Transcript of Radio Ombudsman #24: Derek Richford on how personal tragedy led him to uncover serious failings in maternity care

Derek Richford talks to Rob Behrens about the loss of his newborn grandson, Harry, at East Kent Hospitals University Trust. He explains how his sheer persistence uncovered the truth of what went wrong and eventually led to a criminal investigation at the Trust. He also tells us what organisations involved in the complaint process can learn from his family's tragic experience.

Rob Behrens: Hello, and welcome to Radio Ombudsman. This is Rob Behrens giving you a warm welcome as we begin to reach the end of the pandemic, and hopefully the constraints of lockdown.

Now, we know from experience that the death of a child is always tragic, but it's even worse when the death is avoidable. My guest today has experience of this situation, and he's very welcome. Derek Richford, welcome to Radio Ombudsman.

Derek Richford: Thank you very much indeed. It's good to be here.

Rob Behrens: Derek is the grandfather of Harry Richford. Harry was born on 2 November 2017 and tragically died on 9 November 2017. He's going to tell us about what happened. But you need to know two things.

One is that Derek has been at the forefront of the investigations into Harry's death. He's been a tireless campaigner for justice for both his family, and the other families who have come to harm through the maternity services of East Kent.

I urge you to look at the family website which is [http://harrysstory.co.uk], which is a beautifully accounted description of what happened, and why it happened.

The key issue which is set out there is a quotation which Derek gives us in which he reminds us to go into hospital with your eyes wide open. Which I think is an important lesson for everybody.

Derek, you're very welcome. Can we just say that we do have quite a few families on Radio Ombudsman. We've had that before. But mostly we have Ombudsman leaders, or regulators, so it's good to get the balance, to get the other side of the story when it comes to situations like the traumatic one you've been through.

To begin, could you just tell us a little bit about yourself and your background to enable the listeners to get a bit of a grasp of who you are?

Derek Richford: Absolutely. I would say humble beginnings. I was born in a council house in Orpington, in North West Kent. There were four siblings, and two hard working parents for me. Believe it or not, I left school at 16 with art and woodwork O Level. That was it. I had to make my own way in life.

I married my wife Nikki when I was 20, and she was 19. We've actually been married 40 years this year. We have four children, four granddaughters. Harry would have made five. He'd have been right in the middle of the four grandkids that we currently have.

I run my own small business. Before Harry, I had absolutely no experience whatsoever in investigations or looking into bits and bobs like this. I guess to finish, the answer to that question is

nothing is more important to me than my family. And that's always been so.

Rob Behrens: Thank you. Coming back to the family experience, it would help the listeners if you could just give a brief summary of some of the key things that happened in these few days, and then subsequently the long period afterwards.

Derek Richford: Yes It's difficult to be brief, but I'll be as brief as I can. Harry's mum, Sarah, my daughter in law, had a textbook pregnancy. She was low-risk. She went into the midwife-led unit two days before Harry's due date, and Harry was born on his due date.

He was in the back-to-back position which is known as OP, which is actually very, very common. Most babies will turn before birth and there's no issues.

At 4:00am after Sarah had been admitted, so we're looking at about 10 hours after she's admitted, they break her waters. Still in the midwife-led unit, which is a perfectly normal thing to do, because there's very little progression, and they're trying to progress Sarah along which is absolutely fine.

But by 11:30 the following morning there's still not a lot of progress. I think we're about 4cm by then. So we get ourselves transferred into the consultant-led maternity ward.

The consultant-led maternity ward is obviously right next to the midwife-led unit. The midwife who is there, who receives Sarah, dresses Sarah in a gown and stockings and says, "You're going to need an emergency caesarean quite soon, so we're just prepping you." Which is fine. This is 11:30 in the morning.

The midwives generally are unhappy with the CTG readings. That's the cardiotocograph readings, the band that the lady has around her stomach that keeps an eye on what mum's doing, but also what's going on with baby. At one point, the midwife presses the emergency buzzer. She's really that unhappy. There's a deceleration, as it's known.

People come running, as they do, but the only person that gets to see Sarah, doctor-wise is an ST3 registrar. ST3 being the lowest grade you can be as a registrar. Syntocinon was prescribed which is the inducing drug. Overall, the inducing drug is, if you like, giving more regular and harder contractions.

There are now midwives not happy with the CTGs and three midwives now get involved. Two grade six, and one grade seven. They don't give the syntocinon because they're not happy with the cardiotograph, CTG.

But the ST3 registrar is called back and he said, "No, I'm happy with what's going on. You must give this drug." So they go ahead and they give the drug.

Later on, they're trying to get Sarah's contractions to five in ten minutes. It's known as five in ten. Sarah gets to six in ten, and they were still increasing the syntocinon. Later on, and I'll go through that a little bit later, Sarah was actually overdosed on syntocinon for a period of around ten hours, and that's from the coroner.

At 8 o'clock that night, so we're now 8 and a half hours past when she was dressed in a gown and so on, the registrar that is taking over for the night shift is a locum. It turned out that this locum had never been assessed by the Trust in any way, shape, or form. They'd never even seen his CV. He was being supplied by an agency who were just filling rota gaps. It came out later that actually no one had signed him off whatsoever.

He hadn't even had an induction on that day. He'd been flown down from Scotland just to fill a shift pattern of four days.

At no point was Sarah seen by a consultant until after Harry's birth. All of that is just background, I guess, that you need to know.

Sarah is still only 6 or 7cm at this point. By 9:00pm we've got hyper stimulation which is basically there's too many contractions for baby to be able to cope with it, and they begin to drop down the syntocinon.

Cutting a long story short, by 2:00am it's realised that- sorry. Sarah is fully dilated by the time we get to midnight. Then by 2:00am, a trial of instruments is tried. I.e. forceps. This registrar tries to use ordinary forceps, even though Harry needs to be rotated, so rotational forceps are essential.

He didn't use those because he didn't know how to use them because he was too junior. Fortunately they didn't lock, otherwise there could have been something catastrophic for mum and baby at that point.

He can't deal with it. It doesn't work. So by 3:00am an emergency C-section is agreed. Knife to skin, as it's known, was at 3:18.

The registrar is struggling as Harry's head is so impacted. The reason it's impacted is because, we found out afterwards, there's been so much syntocinon used that the amount of contractions and the level of contractions is so great that his head's been impacted in Sarah's pelvis. So he's struggling to get Harry out. He had made a cut obviously for the caesarean, but he can't get him out.

So he speaks to his F1 who is wholly inexperienced and says, "Right, make the cut bigger." She says, "I can't do that. I've

never done any surgery, I've not been trained." He said, "I don't care. Just do it." She extends the cut with scissors and unfortunately nicks a blood vessel. Sarah lost three pints of blood.

Harry was born pale and floppy at 3:32 in the morning. So 14 minutes after the knife to skin. Far too long. He was passed, and this is where it's sort of the perfect storm. He was then passed to a team of paediatricians, which is two paediatricians. One an ST3, again, the lowest grade of registrar that you can have. And his sidekick, for want of a better word, that night was a GP ST1. A GP on her training going through a hospital.

She'd never had any training in any kind of neonatal or paediatric resuscitation at that point in her career whatsoever. These two basically got caught up in a time warp where they didn't realise what was going on. The coroner said there was a lack of timekeeping and no one really knew what was going on. For 25 minutes they tried to resuscitate Harry and they couldn't do it.

The anaesthetist who was in the theatre on behalf of Sarah, because Sarah obviously needed an anaesthetist because of her epidural, said, "I'm going to put Sarah under," because there was a huge amount of panic at that time. It's recorded within the notes that there is panic and chaos in the theatre. There were around 20 people in theatre.

The anaesthetist put Sarah under full anaesthetic, a general. My son Tom has to leave the theatre because she's under general. He walks over and intubates Harry immediately without any problems whatsoever. At that point, things begin to get a little better. But it's too late for Harry. By that time unfortunately, he's got severe brain damage.

HIE grade three, was what he had. He was then therapeutically cooled, and sent to the sister hospital 40 miles away. In that hospital he was given brain scans and a load of medication to try and see how bad the situation was, can it be covered etc. After seven days, it was decided that he would be a quadriplegic with no cognitive recognition.

Tom and Sarah were advised that it would be the kinder thing to take away life support. They took the very brave decision, in my view, wholly supported by the rest of the family, that that was what was needed to do.

I was in the room with Tom and Sarah, as was my wife Nikki, and Sarah's parents when life support was removed and Harry died within 20 minutes. So that's, if you like, what happened on the night. I don't know if you want me to go into what followed?

Rob Behrens: First of all thank you for telling us that so concisely. It must be very difficult to repeat these things. The last thing that would be on your mind in a situation like that is to go over what happened first of all, but rather the first thing to do is, I presume to grieve about the terrible events that have occurred. What was the impact on the family immediately?

Derek Richford: We were transported from our normal day-to-day bubble, into this bubble of daily trips to hospital to see Harry in Ashford, which was about 40 miles away. Seeing Tom and Sarah every single day. Trying to make sure that we were doing everything we could to comfort them. Trying to come up with the right solutions.

Trying to speak with Tom and Sarah about what options there may be available, working as we could alone. Because access

to doctors at that stage was actually quite tricky. Yes, Harry a consultant and he was well looked after at that sister hospital, however, people didn't want to give you any answers because I guess they didn't have answers.

We were absolutely devastated. I've said to people in the past, that in the last three years I've cried more than I've ever done in my life. The impact on the family, and the wider family, is something that I believe the Trust will never see.

Rob Behrens: There are so many things that come out of that in terms of process. The drugs application, the availability of staff, the inadequate training of staff, and we'll come onto some of that from the lessons learned. But in general, when this happened, and I'm not here to pass judgement on the Trust, that's being done by Bill Kirkup, and so on.

But how did the Trust react and work with you and the family in this situation?

Derek Richford: My initial response to that is that they put the shutters up. Let me just run through a few things for you. On the day of Harry's birth, two consultants, one obstetric, and one paediatric, told us that an RCA would be done. We had to find out what that meant. It was a root cause analysis. That was on the day that he was born.

On the day after he died, so seven, eight days down the line, a post-mortem was arranged. Tom and Sarah said, "When will we talk to the coroner? How does that work?"

Right from that very early point, the day after Harry died, we were told, "Absolutely no need for the coroner. Not the right

person to be in touch with. We know the cause of death. There is nothing for the coroner to investigate here."

We were very troubled by this because it didn't seem right. But, naively, we didn't know that we could have contacted the coroner ourselves. We're still in November of '17 at this point.

In January of '18, we've asked again because we're getting the results now of the post-mortem and what's gone on etc. The post-mortem actually says that it can find nothing wrong with Harry. They describe him as, 'Grossly unremarkable'. Which I found out afterwards meant, "We can't find anything wrong."

It was repeated in a letter from the neonatal consultant to Tom and Sarah that there is absolutely no need for a coroner involvement.

Eventually we got the RCA report. The RCA report took about 100 days to come through. They kept extending it because they said, "Look, this is a very complex matter. It needs to be dealt with," and blah, blah, blah. Again, no issue with that whatsoever.

But then it was repeated in the RCA there is no need for the coroner to be called because the family are asking for this and it definitely is not needed. I wrote to the coroner anonymously – it sounds crazy now, but I did – to say "Look, this is the situation. Would you have expected to have been called?" I did this on the Sunday morning. Our meeting was due to be on the Wednesday.

First thing on Monday morning, "Yes, we would like to have known about this death. Where is the baby lying? What happened? How did this happen? Do you have any copies of this, that and the other?" Immediately my heart jumped and raced. I thought, "My god, we should have had the coroner involved."

But we kept our powder dry until the meeting we had on the Wednesday. On the Wednesday we were in front of four consultants, a corporate governance officer, and a midwife coordinator. There were five of us family members, including Tom and Sarah there.

We had a list of questions. We'd stayed up day and night trying to understand what was in the RCA. The medical terms. What grades people were. All these different things. So we had a great number of bits of detail and we wanted to ask lots and lots of questions.

We arrived for this meeting on March 14 at 2:00. We actually arrived 20 minutes early as you might imagine. We were met and we were taken to a room that wasn't ready. We had to help them set up the chairs and the tables, and pass water around the room. It was just awful, really, really awful.

The meeting was recorded, so all of this is something that is able to be looked at now. We actually asked for the meeting to be recorded, and we recorded it ourselves as well. I did that because at that stage I still didn't trust the Trust. It's a funny word, isn't it, trust.

Anyway, we had our meeting. In that meeting it was repeated that you definitely do not need the coroner. There was a 12 minute section where 2 consultants said, "Absolutely don't need the coroner. You do realise, don't you, that not all baby deaths are reported to the coroner?" It was said in that sort of tone.

I then read out this thing that I'd got from the coroner. I said, "Look, as far as the coroner is concerned, they ought to be told. Look guys, we think you ought to be…" They were reluctant, but they said, "Look, okay." A lot was said during that

three hour meeting. They said, “Okay, we will report it to the coroner.” So, we’d made some ground.

However, it took them five weeks and three days to report it to the coroner after that meeting, and only after we’d chased the Medical Director twice. I cannot to this day fathom how or why that should have been unless, as I’ve said for some time, there is a level of cover-up.

I think it’s only fair to also add to me calling it a cover-up that Harry’s death was reported to the authorities as expected. It wasn’t expected by anyone. In fact, the Trust themselves reported the incident, Harry’s birth, as an unexpected incident internally. But externally they reported it as an expected death.

Had they reported it as unexpected, it automatically would have been reported to the coroner. I will also add to that that the MBRRACE report, which is a statutory form that they have to fill out for any baby deaths, brain damage, and maternal deaths, had nine specific errors. By specific errors I mean totally opposite to the truth.

Were there any complications at birth? None. Was the placenta kept? Yes. No, it wasn’t. It even says it in the post-mortem that the placenta was asked for, but it wasn’t kept. How did you decide the cause of death? Placental histology. No, you didn’t. You didn’t keep it. So, there is a good number of reasons why I say this.

We worked with the CEO, we worked with the Medical Director over a period of time. By the time we get to the end of 2018 we’re writing back to the CEO to say, “We wrote a complaint to you back in the early part of ’18 and we’ve not had a response. We’ve had an acknowledgement, but no response.”

Part of her reply, if I can just quote it, it says, ‘It is understood that we did not log your concerns as a formal complaint at that

time, as there was already a root cause analysis investigation in process.' However, in the RCA itself written ten months before that quote I've just given you, 'The family have submitted a formal letter of complaint. This is being addressed through the serious incident investigation process and through the complaints process.' It wasn't, and never was.

If we finish that section, Sir Roger Gale who is the MP for the hospital, a quote from him straight after Harry's inquest was, "I believe that in the early stages, the hospital authorities were obstructive in their efforts to prevent the facts from being established. What should have been a straightforward process therefore contributed to the family's ordeal." I think that probably is enough for me to give you a flavour.

Rob Behrens: Two things strike me about what you've said. First of all, the last thing the family wants to do in a situation like the one you've described is have a conflict over a complaint, to devote resources to complain. What they want to do is they want to grieve. They're traumatised. They don't want to complain. But you found basically an obstructive response to the questions you were asking.

The second this is that this is not new. We know from many publications that there were issues with the quality and safety of the maternity services of the Trust for years and years before Harry's death. Care Quality Commission investigations, reports by the Royal College of Obstetricians and Gynaecologists, exactly the issues were highlighted that your family experienced.

So, it's puzzling that the Trust were in that obstructive mode when they knew that the kinds of things you were describing had already been raised and needed to be addressed. It's not

only about the Trust, there's a whole series of regulators in this sorry history that you've had to deal with. It's a crowded field. As a family member, what is your view of the regulation, and the coordination of regulation in the Health Service?

Derek Richford: Okay, I think I'll answer this in two parts. Firstly, I don't believe that Tom and Sarah could have done this alone. Not because of their level of intellect, or anything like that, but they would not have been able to deal with it whilst grieving for Harry.

I call it the grandfather effect. Because I was one step removed, and I was therefore able to, if you like, deal with my grief by thinking I'm trying to help Tom and Sarah. At that point we had no idea, as we were peeling back the layers of the onion; we had no idea what a rotten core we would find in the middle. We really had no idea.

You mention the RCOG report. It was me that uncovered that. That report had never been uncovered before. The CQC claim they had never seen it. It was only because I found mention of it in a board report, buried deep in a board report, that I asked for it on freedom of information.

When it came out it was unbelievable. I'll give you one quote from it. 'The assessors are concerned that this practice', and they're referring to locums coming to the Trust, 'Will result in consultants not committed to teaching and supervision to be on-call with a locum, middle-grade doctor, potentially of unknown competence, which could impact on the safety of care in the maternity unit.'

Well, that's what happened to Sarah and Harry. This guy was there. No one had a clue. The consultant who was sitting at home sipping tea on-call had absolutely no idea of the

qualifications of abilities of the guy that was basically in charge overnight. So they knew what was going to go on.

You've asked me about regulators. Frankly, there are too many regulators and they're all working in their own silos. There is absolutely no doubt in my mind that there needs to be radical, radical change.

We have had to work with so many people. The CQC, the coroner, HSIB, the CCGs, GMC, NMC, NHS England, NHS Resolution, the police, Kirkup, our MP and of course, your good selves at PHSO. That's just to give you a flavour.

If we then say, "Okay, we've got too many regulators, let's see how they actually work." Because I reported this to the CQC within days of Harry's death. Really, just to highlight it. It was on the standard form on their website and you get a standard response back. Understandably.

I then followed the standard response back to say, "Look, actually I've uncovered a few more bits here. There's a bit more concern here." And so on.

I want to say this really carefully because to me, I still don't understand it. I cannot understand it. August of '18, 9 months after it's been reported to the CQC, we have an email that says, 'We have held three management meetings to discuss the information shared by yourself and the Trust, including the RCA, both independent reviews, the Trust's action plan, and additional information requested from the Trust.

After an extensive review, we do not believe there has been a breach in regulation. The concerns raised in this incident are centred on an individual's decision, or error. The criminal offences CQC can prosecute against only apply to registered person failures. The action taken by the Trust to date, in line with the recommendations by the independent reviews,

suggest the previous risks have been mitigated. Evidence for this includes the introduction of safety huddles, a consultant handover form, additional staff training, improved recruitment processes and new guidance on difficult intubation.'

We got that, and I read it with disbelief. I replied very nicely and said, 'Thank you so much for looking into this matter, but I believe you've missed this, this, this and this. I hope you don't mind, but because you've exhausted what you're doing, I've copied in Professor Ted Baker, head of CQC hospitals.'

It was only then that we started to get traction. What I would say to you Rob, is how did we get from that email which is absolutely cutting us adrift and saying, 'There is nothing for the CQC here.' To having the biggest criminal prosecution against a Trust that the CQC have ever carried out?

I'm not trying to be big-headed, this is not about that at all, but without me, that would not have happened. It just seems so, so wrong.

Rob Behrens: That ended up with a record fine for the Trust, which is an indication of the seriousness with which the whole situation was looked at.

I hear what you say. Two things, you must have wanted to shout and be angry during this process. One of the things I've noticed about you is that you don't do that very easily. You're very even-tempered. You listen very carefully. You conduct yourself in an exemplary manner. I'm not being patronising here, but other people are more emotional and abrasive when it comes to it. Is that a deliberate policy of yours? Or is it part of your general disposition and character?

Derek Richford: I think it’s a bit of both. The reason I say that is that we actually had a family meeting. It was around August, September of 2019. Bearing in mind we’re now getting on for two years after Harry’s birth and death and we haven’t involved the media at all at this stage. Not once.

We had a family meeting and said, “Look, if we’re going to get the change and the exposure that this needs, we’re going to have to involve the media at some point. Are you happy to do that?” Tom and Sarah made the decision again, very bravely, that yes, they wanted the wider learning to come from all of this.

So we got involved with the media. At that meeting we all agreed that we would not shout, we would not swear, we would not scream, because what we wanted to do was to put across a very reasoned argument. We had been wholly wronged. And as it turned out, and we didn’t know at that time, so had around 200 other families that have now come forward to Kirkup.

Being wronged, if you shout and you scream, people may have a level of sympathy for you. They may say, “Oh that poor family.” But they won’t hear the detail. They won’t hear the depth. What was important to us, as I’m talking to you now, that people understand the depth of the issues that were going on at that time. Because only then can we hope to get proper, detailed change that lasts.

If I could just touch again on, just to give you an idea of how bad things had got at the Trust. Just after Harry’s inquest, the senior coroner for Kent, a lady called Patricia Harding, wrote to solicitors. To quote from her letter, ‘The investigation of Harry’s tragic death has not only exposed a number of failures within the East Kent Hospital Trust, but has led to the discovery that deaths of babies within the Trust which should have been referred to the coroner at the time of the death had not been.

These concerning events, as the inquest found, should never have happened.'

We believe, and again it will come out at some point in Kirkup if this can be proven, is that for the five years prior to Harry, baby deaths were not reported to the coroner.

Rob Behrens: I'm not going to sit here and criticise other institutions because I know that your experience with PHSO was not ideal, and that's putting it mildly. Tell us about your experience with the Ombudsman service.

Derek Richford: Okay. I've already mentioned that were in touch with our MP, Sir Roger Gale, who was extremely helpful. He was in touch with the health minister and at the time, I can't remember who it was now, wrote back and said, 'You need to be in touch with PHSO. They're the people that should be looking into your complaint.' No one at that stage realised quite how bad things were other than the family.

Of course, at that point we were knowing what was going wrong but actually couldn't necessarily prove all of this. At that point the RCOG report hadn't even been discovered.

I rang PHSO on 6 December 2018 and I was given a C number, a case number. Went through the case and was told, "You haven't got an inquest date yet. When you get an inquest date call us back." So it wasn't until November '19 when I knew that the inquest was definitely happening in the January of 2020, that I called back and spoke to a young lady who said, "Oh no, you need to be putting a formal complaint in now. This seems quite urgent."

Okay, so I filled out the forms as you fill them out. Even today, I don't believe that anyone at PHSO, except perhaps yourself Rob, knows Harry's story back to front and knows all the intricacies of what's gone on. The letters that have gone back, the lack of investigation by the Trust, and so on, and so forth.

I think that we were largely cut adrift because, and this is not just PHSO, all of the regulators, and by regulators let's include people that are not necessarily regulators, but they're involved in what we're doing. These people, all of them, spend far more time worrying about treading on each other's toes and not getting into each other's patches. They spend an inordinate amount of time doing that.

It was a result of Harry's death that HSIB and the CQC actually set up a memorandum of understanding in March '19, because at that point they didn't share any information. It was bizarre.

From a PHSO point of view, I think that you were far more interested in, "Ah, hang on a minute." I had conversations with your staff, as you know, that said, "Oh, could you just clarify exactly what it is you'd like PHSO to look at? We only look at certain things." It was almost a matter of, "Unless he can get it on the bullseye, we're not going to be looking." There were more reasons not to look than there would be to look.

I'd done my research, I think you're used to that now. I knew that you would look at the complaint part of how the Trust handled the complaint, and I was pushing everything in that direction.

Then as it got towards, I guess we're now looking at towards the end of 2020, the decision was made, "Actually, Kirkup is doing that job. We don't need to do it. Thanks very much." And off we trot.

Now, that's harsh. And I don't mean to be harsh. But you, as an organisation, had the opportunity to engage with us from 8th December '18. You had the opportunity to engage with us further in November '19. Kirkup wasn't put into place until six months after that second contact with your people. It felt to us all the way through as though actually, you'd rather not. You didn't really have the resources necessarily to be able to look at such a big case.

I would have loved to have had an hour on the telephone with someone to say, "Look, can you just listen to this whole case from start to finish, and then make your decision?" Don't make me decide what I've got to complain about because that doesn't feel right. I'm not going to go to into Tesco and say, "Oh, could I speak to you about this piece of meat that's gone wrong?" And they say, "No, I'm awfully sorry, I only deal with biscuits, sir. Find someone else."

Rob Behrens: I think that's very interesting, and something for us to learn from. There are two issues here. There are two failures at least, maybe three, by PHSO.

One is that once we'd taken it, we failed to allocate it to somebody competent to deal with it as a complex case for over three months. Valuable time was lost, as you say.

Secondly, unrelated, we haven't got a process of prioritising cases immediately as they come in to promote urgency action which you might expect in a situation like the one that you describe. We're thinking about that. It's been exacerbated by the pandemic. But the points you make are very important.

I think the third point is we know that our communication is not as good as it should be. That we have to be better at listening and discussing on the telephone with people what's going on.

We're not there to be a barrier. We should be there to enable people and to help them address critical issues.

It's emotional intelligence on our part that was a failure, I think, as well as the other two things. But thank you for setting that out. We're going to learn from that.

Just moving on a bit. We now have Kirkup. That was one of the reasons why we had to be careful. If you have a crowded field, you mustn't operate without the other parties knowing what it is, is going to be done.

We had some problems with the Titcombe affair about not co-ordinating properly with the predecessor of the CQC. So we do have to sort it out, but it should be done quickly and effectively.

We've now got Kirkup. That's beginning to kick in. Bill Kirkup is speaking to me at the King's Fund in September about why lessons haven't been learned in terms of maternity care. Because he's been doing this since Morecambe Bay, since 2016, the very issues that you're talking about. What do you think has to be done to improve safety for mothers and babies, in the light of your experience?

Derek Richford: I think there's one clear thing right at the very front that I'm not sure has been debated terribly well. That is, if in the situation that we found ourselves in, who should I complain to? That seems like the simplest of questions.

If you Google it, you'll find the first five or six will be lawyers. If you then go down, you find you get to HealthWatch. HealthWatch direct you to the Citizens Advice Bureau. The Citizens Advice Bureau direct you to a template letter that they have to complain about your hospital, or your GP.

If you ask the Trust who you should complain to, “Ah, PALS. You need to complaint to PALS.” Well, I think that most people would agree that PALS are very much intertwined with the Trust, number one. And number two, a case as complex as Harry’s would not have been able to be dealt with by PALS. It was far too extensive, and far too complex.

So, we need a body that people can go to. It should not be down to a grieving family as it was for James Titcombe, as it has been over at Shrewsbury and Telford, as it has in East Kent, for individual families to raise the issues. It has to be far more that there is someone that we can complain to, to give our evidence to, which will give a level of early intelligence. It will give a level of, “Hang on a minute, let me just notify CQC, HSIB, GMC, NMC.” There was to be a go-to organisation.

I surprised myself when I looked into it that actually there isn’t a real answer as to “who should I complain to?”. One could say the coroner, but really he should be notified by the authorities himself, not by the family. And actually, this only applies to a death. What if Harry had been alive and just- did I say just? Wow. Just been brain damaged. Who would we have responded to then?

There isn’t an organisation who will take this away from a grieving family and say, “We will work with you, just to try and get the answers that you need.”

I think one of the key things that we’ve learned from this is that had we have had transparency and honesty from the Trust on day one, I don’t think we would have found everything we’ve found, because we would have been quite satisfied. We would have just said, “Oh my god, you’ve made all these errors. So what have you done about it? Okay, you’ve done this, you’ve done that. Fine.” We would have had that level of engagement.

But we were always pushed away. And I'm afraid that my temperament, and we're going back to that that you mentioned earlier, my temperament is to say, "Do you know what? If you push me back, I'm going to push against you and I'm going to push that bit harder." It was a result of that pushing back, I believe, by the Trust that actually spurred me on.

So, what do we need to do? The issue we have is that good trusts will listen, and they will learn. For all families, and I swear to you this is true, all families want learning to happen. If they've lost a child, or a relative of some description, if they know that this was an error that was made by a doctor, or a process, but actually we've learned from it, and it won't happen again, there's a level of satisfaction and a level of, "Do you know what? It's never going to happen to someone else. Or this is unlikely to happen to someone else."

Good trusts will listen. Bad trusts don't want to listen. They don't want to learn, as we have found. You mentioned, and I've managed to go back as far as 2012 when people were still talking about the Trust. So from 2012 to when Harry was born, a full 5 years, it seemed that the world and his wife, including NHS England, the CQC, the CCG, all the other acronyms, everyone knew that the maternity department up at this Trust was not good, except the people who actually use the service.

No one in this area had a clue that there was a problem with maternity services. We know of at least three families who have said, "Do you know what? I was in all sorts of trouble at that Trust. And I've said, "I know Harry Richford's family," and all of a sudden it changed."

That number one, is good. Number two, is shocking that you should get some kind of different service because you're almost using some kind of threat down the line. It's all to do with escalation. It's to do with processes. It's to do with, how do

you solve a trust who fundamentally don't want to be scrutinised and don't want to be told that what they're doing is wrong?

The medical examiner was mooted back in 2018, I think. I think that's still dragging its feet somewhere along the line. But actually, the medical examiner thing has not happened in any great shape or form, to my knowledge.

Every agency that we engaged with found fault. They found fault with either the process, the procedure, or individuals. In fact, the NMC are still, at this stage, three and a half years later, they're still investigating three midwives. I won't go into that any further, but wow. That's not good for learning, but it's not good for those midwives either having that hanging over them all that period of time. It doesn't seem right.

All of those agencies found fault from the CQC, the GMG. The only consequence has been the Trust has been prosecuted. But what has happened to any of the individuals? Has anyone been told, "Your practice there didn't actually come up to muster. We need to retrain you. We need to talk to you."

It would appear that most people have been told, "Look, don't worry about it. It will go away before too long." I think that that's a real, real issue.

A side issue to all of this is that when we went to court a standard - again, shocked by this - a standard tactic by trusts, certainly our Trust, is that they will admit liability just before they believe an inquest will actually go ahead. That means that on a no-win, no-fee type claim, it means that you get no representation in court whatsoever. So therefore, you find yourself up against the biggest legal eagles that there are. We were up against the Head of Medical Negligence for a solicitor

firm that the Trust had employed, and we shouldn't have had any representation whatsoever.

We were very, very fortunate to have been put in touch with Advocate who arranged for two barristers, and the barristers arranged for three solicitors. Every day, at that inquest, that three-week inquest, we had two barristers and three solicitors there for us every single day. We couldn't have coped without that.

Rob Behrens: Thank you for that Derek. I've got three reflections on the basis of what you've said. Not only to that answer, but also all the way through this conversation. There's a paradox that I know that complaints handling organisations do not always take well to assertive, well-informed complainants. But they should do.

Because we know from your experience, and from lots of other experience, that if complainants are articulate, assertive and seek to get resolution, that actually assists the resolution of issues. It's not a hindrance. Too many people sometimes are cooled out of taking it further because they don't want to get involved in the hassle, and you've never been in that camp.

The second thing I would say is in relation to your point about where does the responsibility lie? I'm not making a crude point here, but there is a debate at the moment about what does just culture mean? One of the reasons for the creation of HSIB, which is a splendid, excellent organisation, is that some people felt that too much emphasis had been put on blame, and not enough on learning.

I think what you're saying is that in some situations, there needs to be accountability of individuals. And that if there's not, you don't get the proper recognition of the seriousness of the issues and better practice going forward.

My last point is this, and it's to thank you. Because what you've done today, is you're putting on public record, ideas about how we, regulators and complaints handlers in the Health Service can do it better, and can learn actively from what has gone wrong.

What we done want is a situation where Morecambe Bay repeats itself through Shrewsbury, through Nottingham, through East Kent, and no one learns anything from it. By coming out and saying this, and pushing it forward, you're helping to ensure that that doesn't happen. So I'm grateful to you. I think you on behalf of PHSO, but also our listeners.

We'll reflect on it, and we'll invite you back to more discussions to show you what we've learned, and how we plan to apply it. So, thank you. How would you sum up what you've got from this?

Derek Richford: I think that overall it's been an enormous learning, very, very sharp learning curve as well, for me to learn about everything that's gone on. In a strange way, there are levels of satisfaction. We have made a difference.

In Harry's year, there were 21 neonatal deaths. Last year there were 7. That drop suddenly happened after Harry's inquest. So I am happy that we have made a difference and that people are now taking this seriously. I think that maternity is now very much on the agenda for every part of the NHS. And so it should be.

I guess I'd like to finish, if you like, by giving the coroner's ruling from 24 January 2020 when Harry's inquest was concluded. And that will be enough for me, thank you.

Harry was hyper-stimulated by an excessive use of syntocinon over a period of approximately 10 hours. Once the CTG reading had become pathological by 2:00am, Harry should

have been delivered within 30 minutes, and not the 92 minutes that was actually happening.

The delivery itself was a difficult one. It should have been carried out by the consultant, who should have attended considerably earlier than she did.

The locum on duty that night was relatively inexperienced. He was not properly assessed and should not have been put in the position of being in charge unsupervised.

There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth, leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.

There was a failure in not requesting the consultant support early enough during the resuscitation attempts. There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the effect that control was lost.

Harry Richford's death was contributed to by neglect.

Rob Behrens: Derek, thank you very much indeed on behalf of all our listeners. This is Rob Behrens signing off from Radio Ombudsman.

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