AIMS For a better birth...

The Kirkup Report

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This report was commissioned following the deaths of mothers and babies over a nine-year period at Furness Hospital Obstetric Unit. National press coverage focused on blaming the 'musketeer' midwives. The reality is more complicated.

One of the major points of the report was the dysfunctional relationships between all the professions working on the Furness Hospital maternity unit. The midwives / obstetricians / paediatricians were at odds with each other and the paediatricians were even at odds amongst themselves. The doctor responsible for the paediatricians at Furness Hospital apparently knew that they were inexperienced but did not give them suitable supervision. The RCOG report talks about bullying and says, 'there should be greater engagement with neonatologists and anaesthetists', but doesn't seem to me to deal with relationships between obstetricians and midwives. From my reading of the report, Kirkup just accepted (possibly with some bewilderment) the excuses of the senior obstetrician that he couldn't stand up to the midwives at Furness Hospital.

It wasn't reported anywhere in the media that the report highlighted a major problem arising from not transferring women in premature labour when they should have been. The (junior, not well trained or supervised) paediatricians then typically adopted a 'wait and see' policy with regard to the resulting premature babies. These babies were now at high risk and being cared for in an inappropriately low-level unit. The ones who did become very ill were transferred to a bigger hospital in a poor state. If they had been transferred earlier, ideally when the mother was in labour, there might have been a better chance of survival and recovery. Having taken in very ill babies, the special care baby unit in the receiving hospital was not surprised if the babies died, and reported accordingly to the Coroner.

This means that parents had to fight to get recognition that the deaths of their babies were not the inevitable, or even likely, outcome of what had been normal pregnancies in healthy women.

Following the Kirkup report the RCOG commented, *'Strict protocols on risk assessment and patient pathways based on agreed national standards (including the capacity to treat high-risk patients and capacity to provide for emergency transfers) are needed in all maternity units.' It appears that this is addressing the problem of transferring women in premature labour when the hospital they turn up to in labour is not equipped to deal with a baby of that prematurity. RCOG usefully suggests: 'At a wider level, programmes must be put in place to help up-skill community practitioners (in this case, GPs and midwives) in areas where the recommended levels of consultant-led care are difficult to achieve.' furthermore, RCOG states: 'At a broader level, in geographically remote areas with small isolated communities, more emphasis should be placed on community-based midwifery and the development of primary care services*

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There are many sensible recommendations about rotating and training staff, setting up 'buddy' systems, and also warnings about staffing levels and unfilled training posts.

Finally, RCOG states: '*The RCOG suggests that project teams consisting of a senior manager, an obstetrician, head of midwifery and patient representatives should be appointed to advise local Clinical Commissioning Groups on the population and workforce needs in catchment areas*.' One hopes that the patient representatives will be of women with experience of maternity care and not just a token woman who has been selected because she has had a baby recently.

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