TELEGRAPH 4.3.15

'Musketeer midwives' blamed for deaths of 11 babies

By Laura Donnelly and Matthew Holehouse

A NATIONAL review of the safety of maternity services has been started after the deaths of 11 babies were blamed on midwives in pursuit of "natural childbirth at any cost".

Jeremy Hunt, the Health Secretary, apologised yesterday to parents who lost children in the Morecambe Bay scandal, after an investigation found major failings behind the deaths of 19 mothers and babies, including 11 lives which could have been saved with the right care.

The inquiry found that a band of midwives, who dubbed themselves the "musketeers", failed to call doctors when they were needed, in their determination that women should have a "natural birth", then colluded to cover up critical blunders.

The head of the NHS said yesterday that the findings were "truly shocking" and began an immediate review of all maternity care in England amid fears that an ideological push for natural childbirth among midwives could be putting babies at risk in other units.

The inquiry, which will report by the end of the year, will examine the safety of current models of maternity care, including "midwife-led centres" run without doctors. More than 100 such centres operate in Britain.

It follows growing concern about infant mortality rates in the UK, which are among the worst in western Europe, and long-running arguments about where and how it is safest for women to give birth.

The investigation into University Hospitals of Morecambe Bay NHS Foundation Trust found that mothers and babies died as a result of a "lethal mix" of failings at Furness General Hospital, in Cumbria, amid "seriously dysfunctional" relations between staff.

It found that the trust's maternity services became strongly influenced by a group of dominant midwives whose "over-zealous" pursuit of natural childbirth "at any cost" contributed to a series of deaths. When babies died, midwives conspired to cover up the failings, the inquiry suggests, concluding that they "distorted the truth" in order to hide blunders from parents and inquests.

The investigation, by Dr Bill Kirkup, a former associate chief medical officer, found that a group of midwives developed a "one for all" approach, and in fact described themselves as "the musketeers" as they agreed "extraordinary" versions of events in order to hide critical errors.

Crucial medical notes disappeared, with "inexcusable" collusion between staff to hide the truth, the report found.

The trust failed to admit the problems to regulators, while it concerned itself with winning coveted foundation trust status.

Authorities which were warned about concerns failed to investigate the deaths, and by 2011 the trust had the highest mortality rate in the country, with 600 "excess deaths" from all causes in the previous four years.

Mr Hunt said the failings, which began in 2004 and went unchecked for almost a decade, amounted to a "second Mid Staffs" scandal, and Dr Kirkup warned of failings "at almost every level" of the NHS in the systems which are supposed to protect patients.

The report criticises the Care Quality Commission, Parliamentary Health and Services Ombudsman and regional health authorities for failing to investigate the failings, despite growing evidence of problems.

Dr Kirkup said the nature of the scandal, and the way it was allowed to go unchecked for almost a decade, meant Morecambe Bay was now "on a roll of dishonoured NHS names" along with Mid Staffs.

Mr Hunt told the Commons: "In both cases, perceived pressure to achieve foundation trust status led to poor care being ignored and patient safety being compromised. In both cases, families faced delay, denial and obfuscation in their search for the truth.

"To those who thought Mid Staffs was a local, one-off failure, today's report will give serious case for reflection," he said.

Andy Burnham, the shadow health secretary, apologised to the families

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on behalf of the previous Labour government, saying the cover-up was "inexcusable". Simon Stevens, the chief executive of NHS England, said the report was "truly shocking".

Successive governments have supported a "choice" agenda in maternity, so that women can give birth at home, in a "midwife-led" unit or in a traditional ward. Last year NHS watchdogs recommended that midwife-led units are suitable for most women to give birth.

Dr David Richmond, the president of the Royal College of Obstetricians and Gynaecologists, said: "We want maximum choice, but we also need safe outcomes. Some sections of the community want to see more home births and more midwife-led units without doctors but as an obstetrician I want to maximise safety because things can go wrong at short notice."

Elizabeth Duff, of National Childbirth Trust, said the review was "well overdue".

The Morecambe Bay investigation criticised conflicts of interests in the supervision of midwives, which allowed failings to go unchecked for almost a decade.

It highlighted the role of Jeanette Parkinson, the trust's "maternity risk manager" from 2004 to 2012. She should have identified and acted on safety concerns, but the inquiry said she was believed to be "part of the close-knit midwifery group of 'musketeers'," as well as their supervisor and a former union representative. Ms Parkinson retired in 2012.

No midwives have been struck off over the scandal, but six cases are due to be heard by the Nursing and Midwifery Council later this year. Dr Kirkup said the events had been brought to light thanks to families who "persistently refused to accept what they were being told". The investigation followed a campaign by James Titcombe, whose newborn son died in October 2008, at Furness General Hospital, from an infection which could have been treated with antibiotics.

Three months earlier 35-year-old Nittaya Hendrickson and her newborn son Chester died at the same hospital after she suffered a heart attack giving birth.

University Hospitals of Morecambe Bay trust apologised unreservedly to the families of those who suffered as a result of poor care.

Culture shift Health Secretary's response

Jeremy Hunt, the Health Secretary, announced the following plans after the publication of the report:

- Professor Sir Bruce Keogh, NHS England medical director, will review professional codes of doctors and nurses to stop people "covering up" mistakes and put incentives in place to encourage them to report incidents.
- Potential creation of a service similar to the Air Accident Investigation Branch, to allow trusts to call in expert teams to establish facts in event of a death, will be examined by NHS patient safety director Dr Mike Durkin.
- Dr Durkin to look at how to better standardise incident reporting guidelines because "the NHS is still much too slow at investigating serious incidents involving severe harm or death", Mr Hunt said.
- Government to legislate on improving the oversight of midwives, taking into account a recommendation from the Kings Fund that it should be independent.
- The Nursing and Midwifery Council to be reformed because it had the "wrong culture" and was too slow to take action.

James and Hoa Titcombe, right, began a campaign after t

WARREN SMITH

Carl Hendrickson with his wife Nittaya, who died along