Baby deaths inquiry to cover two decades

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A maternity unit where 100 babies are feared to have died or been harmed by poor care has been told to hand 20 years of records to regulators as the investigation widens.

Shrewsbury and Telford Hospital NHS Trust will have to provide the review with hundreds of files relating to stillbirths, maternal and neonatal deaths and babies who suffered significant harm between 1998 and last year.

NHS Improvement, the watchdog, will match the records with names of families who have already come forward with concerns; any cases the trust has not yet investigated will be referred back to it. More than 100 are already being investigated and the regulator has promised families that it will examine the alleged failings "properly and thoroughly".

The decision to widen the review was backed by Matt Hancock, the health secretary, who said: "The investigation can range as wide as needed to make sure that we get to the bottom of what happened, that families can find out what happened, and that we can learn the lessons from it."

An initial investigation into 23 incidents was ordered by his predecessor, Jeremy Hunt, last year after families claimed that babies were put at risk by a culture that promoted natural birth over safety.

However, last month it emerged that at least 60 cases involving baby deaths, brain damage and the deaths of four mothers had been identified. More families have come forward, taking the total to 104, some as recent as December last year.

Concerns were first raised about the Shropshire maternity unit in 2009 after Kate Stanton-Davies died six hours after her birth. A report found that her death was avoidable and midwives had ignored her parents' concerns and failed to realise the birth was high risk.

Yesterday Richard Stanton, 48, Kate's father, called the trust's management an "absolute disgrace" for failing to answer his questions at a board meeting.

He said: "The secretary of state is thoroughly backing the review and ensuring it is not closed down or frustrated by the trust and I think it leaves them with nowhere to go. It's their worst nightmare come true. They've got to hand over maternal records for scrutiny and that can only be a good thing."

Last week the Care Quality Commission said the unit had repeated mistakes it was warned about ten years ago.

Deirdre Fowler, director of nursing, midwifery and quality at the trust, said: "We are fully engaging and co-operating with their review in an open and transparent manner and we are committed to learning any lessons that arise from this review to ensure the best care for all of our patients."

The NHS has faced bigger inquiries: the Mid Staffordshire NHS Foundation Trust inquiry investigated between 400 and 1,200 excess deaths. The closest comparison is with the Morecambe Bay inquiry which found 11 babies and one mother died because of poor maternity care. Mr Hancock is believed to want to widen the Shrewsbury inquiry to fend off accusations he is neglecting safety.

Case studies

Kate Stanton-Davies was less than a day old when she died in March 2009. She was clearly pale and anaemic, and her death was avoidable but for a number of failings, a report in February 2016 concluded. Two midwives were blamed, one of whom failed to spot obvious signs the baby was seriously ill. Rhiannon Davies, 44, Kate's mother, had raised concerns about reduced foetal movement but the birth was deemed low risk.

Her parents are fighting for answers and fear more children could suffer from poor care. Richard Stanton, 48, was dismayed at the trust referring to the problems as historical and acting as if "everything is all rosy".

"We are talking about life-changing events," he said. "We are talking about woeful and neglectful failings at all levels and a culture of denial and defensiveness. That is what we have had to battle for nearly nine and a half years now to get the answers as to why Kate died."

Rhiannon Davies with her daughter, who died in her first day

He added: "What we are seeing is a national tragedy unfold in maternity services at this trust where many of these deaths were avoidable."

Pippa Griffiths was a day old when she died in April 2016 from a preventable infection that was not picked up by midwives.

She died from the group B streptococcus infection 31 hours after being born and a coroner ruled that her death had been avoidable. The inquest was told that maternity staff missed a chance to save Pippa when her mother, Kayleigh Griffiths, 31, rang twice with concerns about her health, including to report bloody mucus, a sign of a serious bacterial infection. Pippa developed a purple rash later that night and was rushed to hospital but could not be saved.

Mrs Griffiths said that the trust was claiming to have learnt from historical cases but it should have done this earlier. "It probably would have prevented Pippa's death but they didn't take it seriously and it still doesn't seem like they are taking it seriously. She added: "They've called people scaremongers, saying the numbers are not true and it's denial, denial, denial, but look at the situation. They can carry on with their heads in the sand but we are not going away."