Patient safety within safety science

Safety science has a long history

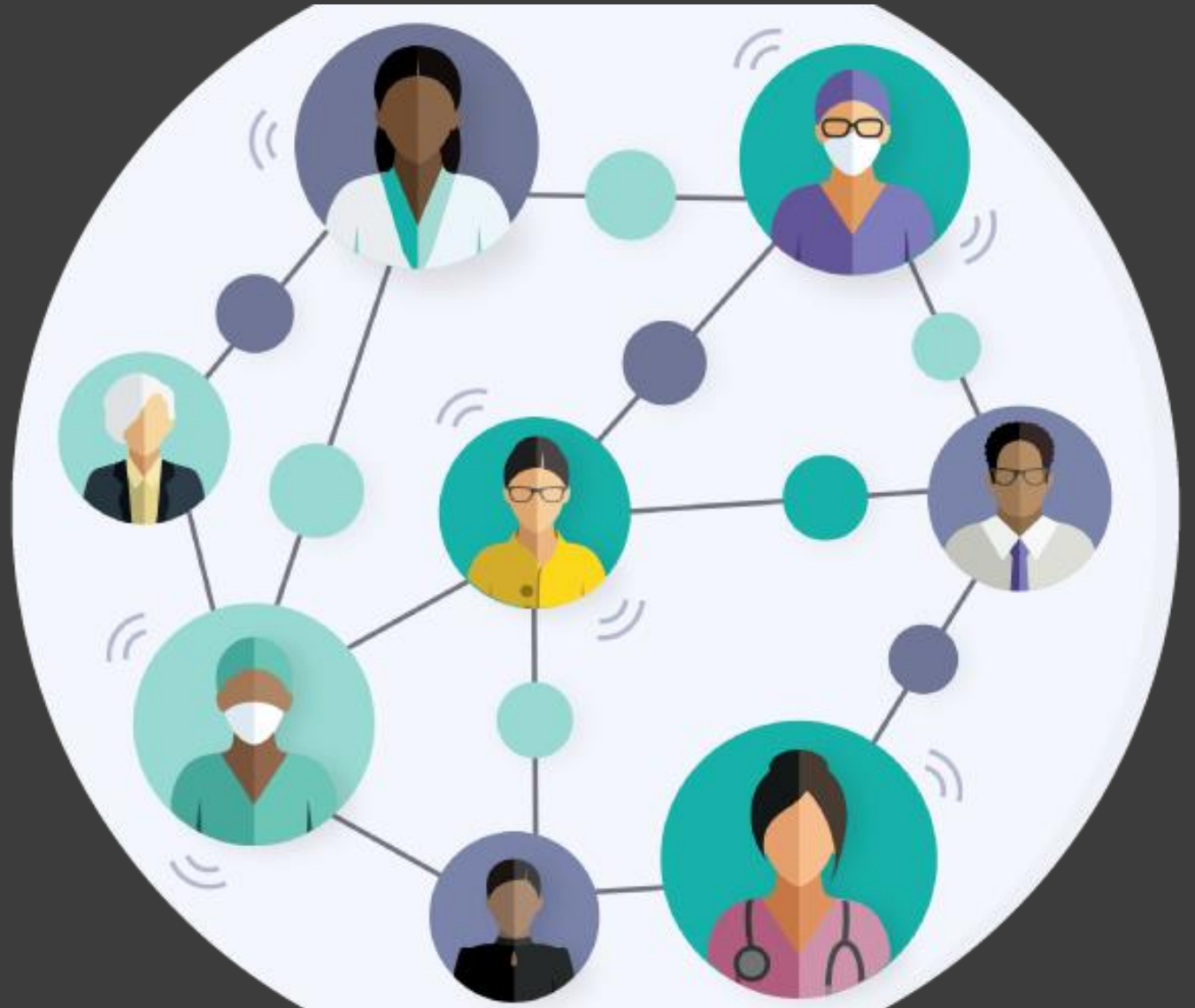# Whose work contributes to safety?

Healthcare staff
Managers
Suppliers
Policy makers
Regulators
Patients, families and carers

Axel Ros
Background

Debbie Clark
Workarounds in practice

Siri Wiig
Collective learning

Catherine Calderwood
Where do we go from here?

Rebecca Lawton
Summary and close

@THIS_Institute

JÖNKÖPING UNIVERSITY

Bridge over troubled water
Part 1, some theory

Safety I & II
Resilience
Work-as-done
Workarounds

Axel Ros

Chief medical officer/Associate professor

Region Jönköping County/Jönköping University

JÖNKÖPING ACADEMY
For Improvement of Health and Welfare

Workaround (according to Wikipedia)

- A workaround is **a bypass** of a recognized problem or limitation in a system or policy.

- A workaround is typically **a temporary fix** that implies that a genuine solution to the problem is needed. But workarounds are **frequently as creative as true solutions, involving outside the box thinking in their creation.**

- Typically they are considered **brittle** in that they will not respond well to further pressure from a system beyond the original design. Placing pressure on a workaround may result in later system failures.

- Workarounds can also be **a useful source of ideas for improvement** of products or services.

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A warm-up

- Who do we have in the room?
  health care practitioners, patient safety practitioners, managers, patients, politicians, policy makers, researchers…?

- Present yourself to a neighbour – and briefly disclose a workaround you have recently done (at work or off-work)
  - what happened?
  - did it go well?
  - how did you feel?

Healthcare is a complex adaptive system

➤ It's a big system!

➤ It is complex

➤ Variability needed to manage variability

➤ Adaptations

➤ Intractable

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Complexity – safety

- Modern healthcare systems are complex

- Complexity relates to variability – changes, disturbancies, challenges and opportunities

- Safety in healthcare has to address the complexity

- Complexity has implications to how we understand safety

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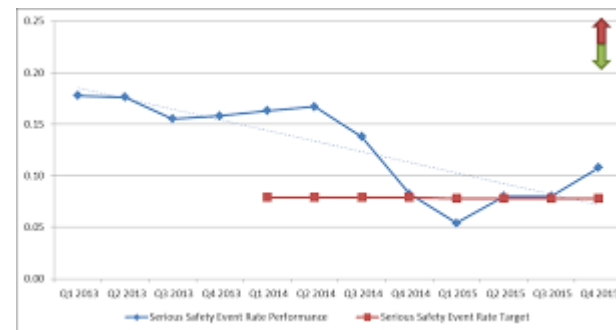FOR IMPROVEMENT OF HEALTH AND WELFARE

What does it mean to be safe?

When we think about safety, we usually think about accidents – about (low probability) events with adverse outcomes.

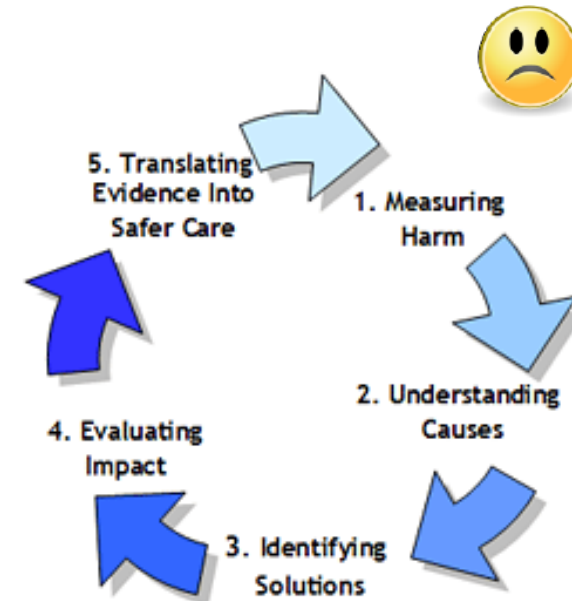A system is safe if as little as possible goes wrong.

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Safety – the traditional way to see it
When nothing goes wrong

Safety is a condition where the number of adverse outcomes (accidents / incidents / near misses) is as low as possible.
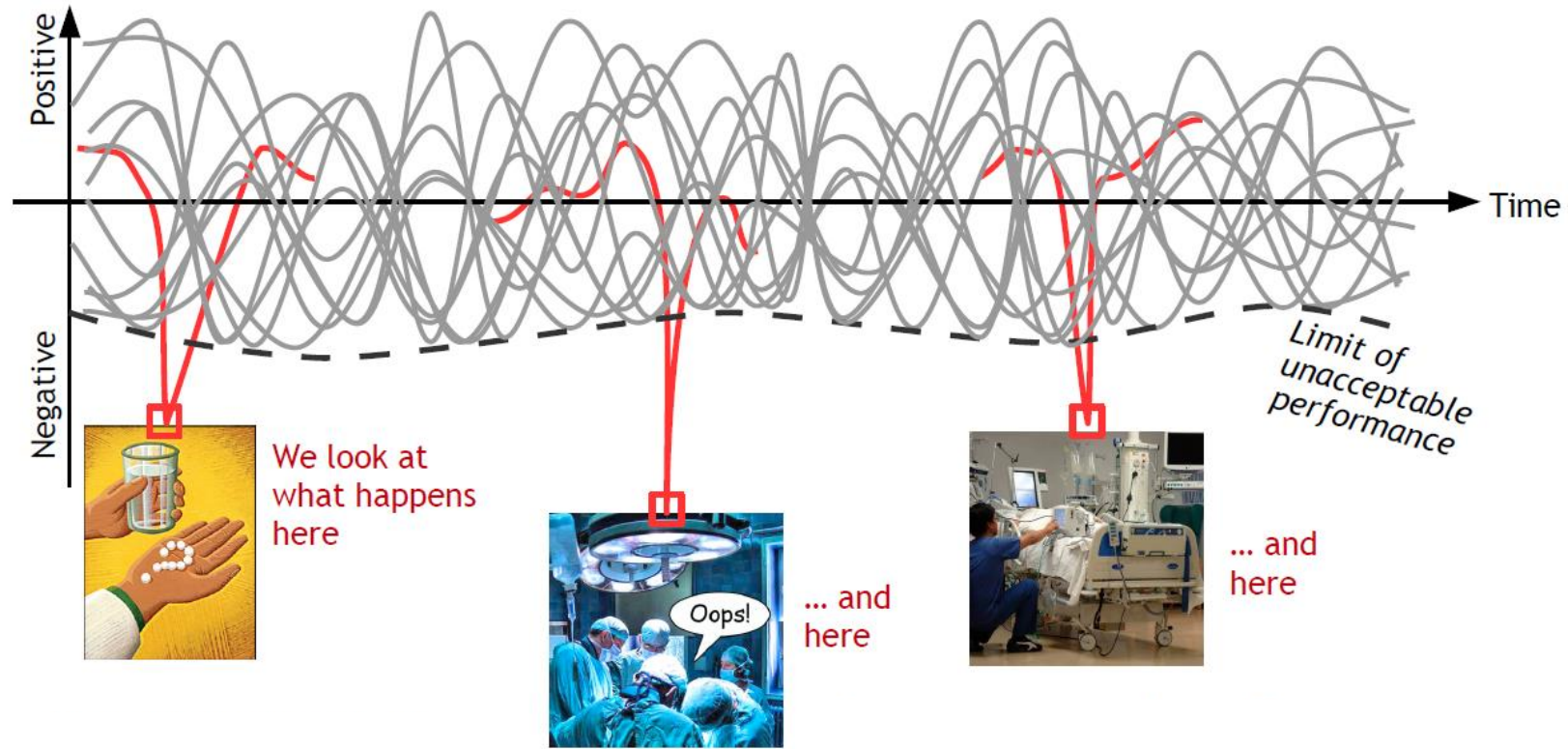
Safety is defined by its opposite – by the lack of safety (accidents, incidents, risks).

The premise for safety is the need to understand why accidents happen.

5. Translating Evidence Into Safer Care

1. Measuring Harm

2. Understanding Causes

3. Identifying Solutions

4. Evaluating Impact

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Safety-I

Managing safety by snapshots

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Managing safety by snapshots

The result of the traditional way of managing safety is that we know something about how failures happens, but almost nothing about how work goes well.

In a complex world everyday work must be flexible to cope with the variability

People adjust what they do to match the situation. These adjustments are inevitable and necessary.

Resources may be limited and uncertain (time, manpower, materials, information, etc.).

Because of resource limitations, performance adjustments will always be approximate.

Performance variability is the reason why everyday work is safe and effective.

Performance variability is the reason why things sometimes go wrong.
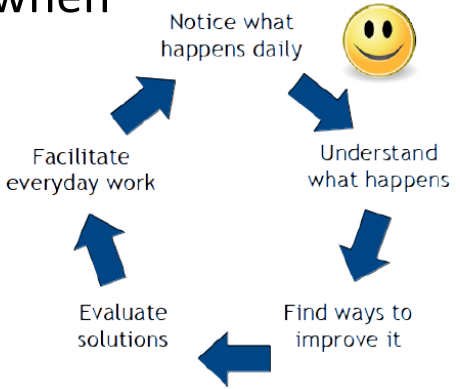
The Jönköping Academy
for Improvement of Health and Welfare

Safety – another way to see it
When everything goes right

Safety is a condition where the number of successful outcomes (meaning everyday work) is as high as possible.

It is the ability to succeed under varying conditions.

Safety concerns should be directed at everyday events, at that which happens when "nothing" happens, when work just goes as it should.

Notice what happens daily

Understand what happens

Facilitate everyday work

Evaluate solutions

Find ways to improve it

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Managing safety differently

To manage safety, we must understand how and why everyday clinical work goes right. This provides the basis for understanding the functioning of the system and how safety is created.
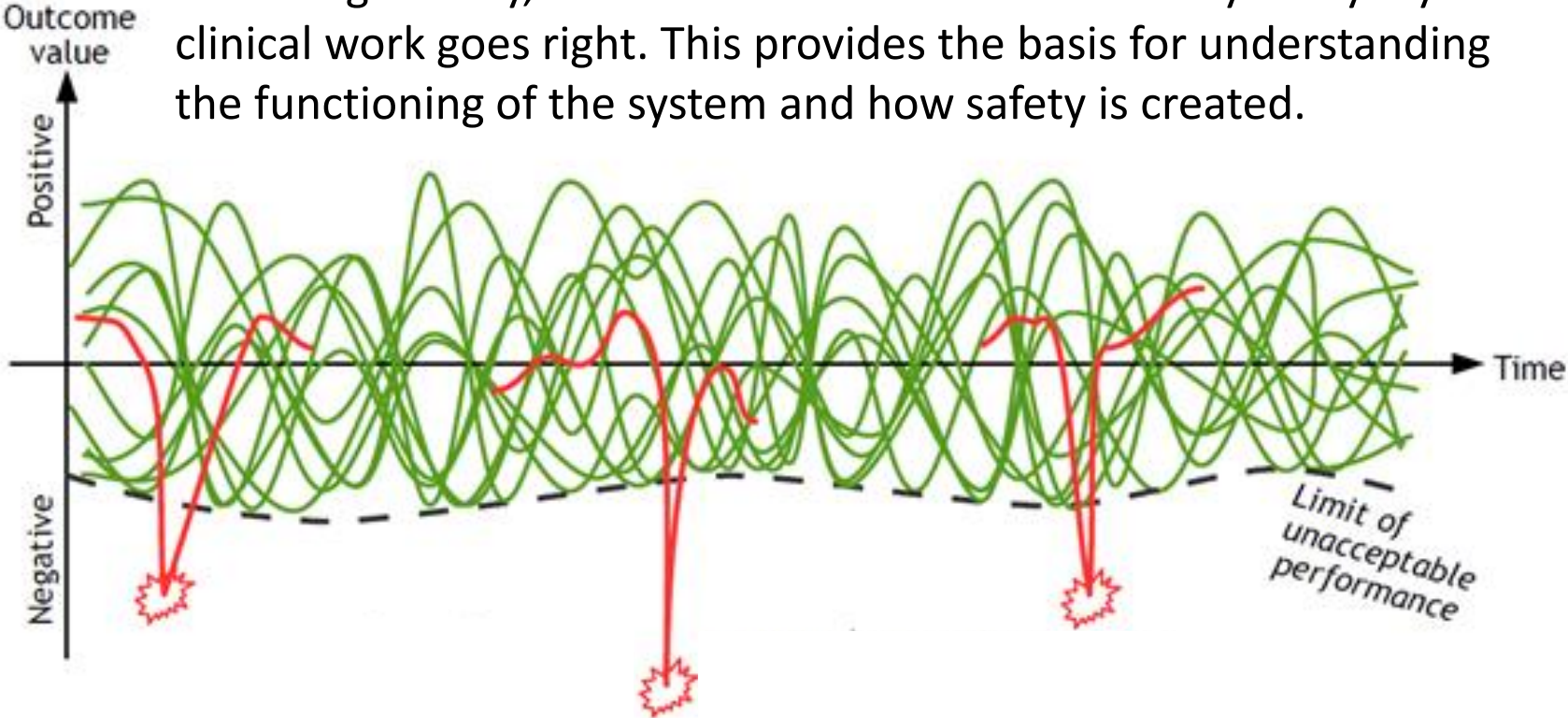

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The focus of resilience

Resilience is an expression of how **a system** (people, groups, and organisations) **cope with everyday situations** – large and small – by **adjusting their performance** to the conditions.
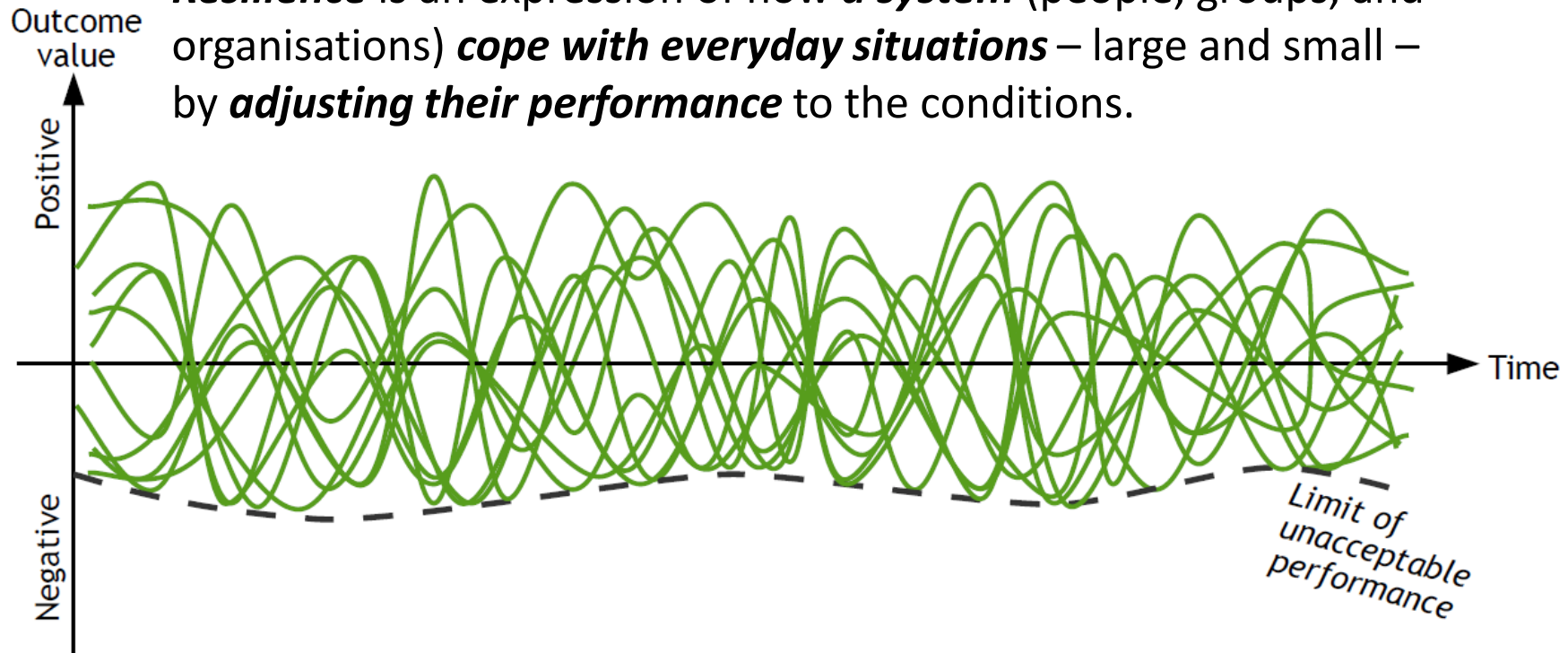
The focus of resilience

Resilience is an expression of how *a system* (people, groups, and organisations) *cope with everyday situations* – large and small – by *adjusting their performance* to the conditions.
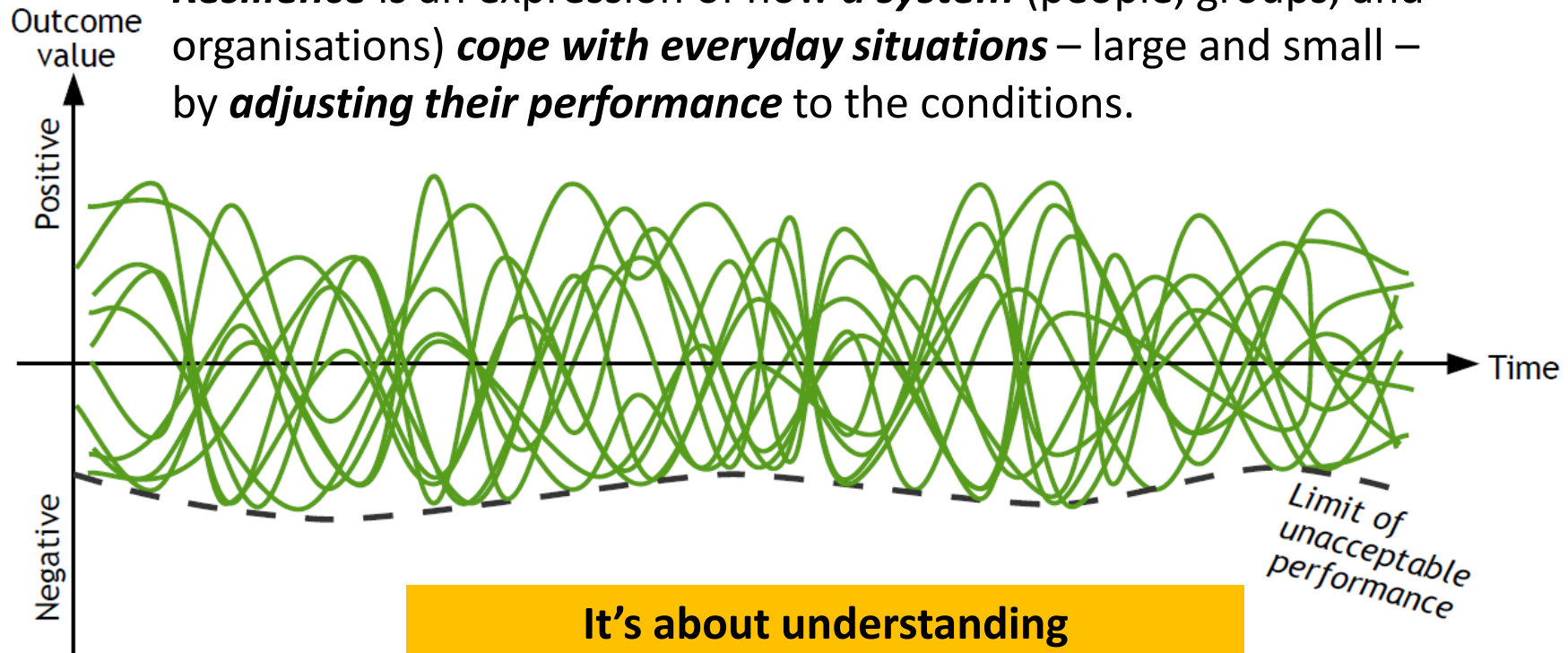
It's about understanding
how people muddle through
their everyday work

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Definitions

Resilience
A resilient system can adjust its functioning prior to, during, or following events (changes, disturbances, and opportunities), and thereby sustain required operations under both expected and unexpected conditions.
(Hollnagel 2015)

Resilient healthcare
A healthcare system's capacity to adapt to challenges and changes at different system levels, to maintain high-quality care.
(Wiig et al 2020)

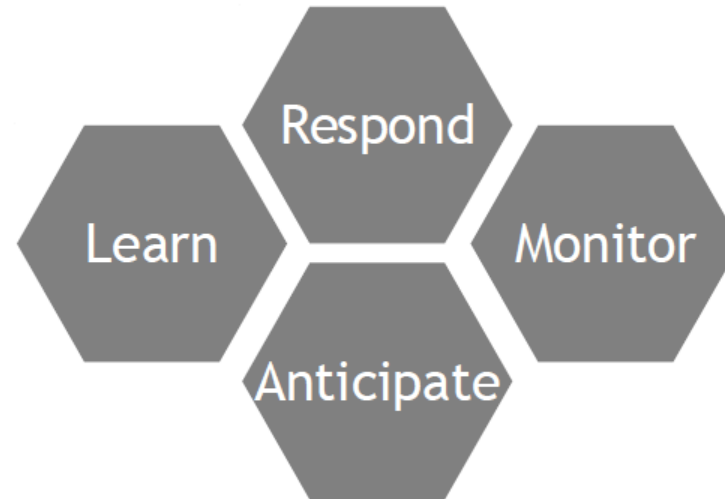*Resilient performance is a (an intrinsic) system property.*

Resilient performance

Resilience is created, it is something that is done

Resilient performance requires that an organisation has the ability to

- **respond** to that what happens,
- **monitor** what is happening,
- **anticipate** what might happen,
- **learn** from everything.

The setting

- County hospital Ryhov, Jönköping, Sweden
- Neonatal intensive care unit (NICU)

- ESBL-producing Klebsiella outbreak June 2015
- 5 infected children, no invasive disease

- Outbreak group leading the work with outbreak containment

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The ability to **Respond**

- Evident both in the outbreak group and the NICU staff
- Both in activities according to routines and in activities that were adaptations to the events and situation

➢ NICU staff responses and actions according to decisions from the outbreak group.

We did what we were told to do, sometimes even more

➢ Sometimes decisions were unclear, or difficult to adhere to

But we managed anyway

The ability to **Monitor**

- Monitoring is a part of the work in the outbreak group
- Monitoring was not an integrated part of the staff work

➢ According to standard routines
   Eco-cultures, environment cultures to detect infections

The ability to **Anticipate**

- To evaluate future events, to be prepared
- To be informed of relevant important matters and reflect over anticipated events increases the abilities to deal with the outbreak

If these cultures turn out positive we will...

➢ Important part of work in the outbreak group

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The ability to **Learn**

- Learning that had an impact on work during the outbreak
- Learning that facilitates situational awareness
- A need to learn more was expressed

➢ There can not be to little information

After a while we took up an afternoon meeting, besides the morning one

➢ Where is the risk?

It's the parents that are careful and thorough; it's us that mixes things up

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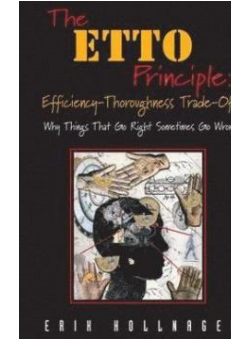FOR IMPROVEMENT OF HEALTH AND WELFARE

Trade-offs and Workarounds

natural and necessary in complexity

ETTO –
Efficiency Thouroughness Trade-off (Erik Hollnagel)

Efficiency – time to perform
relates to being fast and efficient

Thouroughness – time to think, reflect, plan
relates to safety and accuracy

We do trade-offs all the time.

To save time, energy, money…..

Full efficiency and full thoroughness at the same time is impossible.

ETTO –
Efficiency Thouroughness Trade-off

Workarounds!

Efficiency – **time to perform**
relates to being fast and efficient

Thouroughness – **time to think, reflect, plan**
relates to safety and accuracy

We do trade-offs all the time.

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ETTO / workarounds

ETTO – shortcuts and workarounds – to save time, energy, money…..

If you assume that A "always" is true in situation B,
you do not have to check every time – *or do you?*

You only check what is important.
B*ut how can you know? And when?*

Exemples
- *"This is not really important"*
- *"This normally is OK, so we don't have to check"*
- *"This looks like X, so it has to be X"*
- *"We have to finish in time"*

ETTO / workarounds

ETTO – shortcuts and workarounds – to save time, energy, money…..

If you assume that A "always" is true in situation B,
you do not have to check every time – *or do you?*

You only check what is important.
B*ut how can you know? And when?*

Carelesness, or only human?
Regardless, you probably have
to accept that this is the way it is

Exemples

- *"This is not really important"*
- *"This normally is OK, so we don't have to check"*
- *"This looks like X, so it has to be X"*
- *"We have to finish in time"*

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A blood transfusion case

- A busy Saturday at the OR ward

- Two surgeries at adjacent rooms

- Both patients in need of blood transfusion
    in OR 10 Sven Svensson, a male born 1947, personal ID 471112-2476
    in OR 11 Stina Svensson, a female born 1947, personal ID 471103-2464

- Nurse anesthetist in OR10 recieve a blood bag for her patient,
  assumes it is right since she has never got the wrong bag before,
  is in a hurry,
  reads name and ID (in hindsight too) fast,
  and misses that she has Stina Svensson's blood bag in her hands.

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A blood transfusion case

- A busy Saturday at the OR ward
- Two surgeries at adjacent rooms
- Both patients in need of blood transfusion
  in OR 10 Sven Svensson, a male born 1947, personal ID 471112-5076
  in OR 11 Stina Svensson, a female born 1947, personal ID 471103-2464
- Nurse anesthetist in OR10 recieves a blood bag for her patient,
  assumes it is right since she has never got the wrong bag before,
  is in a hurry,
  reads name and ID (too) fast,

  Efficiency before thoroughness

  and misses that she has Stina Svensson's blood bag in her hands

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More examples?

Do you have any own examples of
ETTO
that you want to share?

Muddling through

and

Work-as-imagined vs. Work-as-done

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Work

- laws
- rout
- instr
- expe

Oops!

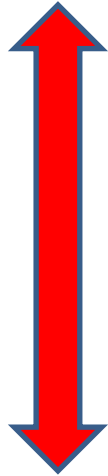THE JÖNKÖPING ACADEMY
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Work-as-done

How the work is actually done, when the ideal meets the reality

- complexity
- adaptations
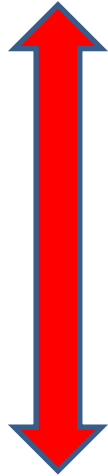- trade-offs
- workarounds
- resources

Work-as-imagined

There is a gap!

Work-as-done

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Work-as-imagined

To reconcile

Work-as-done

- This is reality
- Important to recognize and understand the gap
- Don't blame – learn!
- Often to understand (and fix) preconditions for work

Any own examples?

Do you have any own examples of
WAI vs WAD
that you want to share?

A brief recap

Safety I & II
Resilience
Workarounds / ETTO
Work-as-done vs. Work-as-imagined

The Resilient Health Care Society
www.rhcs.se
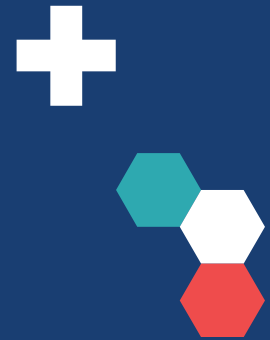
Bridge over troubled waters – Part 2. Do safety standard workarounds support resilience?

you Axel for

Debbie Clark

THIS Institute PhD Fellow

Through taking part in this session you will…

- Have an insight into safety standard workarounds performed in different healthcare contexts.

- Explore what workarounds are achieving, for who, considering the circumstances when using a workaround might be more beneficial than following a standard.

- Gain an understanding of perspectives from different levels of the healthcare system on if and when workarounds contribute to resilient performance.

- Have an insight into if and how studying workarounds can be used to support future improvement efforts.
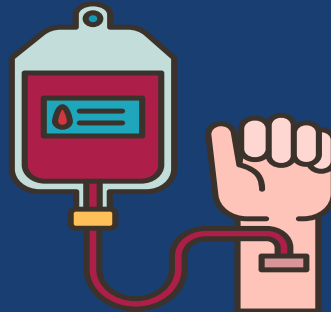
Defining safety standard workarounds.

'An adaptation, improvisation or change, to an existing work rule designed to promote safety, in order to overcome, or lessen the impact of obstacles that are perceived as preventing that work system or its actors from achieving a desired goal.' (Based on Alter, 2014).

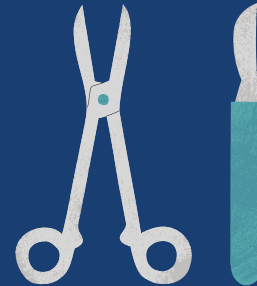# Multiple case study (Flyvbjerg, 2006; Stake, 1995).

Ultra safe

High reliability

Ultra adaptive

Haematology

Elective Surgery

Emergency Department

How is the practice of IV medication administration enacted by registered nurses in different healthcare settings within an acute hospital in England?
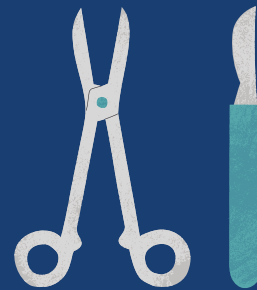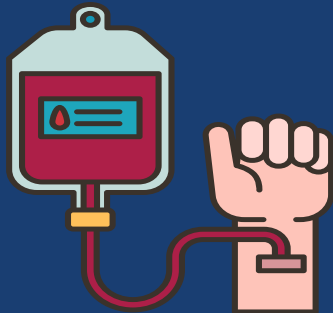
Multiple case study findings.

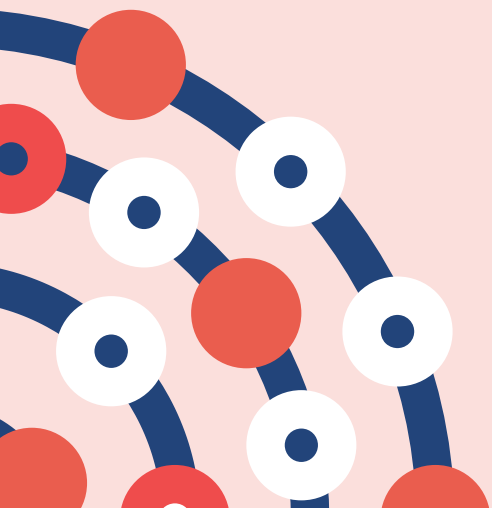A single task may be associated with multiple safety standard workarounds.

Some safety standard workarounds are common across all settings, others are not.

Some safety standard workarounds may be beneficial to patient safety in certain circumstances, others are not.
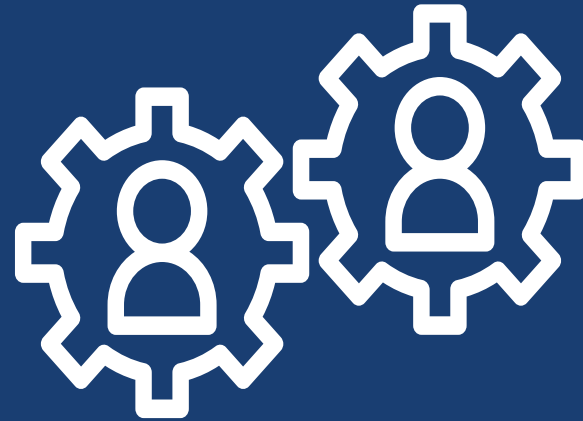
Tabletop discussions

Exemplar safety standard workarounds.

1. Who is the workaround helping?

2. When is the workaround helping?

3. Can the workaround be regarded as safe in some circumstances?

Highly reliable site – Double check omission.

Ultra Safe site – Prescription adaptation.
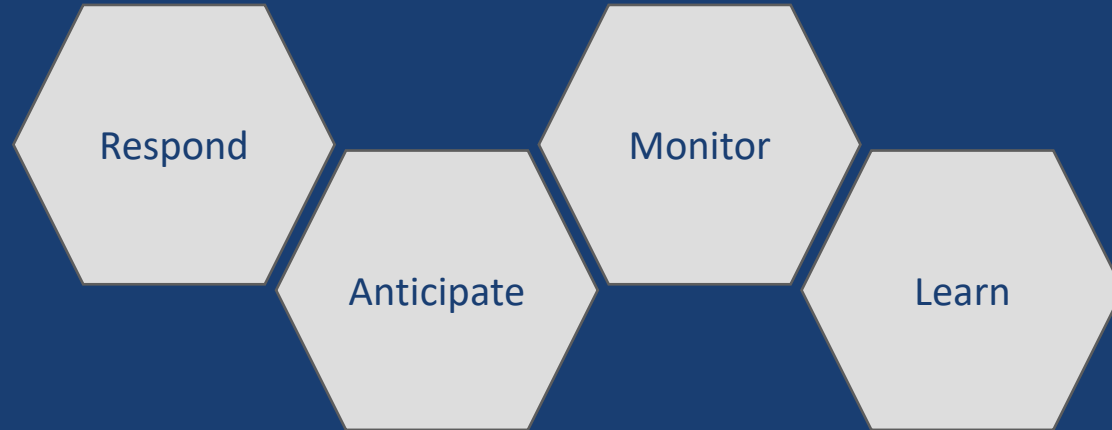
Ultra adaptive site – ePrescription system.

Online focus groups study (Daniels, 2019).
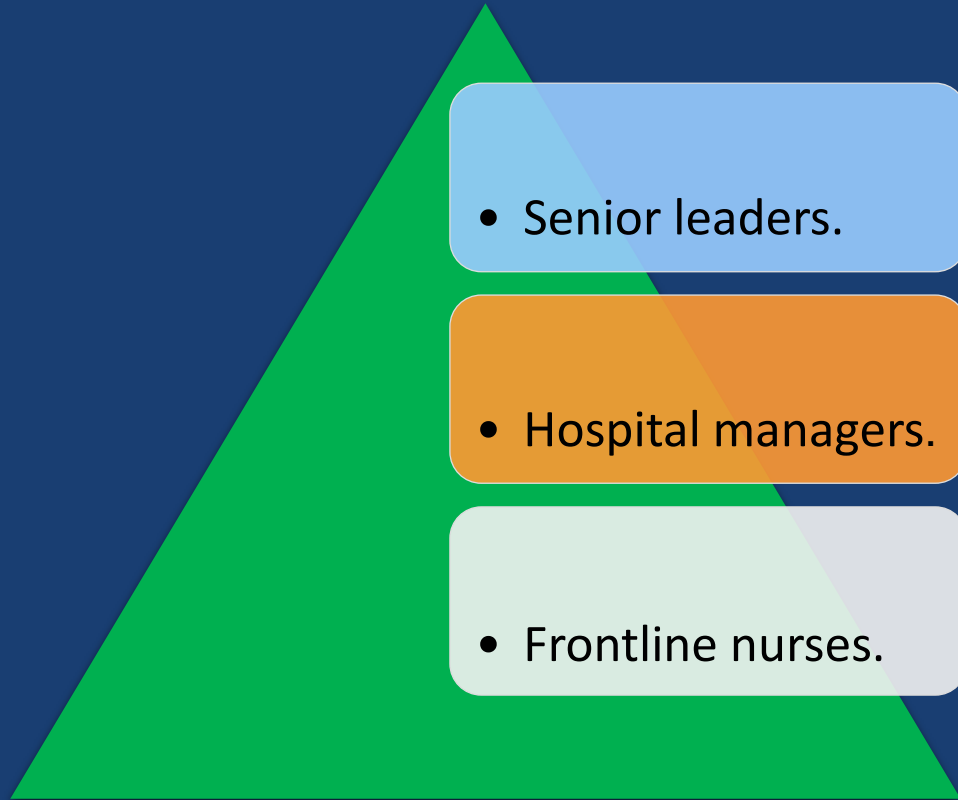
- Senior leaders.

- Hospital managers.

- Frontline nurses.

Workarounds are useful when....

- Adherence to policy perceived to result in less effective care
- Working in challenging conditions
- Balancing risks

I understand that standards are required, but sometimes it's absolutely impossible. And then when we don't follow those standards, people are reprimanded and that doesn't drive a good culture. P16.

What's kind of what's morally right and what's policy right. P13.

It's about balancing risk. I would advise the nurses, doctors, AHPs, use your clinical knowledge and do what you think is right and the best thing for that patient at that time. P24.

![NIHR | Yorkshire and Humber Patient Safety Research Collaboration]

Thank you for taking part.

SHARE | Centre for Resilience in Healthcare

University of Stavanger

SIRI WIIG

Center director, Professor of Quality and Safety in Healthcare Systems, University of Stavanger, Norway

Honorary Professor, Australian Institute of Health Innovation, Macquarie University, Australia

Honorary Professor, University of Wollongong, Australia

Adjunct Professor, Western Norway University of Applied Sciences, Norway

Testing the digital Resilience in Healthcare learning tool to translate safety II thinking and adaptive capacity into practice

University of Stavanger

Funded by The Research Council of Norway

Learn from success and everyday work?

Why resilience and adaptive capacity are crucial

RAPID CHANGES & INNOVATION

COMPLEXITY

EMERGING RISKS

PANDEMICS

RETHINKING CURRENT APPROACHES

SHARE Centre for Resilience in Healthcare

University of Stavanger

The Resilience in Healthcare program (2018-2024)

The primary objective: to reform the understanding of quality in healthcare by the development, implementation, and test of a theoretical and practical RiH framework

Resilient healthcare principles

1. **Complex system** requires to **anticipate** problems, **adapt,** and **prioritise** competing demands

2. **Procedures are not always helpful** - they cannot anticipate all interactions

3. **Adapting safely** to pressures keeps the system functioning -> **improvement efforts** should focus on **strengthening this capacity**

Defining adaptive capacity in healthcare: A new framework for researching resilient performance

J.E. Anderson [a,*], A.J. Ross [b], C. Macrae [c], S. Wiig [d]

[a] Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, Centre for Applied Resilience in Healthcare (CARe), King's College London, UK
[b] Dental School, School of Medicine, University of Glasgow, UK
[c] Centre for Health Innovation, Leadership and Learning, Nottingham University Business School, UK
[d] Faculty of Health Sciences, SHARE – Centre for Resilience in Healthcare, University of Stavanger, Norway

SHARE Center for Resilience in Healthcare
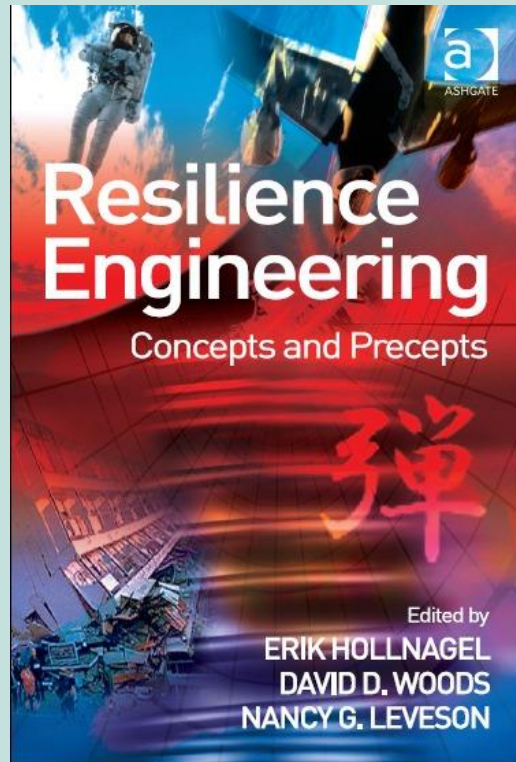University of Stavanger

Resilience and adaptive capacity

Resilience:

- *Resilience is defined as the capacity to adapt to challenges and changes at different system levels, to maintain high quality care*

  (Wiig et al 2020)

- Capacity to adapt to changes is fundamental for quality of care

Resilience Engineering
Concepts and Precepts

Edited by
ERIK HOLLNAGEL
DAVID D. WOODS
NANCY G. LEVESON

DEBATE   **Open Access**

Defining the boundaries and operational concepts of resilience in the resilience in healthcare research program

Siri Wiig[1], Karina Aase[1], Stephen Billett[2], Carolyn Canfield[3], Olav Røise[1,4,5], Ove Njå[6], Veslemøy Guise[1], Cecilie Haraldseid-Driftland[1], Eline Ree[1*], Janet E. Anderson[1,7], Carl Macrae[1,8] and on behalf of the RiH-team

Abstract

Background: Understanding the resilience of healthcare is critically important. A resilient healthcare system might be expected to consistently deliver high quality care, withstand disruptive events and continually adapt, learn and improve. However, there are many different theories, models and definitions of resilience and most are contested and debated in the literature. Clear and unambiguous conceptual definitions are important for both theoretical and practical considerations of any phenomenon, and resilience is no exception. A large international research programme on Resilience in Healthcare (RiH) is seeking to address these issues in a 5-year study across Norway, England, the Netherlands, Australia, Japan, and Switzerland (2018–2023). The aims of this debate paper are: 1) to identify and select core operational concepts of resilience from the literature in order to consider their contributions, implications, and boundaries for researching resilience in healthcare; and 2) to propose a working definition of healthcare resilience that underpins the international RiH research programme.

Main text: To fulfil these aims, first an overview of three core perspectives or metaphors that underpin theories of resilience are introduced from ecology, engineering and psychology. Second, we present a brief overview of key definitions and approaches to resilience applicable in healthcare. We position our research program with collaborative learning and user involvement as vital prerequisite pillars in our conceptualisation and operationalisation of resilience for maintaining quality of healthcare services. Third, our analysis addresses four core questions that studies of resilience in healthcare need to consider when defining and operationalising resilience. These are: resilience 'for what', 'to what', 'of what', and 'through what'? Finally, we present our operational definition of resilience.

Conclusion: The RiH research program is exploring resilience as a multi-level phenomenon and considers adaptive capacity to change as a foundation for high quality care. We, therefore, define healthcare resilience as: *the capacity to adapt to challenges and changes at different system levels, to maintain high quality care.* This working definition of resilience is intended to be comprehensible and applicable regardless of the level of analysis or type of system component under investigation.

Keywords: Resilience, Healthcare, Adaptive capacity, Change, System perspective, Multi-level approach, Conceptualization

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University of Stavanger

Capacities for Resilient Healthcare

Exploring the nature of adaptive capacity for resilience in healthcare across different healthcare contexts; a metasynthesis of narratives

Hilda Bø Lyng [a,*], Carl Macrae [a,b], Veslemøy Guise [a], Cecilie Haraldseid-Driftland [a], Birte Fagerdal [a], Lene Schibevaag [a], Janne Gro Alsvik, Siri Wiig [a]

RESEARCH

Balancing adaptation and innovation for resilience in healthcare – a metasynthesis of narratives

Hilda Bø Lyng[1*], Carl Macrae[1,2], Veslemøy Guise[1], Cecilie Haraldseid-Driftland[1], Birte Fagerdal[1], Lene Janne Gro Alsvik[1] and Siri Wiig[1]

RESEARCH   **Open Access**

Capacities for resilience in healthcare; a qualitative study across different healthcare contexts

Hilda Bø Lyng[1*], Carl Macrae[1,2], Veslemøy Guise[1], Cecilie Haraldseid-Driftland[1], Birte Fagerdal[1], Lene Schibevaag[1] and Siri Wiig[1]

Leadership

Leadership concerns how to facilitate, support, motivate and contribute as a leader of a team/unit. This might, for example, be how managers facilitate opportunities for learning, how they support improvement work and initiatives for change, or how they motivate staff to take responsibility and contribute to creating a culture in which everyone feels included.

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University of Stavanger

Universitetet i Stavanger

Understanding patient and stakeholders' role in resilience

Understanding resilience in teams and role of leaders

RESEARCH

Open Access

Exploring the role of leaders in enabling adaptive capacity in hospital teams – a multiple case study

Birte Fagerdal[1,2*], Hilda Bø Lyng[1], Veslemøy Guise[1], Janet E. Anderson[3], Petter Lave Thornam[4] and Siri Wiig[1]

SHARE Center for Resilience in Healthcare
University of Stavanger

Universitetet i Stavanger

From words to action – What does it take?

SHARE Senter for kvalitet og sikkerhet i helsetjenesten
Universitetet i Stavanger

rih.uis.no/

rih.uis.no

Test the Resilience in Healthcare – A digital learning tool for practice

SHARE Center for Resilience in Healthcare
University of Stavanger

Welcome to the Resilience in Healthcare reflection tool - learning from what goes well

02:56

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University of Stavanger

Background to the tool

Select one of the elements below. We recommend that you start with mapping.

Mapping

Here, you are asked to score your team/unit on three statements for each of the 10 different resilience capacities, in order to map your current status of own team/units' resilience capacity.

Go to mapping

Scenario

Here, you will get an overview of all the learning scenarios. You can use these to consider one or more resilience capacities in depth.

Go to scenarios

Resilience reflection list

Here, you will find a simple overview of how you can reflect on the team/unit's capacity for resilience by reflecting on situations in everyday life.

Go to resilience reflection list

Mapping

Aim:
Awareness of areas of own team/units' capacity for resilience

Mapping

Risk awareness

Risk awareness is about how the team/unit is concerned with, and thinks about, different types of risks to which patients and staffs may be exposed, and the types of adverse incidents that may occur. For example, is the team/unit concerned with prevention and mapping of potential hazards, or is it more focused on handling incidents after they have occurred? This also concerns discussion and communication related to various incidents in order to make good decisions and assess of what is happening.

Structure

Communication

Learning

Facilitator

Alignment

Competence

Coordination

Involvement

Risk awareness

Leadership

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Mapping

Question 1:

We are good at collecting information from various sources and using it to anticipate and prevent adverse situations from arising.

Totally agree — Agree — Neither agree nor disagree — Disagree — Completely disagree
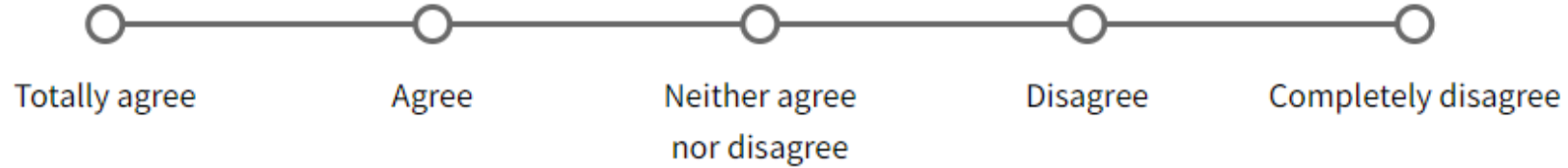
Question 2:

We are keen to have an open discussion about risk across different professions, in order to shed light on a situation from different points of view and find out how to handle various situations. (For example, discussion between a doctor and nurse about a patient's assessment and why it has been assessed in that particular way.)

Totally agree — Agree — Neither agree nor disagree — Disagree — Completely disagree
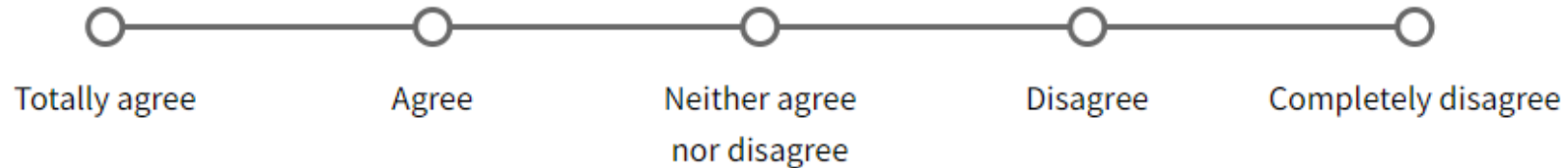
Question 3:

We use clear and precise language with objective information (such as BP/pulse/other measurements) to communicate potential hazards well across professions.

Test in groups 1

1. Open the tool

2. Select one or two capacities (leadership or risk awareness)

3. Discuss in groups the statements and try to respond

4. Reflect on how you could use this in your organisation or unit

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Mapping

Result

These are the three capacities that you excel at. Click on 'See scenario' to get suggestions for the scenarios you can work on further to become aware of what you are good at and why. You will now continue working on the indicators that you perform well on.

Here you perform the best:

Communication

Learning
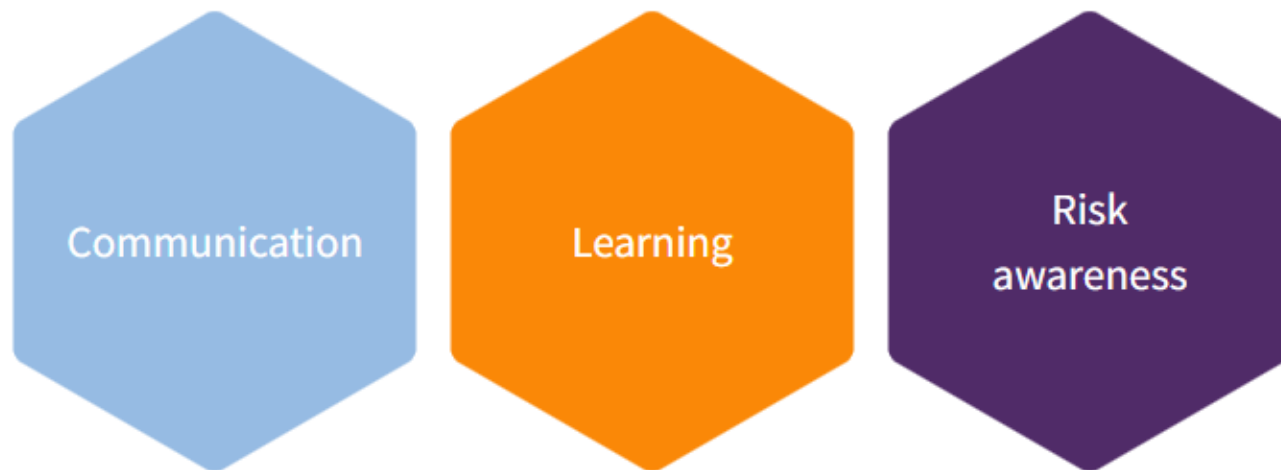
Risk awareness

Mapping

Communication

Learning

Risk awareness

See all results

Communication : 13.05%

Risk awareness : 13.04%

Learning : 13.04%

Facilitator : 12.17%

Structure : 12.17%

Leadership : 11.3%

Alignment : 8.7%

Competence : 6.96%

Coordination : 5.22%

Involvement : 4.35%

Legend:
- Communication
- Risk awareness
- Learning
- Facilitator
- Structure
- Leadership
- Alignment
- Competence
- Coordination
- Involvement

Aim:
Understand *what* your team does that provides positive outcomes

Scenario

SHARE Center for Resilience in Healthcare
University of Stavanger

Scenario

Structure 1

Access to resources and task management

Lack of resources in the department and ambiguities around the distribution of tasks

See scenario

Structure 2

Newly employed staff

Newly employed staff who has challenges settling in

See scenario

Structure 3

Medication administration

Busy work day, challenges with medication administration

See scenario

Learning 1

Simulation at the workplace

Facilitating learning situations at work

Learning 2

Training and skill development

Example of how the management facilitates skills development at the

Learning 3

Patient admission

Newly admitted patient

Test in groups 2

1. Go to the scenario part
2. Select leadership
3. See scenario: Leadership 1
4. Discuss in groups the questions for reflection
5. Reflect on how you could use this in your organisation or unit

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Questions for reflection

1. How does management ensure professional development among staff, even when there is a shortage of resources?

2. What measures are taken to increase staff commitment and motivation in their work?

Resilience reflection list

Here you will find three questions that could help you perform a resilience reflection. The questions are a tool that can be used in everyday work, for example after completing a task, before or after a handover, or any another occasion where you come together and talk to your co-workers. The resilience reflection list consists of 3 simple questions to help you reflect on what went well and why. One of the questions asks you to discuss how the different capacities of resilience contributed to the success of the situation. This is to help you to describe and justify why things went well, so that you can better understand what it is that contributes to better outcomes - and in turn learn from this and transfer it to other situations.

Resilience reflection

1. What went **well** and why?

2. How did the different **capacities of resilience** contribute?

3. What did you **learn** and how can it **be applied** further?

Download the resilience reflection list

Capacities for resilience

Take it home!

SHARE Centre for Resilience in Healthcare

University of Stavanger

Professor Catherine Calderwood

Professor of Health Futures, University of Strathclyde, Glasgow

Consultant Obstetrician NHS Lothian, Edinburgh

Former Chief Medical Officer for Scotland

University of
Strathclyde
Glasgow

You may choose to look the other way but you can never say again that you did not know.

~ William Wilberforce

Can It's a Sin win?

Russell T Davies'
80s drama up
for 11 awards at
television Baftas

→ *Page 9*

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The Guardian

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NHS maternity scandal: police investigate 600 further cases

Report condemns staff failures that may have led to 201 baby deaths

Andrew Gregory
Health editor

Police are examining 600 cases linked to the biggest maternity scandal in NHS history after a damning report into baby deaths condemned health staff for blaming mothers while ignoring their own catastrophic blunders.

The independent inquiry into maternity practices at Shrewsbury and Telford hospital NHS trust uncovered hundreds of cases in which health officials had failed to undertake serious incident investigations, while deaths were dismissed or not investigated appropriately.

Instead, grieving families were denied access to reviews of their care and mothers were blamed when their babies died or suffered horrific injuries.

A total of 201 babies and nine mothers could have or would have survived if the NHS trust had provided better care, the inquiry found.

There were 29 cases where babies suffered severe brain injuries and 65 incidents of cerebral palsy.

Rhiannon Davies, one of the mothers who fought for justice for years after her daughter Kate died in 2009, said the numbers did "not tell the whole story" of the impact on the families.

Sajid Javid, the health secretary, issued a Commons apology yesterday, telling MPs: "We entrust the NHS with our care, often when we're at our most vulnerable. In return we expect the highest standards.

"When those standards are not met, we must act firmly and the failures of care and compassion set out in this report have absolutely no place in the NHS. To the families that have suffered so gravely, I am sorry."

Javid offered reassurances that NHS staff responsible for the "serious and repeated failures" would be

> *'The families live with unimaginable trauma and grief'*
>
> **DCS Damian Barratt**
> *West Mercia police*

held to account. "There is also an active police investigation, Operation Lincoln, which is looking at around 600 cases," he said.

Detective Chief Superintendent Damian Barratt, of West Mercia police, said the investigation was "very much active" and added: "We will be fully reviewing the findings of the report and feeding appropriate elements into our investigation.

"We do not underestimate the impact the report's findings and our ongoing investigation has on the families involved, who have suffered unimaginable trauma and grief that they still live with today."

A combination of an obsession with "natural births" over caesarean sections coupled with a shocking lack of staff, training and oversight of maternity wards resulted in a toxic culture in which mothers and babies died needlessly for 20 years while "repeated failures" were ignored again and again.

Julie Rowlings, whose daughter Olivia died

The lights are off. But Ukraine's rail lifeline brings hope

Shaun Walker
Kyiv

Windows shuttered and lights dimmed, a darkened train pulls into a station platform, also unlit. As the train comes to a halt, attendants toss boxes of humanitarian aid to station workers on the platform.

Huddles of passengers, who arrived at the station hours earlier so as not to be on the streets during curfew hours, search in the inky blackness for the right carriage, before the train is on its way again with a gnashing of wheels and a long hiss of steam.

This scene has played out at stations across Ukraine repeatedly over the last month, as Ukrainian Railways has been engaged in one of the most impressive elements of Ukraine's

▲ *Evacuees on the train for the two-day journey from Kryvyi Rih in eastern Ukraine to Chop, close to the western border with Slovakia* PHOTOGRAPH: JELLE KRINGS

Labour giant Frank Field has quit because the party he's given his life to is mired in anti-Semitism. What are his fellow MPs waiting for?

COMMENT SEE PAGE 16

Daily Mail

FRIDAY, AUGUST 31, 2018   www.dailymail.co.uk   65p

Before tragedy struck: Pippa Griffiths died aged one day; Rhiannon Davies lost daughter Kate after just six hours; and Jack Burn died at 11 hours old

NEW MATERNITY DEATHS SCANDAL

By Sophie Borland and Tom Payne

MORE than 60 babies and mothers are feared to have died or suffered devastating harm at a maternity unit.

An investigation began last January into 23 suspicious incidents at the Shrewsbury and Telford hospital trust.

But the Mail can reveal that this number has almost trebled to at least 63.

The vast majority of the cases involve the deaths of babies and mothers during childbirth. The rest include babies suffering lifelong harm. Some parents say they were

Turn to Page 6

REVEALED: Probe finds 60 babies and mothers have died or suffered serious harm at ONE hospital trust – three times more than first thought

THE TIMES

Thursday March 31 2022 | thetimes.co.uk | No.73745 £2.20 £1.45 to subscribers

Why Bruce Willis is quitting acting News, page 5

Deborah Ross Who's the real Elena Ferrante? Me. Honestly Times2

Childbirth 'is not safe for women in England'

Mothers and babies died avoidably in NHS scandal

Putin faces revolt over blunders in Ukraine

Larisa Brown Defence Editor

King of spin Shane Warne's son, Jackson, 23, told 55,000 people at his father's 'funeral' at a memorial at Melbourne Cricket Ground. Page 27; Sport, pages 60-69

BBC NEWS

THE Sun

Thursday, March 31, 2022 THE PEOPLE'S PAPER 70p thesun.co.uk

H❂LS FROM £9.50 OVER 150 PARKS IN UK & EUROPE

Baby P mum to go free

Wanted Tom dies aged 33 SEE PAGE 7

£10/44

EXCLUSIVE: BEDROOM HAUL

MASKED RAIDER IN BECKS MANSION

At home... Becks & Posh

Posh & David home as thief prowls upstairs

The Ockenden report findings
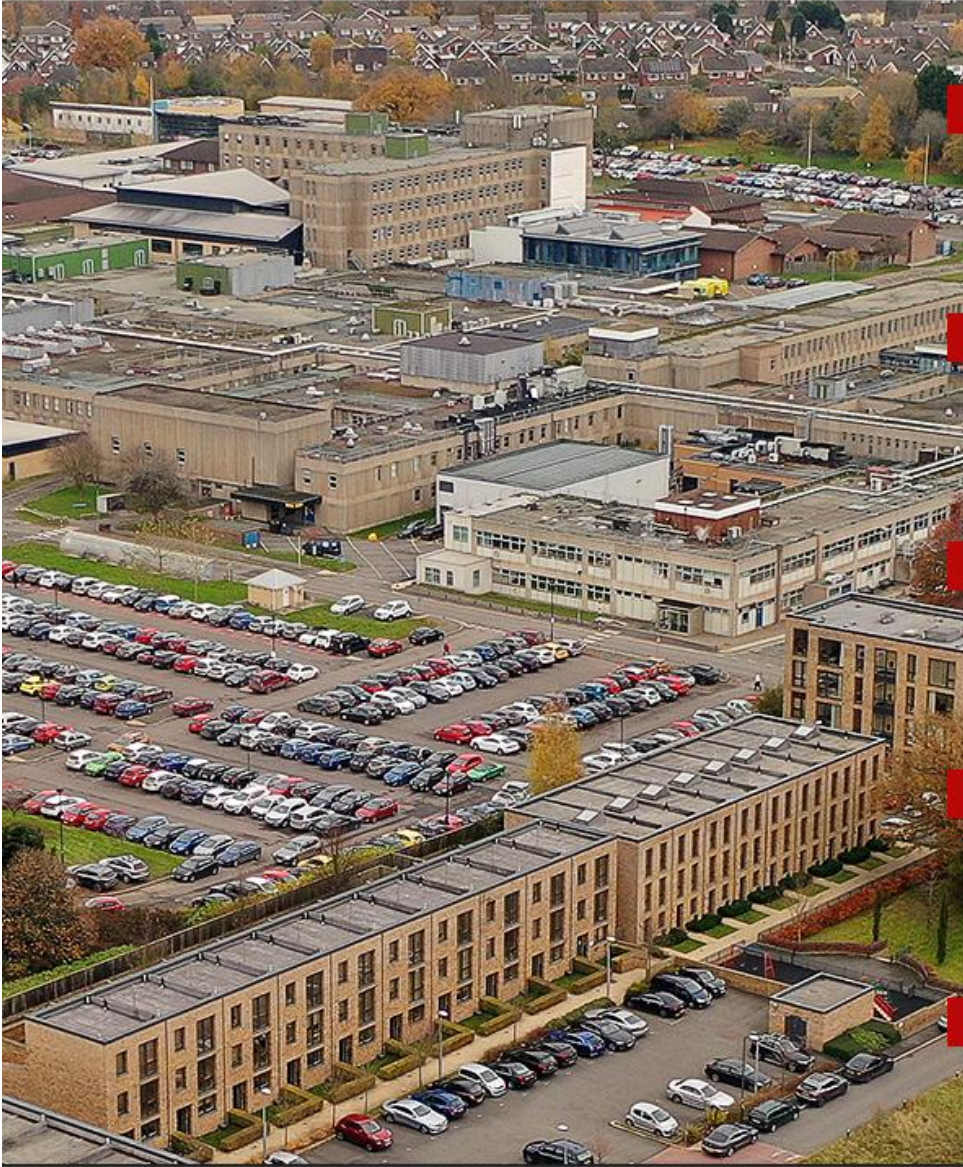
- Examined almost **1,600 cases** spanning **20 years**

- **201 deaths** where concerns over care found

- **131 stillbirths** and **70 neonatal deaths** affected

- Also **29 cases** where babies suffered severe **brain injuries**

- And **65** incidents of **cerebral palsy**

Source: Ockenden Maternity Review

Daily Mail
.com

Call of Duty player, 25, is arrested for

PICTURED: Two men arrested over

The secret codes doctors use to

Stop worrying about mixing drinks:

Scandal of the 'Musketeer' midwives: Five staff who triggered baby deaths scandal at NHS hospital to finally face justice after being allowed to keep working there for seven years

The problems within the Trust fell into five problem areas, which resulted in the service being described as seriously dysfunctional. These were:

1. Clinical competence of a proportion of staff fell significantly below the standard required for a safe, effective service
2. Working relationships between different groups of staff were extremely poor
3. Midwifery care in the unit became strongly influenced by a small number of dominant individuals
4. Advice to mothers that it was appropriate to consider delivery at FGH was significantly compromised by a failure to assess the risks properly
5. A grossly deficient response from unit clinicians to serious incidents with repeated failure to investigate properly and learn lessons

Issues identified in numerous reports

Standards and guidelines	Communication	Extension of roles beyond training
Tolerance of exception	Unacceptable becomes acceptable	Lack of care and compassion

My challenge to you

Can you see anything of what I have discussed in your organisation?

What is the culture – what do you feel?

How will you describe what you do to your family and friends?

THE UNIVERSITY OF STRATHCLYDE

"Do not wait for leaders;
    do it alone, person to person"
                                ~Mother Teresa