Joshua's story

In 2008, Joshua Titcombe died at Furness General Hospital, and his story has made headlines ever since. His father James has campaigned consistently to discover what happened

I met James Titcombe at the Patient Safety Learning launch event back in September 2017 and he kindly gave me a copy of *Joshua's Story*. I had annual leave booked in late October and, for once, I had nothing planned but some well-deserved rest. I made up my mind to read the book during my week of annual leave, attached to my sofa, but you know what they say about best laid plans?

As I settled on the train for the journey back home, I couldn't help but take a sneak peek at the first few pages. The front cover of the book is black with the picture of a tiny hand. I can only assume that this illustrates the black times faced ahead within the book and James acting as Joshua's voice. The title, *Joshua's Story,* makes it personal; it's more than just a news story, more than just another statistic.

I knew the background to this story. I had read the Kirkup Report, on more than one occasion. I knew that there were many failings but I wasn't aware of the sheer number of external bodies that were involved. For those new to maternity and unfamiliar with NHS or maternity governance structures, it gives a very good understanding of what systems are in place.

The first few pages led to the first couple of chapters and, before I knew it, I had read the whole book in just a few days. No mean feat with my busy schedule.

The introduction of *Joshua's Story* struck a chord with me, as I began to read about how James and his wife Hoa met. I started to recall all the couples I had had the pleasure to get to know and all the times I had asked, intrigued, 'So how did you both meet?' Answers ranged from university, to the airport, travelling and even at the circus. This story was no different. It was about a real couple starting their new journey together. It was as real as all the families I had looked after with all the hopes and dreams a new baby promises to bring, only for James and his wife Hoa this was shattered following the tragic and systemic failures at Morecambe Bay Trust in 2008.

Joshua Titcombe was born at 7.38 am on 27 October 2008 at Furness General Hospital. Chapter 1 is told by James, Joshua's dad first and foremost. As James describes the short life of Joshua, who developed a severe infection, I knew that the outcome was going to be painful. Joshua was critically ill and, despite being transferred to a tertiary centre for extracorporeal membrane oxygenation (ECMO), he sadly died. James spends the rest of the book detailing walls of silence and deceit about what happened to his son. For me this was overwhelmingly painful.

Having a keen interest in patient safety, I had followed the Morecambe Bay investigation very closely, eager to learn and to prevent a similar tragedy. I knew that James was a bereaved parent, and I knew that James, along with many other bereaved parents, had campaigned for the investigation into the failings at Furness General Hospital, resulting in the Kirkup Report. What I did not appreciate or fully understand before reading *Joshua's Story* was the impact this took on James, for whom time simply stood still. The painful realisation starts immediately, after Joshua's death when, numb with grief, James and Hoa leave the hospital to the sound of fireworks and celebrations. For James and Hoa their life was frozen. For everyone else it was early November and a time to celebrate Guy Fawkes Night. As I write this blog, it is early November 2017, and I can see fireworks outside of my front room window. I wonder if time has thawed for the Titcombes. I suspect it has not fully.

Chapter 3 is aptly named 'Searching for Answers'. This could be the title of the whole story, as James spends the rest of the book detailing how he tirelessly searched for the reasons for his son's death, which filtered through very slowly, and not always truthfully. Here lies the crucial point: no parent should have to search for answers as to how their baby died. Each Baby Counts and NHS Rapid Resolution is working hard to ensure this.

It seemed at every level there was a failing. Personally, I have never liked the word 'fail'—in fact, I have a complete aversion to the phrase 'failure to progress'. There is power in words. There are several definitions of the word fail. A universal definition seems to be: 'to not achieve a desired outcome'. To fail, you have to be aware of the desired outcome. If you are revising for an exam, you know the desired outcome: a pass. I am under no illusion that there were blatant cover ups in Joshua's story. But at times I felt that what was described was not a failure. I felt that staff must have lost sight of the desired outcome. This was an important realisation whilst reading this book. It is important to reflect, to be open and honest, form good working relationships with every single one of your colleagues, and, crucially, to listen to parents.

I will not spoil the outcome of the book, as it is more powerful if you read it. You certainly will not regret it.

I am very proud of the NHS and I love my work. This book was a reminder of what happens when it goes terribly wrong, and a reminder about the basics of human relationships.

Thank you, James, for telling Joshua's story. **BJM**

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