birthrights

Response to Department of Health consultation on rapid resolution and redress scheme for severe birth injury

Introduction

We welcome the Department of Health's proposals for the creation of a rapid resolution and redress scheme (RRR) for severe birth injury. The families of children who suffer severe injury during birth often face insurmountable obstacles to obtaining proper investigation and recognition of what went wrong and appropriate compensation for the damage done to their child. Our legal system, beset by delay and adversarial process, has failed families for too long. As many other countries have recognised, there is a compelling need to support people victims of medical injuries rapidly and without confrontation. The benefits to the healthcare system, and the professionals working in it, are equally profound: redress schemes are shown to improve care, reduce harm and reassure professionals that they can practise without fear of litigation if something goes wrong.

The case for RRR is clear, but it must be designed and implemented in a manner that ensures it meets the needs of children and families and offers a sustainable model for the future. We have significant concerns that the scheme proposed by the Department of Health will fail to do these things. We set out our two principal criticisms of the proposals below, before answering specific consultation questions.

(1) Exclusion of stillbirths and neonatal deaths is arbitrary, insensitive and will undermine the purpose of the scheme

The numbers of stillbirths and neonatal deaths attributable to intrapartum care are very small. Denying these families the opportunity to receive the support offered by RRR is unfair and insensitive. RRR is intended to reduce birth injuries by sharing and implementing learning. Determining eligibility by whether the baby survived is arbitrary: the lessons learnt from intrapartum stillbirths and neonatal deaths are equally valuable to those learnt from cases of severe brain injury. The inclusion of these babies in the scheme would have a limited effect on the overall cost as there would be no ongoing payments and any compensation offered by RRR would be low.

In 2015, the government announced the National Maternity Ambition to halve the number of stillbirths, neonatal death, maternal mortality and brain injuries by 2030. RRR is a central mechanism for achieving this ambition, as the consultation recognises. The proposed exclusion of stillbirths and neonatal deaths is at odds with these plans and would be a lost opportunity to join up government initiatives.

(2) Administration of the scheme by the NHSLA will reduce its credibility and effectiveness

The NHSLA is established to indemnify NHS Trusts and administer and defend legal claims when something has gone wrong. It represents the interests of NHS Trusts; it is not independent or impartial. While we recognise that the government is seeking to develop the remit of the NHSLA (now 'NHS Resolution'), its core function remains the defence of adversarial litigation. Giving NHSLA responsibility for the RRR scheme seriously undermines its credibility as an independent scheme

designed to achieve genuine resolution and redress free from the influence of the NHS Trust responsible for the harm. RRR will need to have a close relationship with the NHSLA and might share board members, but for it to have credibility and legitimacy, it should be a free-standing scheme administered outside the NHSLA.

Question One: Investigation Design.

Do you agree that the scheme should include early investigations, conducted by professionals independent from the trust involved, potentially including at least one obstetrician and one midwife?

We agree that an early investigation is critical to providing resolution to the families and learning for professionals. The investigation must be transparent, independent and open-minded. It should adhere to the standards of investigations undertaken by the Healthcare Investigation Safety Branch (HISB). In our view, investigations by clinicians are not an appropriate or effective means of carrying out these investigations. Clinicians are not investigators. They can provide expert advice on specific clinical issues but they are not trained in the investigative process nor are they accustomed to weighing up evidence. It is not an effective use of their training and expertise to conduct investigations. Furthermore, the inappropriateness of using supervisors of midwives as investigators has been recognised by the government when it abolished supervision and delegated investigation to the Nursing and Midwifery Council.

If yes, how independent would the investigating team need to be in order for families to have confidence in the findings? Would investigations need to be conducted;

- **by clinicians in the trust, that were not involved in the incident being investigated nor have had direct management of those involved.**

As above, clinicians are not the right people to carry out these investigations. If clinicians are to be investigators, there should be a system of training and accreditation. They should not come from the same Trust in which the incident occurred as that would seriously compromise their independence and the family's faith in the process.

- **outside the trust involved, for example through the proposed regional Maternity Clinical Networks (proposed by Better Births)?**

Yes, if clinicians undertake the investigation, they should come from outside the Trust.

- **with oversight from the Royal Colleges or other independent bodies?**

There should be a system of training and accreditation for RRR investigators administered by an independent body.

Question Two: Investigation Design.

We are aiming to launch an investigation into the incident with 90 days. Do you agree with this approach, or have comment on the feasibility?

If the Department of Health is committed to rapid resolution and an early investigation, we do not believe that 90 days is a satisfactory time period in which to launch the investigation. It should begin within days of the identification of a baby who meets the eligibility criteria. The family should immediately be assigned a case worker by RRR who holds an initial meeting with them to explain the RRR scheme and process. The 90-day delay appears to be based on the fact that the clinicians' availability will be limited. This supports our view that clinicians are not the appropriate investigators. If they are to be used, it does not prevent the early allocation of an RRR case worker.

Question Four: Investigation Design.

Do you agree that the scheme should include an early apology to families, in the form of an early expression of regret?

No. RRR is independent from the NHS Trust it is investigating. It is not responsible for apologising to the family, though it may facilitate such an apology by the Trust itself. RRR should offer families an individualised expression of sympathy and a guarantee of an open and fair investigation.

Do you agree that the investigations should offer families the opportunity to be involved in the investigation process, with the option for a face-to-face meeting to discuss the findings?

The family should be at the centre of the investigation. Their views and questions about what went wrong should be the starting point. They must be regularly informed of the investigation's progress and they should be given an opportunity to comment on the evidence as it emerges and to see the conclusions in draft before they are finalised. The support of a case worker will be essential to ensuring that families are able to participate effectively and without exacerbating their trauma.

Question Thirteen: Scheme Administration

Do you agree that NHSLA (or new division within NHSLA) should administer the scheme?

No. As explained above, we believe that RRR should be administered independently from the NHSLA. It should have its own board, which could include NHSLA members, but its governance should be separate and it should be accountable directly to NHS England or the Secretary of State.

As NHSLA collects the CNST premiums from Trusts, it would be sensible for NHSLA to administer and make the payments mandated by RRR.

Question Fifteen: Administrative Eligibility

Do you agree with the principle of administering the scheme using an avoidable harm test?

Yes. Avoidable harm is a preferable test to negligence because it shifts the focus from the individual clinician to the system in which the incident occurred. In this way, it meets the urgent need to shift the emphasis from individual fault towards a systems-based approach which recognises collective responsibility for standards of care.

Question Sixteen: Avoidable Harm

Do you prefer the proposed 'Experienced Specialist' test (EST) or the 'Reasonable Care' test (RCT)?

We do not believe either test is appropriate. The consultation recognises that the benefit of avoidable harm is the focus on healthcare systems. It is therefore illogical to apply a standard that focuses on the

care provided by the individual clinician. Instead, the test ought to be whether or not the harm could have been avoided if the system was an optimal one. This would examine the care given by the individual clinician as only one aspect of the system and judge that care by the standard of an experienced specialist. This approach would lead to wider and more valuable learning applicable across the NHS.

Question Seventeen: Piloting the scheme

Should the scheme be piloted?

No. The numbers of babies that will be eligible for RRR are small and we are concerned that a pilot scheme would not produce a large enough sample from which to evaluate results. Furthermore, the operation and benefits of RRR will take many years to evaluate as the scheme is designed to give long-term support to families. Pilot schemes are not designed to continue in existence for a time scale of this sort.