avma for patient safety and justice
action against medical accidents

PRESS RELEASE

For immediate release

Morecambe Bay Report Highlights Repeated Failures to be Open & Honest

AvMA Says This Will Have National Implications For NHS

London, 3rd March, 2015: Action against Medical Accidents (AvMA - the charity for patient safety and justice) welcomes Professor Kirkup's report published today, but has called for action at a national level to ensure individual maternity services, regulators and the Parliamentary and Health Service Ombudsman learn from the tragedy at Morecambe Bay. AvMA provided support to the family of Joshua Titcombe whose death was one of the key cases that led to the inquiry and campaigned alongside the many families affected to secure the inquiry.

Between 2004 and 2013 there were a series of deaths of mothers and newborn babies at Furness General Hospital in Cumbria. The inquest into the death of one of the babies, Joshua Titcombe, heard evidence that there was an 80% chance he would have survived if antibiotics had been administered in the hours after he was delivered. An internal review at the hospital described team-working between key staff as "dysfunctional in some parts." Eight Morecambe Bay midwives face disciplinary action by the Nursing and Midwifery Council and a police investigation is pending.

The Inquiry has looked into not only the failures concerning individual care but also how the hospital trust reacted to the reviews that were carried out. There are broader concerns about why the Parliamentary Health Services Ombudsman (PHSO) refused to investigate in 2010, the failure of the Care Quality Commission (CQC) to intervene effectively despite being aware of problems, and that senior officials at the CQC intended to suppress an internal report, critical of its own regulatory failings.

The report makes 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon.

AvMA chief executive Peter Walsh said "This report has implications for all of the NHS. We pay tribute to the bravery and determination of the families without whom the inquiry would never have happened. Like them we want to see organisations and individuals responsible for cover ups and gross failure leaving patients at risk held to account. We want each regulator and the Department of Health to demonstrate in practical terms how similar failings will be prevented in the future. The Ombudsman service must be reformed as a matter of urgency. If ever anyone still needed convincing of the need for the statutory Duty of Candour which this charity campaigned for for years and is now being brought in, this sorry episode does"

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