

Procedures related to adverse clinical incidents and outcomes in medical care

A Paper submitted to the House of Commons Select Committee on Health on 4th June, 1999

We are pleased that, at last, someone is looking into this matter and that we now have an opportunity to express our concern.

AIMS is a voluntary pressure group. We operate a free help line and deal with enquiries and complaints about maternity care throughout the United Kingdom. Our complaints work involves supporting many distressed clients throughout the procedure, so that we have good feedback on the success rate of our clients achieving their aims and also the many difficulties they encounter in the process. At any one time we are dealing with around 80 serious complaints about maternity care in the UK. Because we are concentrating on maternity work we are able to see certain clinical errors are increasing or decreasing and we get early warning of adverse effects of new treatments or new technology. We can identify trends, common errors and adverse effects of particular treatments. Although our work concentrates on maternity care it also naturally includes paediatrics, psychiatry, general practice and gynaecology.

The general state of maternity care in the UK

Your enquiry is timely because we believe that the overall quality of maternity care in the UK has declined in the last two to three years and is continuing to deteriorate. This does not mean that there are not many units providing good and even outstanding care, but our feedback from both the public and professionals suggests that a combination of factors has put the service under excessive pressure. These factors are:

1. The change in midwifery and nursing training to become more college based. Midwives deliver the majority of babies in this country and midwifery requires not only clinical knowledge but practical skill, and these skills need to be acquired by supervised practice and apprenticeship. Nowadays we have more complaints that newly qualified midwives are given responsibilities beyond their competence and that they are not fit for unsupervised practice.
2. Under extreme financial pressures Trusts have reduced not only staffing levels but, just as important, the ratio of senior grades staff. This

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means that there are fewer midwives with the experience and skill to support and supervise junior colleagues. Trusts have not realised what an important role experienced midwives (and nurses) have played in the training and supervision of junior doctors, so that quality of medical care has also suffered.

Under these pressures we have found that some of the best and most experienced midwives have left because they have been demoralised at being unable to provide the quality of care which they know is necessary.

The workload on the delivery suite cannot be predicted and is variable.. We are seeing more complaints of adverse outcomes in women who were known to be high risk but who had inadequate care during labour, because the midwife was also caring not only for other women but other high risk women in labour at the same time. It cannot be stressed too strongly that safety for mother and child during and after delivery depends on continuous intelligent watchfulness and that a low-risk situation can become high-risk very quickly.

We believe that a number of Trusts are relying on bank or agency midwives to help them to cope. We have not seen any studies of what extra risks this may pose. We do know that locum doctors seem to increase risk. From experience, one of the first questions we ask in the case of medical disaster is "Was the obstetrician a locum?"

3. Changes in junior doctors' training have made the situation even worse and they suffer from the same problem as midwives in lack of continuous supervision and they are also required to cope with situations outside their competence.

4. Mothers are now being discharged earlier from maternity units. This means that adverse events are not fully documented and recognised unless they cause emergency re-admission e.g. caesarean scars which burst open after the woman has been sent home. A particular concern is high infection rates, which again are not fully recognised because symptoms may not become apparent until after discharge and then they may not be adequately documented since post-natal home visits by midwives have also been reduced. It should be noted that recent research has shown that too early discharge can increase post-natal depression rates (Dowsell T et al, 1997)

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When approached for help with a complaint there are a number of standard questions we ask, because these issues feature repeatedly in the complaints we receive:

On which day of the week did the incident occur and at what time of day? (research indicates a greater number of errors occurring at night, weekends and bank holidays)

Was the obstetrician a locum? (We find that locums are frequently involved in serious errors)

When did the midwife qualify? What was the doctors grade? If there was an emergency who was the most senior doctor around? (We find greater numbers of junior doctors and midwives involved in complaints, and a lack of available senior staff)

Was the midwife caring for other mothers as well as you? (Staff shortages feature in many of our complaints)

Were the midwives changing shift at a crucial time?

Complaints Procedure

The Complaints Procedure presents a series of hurdles for complainants to jump. Many complaints are multi-dimensional. One complaint, for example, might include behaviour of staff, inadequate monitoring, inappropriate intervention, lack of cleanliness in wards, poor quality food. Pursuing these complaints often takes intelligence, energy, expense, emotional stress and persistence. We find that even professional people find it taxing, and some of the complainants we have supported are doctors, nurses or midwives themselves.

It would help enormously if people were given detailed straightforward and honest replies to their questions at the very beginning, instead of having to extract information painfully and over a long period of time. Many complainants get the impression very early on that the Trust or the practice is prevaricating or dishonest, and hope of an amicable resolution is lost at an early stage because of the style of response.

Although respondents have learned the lesson that an expression of regret is not necessarily an admission of legal liability, too often what we see is the skilled pseudo-apology e.g. "We are sorry if you feel you have cause for dissatisfaction", which leaves the complainant angrier than ever. Although we carefully advise our clients to list their factual questions clearly, one by one, they seldom get straightforward responses to all the questions.

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They are almost invariably offered a meeting and the quality of these varies enormously. Sometimes appropriate staff are not present and people who do attend have not been adequately briefed beforehand and time is wasted. A meeting is usually offered on the hospital premises when for some of our complainants this is the last building they want to visit. Sometimes complainants who go to these meetings emerge more distressed and angrier than they were before.

Very often complainants are not given a copy of the notes taken at the meeting, and if they are given a copy of the notes they do not have a chance to correct inaccuracies. The letter the complainant receives after the meeting often fails to reflect decisions which complainants thought had been arrived at during the meeting.

Access to Health Records

An important additional factor is the question of access to health records. We always advise clients to obtain their records before proceeding with any complaint. Sometimes once they have seen and understood these they realise that they have no cause for complain; or they may realise that what they thought was a major error was not the real source but the cause lay elsewhere. The Access to Health Records Act and the Data Protection Act have helped us all a great deal. However, there are three problems:

1. The forty days which record holders are allowed before complying with a request for records. This greatly adds to stress, can prevent people going for alternative sources of care as quickly as they otherwise might, and allows time for "doctoring" of records - of which we have seen many examples.
2. In our experience very few Trusts even comply within the forty day limit. These prolonged delays and can put people outside the time limit for the Ombudsman, and the Trusts are well aware of this.
3. Many Trusts are grossly overcharging for photocopying and this is beyond the means of many of those who approach us e.g. 25-35p a sheet, plus the £10.00 access fee. Please note that parents may have to obtain records from a number of sources e.g. General practitioner, maternity unit, specialist paediatric unit at another hospital, and each of these can charge the basic £10.00 plus the photocopying charge. We cannot stress too strongly how important it is to see the complaint in the context of the notes. In many cases the inaccuracy or inadequacy of the notes becomes a complaint in itself. An examination of the records can show that women were given dangerously high doses of drugs, or that prescribed drugs were not given, or that the fetus had been in severe distress for a very long time before appropriate action was taken, or that caesarean sections allegedly

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done for fetal distress were in fact unnecessary because there was evidence on the notes that the baby was not in distress.

Many people are unaware of their rights under the Access to Health Records Act and the Data Protection Act. Only today we had a call from a woman who had made a written request followed up by a telephone call, to a London teaching hospital when the notes were not forthcoming, and she has been told that she is not entitled to the notes but she will be allowed to see a summary.

Time limits for making a complaint

Since we spend a great deal of time talking to, meeting, and supporting complainants we would like to point out how very stressful the mere process of making a complaint is. The procedures were designed to meet the needs of the NHS and not primarily the needs of complainants.

One of the main problems is the time limit. No time limit existed for hospital complaints until the new procedures were introduced. This was against the recommendations of the Wilson Committee which said there was no need for a time limit. Many of the people who come to us are traumatised, many have post traumatic stress disorders from their birthing experience, others have quite serious physical injuries following childbirth, some have damaged children and others have been bereaved. It is our experience that the more serious the complaint, the longer it takes for the woman to deal with it, and it is not uncommon for a woman to raise a complaint during the next pregnancy, which may have been delayed for some years because of the previous traumatic birth.

Trusts vary in their response to "out of date" complaints. Obviously, most serious complaints cannot be ignored, but complainants are sometimes told that this will not be logged as an official complaint, as it is out of time, so it is not included in official records.

We also deal with cases of maternal death and "near misses". Many of these people cannot cope with making a complaint so soon and we do not encourage them to do so. Our primary aim is to make sure people have the care they need and that they are aided towards emotional resolution and recovery. We think that if they wish to make a complaint that is a decision they should make when they are strong enough to cope and emotionally ready. In a recent case, a woman who had suffered from post-partum psychosis did not cover all the areas in her complaint which she should have done because she was not sufficiently recovered.

The complaints procedure sets time limits on responses by the NHS and actions by the complainant. Many of our clients find thinking about what

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happened and dealing with meetings and correspondence so emotionally draining that they need several weeks respite at least in between stages, and this process cannot, and should not, be hurried. It is not uncommon for parents and other family members to differ in the way they deal with tragedy and bereavement. We try to help couples to recognise the different coping styles of each other but, again, this means that proceeding slowly may be important.

Quality of investigation

There is one point we cannot emphasise too strongly and that is the lack of true investigation of complaints and their causes. The usual procedure seems to be that the complaint is forwarded to the consultant or head of midwifery for comment, and their response (usually a denial) is encapsulated in the reply the complainant gets. There is far too little actual checking of factual information and also the previous behaviour or record of the staff members concerned. Detailed reports by earlier Health Service Commissioners (HSC) showed over and over again that the first true investigation occurred only when the Ombudsman's staff went into the hospital and checked the facts. This, of course, was before the HSC was empowered to investigate clinical complaints. We had hoped that this quality of investigation would be extended to clinical issues. Unfortunately, the latest Ombudsman is doing fewer detailed investigations and our views on this have been the subject of evidence provided to another House of Commons Committee on Public Administration.

For emotional resolution of complaints it is important that parents should feel that lessons have been learned and action has been taken to remedy any defects in care discovered. With many perinatal deaths there is an internal hospital meeting but parents are seldom told this, and they are not given the results. This, of course, is both to protect reputations and to prevent litigation, even when the family is not in the least interested in suing. This means that much useful information which could help to reduce grief does not reach the family. So far as the internal meetings themselves are concerned, from feedback we get from some of those who take part we understand that much of it is a face saving exercise, that junior staff can be scapegoated and that serial senior offenders emerge unscathed.

Independent Panel

It has already become evident from reports from CHCs and the Health Service Commissioner that the panel's convener has an almost impossible job, and the individuals concerned have been inadequately prepared for it. Our own experience of complainants confirms this. And, of course, there is a very wide variation in the number of independent panels set up between one district and another. Each panel is new, inexperienced, and learning on the

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job. We warn all our clients to have low expectations of both convenors and the so-called independent panel hearing if they actually get one.

The fact that the independent panels have no formal procedures puts complainants at a disadvantage compared with the old Medical Service Committees which looked at GP complaints. Under the earlier procedure complainants saw the formal response of the doctors they were criticising and had all the correspondence from them before the hearing. Each side heard all the evidence given by the other, and heard all the witnesses and all the questions addressed to them by the panel. Under the new system the usual procedure is that the complainant does not see a formal written response by the doctor or midwife they are complaining about, nor are they present when they give evidence and are questioned. This means that in response the staff can give inaccurate or dishonest responses which the complainant is unable to refute. This assumes particular importance when we know that it is not uncommon for accused doctors and midwives to make allegations about the behaviour of patients or their relatives and these allegations affect responses to the complaint, but the complainant is often not made aware of them.

We have seen a number of reports by the medical advisers involved and have found them both biased and unhelpful and sometimes medically inaccurate. We should explain that we are used to seeing many medical opinions on both sides in litigation cases.

Like the administrators, the panel itself does no investigation and usually proceeds by interviewing in private individual witnesses. The lack of rules or even guidelines means that the most unsophisticated have least protection.

All the studies we have seen of the new procedure show that panels are not regarded by complainants as "independent"; and our clients' experience of using convenors and independent panels has invariably been so disappointing and demoralising that we strongly advise them not to have high expectations of success.

Litigation

There has been far too much emphasis on litigation as a problem in itself for the NHS. The primary problem is avoidable injury and death, and that is what NHS managers and politicians should be concerned about, not whether some people (and it is a small minority of those injured) take action.

In our experience, most of our clients who go to lawyers do so because they are justifiably frustrated and incensed by the way their complaint has been dealt with. In many cases of stillbirth or neonatal death parents do not want money for a dead baby, and some are even insulted by the suggestion that they should pursue litigation in order to get compensation. In other cases,

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litigation is pursued because there has been serious injury and/or loss of income or expected future high expense, and if the parents themselves did not get damages to provide extra care for a handicapped child the state would be paying even more. Seriously damaged children are expensive to care for wherever the money comes from, and if their parents have money for their care from legal action this reduces subsequent demand on NHS and Social Services.

Unfortunately, it is our experience that once a case is turned over to the Trust's lawyers it is seen as simply a legal problem in their hands and many of the issues on exactly what went wrong and why, are not adequately investigated and pursued by management.

Appended to this evidence is an article by Jean Robinson published in the British Journal of Midwifery, October 1997.

General Practitioner (GP) complaints

The most disturbing aspect of the current complaints procedure concerns the way GP complaints are managed. Instead of being managed by the Health Authority as before, GP practices are supposed to deal with their own complaints. In our experience, and in the experience of many Community Health Councils (CHCs), complainants are appalled that in the first instance they are supposed to take their complaint to the practice itself. They have no faith in such a system and many do not proceed further. If they go then to the Health Authority they are offered the services of a "conciliator". Conciliation can only work if both parties are willing and ready for it. Where families believe the GP was responsible for the death of a child or a mother, this is the last thing they want at that stage, or perhaps at any stage.

This has important implications for quality of care. The Health Authority is no longer the central collecting point for all major complaints about GPs. Under the old system they knew which GPs were the subject of the most frequent and serious complaints. Although they distribute money on behalf of the taxpayer they no longer have an adequate protective and monitoring role on behalf of the public because the system does not allow them to carry it out.

A further point is the separation of disciplinary procedures from the complaints procedure. Formerly a complainant could set in motion a tribunal which investigated a breach of terms of service whose findings could be sent to the General Medical Council by the Department of Health. From the experience of one of our committee, who was a long serving member of the GMC, some of the most dangerous doctors in the country were removed from the register by this route.

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This was the only piece of true power which the public ever had over doctors. It pre-dated the NHS. It was removed when the complaints procedure was revised. Whereas many complaints can be satisfactorily resolved by a conciliatory and informal procedure it is not suitable for all, especially many serious clinical complaints. In many cases, without access to a formal tribunal of the old kind, complainants are unable to get both the information they require, emotional resolution, and a sense that justice has been done. We regard this change as a retrograde step but recognise that consumer power in the NHS is not and never will be a match for the power of the British Medical Association.

This lack of control over quality of care in general practice makes us very anxious about the future of Primary Care Groups, which GPs will dominate.

Most antenatal and postnatal care in this country is in the hands of general practitioners. The majority of women have "shared care" and are referred to the hospital for delivery. THIS MEANS THAT PREGNANT AND NEWLY DELIVERED WOMEN ARE GETTING CARE FROM DOCTORS WHO OFTEN HAVE INADEQUATE AND OUTDATED TRAINING. The structure of the payment system has much to answer for. Generous payments for ante and postnatal care, and moderate payment for the inconvenience and responsibility of attending the birth, has encouraged this discontinuity in care. In addition, GPs on the obstetric list are paid at a higher rate for past obstetric experience or training, however long ago that training took place. There is no requirement for them to attend refresher courses to remain on the list. Midwives, on the other hand, have to attend regular refresher courses to remain on their register.

We constantly see evidence of dangerous or inadequate practice by GPs e.g. we ourselves have advised women to go immediately to hospital when they describe to us life-threatening symptoms of fulminating pre-eclampsia which GPs have ignored. We also see many cases of undiagnosed and inadequately treated postnatal problems in mothers and babies. These include severe perineal trauma, serious mental illness following traumatic high-tech deliveries, and many illnesses in the newborn. GPs are woefully ignorant on breastfeeding, including possible effects on the baby of drugs they prescribe for the mother. They frequently advise women to stop breastfeeding, in cases of doubt. They seem unaware of the extensive research which shows many benefits to long term health of breastfed children.

GPs have a vested interest in getting women into hospital for the birth. Information leaflets suggest that women will receive balanced information from GPs upon which they can make a decision about where to give birth. Despite advice from the Royal College of General Practitioners and the Royal College of Midwives advising GPs that if they are opposed to home births they should not strike women off their lists but refer them to the local

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Director of Midwifery Services, we are still receiving calls from women who have been stuck off their GP's list for this reason. Furthermore, we are alarmed by the level of ignorance many GPs display when advising women on home births.

The standard of GP care varies considerably from one part of the country to another. For example, we know of one CHC officer who would not register with any GP in the area which she covered. A good doctor may well recognise that his practice was not up to standard on a particular occasion. A poor doctor may reject a clinical complaint because he simply does not know the depth of his own ignorance.

The culture of the institution

Since we have supported people who have made complaints about many hospitals over a long period of time we have become well aware that each maternity unit has its own culture - e.g. some have a high-tech intervention culture, some give more equal status to midwives, some deal more constructively with complaints than others. Very often an arrogant clinical culture is allied to an administrative culture which is subservient to it and not independent from it. When we receive a complaint about hospital 'A', however serious, well written, or well founded, we know that the client has a very poor chance of a constructive outcome. When we receive a complaint about hospital 'B' then we know they have a better chance. In addition there are individual consultants who are notorious for their unhelpful response to any complaint; some of them act as medical advisers to complaints panels at other Trusts! Sometimes a new broom is brought in but they are either overwhelmed and become dispirited, or move out when they realise they can achieve little.

Administrators' ethical standards

Although doctors, midwives and nurses are at least subject to the ethical code of conduct of their professional body, administrators are under no such control. They do not have a code of conduct and there is no professional body from which they could be removed and which could stop their right to practice. The ethical standards of administrators should be investigated. Too many of them put short term protection of the reputation of the Trust above thorough investigation of a complaint and an honest response to the complainant.

Quality of Medical Care

Many of the official Confidential Enquiries - into Maternal Deaths, Stillbirths and Neonatal Deaths and Perioperative Deaths have shown that lives were lost because junior doctors were doing work beyond their level of

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competence. We ourselves have asked that more detailed enquiry should be made into why a senior doctor was not called. Of course, one of the problems of inexperience is that you may not know until it is too late that you are out of your depth. However, from detailed comments from our complainants, and our contacts with maternity unit staff, we are aware that some consultants are more "callable" than others. There are sometimes also cultural differences which can lead to misunderstandings. We believe that a qualitative study on these problems might produce useful information.

Although we hear many comments, we do not know exactly how much the amount of private work some consultants engage in affects their presence in the hospital and their availability to teach and supervise junior medical staff. It seems to us astonishing that there is so little data on this.

It is also scandalous that women have increasingly been forced to give birth in very large maternity units where many thousands of babies are born each year and yet there is no guarantee that there will be a consultant obstetrician on the premises 24 hours a day, 7 days a week. The continuous presence of a consultant on a labour ward is standard procedure in Dublin and may be a contributory factor in their apparently good results. When women are told that hospitals are the safest place to give birth they are usually unaware that perinatal mortality rises at weekends, Bank Holidays, and on the twice-yearly input of new house officers. (All Wales Perinatal Survey, 1996)

In a number of our cases a junior doctor has telephoned the consultant at home for advice and has apparently been given instructions to proceed with caesarean section, for example. Unfortunately, the junior may simply not have the knowledge or experience to describe the situation accurately, or may not have conducted a thorough enough examination. This can result in the consultant receiving information which has been assessed by someone who is not competent enough to make that assessment, and the consultant gives orders over the telephone instead of coming in.

Training deficiencies

Many adverse events in recent years have occurred not because of faults by particular individual members of staff - although they will get the blame - but because of major training defects in the bodies responsible for training both midwives and doctors, e.g. the widespread deficiencies in ability to interpret readings from electronic fetal heart monitors, and deficiencies in ability to resuscitate newborn babies. Both of these have been highlighted in the Confidential Enquiries into Stillbirths and Deaths in Infancy, but electronic fetal heart monitoring has also been a regular factor in our cases, and in litigation cases covered by Action for Victims of Medical Accidents. The Committee might perhaps wish to enquire how such widespread deficiencies came about and who is responsible.

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Unfortunately both doctors and the public can be misled by the availability of modern technology and drugs, and believe that their mere existence provides better care and greater safety. This is not so. Their appropriate use can be helpful, but often they are overused and do more harm than good (particularly in cases where women could give birth happily without interventions), or their use is not intelligently applied because staff are not adequately trained in their benefits and disadvantages.

Staff checks

It is our usual practice to check the registration of the doctor, or perhaps the midwife, in cases of alleged incompetence. If the full name of the doctor is unknown, or unclear, we ask our clients to obtain it from the Trusts. It is quite common for them to refuse to supply this information, even though in a past Ombudsman case the Health Service Commissioner has decided that the information should be given unless there is very good reason not to do so. In one of our cases we discovered that a doctor had been claiming membership of the Royal College of Obstetrics and Gynaecologists for several years before he passed the exam, and in another case an overseas doctor was not registered with the GMC at the time he mistreated a woman in labour. In two other cases we established that 'senior' doctors giving opinions were not recognised by the GMC as trained specialists.

The Trust which is employing underqualified or unregistered doctors, or which is careless in its employment procedures, has a vested interest in keeping information from complainants, and we think that they should not be able to do this without sanctions.

Social Services

It is impossible to write about problems with quality of health care without also mentioning the interaction with social services. We have a growing problem with threatened or actual child protection procedures. In our experience, from a growing number of cases, Social Services intervention is not only unhelpful but is often positively toxic to the family. We would draw the Committee's attention to the lack of evidence on benefits and adverse effects of social work intervention. The sensitivity, and quality, of social work varies enormously from one area to another. We are also deeply concerned at the number of complaints we have (with supporting evidence) of dishonesty in social work reports. A combination of poor paediatric diagnosis and ill-considered social work intervention can do long-term damage to families. Very often a fraction of the money spent on these investigations and procedures could be far better spent by the family itself on basic support.

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Community Health Councils

We usually recommend that our complainants contact their local CHC. Firstly the local CHC can supply support and information and background about local services. Secondly the CHC may know of other similar incidents. Thirdly because the CHC needs to know what is going wrong on their patch. However, there is a substantial variation in the quality and amount of complaints advice which CHCs can provide. None of them has adequate resources to do the work, some of them are excellent and some are very poor and we do not even recommend that they are contacted. In a few areas complainants have told us of strong suspicions of bias on the part of CHC officers, and that they seemed only willing to provide reassurance about local services. Some CHCs, having been amalgamated, now cover geographical areas or a size of population which makes it almost impossible for them to do their work effectively. However, the mere fact that a CHC office exists, and has done so for a long time, means that there is a body of information available under separate control in the community.

We trust that this information will be helpful to your inquiry and if the Committee wishes to have more detailed evidence we would happy to speak with them if required.

Beverley Lawrence Beech, Hon Chair, AIMS
Jean Robinson, Hon Research Officer, AIMS

4th June 1999

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Note:

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