Campaign document to support the need for a statutory public inquiry into maternity safety in England

Maternity Safety Alliance

Index

Executive summary

A group of families who have been affected by failures in NHS maternity care, including bereaved parents and grandparents, are calling for a full statutory public inquiry into maternity safety in England.

Babies are too precious to keep on ignoring the reality that despite a raft of national initiatives and policies implemented in the wake of investigations and reports, systemic issues continue to adversely impact on the care of women and babies. Far too much avoidable harm continues to devastate lives in circumstances that could and should be avoided. Fundamental reform is needed.

The same failings in care have been repeatedly found in reviews of maternity services in Morecambe Bay, Shrewsbury and Telford, and most recently in East Kent, and the same conclusions are expected from the ongoing review at Nottingham. Over and over again we hear that 'lessons will be learned' – and yet those same failings continue. And they don't just continue in isolated corners of the NHS, they are present to some degree in almost every NHS Trust in England with the most serious kind of avoidable harm occurring everywhere.

We now have a good understanding of what clinical best practice looks like, but the barriers to ensuring every mother and every baby receives safe care have so far proved insurmountable, with problems in culture, leadership, inequality, service structures, education and training, accountability, and governance seemingly intractable.

Despite enormous efforts by many people over many years, the NHS continues to fail to provide safe maternity care, with vast financial costs. The latest figures from NHS Resolution show that in 2022/23 the total paid out for clinical negligence relating to maternity care was £2.6 billion and the total projected 'cost of harm' for the same year (the present value of the estimated costs of claims expected to be received) is £4.2 billion. That's £133 a second, £8,000 per minute, £480k an hour and £11.5m each and every day. The human cost in lives lost and forever changed cannot be measured.

It's time to recognise that efforts so far, whilst well intentioned and supported by many, have not been enough. Indeed, recent data shows that stillbirths, perinatal deaths, and maternal deaths are actually on the increase. And to add insult to injury, some clinicians and NHS leaders continue to work against the changes we know are needed to save lives, putting their 'normal birth' ideology or organisational reputations above doing the right thing.

There are now calls for yet another unit level inquiry into maternity services at Leicester. Such a process is clearly badly needed, but we are firmly of the view that a whole system analysis through a national public inquiry is the only way we can truly understand what has gone wrong, why it keeps on going wrong, and most importantly find a way to fix the system and make sure every mum and baby receives the safe and compassionate care they deserve.

We have spent years, and in some cases decades, campaigning for change and are horrified that despite our efforts, and recommendations from investigations that we have fought for,

mums and babies are still suffering and dying due to the same failures in care that we experienced.

A national statutory inquiry is now essential. Without such a process, calls for individual unit level investigations are set to continue, families will continue to be forced to fight for answers and change, and we are destined to see the same problems repeated time and time again – with catastrophic human and financial consequences.

Only a judge-led, full statutory public inquiry can command the confidence of harmed families, healthcare providers and other stakeholders, and come to independent conclusions, free of party politics, that can then be taken forward and fully implemented to save the lives and health of mothers and babies. A full statutory national public inquiry must be ordered without any further delay.

Maternity Safety Alliance

The Maternity Safety Alliance is campaign group formed of families who have been affected by failures in NHS maternity care. The experiences of our members extend over two decades, including recent and tragic cases where babies have died due to unsafe maternity care. We are campaigning for a full national statutory public inquiry into maternity safety in the NHS in England.

Our members include:

Dr Jack and Sarah Hawkins

Harriet Hawkins | Harriet died in utero at NUHT in 2016.

The tragic and avoidable death of Jack and Sarah's daughter, Harriet, in 2016 due to a mismanaged labour by Nottingham University Hospitals Trust prompted them to demand an investigation and challenge the original explanation they were given as to the cause of her death. At the time the couple both worked for NUHT – Jack was a Hospital Consultant (Clinical Director in the Emergency Care Improvement Support Team of NHS Improvement) and Sarah, a Senior Physiotherapist.

Because Harriet was stillborn, there was no inquest into her death, and the couple were told she had "died of an infection". Their medical knowledge meant they knew this to be untrue, therefore with the support of their solicitors they embarked on their own investigations to discover the truth behind their daughter's death which exposed the inadequacies in NUH's maternity services. This prompted them to 'whistleblow' on the problems in maternity services at NUHT.

With a PR campaign and the collective voice of families affected, the campaign intensified and resulted in an independent review of maternity services in Nottingham, led by Donna Ockenden which started in November 2022. This review (which is ongoing) has revealed that the maternity scandal at NUHT is now the UK's biggest to date, with 1800 families coming forward and hundreds of NUH staff members joining in the review.

They continue to coordinate and uncover experiences of others who have suffered maternity trauma at NUH. In short, they have been the powerhouse behind exposing the maternity scandal at NUHT. Each new story shared forces the couple to relive their own trauma, but they do so in memory of Harriet and all the other babies who have died.

James Titcombe OBE

James became involved in patent safety following the loss of his baby son Joshua due to failures in his care at Furness General Hospital where he was born in 2008. James's campaign for answers following Joshua's death eventually led to the Morecambe Bay Investigation, Chaired by Dr Bill Kirkup, which published its report in 2015.

Formerly a project manager in the nuclear industry, James now works to promote patient safety improvement and culture change in the NHS and more widely.

James was awarded an OBE for service to Patient Safety in 2015 and in 2018, completed a PGCert in Patient Safety at Imperial College, London. James's book, Joshua's Story was published in 2015.

Emily Barley

Emily Barley's daughter, Beatrice, died during labour in May 2022 at Barnsley Hospital. Beatrice was full term and healthy, and died because medical negligence meant she did not get the emergency caesarean she needed. For many hours Emily was left without care, her concerns ignored by midwives, meaning important warning signs were missed.

Later, when monitoring of Beatrice's heart showed that she was struggling and then dying, both midwives and obstetricians were complacent and did not recognise or act on the emergency. They also continued to ignore pleas for help from Emily and her birthing partner.

Beatrice's death, Emily was a public affairs consultant and the leader of the Rotherham Council Conservative Group. She also stood for the Conservatives in the 2019 General Election and was on the path to Parliament. Beatrice's death and the negligence that caused it destroyed Emily's mental health and her career is lost.

Emily now campaigns for maternity safety, and started by bringing together the Maternity Safety Alliance.

Other organisations who are also calling for a full statutory public inquiry on maternity safety in England

The human and financial costs

The best available data on the human and financial cost of harm is set out below. This should be treated with caution as most deaths and injuries are self-reported by hospitals and have in the recent past been found to be under- or mis-reported, with, for example, deaths caused by negligence recorded as 'expected', and live births recorded as stillbirths. The scale of this under- and mis-reporting is at present unknown.

Nevertheless, the statistics that are available demonstrate large scale failure across the NHS, with avoidable harm, including the most serious kinds of avoidable harm, occurring at every NHS Trust in England. The latest figures also show a worsening picture, with more mothers and babies dying than in previous years.

Perinatal deaths and injuries

- The most severe avoidable harm to babies – deaths and/or brain injuries – occurs in every NHS Trust in England.[1]
- According to HSIB/MNSI[2], which investigates when a full-term baby dies during labour, dies within 7 days of being born, or is born with a suspected brain injury, in England, brain injuries have reduced while deaths have increased:

	2019/20	2020/21	2021/22	2022/23
Intrapartum stillbirths	118	170	166	192
Early neonatal deaths	115	112	113	91
Suspected HIE/brain injury	686	655	636	555

- The latest figures show the rate of babies stillborn increased from 3.33 per 1,000 in 2020 to 3.54 per 1,000 in 2021.[3]
- Neonatal mortality rates also increased from 1.53 per 1,000 live births in 2020 to 1.65 per 1,000 in 2021.[4]

Maternal deaths and injuries

- From 2017-19 to 2018-20 maternal deaths during pregnancy or within six weeks of giving birth increased by 24% to 10.9 deaths per 100,000,[5] and in 2019-21 maternal deaths increased again, to 11.7 per 100,000.[6]
- MBRRACE UK reports that the governments target to halve maternal deaths between 2010 and 2025 is unlikely to be met, as since 2009-10 deaths have increased by 15%.[7]

[1] Maternity investigations, HSIB/NHS England, July 2022 (data obtained through FOI)
[2] Maternity investigations, HSIB/NHS England, May 2023 (data obtained through FOI)
[3] Stillbirths in UK rose in 2021 for first time in seven years, The Guardian, September 2023 https://www.theguardian.com/lifeandstyle/2023/sep/14/stillbirths-in-uk-rose-in-2021-for-first-time-in-seven-years
[4] Perinatal Mortality Surveillance 2021, MBRRACE-UK, 2023. https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/
[5] Saving Lives, Improving Mothers' Care, MBRRACE-UK, November 2022: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf
[6] Saving Lives Improving Mothers' Care, MBRRACE-UK, October 2023. https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[7] Saving Lives Improving Mothers' Care, MBRRACE-UK, October 2023. https://www.npeu.ox.ac.uk/mbrrace-uk/reports

- Mums in the UK are three times more likely to die than mums in Norway, and there are proportionally more maternal deaths in the UK than in Italy, Denmark, and France. One recent study which looked at data on maternal deaths from seven countries found that only Slovakia is more unsafe than the UK.[8]
- Other avoidable injuries to mothers include organ damage and perineal trauma causing incontinence, with most injuries to mums not counted.
- Around 30,000 women suffer birth trauma (a type of PTSD) each year, with long-lasting effects on their mental health.[9]

Inequalities

- Black babies are more than twice as likely to be stillborn and Asian babies more than 1.5x more likely be stillborn as white babies, with the relative rates per 1,000 births across the UK being: Black: 7.52, Asian: 5.15, and White: 3.3.[10]
- Black mothers are four times more likely to die than white mothers, while Asian mothers are twice as likely to die as white mothers. [11]
- Mothers from the most economically deprived areas are twice as likely to die as those from the least deprived areas. [12]

Workforce and CQC

- Research by the Royal College of Midwives has shown that in a single year 677 midwives left the profession, on top of the already identified shortage of 2,000 midwives, and in 2022 57% of midwives were considering leaving the profession.[13]
- In July 2021, 41% of maternity units were rated 'inadequate' or 'requires improvement' by the Care Quality Commission (CQC).[14]
- By October 2023 this had increased, with 49% of maternity units rated 'inadequate' or 'requires improvement' overall by the CQC, while 65% were rated 'inadequate' or 'requires improvement' for safety.[15]
- The latest survey of women's experiences of maternity services by the CQC (Jan 2023), shows a worsening picture.[16]

[8] UK women 'more likely to die' around pregnancy than Norway and Denmark mothers, ITV, November 2022: https://www.itv.com/news/2022-11-16/uk-women-more-likely-to-die-around-pregnancy-than-norway-and-denmark-mothers
[9] Prevalence and risk factors of birth-related posttraumatic stress among parents: A comparative systematic review and meta-analysis, Science Direct, June 2022: https://www.sciencedirect.com/science/article/abs/pii/S0272735822000423
For further information and context please see Birth Trauma Association: https://www.birthtraumaassociation.org.uk/
[10] Stillbirths in UK rose in 2021 for first time in seven years, The Guardian, September 2023 https://www.theguardian.com/lifeandstyle/2023/sep/14/stillbirths-in-uk-rose-in-2021-for-first-time-in-seven-years
[11] Saving Lives Improving Mothers' Care, MBRRACE-UK, October 2023. https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[12] Saving Lives Improving Mothers' Care, MBRRACE-UK, October 2023. https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[13] 'Exhaustion, sadness and stress': Midwives leaving the job as burnout takes its toll, Sky News, July 2022: https://news.sky.com/story/exhaustion-sadness-and-stress-midwives-leaving-the-job-as-burnout-takes-its-toll-12657980
[14] Safety, equity and engagement in maternity services, Care Quality Commission, May 2022: https://www.cqc.org.uk/publications/themes-care/safety-equity-engagement-maternity-services
[15] State of Care, CQC, October 2023. https://www.cqc.org.uk/publications/major-report/state-care
[16] National survey shows decline in positive maternity experiences, Care Quality Commission, January 2023: https://www.cqc.org.uk/press-release/national-survey-shows-decline-positive-maternity-experiences

Financial cost of harm

- In addition to the human cost of failure, two thirds of the NHS clinical negligence compensation bill is due to failures in maternity care – around £4bn a year.[17]
- The total cost of harm, including legal and other costs, is now around £8bn – more than double the total cost of providing maternity care.[18]

[17] The £1bn cost of maternity blunders: Jeremy Hunt exposes damning toll of lawsuits against NHS, Daily Mail, September 2020: https://www.dailymail.co.uk/news/article-8745487/The-1bn-cost-maternity-blunders-Jeremy-Hunt-exposes-damning-toll-lawsuits-against-NHS.html Annual report and accounts 2021/22, NHS Resolution, July 2022: https://resolution.nhs.uk/wp-content/uploads/2022/07/NHS-Resolution-Annual-report-and-accounts-2021_22_Access.pdf, Maternity payouts cost NHS twice the price of care itself, The Times, April 2023

[18] The £1bn cost of maternity blunders: Jeremy Hunt exposes damning toll of lawsuits against NHS, Daily Mail, September 2020: https://www.dailymail.co.uk/news/article-8745487/The-1bn-cost-maternity-blunders-Jeremy-Hunt-exposes-damning-toll-lawsuits-against-NHS.html Annual report and accounts 2021/22, NHS Resolution, July 2022: https://resolution.nhs.uk/wp-content/uploads/2022/07/NHS-Resolution-Annual-report-and-accounts-2021_22_Access.pdf, Maternity payouts cost NHS twice the price of care itself, The Times, April 2023

Issues and themes of failures

The scale and depth of failure in maternity care is vast. Some of the key issues highlighted by investigations and the experiences of harmed families are set out below. So far, none of these have been properly addressed by NHS leaders of the government. Some have received attention but this has mostly been just lip-service, and other areas of failure continue to be ignored by people in positions of power and responsibility.

Broken culture

Not listening to women

Women should be listened to and treated with respect. They should be given solid, evidence-based information on all their options, in a way they can understand it, free from ideology, and their choices should be respected. When women have questions, raise concerns, or ask for help they should always be listened to and treated with compassion. All too often women experience the exact opposite of this leading to a wide range of avoidable harm, and it's got to stop.

Listening to women is not just a 'nice to have', it is safety critical. Time and again investigations into the deaths of babies have shown that when women or their partners raised concerns they were dismissed, meaning key opportunities to safe the baby's life were missed.

In other cases, while mother and baby have been physically fine, not being listened to and being treated cruelly at such a vulnerable time has caused serious and enduring psychological injuries.

Normal birth ideology

First identified as a cause of harm in the investigation into avoidable deaths at Morecambe Bay, published in 2015, normal birth ideology holds that the best way to give birth is with minimal intervention. This has contributed to avoidable harm by creating a reluctance to intervene in the birthing process, most notably by reluctance or outright refusal to move to caesarean birth when it is indicated – meaning the baby was born dead, or suffered oxygen deprivation causing a serious, often fatal, brain injury.

Despite investigations repeatedly finding normal birth ideology has been a factor in avoidable deaths and other kinds of harm, some midwives and obstetricians continue to advocate for so-called 'normal births' – sometimes described as 'natural' or 'physiological' births – preventing lessons being truly learned.

An emphasis on normal birth has also led to women being given incorrect information and not being informed of their risks. The East Kent investigation report said:

> *"We believe that insufficient attention has been given nationally to the language that is used around "normality" and to the presentation of information, or to the expectations that both can create among both maternity staff and mothers.*

Language and information that are helpful in the majority of cases can have disastrous consequences when labour does not progress physiologically." [19]

One of the problems with normal birth ideology that has been identified has been a reluctance by some midwives to escalate to their medical colleagues as they seek to 'keep out' obstetricians. This kind of 'turf war' over mothers and babies has caused fatal delays in emergency situations.

However, while midwifery groups tend to be more vocal in their promotion of normal birth, it is also true that some obstetricians subscribe to this point of view. For example, at Oxford obstetricians voted for a total ban on maternal request caesareans in their belief that natural was best. This ban, denying mothers their choice of birth, was in place for several years.

Bullying culture and poor leadership

The way staff treat each other has been identified as another recurring theme in maternity investigations, with bullying culture seemingly common, particularly on labour wards. Examples include belittling and aggressive behaviour towards colleagues, in-group and out-groups (cliques), and racist bullying.

At times bullying and normal birth ideology have combined to make care especially unsafe, as found in the investigation of maternity services at East Kent:

"We heard that midwives who were not part of the favoured in-group at WHH were sometimes assigned to the highest-risk mothers and challenged to achieve delivery with no intervention. This was a downright dangerous practice." [20]

Poor leadership is also a cause of continuing failure, taking in a range of problems including bullying 'power trip' type behaviour, managers who play favourites with their staff, leaders within maternity services who treat hospital policies/best practice as optional, and hospital leaders, including at the executive and board level, who do not exercise proper scrutiny or obtain proper assurance.

There have also been all too many cases where leaders engaged in cover up culture, including suppressing whistleblowers, lying about how deaths or injuries happened, and refusing to accept when they have a problem with safety in maternity.

Culture of complacency

Avoidable deaths and avoidable life changing or life limiting injuries should not be considered normal in maternity care. However, at present, too many NHS leaders measure success in terms of averages, and as long as 'only' an average number of babies have been killed by negligence, they are content.

[19] Maternity and neonatal services in East Kent: 'Reading the signals' report, Department of Health and Social Care, October 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
[20] Maternity and neonatal services in East Kent: 'Reading the signals' report, Department of Health and Social Care, October 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

This attitude is found throughout the system, including service managers, hospital chief executives, and leaders in NHS England and the CQC. Where monitoring at the national level exists, it is largely based on detected 'outliers', which in effect means turning a blind eye to avoidable deaths at hospitals were there are not many. This acceptance of failure, where failure means avoidable deaths, is a key barrier to change.

At the same time, NHS leaders say that because a majority of mothers and babies complete pregnancy live and healthy, this means the majority of care is safe. But the sad reality is that all too often these 'good outcomes' were down to luck, rather than quality care. Good outcomes often happen even when women were ignored or dismissed, monitoring of mother and/or baby were not done in line with best practice, or other failings in care occurred, and indeed surveys of mothers often find that a high proportion of women experienced these kinds of failings.

The way hospital and national NHS leader maternity care and outcomes means that unsafe care is not picked up and has become normalised across the system.

Failing regulation

Governance and accountability are failing at all levels of NHS maternity care, and this failure is allowing avoidable harm and deaths to continue. At the executive level, when leaders fail they are at worse shuffled to another lucrative position in a different hospital. At the clinician level, the regulatory bodies of the GMC and NMC are failing to do their jobs. And between the executive and clinical levels there are layers of managers who are regularly completely unaccountable for their actions or inaction.

It was recently reported that the NMC is more concerned with limiting referrals and reducing its workload than with ensuring midwives are safe to practice, including failing to investigate thousands of complaints and failing to take racist incidents seriously, leading to accusations of 'institutional racism'.[21]

Families report that both the NMC and GMC have failed to investigate their concerns about negligent clinicians properly, with sometimes years of delays between referrals and decisions, as well as some decisions being made quickly without hearing any evidence from the family that made the report. At the same time, whistleblowers report that threats of referrals to regulators have been used to suppress their voices, and they do not have confidence that NMC and GMC process will be fair.

In addition, the CQC has repeatedly failed to identify unsafe maternity services and indeed has at times praised NHS Trusts which have gone on to be the subject of maternity scandals, as at Shrewsbury and Telford, where a review of care found that the CQC *"gave false reassurance"*.

[21] Nursing watchdog failing to investigate thousands of complaints amid concerns rogue staff going unchecked, The Independent, October 2023. https://www.independent.co.uk/news/health/nursing-midwifery-council-complaints-rejected-b2429332.html
Nursing watchdog accused of discrimination for letting racism complaints 'go unchecked', The Independent, September 2023. https://www.independent.co.uk/news/health/racism-nursing-midwifery-council-nmc-b2419542.html

While the CQC's new maternity inspection programme, which began in July 2022 and intends to inspect every maternity service that has not been rated since April 2021, is welcome, families remain concerned. These concerns include that families are not being consulted properly as part of the inspections regime, systemic and reoccurring failures are not being identified, and unsafe services are nevertheless being rated 'good'. It is not at all clear that the CQC understands the key ingredients of safe care and families are particularly worried that the CQC continues to miss problems with culture and normal birth ideology.

In addition, there is a disconnect between the CQC's findings and its public statements. Despite rating 65% of maternity units as 'inadequate' or 'requires improvement' for safety, CQC representatives continue to say it is safe to give birth in England.

Education and training

There is a serious lack of assurance that the education and training at the start of their career is providing midwives and obstetricians with the skills they need to practice safely, and it is clear that skills and knowledge are not always maintained and updated to reflect current best practice. At the same time, there is serious concern that some education and training is rooted in ideological views of birth rather than evidence.

Staffing and resourcing

There are too many vacancies and not enough staff in maternity care, in terms of both midwives and obstetricians, and we need a long-term plan to fix this. Disputes over pay and conditions are ongoing and must be resolved.

However, it is also time for a proper conversation about other issues that midwives and doctors report are pushing them out of their professions, with unsafe practices and bullying cultures at the top of the list.

Whilst staffing and resourcing is undoubtedly an important part of the conversation around maternity failings, many families say that it is over-egged and report that staffing and resourcing were not a factor in the death or serious injury of their baby. They argue that culture and not being listened to were much more important factors in the avoidable harm they suffered.

Indeed, in the East Kent maternity investigation report, published in 2022, said:

> *"Although there are shortcomings in the physical infrastructure at both hospitals, and there have been periods of staffing and resource shortages, we have not found that these played a causative role in what happened. While these factors require attention, and are rightly the subject of national consideration, they do not justify, explain or excuse the experience of the families using East Kent maternity services as revealed by our Investigation."*[22]

[22] Maternity and neonatal services in East Kent: 'Reading the signals' report, Department of Health and Social Care, October 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

Failed attempts to improve maternity care

Over the last decade there have multiple national schemes and local investigations intended to understand what is happening in maternity care and set out actions and visions for change. While much of the analysis has been useful, it has not been implemented across the system and instead the same failings have been found time and again. Some of the analysis instead of being useful has actually been counter-productive, buying into discredited and unsafe ideological views about birth and making care less safe.

It has become increasingly clear that failure extends across the entire system. Indeed, as Dr Kirkup wrote in the letter published with the investigation into East Kent maternity service:

> *"It is too late to pretend that this is just another one-off, isolated failure, a freak event that "will never happen again"."*

National schemes

Better Births

Published in 2016[23], the Better Births report was the result of a National Maternity Review commissioned by NHS England and chaired independently. Among other things, the Review found that: *"Despite the increasing numbers and complexity of births, the quality and outcomes of maternity services have improved significantly over the last decade."*

Better Births set out a five-year vision for maternity care in England, built around seven key themes:

- Personalised care
- Continuity of carer
- Better postnatal and perinatal mental health care
- A new payment system
- Safer care
- Multi-professional working
- Working across boundaries.

The implementation of the Better Births vision became the responsibility of NHS England's Maternity Transformation Programme, and in 2020 NHS England and NHS Improvement published a review of Better Births[24], concluding that *"good progress is being made"* and highlighting a number of areas of 'improvement'.

The review of Better Births also highlighted some areas for further action, attributing most of these to issues with data quality of time lags in data. The areas for action were: understanding

[23] Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, NHS England, February 2016. https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/

[24] Better Births Four Years On: A review of progress, NHS England, March 2020. https://www.england.nhs.uk/publication/better-births-four-years-on-a-review-of-progress/

the incidence of brain injuries, tackling inequalities, accelerating work on pre-term birth, and *"public concern about the quality of care in a small number of individual units".*

The Better Births vision and its implementation have been widely criticised as contributing to failures in care, and indeed deaths, seen across the country. Criticisms of the scheme are mostly based around its ideological view of birth, whereby natural or 'normal' birth was promoted to the detriment of safety, particularly as a result of NHS England's target to limit caesarean birth rates (abandoned in February 2022 due to safety concerns[25]), and the emphasis Better Births placed on midwifery led units, keeping doctors out of births, and generally 'de-medicalising' birth. Another key plank of the Better Births model, continuity of carer, whereby a mother receives care from one midwife or a small team of midwives throughout their pregnancy, labour and postnatal period, was also dropped in 2022 due to safety concerns raised[26] by the Ockenden Review.

A further criticism of Better Births and the Maternity Transformation Programme is that it did not identify failing and dangerous maternity services, and presented a positive picture of maternity care across the country when proper scrutiny would and should have exposed very serious failures including hundreds avoidable deaths.

Each Baby Counts

The Each Baby Counts programme[27] was run by the Royal College of Obstetricians and Gynaecologists (RCOG) with the goal of reducing the number of babies who die or are born brain injured because of events during labour. The programme ran from 2014 to 2020, covered the whole UK, and looked at cases of full-term babies who died during labour, died within seven days of being born, or who were born with a suspected brain injury. The programme was reliant on lead reporters for notifications of eligible babies, and expert reviewers looked at the reports of local investigations. This inevitably meant that not all babies meeting the eligibility criteria were submitted to the programme, and not all local investigations were of good quality.

Each Baby Counts published four annual reports analysing cases from 2015 to 2018, plus a thematic report on anaesthetic care. The annual reports shared overall numbers of eligible babies, key themes and points of learning aimed at preventing future deaths and injuries, information about local investigations including whether they had family involvement, how many investigations were excluded due to a lack of information, and what percentage of cases the expert reviewers thought could have had a different outcome with different care.

[25] Abandon 'normal birth' targets, hospitals in England told, The Guardian, February 2022. https://www.theguardian.com/society/2022/feb/20/abandon-normal-birth-targets-caesarean-sections-hospitals-england
[26] Ockenden review: summary of findings, conclusions and essential actions, Department of Health and Social Care, March 2022. https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions
[27] Each Baby Counts, Royal College of Obstetricians and Gynaecologists, 2015-20. https://www.rcog.org.uk/eachbabycounts

The annual eligible cases for the whole of the UK were as follows:

	2015	2016	2017	2018
Intrapartum stillbirths	126	124	130	121
Early neonatal deaths	156	145	150	165
Brain injuries	854	854	850	859
Total babies	1,136	1,123	1,130	1,145
'Might have had a different outcome with different care'	76%	71%	72%	74%

The final report, published in 2020, said: *"We have unfortunately not seen the impact in the annual figures that we had hoped"* and *"Thus far, little demonstrable action has been taken in widely implementing recommendations to change practice."*

The annual reports also gave details of contributory factors that influenced the outcomes for babies. In 2020, some examples of contributory factors included:

- Individual human factors (maternity team) theme, such as lack of situation awareness or lack of leadership (58% of babies)
- Incorrect assessment of risk (56% of babies)
- CTG and blood sampling theme, such as incorrect interpretation or failure to escalate (56% of babies)
- Failure to follow guidelines/locally agreed best clinical practice (50% of babies)
- Poor intra- or inter-professional communication (43% of babies).

Note: for many babies multiple contributory factors were identified.

The Each Baby Counts programme had clear weaknesses in its methodology given its reliance on hospitals to notify and investigate cases properly. Nevertheless, the overall learning points identified were valuable and those same points have been reflected in various local investigations and other maternity safety schemes.

The failure of NHS leaders and clinicians to implement learning, including from Each Baby Counts, is one of the biggest causes of unsafe maternity care.

HSIB/MNSI

From 2018 the Healthcare Safety Investigations Branch (HSIB), hosted by NHS England, was tasked with investigating babies meeting the same criteria as the Each Baby Counts programme (above), plus deaths of mothers from conditions caused and/or exacerbated by pregnancy. Unlike Each Baby Counts, HSIB only looked at eligible cases in England.

HSIB's purpose was to investigate these cases independently and without apportioning blame, to discover and then share learnings from incidents, with the objective of reducing the number of deaths and brain injuries. It did this by investigating cases then producing a report with 'safety recommendations' for hospitals to implement. HSIB also produced some thematic reports, however unlike Each Baby Counts HSIB did not provide any analysis of what proportion of cases different care might or would have led to a different outcome.

After a stepping up period, HSIB maternity investigations became fully operational in 2019/20, and from that point became the most reliable source of data on these deaths and brain injuries. However, there were still some weaknesses in HSIB's data as they continued to be reliant on hospitals correctly notifying them of eligible cases.

The annual eligible cases, by financial year, for England were as follows:

	2019/20	2020/21	2021/22	2022/23
Intrapartum stillbirths	118	170	166	192
Early neonatal deaths	115	112	113	91
Suspected HIE/brain injury	686	655	636	555
Maternal deaths	44*	77	64	78

* HSIB says the maternal deaths figure for 2019/20 is incomplete

HSIB's maternity investigation programme has been criticised by families and whistleblowers on several points[28] [29]. These include concerns that:

- Families were not at the centre of investigations and were often excluded, which causes compounded harm.
- When they complained, families were not listened to.
- Investigations were not always rigorous, and were sometimes incomplete or incorrect, with at times serious consequences such as missed learning, misled families, and even misled inquests.
- HSIB was not truly 'independent', and instead shared the same culture as NHS providers and therefore was blind to some failings.
- By focusing only on systemic or process issues, investigations often missed key points of learning including individual negligence or incompetence, and issues around culture and leadership.

The statutory basis on which HSIB worked has also been criticised, including that:

- HSIB had no power to compel staff to cooperate with investigations, meaning that some investigations were completed without any staff input.
- HSIB has no 'teeth', meaning that its recommendations can be ignored. Indeed, analysis has found that the same or similar failings have been found repeatedly at the same hospitals, indicating that despite receiving HSIB reports many hospitals have not learned.

Overall, the programme was ineffective against its objective, as while brain injuries to babies decreased, deaths of mothers and babies increased during HSIB's years of operations. Unlike Each Baby Counts, HSIB provided no analysis on why it thinks this has happened – instead,

[28] Revealed: Concerns about maternity programme of the Healthcare Safety Investigation Branch, Channel 4 News, May 2023. https://www.channel4.com/news/revealed-concerns-about-maternity-programme-of-the-healthcare-safety-investigation-branch
[29] Allegations of bullying within maternity programme of the Healthcare Safety Investigation Branch, Channel 4 News, May 2023. https://www.channel4.com/news/allegations-of-bullying-within-maternity-programme-of-the-healthcare-safety-investigation-branch

its leaders claimed that the programme was a success. Indeed, HSIB's 2023 annual report[30] featured only the data on the reduction of brain injuries to babies, hailing this as proof of its success, while leaving out data on deaths and providing no analysis of this.

In October 2023, HSIB was closed and its maternity investigations function was moved to a new body, the Maternity and Newborn Safety Investigations Special Authority (MNSI), hosted by the CQC. Its processes and most of its staff remained the same as when the programme functioned as HSIB, and therefore it is feared that the same weaknesses and failures will continue.

Local reviews

Morecambe Bay

The Report of the Morecambe Bay Investigation was published in 2015[31]. The investigation by Dr Bill Kirkup looked at maternity and neonatal care at University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013. Like the maternity investigations that followed, this was instigated by affected families after years of considerable effort.

The investigation found *"a series of failures at almost every level – from the maternity unit to those responsible for regulating and monitoring the Trust"*, which were described as *"serious and shocking".*

It found a "lethal mix" of failures that led to the avoidable deaths of 11 babies and one mother. Failures were identified in five principal areas:we

- Substandard clinical competence.
- Extremely poor working relationships, particularly between different staff groups.
- A move to pursue normal birth "at any cost".
- Inappropriate and unsafe care due to failures in risk assessments and care planning.
- Grossly deficient responses to adverse incidents.
- Repeated failure to investigation and learning from serious incidents.

The Morecambe Bay investigations was the first time the interplay between poor working relationships and normal birth ideology, and the impact this had on patient safety was identified. It said:

> *"The obstetricians have poor working relations with the paediatricians and the paediatricians do not have good relations with each other. More than one paediatrician described the paediatric consultants as "a dysfunctional team". The relationship between the obstetricians and the midwives is, we believe, more subtle and is reflected in their clinical practice, with evidence that the midwives sought to avoid involvement of the obstetricians in the care of their patients, while the obstetricians remained content to wait to be called (and sometimes then to be dismissed again as no longer*

[30] Maternity Investigation Programme Year in Review 2022/23, HSIB, August 2023. https://www.mnsi.org.uk/news/maternity-investigation-programme-year-in-review-202223/
[31] Morecambe Bay Investigation: Report, Department of Health, March 2015. https://www.gov.uk/government/publications/morecambe-bay-investigation-report

needed). We heard that the origin of this way of working rested with one or two influential midwives, who pursued normal childbirth "at any cost", and that this deeply flawed approach became more widespread and embedded in the practice of the unit. It is evident that none of these manifestations of poor working relations are in the best interest of the patients, but there is a lack of awareness among staff of their responsibility to help solve these problems."

The report also pointed to an unwillingness to be honest about failings when they occurred, describing investigations as rudimentary, inadequate, over-protective of staff and failing to identify problems. It said that senior staff in the unit must have known by 2007 that there were serious problems in working relationships and clinical competence, but there was no attempt to escalate this. When concerns finally were escalated and an external review was conducted, the response within the service was "shaped by denial", and at times "hostile" rejection of criticism.

The investigation also identified significant regulatory failure. It said:

"There was significant organisational failure on the part of the CQC, which left it unable to respond effectively to evidence of problems. The North West Strategic Health Authority (NW SHA) and the Parliamentary and Health Service Ombudsman (PHSO) failed to take opportunities that could have brought the problems to light sooner, and the Department of Health (DH) was reliant on misleadingly optimistic assessments from the NW SHA."

Shrewsbury and Telford

The Ockenden Report, following the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust, was published in March 2022. The care of 1,486 families and 1,592 clinical incidents experienced by them was reviewed by the panel. Most of the care examined took place between 2000 and 2019, but some cases were as early or late as 1973 and 2020.

The review concluded that in all 12 of the maternal deaths it reviewed, care had not been in line with best practice at the time, and in nine cases care could have been significantly better. It was found that different care would or might have resulted in a different outcome in 25% of the stillbirths examined, 66% of the hypoxic brain injuries examined, and 28% of the early neonatal deaths examined.

In line with other investigations, the Ockenden Review found a push for 'normal births' impacted on patient care. Shrewsbury and Telford had a low caesarean rate it was proud of, and midwives reported pressure to avoid escalating concerns to doctors in case that led to intervention. One member of staff said: *"they [shift leaders] would just let things run purely because they didn't want the doctors to come in",* while another told the review:

"when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly…..because they told me they want to keep the caesarean section really low"

There was an ‘us and them’ culture between midwives and doctors, with delays to escalate concerns as well as examples of senior clinicians failing to act when cases were escalated to them.

The report also said that at times staff were ‘overly confident’ and operated outside of their scope, and found repeated examples of a lack of multidisciplinary working and failures to escalate concerns. Care was also frequently delayed, and some women were inappropriately discharged, only to be readmitted, seriously unwell, later. There were also many examples of failures to follow clinical guidelines on critical areas of care such as fetal heart rate monitoring, maternal blood pressure, management of gestational diabetes and resuscitation, with at times tragic consequences.

The investigation also found that gaps in staffing and training impacted negatively on the operation of the service, with a key area of concern being the lack of availability of senior midwifery, obstetric and anaesthetic support.

In the aftermath of serious incidents families reported a lack of compassion, attempts by clinicians to justify actions or omissions in care, and in some cases families being blamed for what happened. There was a lack of transparency and dialogue with families when things went wrong, and poor quality investigations meant opportunities for learning were missed. Investigations were cursory, not multidisciplinary, and did not recognise systemic failings. Some cases were not investigated at all as the maternity governance team inappropriately downgraded some incidents to avoid scrutiny.

At Trust board level, there was constant change, failure to encourage service improvement, lack of oversight and understanding of the issues in maternity, and lack of strategic direction. In addition to this failure at board level, the review found that the CQC and local Clinical Commission Group (CCG) failed to recognise the problems despite concerns being raised by families, and in their reports instead provided false reassurance.

East Kent

Reading the Signals[32], the report on the investigation of maternity and neonatal services at East Kent Hospital University NHS Foundation Trust was published in 2022. The independent investigation, led by Dr Bill Kirkup, looked at what happened between 2009 and 2020 at the maternity units at the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford.

The investigation concluded that:

> *“Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.”*

[32] Maternity and neonatal services in East Kent: 'Reading the signals' report, Department of Health and Social Care, October 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

The investigation identified that five key themes of failure were the "origins of harm". These were:

- **Failures of teamworking:** including tribalism between professions and factionalism within professions, dysfunctional relationships and a lack of trust, bullying and cliques, midwives and obstetricians not working to shared goals, and the wrong people with the wrong skill doing things like risk assessments.

- **Failures of professionalism:** staff were disrespectful to women and disparaging about their colleagues, including in front of women. When something had gone wrong, some clinicians sought to deflect responsibility on to colleagues and at times even blamed mothers.

- **Failures of compassion:** the investigation panel were "shocked" by examples of uncompassionate care, which included dismissing women and their concerns, ignoring or disbelieving women who were in pain, and minimising and making insensitive comments when women experienced harm.

- **Failures to listen:** there were repeated failures to listen to women which at times contributed to bad clinical outcomes, including deaths, as vital clinical information was dismissed.

- **Failures after safety incidents:** safety investigations were narrow, defensive, and sought to minimise the harm that had occurred, frequently providing false reassurance rather than learning. At times, junior members of staff were blamed for wider failings. Families were not communicated with openly and were not told the outcomes of inadequate investigations.

At Trust board level, members failed to address problems in maternity despite being aware of them. Instead, their actions gave the *"appearance of covering up"*. Problems were treated as one-offs and the full scale and systemic nature of failures was not acknowledged. The Trust also focused on reputation management to the detriment of safety.

When senior staff identified and challenged poor behaviour they were replaced, and those that remained either personified poor culture or turned a blind eye. Bullying was not dealt with, and nor was unacceptable behaviour of consultant obstetricians, which included refusing to attend hospital when on-call.

Regulators *"failed to identify the shortcomings early enough and clearly enough to ensure that real improvement followed".* Regulation failed because of a mix of Trust denialism, internal tensions e.g. at the RCM which has several roles which at times are in conflict, and the regulators themselves being ineffective.

The report made clear that shortages in staff and resources were not causative of the failures that led to deaths and other harm, and noted a 'victim mentality' at the Trust. It said: *"Those who should have provided leadership have been tempted to regard themselves as victims of geography, recruitment difficulties and a neglected estate."*

It also found that while there was not a Trust policy to limit or reduce intervention, culturally there was an emphasis on ‘normal birth’. Midwives were encouraged to see themselves as being there to defend against medicalisation of birth, with vaginal birth set out as an ‘ideal’ to ‘achieve’. The way normal birth was spoken about influenced clinicians, making them reluctant to escalate concerns or intervene in otherwise inexplicable situations. At times, this also meant that women were not informed of the risks of vaginal birth, including when they were high risks.

Why they have failed

The reasons national and local schemes and investigation have failed to make a difference to the care mothers and babies receive are complex. One of the reasons a national public inquiry is so important is to understand why learning has not been implemented, and what can be done differently in the future to make sure that it is.

Some of the reasons these schemes have failed include:

- Continuing lack of honesty about the scale of the problem, with NHS England, CQC, etc, still taking the view that maternity care across the country is ‘safe’ and treating avoidable harm as isolated incidents rather than a symptom of systemic failings.

- Lack of ambition, with woolly, uncertain, unmeasurable aims to ‘improve’ care or make it ‘safer’, instead of the firm objective for a maternity care system with zero avoidable harm and the determination to do everything necessary to achieve that.

- Failure to implement learning for a range of reasons, such as ideological opposition to findings, a lack of will and/or focus among NHS leaders, and the inability to lead change of the scale and complexity that is required.

- Lack of evaluation of the effectiveness of schemes, both national and local. Action plans are created and implemented, but no evaluation is done to ensure they are meeting their original objectives – and then the next plan or scheme comes along, doing the same thing again.

- The terms of previous investigations and reviews means that big pieces of the puzzle are excluded, and the wider context in which maternity scandals occur is not examined; there has not been a whole system analysis which looks at how different areas, issues and factors interact to cause avoidable harm.

National public inquiry

It's time to recognise that maternity care in England is broken. To bring about the fundamental changes that are needed, we must abandon piecemeal change and have a full and thorough statutory national public inquiry.

Too many schemes, programmes and investigations have tried and failed to make maternity care safe, and it's clear that a whole system analysis is now needed to tackle wide-ranging systemic failings.

Only a judge-led, full statutory public inquiry can command the confidence of harmed families, healthcare providers and other stakeholders, and come to independent conclusions, free of party politics, that can then be taken forward and fully implemented to save the lives and health of mothers and babies.

This national public inquiry must include objectives to:

- Ascertain the true scale, breadth, and nature of avoidable harm in NHS maternity services in England.
- Ensure that the voices of women, families and staff across the maternity system are heard.
- Understand how maternity services are functioning on the ground.
- Understand how clinical education, regulatory authorities, and other organisations influence or fail to influence the quality and safety of provision.
- Examine how the way maternity services are commissioned and structured impacts or fails to impact on the quality, safety, and improvement of care.
- Understand the origins of rotten culture – including lack of compassion, not listening to women, and normal birth ideology – as well as how they have been allowed to continue and how to stop these.
- Understand the nature and impact of deficient leadership, and how to select and train competent and compassionate leaders, both clinical and non-.
- Understand how and why Black and minority ethnic group women and their babies are even less likely to receive safe care and suffer avoidable harm at higher rates.
- Examine the effectiveness of the current maternity safety improvement architecture.
- Learn from excellence in the UK and abroad.
- Examine the barriers to maternity safety improvement, including the clinical negligence legal system.
- Examine the issues around staffing and resourcing, including terms and conditions, retention strategies, and safe staffing levels.
- Review the existing systems of accountability and governance for maternity safety at all levels of the system.
- Review how the maternity system is learning from adverse events and how learning is shared and disseminated.
- Determine how maternity care should be reformed to create and sustain real improvement, safe care, and zero avoidable harm.

Maternity Safety Alliance

Fighting to make all births safe.