most important things to tackle is defensive medicine and stopping staff hiding their errors. The only way you do that is if you bring in a just culture and say to staff, "We are going to create a system where you can talk about the errors openly." You bring in the concept of safe space. I know that has not gone through yet, but it is a really important part, so that staff can open up about what happened, why it happened and how they can learn from it.

The problem in all of this is that, unless you break down the barriers, change the system and allow people to do that, you will not promote learning. You will get a worsening culture of defensiveness and you will never ever tackle the problem. That has to be part of the solution, and I do not think that the criminal law can provide that. If you can pass recommendations and get agencies like NHS Resolution and NHS Improvement to say, "This is how we want it to be done," and bring that in, it could have a big effect on what happens going forward. Just keeping going with what we have at the moment will never improve things. We have to embrace a just culture— although not no blame—with openness and accountability that looks forward.

I was reading a lot of what Aidan and Sidney Dekker have put forward, which was very interesting. In all of these things we have to look at who is hurt, how we are going to make it better for them and whose obligation it is to do that. If we look at those three elements, it will go a long way to stopping, "How do we fix the blame?" very early on in investigations. If all parties concerned sit down and say, "This has happened. Who is hurt, what do they need and whose obligation is it to provide it?", those three very simple principles, operating in a just culture, could make a very dramatic difference, but we have to be committed to them. We have to say that that is what all our organisations have to do.

Q115 **Chair:** This is about tort law. One of the differences in Sweden, as we heard from Dr Gustafson, is that in Sweden you do not need to prove gross negligence by a clinician in order to get compensation. You only need to prove that care was not delivered according to best practice. The bar is much lower.

We also heard from Helen Vernon that she settles two multimillion-pound cases every week for a severely disabled child, including one this year of £37 million. When a child is born disabled, the parents are obviously very worried about family finances, and they want to get as much support as they can. The only way they can get that support is if they can get someone to agree that there was gross negligence. Do you not think that there is some element where the law incentivises confrontation rather than the just culture that you are talking about?

Dr Vaughan: Totally. You do not have to prove that the staff were guilty of gross negligence, because obviously that is beyond the pale and is the most severe. It is more the civil standard of clinical negligence, which is different from the criminal standard.

A basic problem with the system is that, to get compensation, parents have to sue, particularly in maternity. That is the way we have set it up. What we heard this morning from Sweden is very powerful. It seems to me that several years ago they were operating like us, but they have actually managed to change their system. We should listen very hard to what Dr Gustafson said in that respect. We can learn from that. It is really powerful.

From the point of view of learn and not blame, we must prioritise and bring in your work with Safe Spaces, which is really important. We must emphasise the freedom to speak up about what goes wrong. In all of this, the most important thing from the parents’ point of view, as I have said previously, is that, if you have been harmed, you have appropriate support, an honest explanation and compensation if you are due it.

If you are a member of staff on the frontline, the most important thing from your point of view is that you feel able to talk about it and learn from it, and that you are not going to lose your livelihood, your reputation and everything that goes with it. If you can ensure that you tackle both of those, we have a consistent way ahead. We have solutions to the problem if we look at both of those two areas.

From an organisational point of view, there are all sorts of duties that an employer must comply with. The tendency that we see on the frontline is for employers to say, “Who is to blame here?” We need to change all of that. In order to bring in an open culture, you need an employer to say that the default is that the employer may well have caused something to happen once you have taken out all the intentional errors. We are talking about honest errors.

Q116 **Taiwo Owatemi:** Earlier, you mentioned Dr Sellu and the importance of healthcare professionals being able to talk about a situation and what we can learn from it. At what point do you think oversight bodies should have drawn the line for a standard mistake in diagnosis that would rise to the level of gross negligence? What factors should have been taken into account in that situation and what could we have learned from it?

Dr Vaughan: Going back to my earlier point, I can tell you that the first investigation was the one that went wrong there. The first investigation, which was the hospital investigating what happened to Mr Hughes in the Sellu case, was all about fixing the blame. One of the most important recommendations that came out of Leslie Hamilton's review, which followed the Norman Williams review that Jeremy asked for, was that, if you get a first investigation and a member of your staff is under investigation for a criminal offence, the CQC should come in and look at that organisation, because either the organisation is dysfunctional or the department is dysfunctional. That has not happened.

In answer to your question, we have moved forward and tried to learn some of the lessons of the Sellu case. One of the most important lessons is what you alluded to, which is that you do not just look at one individual; you look at the organisation. That applies across maternity care as well. This morning, we heard two very powerful patient advocates talk about the failures in the first investigation of what happened after the death of their children. If that first investigation is got right, and you look at the investigation as well as the staff, you should avoid a lot of the fallout that is going on.

I do not think there should be early resort to criminal investigation either. My overwhelming impression of what happened in the Sellu and Bawa-Garba cases was that early resort to criminal investigation helped no one. The police, particularly in the Sellu case, assumed that the organisation was free of blame, and that everything the organisation said was actually what happened, when in fact we found that the reverse was true and that there was some covering-up on behalf of that organisation. The only way to stop that happening is to investigate both of them. That did not happen in equal fashion.

Q117 **Dr Evans:** Dr Vaughan, thank you very much. To pick up on some of those points, I know from my time in practice that one of the biggest things in terms of defensive medicine is the approach that clinicians take; they are always thinking in the back of their head, "Am I going to get struck off if I miss something here?"

That leads immediately to the GMC and the way in which it features. You have hinted a little bit about the CQC. How do we try to unwind that approach and what roles as regulator the GMC has? At the same time, it is the one that doctors pay into to be able to practise, and yet it holds the gate as to whether they can indeed carry on practising, and the investigation is to go there. Is that perception wrong from the medics who are practising? Is it the GMC, or is there something else going on that could be done to affect that?

Dr Vaughan: The GMC, of course, fulfils a very important role. Patients have to know that the doctor that they see is able to fulfil certain standards. They have to have that confidence. We cannot get rid of the GMC; it fulfils a very important role.

Having said that, I am sure you saw the fallout as a result of the Bawa-Garba case. I think that is why Jeremy was right to take it so seriously, which he did. There was a lot of soul searching at the GMC after that. They have actually learned quite a lot about their processes since the Bawa-Garba affair.

There has been a lot of work by Roger Kline and Dr Doyin Atewologun. There is a race issue. I am not saying that the GMC is racist, but there is a fear among the medical profession—many of our staff are from black and ethnic minority backgrounds—that, when they look around and see who gets convicted and referred in excess numbers to the GMC, there is an excess number of black and ethnic minority doctors.

I was very concerned. If I look at one thin end of the wedge at gross negligence manslaughter—these are very small numbers so you have to be very careful about interpreting them—there seemed to be an equal number of charging decisions by the CPS of black and ethnic minority versus white doctors, but, when it comes down to it, in the last 10 years it is only black and ethnic minority staff who have actually been convicted. That includes Portuguese staff—anyone from a black or ethnic minority. It is those who are convicted.

I think the GMC has a hard task because it knows that, if you are a white doctor, you are less likely to be referred to the GMC. There is a danger that black and ethnic minority staff think that the GMC is more likely to be used as a weapon against them. There is a tendency in hospitals for people to say, "I'll refer you to the GMC," and use it as a weapon. I hope that working with the GMC, and all our politicians, doctors and doctor organisations, we can defuse some of that fear and weaponisation, and that the GMC will be more mindful about investigations that do not need to go anywhere near it.

Q118 **Dr Evans:** That is really important. You have touched on two parts. The first part, in the case you referred to, was about reflective learning and openness. There was a big fallout by the medical profession about what they would even write in their reflective learning and what they would be prepared to discuss in their appraisals. You have two levers pulling against each other.

What are your comments on reflective learning to try to improve as a clinician? On that side, in your experience with regard to BAME and getting complaints, how much of it is down to communication, as opposed to actual ability in terms of practice or outdated practice methods, if it is coming from abroad? Is there a discrepancy between the two if you are comparing British trainees and British-trained graduates, both white and BAME, with doctors from abroad? Are you able to address both those angles?

Dr Vaughan: Can I just deal with the first one? Reflective practice was huge for the profession. That is the way we learn; you sit down and talk to someone and say, "I got this bit wrong." There was a grave concern that criminal courts could access reflective practice and, therefore, doctors and nurses would be denied learning from those incidents. Reflective practice notes can still be accessed by a criminal court, but the GMC agreed that it would not call for them when it was investigating doctors who were due for a hearing. That was very helpful. As I am sure you know, reflective practice can be used in your favour as well, but you have the choice.

To a large extent, the details about reflective practice have been addressed by the report by the Academy of Medical Royal Colleges, which specifically looked into it and produced a lot of guidance for the profession about anonymising. A lot of the fear that came out surrounding Bawa-Garba and reflective practice has now been addressed by the Academy of Medical Royal Colleges. I was very pleased with that report, but we have more work to do and there is still a fear out there. You are very right to draw that to everybody's attention.

It would take me quite a long time to answer all your points on black and ethnic minority doctors. I would like to send you a very full written report on the issue that answers all of your concerns. There is no doubt that there are great concerns about how black and ethnic minority doctors are dealt with. It is not as simple as saying, "It is because they don't learn what they should do abroad." Hadiza Bawa-Garba was fully trained in this country. David Sellu did his medical training in this country. It is not as simple as saying that they have come here. There are some complex cultural issues. I think that there is racism.

I do not think that the GMC is inherently racist, but we all know that there is racism in our society. There is a very complex way of trying to understand that. I would like to send the Committee a full written submission that answers about five or six of your points, because it is absolutely key that we try to understand the issue. I have done quite a lot of work with Roger Kline and communicate with him regularly. I would like him to contribute.

Dr Evans: We would welcome that. We are looking at BME in a separate inquiry into workforce burnout. That would work across both inquiries, if the Chair is happy to accept a submission to both. Thank you very much for answering those questions.

Chair: We will take a final question from Dean on this point. We will then move on to Sonia MacLeod, who has been very patient.

Q119 **Dean Russell:** My question is about the culture of learning we have touched on. We live in a digital age. From everything we have heard so far, it sounds to me as if this is very much about person-to-person reporting of concerns and issues. As I understand it, the NHS has well over 1 million members of staff. Has there been any investigation of, or a look at, the use of technology to enable staff anonymously to report concerns, share learnings or identify areas for improvement? If that has been looked at, I would be interested to find out about it. If it has not, do you have thoughts about why? Is there a concern that, if every member of staff shared learning or concern about issues, it could open a Pandora's box of problems that it would be easier to be ignorant of than to address?

Dr Vaughan: The first important thing is that there should be a presumption of good intention, before we go anywhere else. Most staff in the NHS come in to do a good day's work. I am not an expert in error, but I know that people who have looked at it have found that there are hundreds and thousands of errors that could happen each day. They only don't happen because of the good intentions of the staff.

The other worry is that we should not be driven just by outcome. If someone dies, or some awful thing happens, we suddenly become very focused, but our approach should always be consistent in each case, whether something does or does not happen. Bringing in that consistency is fundamentally important. If you do not do that, you end up with people being horribly reactive when bad things happen. That is why you get the culture of fear.

Technology has a great deal to do with it. We already have the Datix system in our hospitals, where people can register things. Sadly, you will not be at all surprised if I tell you that Datix is also used as a weapon in healthcare. I have a feeling that if I wandered into a Swedish hospital that would not be the case. They are obviously doing something right there.

We need to have a very careful look at how we do it. We have the stuff in place. We have Datix. We have committed staff who, in general, have good intentions. It is about using all of that. I absolutely believe—I know—that, when things have gone wrong in maternity in particular, it is because of simple things like the fact that the doctor did not have the full notes of the patient's pregnancy and was not aware that the baby was not growing well at that stage. They did not have the notes and they were dealing with all sorts of other things at the same time.

Very simple things like streamlining patients' notes and having access to full electronic notes would help with that. There are very simple errors that software and technology could help us with, but that is not the whole answer. The answer has to include good intentions, not being focused just on bad outcomes, but trusting staff, and studying hard other nations that have got the just culture more in place than we have and learning from them.

Q120 **Rosie Cooper:** I would like to address the issue of whether the NHS actually learns from serious incidents. I ask that because of my involvement in Liverpool Community NHS Trust, where Professor Kirkup is currently doing a second investigation. The culture in the new organisation has changed from "Who did it?" to "What happened?" That is really good, but the reality is that everybody missed it; all the regulators, everybody. When it came to it, there were action plans for everyone involved, including the centre and NHS England. Everybody held all the constituent parts to account, yet NHS England did not really look at itself, and the regulators have not really looked at themselves. I agree that Datix is used as a weapon but—

Chair: Rosie, we have lost you for some reason. Can you hear me? I am very sorry. We have a technical glitch.

Rosie Cooper: Can you hear me now?

Chair: We can hear you now. Could you be very brief? We have to wrap up this bit of the session.

Rosie Cooper: Absolutely. Where did I get to?

Chair: I don't know. Do it all from scratch, but very briefly.

Rosie Cooper: I will do it very quickly. At Liverpool Community NHS Trust, the culture changed from "Who did it?" to "What happened?" That was a really important change. Everyone missed it—regulators and the centre. Everyone wants to hold everyone else to account, yet they do not hold themselves to account. I agree that Datix has been used as a weapon, but junior staff use it to protect themselves against an exec or NHS England—

Chair: I am sorry, Rosie. What is the question?

Rosie Cooper: I really want to know whether the NHS actually learns from serious incidents. That was the first comment that I made.

Dr Vaughan: Rosie, you are absolutely right. Is it all right for me to call you Rosie?

Rosie Cooper: Yes, please.

Dr Vaughan: You are absolutely right. I have listened to you before on the Committee. You always highlight very important things, because you are intimately involved in them. You are absolutely right: there is a track record in the NHS. We have scandal after scandal, but let's make sure that we do not lose focus on this; we also have a record of treating thousands and thousands of patients safely every day and a very dedicated staff. For all the system's faults, and I have worked in it for nearly 25 years now—it has saved my life as well—I am still immensely proud of what we have in the NHS.

I want us to look forward. One of the reasons why I was very pleased to come along to give evidence today is that I recognise that we have reached a turning point. We have heard some powerful testimony. It is not that we have not heard that before this morning—we have—but I think that we can really move on. We are going to come out of Covid. We are going to get stronger. We are going to change our culture, because we have to. We have no choice about that.

I have no argument in agreeing with you that the NHS has had problems learning from its errors, of which there have been many, and I have no problem with expecting that we will continue to make errors, because to err is human. However, I really believe that if we adopt some of the principles we have heard about this morning, as is our duty and responsibility, we have a better future to look forward to both for us as patients—I am one, and I am very confident about having the NHS keep treating me—and for our staff. As one of those, I am very committed to staying in the service and to all of us serving the patients we need to serve.

You are right, but in the future, if we adopt those principles, we will change. We have seen what has happened in Sweden, and have heard Dr Gustafson tell us that that is possible. I firmly believe that. I have also been to New Zealand, where I have seen that process as well. I believe that it can happen for the NHS.

Q121 **Chair:** Last but not least, we will hear from Dr Sonia MacLeod, who is a researcher in civil justice systems at the Centre for Socio-Legal Studies at Oxford University. Thank you very much for being so patient.

Obviously, you bring a legal perspective to these issues. The central thing we have been talking about this morning is how we move from a blame culture to a learning culture. We heard very powerful testimony at the start from James and Darren about what happens when a blame culture sets in. Then we heard about what happens in Sweden. Do we need to make legal changes? Do we need to make process changes? What is your perspective on the biggest things that we need to change, and what needs to happen next?

Dr MacLeod: The answer is that we probably need to make both. I listened to both James and Darren this morning, and I pay tribute to them for being able to tell their stories as they have. One of the things that was very clear, particularly from Darren's testimony, was the struggle to obtain clear information. We need to look at the two objectives that we have: to reduce the level of avoidable harm and to provide redress. If we want to deliver on both of those, what do we need to do?

The harm is not inevitable. It is avoidable. Pelle told us very clearly that their levels of neonatal brain injury and stillbirth are far lower than ours. That says that we can improve. There is scope to do that. How do we improve?

My personal view is that litigation is one of the barriers to an open culture. At present, litigation is the only way people can obtain redress, but we have known for a long time that what people want is not just financial compensation, but improvements to prevent it from happening in the future. They want an apology—a genuine apology—and accountability. They want staff disciplined, if necessary, but they want to make sure that when you go forward it does not happen again.

Litigation as a means of delivering redress is adversarial. It is very slow, compared with some of the mechanisms that are used in other jurisdictions, such as Sweden. I was really interested to hear New Zealand mentioned previously. New Zealand is another system that has moved away from litigation and uses a non-adversarial model—an administrative model. We need to say, "What do we have at the moment that is preventing open disclosure and a just culture from being embedded?" I would argue very strongly that adversarial litigation is a problem.

If we think about it from a clinician's point of view, in a maternity incident, they are investigated by HSIB if they meet the "each baby counts" criteria. HSIB comes in and says, "We are looking at this in a non-adversarial, investigative way. We are looking not for blame but to establish what happened." At the same time, the same clinician has to report, via their legal team, to the early notification system, which inevitably is looking to establish liability and blame. That is simply a reflection of what the system does. The clinician is pulled two ways at the same time. It is not surprising, therefore, that what we get is inhibition on an open culture. On the one hand, we are saying, "Come and tell us what happened. Be open with us." On the other hand, there is the perception that, if they tell us what happened, they might be blamed.

Q122 **Chair:** Can I push you a bit, Sonia? If you were the Health Secretary and wanted to change the adversarial culture to bring down our neonatal death rates, what practical changes would you make?

Dr MacLeod: One thing that is absolutely essential is implementation of rapid resolution and redress, as it was outlined in "Better Births"—as an administrative scheme that works not on a "negligent" threshold but on an "avoidable harm" threshold, similar and akin to the system used in Sweden.

One of the interesting things in New Zealand is that they switched from using medical malpractice to using treatment injury. Medical malpractice was much more akin to negligence. It was that sort of threshold. Treatment injury is much more like avoidable harm. When New Zealand made that shift, the average time that their claim processing took dropped from over five months to 13 days. That time drop for processing means faster resolution and faster learning. It was attributed to the fact that clinicians were prepared to say, "Yes, something went wrong," when they would not have been prepared to say, "I was to blame for what happened."

Having avoidability as a threshold is hugely key to driving faster learning and a much better process, not just for the clinicians but for the families on the receiving end of it. Families have been through enough. They have been to hell and back already. You do not want a process that makes it worse. You want a process that is able to provide them with what they need. That includes information, an apology and financial compensation, where that is needed.

Q123 **Chair:** Can I ask you about a particular detail of the way compensation works here? I think it is based on a formula that means that the child of a banker would get more compensation than the child of a manual worker if, for example, the child was born disabled. That seems very perverse. Is that how our system works?

Dr MacLeod: The idea of compensation is to put you in the position you would have been in had the incident not occurred. That includes loss of future earnings. Loss of future earnings is calculated based on what kind of job you think it is likely that the child would have had. That will be determined partly by parental income and socioeconomic status.

Q124 **Chair:** Do you think that is just?

Dr MacLeod: Personally, I do not think that it is. It is very different from the system that is used in other countries. I am sure that Pelle would explain this better than I can, but in Sweden, for example, future earnings are calculated from the average national wage, rather than the individual's circumstances.

Q125 **Chair:** I have a final question on legal changes to try to stop the process moving into litigation. We have the rapid resolution scheme, which I think I got agreement for when I was Health Secretary, but it has never been implemented. That applied only to maternity. Is there something you would recommend or would like to see happen for all cases of harm when things go wrong, to try to create that learning culture?

Dr MacLeod: Absolutely. Maternity is hugely important. In the last set of reports, it accounted for 9% of the number of claims, but over half of the compensation paid. Maternity certainly gets a lot of focus, because it is very expensive. You have heard the figure of £37 million for a single settlement. The bill is not small, so it becomes a focus.

I think the changes should run right across clinical negligence as a whole. Administrative schemes should be brought in to replace litigation. Only when you do that, do you free everyone from the barriers and the inhibitions about admitting and disclosing what has happened. Only then will you really get a just culture.

As part of that, there are legal changes that could be made. There are quite a few of them, but you need whatever administrative scheme you design to be at least as attractive as litigation. You need there to be parity between what you would be given under the scheme and what you would be given in litigation. That can include things like looking at reform of section 2(4) of the Law Reform (Personal Injuries) Act 1948, which is highly technical. I am sorry to get technical, but that piece of legislation says that if you are injured you must be paid compensation based on the cost of private healthcare, rather than the cost of NHS provision. There is an argument for saying that if you have been harmed by the NHS, which is, in its essence, a public good, we need to look at a rebuttal or a presumption that we do not go down the route of paying private rates.

Q126 **Chair:** You are saying that you could reduce the cost of individual claims by paying people the additional costs caused by a harm that someone has received, as I think happens in Sweden, but you would widen it to many more people, because avoidability or preventability would be the criterion, rather than negligence.

Dr MacLeod: Absolutely. You need a practical solution that is affordable. It is difficult. One of the issues at the moment is that clinical negligence is not sustainable at the current level. The National Audit Office report was very clear that we need to look at mechanisms to reduce that. The best way of reducing it is to stop harm, and I do not think that anyone would argue but that that has to be the core objective. We also need to look at how we achieve that. We can achieve it by more open disclosure and, therefore, better learning that goes towards harm reduction. We can also look at mechanisms for saying, "Can we look at what is offered?" Rather than offering money, we could offer more in terms of care packages—things like that. There are options. It is quite technical and detailed. I am happy to submit a more detailed follow-up, if that would help.

This will sound strange, given what I have just said, but one thing that I would really like to see as an immediate response is better legal aid provision for babies who are brain injured. At the moment, there are babies who suffer catastrophic brain injuries whose litigation cases are funded on conditional fee arrangements—no win, no fee—rather than through legal aid. If we are saying as a society that we think babies who are brain injured should have legal aid funding, we need to make sure that that legal aid funding is sufficient to allow cases to be brought by solicitors.

I have spoken to a lot of solicitors who say, "No, we don't run our brain injury cases on legal aid. It is simply too slow and cumbersome, and doesn't provide enough money for the expert witnesses." Those children end up on CFAs. CFAs are fine, but they mean that there is a success fee included, which is up to 100% of the lawyers' fees, capped at 25% of the damages. That comes out of the damages. Children receiving compensation actually lose part of it. They would be eligible for legal aid, but they are not on it because it is unwieldy and unworkable. If we are saying that compensation is there to compensate someone for their injuries, I do not think that it is right that they lose part of it simply because our legal aid system is not good enough.

Q127 **Chair:** It would be incredibly helpful if you could write to us covering the legal aid issue; the rolling out of administrative schemes as an alternative to litigation; what those schemes need to be successful, including your point about the fact that you have to be able to be confident that you would access an equivalent amount of compensation; the importance of preventability, rather than negligence, as the benchmark, as is the case in Sweden; and reform of the personal injuries Act. I am afraid that is quite a long menu of things to bring in.

Dr MacLeod: That's fine.

Chair: That has been very helpful. Dean has a final question and then, before we wrap up, I will go back to Jenny Vaughan to ask whether she has any further reflections.

Q128 **Dean Russell:** My question is about how this ties together across the NHS and social care. We talk often, especially today, about compensation to families. This will affect people's lives for decades to come, especially the lives of babies and children who have been severely disabled, and the cost of that to the system is immense as well. Has there been any economic assessment of the cost to the NHS and social care when failings happen? How is that factored into putting a similar amount into prevention, so that those things do not happen in the first place? We talk about millions through compensation. Obviously, that is essential for the family, but there are underlying costs as well.

Dr MacLeod: Absolutely. Yes, there has been an assessment, but I am probably not the best person to talk about the detailed economic analysis, I am afraid. I am not an economist. The one thing that is incredibly clear is that harm prevention—reducing numbers down to the bare minimum—is far and away the most effective option for the use of money. We are very clear that Sweden's rates are far lower than ours, so it can be done. When it comes to prioritising, I am afraid that the cost-benefit analysis of each of the interventions is more detailed economics than I am capable of.

Q129 **Dean Russell:** Forgive the question—it is no problem if you do not know the answer—but I would be very interested to know whether these costs are looked at from both the NHS and the social care side of things. A lot of support is given at home, through care outside hospitals and through GP surgeries.

Dr MacLeod: They are looked at. The other thing is that we have international comparators as well. We look at what we do here, but we also need to look to international comparators. There are birth injury compensation funds in the United States. There is one in Florida and one in Virginia. There are schemes like the Swedish scheme, and the Accident Compensation Corporation in New Zealand. Each of those has a different balance of providing social care, nursing care, healthcare, home adaptations and things like that. It is not as if we are the only place we can look to. We can look outside the UK, but it is far more nuanced and detailed economics than I can do, I am afraid.

Dean Russell: Thank you for trying to answer. I appreciate it.

Q130 **Chair:** Finally, could we have a quick wrap-up comment from Jenny

Vaughan, having heard what Sonia said?

Dr Vaughan: I thought that was absolutely excellent, Sonia. I endorse all of it. Here at the Doctors' Association, we have our Learn not Blame campaign. One of our core points is that, basically, we do not think that tort law is the best way of dealing with claims. It is all about restorative justice. That is what we want. As you say, no-blame compensation would offer wider restoration for a larger number of families. If we used the criterion of avoidable harm, instead of requiring people to pursue civil negligence claims, it would transform the system overnight. Staff would feel much more confident about speaking up, and the learning that is necessary in all of these incidents would be far more likely to take place.

It would answer Rosie's overall point about whether the NHS will learn. If we changed this, it would be dramatic, important and profound. If I am here in 15 years' time—if I am, I will have outlived my doctors' expectations, which I would love to see—I think we could be there. We would get harm reduction, and we would not get cases of doctors being hung out to dry, particularly if they are black and ethnic minority doctors.

Chair: Thank you very much, Dr Jenny Vaughan and Dr Sonia MacLeod. I also thank all the other witnesses we have heard this morning. It has been an incredibly important session. The world is thinking about coronavirus, lockdowns and many other issues, but these are deeply important issues. I know that I speak for everyone in thanking Darren Smith and James Titcombe for their evidence right at the start, which put the whole session into perspective. Thank you, Dr Gustafson, for joining us from Sweden. I thank Helen Vernon as well. We have really appreciated your time.