OCKENDEN REPORT

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust

24 June 2026

Return to an Address of the
Honourable the House of Commons
dated 24 June 2026 for

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust

Our Report

HC 284

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

24th June 2026

Dear Secretary of State,

I publish my Report of the Independent Review of Maternity and Neonatal Services at Nottingham University Hospitals NHS Trust at a pivotal point for the NHS in its efforts to ensure the consistent delivery of safe, high quality and compassionate perinatal care for all families.

This Report demonstrates what ensues when leadership, governance and culture are not robust: poor practice is not investigated; learning is not integrated; and mothers and babies are failed by an organisation they should be able to rely upon absolutely during a period of acute vulnerability in their lives.

This Review owes its origins to a courageous group of Nottingham families who have endured needless grief and pain following death and injury during childbirth, including: Harriet Hawkins, and her parents Jack and Sarah; Wynter Andrews, and her parents Gary and Sarah; Baby Ladybird, and her parents Carly Wesson and Carl Everson; Quinn Lias Parker, and his parents Emmie Studencki and Ryan Parker; Kouper Needham, and his parents Dave and Natalie; Teddy, and his parents Kimberley Errington and Jason; Caitlin Gwinnett-Stringer, and her parents Emily and Darryl; and Felicity Benyon.

These families came together, united in their shared experience of harm and bereavement, and determined that maternity services needed to be improved, both in Nottingham and across the nation. When this Review was agreed by the former Secretary of State for Health and Social Care, the Rt Hon Sir Sajid Javid, they were just a small group of families who were demanding accountability and answers for themselves, as well as the many other families that they knew who had experienced harm. By the time the Review closed in May 2025, the number of families involved had grown to nearly 2,500, whose experiences occurred predominately between 2012 and 2025.

My independent maternity Review Team have identified clear evidence that forms the basis for both Local Actions for Learning (LAfLs) and England-wide Immediate and Essential Actions (IEAs). These should be swiftly implemented at the Trust and across the wider perinatal system in England. As you will read, the overarching principle is that women, families and staff must be able to seek urgent additional clinical review by utilising Martha's Rule; women must be at the centre of clinical communication and informed decision-making; and there must now be standardisation of national assessment and escalation processes across perinatal care.

Many of the issues described in this Report have been known about at NUH since at least 2010, including: insufficient staffing and funding across perinatal care settings; the inability of staff to undertake even basic (often, mandatory) training; a persistent failure to listen to and believe mothers and fathers; and a corresponding failure to investigate, and therefore learn from, mistakes.

I appreciate that your recent appointment has meant that you have not yet had the opportunity to engage with many harmed and bereaved families, but it is my sincere hope that the efforts of your predecessors will sustain momentum for change at this pivotal moment. Rt Hon Wes Streeting MP met with bereaved and harmed families from Nottingham and across the country, and I know he recognised that immediate action is needed to respond to the alarming statistics that continue to mark maternity care in England. A pledge was made in 2015, by the then Conservative administration, to reduce the rate of stillbirths, neonatal and maternal deaths in England by 20% in 2020 and 50% by 2030. Whilst there are fewer stillbirths, they are still above pre-pandemic levels[1] and maternal deaths are at a 20-year high[2] – with women living in the most deprived areas and black women remaining at greater risk of death.

You will also be aware of the startling statistic that clinical negligence is costing the NHS almost the same in legal compensation as it spends on the delivery of maternity care itself. According to the NHS Resolution annual

1 ONS birth summary (2024) in England and Wales – data for 2022 [Online]. Available on: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2022refreshedpopulations (Accessed: 13/06/24)

2 https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2022-2024

report 2024/25, 51% (£2.5bn) of the total negligence cost of harm (£4.9bn) relates to maternity – an increase from 49% in 2023/24. Whilst these figures are substantial, behind them is the incalculable effects –financial, physical, emotional and psychological – on the families themselves, with many careers and relationships shattered by what they experienced at NUH. Maternity systems are under increasing pressure due to the growing acuity of expectant mothers' clinical needs, but this cannot by itself account for these worrying outcomes.

Safe and equitable care must now be the only acceptable standard.From my conversations with women and staff across the country I know that true excellence relies on empathetic leadership, individualised care, and an unwavering commitment to systemic equity. The expectations families bring to maternity care are, in truth, modest: competence, honesty, timely intervention and safety, with women receiving dignified and kind treatment from their first contact with maternity services through to their discharge and health-visitor provision.

It is our hope that, where this report identifies where those ordinary expectations were not met, that light will be shone on the critical role of regulators to ensure greater accountability. Women and families deserve rigorous systems of regulation that are easily accessible and responsive to people when they need them, alongside a renewed focus on professional conduct and self-regulation among staff. In particular, swift and effective action must follow cruel behaviour on maternity wards; concerningly, both mothers and staff 'on the ground' in Nottingham have reported to my team the damaging results of being bullied by a small minority of powerful leaders who had been allowed to 'infect' the unit.

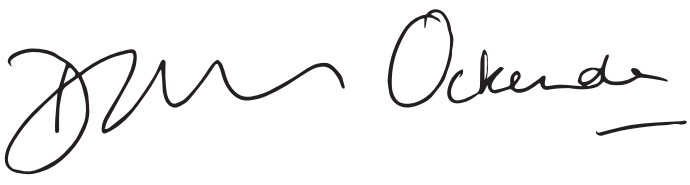
Many of the themes identified throughout the report are not new to those who oversee maternity care in England. As with my last report, our approach has been to examine not just the clinical care 'in the moment', but also the wider factors that influence the perinatal landscape. Through listening to families and staff, we acknowledge that many of the systems of oversight established for maternity care are no longer fit-for-purpose; moreover, as the regulators will be aware, such inadequacies in governance have regularly compounded the harm to families.
The focus of professional bodies and the Department must be committed to upholding professional standards while continuing to learn from the experiences of women and families.

As I conclude this Review, I do so with both profound sadness for the families whose lives have been forever changed by the pain they have endured and with hope for the future; hope that, through listening to the experiences of women, families and front line staff at NUH, and by acting decisively on the findings of this Review, we can begin to rebuild trust in maternity and neonatal services. A civilised National Health Service will be judged not only by the excellence it achieves, but by the harm it prevents. In maternity care, where trust is absolute and vulnerability acute, failures carry consequences measured across lifetimes. The families of Nottingham have shown extraordinary courage, dignity and determination in the face of the devastating consequences that continue to mark their lives, and their voices must now become the catalyst for lasting national change.

I firmly believe that safe, compassionate and equitable perinatal care is still achievable in Nottingham and across England, but only if there is unwavering commitment to accountability, learning, transparency and kindness at every level of the system. We owe it to every mother, every baby and every family whose terrible experiences are recorded here that they are never repeated. Now is the time for focused, collective action to ensure sustained improvement that will allow every woman in England to have confidence in the care that they will receive when giving birth in the NHS.

Thank you, Secretary of State, for your ongoing support.

Yours sincerely,



Donna Ockenden

Chair of the Independent Maternity Review

Acknowledgements

Today I want to acknowledge the more than 2,500 families who came forward to tell the Review Team what happened to them during their maternity and neonatal journey at Nottingham University Hospitals NHS Trust (NUH). For many parents and their families, participation in this Review required them to revisit the most painful moments of their lives; the deaths of babies, life-changing injuries, and the serious harm suffered by mothers. Families spoke with courage, honesty and dignity about events that have had a profound and lasting impact on their lives. Their willingness to do so has been absolutely central to the work of this Review.

Thousands of families have entrusted the Review Team with their accounts. Their participation was motivated not only by a desire for answers, but also by a commitment to sharing their experiences so that others would not endure similar circumstances. Undertaking such reflection for the benefit of others demonstrates considerable generosity. They wanted their experiences and the lives of their babies and partners to lead to learning, accountability and meaningful change. The input from these families has shaped each phase of the Review process and has been integral to the findings and actions we say must happen that are found in this Report.

I would particularly like to recognise the families who set up and supported the Affected Families Group, they worked tirelessly to ensure this Review happened and then continued throughout the Review to ensure families remained at the heart of this investigation. I extend my most grateful thanks and admiration: to Sarah and Jack Hawkins, whose daughter Harriet died avoidably in 2016 following significant failures in maternity care; Sarah and Gary Andrews, whose daughter Wynter Sophia died shortly after birth in 2019 after significant failures in care; Felicity Benyon who suffered permanent harm; Carl Everson and Carly Wesson, parents of Ladybird and Emily and Darryl Stringer and their daughter Caitlin. Through their courage in sharing their own experiences and their determination to support others, they have ensured that this Review remained grounded in the lived experiences of those most affected.

I would also like to acknowledge the many other families whose experiences have helped to bring these issues to light, through their participation in and support of The Review. These include Emmie Studencki and Ryan Parker, parents of Quinn Lias Parker; Natalie and Dave Needham, parents of Kouper and Kimberley Errington, mother to Teddy. Each of these families have spoken about the harm and loss they experienced, and their determination to seek answers has contributed to a wider understanding of the issues examined in this Report.

This Review has been informed by a substantial and unprecedented body of evidence, including accounts from many hundreds of families, detailed examination of clinical and governance records, and very significant contributions from healthcare professionals and experts. While this work builds on learning from previous national maternity reviews, the scale and depth of evidence gathered in this Review has provided further insight into patterns of harm, organisational culture, inequalities in maternity provision, and the care provided to families following the death of babies or mothers. In particular, The Review has identified concerns relating to the lack of bereavement support and after death care, including how babies and their families are cared for during this most sensitive and important period. The findings presented in this report therefore reflect both the unique experiences of the families involved and the specific circumstances identified within maternity and neonatal services at Nottingham.

I would also like to acknowledge the local, regional and national organisations that have engaged with and supported The Review to provide vital support to families affected by baby death and harm, maternal harm and birth trauma, including but not limited to The Stillbirth and Neonatal Death Society (SANDS), Sands United FC Nottingham, Aching Arms, Forever Stars, The MASIC Foundation, The Little Ted Foundation, Zephyr's, Footprints Baby Loss, Peeps HIE Charity and the Birth Trauma Association.

Finally, I would like to thank the more than 800 current and former clinicians, midwives, nurses, other healthcare professionals of NUH including Anthony May, Chief Executive Officer at Nottingham University Hospitals (NUH) Trust and Nick Carver, Chair of the Board at NUH who contributed to this review and who

shared their perspectives openly and honestly. I also wish to acknowledge the excellence of my Review Team and the many organisations and experts who supported this work.

This Report is dedicated to the lost and forever changed lives of mothers, fathers and babies whose experiences have shaped this work. Their commitment must contribute to a legacy of safer care for every family that follows in their footsteps.

We recognise that for many families, the impact of these events extends far beyond the initial loss of life or injury. It is reflected in the years that follow, in the lives not lived, the milestones not reached, and the futures that were taken away. These are the lost years of what might have been, had safe and appropriate maternity care been provided.

Their lives, and the enduring love of the families who continue to speak for them, must remain at the heart of all efforts to improve maternity care, now and in the years to come.

Why this Report is Important

When considered alongside action taken from previous and forthcoming reviews, it is perhaps understandable that there may be uncertainty regarding the extent to which this Report will influence the future of maternity services. Similar findings and recommendations have been made in earlier inquiries, yet sustained and meaningful change has not always been realised. This may be discouraging for those committed to improving perinatal care for women and their families.

However, this Review offers an important opportunity to reflect more deeply on the learning identified across the many aspects of care it has examined. It is not only the clinical recommendations that are of significance, but also the wider insights into culture, systems and behaviours. Recognising and acting on this broader learning will be essential to achieving meaningful and lasting improvement in the safety and quality of perinatal care.

The loss of, or serious harm to a baby or mother during childbirth is an immeasurably heartbreaking experience that leaves profound and lasting wounds. The impact reaches far beyond the parents, touching the hearts of extended family and the entire community. When the loss is considered preventable, its impact is even more profound. In such cases, answers and accountability, alongside appropriately resourced and provided psychological support is imperative to help families to begin to rebuild their lives and start to restore stability.

First and foremost, this Review has allowed the voices of parents and bereaved families to be genuinely heard. We have carefully assessed each case; whether involving loss, death or serious harm; considering the unique circumstances and the perspectives of the families involved. Our independent evaluation aimed not only to determine whether incidents could have been prevented or if the system may have let families down, but also to carefully consider the actions taken to address any shortcomings. Through this sensitive and holistic approach, we hope the Review has provided answers and comfort to families. Importantly, the process has deepened our understanding of culture, compassion, bereavement and after death care, and the significance of transparent and honest communication, especially when deficiencies in care are identified, always keeping the well-being of those affected at the heart of our work.

In most circumstances, clinicians are committed to providing safe, compassionate and high quality care. Equally, families rarely seek to attribute blame to individuals when care has been delivered in good faith. What matters most to parents and their families is that, when harm does occur, the truth is told, that accountability occurs, and that meaningful learning is identified and acted upon. In this way, such, sometimes life changing harm, can be transformed into opportunities for improvement, helping to reduce the likelihood of similar experiences being repeated for others.

When responses are inappropriate and covert, unacceptable behaviours, such as denial, gaslighting or victim blaming, are encountered, individuals can experience significant psychological distress. Recognising the impact of behaviour is crucial in understanding how grief may evolve and why families then feel compelled to pursue accountability. This situation can place considerable strain on parents and erode confidence in perinatal services. It also affects staff members, many of whom remain committed to delivering compassionate care despite their responsibilities being delivered in extremely challenging circumstances. By addressing these issues openly and constructively, we can foster a more supportive environment for families and staff alike, helping to rebuild trust and promote positive change within the perinatal care.

The culture of compounding of harm needs to stop! It has been noted in many reviews and still seems widespread today and it is causing significant distress and despair to those already irreparably damaged either through misfortune or clinical error.

Similarly, when coordinated services achieve a positive result in cases with a poor outcome or an unfavourable prognosis, it is essential to analyse and acknowledge factors contributing to success so

they may be replicated. Through expanding our perspective beyond families who have faced the most adverse outcomes, we have recognised the value of identifying substandard care even where outcomes are favourable, as well as exemplary care in situations with poor prognosis or results. It is necessary to re-examine our methods for evaluating clinical care to ensure they are both equitable and accountable.

Current maternity grading systems do not fully reflect this reality, as they focus too heavily on outcomes rather than the quality-of-care processes, including listening, early recognition, escalation and teamwork. A more efficient approach is needed; one that recognises not only where care has fallen short, but also where staff have delivered excellent care in challenging circumstances and prevented harm through skill, vigilance and effective teamwork. Learning from these examples offers a different and often constructive perspective on safety: not only understanding what went wrong but understanding what helps care go right. This shift has the potential to transform culture across perinatal services, creating a more just, open and respectful environment for families and staff alike, strengthening trust, improving morale, and supporting meaningful and lasting improvement.

The development of the IEAs and a new assessment tool under development by the Ockenden Team, aims to initiate a cultural shift within maternity services. Success requires comprehensive engagement from all maternity service providers, Governmental support led by the Maternity and Neonatal Taskforce, and ongoing inclusion of diverse and representative perspectives from service users in order to maintain direction and progress.

Contents

Letter to the Secretary of State for Health and Social Care from Donna Ockenden i

Acknowledgements iii

Why this Report is Important v

Executive Summary ix

Concerns that Led to the Review 1

Nottingham University Hospitals NHS Trust – Background Information 10

Methodology 18

Our Findings Following the Review of Family Cases 29

Signature Case 39

Family Experiences and Wider Maternity Experiences 68

The Psychological Impacts of Birth and Suboptimal Care 87

Staff Voices 94

Antenatal Care 119

Intrapartum Care 147

Obstetric Anaesthesia 167

Neonatal 185

Postnatal Care 203

Maternal Deaths 229

Post-Death Care 235

Corporate Culture, Governance & Leadership 248

Clinical Governance 271

Clinical Leadership 296

Addressing Inequalities in Care 321

Immediate and Essential Actions to Improve Care and Safety in Maternity Services Across England 328

APPENDICES:

Appendix 1: Overview of the GMC's Work to Support the Independent Maternity Review (IMR) of Nottingham University Hospitals (NUH) NHS Trust 341

Appendix 2: Glossary of Terms 344

Appendix 3: References 371

Executive Summary

Overview

1. This Review was commissioned in June 2022 and considers the provision of maternity and neonatal care at Nottingham University Hospitals Trust (NUH) between 2012 and 2025.
2. Identified cases of families using the maternity service were examined in detail. In the main these included mothers and/or babies who experienced loss, damage or harm during pregnancy, childbirth and the early postnatal period.
3. The primary objective of the Review was to determine whether the care received in each of these cases had a material effect on the poor outcome.
4. Through aggregating the results of these individual case reviews, it has been possible to offer analysis of the overall standards of care and the causes of any organisational or professional weaknesses.
5. The purpose of this Report is to provide
   a. Assurance to families that their care has been openly and independently assessed and provide answers to questions regarding the quality and safety of the care they received.
   b. Assist the Trust on its improvement journey by exploring the leadership, management, clinical culture and organisational context of maternity and neonatal services over an extended period.
   c. Offer maternity units across England a framework through which to assess their own service
6. Key statistics

Table 1: Clinical Cases by Year and Grading

YEAR	CASES	MATERNITY GRADED 0-1	MATERNITY GRADED 2-3	% OF TOTAL GRADED 2-3	NEONATAL GRADED 0-1	NEONATAL GRADED 2-3	% OF TOTAL GRADED 2-3
Pre 2012	82	54	26	32%	38	8	10%
2012	146	117	28	19%	61	4	6%
2013	155	119	37	24%	75	5	6%
2014	171	128	41	24%	86	4	4%
2015	156	123	30	20%	84	6	7%
2016	148	116	32	22%	78	2	3%
2017	158	110	45	29%	73	3	4%
2018	138	103	33	24%	67	5	7%
2019	134	103	31	23%	55	6	10%
2020	146	117	27	19%	70	7	9%
2021	169	128	36	22%	73	13	15%
2022	155	118	33	22%	76	4	5%
2023	128	97	28	22%	45	7	13%
2024	104	81	17	17%	40	2	5%
Jan-May 2025	36	33	0	0%	16	0	0%
Totals	**2026**	**1547**	**444**		**937**	**76**	
Average %				**21%**			**6%**

Signature Case

7. This Review and this Report begin with the experiences of a single family without whose resilience and tenacity the opportunity to investigate the safety and culture of maternity care at NUH might not have been possible.

8. Baby Harriet Hawkins died just before her birth on 16 April 2016. After three internal investigations, a fourth external review published in December 2017, confirmed that her death was avoidable and was due to the poor care her mother, Sarah, received in the very latter stages of her pregnancy.

9. Jack (Harriet's father) and Sarah's story does not end there. Their search for justice for Harriet, for some accountability from the Trust, for truthful answers about what went wrong and why and some assurance that things would change, has been met by almost ten years of obfuscation, delay, callousness and incompetence.

10. The list of organisations that failed the Hawkins family include the Trust itself, the NMC, the Human Tissue Authority and Care Quality Commission (CQC). The failings include: inadequate storage of Harriet's body after death, insensitive communications from a range of organisations, ineptitude in undertaking regulatory functions, suppression of information and inadequate investigations, defensive interactions and care described by Sarah and Jack as cruel.

11. It is unusual to dedicate so much space and time to one family in a Review of this nature. It is not that the Hawkins family are any more deserving than any other of the more than 2000 families covered by the Review, but rather that the Hawkins family's experience is unique and therefore instructive, because whatever could go wrong for them did, and whoever should have been there to support them, was missing.

12. In the belief that sunlight is the best of disinfectants, we have included this detailed account of the Hawkins family's experiences since 2016 because only through subjecting our public bodies to transparency and scrutiny can we hope to promote better governance and ethical behaviour.

Family/Maternity Voices

13. Families were the driving force behind the Review and transformed it from a locally arranged review into the largest maternity inquiry in NHS history. Around 2000 of the families whose cases were reviewed agreed to share their experiences and a further 520 families chose to provide feedback on the care they received. Collectively these illustrate recurring issues, patterns and variations in experiences across the system.

14. Across the maternity pathway, families described experiences that were strongly influenced by: the quality of communication, whether care and information were consistent, the extent to which they felt listened to and believed; their involvement in decision making and the way in which any concerns were responded to.

15. Where these elements were present, families reported feeling reassured and supported. Where they were absent, experiences were often described as confusing, distressing or dis-empowering.

16. Women described experiences shaped by a loss of autonomy, inadequate communication, poor emotional and psychological safety, understaffing, delayed or missing observations, and failures in escalation. These issues span more than a decade, suggesting that challenges were deeply embedded and not limited to individual staff members, isolated events, or short-term operational pressures.

17. Positive accounts of compassionate, skilled staff were heavily outweighed by experiences indicating systemic fragility. The juxtaposition of excellent individual practice against a background of structural dysfunction underscores the significance of leadership, oversight, and culture in shaping the conditions for safe and respectful maternity care.

18. The themes arising from families echo those in previous maternity reviews: little in the way of continuity of care; lack of meaningful choice or informed decision making; difficulty in accessing early labour assessment; unsympathetic and unsupportive labour care; short staffing; lack of basic immediate postnatal care and exclusion from decision making.
19. Women from minority ethnic backgrounds to Women from global majority populations here and throughout as this is the most updated term for this group of Women.

Psychological Impact of Birth and Sub Optimal Care

20. The Review observed markers of psychological distress not only among numerous families who shared their experiences, but also among clinicians involved in traumatic births and indeed some clinicians who themselves experienced maternity loss, damage or harm.
21. The main themes associated with psychological harm included: inadequate pain relief; poor communication and lack of agency; lack of transparency; clinical mismanagement; lack of compassion; failure to recognise vulnerability and physical trauma with long term health consequences.
22. It was particularly disappointing that during the Review, in 2025 funding of the dedicated support service for mothers who experience pregnancy/baby loss (PETALS) was discontinued. Whilst this workload is now being picked up by various local charities, there are issues of capacity and waiting lists and staff being unsure about which options are appropriate and available.
23. As part of this Review all families included have been offered support from a Family Psychological Support Service which provides a referral service for a range of therapeutic approaches and is networked with other local support services.

Staff Voices

24. More than 800 individual members of NUH staff (past and present) either contacted the Review directly or via staff meetings to share information.
25. Some staff described pride in their service and the care they provide, as well as positive working relationships with colleagues with around half confirming both that colleagues support each other and are committed to improving safety. However, this was outweighed by negative experiences of working life at NUH.
26. Staffing levels was the most serious and pressing issue raised, with only 11% reporting sufficient staff for the workload and 59% that staff regularly work longer hours than is best for service quality. Moreover, staff all agree that senior and executive managers have either ignored or have been unable to respond to the concerns being raised over many years.
27. A bullying and toxic culture has been a long-running theme in NUH's maternity services. More than 40% had either witnessed or personally experienced bullying by managers or other colleagues as a regular part of their working environment. Some staff members were specifically and consistently mentioned as forming intimidating cliques that were/are well known, but not confronted or challenged.
28. NUH data indicates that only 8% of the midwifery workforce is from a global majority background (compared to 26% of the entire NUH workforce and 34% of the obstetric workforce). It is therefore not surprising that very few of the staff who engaged with the Review raised issues relating to personal experiences or witnessing racism within the working environment.
29. The top five issues raised about maternity/obstetric management were that historically they were: invisible, unapproachable and unresponsive; ignored concerns raised; bullying, rudeness and aggression; rapid turnover.

30. There is a running theme of poor governance within maternity going back to 2012, including Serious Incidents (SIs) not being investigated and reported in a timely manner and failure to learn and change after incidents.

31. Amongst staff still working in the Trust there is a strong theme of commitment to improvement and some optimism that this time things can change.

Antenatal Care, Including Fetal Medicine

32. The Review identified some examples of excellent multidisciplinary care, particularly within fetal medicine, ultrasound, maternal medicine and a number of specialist pathways for women and babies at risk. This included personalised and compassionate counselling, excellent documentation of discussions relating to birth planning and families feeling empowered to participate in decision-making.

33. Overall antenatal care was characterised by long-standing systemic weaknesses that affected consistency, safety and experience. This included multiple examples of variation in risk assessment, surveillance, documentation, communication and escalation, contributing to missed opportunities for earlier intervention and avoidable harm.

34. A central theme is the fragmentation of care and its consequences. This has included: inconsistent application of national guidance, gaps in continuity, variable use of electronic records, failures in communication, false reassurances and normalising of abnormal findings.

35. Women and families repeatedly described feeling unheard, inadequately informed and unsupported when expressing anxiety, particularly in relation to reduced fetal movements, emerging medical complications, and complex decision-making. These experiences were further compounded for vulnerable women and babies.

36. There is a recurring theme in the lack of adequate communication support for women whose first language is not English. This included reliance on family members to interpret, the absence of professional interpreters during complex fetal medicine consultations, booking appointments conducted without language support, and missed opportunities to ensure informed consent.

37. A particular ‘weak link’ over the period covered by the Review has been triage, with multiple examples of poor telephone risk assessment, missing documentation and a culture of discouraging women to attend in-person. There is evidence this has significantly improved since 2022.

38. The management and delivery of Induction of Labour care is identified as of particular concern, with: poor cardiotocography (CTG) monitoring and interpretation, delay in conducting speculum examination and reluctance to escalate concerns and transfer to labour ward due to professional cultures.

Intrapartum Care

39. The Review Team identified recurring examples of what was described as suboptimal care in intrapartum fetal monitoring, assessment and management of the latent phase of labour, and the identification, recognition, and management of post-partum haemorrhage (PPH).

40. Common themes included: unclear, inconsistent or absent local guidelines and late adoption of national guidance and best practice; failure or delayed escalation; inadequate training, management and oversight and specifically a toxic bullying culture amongst the labour ward coordinators which spanned a considerable period of this Review; failure to learn from incidents and audits or to translate lessons into improvements in care.

41. In relation to fetal heart monitoring (CTG interpretation) the Review saw examples of incorrect interpretation, inappropriate use of oxytocin, poor documentation, failure to use fetal scalp electrodes when indicated; lack of coordinator oversight, poor escalation and poor training.

42. Common themes found in assessing care during the latent phase included: inappropriate communication and language; poor documentation; inconsistent local guidelines; unsupportive culture; clinical mismanagement and the inappropriate and untimely use of oxytocin.

43. Examining care during the 3rd stage of labour, the Review found numerous examples of inconsistent guidelines, delays in recognition and escalation of PPH and major obstetric haemorrhage (MOH), poor documentation and poor risk assessment.

44. These findings sit within a wider context of systemic cultural, staffing and administrative challenges. Together, these factors contributed to an environment in which the implementation and dissemination of change were slow, clinical guidelines lacked clarity, and the supportive role of the labour ward coordinator was consistently lacking in clinical records or reflected in Staff Voices.

45. More positively, there is evidence of a notable improvement in fetal monitoring practice following the introduction of a dedicated fetal monitoring lead midwife in April 2021.

Obstetric Anaesthesia

46. Overall, the anaesthetic care provided was assessed to be of a high standard, with very good quality care delivered for the vast majority of women and their families. In 91% of cases reviewed, care was graded 0 or 1, reflecting practice where there were either no concerns, often with elements of excellent care, or only minor concerns that did not impact on clinical outcomes.

47. A smaller proportion of cases raised concerns. Areas identified included suboptimal management of epidural analgesia in labour, including instances of intra-operative pain, alongside challenges in the management of MOH. In addition, there were occasions where escalation to senior support was delayed, and where recognition of the deteriorating woman could have been improved.

48. The issues identified were not considered unique to NUH. Rather, they reflect challenges that are recognised across maternity services more widely within the NHS.

49. The Obstetric Anaesthetic service at NUH has appropriate levels of consultant presence on labour ward during the day and evenings and dedicated on-call rotas. It operates weekly antenatal clinics and fortnightly postnatal clinics and demonstrates continuity of care, regular review of outcomes and opportunities for learning.

50. The anaesthetic service at NUH is clearly held in high regard by all professional colleagues working in maternity and neonatal care.

51. The Review found consistent evidence of early anaesthetic involvement in complex cases during the antenatal period, leading to effective senior-led multidisciplinary decision-making, improved care planning, enhanced safety, and a better experience for women.

52. The Review encountered examples of exemplary care when women had to be admitted to ICU, demonstrating a proactive approach to addressing the psychological and emotional needs of families and significantly mitigating the emotional and psychological impact of maternal critical illness.

Neonatal Care

53. Overall, the neonatal care observed was in line with national expectations, with many clear examples of good and exceptional practice. Compassionate, family-centred care was evident throughout.

54. Until December 2024 significant cot capacity pressures and short-staffing was having an impact on workload pressures and the quality and safety of neonatal services. A new larger unit opened in December 2024.

55. The Review examined all cases of resuscitation within the cohort. In most cases, the neonatal team responded promptly and followed national guidance. Resuscitation was generally well documented on a dedicated newborn resuscitation sheet, and senior support was present at the outset or arrived promptly.

Postnatal Care

56. The Review examined the postnatal care associated with 2,200 cases, finding that in most cases this was appropriate and in many instances was delivered with high levels of professionalism, compassion, and effective multidisciplinary working. The quality of bereavement care reached an exceptionally high standard in a significant number of cases, and the commitment of individual staff to families in the most difficult of circumstances was consistently evident.

57. It also documents a pattern of recurring failures in core postnatal safety processes. These failures were not isolated incidents but recurred across the review period in both hospital and community settings. They include: failures in the monitoring and escalation of maternal hypertension and clinical deterioration; failures in VTE risk assessment and thromboprophylaxis; failures in the recognition and management of the unwell or poorly feeding baby; failures in discharge communication across hospital, community, and primary care; and failures in the provision of compassionate, culturally sensitive, and equitable care.

58. These themes were exacerbated by chronic workforce pressures on postnatal wards, variable consultant involvement following transfer from higher-dependency settings, an absence of governance around the role of Maternity Support Workers in the community, and the inappropriate substitution of telephone contact for face-to-face clinical review. In several cases the consequences of these failures were severe and irreversible.

59. The Review also identifies a recurring and serious failure in accountability to families: explanations that were incomplete or inconsistent with the clinical record, debrief appointments that were delayed or not offered, and written communication that lacked compassion or clarity.

Maternal Deaths

60. The Review examined 27 maternal deaths that occurred between 2006-2024. Five cases fell outside of the Terms of Reference of the Review. Of the 22 remaining cases, reviewers identified failures in care that may have or substantially impacted on the outcome in six deaths.

61. The profile of maternal deaths at NUH over this period broadly aligned with the known demographics and causes as identified by MBRRACE. 11 of the deaths occurred to women living in the most deprived areas of the city and 14 occurred amongst women who were not white British.

62. The common failures reviewers identified that might prevent future maternal deaths included: listening to women and families and acting promptly on concerns; continuity of care particularly for those with additional social/medical complexities; robust clinical governance to ensure timely information sharing across organisations and prompt access to imaging for women presenting with concerning neurological symptoms.

After Death Care

63. Given the particularly distressing evidence uncovered relating to the post death care of baby Harriet Hawkins in the exemplar case; it was agreed to include a full review into the quality and safety of Post Death Care. This comprised care of 17 babies and one adult who died.

64. The Review found evidence of recurring examples of failure to protect the dignity of the deceased, including an early gestation baby disposed as clinical waste; dehumanising language by clinicians; poor mortuary care, including failure to comply with legal requirements and inadequate arrangements for undertaking paediatric post-mortems.

65. In addition, the Review found poor governance and little evidence of learning from incidents or of embedded change. Following a recent inspection by the Human Tissue Authority, a comprehensive action plan is now in place.

Corporate Culture Governance and Leadership

66. Maternity and Neonatal Services do not operate in isolation but within wider Trust division and corporate structures, with ultimate responsibility for quality and safety resting with the Chief Executive and Board. On reviewing Trust minutes and reports, examining external reviews and staff testimonies it is clear that a number of known issues, challenges and failings in maternity were at various times sidelined and ignored, deemed too difficult or were of insufficient priority.

67. In total, six external reviews were commissioned into maternity and neonatal care at NUH between 2015 and 2022. All were extremely critical of the culture, departmental and consultant behaviour and overall governance of the service. It is therefore clear that the challenges and weaknesses evident throughout our Review were known by service and corporate leaders as far back as at least 2015.

68. The Review identified several Board failings including: significant issues not referred to or discussed by the Board, Board members with insufficient curiosity to challenge and a culture of leaving significant operational issues within sub-committees.

69. Within the Executive team and senior maternity management, there is evidence of decisions not to escalate to the Board and reassurance rather than assurance that problems were being dealt with. With midwifery leaders not having direct access to the Board, there was a disconnect between strategic direction and operational management.

Clinical Governance

70. The Review found evidence of long-standing and systemic failures in maternity governance, characterised by chronic under-resourcing, unclear leadership structures, ineffective governance processes, barriers to escalation, and a failure to learn in a timely way from incidents.

71. The consequences were significant: investigations were delayed, similar incidents recurred, and families experienced prolonged uncertainty and avoidable harm. Staff described burnout, illness, and missed opportunities to improve quality and patient safety.

72. Six previous reviews of maternity governance delivered assessments mirroring those found in this Review, including: consistent evidence of under-reporting and misclassification of incidents, failure to comply with Duty of Candour, inappropriate management of cases outside the SI framework and lack of effective leadership and governance oversight. Governance teams were frequently under-resourced and poorly managed, and staff described low morale and a culture in which concerns were not consistently heard or acted upon.

73. In August 2022 a new national framework for clinical governance was introduced in England, Patient Safety Incident Reporting Framework (PSIRF). Like many other Trusts NUH has struggled to implement PSIRF. In maternity, the policy for including incidents is vague, resulting in under reporting. There has been insufficient workforce capacity to undertake training and investigations, or to participate in learning or reflective practice, with a lack of funding and immature skills hindering the shift to a just culture.

74. Overall, the Review Team found substantial weaknesses in reporting, monitoring, and assurance across national maternity programmes, including the Clinical Negligence Scheme for Trusts requirements and CQC actions. Inconsistent governance processes, combined with cultural barriers led to repeated failures to demonstrate compliance and limited the Trust Board's ability to exercise effective oversight.

Clinical Leadership

75. Staff voices and external reviews point to prolonged periods of maternity leadership instability, fragmented governance arrangements, and a workplace culture which has been characterised by fear, disengagement, and a lack of psychological safety.

76. These clinical leadership challenges across all levels have had significant operational consequences, affecting day-to-day decision-making, staff wellbeing and professional practice. The Review saw evidence of leadership absences during periods of high pressure and after clinical incidents.

77. Since 2021, NUH has implemented deliberate measures to strengthen visible clinical leadership within maternity services.

78. The Review saw evidence that long-standing and chronic workforce shortages placed significant strain on maternity and obstetric services, particularly on labour wards, with staff frequently required to support multiple women in labour. In the neonatal service, staffing shortages led to staff frequently forced to prioritise the most essential tasks over comprehensive care. Across obstetric services, clinical demand continued to exceed available workforce capacity up to 2024. Throughout 2024, obstetric staffing issues were repeatedly escalated to the Board.

79. Staff across the services and previous external reviews reported experiences shaped by long-standing cultural challenges, including hierarchy, bullying (particularly by some labour ward coordinators), nepotism, aggressive behaviour, patterns of inconsistent professional values and poor psychological safety.

80. Work on changing and improving the culture within the maternity service is evident from 2021, when NUH implemented measures to strengthen listening, accountability, and staff engagement. These included regular reviews of Freedom to Speak Up reports, Datix insights, staff surveys, and quarterly Listening Forums led by the Director of Midwifery.

81. Evidence presented through the Review indicates measurable progress in leadership, workforce development, culture, training, and learning. The most recent CQC inspection published in 2026 recognised areas of improvement; however, further work is required to embed these changes and ensure they are sustained.

Addressing Inequalities in Care

82. Nottingham is one of England's most demographically diverse and socio-economically deprived cities. The Review set out to explore how women from Black, Asian, other global majority population groups, women living in deprivation, and other seldom-heard groups were represented in the overall Review cohort.

83. In addition to meeting families within the Review, the Review Team undertook targeted engagement with seldom heard communities.

84. Global majority voices were under-represented within the Review families who felt able to share their stories. From their accounts the following key themes emerged: communication failures; not being believed; cultural misunderstanding; fear, mistrust, and power imbalance; systemic barriers.

85. These factors influenced women's ability to escalate concerns, seek help, and engage fully with care. The experiences of fathers and partners further emphasised the importance of inclusive, family-centred care, particularly during the labour, delivery, and postnatal periods, where exclusion compounded stress and limited effective advocacy for women.

86. From 2012 onwards NUH was aware of negative health experiences and outcomes for women and families from Black, Asian, other global majority population groups, disadvantaged communities, and those with protected characteristics.

87. In 2022, NUH launched an Inclusive Maternity Work programme to address structural inequalities and improve care for women from Black, Asian, and minoritised ethnic backgrounds, and those experiencing social risk.

Concerns that Led to the Review

1. Introduction

Nottingham University Hospitals (NUH) was formed in 2006 through the merger of Queen's Medical Centre (QMC) and Nottingham City Hospital (NCH). During the following 20 years, the Trust's maternity and neonatal services were increasingly scrutinised due to ongoing indications of maternity governance, safety issues and cultural challenges, which were repeatedly raised by staff and external reviewers. Despite multiple internal and external reviews, meaningful change was slow.

What follows is a timeline of events, including high profile clinical cases of harm that ultimately led to the Independent Review into Maternity Services at NUH.

Case Study: Ryan (2007)

In 2007, Ryan Sissons was born without complication. However, his subsequent care was marked by a series of systemic clinical failures. Despite his mother, Sarah, repeatedly raising concerns regarding his inability to feed, her observations were consistently disregarded by medical staff. A critical delay followed; Ryan waited over eight hours for a specialist review by a neonatologist while his condition visibly deteriorated. During this period of inaction he suffered severe hypoglycaemia, leading to seizures that resulted in permanent, irreparable brain damage.

The NUH initially denied liability, necessitating a protracted legal process. It was not until a settlement was reached in 2019 – 12 years after his birth – that the Trust formally acknowledged that timely intervention would have prevented Ryan's life-changing injuries.[1]

2. Early Warning Signals (2010-2014)

From 2010 onwards, a series of indicators began to emerge that pointed to underlying weaknesses in governance, leadership, and organisational culture within NUH. These issues were identified through a combination of internal reporting, regulatory activity and staff feedback.

A confidential internal report in 2012 raised concerns regarding leadership capability and organisational culture at both Board and Executive level. At the same time, the Trust's Board Quality Committee identified a backlog of Serious Incidents (SIs) across the organisation, indicating failings in the timely investigation and resolution of patient safety events. This delay to investigate prevented valuable learning from these incidents, to prevent further harm.

These local concerns developed alongside a growing national focus on patient safety. The publication of the Berwick Safety Review (2013) emphasised the need for openness, learning and system-wide approaches to safety improvement. The principles set out in this Review provide an important context against which NUH's response to emerging concerns can be understood.

Regulatory findings during this period reinforced these concerns. An inspection by the Care Quality Commission (CQC) in November 2013[2] identified NUH as a high-risk Trust. The inspection highlighted midwifery staff shortages, increasing safety problems, and mortality alerts. It also noted that concerns relating to outcomes were not consistently acknowledged within obstetric leadership. Although the

1 NottinghamshireLive. Hospital mistakes left my son with permanent brain damage. The fact he can walk is a miracle. nottinghampost.com. [Online] 29 December 2025. [Cited: 16 03 2026.] https://www.nottinghampost.com/news/local-news/hospital-mistakes-left-son-permanent-10594608

2 CQC 2014 Nottingham University Hospital NHS Trust, Nottingham City Hospital, Quality Report. Available from: https://api.cqc.org.uk/public/v1/reports/e6b18d3f-fabe-44a5-b77f-73f4f90f6323?20210130084636

inspection took place in 2013, the report was not published until July 2014, limiting both the timeliness and effectiveness of external scrutiny.

Alongside formal reporting, staff feedback and whistleblowing from 2014 onwards raised concerns about organisational culture, including the handling of safety concerns and the responsiveness of leadership. These accounts suggested that issues were not only failing to be identified but were not consistently acted upon.

The findings indicated that there were already clear warning signs of systemic weaknesses within the Trust dating back to the early 2010s. While each issue in isolation might not have indicated a system-wide failure, the culmination of issues over time should have prompted earlier and more decisive intervention.

Case Study: Kaiden

In 2013, a teenage mother, following repeated concerns about her baby's movements and bleeding, was informed that her son Kaiden had died intrauterine, just a day before his due date. Not until almost 10 years later, prompted by the Ockenden Independent Review, did Kaiden's mother receive contact from the Trust, identifying issues with her care that might have made a difference and apologising for not sharing this news with her sooner.[3]

3. Escalating Problems and Missed Opportunities (2015–2016)

By 2015, concerns regarding maternity services at NUH had moved beyond early warning signs and were being raised more explicitly within governance structures. Evidence presented to the Trust Board indicated ongoing safety concerns, including workforce pressures, cultural issues, and weaknesses in escalation processes. Despite this, reassurances were provided that clinical outcomes were satisfactory and were operating safely.

During this period, significant concerns were raised regarding staffing levels, particularly in midwifery. It was alleged that preparations for regulatory inspection and a CQC visit[4] had been managed in a way that did not reflect operational realities. This prompted the commissioning of an external review.[5] While this Review identified concerns relating to leadership, culture and workforce pressures, the Trust Board was advised that there were 'no issues with practice and clinical outcomes are good'.[6] As a result, the urgency and scale of response did not reflect the seriousness of the concerns raised.

Case Study: Felicity

In 2015, during a complex caesarean section involving an invasive placenta, Felicity Benyon underwent an inadvertent cystectomy, resulting in permanent, life-altering injuries. The subsequent investigation and incident management lacked transparency and failed to accept accountability. It was not until 2017 that the Trust provided a formal apology.[7]

At a national level, this period coincided with the publication of significant maternity and patient safety reports, including the Morecambe Bay Investigation (2015) and Better Births (2016). These reports emphasised the importance of culture, multidisciplinary working, and learning from incidents. However,

3 BBC. NHS trust apology after boy's stillbirth in 2013. www.bbc.co.uk. [Online] BBC, 2018 October 2024. [Cited: 16 03 2026.] https://www.bbc.co.uk/news/articles/cj31d77v617o

4 Quality Assurance Committee (QuAC) Meeting held on 21 October 2015 – Confidential appendix one [internal document]

5 NUH, Maternity service – external review action plan, June 2016, internal document

6 Quality Assurance Meeting Minutes of meeting held on 20 July 2016, internal document

7 Nottingham Post. Nottinghamshire mum told 'we saved you' after bladder accidentally removed in C-section. www.nottinghampost.com. [Online] 21 Sept 2023. https://www.nottinghampost.com/news/nottingham-news/nottinghamshire-mum-told-we-saved-8760939

evidence suggests that these reports were not fully embedded within NUH. The Board were advised that there were no concerns at NUH and that there was a strong multidisciplinary team. While such assurances may have been intended to promote confidence, they contributed to a reduced sense of urgency and inhibited critical and timely examination of underlying issues.

Financial constraints were identified as a barrier to addressing workforce shortages, particularly in relation to medical staffing. While these constraints provide context, they do not fully account for the lack of sustained action in response to known workforce issues. It is suggested that structural and cultural factors, including reliance on reassurance and limited challenge within governance processes, played a significant role in delaying effective intervention.

Case study: Harriet Hawkins

In April 2016, Harriet Hawkins was stillborn after her parents, Sarah and Jack, both healthcare professionals at the Trust themselves, were repeatedly prevented from receiving the essential care they needed during an obstructed labour that had been misdiagnosed as the 'latent phase'. Harriet's avoidable death was compounded by a systemic cover-up and investigations designed to mislead, which took a profound toll on the couple's wellbeing. Their fight for the truth became a watershed moment, revealing a dangerous lack of transparency and a total breakdown in hospital governance. This became the patient safety catalyst for the Nottingham Maternity Review. (See also 'Exemplar Case' chapter)•*

During this period of time, there were a multitude of missed opportunities for the Trust to respond decisively to emerging concerns. Risks had been identified through internal reporting, external review, and national learning; yet the organisational response did not provide the changes required to prevent subsequent harm.

4. Leadership Instability and Escalating External Scrutiny (2017-19)

By 2017, significant concerns regarding maternity services at NUH prompted both leadership change and increased external scrutiny. This period was characterised by organisational instability, continued governance weaknesses, and growing evidence of earlier unresolved concerns.

In 2017, both the Chief Executive Officer and the Chair resigned, following a critical Well-Led Review (2017) led by the CQC. This Review identified concerns related to leadership, governance and organisational culture across the Trust. Internal reports identified major weaknesses in maternity governance, with escalating concerns from the Clinical Commissioning Group (CCG) and NHS England (NHSE), leading to further independent scrutiny. Although some improvements were reported, there is limited evidence that these resulted in sustained or embedded change. Several babies died or suffered harm during this period, with incidents often revealing recurring themes: delayed escalation, poor monitoring, and insufficient staffing.

Changes to senior leadership occurred but the underlying concerns persisted. After the external investigator for the Hawkins' case was appointed as Director of Midwifery for NUH, the credibility and question of a conflict of interest were raised, which risked undermining confidence among families and staff.

Staff concerns raised during this period increased. In 2018, 50 maternity staff submitted a formal letter to the Trust Board Chair, raising concerns about staffing levels and patient safety, which represents a significant escalation from reporting to the leadership team. The Trust CEO has confirmed that these concerns were not addressed appropriately. Alongside this internal development, the Trust faced increasing external pressure relating to performance, safety and financial sustainability.

By 2019, NUH was at risk of being placed into special measures. Maternity services were unable to meet key requirements of the NHS Resolution and Maternity Incentive Scheme, particularly in relation to

• NB: Note 'latent phase of labour' is a term that the Hawkins family believe was wholly misused in their care and the significant role this misuse played in Harriet's death. The term is used throughout the Report for professional understanding only as this is a recognised term described in NICE guidance.

workforce and governance standards. This failure to meet nationally defined safety actions provides further evidence of systemic weakness in governance and assurance.

Crucially, this period was marked by the reappearance of SIs with recurrent themes. As highlighted in the following case reviews, there were issues with delayed escalation, failure to recognise clinical deterioration, inadequate monitoring, and insufficient staffing, which are repeated throughout.

Case study: Baby Ladybird (2019)

Carly Wesson and Carl Everson were incorrectly advised to terminate their pregnancy at NUH in 2019. Subsequent investigations revealed their daughter 'Ladybird' was a healthy baby. The lifelong psychological trauma for this family is immeasurable. For Carly and Carl, the weight of their loss is inseparable from the fact that the decisions made were based on misinformation. The subsequent SI process was flawed, with inaccurate findings. The Trust was required to repeat the investigation due to the significant errors found within the initial report.[8]

Later that year:

Case study: Baby Kouper Needham (2019)

Baby Kouper Needham died at home aged one day. Concerns were raised by his family regarding feeding difficulties, but his clinical condition and the concerns of his parents were not acted upon. Subsequent review identified issues in postnatal care, including inadequate clinical assessment and lack of escalation. His family's concerns about his colour and poor feeding were repeatedly dismissed by midwives prior to his death. The family's trauma was worsened when harrowing post-mortem photos of Kouper were sent to them at home without warning.[9]

Less than two months later:

Case study: Wynter Andrews (2019)

The death of Wynter Andrews on 15 September 2019 was described by HM Coroner as a 'clear and obvious case of neglect' resulting from a 'catalogue of failings' by the NUH. A major factor in the case was the misdiagnosis of the latent phase of labour. Consequently, Sarah, Wynter's mother did not receive the required one-to-one care or the level of medical attention that her high-risk labour required. HM Coroner ruled that if Wynter had been delivered earlier, her death would have likely been avoided.[10]

The events from 2017 to 2019 demonstrate a system under increasing strain. Leadership instability, ongoing governance weaknesses, and repeated safety concerns combined to create an environment in which risks were known but not effectively mitigated. The failure to respond adequately to family and staff concerns, external scrutiny, and recurring incidents signifies significant escalation from the missed opportunities identified in earlier years.

5. Crisis Point and National Intervention (2020-2021)

By 2020, concerns regarding maternity services at NUH had escalated to a level requiring rigorous external investigation. The COVID19 pandemic placed additional strain on an already challenged service. However,

8 BBC. Couple believe law was broken in abortion sign-off. www.bbc.co.uk. [Online] 16 February 2025. https://www.bbc.co.uk/news/articles/cpwxp-zn4e9go

9 Nottinghampost. Nottinghamshire parents sent 'harrowing' photos of dead baby's autopsy in error. www.nottinghampost.com. [Online] 23 Aug 2024. https://www.nottinghampost.com/news/local-news/nottinghamshire-parents-sent-harrowing-photos-9502396

10 BBC. 'Obvious neglect' in baby's death at Queen's Medical Centre. www.bbc.co.uk. [Online] 7 October 2020. https://www.bbc.co.uk/news/uk-england-nottinghamshire-54452810

while the pandemic provides important context, the evidence indicates that many of the issues identified during this period were long-standing and predated this.

The Health Safety Investigation Branch, now Maternity and Newborn Safety Investigations raised concerns relating to stillbirths, safety culture, and the application of Duty of Candour within NUH maternity services in 2020. In response, the Trust developed a Maternity Safety Transformation Plan. However, subsequent regularity assessments by the CQC rated maternity services as 'inadequate', and in October 2020, NUH was placed on the NHSE Maternity Improvement Programme, reflecting the level of concern at a national level.

Case study: Edward 'Teddy' Errington-Rozkalns

Edward 'Teddy' Errington-Rozkalns died at one day old in November 2020 following failures to recognise the need for hypoglycaemia screening. An inquest in 2021 identified that multiple healthcare professionals did not recognise the clinical indicators requiring investigation. While the precise cause of death could not be definitively determined, the Assistant Coroner identified 'undoubted failings' in care.[11]

In December 2020, the Ockenden Independent Review of Shrewsbury and Telford Emerging Concerns Report was published, outlining seven immediate and essential actions, aimed at improving safety. These actions focused on listening to families, facilitating multidisciplinary training, managing complex care, conducting ongoing risk assessments, appointing specialised fetal monitoring leads, and ensuring informed consent.[12]

During 2020 and early 2021, additional CQC inspections,[13,14] a Well-Led Review,[15] and NHS Staff Survey results[16] identified ongoing systemic cultural concerns within NUH maternity services, including bullying, racism, suboptimal leadership, and ineffective governance. Both CQC reports rated the maternity services as 'inadequate'.

This was followed in September 2021 by the Trust's inclusion in the National Recovery Support Programme after the issuance of a Section 29A warning notice. This formal intervention is reserved for organisations requiring significant improvement to ensure patient safety and quality of care.

Leadership instability continued during this period. In May 2021, the Chief Executive left the Trust and an interim Chief Executive was appointed. At the same time, turnover in senior midwifery and nursing roles remained high, further limiting organisational stability and continuity.

External scrutiny intensified further in October 2021, as NHSE and NHS Improvement (NHSI), together with the Nottingham and Nottinghamshire CCG, commissioned an initial thematic review into maternity services at NUH. This marked a transition from internal and regional oversight to an independent review process.

Crucially, this period was also marked by a number of SIs and deaths in which failings in care were identified as contributory. These events, and the Trust's handling of them, attracted significant regulatory and legal attention.

The events between 2020 to 2021 indicated that maternity services at NUH had reached a point of systemic failure. Concerns were no longer limited to internal reporting or isolated incidents, but were reflected consistently across regulatory findings, national investigation bodies, and formal oversight mechanisms.

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11 BBC. Undoubted failings' by Nottingham hospitals trust in baby death. www.bbc.co.uk. [Online] 22 October 2021. https://www.bbc.co.uk/news/uk-england-nottinghamshire-59016685

12 Ockenden, Donna. Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust; Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. www.gov.uk. [Online] 10 December 2020. https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

13 CQC (2020) Nottingham City Hospital; Summary of findings. Available from: https://api.cqc.org.uk/public/v1/reports/db48200b-a62a-4386-9e3d-b0ef95e4be5c?20210112181725

14 CQC (2021) Nottingham City Hospital; Inspection report. Available from: https://api.cqc.org.uk/public/v1/reports/8f90eb71-85af-4d3f-9b2c-a77e18ec5e03?20221129062700

15 CQC September 2021, Nottingham University hospitals NHS Trust Inspection report

16 NUH Family Health Division, Obstetrics & Gynaecology + Fertility, National Staff Survey 2020, March 2021; [Internal document]

Case studies: (2021)

Between April and July 2021, three babies died while under the care of NUH. In each case, failings in care were identified as contributory. These cases resulted in a landmark prosecution by the CQC, marking a significant escalation in regulatory response. The handling of these cases also raised concerns regarding transparency and engagement with families. HM Coroner described the Trust as 'obstructive' in relation to delays in disclosing evidence, compounding the distress experienced by families.[17,18]

6. Challenge to Oversight and Loss of Confidence (2022)

By 2022, concerns regarding maternity services at NUH had progressed beyond questions of performance and safety. A broader loss of confidence was noted in the Trust and regional oversight structures' ability to respond effectively. This period was characterised by escalating concerns from families, continued regulatory intervention, and recognition that existing review processes were insufficient.

Throughout 2022, progress towards required improvements was widely regarded as too slow. Regulatory bodies, including the CQC and NHSI issued further enforcement actions, reflecting ongoing concerns regarding safety, staffing and governance. Significant staffing gaps remained, including a midwifery deficit exceeding 120 whole-time equivalent, together with a shortage of obstetricians that continued to affect the service's ability to deliver safe care. Reviews and staff feedback continued to identify issues, including bullying, poor behaviours, and a lack of effective learning from incidents, suggesting that despite the scale of external scrutiny, these cultural and governance challenges had not yet been resolved.

A defining feature of this period was the increasing organisation and mobilisation of affected families. In April 2022, approximately 100 families wrote to the Secretary of State for Health and Social Care, the Rt Hon Sajid Javid MP, expressing a lack of confidence in the existing regionally-led review of maternity services. Families described the process as 'insufficiently independent' and 'not fit for purpose'.

In response to these concerns, NHSE's national team terminated the existing review and appointed Donna Ockenden in May 2022 to lead a new, fully independent, external inquiry into maternity services at NUH. This Review commenced on 1st September 2022 and the decision represented a significant escalation; indicating that prior mechanisms for review and improvement were no longer considered adequate.

Leadership changes during this period sought to stabilise the organisation. A new Director of Midwifery was appointed in July 2022, followed by the appointment of a permanent Chief Executive in September 2022. While these appointments were important in establishing new leadership, they occurred within the context of significant organisational change and did nothing to raise confidence among families and staff.

Wider national context reinforced the seriousness of the issues identified. The publication of *Reading the Signals*[19] highlighted systemic failures in maternity services elsewhere in England, emphasising the importance of listening to families, strengthening multidisciplinary working and improving transparency. The parallels between these findings and concerns raised at NUH are notable.

The events of 2022 represent a critical transition from 'crisis' to 'loss of legitimacy' within NUH. The commissioning of an independent national review marked the recognition that more fundamental scrutiny and system-wide examination were required.

17 BBC. Quinn Parker: Mother of dead baby 'suffered bleeding days before'. www.bbc.co.uk. [Online] 26 April 2022. https://www.bbc.co.uk/news/uk-england-nottinghamshire-61234268

18 BBC. Troubled NHS trust pleads guilty in baby deaths case. www.bbc.co.uk. [Online] 10 February 2025. https://www.bbc.co.uk/news/articles/cx-2ylngp7r5o

19 Kirkup, B. Reading the signals: Maternity and neonatal services in East Kent - the report of the independent investigation. www.gov.uk. [Online] 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

7. Early Signs of Improvement under Sustained Scrutiny (2023–2024)

By 2023, there were indications that maternity services at NUH were beginning to demonstrate improvement. These developments followed a prolonged period of external scrutiny, leadership change, and regulatory intervention. While these improvements are important to recognise, they must be understood within the context of long-standing and systemic failures, the impact of which continued to be felt by families and staff.

CQC inspections during this period reported early signs of success,[20] including improvements in compassionate care and a clearer organisational commitment to improve. The overall maternity rating moved from 'inadequate' to 'requires improvement', indicating that progress was being made, although significant concerns remained.

The Trust also began to acknowledge more openly the scale and duration of previous failings. Public statements included apologies to affected families, including the family of Wynter Andrews; recognising deficiencies in care and failings in the handling of investigations. This shift towards greater transparency is consistent with national expectations regarding candour and organisational learning.

Concurrently, consequences continued to be realised through legal and regulatory processes. In 2023, NUH was fined £800,000 following prosecution by the CQC in relation to failings in maternity care.[21] The Court recognised the need to balance financial penalties for a public funded organisation with the importance of accountability and deterrence.

Operational and structural improvements were also reported. These included updates to clinical guidelines, efforts to address workforce gaps and investment in maternity and neonatal services, including fetal medicine and neonatal facilities. Staff engagement and communication mechanisms were described as improving, with greater emphasis on learning from incidents and supporting multidisciplinary learning.

In 2024, further regulatory activity highlighted both progress and ongoing risk. Section 29(a) enforcement notices for maternity and leadership were lifted, indicating improvement in key areas. However, subsequent CQC inspections conducted in June and July 2024 identified seven regulatory breaches, demonstrating that risks to safety and quality had not been fully mitigated. Delays in the communication of inspection findings from the CQC limited the Trust's ability to respond in a timely manner, further complicating the improvement process.

8. Legal Accountability and Police Investigation (2025)

By 2025, the long-standing concerns regarding maternity services at NUH had progressed into a phase characterised by formal legal accountability and ongoing investigation. These developments represented a significant escalation beyond regulatory oversight and organisational review, reflecting the seriousness and duration of the failures identified.

In February 2025, the Trust pleaded guilty to six charges brought by the CQC,[22] relating to failures to provide safe care and treatment to three mothers and their babies (Quinn Parker, Adele O'Sullivan and Kahlani Rawson). These charges concerned cases from 2021 in which failings in care had been identified as contributory to the outcomes. The court imposed a total financial penalty of £1,667,944.

These proceedings mark a critical point in the history of the Trust, demonstrating that the issues identified

20 CQC Nottingham Universities Hospitals NHST Trust inspection report 2023, Available from: https://api.cqc.org.uk/public/v1/reports/9fe0ae-ba-f8b2-4364-83b2-aacab4c632d2?20231121142743

21 BBC. Wynter Andrews: NHS trust fined £800k over baby's neglect death. www.bbc.co.uk. [Online] 27 January 2023. https://www.bbc.co.uk/news/uk-england-nottinghamshire-64422598

22 CQC Press Release 13 February 2025. www.cqc.org.uk/press-release/cqc-prosecutes-nottingham-university-hospitals-nhs-trust-after-it-failed-provide-0

were not solely matters of internal governance or regulatory concern, but had reached the threshold for criminal liability. The guilty pleas provide formal legal recognition of failures in care over an extended period.

In parallel, the ongoing police investigation, known as Operation Perth, continued to examine evidence relating to maternity services at NUH. Evidence was found that indicated the existence of deleted records, which raises concerns regarding record-keeping, transparency, and the integrity of governance processes. The police confirmed that their investigation includes consideration of potential incidents of corporate manslaughter, along with other serious offences. This represents an unprecedented level of scrutiny in relation to maternity services within the NHS and reflects the gravity of the concerns identified.

These developments must be understood within the broad context of the Review. Over many years, repeated warnings were raised by staff, families, regulators, and external reviewers. Opportunities for learning and improvement were identified but not consistently acted upon. The progression to legal accountability and criminal investigation in 2025 is the culmination of long-standing and systemic failures.

9. Summary

The chronology set out in this chapter demonstrates that the concerns leading to the commissioning of this Review developed over many years in the presence of repeated warning signs.

From as early as 2007, indicators of risk were identified through internal reporting, SIs, regulatory inspection, and staff feedback. These included concerns relating to leadership, organisational culture, incident management, and workforce capacity. While each of these issues might initially have appeared manageable in isolation, their persistence and convergence over time pointed to more chronic systemic weaknesses.

During the period 2015 to 2016, these early warning signals were accompanied by clear opportunities for intervention. Concerns were formally raised within governance structures, external reviews identified issues in leadership and culture, and national reports, including the Morecambe Bay Investigation (2015) and Better Births (2016), set out explicit expectations for improvement. However, the response at organisational level was characterised by reassurance rather than critical challenge, limiting the extent to which meaningful change was achieved.

Between 2017 and 2019, concerns became more explicit and more urgent. Leadership instability, increasing external scrutiny, and formal escalation by staff reflected a system under growing strain. Despite this, there is limited evidence that governance processes were sufficiently robust to ensure that risks were effectively identified, escalated, and mitigated. The recurrence of SIs during this period demonstrates that learning was not consistently embedded in practice.

By 2020 and 2021, these issues had reached a point of systemic failure. Regulatory bodies, including the CQC, and national investigation organisations such as the Healthcare Safety Investigation Branch, identified serious and persistent concerns relating to safety, leadership, and culture. The escalation to national intervention, including inclusion in the Maternity Improvement Programme and the National Recovery Support Programme, reflects the severity of the situation.

In 2022, the focus of concern broadened to encompass the effectiveness and credibility of oversight processes themselves. Families expressed a lack of confidence in existing review mechanisms, leading to the termination of the initial regional review and the commissioning of an independent inquiry led by Donna Ockenden. This represents a significant loss of confidence in the ability of local and regional systems to provide adequate scrutiny and assurance.

The period from 2023 onwards shows early signs of improvement, including strengthened leadership, enhanced regulatory ratings, and greater openness in acknowledging past failings. However, these developments are recent and remain fragile, taking place in the context of long-standing systemic issues and ongoing external scrutiny.

By 2025, the progression of events had reached a point of formal legal accountability. Guilty pleas entered by the Trust in response to charges brought by the CQC, together with the ongoing police investigation (Operation Perth), represent an unprecedented level of scrutiny. These developments reflect not only the seriousness of individual cases, but the cumulative impact of failures over an extended period.

The various reviews and reports within NUH revealed a pattern of:

- repeated warnings that were not acted upon in a sustained or effective manner
- failure to embed learning from incidents and reviews
- cultural and structural barriers to escalation and transparency
- chronic workforce pressures affecting safety and governance
- limitations in organisational and system-level oversight

The consequences were significant. Women and babies experienced avoidable harm, families were not consistently informed or involved in a timely way, and staff reported working within systems that did not adequately support safe practice or open escalation.

While recent improvements are acknowledged, they follow a prolonged period during which earlier intervention may have mitigated harm. The events described in this chapter therefore provide the essential context for the findings and recommendations that follow.

Nottingham University Hospitals NHS Trust – Background Information

Nottingham University Hospitals NHS (NUH) Trust was formed on 1 April 2006 through the merger of Nottingham City Hospital and Queen's Medical Centre (QMC) NHS Trusts. NUH currently serves over one million individuals annually at Nottingham City Hospital, QMC, Ropewalk House, and within the community. With over 19,000 employees and 750 volunteers, NUH is the largest employer in Nottinghamshire and ranks among the biggest and busiest NHS Trusts nationwide, operating with an annual budget of £1.7 billion.

As a specialist centre for a range of national and international services, including stroke, renal, neurosciences and cancer services, NUH cares for people from across the East Midlands and beyond.

The Trust delivers acute hospital services across three primary locations:

- QMC serves as the principal acute facility, housing the Emergency Department, Major Trauma Centre, Nottingham Children's Hospital, and both maternity and neonatal units. Additionally, QMC accommodates the University of Nottingham's School of Nursing and Medical School.
- Nottingham City Hospital specialises in planned care and the management of long-term conditions, including the Cancer Centre and Cardiac Centre, as well as maternity and neonatal units.
- Ropewalk House offers a range of outpatient services, such as diabetic eye screening, audiology, and breast screening.

Furthermore, NUH extends certain services into the community and is scheduled to launch the National Rehabilitation Centre (NRC) in Spring 2026. This will be the country's first NHS NRC and will create a 70-bed purpose-built facility close to the Defence Medical Rehabilitation Centre.

Since c2014 the Trust has faced a number of challenges including:

- Increasing inability to cope with ED demand
- Rising annual deficit
- Failed outsourcing of estates and facilities services
- Problematic transition to a new digitalised patient system
- Discontinuation of merger with neighbouring Sherwood Forest Trust

This has been reflected in declining CQC ratings which from 2013-2019 were overall 'Good' for the whole Trust, and since 2021 have been overall Requires Improvement, with a S29A[23] warning notice issued in 2021 in respect of leadership, risk, governance and culture, all of which were deemed to require significant improvement. The S29A warning notice was removed following the 2023 inspection.

In 2018 NUH was the setting for the third series of the BBC documentary 'Hospital'.

Over the period of this Review (11 January 2012 to 31 May 2025) NUH has had three substantive and one interim Chief Executive, three Medical Directors, four substantive and two interim Directors of Nursing and four substantive and three interim Directors of Midwifery.

23 The Care Quality Commission (CQC) issues this formal notice to NHS Trusts when an inspection identifies a need for 'significant improvement' in the quality of healthcare provided. It sets a strict legal deadline for compliance. If the Trust fails to address the specified concerns within the given timeframe, the CQC can escalate enforcement action, which may include: restricting or suspending services, cancelling the provider's registration, recommending the Trust be placed into Special Measures (now often referred to as 'oversight' under the NHS System Oversight Framework) https://www.cqc.org.uk/guidance-regulation/providers/enforcement/section-29a-warning-notices-nhs-trusts-and-nhs-foundation-trusts

Maternity Services Provided by NUH

The Maternity Service at NUH ranks as the sixth largest nationally. The 2006 merger created a maternity service based on two sites, with two neonatal units; however, community midwifery services remained organised and managed by the PCT until 2013.

The current provision includes consultant-led care, midwifery-led care, and specialised feto-maternal services as well as neonatal services at both City Hospital and QMC. Notably, the fetal medicine service was relocated to the QMC site in October 2024.

Nottingham City Hospital currently provides a range of maternity services and has inpatient antenatal, intrapartum and postnatal beds available for women.

- The facility comprises two wards: Lawrence Ward, which accommodates 27 mixed antenatal and postnatal beds, including designated beds for neonatal transitional care; and Bonnington Ward, an 18-bed mixed antenatal and postnatal ward
- Bonnington Ward includes a dedicated four-bed bay for induction of labour
- The labour ward offers 13 beds and is equipped with two obstetric theatres, supported by 24-hour anaesthetic coverage.
- The Sanctuary Birth Centre is a separate midwife-led unit with four beds
- A bereavement suite is available
- Direct access to the neonatal unit is provided
- There is a five-bed combined maternal and fetal surveillance triage unit, where urgent care is offered to women outside their routine clinical appointments
- A distinct Day Assessment Unit is available for scheduled appointments

The **QMC** offers comprehensive maternity services, including inpatient antenatal, intrapartum, and postnatal care. The fetal medicine service is located on the QMC campus.

- There are two dedicated wards: Ward B26 serves as an 18-bed antenatal unit, while Ward C29 provides 26 postnatal beds, including transitional care cots
- The labour ward accommodates nine women in labour, with an additional four observation beds and an induction of labour ward
- Facilities include two obstetric theatres with 24-hour anaesthetic coverage
- A separate four-bed midwife-led unit known as the Sanctuary Birth Centre
- A bereavement suite
- A standalone triage unit featuring a three-bed triage room and a separate assessment space equipped with two trolleys
- The Day Assessment Unit, located on B26, comprises four beds
- Six lodging rooms are also available for parents with infants admitted to the Neonatal Unit on B26

Community midwifery services are distributed among fifteen teams and bases throughout Nottingham City and Nottinghamshire. Alongside these geographically organised services, there are also specialist community midwifery teams dedicated to areas such as adolescent care, alcohol and substance misuse, mental health, homelessness, and domestic abuse support.

Since 25 March 2024, there is a separate home birth team supporting women who choose to birth at home 24 hours a day. This follows a period of time where the homebirth service became a partial service from April 2020 during the Covid 19 pandemic but suspended from 16 January 2024 following safety concerns.

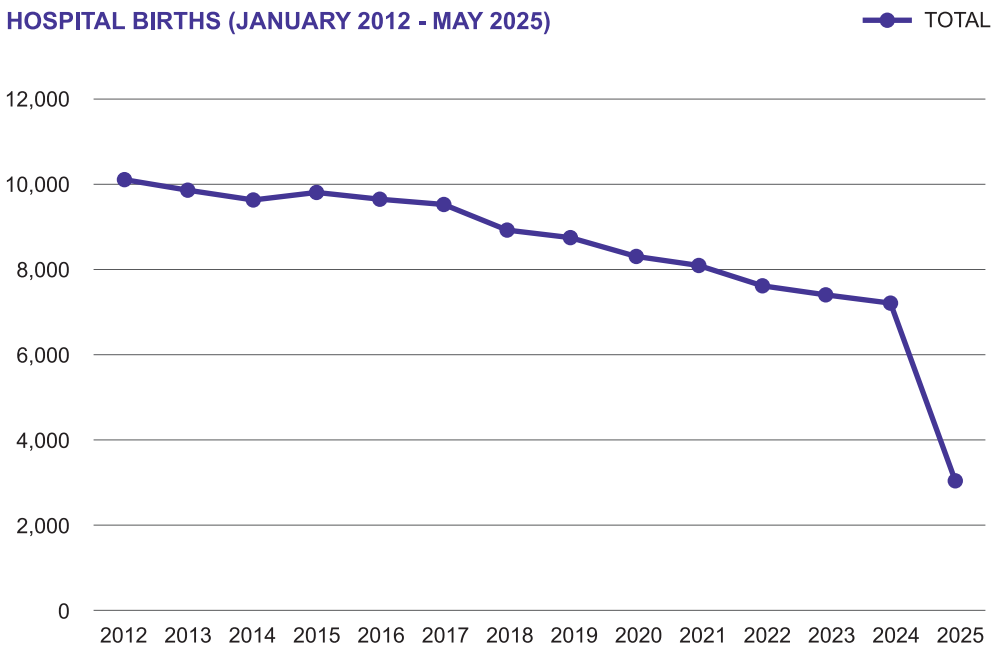
Birth Rate

The number of registrable births (live and stillbirths) at NUH hospital sites from 01 January 2012 to 31 December 2025 is summarised in Table 1 and represented in Diagram 1 below:

Table 1: Number of registrable (live and stillbirths) at NUH hospital sites

YEAR	BIRTHS TOTAL
2012	10,097
2013	9,856
2014	9,638
2015	9,812
2016	9,667
2017	9,522
2018	8,937
2019	8,728
2020	8,301
2021	8,082
2022	7,619
2023	7,393
2024	7,218
2025	7,152
TOTAL	**122,022**

Diagram 1: Hospital Births



Delivery Rate

The number of babies born at more than 22 weeks gestation at NUH hospital sites from 01 January 2012 to 31 December 2025 is summarised in Table 2 and represented in Diagram 2.

Table 2: Number of babies born at more than 22 weeks gestation at NUH hospital sites

YEAR	BABIES TOTAL
2012	9,929
2013	9,720
2014	9,491
2015	9,684
2016	9,508
2017	9,371
2018	8,789
2019	8,596
2020	8,185
2021	7,975
2022	7,508
2023	7,307
2024	7,193
2025	7,150

Demographics (Ethnicity, Age and Deprivation)

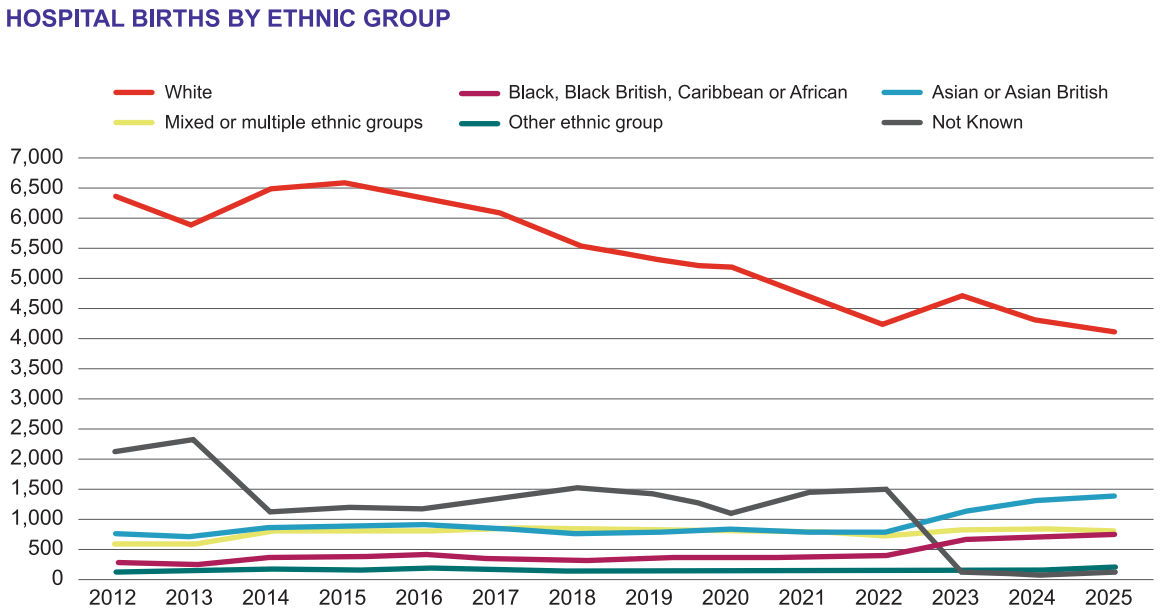
Ethnicity of Mothers

Table 3 shows the registerable births (live and stillbirths) at NUH hospital sites from 01 January 2012 to 31 December 2025 by ethnicity group. This has further been represented in Diagram 3.

Table 3: Registerable births (live and stillbirths) at NUH hospital sites by ethnicity group

YEAR	BIRTHS TOTAL	ETHNIC GROUP					
		White	Black, Black British, Caribbean or African	Asian or Asian British	Mixed or multiple ethnic groups	Other ethnic group	Not known
2012	10,097	6313	265	730	561	125	2103
2013	9,856	5876	251	691	583	142	2313
2014	9,638	6459	325	828	754	166	1106
2015	9,812	6552	342	859	754	134	1171
2016	9,667	6340	382	882	758	166	1139
2018	8,937	5531	292	732	788	124	1470
2019	8,728	5304	341	776	764	137	1406
2020	8,301	5167	362	807	753	126	1086
2021	8,082	4687	342	758	758	125	1412
2022	7,619	4173	376	771	689	120	1490
2023	7,393	4694	645	1087	766	133	68
2024	7,218	4243	707	1310	791	121	46
2025	7,152	4067	719	1364	753	179	70

Diagram 2: Registerable Births (Live and Stillbirths) at NUH Hospital Sites by ethnicity group



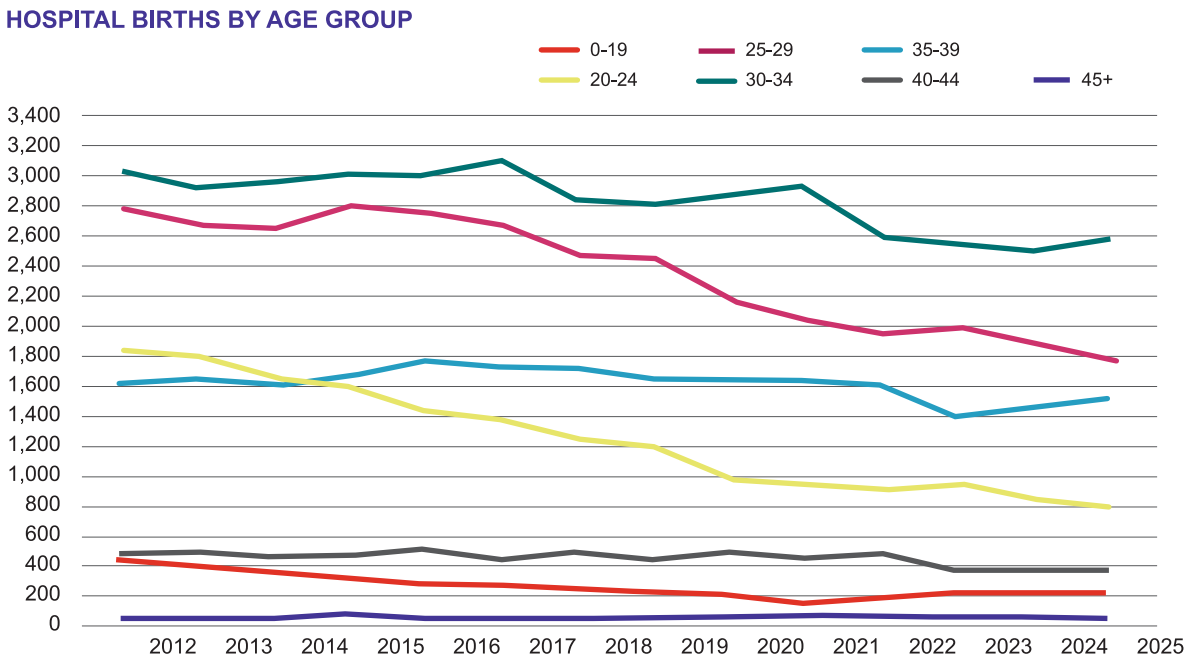
Age Group of Mothers

Table 4 presents registerable births (including both live births and stillbirths) at NUH hospital sites from 1 January 2012 to 31 December 2025, categorised by maternal age group. Diagram 4 further illustrates these findings.

Table 4: Registerable births (live and stillbirths) at NUH hospital sites categorised by maternal age group

YEAR	BIRTHS TOTAL	MATERNAL AGE BANDINGS						
		0-19	20-24	25-29	30-34	35-39	40-44	45+
2012	10,097	408	1824	2772	3002	1637	424	30
2013	9,856	364	1783	2664	2907	1662	446	30
2014	9,638	335	1649	2643	2936	1622	426	27
2015	9,812	304	1578	2779	3001	1684	426	40
2016	9,667	260	1421	2745	2982	1780	447	32
2017	9,522	248	1364	2654	3090	1733	405	28
2018	8,937	231	1245	2457	2804	1730	437	33
2019	8,728	199	1178	2448	2799	1674	394	36
2020	8,301	187	968	2153	2855	1660	440	38
2021	8,082	136	906	2026	2906	1651	419	38
2022	7,619	168	871	1927	2574	1606	438	32
2023	7,393	203	929	1972	2545	1402	303	30
2024	7,218	207	832	1878	2500	1465	309	22
2025	7,152	179	783	1760	2561	1512	324	29

Diagram 4: Registerable births (live and stillbirths) at NUH hospital sites categorised by maternal age group



Indices of Deprivation

Postcode data is recorded at the individual level for registerable births (including both live births and stillbirths) occurring at NUH hospital sites from 01 January 2012 to 31 December 2025.

Table 5 presents the number of registerable births at NUH hospital sites, specifying individuals whose home postcodes are NG, DE, LE, or other areas, from 01 January 2012 to 31 December 2025.

Table 5: Number of registerable births at NUH hospital sites specified by home postcodes

YEAR	BIRTHS TOTAL	HOME LOCATION				
		Nottingham (shire)	Derby	Leicester	Other	Not in Nottingham (shire)
2012	10,097	8976	545	445	131	11.1%
2013	9,856	8765	552	402	137	11.1%
2014	9,638	8573	519	412	134	11.0%
2015	9,812	8719	508	462	123	11.1%
2016	9,667	8649	427	485	106	10.5%
2017	9,522	8545	444	436	97	10.3%
2018	8,937	7942	455	419	121	11.1%
2019	8,728	7778	399	411	140	10.9%
2020	8,301	7369	420	390	122	11.2%
2021	8,082	7181	403	375	123	11.1%
2022	7,619	6793	375	339	112	10.8%
2023	7,393	6756	348	223	66	8.6%
2024	7,218	6565	319	262	72	9.0%
2025	7,152	6512	346	229	65	8.9%

Conclusion

In summary, Nottingham University Hospitals NHS Trust is one of the largest and most complex maternity providers in England, delivering care to a diverse population across multiple hospital and community settings. Over the period covered by this Review, the Trust has experienced substantial organisational, operational, and leadership challenges, including pressures relating to emergency demand, financial sustainability, digital transformation, and regulatory scrutiny. These challenges have occurred alongside significant changes within maternity services, including service reconfiguration, evolving models of community provision, and fluctuations in leadership across senior clinical and managerial roles.

The maternity service itself provides a broad spectrum of specialist and tertiary care, supporting women and babies with both routine and highly complex needs across Nottingham City Hospital, Queen's Medical Centre, and community services. The demographic profile of the population served reflects increasing ethnic diversity, varying levels of deprivation, and changing maternal age patterns, all of which have implications for service demand, equity of access, and clinical risk. At the same time, birth rates and delivery numbers have shown a sustained decline over the review period.

This background context is important in understanding the environment in which maternity care at NUH has been delivered. The scale, complexity, and sustained pressures within the organisation provide essential context for the findings and themes explored throughout this Review.

Methodology

How We Approached this Review

1. Background

The Independent Review into Maternity Services at Nottingham University Hospitals NHS Trust (NUH), chaired by Donna Ockenden, was commissioned by NHS England (NHSE) in May 2022. The circumstances leading to the Review are covered in Chapter 8.

The Review had three key workstreams:

- To provide an independent clinical review of all known cases of loss, damage or harm experienced during maternity and neonatal care delivered by NUH between 2012 and 2024 to determine whether the quality of care provided had any impact on the outcomes experienced;
- To listen to, engage with and give voice to the experiences of the families who had experienced loss, injury or harm, both during their maternity and neonatal journey and subsequently;
- To collect and analyse information from the Trust itself, its staff and external stakeholders about the context and circumstances in which maternity and neonatal care was delivered over this period.

2. Independent Clinical Review

A multidisciplinary Clinical Review Team comprising clinical specialists and governance experts was sourced through the NHS Procurement Framework. A secure data platform and established data protocols were inherited from The Review of Maternity Services at Shrewsbury and Telford[24].

While the Review encompassed the period January 2012 to May 2025, it also included families outside this timeframe, among them 103 families who had participated in the previous NHSE and local clinical commissioning group thematic review that was subsequently abandoned.

Initially an open book opt-in methodology was implemented. The Trust contacted families within the ToR, providing them the opportunity to participate in the Review. 1,375 families were initially contacted and 328 responded positively.

The review Team expressed concern that the opt-in nature of participation was proving a barrier to inclusion and transitioned to an opt-out methodology, whereby all cases meeting the ToR were automatically included, unless families specifically asked to be excluded. At the conclusion of the Review, participation had risen to 2,536 families with 88 families choosing to opt out (3.5%) [See Table 1]. With some families having more than one case to review, the total cases reviewed were 2,511. These improvements have contributed to enhanced data reliability and strengthened the relevance of findings to the local population.

An additional 556 families contacted the Review to share their experiences. While many of these cases did not meet the ToR for formal inclusion, their perspectives were considered valuable to understanding the issues at NUH. Of these, 533 families consented to have their stories included in a thematic analysis [Family and Maternity Experiences]. This self-selecting group gave greater insight into the nature of care experienced at NUH even when outcomes did not meet the ToR.

24 https://assets.publishing.service.gov.uk/media/624332fe8fa8f527744f0615/Final-Ockenden-Report-web-accessible.pdf

Table 1: Family Cohorts and Timing of Entering the Review [Not including cases entering Review via alternative routes]

COHORT	NUMBERS	OPT OUT	RUNNING TOTAL
Previous review families	99	0	99
Open books 1, 2 and 3	1093	50	1142
Open book 4	86	3	1225
Open book 5	49	2	1272
Open book 6	23	1	1294
Open book 7	8	0	1302
Open book 8	12	0	1314
Open book 9	10	1	1323
Open book 10	10	1	1332
Open book 11	12	0	1344
Open book 12	16	1	1359
Open book 13	7	0	1366
Open book 14	7	0	1373
Open book 15	9	0	1382
Open book 16	2	0	1384
Open book 17	3	0	1387
Extended Open Book Neonatal	281	17	1651
Extended Open Book Stillbirths	28	6	1673
Totals	**1755**	**82**	**1673**

3. Data Platform

Access to the families' maternity records was facilitated by NUH through the upload of shared patient information to the electronic document and records management platform CCube, commissioned by NHSE. The Review's secure server and information governance protocols, overseen by a certified external IT service protected all data provided by families themselves, the Trust, and generated by the clinical specialist reviewers.

All cases meeting the ToR were reviewed by at least two clinical specialists, with other members of the multidisciplinary team included as required. Following review of all clinical notes, family interview transcripts, and other documentation within the maternity records, each case was graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy grading system as follows:

Grade 0 – Appropriate care in line with best practice at the time.

Grade 1 – Minor concerns; care could have been improved but different management would have made no difference to the outcome.

Grade 2 – Significant concerns; suboptimal care in which different management might have made a difference to the outcome.

Grade 3 – Major concerns; suboptimal care in which different management would reasonably be expected to have made a difference to the outcome.

Where cases received a Grade 3, an additional evaluation was performed by the designated clinician to uphold the integrity of the assessment and examine the findings thoroughly.

On completion, each case was subject to a quality review by another clinician to verify that all data had been entered, all relevant clinicians had completed reviews, and to ensure consistency in grading. Once verified, individual family feedback was prepared based on the findings.

This process enabled the Review to identify potentially avoidable incidents – including where this could not be established with reasonable certainty – as well as broader areas for improvement in care. Limitations to this outcomes-based grading system are discussed further in the report.

4. Family Feedback

Every family whose case has been reviewed will receive personal and individual feedback. This will be distributed promptly following the publication of this report in phased intervals from July to December 2026, depending on the family's entry point into the Review. Feedback will detail the final grading assessment, provide a summary of the care provided, and include the rationale behind the assigned grade. Recognising that some families may have anticipated higher gradings, or may be surprised by identified issues in their care, support processes will be established to ensure clinical staffing of telephone lines and continuous access to psychological support.

For all instances of maternal death, and for care assessed as Grade 2 or 3, families will be offered the opportunity to participate in face-to-face meetings, either through video conferencing or in person in Nottingham.

5. Family Engagement

The Review employed both proactive and reactive strategies to engage families, facilitating their participation in the development process and fostering a genuinely co-designed methodology.

The Review's website and social media channels were launched at the outset of the Review, serving as key platforms for disseminating information, keeping families informed, and providing a directory of resources including local, regional and national charities and organisations. The website offers content in the eight most widely spoken languages in Nottinghamshire and presents updates both written and video formats to enhance accessibility.

The Review Team conducted desk research to gain an understanding of Nottinghamshire's population, informing decisions such as offering translated correspondence and integrating a translation tool within the website.

Family engagement was systematically developed throughout the Review to address families' evolving needs. The Chair fostered strong, collaborative relationships with families, creating an environment that encouraged ongoing feedback and maintained accountability regarding the Review's methodology and any adjustments made to it. These feedback meetings provided valuable insights that shaped both the communication approach and engagement strategy.

Ensuring representation from seldom-heard communities was a critical aspect of the Review. Groups frequently under-represented in public decisions or services, including global majority communities, people with disabilities, individuals experiencing social exclusion or restricted access to information, and families affected by poverty, were proactively engaged to facilitate their meaningful participation, rather than categorised as 'difficult to reach'. Targeted strategies included partnership with organisations such as Nottingham Women's Centre, which supports individuals experiencing financial hardship and homelessness, and outreach to those working alongside refugees and asylum seekers.

As part of its engagement efforts, the Review provided lunch during group family meetings and, in specific contexts – such as sessions at Nottingham Women's Centre and home visits supported by interpreters –

offered compensation for participation in line with The National Institute for Health and Care Research[25] and NHS[26] guidelines.

5.1 Family and Community Voices Group

At the outset of the Review, the Chair formed a Family and Community Voices Group consisting of four members from the original families group, alongside representatives from diverse local community groups. The Group convened over a 10-month period from June 2023 to March 2024 and provided meaningful insights into developing a comprehensive and inclusive strategy for communications and engagement. The group informed a number of aspects of the Review, including:

- The transition from an opt-in to an opt-out methodology.
- The development of informational videos in the primary languages spoken throughout Nottinghamshire.
- The introduction of the 'purple envelope approach', ensuring families could easily recognise correspondence from the Review Team and to open it at a time when they felt emotionally prepared and supported.
- Remaining attentive to cultural differences among various groups.

5.2 Family Voices

All families participating in the Review were offered the opportunity to meet with a senior clinician, and some also engaged directly with the Chair through video conferencing or in-person sessions. Families who had experienced maternal death were invited to a face-to-face meeting with the Chair. In total, 459 family meetings were conducted with clinicians or the Chair. These sessions were recorded and manually transcribed by professional transcription services to ensure accuracy. Interviewers reviewed the transcripts before they were forwarded to families, giving them the opportunity to clarify or include additional information.

The transcripts underwent thematic analysis to inform the Family and Maternity Experiences chapter and to provide the vignettes and quotations that support the conclusions presented in this report.

Families who contacted the Review but whose outcomes did not meet the ToR were offered the opportunity to share their perspectives by telephone or email. Although their outcomes were often not adverse, their accounts frequently echoed themes identified in the family interviews, providing valuable additional insight into the issues at NUH maternity services.

Psychological support services were available to all families participating in the Review, in recognition of the potential emotional impact. A total of 482 families accessed support through this independent external specialist resource, and the diversity among families who used these services reflects the effectiveness of the Review's engagement strategies.

5.3 Family Meetings and Stakeholder Engagement

One of the drivers for this Review was the unsatisfactory experiences of many families within NUH maternity services and the ongoing difficulties they encountered when attempting to voice concerns. These encompassed challenges with the Trust's complaints and governance processes, as well as broader issues regarding the role of professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC).

25 NIHR (2025) Payment for public involvement in health and care research: a guide for organisations on employment status and tax. Available from: https://www.nihr.ac.uk/about-us/who-we-are/policies-and-guidelines/public-contributor-reward-policy/organisations-employment-status-and-tax

26 NHS HRA Payment for public involvement in health and care research: a guide for organisations on employment status and tax. Available from: https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/resources/payment-public-involvement-health-and-care-research-guide-organisations-employment-status-and-tax/

Family meetings were convened in Nottingham every two months, with representatives from the NMC, GMC, Police, Family Psychological Support Service, media, local MPs, and charities in attendance. These sessions provided stakeholders with progress updates on the Review and gave families the opportunity to put questions directly to those representatives.

Meetings were held in venues that were conveniently located and accessible by public transport, with provision for families requiring disabled access. Crèche services, lunch, and parking were provided for all participants, and travel and related costs were covered for families experiencing significant financial hardship.

6. Working with Stakeholders

6.1 Working with NUH

During the Review, the Chair established a constructive working relationship with the CEO and senior leadership team at the Trust, fostering open and transparent communication.

Through relevant information sharing agreements, the Trust efficiently facilitated the transfer of substantial volumes of data throughout the review period. This encompassed, but was not limited to, all clinical policies, maternity and board meeting minutes - including those from quality assurance meetings - external reviews and reports (such as MBRRACE-UK and Care Quality Commission (CQC)), Clinical Negligence Scheme for Trusts compliance materials, corporate policy documents, staff rotas, and staff survey results.

The Review Team established a process with NUH for requesting additional information relating to both individual cases and organisational policies and processes. In total, 1,200 supplementary requests were issued to the Trust, with a further 50 made to external Trusts.

When urgent safety issues arose, they were escalated without delay to the CEO of the Trust via the Chair to enable prompt action and resolution. Families who contacted the Review, whether as participants or to report immediate concerns, were referred back to the Trust directly. In total, 268 escalations were made, enabling the Trust to ensure timely resolution and appropriate safety management.

The Review Team delivered direct feedback at ‘Learning and Improvement’ meetings held every two months. These were convened between the CEO of the Trust, the Review Chair, the Chief Nursing Officer for England, the Regional Chief Nurse, the National Clinical Director of Maternity, and the Improvement Director and Policy Adviser for NHSE, alongside key members of the Trust’s executive team. The objective was to facilitate prompt learning and improvement as concerns were identified during the course of the Review. A log of decisions and actions was systematically maintained under the supervision of the Chief Nurse. Of 19 scheduled sessions, 17 took place. As at January 2026, 135 actions for learning had been identified, which will continue to be monitored following publication of this report.

The Review depended on the Trust’s collaboration to disseminate timely updates, essential information, and correspondence to all staff members. Through coordinated efforts, both the Review and the Trust provided consistent support to staff and ensured prompt responses to any concerns raised throughout the process.

6.2 Nottinghamshire City Councillors, County Councillors, and Members of Parliament

The Chair maintained regular dialogue with City and County Councillors and the Nottinghamshire and Derbyshire Members of Parliament, all of whom received regular updates on the Review. Councillors and Members of Parliament worked in partnership with the Review Team to promote accurate information about the Review, including through posters displayed in council buildings and items in their constituent newsletters.

Local Members of Parliament attended family meetings to offer their support, meeting with families both in group settings and individually, and inviting families to participate in All-Party Parliamentary Groups on topics such as baby loss.

Regulatory Bodies

Erosion of trust in NHS regulators has been a specific feature of the experience of Nottingham families, mirroring increasing national scrutiny.[27] The Review sought to promote effective dialogue between families, the NMC and GMC, delivering timely insights and feedback while seeking to minimise the impact of subsequent investigative processes on families already navigating traumatic experiences and ongoing proceedings.

Initial early meetings with regulators, held at the request of families, were fraught,[4] with families relaying that they perceived them as 'part of the system' that had let them down. Families reported that:

- There was a lack of engagement from both the NMC and the GMC;
- investigative processes took too long;
- cases were closed down without involving the families;
- the professional voice was believed over and above that of families;
- many families were unaware that, as members of the public, they could refer concerns to professional bodies;
- the current process was ineffective where the Responsible Officer[28] at the Trust was not independent or acting with integrity; and,
- the language and tone of communications with families was not trauma-informed.

While families understood that not all concerns would lead to regulatory action, the lack of weight given to those concerns left them feeling that they were 'knocking on a closed door' and that poor practice was being allowed to continue. They also raised concerns that students were still being placed at a Trust that was the subject of a maternity review and had received poor CQC inspections.

Discussion arose regarding the limitations of the GMC's five-year rule[29], which restricted families' ability to bring fitness-to-practice cases and meant that many, who were previously unaware of the GMC were unable to make historical referrals. It was noted, however, that this rule could be overridden where it was considered to be in the public interest, such as in the context of an independent review.

These interactions provided significant insights into the effects of regulatory processes on affected families. The Review helped to facilitate engagement, supporting families in navigating their experiences and ongoing proceedings. Apologies from regulators were forthcoming, but families made it clear that they needed to see action[30]. It was agreed that:

- The NMC and GMC would attend the two-monthly meetings with families to aid accountability and transparency;
- information sharing protocols would be established for the transfer of emerging concerns in real time between the Review and the regulatory bodies;
- the NMC and GMC would improve public awareness of their function and how to refer concerns [Leaflet already created by NMC signposting to GMC][31]

27 Minutes of meeting held 19 June 2023, Families' meeting with GMC/NMC.

28 Designated responsible officer who holds legal accountability for medical revalidation, fitness to practice and liaising with regulatory bodies

29 https://www.gmc-uk.org/cdn/documents/dc12553--guidance-for-decision-makers-on-the-five-year-rule--external-_pdf-82134517.pdf

30 Provides an outline of the ongoing work Regulators have undertaken to support the Review, see Appendix.

31 https://www.nmc.org.uk/globalassets/sitedocuments/factsheets/raising-aconcern-about-your-maternity-care.pdf

- the NMC and GMC would set up 'case surgeries' locally to give harmed families easier access to regulators;
- the role of both regulators to be made clear – that their purpose is not to punish, but to ensure the safety of public;
- the 'five-year rule' would be challenged.[32]

Throughout the Review, the identification of individual registrants proved challenging owing to signatures and designations in records being absent or illegible. This hindered the efficiency and effectiveness of regulatory investigations. The implementation of digital records is expected to address this in part, though challenges will persist in relation to historical cases.

6.3 Royal Colleges

Quarterly updates were held between the Chair and the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Chair was also invited to present at conferences in obstetrics and gynaecology hosted by the Royal College of Anaesthetists to discuss the Review process and share key insights.

6.4 HM Coroner

Direct communication between HM Coroner and the Chair facilitated the identification of a previously unrecognised cohort of neonatal cases, particularly those where infants were born at one Trust and subsequently transferred to NUH for neonatal intensive care. As a result, a group of extended neonatal open book cases was established for review. A total of 256 cases were identified during the review period, all of which underwent screening; 16 were determined to require comprehensive neonatal review.

6.5 Nottingham University Medical Schools

Through collaboration with the Medical Schools, the Chair engaged with medical students and resident doctors across paediatric, neonatal, and obstetric and gynaecological specialties. Their feedback provided insight into the culture within the Trust and highlighted challenges currently faced in the units.

This engagement also facilitated a connection with the Jewish community through the medical school Dean, with additional information about the Review disseminated to families via the Nottingham Liberal Synagogue newsletter.

6.6 Working with Operation Perth

Operation Perth is Nottinghamshire Police's investigation into deaths and serious injuries related to maternity care provided by NUH, running in parallel with this Review.

Operation Perth commenced in spring 2024 and continues to engage with families, individuals, organisations, and services to identify cases that meet the threshold for a police investigation and to support affected families.

The investigation reviews material examined by this Review to identify whether, on the balance of probabilities, a criminal offence occurred. Offences within scope include gross negligence manslaughter and serious assaults under the Offences Against the Person Act.

32 Since March 2026, the UK government is actively seeking to change the GMC 'five-year rule' as part of a wider overhaul of medical regulation. https://www.gmc-uk.org/news/news-archive/gmc-welcomes-plans-to-reform-restrictive-legislation#:~:text=And%20end%20to%20the%20'five,a%20requirement%20to%20consult%20stakeholders.

In May 2025, Operation Perth disclosed that NUH is subject to a corporate manslaughter investigation to ascertain whether there has been a gross breach in the duty of care owed by the organisation in providing maternity or neonatal services, which has caused or contributed to any person's death.

The operation is structured using Major Incident Room Standardised Administrative Procedures (MIRSAP)[33] facilitated by the Home Office Large Major Enquiry System (HOLMES).[34] It is led by a Senior Investigating Officer (SIO) and supported by Deputy Senior Investigating Officers (D/SIOs).

Home Office Special Grant Funding has been secured to support the investigation, which involves around 70 police staff in roles including investigators, disclosure experts, researchers, analysts, HOLMES indexers, document readers, and investigative supervisors.

Nottinghamshire Police remains committed to conducting a thorough and transparent investigation to ensure accountability and justice for the affected families.

7. Local and Regional Media

The Review maintained a strong and constructive relationship with local, regional, and national press, which contributed significantly to its reach and public profile. Media campaigns and interviews enabled the press to raise awareness of the Review among the local population and ensure ongoing communication about its progress.

As part of our regular monthly visits to Nottingham, the Review Team conducted interviews with local and regional media outlets, disseminating information to the public and promoting community participation.

Our established media contacts consist of organisations operating across print, digital, and broadcast platforms. These contacts include:

- BBC East Midlands Today
- BBC Radio Nottingham
- Notts TV (no longer in broadcast)
- ITV
- ITN
- Nottingham Post
- PA Media
- Hits Radio
- Gem Radio
- The Guardian
- Sky
- Kemet FM

The Chair of the Review has also conducted supplementary interviews with:

- HSJ
- LBC
- Woman's Hour (Radio 4)

33 Major Incident Room Standardised Administrative Procedures (MIRSAP) are national standards for managing information in major crimes, such as homicides, within UK policing. Updated by the NPCC in 2021, MIRSAP ensures consistent recording, linking, and processing of investigation data through the HOLMES computer system to support Senior Investigating Officers.

34 The Home Office Large Major Enquiry System (HOLMES) is a specialised computer system used by UK police forces to manage large-scale investigations, such as murders, complex frauds, and major disasters. It centralises data, enabling real-time collaboration, document management, and cross-referencing of evidence across different police forces.

- The Independent
- The Guardian
- Capital FM
- Global Radio
- BBC
- The Daily Mail
- The New Statesman
- Sky
- The Telegraph
- The Times
- Channel 4

Some of these interviews focused on Donna Ockenden's background and professional experience, including her conduct of earlier reviews, rather than directly on this Review. They nonetheless contributed positively to its visibility and reputation.

One of the Review's most notable media engagements took place at Kemet FM, an urban radio station in Nottingham dedicated to the music and culture of the city's African and Caribbean communities. In April 2024, Donna Ockenden and Anthony May, Chief Executive of the Trust, participated in an interview that was broadcast throughout Nottinghamshire and the Caribbean. The appearance led to increased engagement from Black families; notably, one family reported learning about the Review from relatives in the Caribbean who had heard the broadcast. The interview also facilitated the establishment of a relationship with the Majority Black Led Churches (MBLC), through connections between Kemet FM journalists and the MBLC.

8. Social Media

The Review managed social media accounts on Facebook, Instagram, and X (formerly Twitter). These platforms served as supplementary channels for communicating updates to families on topics including family events, progress reports, team introductions, and initiatives to encourage engagement.

9. Ockenden Maternity Review Website

The Review's website serves as an information hub for families, offering content in the eight most widely spoken languages in Nottinghamshire. It explains the Review's purpose and scope while directing users to relevant resources. To enhance accessibility, updates are presented in both written and video formats.

Content included announcements, updates, event details, a directory of support charities and organisations, monthly update videos, and dedicated sections covering the ToR, opt-out arrangements, family feedback, frequently asked questions, biographies of the Review Team, and contact information.

This approach supported a consistent response to emerging themes requiring further analysis, while ensuring coherent communication across all phases of the Review.

In June 2024, for example, in response to emerging concerns relating to medical termination of pregnancy, the Review issued an appeal for families to share their antenatal experiences. Given the sensitivity of this aspect of maternity care, the Review Team sought guidance from Antenatal Results and Choices, a charity supporting families facing decisions after difficult antenatal test results. Their expertise informed the development of appropriate wording and a considerate outreach strategy. Information was subsequently distributed to GP surgeries, local community organisations including the MBLC, and regional media outlets.

The Review Team served as the primary channel for communicating with families on matters that may affect them, acting as an intermediary between stakeholders and families.

One effective example occurred when police discovered that data containing information on numerous cases within the Review had been intentionally deleted.[35] A prompt and supportive response was necessary to ensure that families were kept informed and reassured. The Review Team used their experience of working with families to help develop appropriate communications and set of answers to likely questions from families, and the team was augmented in order to handle the families' questions and concerns promptly and effectively.

This experience reinforced the importance of ongoing engagement with regulators to facilitate the broader dissemination of insights and feedback. Regulators participated in family meetings to clarify their responsibilities and established open surgeries to give families easier access to regulatory support. Information sharing agreements between the Review and regulatory bodies ensured that emerging concerns about specific clinicians could be brought promptly to regulators' attention, supporting their mandate to protect the public.

10. Delays in Publication

Delays in publication were inevitable given the iterative nature of the Review and the successive expansions of its ToR and scope. Particular pressures arose during the resident doctors' strikes: as senior clinicians working within the NHS had reduced capacity to undertake work for the Review due to the increased clinical demands in their own Trusts. Similar pressures were felt during holiday periods, when NHS staffing requirements reduced reviewers' availability.

11. Oversight and Reporting to NHSE

The Chair provided reports to the Oversight Committee every two months to track progress in accordance with the Review's ToR. The Oversight Committee was led by the Chief Nursing Officer for England, who was responsible for delivering oversight and strategic guidance throughout the Review.

Concurrently, the Contract Delivery Committee was established to monitor the progress of the Review, with particular emphasis on case completion, deliverables, key performance indicators, and financial oversight. These meetings, held every two months, were attended by the Review Chair and presided over by the Programme Director for NHSE, with membership also comprising the Finance Lead and Commercial Lead from NHSE.

12. Closedown to the Review

The Review closed to new families on 31 May 2025.

13. Cost of the Review

The structure and process described in this chapter, and the significant volume of work and communication required to conduct a Review of this scale, explain the expenditure associated with the Review. It has been essential to ensure that public funding is used with maximum efficiency and that all outputs are of a sufficiently high standard. All costs have been accounted for on a monthly basis, encompassing routine administrative expenses through to the management of multiple secure platforms.

To provide more context, NHS Resolution settled clinical negligence claims related to maternity care,

35 https://www.theguardian.com/society/2025/jun/10/loss-of-data-relating-to-inquiry-at-nottingham-universities-nhs-trust-most-likely-deliberate-say-police

totalling £1.3 billion in 2024/25[36], representing 42% of the total value of all notified clinical negligence claims. The high cost of these claims reflects the life-altering, long-term impacts and significant hardships faced by affected families. Beyond these direct costs, the indirect consequences of relationship breakdown, loss of employment, and broader familial disruption represent significant factors within the wider landscape of healthcare economics. Improving maternity safety must therefore remain a critical priority – not only to prevent individual suffering but to safeguard public funds for the broader benefit of healthcare services.

By implementing the actions recommended in this report, the cost of the Review will represent a fraction of the potential savings associated with preventing birth injury and baby loss.

14. Conclusion

The methodology underpinning this Review has been designed from the outset to be rigorous, inclusive, and transparent. The scale of participation – over 2,400 families, 459 family meetings, and more than 2,500 cases reviewed – reflects both the extent of harm experienced at NUH and the commitment of families to ensuring that their experiences are heard and acted upon. Throughout the process, the Review has sought to maintain the trust of families, work constructively with the Trust and its partners, and deliver findings of sufficient quality and credibility to drive lasting improvement. The actions set out in this report represent the culmination of that work. Their implementation is now the responsibility of NUH, NHSE, and the wider system.

36 NHSR (2025) Annual report and accounts. Available from: https://assets.publishing.service.gov.uk/media/687a2dae312ee8a5f0806b6f/nhs-resolution-annual-report-and-accounts-2024-to-2025-hc1065-web-accessible.pdf

Our Findings Following the Review of Family Cases

This Independent Review examined the experiences of over 2,500 families who received maternity and neonatal care at Nottingham University Hospitals NHS Trust (NUH) between 2012 and 2025. Through detailed case reviews, engagement with families and over 800 current and former staff members, examination of governance documentation, and analysis of external reports and regulatory findings, the Review identified long-standing and deeply embedded systemic failures across multiple areas of maternity and neonatal care.

Grading of Care

All the clinical incidents were reviewed by members of the Review Team which comprised obstetricians, midwives and other specialist as appropriate. The clinical care was graded using an established grading of care scoring system (CESDI). Further details of how this system was used is laid out in detail within the methodology section of the report.

Overall Statistics

Upon conclusion of the Review, rigorous data cleansing was conducted to ensure an accurate and equitable representation of the local statistics for Nottingham University Hospitals (NUH). Following the systematic exclusion of families who elected to opt out, unvalidated records, cases determined to be outside the Terms of Reference (TOR) post-review, and the neonatal extended open book cohort, a final sample of 2,030 families was retained. Within this cohort, numerous instances involved multi-case reviews or concurrent maternity and neonatal gradings. Table 1 delineates the annual distribution of case gradings alongside the corresponding percentages of cases designated as Grades 2-3, which signify potentially avoidable outcomes. These longitudinal trends and avoidability metrics are visually illustrated in Charts 1 and 2. Clinical review findings for each major incident category is shown in Table 2.

Table 1: Clinical Cases by Year and Grading

YEAR	CASES	MATERNITY GRADED 0-1	MATERNITY GRADED 2-3	% OF TOTAL GRADED 2-3	NEONATAL GRADED 0-1	NEONATAL GRADED 2-3	% OF TOTAL GRADED 2-3
Pre 2012	82	54	26	32%	38	8	10%
2012	146	117	28	19%	61	4	6%
2013	155	119	37	24%	75	5	6%
2014	171	128	41	24%	86	4	4%
2015	156	123	30	20%	84	6	7%
2016	148	116	32	22%	78	2	3%
2017	158	110	45	29%	73	3	4%
2018	138	103	33	24%	67	5	7%
2019	134	103	31	23%	55	6	10%
2020	146	117	27	19%	70	7	9%
2021	169	128	36	22%	73	13	15%
2022	155	118	33	22%	76	4	5%
2023	128	97	28	22%	45	7	13%
2024	104	81	17	17%	40	2	5%
Jan-May 2025	36	33	0	0%	16	0	0%
Totals	**2026**	**1547**	**444**		**937**	**76**	
Average %				**21%**			**6%**

Chart 1: Percentage of Maternity Cases Graded 2-3 Year

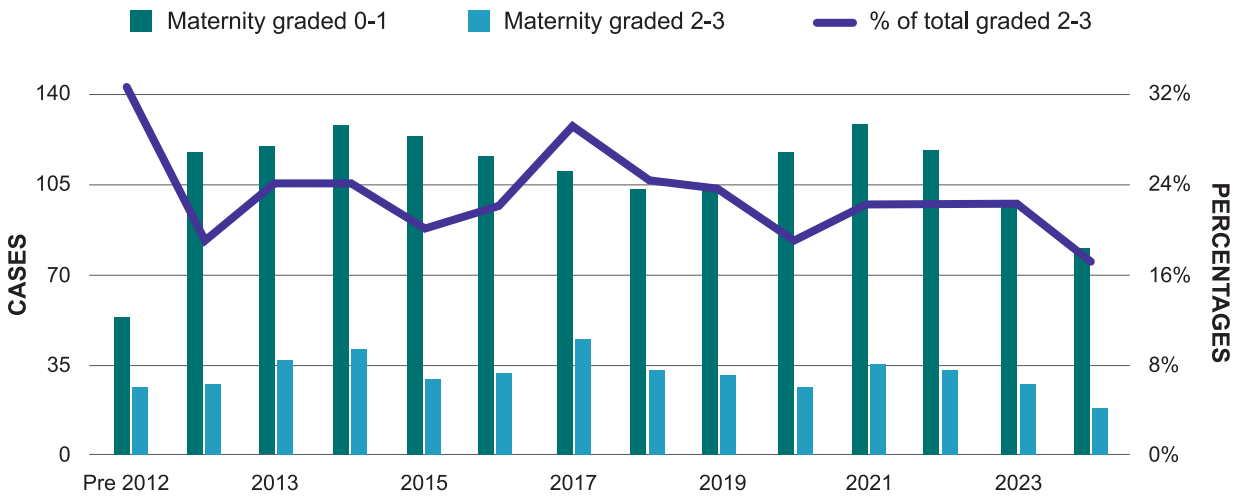


Chart 2: Percentage of Neonatal Cases Graded 2-3 Year

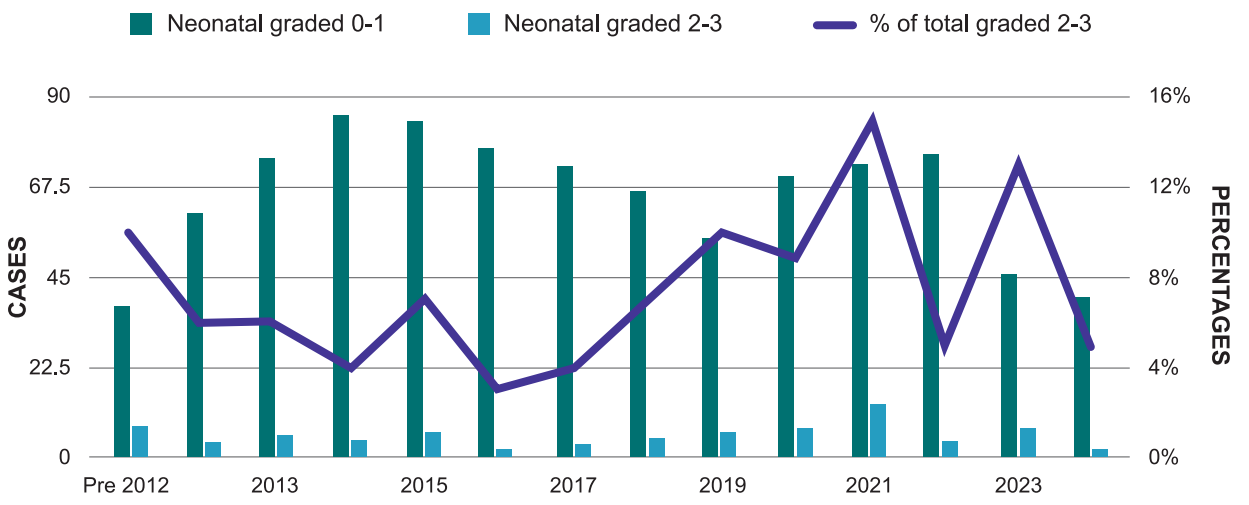


Table 2: Clinical Review Findings for each of the Major Incident Categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS	GRADING OF CARE SCORES 2 OR 3 (WHERE GRADED) 0	1	2	3	PERCENTAGE OF CARE AT GRADE 2 AND 3
Maternal Death		27	11	8	5	1	21.4%
Massive Obstetric Haemorrhage		115	32	52	26	4	26.1%
4th Degree Tear		142	42	79	19	1	14.1%
Severe PET		76	15	39	20	1	28.6%
Unexpected Admission to ITU		130	27	55	32	13	35.6%
Stillbirth	Mother	462**	184	182	76	17	20.1%
	Baby*		21	6	1	0	0.2%
HIE	Mother	185**	34	53	59	34	50.3%
	Baby		108	62	11	1	6.5%
Neonatal Death	Mother	258**	123	97	20	11	12.0%
	Baby		140	75	23	8	12.0%
Cerebral Palsy	Mother	19	4	10	4	1	26.3%
	Baby		12	3	4	0	21.1%
IVH	Mother	61**	29	20	7	0	11.5%
	Baby		27	25	6	1	11.5%
PVL	Mother	11	5	5	1	0	0.0%
	Baby		4	6	0	0	9%
Stroke	Mother	21	4	9	8	0	38.1%
	Baby		12	9	0	0	0.0%

*WHERE RESUSCITATION WAS ATTEMPTED, ** INCLUDING MULTIPLES BIRTHS

Ethnicity Data

Ethnicity data was available for 99% of the families included in the Review. This metric relies on unverified source information supplied by the Trust, supplemented by data extracted from medical records by the Review Team. Proportionally, the Trust holds known ethnicity data for only 87% of the birthing population; however, through the integration of the additional information secured by the Review, the data availability threshold was elevated to 99%.

Table 3: Ethnicity Data for Mothers in the Review

ETHNICITY	NUMBERS	PERCENTAGE (ROUNDED)	COMPARATIVE DATA = DEMOGRAPHIC OF WOMEN GIVING BIRTH AT NUH DURING REVIEW PERIOD*	ODDS RATIO
White	1469	74%	62%	1: 1.19
Black	164	8%	5%	1: 1.60
Asian	218	11%	10%	1: 1.07
Mixed	81	4%	8%	1: 0.50
Other incl Chinese	47	2%	2%	1: 1.00

Table 4: Gradings of Maternity Care by Ethnicity

GRADE OF MATERNITY CARE BY ETHNICITY (WHERE GRADED)	0-1 (%)	2 (/%)	3 (n/%)
White	77%	18%	5%
Black	78%	18%	4%
Asian	76%	19%	5%
Mixed	83%	13%	4%
Other	84%	9%	7%

Table 5: Gradings of Neonatal Care by Ethnicity

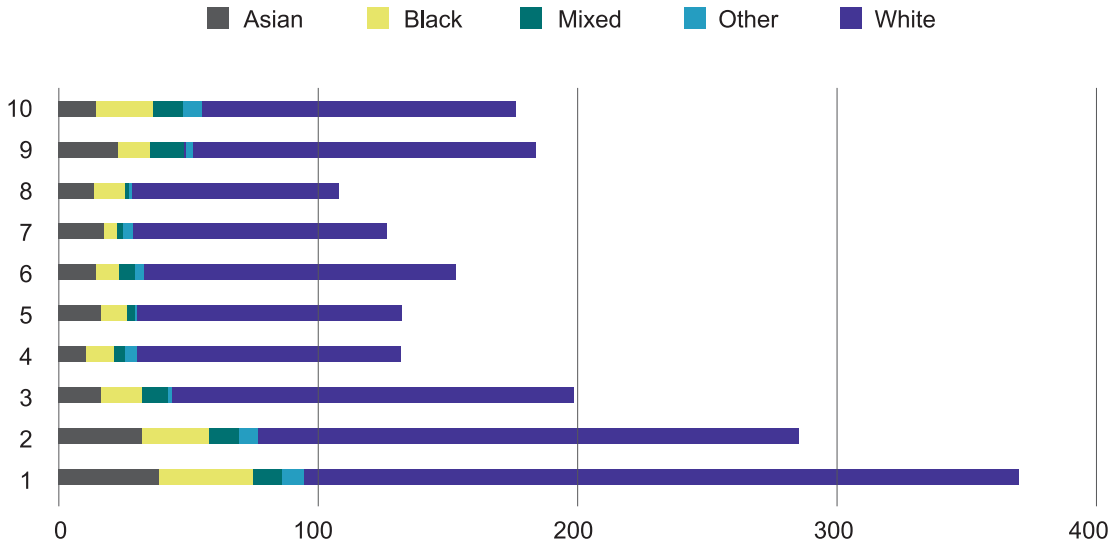
GRADE OF NEONATAL CARE BY ETHNICITY (WHERE GRADED)	0-1 (%)	2 (%)	3 (%)
White	93%	6%	1%
Black	94%	5%	1%
Asian	93%	7%	0%
Mixed	86%	11%	3%
Other	92%	8%	0%

Deprivation Data Analysis

The Index of Multiple Deprivation (IMD) serves as the primary metric to evaluate socioeconomic status by proxy of geographic location. This index categorises geographical areas into deciles on a scale from 1 to 10, wherein Decile 1 denotes the highest concentration of relative deprivation and Decile 10 signifies the lowest.

To identify socioeconomic trends within the evaluation cohort, residential postcodes collected from participating families were cross-referenced using the Postcode IMD Decile Mapper.[37] This process facilitated the mapping of participant distribution across national deprivation brackets to establish a baseline demographic profile which was then separated by ethnicity (Chart 3). This identified that 35% of the cases within the Review came from the IMD 1 and 2 (20%) giving an odds ratio of 1:1.75 for families living with poverty, this endorses the wider picture of maternity care across the UK.

Chart 3: IMD Decile and Ethnicity



Maternal Deaths

The Review of maternal deaths demonstrated the devastating and enduring impact of maternal mortality upon families and communities. 27 maternal deaths associated with maternity care provided at NUH between 2006 and 2024 were reviewed. Although many women received appropriate care, the Review identified cases in which different management may have altered outcomes. Themes included failures in escalation, inconsistent multidisciplinary working, communication challenges and variation in continuity of care for women with complex medical conditions.

The experiences of bereaved families described throughout the Review were among the most distressing accounts heard by the Review Team. Whilst some families received compassionate and exemplary bereavement care, others described insensitive communication, poor coordination of care, inadequate facilities and failures to uphold dignity following the death of a mother or baby. The Review identified serious failings in post-death care processes, including failures in mortuary systems, communication and information handling, which caused additional and avoidable trauma to grieving families.

Maternal Morbidity

The principal categories of major incidents associated with maternal morbidity comprised fourth-degree perineal tears, unanticipated admission to the Intensive Care Unit (ICU), severe pre-eclampsia toxaemia

37 Ministry of Housing, Communities and Local Government, 2025

(PET), and massive obstetric haemorrhage (MOH; defined as blood loss exceeding 3 litres). Our Review suggests that unanticipated admission to ICU represented one of the most preventable adverse maternal outcomes, followed by severe PET and MOH. These categories are considered in greater detail within the relevant chapters.

Complications arising during pregnancy and childbirth may have profound and enduring consequences for mothers and their families. These effects are not solely physical; there is also a substantial associated psychological impact, particularly where the experience is compounded by suboptimal or unkind care. Although this issue is explored further in Chapter 12, given that many of these major clinical outcomes may be preventable, the imperative for improvement should not be underestimated.

Stillbirth

The neonatal chapter identified several systemic factors relevant to stillbirth prevention and the management of babies compromised around the time of birth. The Review Team described long-standing pressures within the Nottingham neonatal service, including chronic capacity issues, split-site working, delayed access to intensive care, and insufficient consultant availability overnight. Concerns were also identified regarding delays in emergency neonatal resuscitation, equipment preparedness, and failures to follow national newborn life support guidance. The Review found that some babies born following significant antepartum haemorrhage or placental abruption experienced delays in recognition and treatment of severe blood loss, including delayed emergency transfusion. These findings suggest that organisational pressures, delayed escalation, and deficiencies in emergency response systems may have contributed to adverse perinatal outcomes and increased risks for babies experiencing severe intrapartum compromise

Hypoxic-Ischaemic Encephalopathy (HIE) Summary

The Review found that the Trust had appropriate national guidance and structured assessment processes for therapeutic hypothermia in babies with HIE, and that in most cases care was good and in line with national standards. However, recurring concerns were identified regarding delays and deviations in cooling practice. Passive cooling was routinely continued within the neonatal intensive care unit beyond what national guidance recommended, potentially impairing neurological assessment and delaying active cooling. Several babies experienced delayed achievement of target cooling temperatures, including cases where active cooling commenced after the recommended six-hour treatment window. Additional concerns included delayed cerebral function monitoring and one case where coagulation abnormalities during cooling may have contributed to worsening intracranial haemorrhage. The Review also identified cases where prolonged untreated hypoglycaemia may have compounded hypoxic brain injury. Overall, while most HIE management was appropriate, the Review concluded that inconsistent adherence to evidence-based cooling pathways created avoidable risks of further neurological injury in a small number of babies.

Neonatal Death

The Review concluded that most neonatal care at the Trust was good or excellent, but identified a small number of cases where care contributed, or was likely to have contributed, to neonatal death. The most significant overarching finding was that the neonatal service operated for many years under severe and sustained capacity pressure across two sites, with overcrowding, frequent transfers of critically ill babies, and insufficient consultant cover out of hours. Specific concerns linked to neonatal deaths included delays in emergency blood transfusion for babies with severe blood loss, failures in airway management with repeated intubation attempts and preventable extubations, delayed escalation to senior clinicians, and failures to follow agreed difficult airway plans. Several babies died following hospital-acquired infections, including Pseudomonas sepsis, within environments described as overcrowded and lacking adequate isolation facilities. The Review also identified avoidable failures in recognising and managing severe neonatal hypoglycaemia, some resulting in collapse, seizures, brain injury, or death. The Review concluded that chronic under-resourcing, delayed implementation of safety improvements, and inconsistent learning from incidents increased the risk of avoidable neonatal harm and mortality.

Cerebral Palsy

The Review Team identified several areas of neonatal care associated with risks of acquired brain injury and potential long-term neurodevelopmental impairment, including cerebral palsy. In particular regarding delayed or inconsistent management of HIE, prolonged untreated hypoglycaemia, delayed emergency transfusion in severely anaemic babies, recurrent hypoxia during repeated intubation attempts, and inadequate management of coagulation abnormalities during cooling therapy. The Review described cases where babies experienced severe hypoglycaemia with prolonged low blood glucose levels, seizures, or hypoxic brain injury, noting that some of these injuries were avoidable and may have compounded existing neurological damage. Delays in achieving therapeutic hypothermia targets and repeated episodes of collapse or oxygen deprivation during airway management were also identified as significant risks for permanent neurological injury. While the Review did not specifically quantify cases of cerebral palsy, it identified multiple examples where failures in neonatal care may have contributed to long-term brain injury and adverse neurodevelopmental outcomes.

Neonatal Care

The neonatal review identified many examples of compassionate and high-quality neonatal care, with outcomes overall in line with national expectations. However, important concerns remained regarding cot capacity pressures, transfer arrangements, consultant cover across geographically separate neonatal intensive care units, and inconsistencies in aspects of neonatal safety and escalation processes. The Review found examples in which capacity pressures resulted in multiple transfers of vulnerable babies between units, exposing them to additional clinical risk.

Maternity Care

The findings of this Review demonstrate that, over a prolonged period, women, babies and families were failed by a service which too often did not listen, did not learn, and did not respond adequately when concerns were raised. Whilst examples of excellent and compassionate care were identified throughout the Review, these frequently existed despite wider organisational and cultural problems rather than because of the systems and leadership supporting them.

The Review found repeated failures in fundamental aspects of safe maternity and neonatal care. These included deficiencies in antenatal risk assessment, fetal surveillance, triage processes, escalation of clinical concerns, intrapartum monitoring, postnatal care, neonatal management and bereavement support. Across multiple cases and over many years, opportunities to recognise deterioration, escalate concerns and intervene appropriately were missed.

Women and families consistently described experiences characterised by poor communication, fragmented care, lack of compassion and failure to listen to their concerns. Many women reported feeling dismissed, disempowered or blamed when expressing anxiety or reporting symptoms including reduced fetal movements, pain, hypertension and postnatal deterioration. Families repeatedly described circumstances in which they felt they were not listened to until clinical situations became critical.

The Review identified recurring concerns regarding triage and escalation processes. Women frequently described difficulty accessing assessment and advice and reported interactions in which service pressures appeared to influence decision-making. In several cases this contributed to delays in assessment, treatment and escalation of care.

Significant concerns were identified regarding intrapartum care, including failures in fetal heart rate monitoring, CTG interpretation, recognition of fetal compromise and escalation to senior clinicians. In a number of cases these failures contributed to severe neonatal injury, stillbirth and neonatal death. The Review found repeated examples of poor multidisciplinary communication and failures to recognise evolving risk during labour and birth.

Postnatal care emerged as a significant area of concern throughout the review period. The Review identified failures in postnatal monitoring, recognition of maternal deterioration, management of hypertension and venous thromboembolism risk, infant feeding support and neonatal surveillance on postnatal wards. In several cases, babies who demonstrated signs of poor feeding, hypoglycaemia, infection or clinical deterioration were not appropriately assessed or escalated, leading to avoidable harm and, in some instances, death.

The Review also identified failures in communication between hospital and community services, including discharge communication to general practitioners and community midwifery teams. In some cases, families experienced deeply distressing situations in which healthcare professionals were unaware that a baby had died or that a woman had experienced stillbirth or significant maternal complications.

The obstetric anaesthetic review similarly identified high overall standards of care, with the majority of cases graded as demonstrating appropriate or good care. The Review found evidence of strong multidisciplinary working, visible consultant leadership and supportive team culture within anaesthetic services. Nevertheless, important learning emerged regarding medicines safety, management of major obstetric haemorrhage, labour epidural management and escalation in deteriorating patients.

Culture and Leadership

A central and recurring finding throughout this Review has been the impact of organisational culture. Many staff members described working within environments characterised by fear, bullying, poor psychological safety and ineffective leadership. Staff repeatedly described feeling unable to raise concerns safely or believing that concerns raised over many years had been minimised or ignored. More than 40% of staff engaging with the Review described either witnessing or personally experiencing bullying behaviours.

Leadership instability was identified as a major contributory factor affecting the quality and safety of maternity services at NUH. Between 2017 and 2021 there was sustained turnover in senior maternity leadership positions, including repeated changes in Directors of Midwifery and other senior operational roles. Staff described inconsistent leadership visibility, poor support following incidents and confusion regarding accountability and escalation pathways.

The Review found evidence that staff shortages and operational pressures affected all areas of the maternity pathway. Staff described routinely working beyond safe capacity, inability to complete mandatory training and insufficient opportunity for reflection, supervision and learning. Workforce instability, high sickness absence and reliance on temporary staffing contributed to fragmented care and reduced continuity for women and families.

Clinical Governance

The Review also identified long-standing and systemic failures in clinical governance. Multiple internal and external reviews over more than a decade repeatedly identified concerns relating to incident reporting, investigation quality, harm grading, duty of candour, leadership oversight and organisational learning. Despite these repeated warnings, improvements were often incomplete, delayed or unsustained.

The Review identified evidence of poor governance structures, inadequate Board oversight and a disconnect between assurances provided to Trust leadership and the lived experiences of families and front line staff. External reviews, regulatory findings and commissioner concerns repeatedly highlighted weaknesses in maternity governance, culture and safety processes over many years.

A recurring finding throughout this Review was the failure to learn effectively from incidents. Families were frequently told that lessons would be learned following harm or bereavement, yet similar incidents recurred repeatedly over many years. Investigation processes were often inconsistent, delayed and insufficiently multidisciplinary. The Review found evidence that harm was sometimes downgraded, concerns were inadequately escalated and opportunities for thematic learning were missed.

Birth Trauma

The Review also heard powerful testimony regarding the psychological impact of traumatic birth experiences and suboptimal care. Families described enduring anxiety, depression, post-traumatic stress disorder and long-term emotional trauma, often compounded by poor communication and inadequate follow-up support. Staff also described significant emotional exhaustion, moral distress and psychological harm arising from working within pressured and unsupported clinical environments.

Looking Forward

The Review Team recognises that many staff working within NUH maternity and neonatal services were compassionate, committed and deeply affected by the harm experienced by families. Numerous examples of excellent clinical practice, multidisciplinary collaboration and individual kindness were identified throughout the Review. More recently, there is evidence that some improvements in leadership, governance, multidisciplinary working and safety culture have begun to emerge following increased scrutiny and external oversight.

However, the Review is clear that these improvements follow years of avoidable harm experienced by women, babies and families.

The findings of this Review demonstrate that the issues identified at NUH are not isolated or unique to one organisation. Many themes identified throughout this Review mirror findings from previous national maternity reviews and inquiries, including failures in listening to women, workforce shortages, inconsistent application of guidance, poor interdisciplinary working, inadequate governance arrangements and cultures resistant to challenge and learning.

The Review Team maintain the view that at the centre of this Review remain the voices of women, babies and families. Their courage, persistence and determination to seek truth and accountability have ensured that these issues can no longer remain hidden. The findings of this Review must now act as a catalyst for sustained and meaningful change within Nottingham University Hospitals NHS Trust and across maternity and neonatal services nationally.

Signature Case

This chapter sets out the Review Team's assessment of all the evidence concerning clinical practice in this case. Where differing accounts exist, these remain unresolved.

Harriet Hawkins

Harriet's story has been selected as an exemplar case enabling the Review Team to present the human impact of failings in a way that is accessible, meaningful and grounded in lived experience. Whilst the Review considered the experiences of many families, the Hawkins family's case encapsulates several recurring themes identified across the wider cohort, including failures in risk assessment, communication, escalation, multidisciplinary working and compassionate engagement with families. As such, it offers a coherent narrative through which broader findings and learning can be understood.

Importantly, the selection of a single case as an exemplar is not intended to elevate one family's experience above others', nor to imply that their experience was unique. Rather, it serves as a representative lens through which the cumulative evidence of the Review can be examined. The case reflects patterns of care and systemic concerns repeatedly identified across other families' accounts, whilst also demonstrating the profound and lasting impact maternity care failures can have on parents, babies and extended families.

Using Harriet's story also supports transparency and public understanding by grounding the actions the Review Team say are essential in a real and recognisable account of care. It helps connect strategic findings with the realities of front line maternity services and reinforces why organisational learning, accountability and cultural change are essential to improving safety and outcomes for women and babies.

Through sharing this case, the Review seeks to honour Harriet and her family's experience, ensure that their voices contribute meaningfully to national learning, and strengthen the imperative for sustained improvement across maternity services.

Executive Summary

Sarah and Jack Hawkins were both employed by Nottingham University Hospitals NHS Trust (NUH) at the time of Sarah's pregnancy and birth of their daughter, Harriet Hawkins in 2015/2016. Sarah and Jack experienced the intrapartum death of their baby girl, Harriet, following a prolonged labour complicated by malposition, and compounded by potential missed opportunities within the maternity service to listen, document, escalate, or act upon parental concerns. There is documented evidence that demonstrates that Sarah's symptoms and concerns were not acted upon, with Sarah being repeatedly told that she was 'not in labour', which is a theme that was found across the timeline of the Review.

Sarah's phone calls were not all documented by NUH, but are also evidenced by her own phone records. This theme of inadequate record-keeping of triage phone calls was also seen as a wider theme within the Review. Sarah was not invited in to attend the hospital when calling in pain, even after multiple calls, which was not in line with the local guideline.

Harriet died during Sarah's labour at 40 weeks and six days' gestation. The Review Team has concluded that there were nine missed opportunities in care many of which, if taken, most likely would have altered the outcome. Sarah and Jack described to the Review their experiences of interactions with members of staff as lacking compassion. They also reported that they experienced similar behaviours throughout their subsequent interactions with NUH until very recently. Following Harriet's death, both Jack and Sarah felt that NUH's responses to their concerns put up barriers to the task of answering questions surrounding Harriet's death. Sarah and Jack described feeling distressed by delays in the investigation process, and by responses from NUH that they perceived as defensive. They felt that the length and nature of the investigation contributed to their ongoing distress and believed that aspects of this additional distress might have been avoided had the initial response been different.

Shortly after Harriet's death Sarah and Jack began to document their experiences in detail, recording events to preserve their experience. They have continued to seek answers regarding Harriet's death ever since, and have also advocated for improvements in maternity care for other families affected by adverse experiences at NUH.

The focus and persistence brought by Sarah and Jack Hawkins to achieve a proper investigation of Harriet's death resulted in several investigations, which progressively brought to light not just the immediate issues they confronted but also deficiencies in the underlying culture and management of NUH; that resulted in the commissioning of this Review, and there remain other inquiries ongoing.

This chapter therefore also describes those investigations, the concerns that arose from them, and why they did not bring matters to a close.

The immediate circumstances surrounding Harriet's death were subject to four investigations between April 2016 and December 2017, as follows.

Investigation 1 (2016):

NUH undertook an internal review, led and written by maternity staff within the organisation. The incident was not classified as an intrapartum stillbirth and was therefore not managed through the Trust's serious incident review process. A formal root cause analysis was not undertaken.

The investigation incorporated findings from Harriet's first post-mortem examination. Concerns were later raised by Sarah and Jack Hawkins regarding the completeness and accuracy of the clinical information provided to the pathologist. In particular, they believed that relevant information relating to the prolonged labour was not fully reflected. The clinical history documented in the report stated that Harriet had been diagnosed as deceased prior to the induction of labour, whereas Sarah was reported to have been 9cm dilated at the time care escalated.

The investigation did not examine in detail the care provided to Sarah during labour, including the contacts she made with the maternity service in the days preceding Harriet's death. Sarah and Jack also reported that, despite requesting to contribute directly to the investigation, their accounts and experiences were not included within the investigation findings. Concerns regarding the circumstances of Harriet's death had already been raised with senior leadership within the Trust at that stage.

The investigation concluded that Harriet's death was attributable to infection and identified no concerns regarding the standard of midwifery or obstetric care provided. It also considered a number of clinical decisions and adherence to local guidance. These included the management of repeated telephone contacts during labour, the administration of diamorphine during the latent phase of labour, and the actions taken when the fetal heart could not be identified during the second stage of labour. Sarah and Jack subsequently questioned whether these aspects of care and adherence to local guidance had been fully explored within the process.

Sarah and Jack were invited to attend a routine stillbirth meeting on 13 July 2016, approximately three months after Harriet's death, to discuss the findings relating to her care.

Investigation 2 (2016):

This investigation was undertaken by an external reviewer following requests from Sarah and Jack Hawkins for an independent review. The investigation incorporated information and accounts provided directly by Sarah and Jack.

The investigation identified a number of concerns relating to Sarah's care, and Harriet's death was reclassified as a serious incident. However, the investigation did not depart from the earlier conclusion that Harriet's death was considered unavoidable and associated with infection. Sarah and Jack expressed concern that amendments between the draft and final versions altered the emphasis and tone of the report. This was later investigated by a legal firm, Browne Jacobson, which was unable to draw firm conclusions

but noted substantial edits, and that the process followed was not fully consistent with the original intention that the investigation be external.

Investigation 3 (2017):

The Local Supervisory Authority (at that time a statutory midwifery regulatory function) reviewed only the midwifery elements of care. This investigation did not aim to address the cause of death but it did highlight a series of system care failings. It also made recommendations, including for wider service organisational actions, but did not recommend any referrals to the Nursing and Midwifery Council.

Investigation 4 (2017):

This investigation was undertaken by the Clinical Commissioning Group using the Serious Investigation / Root Cause Analysis process. It included a third post mortem, with correct clinical information given to the pathologist regarding the long labour Sarah and Harriet had undergone. This investigation concluded that Harriet died from a sudden hypoxic event when she was already susceptible due to prolonged dysfunctional labour and early signs of infection. The investigation found multiple missed opportunities for intervention and appropriate monitoring. Its assessment was that if these measures and normal safety interventions had been undertaken and monitoring had occurred as appropriate, then labour would have been shortened and therefore the intrauterine, intrapartum fetal death of Harriet would not have occurred.

Following these four investigations Sarah and Jack Hawkins continued to press for a thoroughgoing review of maternity services at NUH, as well as for further investigation of aspects of Harriet's post-death care.

In 2020, NHS England and NHS Improvement (NHSE/I), together with the NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG), commissioned an external review of NUH. Sarah and Jack Hawkins contributed to defining the scope and terms of this Review.

Nevertheless, families participating in this thematic reviewbegan to lose trust in the process. The families coordinated and met with local MPs to escalate their concerns. Local MPs were responsive to their constituents. In a letter addressed to the then Health and Social Care Secretary, the Rt Hon Sajid Javid MP, they expressed concerns that the thematic review was progressing 'with the viscosity of treacle' and their confidence in its capacity to deliver meaningful and effective intervention had waned. It was observed that an increasing number of families were sharing their experiences through maternity support groups on social media.

The families also raised concerns that an additional report would not substantially influence NUH's capacity to implement necessary changes, citing prolonged public scrutiny from diverse sources with little evident progress. Immediate measures were considered essential, and ultimately it was requested that Donna Ockenden, who had recently released her report on Shrewsbury and Telford Maternity Services, be appointed as Chair for a newly structured review. The 2020 Review was closed prior to publication, and this Review was commissioned in May 2022.

Harriet's post-death care at the mortuary was investigated by John Pitchers, Chair of the Association of Anatomical Pathology Technology. This was prompted by information in email records obtained by Sarah and Jack Hawkins through a subject access request made to NUH under data legislation. John Pitchers' report identified 17 areas of concern (see below). This Review has also looked at post-death care at NUH (see Post Death chapter).

Additional and Ongoing Investigations

In addition, a number of other review and investigatory processes remain ongoing.

In 2017 the Hawkins family referred NUH to the Human Tissue Authority over concerns about the handling of slides obtained in Harriet's first post-mortem. The HTA's no-fault conclusion at that time, and the conclusions in John Pitchers' report, are under further discussion and review within the HTA.

The Care Quality Commission is reviewing compliance with duty of candour obligations at NUH.

Sarah Crowther KC is leading an investigation into whistleblower allegations to this Review concerning the making and use within NUH of a telephone recording of Jack Hawkins made without his knowledge, and when he was distressed, in December 2017.

Timeline of Care Received by Sarah, Jack and Harriet Hawkins

This timeline has been developed following a comprehensive review of the clinical records, post-mortem findings, previous investigations, email correspondence, interview recordings, staff interviews, and written reflections, with the support of Sarah and Jack Hawkins' recollections as identified below. It is important to acknowledge that findings from maternity care reviews must always be interpreted with caution. Such reviews are undertaken with the benefit of hindsight and knowledge of the outcome, but without the context, pressures and uncertainties present at the time of the events.

Retrospective analysis can illuminate system and clinical issues, yet it can never fully recreate the lived reality of the moment. Families affected by serious incidents whilst under maternity care deserve honesty, transparency and compassion. For Jack and Sarah these events have left a lifelong impact.

Background

Sarah Hawkins (nee Parry), Harriet's mother, worked as a senior physiotherapist for NUH and was 33 years old when she became pregnant with Harriet in 2015. Jack Hawkins, Harriet's father, also worked for NUH as a consultant doctor. This was Sarah's second pregnancy, having suffered from a miscarriage in 2014 at 8 weeks gestation.

Antenatal Care

On 1 September 2015 Sarah had a reassurance scan which confirmed a live embryo.

On 9 September Sarah attended a booking interview with a staff member at 8 weeks gestation, with an expected due date by scan of 11 April 2016. Sarah was a non-smoker with a body mass index (BMI) of 19.3 at booking with no family, medical or psychosocial history of note. It was documented that Sarah's father has hypertension. Booking blood pressure was 97/59mmHg and risk of venous thromboembolism score 0. Booking bloods and mid-stream urine were taken and within normal range. Sarah's blood group was A positive, antibodies negative. Sarah was appropriately booked to be managed under the 'low-risk' midwifery led pathway following her booking interview.

On 9 October Sarah attended for a dating scan where Nuchal Translucency was also performed as part of screening for Down's syndrome, Edwards' syndrome and Patau's syndrome. First trimester screen for Down's Syndrome was low risk (1:437).

Sarah had a routine antenatal visit on 4 November at 17 weeks and 2 days, her blood pressure was 109/62mmHg (remained normal), urine was also normal.

On 26 November an anomaly scan was performed. There were 45 ultrasound images available for review, which were recorded in scan duration of 13 minutes and 29 seconds. This scan has been reviewed and demonstrates good technical quality, compliant with the Fetal Anomaly Screening Programme (FASP) and local protocol at NUH. No abnormality was identified.

On 6 January 2016, at twenty-six weeks and two days gestation, Sarah had a routine antenatal appointment, her blood pressure was 121/58mmHg (i.e. it remained normal), and her urine remained normal. Symphysis fundal height measurement was 24cm, fetal movements were felt.

On 25 January 2016 Sarah was reviewed in an Obstetric-led clinic for infectious disease and acute medicine. This was prompted by a 2-week trip to Belize in December 2015, where Sarah suffered multiple mosquito bites and went onto develop a macular papular rash accompanied by generalised aching and fever. At this time there was worldwide concern about a Zika virus outbreak. Sarah was screened for

Cytomegalovirus (CMV), Epstein–Barr virus (EBV), Parvovirus B19, Dengue, Chikungunya and Zika Virus, all of which were negative.

On 27 January Sarah attended for a routine antenatal appointment at 29 weeks and 2 days. Sarah's blood pressure was 116/64mmg (remained normal), urine remained normal, symphysis fundal height measured 29cm, fetal movements were felt, Sarah's haemoglobin (Hb) level was 106g/l platelets 231, Sarah was commenced on oral iron tablets. Sarah's whooping cough vaccine was given.

On 1 February 2016 at 30 weeks pregnant Sarah attended the fetal medicine unit for a scan due to having had potential contact with Zika virus; this appointment was to review if there was microcephaly present, which means a small head and is a severe condition caused by contracting Zika virus during pregnancy, usually if a mother becomes infected during the first trimester of her pregnancy, causing poor development of the brain. Sarah had a growth scan in the department. Harriet's biometry was as follows: biparietal diameter 72.6mm, head circumference 270.8mm, abdominal circumference 245.0, femur length 57.1mm, estimated fetal weight calculated using Hadlock to be 1361g.

This scan has been reviewed by a sonographer and fetal medicine consultant within the Review Team. There are 6 ultrasound images available for review, the scan duration was 6 minutes and 16 seconds. These 6 images include 2 x head circumference images (268.3mm and 273.3mm), 1 x abdominal circumference image (238.4mm), 1 x umbilical artery doppler measurement, 1 x trans cerebellar diameter and 1 x posterior ventricle measurement. The ultrasound report used head circumference 270.8mm, abdominal circumference 245mm and femur length 57.1mm. This suggests there was an image of femur length measurement and probably another abdominal circumference measurement image, which either have not been stored on the ultrasound machine and/or have not transferred over to the Review Team. Estimated weight was plotted on Chitty charts, and no centiles are documented within the reports which were generated on Viewpoint. Visually the estimated fetal weight appears to be around the 20th centile on the Chitty chart. Normal brain anatomy was noted, no calcifications were seen. Other anatomical structures reviewed; no intra-abdominal calcifications either. There was positive end diastolic flow and no evidence of microcephaly. A plan was made to re-measure on 29 February 2016.

On 10 February 2016 at 31 weeks and 2 days Sarah has a routine antenatal appointment. Sarah had normal blood pressure; BP 107/68mmHg, normal urinalysis, and her symphysis fundal height measured 31cm. This was appropriately plotted on the growth chart.

On 29 February Sarah was scanned at 34 weeks and zero days. Harriet's biometry was recorded as: head circumference 312.2mm, abdominal circumference 293.1mm femur length 63.9mm. Estimated fetal weight using Hadlock was 2202g.

This scan has been reviewed by an ultrasound practitioner and fetal medicine consultant within the Review Team. There are 6 images available for review, which were recorded in scan duration of 4 minutes and 21 seconds. There are 5 ultrasound images including 1 x head circumference (318.7mm), 1 x abdominal circumference (298.8mm), 2 X femur length (55.4mm and 63.9mm) and 1 umbilical artery doppler. The 6th image displays measurements recorded, which includes 2 x head circumferences (318.7mm and 305.7mm), 2 x abdominal circumference (298.8mm and 287.3mm) and 3 x femur lengths (55.4mm, 63.9mm and 60.5mm). This suggests there are some images which either have not been stored and/or not transferred to the Review Team. Harriet was recorded as active with normal growth, liquor and doppler. Sarah was still waiting to hear about the serology result, and was to be contacted by infectious diseases. A plan was made to see Sarah again in 4 weeks' time. There was no suspicion of congenital Zika syndrome.

On 2 March 2016 at 34 weeks and 2 days Sarah had a routine antenatal appointment. Sarah's blood pressure was 108/69mmHg (remains normal), normal urinalysis, and her symphysis fundal height measured 34cm, which was plotted on her growth chart. Harriet was head down (cephalic), free (head not engaged in the pelvis) and fetal movements were felt.

On 15 March 2016 at 36 weeks and 1 day Sarah had a routine antenatal appointment. Sarah had normal blood pressure, although the diastolic measurement was raised from Sarah's booking blood pressure (97/59mmHg) to blood pressure of 110/80mmHg, urinalysis was normal, significant oedema was recorded

within the hand-held notes. Sarah's symphysis fundal height measured 35cm (1cm growth in 2 weeks, plotted on the growth chart, remaining on the same trajectory as prior to this appointment). Fetal movements are documented to have been felt. Harriet was head down (cephalic). The presenting part (Harriet's head) was documented to be 3/5 palpable (meaning Harriet's head had started to engage into Sarah's pelvis). Sarah's haemoglobin (Hb) had improved to 120g/l with platelets 224, both of which are normal.

On 30 March 2016 at 38 weeks and 2 days, Sarah attended a routine antenatal appointment. Sarah's blood pressure continued to be higher than her booking blood pressure with a blood pressure 128/80mmHg. It was recorded in the handheld records that Sarah had 'significant oedema' to her feet. Sarah's symphysis fundal height was SFH 36cm (1cm growth in two weeks, 2cm growth over a 4-week period, this plotted normally on growth chart used by NUH in 2015/2016). Fetal movements are documented as felt. Harriet's head was the same as previously and found to be 3/5 palpable.

Aromatherapy was provided to Sarah at this appointment, but no details on which aromatherapy. There are some essential oils that would be contra-indicated in pregnancy. It was documented that Sarah was prepared for baby, and discussed a membrane sweep. NUH had their own guideline at the time on aromatherapy, 'Guideline for Administration of Aromatherapy with Childbearing Women' (2015). This guideline advised that criteria for use were hospital, Sanctuary or home. The guideline advised that it was for massage and inhalation, and could be added to the birthing pool. There are advised amounts which should be used to ensure safety, but it does not appear Sarah was given additional information on this, or advice on what to do if a reaction occurred. NICE guideline cg190 Intrapartum care for healthy women and babies (2014) states 'Do not offer or advise aromatherapy'. There were a number of different oils recommended within local guidance by NUH at this time, for multiple uses and covering many issues, from normal physiological birth to urinary retention, anxiety, nausea and recovery from a caesarean section. More detail on this can be found within the intrapartum chapter.

On 31 March at 38 weeks and 3 days Sarah was scanned. Estimated fetal weight was not calculated as the head circumference was not able to be obtained due to a deeply engaged head. Harriet's biometry was measured; abdominal circumference 362mm, femur length 66mm. There are no images of this appointment available to the Review Team, the images have either not been stored or not been transferred over to the Review Team. It was reported in the narrative that Harriet was in right occipital-anterior position, meaning her back was facing outwards on Sarah's right. There was documented positive end diastolic flow, which is the background flow of blood still available to the baby at the end of the relaxation stage of the fetal cardiac cycle. There was also report of good blood flow and good fetal movements. Both of these observations are a positive sign of placental health, and that at the time of this scan Harriet appeared well.

It was documented that Harriet was difficult to measure, but showed good growth of abdominal circumference. Blood tests were negative for infectious diseases, including Zika virus. Sarah was reassured. A plan was made to await labour. The fetal weight at this appointment was not calculated. The Review Team calculated Harriet's estimated fetal weight using the same growth calculator used by the Trust at this time for ultrasound scans and found the estimated fetal weight to be 3422g, this would place Harriet on the 59th centile. Harriet's actual birthweight was 3080g, 18 days after this scan. Harriet would have been expected to gain weight between this scan and her birth. This was a technically difficult scan and it is not uncommon in later gestations for growth to be inaccurate and for an overestimation of fetal weight to be made. This has been shown in the Big Baby trial where 60% of babies diagnosed as being large for gestational age were found to be of a normal centile at birth.[38]

Ultrasound machines are often set up to automatically download measurements from the machine to computer and Viewpoint. It appears that the staff member used the machine-generated average measurement, instead of taking multiple images and then selecting the best image and measurement. At the time of this scan NUH did not have a guideline or protocol for fetal growth surveillance. In 2017 NUH created 'The Obstetric Ultrasound protocol' which advised that 'best possible abdominal circumference

38 Gardosi, J., et al. (2025) 'Induction of labour versus standard care to prevent shoulder dystocia in fetuses suspected to be large for gestational age in the UK (the Big Baby trial): a multicentre, open-label, randomised controlled trial', The Lancet, 405(10491), pp. 1743–1756.

should be measured and recorded on the report'. However, this protocol was made live from 2017, a year after Harriet was born, and whilst it was felt to be best practice by the Review Team to have obtained the best image and measurement, there still was minimal national guidance on this in 2026.

On 13 April 2016 at 42 weeks and 2 days, Sarah attended for a routine antenatal appointment. Sarah's blood pressure remained higher than her booking of 124/84mmHg, still within a normal range. Sarah's urine had 1+blood, although she had a history of losing her mucous show that morning, so this was not of concern as the mucous show would most likely have caused some contamination to the sample, no oedema was documented. Harriet's head was 4/5 engaged into Sarah's pelvis. Harriet's heartbeat was recorded to be heard and normal, and Sarah's symphysis fundal height measured 38cm.

Fetal Growth Surveillance

The growth of the baby can be assessed by monitoring of the symphysis fundal height (SFH) or fetal measurements and estimation of the fetal weight (EFW) on ultrasound. In the UK, there is still a wide variation in the charts used to plot these measurements, all of which have a margin of error, and national guidance has not specified which specific charts are recommended.

At the time of Sarah's pregnancy (2015-2016), NUH had the local guideline 'Guideline for Ultrasound procedures performed in Family Health by the midwife sonographer services' implemented in June 2015. This included a booking risk assessment of who should be referred for a growth scan. This was similar to RCOG 2013 guidance,[39] and detailed a clear pathway for low-risk women having SFH monitoring and referral if SFH < 5th centile (this was 10th centile in the 2013 RCOG guidance) or crossing centiles.

The (RCOG) 2013 guidance also recommended that symphysis fundal height (SFH) measurements be plotted on a customised growth chart rather than a population-based chart. Customised charts used maternal characteristics such as height, weight, parity and ethnicity incorporated which based upon previous data changed the shape of the curve, meaning each chart was individual to the woman. In contrast, population-based charts assume optimal growth under ideal conditions and do not individualise centiles in the same way. Not all trusts in the UK adopted the recommendation of customised charts, and NUH were not an outlier in using the 1982 Cardiff chart.[40] NICE guidance has never recommended one type of chart over another and the current RCOG guidance[41] moved to follow NICE guidance.

One of the core problems faced by both parents and clinicians is that the thresholds used to trigger further surveillance or an intervention (for example, below the 10th centile or above the 90th centile) depend entirely on the chart applied. A baby plotted at the 8th centile on one centile chart may appear at the 20th centile on another. This can alter whether the baby is labelled as small for gestational age or fetal growth restricted or not, and whether further surveillance is indicated, or whether an induction of labour would be considered to reduce the risk of a stillbirth. Sarah Hawkins was receiving both symphysis fundal height measurements and also growth scans, although the purpose of the growth scans was to review for features linked to Zika virus such as microcephaly, not because Sarah had any risk factors for fetal growth restriction.

It is possible if a different chart had been used that between 34 and 38 weeks the symphysis fundal height which only changed 2cm in 4 weeks might have crossed centiles, and the action for this would have been to perform a growth scan. However, Sarah had a pre-arranged scan a few days later, and whilst the estimated fetal weight was not calculated at the time of the scan the Review Team has calculated this and from the measurements of the abdominal circumference and femur length only the estimated fetal weight was found to be normal at thirty-eight weeks. These scans were only performed due to Sarah having a mild illness whilst in Belize during a time when concern was high regarding Zika virus, had this not happened no scans would have occurred.

39 RCOG (2013) The Investigation and Management of the Small-for-Gestational-Age Fetus, Green top guideline No.3, Royal College of Obstetricians and Gynaecologists, London

40 Calvert, J.P., Crean, E.E., Newcombe, R.G. and Pearson, J.F. (1982) 'Antenatal screening by measurement of symphysis–fundus height', British Medical Journal (Clinical Research Edition), 285(6345), pp. 846–849.

41 Royal College of Obstetricians and Gynaecologists (RCOG) (2025) The investigation and management of the small-for-gestational-age fetus. Green-top Guideline No. 31 (Updated). London: RCOG.

Post-mortem findings for Harriet further highlight the limitations and controversies around growth and centile assessments and agreements. The initial post-mortem reported Harriet's birthweight at the 50th centile, however a subsequent independent post-mortem commissioned by the Clinical Commissioning Group identified Harriet's weight as being on the 9th centile; this was based on the same weight, Harriet was not re-weighed. Subsequent post mortems were completed with slides and clinical information gathered from the initial one. This highlights the significant disagreements which exist between different models of assessment, causing confusion around a pathological causation or unexplained causation. It should be noted that the birthweight of a stillborn baby would be unlikely to reflect the live birth weight due to changes in the weight following the death of a baby, and the diagnosis of fetal growth restriction should be a diagnosis by the pathologist based on the histological changes in the placenta and the baby, and not based on the birthweight.

The use of a wide variety of growth centile charts across the UK reflects differing interpretations of what constitutes normal growth and how best to detect pathology. However, this variation introduces clinical inconsistency, communication challenges, potential to increase parental anxiety, potential to overlook possible growth restriction, concerns around equity, and methodological problems for audit, research, and observing national trends.

A more transparent national conversation is needed about the purpose of growth assessment, to review whether we are aiming to describe, prescribe, customise, or standardise fetal and infant growth. Until there is greater alignment, clinicians and parents will continue to navigate a system in which the same baby can appear differently depending on which chart is used. Please see the Antenatal chapter for more details.

Intrapartum Care

There follows a list of contacts made with maternity services at NUH by Sarah in labour. Phone calls do not appear to have been recorded by NUH, and so this list uses phone records and recollections provided by Sarah and Jack.

1st Contact:

Sarah's first contact was a phone call to Queens Medical Centre (QMC), on 13 April at 09.27am. The call lasted 3 minutes 18 seconds. Sarah was 40 weeks and 2 days pregnant. Sarah called the maternity unit at QMC for advice due to experiencing irregular contractions every 6-9 minutes, Sarah recalls these had been going on through the night before making this call. The Staff Member provided advice about the latent phase of labour and Sarah was advised to call back when her contractions increased or if she had any other concerns. Sarah was advised to attend a pre-arranged antenatal appointment later that morning. Sarah informed NUH of the 'show' and her contractions. She was advised this was normal. Mucoid brownish PV discharge continued after the show until the birth. Sarah was advised to continue with TENS/ movement/ baths. Sarah and Jack were told that the contractions were not regular/ long enough to warrant admission but chose to keep the planned antenatal appointment booked for that morning. The advice they were given was appropriate and in line with routine practice in 2016.

2nd Contact:

The second contact was a face-to-face antenatal appointment on 13 April at 11:14am. Sarah was 40 weeks and 2 days pregnant. It was recorded that fetal movements were felt and the fetal heart was regular. Abdominal palpation showed that the fetal presentation was cephalic and the fetal head 4/5 engaged. It was documented that Sarah had experienced contractions overnight which had now increased in frequency and were 2:10 lasting 30-40 seconds, and were strong on palpation; Sarah was using a TENS machine. A vaginal examination was performed with consent and the fetal heart auscultated before the examination and recorded as fetal heart heard and regular. The vaginal examination documented that external genitalia were normal, cephalic presentation and the station of the fetal head was -2cms above the ischial spines. Sarah's cervix was 1 centimetre (cm) long and 2-3cms dilated with the membranes intact.

It was documented that a membrane sweep was performed and the fetal heart was heard, Sarah recalls this was around 150bpm and the parents heard this. It was documented that the findings were explained to Sarah and Sarah was advised to call Labour Ward (LW) when the contractions increased in frequency or should she have any concerns. Sarah was advised about eating and drinking, mobilising, and using warm baths. Advice was also provided about using simple analgesia and to continue using the TENS machine. This advice was appropriate.

A follow-up appointment was arranged for the following week should this be required. Sarah expressed concern that she might not be admitted when she felt she needed to be. Sarah recalls being told that "they normally wait until you call three times and then they have to bring you in if you feel like you need to be admitted". This advice was outlined within the NUH latent phase of labour guideline (2014) to invite women into triage if they call three times, however it should be noted that this should have been interpreted to act as a safety net for women not deemed to be in labour but clearly needing support/assessment, rather than as a requirement for women to call three times before they would be allowed into the hospital. This potentially represents a misunderstanding of the guideline and a culture of gatekeeping access to the labour ward. This theme was also picked up within the wider review; that staff were reluctant to invite women to attend the hospital who called when they were in labour. A woman calling a maternity hospital at any point in labour and requesting to attend should be welcomed in for care, emotional support, assessment of their wellbeing, and fetal surveillance.

3rd Contact

Sarah's third contact was a second phone call to QMC on 13 April at 7:35pm. The call lasted 6 minutes 49 seconds. Sarah called for advice. It was documented that Sarah had a membrane sweep that morning and that she was becoming increasingly uncomfortable with the contractions and unable to talk through them on the phone. Fetal movements "Normal" was ticked. Sarah was invited to attend QMC for assessment. This was appropriate management.

4th Contact

Sarah attended QMC for a face-to-face review on 13 April at 8:30pm, 9 hours after the last vaginal examination. She was admitted to Sanctuary birth centre, and was reviewed.

Sarah's blood pressure was 130/76mmHg, heart rate 75bpm, temperature 36° Celsius. Urinalysis was normal and the fundal height was recorded at 35cms, which was not plotted on Sarah's growth chart. This symphysis fundal height was 3cm different to the midwife's measurement earlier that day; this is a known issue due to different individuals undertaking the same assessment and is widely documented. However, it was not acknowledged or considered as a risk factor for place of birth or further explored . On palpation the fetal lie was documented as longitudinal with a cephalic presentation and an occipital-posterior (OP) position was identified. The fetal heart was recorded as 150bpm. It was recorded that a vaginal examination was declined and the contractions were 1:10 lasting 20 seconds. It was also documented that fetal movements were felt. A plan was made for simple analgesia and for Sarah to be discharged home to await progress in labour. Sarah was given 60mg of Codeine Phosphate. Sarah recalls being given a leaflet on labour and being told she was not in labour at this point.

Sarah and Jack's recollection differs from the record. They recall being told that there was no indication for a vaginal examination as this would not change the management as Sarah was not contracting enough. NICE Intrapartum Care 2014 guidance supports the rationale of not performing a vaginal examination at this time, but also advises to listen to a woman's history and to consider her preferences and her emotional and psychological needs.

Sarah told the Review Team that during this time she had 3 painful contractions in 10 minutes, that she informed the staff member of this and was told it did not matter as they were not lasting long enough, although the staff member had not been present to time these contractions. Sarah agreed to go home. Sarah feels that no time was spent by the staff member to assess her contractions. Palpation of contractions

is a basic Midwifery assessment to measure strength and length of contractions, in addition to observing the woman's experience during the time. Sarah does recall having a hand briefly placed on her abdomen when she was having a contraction. Sarah remembers she was told her baby was now lying back-to-back, which was why it was more painful. Sarah reports that she had a bad night's sleep with painful contractions ongoing throughout the night following her return home.

Staff voices on care of women in the latent phase of labour

Staff who worked at NUH prior to 2017 shared with the Review Team that there was a culture of not admitting women who were seeking admission in labour:

Staff Member: *"There was nowhere for those women to safely go to, because they were perceived as bed-blocking on labour suite and there was never – wouldn't be staff for the care, so, they'd often be put on a side ward, on either Lawrence Ward or the ward next door. But these were busy stretched units with a lot of need, and latent phase of labour would be very low down on the priority list. Honestly, when I worked there, it would be when they complained enough, when they complained loud enough, but they need to do that, because we hadn't – we didn't have Entonox on – on the ward, we didn't have staff, we didn't have – they would often be given a side room, just so they were in the hospital, but there would be no care given. There was no guidance at that period, but I think they now say, if somebody has phoned in three times, they automatically get seen regardless of what they are phoning for."*

Staff Member: *"Okay. So – so, latent phase of labour. That ended up being – when we looked at our incidents, there was so many instances of women, I'm just going to say, feeling fobbed off. And when we were looking at it from a clinical incident perspective and we're looking back now and we're thinking, so, why wasn't they invited in then. You know, why were they fobbed off – or sent home so quickly?"*

Staff Member: *"We did send/encourage women home in the latent phase of labour often without risk assessment so there were missed opportunities, most came back in when labour advanced... 2016-18 didn't have overnight triage, hugely understaffed and over run."*

Sent home in labour – 1st potential missed opportunity

In 2016 it was commonplace in UK maternity services to encourage women to remain at home during the latent phase of labour. NICE 2014 guidance states 'encourage her to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed'. NICE also states within its 2007 and 2014 guidance 'If a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent first stage of labour'.

The advice to encourage women to remain at home (unless it was unsafe or causing them distress) was driven by interpretation of research that early hospital admission was associated with higher rates of obstetric intervention, including caesarean section, labour augmentation with oxytocin, and epidural analgesia.[42,43,44,45,46,47] This interpretation of findings supported the inference that delaying admission until active labour could reduce the likelihood of medical intervention, by supporting the normal physiological process of birth, and so it was common practice to encourage women to stay at home where it was

42 Bailit, J.L., Dierker, L., Blanchard, M.H. and Mercer, B.M. (2005) Outcomes of women presenting in active versus latent phase of spontaneous labor. Obstetrics and Gynaecology, 105(1), pp. 77-79.

43 Hemminki, E. and Simukka, R. (1986) The timing of hospital admission and progress of labour. European Journal of Obstetrics, Gynecology, and Reproductive Biology, 22(1-2), pp. 85-94.

44 Holmes, P., Oppenheimer, L.W. and Wu, W.S. (2001) The relationship between cervical dilatation at initial presentation in labour and subsequent intervention. British Journal of Obstetrics and Gynaecology, 108(11), pp. 1120-1124.

45 Klein, M., Lloyd, I., Redman, C., Bull, M. and Turnbull, A.C. (2003)* A comparison of low-risk pregnant women booked for delivery in two systems of care: shared-care (consultant) and integrated general practice unit. II. Labour and delivery management and neonatal outcome. British Journal of Obstetrics and Gynaecology, 90(2), pp. 123-128.

46 Petersen, K.S., et al. (2011) The timing of interventions during labour: Descriptive results of a longitudinal study. Midwifery. 27(3) pp. e267-e273

47 Rahnama, P., Ziaei, S. and Faghihzadeh, S. (2006) Impact of early admission in labor on method of delivery. International Journal of Gynecology & Obstetrics, 92(3), pp. 217-220.

believed that the release of physiological oxytocin, the hormone responsible for uterine contractions, would flow more freely. This is because its production is directly inhibited by the hormone cortisol (the hormone released in response to stress, pain and fear). However, this interpretation was not without limitations and nuances.

For example, some women would feel more relaxed in hospital surrounded by midwifery and medical support, whereas others would prefer their own home. Some women feel in control of their pain and some do not. Both Sarah and Jack Hawkins worked in hospitals and might have preferred to stay in, but they say this was not given to them as an option. This assessment should have been individualised for Sarah's needs, not based upon a uniform approach in response to unit acuity to reduce the flow through the labour ward. NICE (2014) guidance on intrapartum care highlights the importance of assessing fetal movements and discussing women's expectations, and it does not support keeping a woman at home if she is distressed. This is further discussed in the intrapartum chapter.

The research on the progression of physiological labour does not review if the women who experienced spontaneous labour and presented later requiring less intervention might have benefited from a more favourable position of their baby at the onset of labour. Furthermore, a Cochrane review (published after Harriet' birth) has suggested that there was no significant difference in outcomes in women who chose to remain at home until established labour, compared with those who presented earlier but were not yet in active labour[48].

It has also been noted within the literature that feelings of distress and anxiety may theoretically prolong labour due to the secretion of catecholamines that counteract the release of oxytocin.[49,50,51] Research also highlights that emotional distress in the latent phase is linked to an increased likelihood of instrumental vaginal birth, and women with increased reported pain in the latent phase may be less likely to have a spontaneous vaginal delivery.[52] This may again be due to malposition of the fetus, which causes more pain.

Leaflet on the latent phase of labour

The leaflet provided by NUH 'The latent phase of labour', (2014) is consistent with the belief that women should stay at home as long as possible. It states *'Labour is a physiological process, which can often take a long time. Every woman's labour is different… If you telephone the midwife for advice, and everything sounds normal you will be encouraged to remain at home for as long as possible. Most women are more relaxed at home in the latent part of the first stage and you can use this leaflet to help you to manage this part of your labour. There is also evidence to show that the further on in labour you are when you come in to hospital, the more likely you are to have a normal birth.'* This leaflet sent a clear message to women that they should stay at home for as long as they could if they wanted a normal birth. It encouraged women to stay at home potentially longer than was safe to do so, as they were not receiving intrapartum care, which even in women who are considered to be 'low risk' or to have a 'low chance of hypoxia' is in place to identify those babies which for some reason can come to harm in labour. In Sarah's case this approach appears to have resulted in a loss of personalised care, lack of fetal monitoring, and a loss of risk assessment of labour dystocia, which in the Review Team's assessment were contributory factors in Harriet's death.

Sarah provided a history of regular uterine activity at this time and had been contracting continuously at home. Sarah could have been offered admission to the hospital for rest, analgesia and emotional support.

48 Kobayashi S, Hanada N, Matsuzaki M, Takehara K, Ota E, Sasaki H, Nagata C, Mori R. (2017) Assessment and support during early labour for improving birth outcomes. Cochrane Data Syst Rev 4: CD011516.

49 Alehagen, S., Wijma, B., Lundberg, U., & Wijma, K. (2005). Fear, pain and stress hormones during childbirth. Journal of Psychosomatic Obstetrics & Gynecology, 26(3), 153-165. https://doi.org/10.1080/01443610400023072

50 Lederman, R., Lederman, E,. Work, B,A,. McCann, D, A,. (1978) The relationship of maternal anxiety, plasma catecholamines, and plasma cortisol to progress in labor, American Journal of Obstetrics and Gynecology, Volume 132, Issue 5, Pages 495-500, https://doi.org/10.1016/0002-9378(78)90742-1.

51 Simkin P. (2011) Pain, suffering, and trauma in labor and prevention of subsequent posttraumatic stress disorder. Journal of Perinatal Education. Summer;20(3):166-76. doi: 10.1891/1058-1243.20.3.166.

52 Wuitchik M, Bakal D, Lipshitz J. (1989) Clinical significance of pain and cognitive activity in latent labor. Obstet Gynecol. Jan;73(1):35-42. PMID: 2909041.

It would have been appropriate to offer a cervical assessment of Sarah's progress in labour, and consider that if her cervix was not dilating that this was a prolonged latent phase. Instead, Sarah's symptoms of labour and pain were minimised, invalidating her in the process.

Recognition of prolonged latent phase or labour dystocia

Diagnosis of a prolonged latent phase or labour dystocia presents particular challenges within this framework. Labour dystocia is a broad and contested term used to describe labour that is 'not progressing as expected', yet what constitutes 'expected' progress is itself socially and clinically constructed. The aetiology of dystocia remains incompletely understood. It may present as diminishing contractions or as minimal cervical dilatation despite ongoing contractions. In a multicentre cohort study of women having their first baby, it was identified that many women who were eventually diagnosed with labour dystocia initially presented with cervical dilatation under 4cm, so supporting the use of vaginal examination in this diagnosis.[53]

The variability in intervention timing between practitioners and between settings, both nationally and internationally, further exposes this uncertainty.[54] If labour dystocia were a clearly defined and objectively measurable pathological state, such variability would be less marked. Instead, practice patterns reflect differing interpretations of when labour ceases to be a normal physiological process, and becomes pathological. The latent phase of labour leaflet which was given to Sarah stated that women who remain at home longer are more likely to achieve vaginal birth. It is true that women whose labour progresses normally are inherently more likely to achieve vaginal birth, but those with true labour dystocia are not. Without clear diagnostic criteria, advice to 'stay home longer' may either protect physiological labour from intervention or it may delay recognition of emerging pathology if, throughout history taking, listening to the woman and a holistic risk assessment is not considered.

Clinicians are therefore required to operate within epistemic uncertainty. They must balance the risk of over-diagnosing dystocia, leading to unnecessary intervention, against the risk of under-recognising genuine obstructed labour. Cohen and Friedman (2023)[55] highlight that significant gaps remain in understanding the mechanisms and optimal management of prolonged labour. There is not yet any dedicated national guidance in England addressing care in the latent phase of labour. The absence of national guidance for the latent phase of labour creates variation, leaving responsibility of interpretation for defining pathology to individual clinicians and local culture.

Importance of women's experience

Alongside the responsibility to ensure the physical safety of a mother and baby during labour, emotional safety and support achieved through kind attentive care has been found through research to hold equal importance for women.[56] The World Health Organization recognises research[57] identifying that, for women, a positive birthing experience itself is equally valued to safety outcomes which are measured. Although this research was published after Harriet was born, kind, compassionate and individualised care was a fundamental expectation, and a minimum requirement to provide to women and their families in 2016. Had this basic need been met for Sarah, Jack and Harriet, it is highly likely that Harriet would not have died during labour. A national guideline is needed for caring for women during the latent phase, centred around women being listened to and their psychological safety and cultural needs being met.

53 Kjærgaard, H., Olsen, J., Ottesen, B. et al. (2008) Obstetric risk indicators for labour dystocia in nulliparous women: A multi-centre cohort study. BMC Pregnancy Childbirth 8, 45 https://doi.org/10.1186/1471-2393-8-45

54 Neal JL, Ryan SL, Schorn MN, Buxton M, Holley SL, Wilson-Liverman AM (2015).Labor dystocia: uses of related nomenclature. Journal of Midwifery & Women's Health;60(5):485-98

55 Cohen WR, Friedman EA. (2023) The latent phase of labor. Am Journal of Obstetrics and Gynecology. ;228(5S):S1017-S1024. doi: 10.1016/j.ajog.2022.04.029. Epub 2023 Mar 15. PMID: 36973092.

56 Downe S, Finlayson K, Oladapo OT, Bonet M, Gulmezoglu AM (2018) What matters to women during childbirth: A systematic qualitative review, PLOS ONE, 13 (5)

57 World Health Organization (WHO) (2018) WHO Labour Care Guide: User's manual. Geneva. World Health Organization.

5th Contact

The fifth contact was a phone call made by Sarah to QMC, on the next day,14 April, at 12:04pm. The call lasted 5 minutes exactly. Sarah and Jack called to say contractions were continuing, and that Sarah had not slept; Sarah advised she had been contracting without a break and that contractions were coming every 3 minutes. Sarah recalls being told they were not regular enough, to continue with codeine phosphate at home, to have a bath and a sleep, and to eat jelly babies for energy. Sarah reports that when she was asked if her baby was moving normally, she said, *"I'm not sure because I'm in so much pain, I can't tell"* and the midwife told her that was normal in latent labour.

This call should have prompted an invitation into the hospital for further antenatal assessment. Sarah was at the point where she was in too much pain to notice Harriet moving. Further assessment was therefore needed to confirm fetal wellbeing, such as a Cardiotocograph (CTG), and Sarah should have been offered a cervical assessment, and pain relief. This phone call cannot be found in the hospital records. However, this was Sarah's third phone call and therefore, according to NUH's local guideline, Sarah should have been invited in.

6th Contact

The sixth contact was a fourth phone call to QMC the following day, 15 April at 3:27pm. The call lasted 7 minutes and 13 seconds. It was documented Sarah was contracting 1:10 lasting 60 seconds (although the call was shorter) with some contractions being stronger than others. Sarah disputes this record remembering that she felt her contractions were more frequent than this. Normal fetal movements were recorded. The latent phase of labour was recorded as being discussed, along with analgesia, and it was agreed that Sarah would call back if there were any concerns.

This call should be seen in the context of previous calls; it was already a 'call-back' as there were concerns. Although there was no prompt on the call sheet to ask about number of calls (which itself is a deficiency) Sarah recalls volunteering that information. Sarah should have been invited in at this phone call.

7th Contact

Sarah made a fifth phone call to QMC on 16 April, just after midnight, at 00:14.am. The call lasted 3 minutes and 40 seconds. This phone call was recorded but the record was not signed. It is documented that Sarah was contracting 2-3:10 lasting 60 seconds, fetal movements were felt and there was no spontaneous rupture of membranes. It was recorded that there was 'PV bleeding' (meaning that Sarah was bleeding vaginally). Sarah does not recall this and in the Review Team's collective experience it has the mark of a record made in order to be able to defend a decision to invite a woman in if challenged by colleagues. Sarah was invited and advised to attend hospital, which was the correct advice to give her at this time.

8th Contact

Sarah promptly attended QMC at 1:15am; she was admitted to the Sanctuary Birth Centre at Queens Medical Centre and reviewed.

It was recorded that Sarah was contracting 2-3:10, BP 134/84mmHg, pulse 96bpm, and the fetal heart was recorded at 135bpm. Following abdominal palpation, it was recorded that the fetal lie was longitudinal and the presentation was cephalic. Sarah was unable to provide a urine specimen for urinalysis at this point. Sarah was later found to have urinary retention, and there was a lack of professional curiosity and appropriate bladder care throughout.

There is nothing about bleeding documented within this admission, despite the note and although it would be expected that this question be asked when meeting a woman in labour as part of risk assessment. If bleeding is present that would indicate that the place of birth should be the obstetric-led labour ward with continuous fetal monitoring, and a multidisciplinary team of obstetricians, anaesthetists and midwives. Sarah's blood pressure was significantly higher than her booking blood pressure, but that was not noted. Her temperature was not recorded.

At 01:50am on 16th April Sarah was able to pass urine, and there was blood present within it. There was no documentation of the volume of urine that was passed. Sarah's contractions were reported as 3:10 of moderate strength lasting up to 50-60 seconds. Aromatherapy (clary sage, frankincense, lemon) was provided, alongside a discussion regarding mobilising, taking a bath, and performing a vaginal examination. The Review Team note that the use of clary sage here was contraindicated, as it is known as nature's syntocinon and might have put Sarah at risk of overstimulation. NICE (2014) Intrapartum guideline[58] advised 'Do not offer or advise aromatherapy, yoga or acupressure for pain relief during the latent first stage of labour. If a woman wants to use any of these techniques, respect her wishes'. However it appears to have been routine practice at NUH, which had its own guideline on this.

At 2:20am it was recorded that a vaginal examination was performed with consent to see if Sarah was in established labour. Sarah's cervix was 3cm dilated and fully effaced, the membranes were bulging and the presenting part was -1cm above the ischial spines. It was recorded that the fetal heart was heard and regular and listened to for one minute post the procedure and was 140bpm with no audible decelerations. Fetal movements were reported. These findings were explained to Sarah, it was documented that Sarah wished to stay, and was requesting analgesia as feeling very tired (recorded as tired ++).

From this vaginal examination and contraction strength and frequency Sarah should have been considered to be in labour. There was no mention of bleeding seen at the vaginal examination. Sarah's cervix had completely effaced and dilated to 3cm, membranes bulging which indicates the strength of the contractions. The Review acknowledges the NICE CG190 2014 definition of the latent phase of labour: *'Latent first stage of labour – a period of time, not necessarily continuous, when: there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4cm.'* However, by holistic definition Sarah was establishing in labour, and at the point of requiring 1:1 care and pain relief. Contracting 3:10 moderate to palpate means Harriet was experiencing this uterine activity and therefore fetal surveillance should have been increased to auscultating every 15 minutes as contractions are known to temporarily interfere with placental perfusion. This is basic intrapartum care in recognition of the fact that we will not identify all babies whose placenta is beginning to fail and even a healthy term baby can only tolerate continuous contractions for a certain period of time.

At 02:43am 10mg of Diamorphine and 12.5mg of prochlorperazine maleate (Stemetil) were given intramuscularly to Sarah. There was no evidence of medical review of Sarah prior to this being prescribed. In addition, there was no auscultation of Harriet's heartbeat performed prior to or following administration of diamorphine, a strong opioid, the last auscultation being documented at 02:20am following vaginal examination.

At 02:58am toast and orange juice were provided. At 03:15am the fetal heart was heard and was regular with no audible decelerations for one minute following Sarah's contraction at 130bpm. It was documented that Jack was provided with a bean bag and sheets and the lights were dimmed. At 04:15am the fetal heart was heard and was regular at 138bpm for one minute, no audible decelerations were heard. It was documented that Sarah reported to be feeling more comfortable. At 05:25am further analgesia was provided (1g of Paracetamol and 60mg of Codeine Phosphate); it was documented that Sarah reported diamorphine was wearing off and contractions had decreased and were not as strong. At 05:30am the fetal heart was heard at 132bpm post contraction, no audible decelerations, and it was planned for Sarah to return home in 1 hour if contractions remained irregular and incoordinate. 'Sarah happy with plan' is documented within the notes. At 6:15am it is documented that Sarah reported contractions had decreased in strength and frequency, and that 'Sarah is happy to go home'. The Review Team considers that Sarah should not have been advised to go home without an obstetric review for her prolonged latent phase, or following the requirement for strong opiates.

Sarah and Jack do not agree with the clinical records at this time. Sarah recalls being told that she was in the latent phase of labour, and when she requested gas and air (Entonox) that this request was declined. There is no evidence of this discussion in the clinical record. Sarah remembers requesting an epidural

58 NICE (2014) Intrapartum care for healthy women and babies. Clinical guideline [CG190]. Published: 03 December 2014.

because she felt she could not cope with the pain and reports being advised that she did not need an epidural, and that she could not have one but could have a bath. There is no evidence of this in the clinical record, but we note that Sarah's recollection is clear.

Sarah recalls that she had been frequently in and out of the bath for the past few days and did not wish to do this. Sarah recalls the contractions never stopped, but continued to be strong and painful. The discharge summary states: 'Attended MLC with H/O tightening 3:10, cervix on arrival 3cm dilated fully effaced. Diamorphine given and simple analgesia. Sarah has since slept and reports strength and frequency have decreased.' Sarah remembers they had a discussion with regards to going home and she was told that her labour would progress better at home. Sarah recalls she agreed to go home, but on the proviso that when she felt like she needed to come back again she would be able to without any problem. Sarah was told she could return when she needed to, merely needing to telephone the labour suite and give her name. Sarah was clear she did not want to have to give clinical information and be reassessed on this call. This was agreed by the Staff Member. Sarah recalls leaving the midwifery-led unit holding a sick bowl and saying that she really was not feeling well.

The Review Team notes that there was no documentation of a palpation of contractions or consideration for a vaginal examination prior to discharge. There was a focus on the dilatation alone, not taking into consideration the full clinical picture of a cervix which has progressed significantly from a non-labouring cervix to being fully effaced 3cm, in a woman requiring opiates, who on admission had strong moderate and regular contractions. Holistically, Sarah was in labour at this point and both maternal and fetal surveillance and emotional support were indicated to ensure both the physical and emotional safety of Sarah and Harriet. The Review Team concludes that it would have been appropriate for Sarah to have had an obstetric review and a conversation offering her choices prior to returning home.

9th Contact

Sarah called QMC for the 6th time on 16 April at 1:48pm; the call lasted 6 minutes 3 seconds. There appears to have been no hospital documentation of this phone call Sarah reports she requested admission to hospital as this was agreed when she was discharged but was told during the phone call "It doesn't work like that". Sarah and Jack report that they were advised to call back in an hour as the contractions were not regular enough. Sarah reports being asked about fetal movements again and explaining she could not tell because her contractions made it too painful. Sarah felt that the Staff Member appeared not to be concerned.

At this point it would have been reasonable to invite Sarah in for a full assessment inclusive of fetal monitoring of Harriet. Sarah had been in the latent phase, contracting regularly without a break for a prolonged period of time, requiring opiates. This should have included a CTG , as Sarah reports she was in too much pain and was unable to confirm fetal movements.

10th Contact

Sarah called a 7th time to QMC at 03:21pm; the call lasted 2 minutes 21 seconds. There appears to have been no hospital documentation of this phone call. Sarah reports that she informed the Staff Member she was exhausted, she had tried a bath but this was not working. Sarah recalls she was asked about fetal movements and she said it was difficult to know with contractions, again she felt that the Staff Member was not concerned. Sarah reports being told that as the contractions were still not 'improved', that she was not in labour and therefore she was not invited to attend the Sanctuary Birth Centre for assessment.

The Review Team considers that this was unacceptable. Sarah should have been invited in to the labour ward for care in labour, a CTG, and obstetric review for possible obstructed labour. There was a clear bias towards Sarah having a normal latent phase of labour, not listening to Sarah's history, along with a lack of any risk assessment, a lack of consideration of any pathology given the length of the latent phase, and little kindness, empathy or accountability for a woman in labour.

A Staff Member commented to the Review Team on latent phase treatment as follows:

"Women in latent phase were, they were the least prioritised on labour suite. The birth centre, it's next to labour suite, but when you're working there, you are very much on your own really. If you pull the emergency buzzer, that sounds on labour suite and people can hear that. But to me, you can't just stick your head out of the room and have someone there. So, there was a lot of pressure to make women in the latent phase normal. A lot of pressure if you were doing a VE to make her three centimetres. Yes, that's what would go on the board, that's what you'd document. And you're latent phase. Yes, so, at the time, it was completely acceptable practice to give latent phase women diamorphine without an obstetric review. Yes, that was completely accepted practice. Encouraged practice really. Try and send them home. Try and I would really say coerce them into going home. It wasn't encouragement."

11th Contact

Sarah made an eighth phone call to QM Centre on 17 April at 02:18am; the call was transferred to City Hospital as QMC was closed to new arrivals due to lower-than-expected staffing levels. The call lasted 4 minutes 42 seconds. Sarah reported contracting 3 times in 10 minutes, with some vaginal discharge. It was documented that the midwife offered Sarah admission for assessment and analgesia, but that she was happy for Sarah to stay at home for a while longer. It is also recorded that Sarah was happy with this plan to ring back if she experienced spontaneous rupture of the membranes or if the contractions became stronger. However, Sarah has described to the Review Team that this was *"the worst phone call of my life. I remember crying down the phone just asking for help. That call is etched into my brain and nightmares for life".* Sarah and Jack also recall that the midwife told them that she was confident that Sarah was not in established labour.

By this stage Sarah had a history of a prolonged latent phase, and a history of requiring admission for strong opiates. This should have been a red flag to the midwifery staff to ask Sarah in for support and assessment and escalation to an obstetrician if there was slower than expected progress in labour, or concerns with the fetal heart. Diamorphine had been given just under 24-hour hours before this call, so would have been ineffective at this point. Alternative pain relief options were available, such as an epidural. Hospital documentation of there not being a contraction for 7 minutes during the call (which the Hawkins' record times at 4'42") appears dismissive of Sarah's pain and presentation and does not reflect the kind and compassionate care that Sarah needed at this point, and which there was a duty of care to provide to her.

The temporary closure of QMC at this time leads the Review Team to observe that almost a quarter of staff who spoke with the Review Team talked about issues relating to unit closures or diverts. It is clear from staff voices that staffing at NUH started to become a serious issue from 2010 onwards and from 2015 staff were experiencing severe stress. Most of the staff working at that time report an explicit NUH policy not to close beds or a unit, even when severely short staffed. Night shifts and weekends were the worst times and with no on-site senior midwifery managers, coping with too many women and not enough midwives was the responsibility of labour ward coordinators and ward managers. Staff report receiving no support when escalating concerns, unsympathetic and off-hand management, and different policies applied on the two sites, with little communication between them and no culture of helping each other. There was no evidence of any plan to involve the obstetric team, including the consultant on call, when the care of pregnant women in a maternity department became higher risk. All discussions about 'staff' seem to relate to midwives, yet there was a substantial team of doctors with useful skills who should have been involved.

12th Contact

A ninth phone call was made by Jack to QMC, referred to City Hospital, at 03:37am as Sarah could not face speaking to the hospital again.

The Staff Member answering the call asked to speak to Sarah, but Jack advised she was in too much pain. The hospital record documents that Sarah had bulging membranes (from a description provided by

Jack of a 'water filled blister' visible at the entrance to the vagina). Jack recalls being asked to confirm if he thought the presentation might be a cord, which Jack was unable to confirm but thought it was not. Jack was asked *"do you feel that you can get her here safely in the car or do you feel you need an ambulance to come?"* and Jack replied to say that driving directly to hospital would be quicker. QMC confirmed they were unable to accept admissions but Sanctuary Birth Centre, at the City Hospital site, would be expecting Sarah. Documentation suggests that the Staff Member appreciated the urgency of this situation, offering an ambulance, trying to facilitate a shorter drive, and ensuring they knew where to come.

13th contact

Admission to the Sanctuary Birth Centre – 9th Potential missed opportunity

Sarah and Jack are recorded as arriving at City Hospital at 04:16am on 17 April , where they were admitted to the Sanctuary Birth Centre, room 4. Sarah recalls that when she arrived at the door she could hardly walk, and that a Staff Member said to her *"Is it still hanging out of you?"* at which point she remembers bursting into tears. Sarah told the Review Team *"Not one person got up to help me as I struggled down the corridor".*

The Review Team considers that Sarah was not suitable for midwifery-led care and should have been admitted to the labour ward where she should have been immediately reviewed by the multidisciplinary team until a cord prolapse had been excluded. It appears there was a shift in interpretation and level of concern from the phone call in which Jack was offered an ambulance to when Sarah and Jack arrived, when Staff Members were inappropriately jovial with Sarah and Jack on admission to the unit and they were admitted to midwifery-led care.

At 4:45am it was recorded that fetal movements were felt by Sarah recorded as 'FMF by mum +++' but Sarah disputes this was asked during this admission, and recalls that she was not able to feel movements from Harriet. It was documented that a bag of membranes was visible at the introitus with no rupture of membranes or vaginal bleeding noted. The fetal heart was recorded at 130bpm via a Sonicaid. Sarah's observations were recorded as: Blood Pressure (BP) 130/70mmHg, pulse 80bpm, respiratory rate 16bpm. Sarah was unable to provide a urine sample. Temperature was not recorded. Abdominal palpation also found Harriet to have a longitudinal lie with a cephalic presentation (head down) which was 2/5 engaged; nothing is noted about the shape of Sarah's abdomen being unusual.

The next entry is at 4:50am when there is one long entry, with multiple actions and discussions. Sarah has told the Review Team when she went into the room she was stood clasping onto the bed in pain, she was asked if she needed to push, she said that she did, a vaginal examination was performed, it was offered to Sarah to break her waters, which when broken were clear. Sarah and Jack recall that the Staff Member then advised Sarah there was no time for any pain relief so her only option was a waterbirth, although the hospital record does not record this.

The 04:50am entry records that Sarah did not wish to pass urine and was offered an in-out urinary catheter; that the reasons why were discussed but this was declined as Jack informed the midwife that Sarah had been passing minimal amounts of urine for the past 18 hours, due to poor hydration. Sarah disputes this documentation, and recalls that in response to Jack's concerns she was told "Oh, just make sure you drink lots of fluid". Sarah does not recall a discussion about a catheter.

It was also documented at 4:50am that Sarah was contracting 3:10 which were strong on palpation. On vaginal examination a bag of membranes was visible at the introitus, Sarah's cervix was noted as being 9cms dilated, the presenting part was at the ischial spines, and the membranes ruptured on contact, no cord or abnormality was felt and clear liquor was observed. It was documented that there was a discussion about analgesia and Sarah wished to use the pool (as noted above, Sarah disagrees with this record), so it was filled.

For a first-time mother 'normal' progress from this point in labour would be to progress to a cervix of full dilatation over 2 hours (NICE 2014), then a passive second stage would follow, and then an active second

stage and so Sarah might have had a further 3-4 hours left in labour, if not longer. If a full history had been taken by listening to Sarah and Jack, comprehending that this labour had not progressed 'normally', the midwives would have more evidence that Sarah might have a prolonged second stage and be left in pain for a prolonged period. Sarah should have been referred to discuss pain relief options with an anaesthetist at this time.

Sarah and Jack remember they were in the room for about an hour and 20 or 30 minutes before learning that Harriet had died. Jack informed the Review Team that Staff Members were struggling with the liner for the pool, and that he was helping them. Sarah was asked about what kind of music she would like, and discussing using lavender.

There is documentation that the fetal heart was heard at 132bpm post vaginal examination. Maternal pulse was not recorded simultaneously to differentiate the two heartbeats, which is best practice. Sarah and Jack dispute that the fetal heart was heard at this time, saying that the number on the screen was between 88-92bpm which Jack manually palpated as Sarah's pulse.

A Staff Member took handover of care at 5:00am. This person noted the unusual shape of Sarah's abdomen, discussed bladder care, and made a plan to pass an intermittent catheter after auscultating the fetal heart.

Sarah and Jack told the Review Team that once the pool was filled, the Staff Member said she just wanted to check the baby's heartbeat before Sarah got in. Harriet's heartbeat could not be found and the Staff Member told Sarah and Jack she was going to find some help as she was struggling, and left the room to call for assistance.

Staff Members returned to the room with a CTG machine and although the fetal heart was not audible, the CTG machine was observed to have 118-126bpm displayed on the screen. Sarah's pulse has 84bpm. Sarah and Jack dispute this documentation and told the Review Team *"This did not happen. Harriet's heartbeat was never found during this admission".*

NUH's local trust guidance (1092) Stillbirth (2005) guideline provides advice on diagnosing a stillbirth: 'Fetal death must be diagnosed by ultrasound. Cardiotocography can be very misleading, as the heart rate tracing of an anxious mother may be mistaken for that of a fetus. Even heart rate tracings achieved by scalp electrode can record the maternal heart rate when the fetus has died. The ultrasound must be performed by a trained person.' The Review Team agree with that guidance; using a CTG was wholly inappropriate due to the known risk of artefact, whereby the CTG picks up maternal pulse, and can also double the rate, appearing as a falsely reassuring normal fetal rate[59].

A Pinard stethoscope would have been a more reliable tool to confirm for a fetal heart. A CTG is not the appropriate tool to use when unable to locate a fetal heartbeat, and a CTG should not be commenced without confirming a fetal heart rate is present to begin with, using either a Pinard stethoscope or a handheld doppler which has a smaller and more precise beam which is less likely to pick up maternal sounds. When unable to locate the fetal heart with a Sonicaid or Pinard stethoscope an urgent bedside ultrasound scan is the next appropriate action.

At this point an obstetric review was requested and an ultrasound scan machine brought into the room. The Review Team feel the emergency buzzer should have been pulled at this time. The ultrasound scan commenced at 5:19am and was abandoned at 5:22am because of lack of visibility due to a full bladder. It was noted at this point that Sarah's abdomen appeared like Bandl's ring. A 'Bandl's' ring is a significant sign of obstructed labour and potential uterine rupture. It happens when there is excessive retraction of the upper section of the uterus and can be seen as an oblique palpable abdominal ridge. Sarah told the Review Team that at this point a Staff Member said to her, *"Why didn't you tell me you weren't weeing?"* Sarah replied, *"I didn't know"*. Sarah reports that the Staff Member then said, "*Well, you're meant to be a physio, aren't you?".*

59 Medicines and Healthcare products Regulatory Agency. (2014) Fetal Monitor/cardiotocography (CTG) – adverse outcomes still reported. Device safety information. [Online] Available from: https://www.gov.uk/drug-device-alerts/medical-device-alert-fetal-monitor-cardiotocograph-ctg-adverse-outcomes-still-reported. Accessed [11/04/2026]

Diagnosis of Harriet's death

A catheter was passed and Sarah drained 1500 to 2000mls of urine. Following Sarah's bladder being emptied the ultrasound scan was completed and it is documented that no fetal heart was recorded at 05:35am. Harriet's death was described as an Intrauterine Fetal Death (IUFD) in the maternal records. The parents clearly remember being scanned, and then being told *"I'm sorry, your baby's dead",* before leaving the room. It does not appear in the records that a second scan for confirmation was ever performed, in line with best practice in the UK as per the RCOG 2010 Greentop guideline; Late Intrauterine Fetal Death and Stillbirth.

At 5:55am Sarah was moved into room 8 on the labour ward and Sarah requested an epidural. The anaesthetist was called for. Sarah's temperature was 36.9° Celsius and there are no signs of any infection at this time. At 6:08am an Anaesthetist was present to counsel for an epidural and site a cannula. At 6:23am blood samples were sent for Group and Save and routine bloods for intrauterine fetal death. At 6:30am the Anaesthetist documented that they had reviewed Sarah's history, had a long discussion with Sarah and Jack, and that they felt the difficulty was that Sarah was 9cm with urges to push, coupled with not having recent blood test results. Following discussion a plan was made to await Sarah's clotting results before proceeding with neuraxial block. A plan was made to have Morphine PCA until blood results were back.

At 7:30am blood results were not back yet, a vaginal examination was performed, presenting part visible on parting labia. The cervix was fully dilated, meconium-stained liquor draining. Sarah was very keen on an epidural and being pain free for delivery. Sarah had strong urges to bear down but no pain in between contractions. At 8:30am blood results were still not available, there was a problem with treatment of the blood bottle and a further sample was needed, which was taken and walked over to the lab. Sarah was clear she wanted to wait for an epidural prior to active second stage. At 9:20am Sarah's clotting results came back as normal and the epidural was sited.

Delay in Epidural

At 05:55am, Sarah Hawkins expressed a strong desire for an epidural to manage the increasing pain of labour. The anaesthetist arrived at 06:08, discussed epidural analgesia, and proceeded with cannulation and blood sampling.

At 06:30am, it is documented that Sarah had arrived earlier that morning, and while a fetal heart had initially been detected a scan had since confirmed the intrauterine death of the baby. It was also noted that no blood samples had been taken yet and so staff proceeded with cannulation and sent bloods, including a clotting screen. By now, Sarah was in the late stages of labour (cervix 9cm dilated and strong pushing urges). The Review Team therefore feels that the appropriately sought telephone advice from a Consultant who recommended waiting for the clotting results before proceeding with the epidural was correct. This was in accordance with the guidelines outlined by the Royal College of Obstetricians and Gynaecologists (RCOG) Green Top Guideline number 55 of 2010 'Late Intrauterine Fetal Death and Stillbirth'; which recommends clotting tests in the case of a late intrauterine fetal death as "maternal sepsis, placental abruption and pre-eclampsia increase the probability of DIC. Especially important if woman desires regional anaesthesia. Whilst Harriet's death was intrapartum, the same conditions may be co-existent and cause abnormal clotting which would render neuraxial blockade unsafe. No recent blood results were available (last taken on 15 March). The Review Team therefore agree that it was appropriate to request this blood test and wait for the result. The plan was explained to Sarah and Jack.

Consultant review of Sarah in Labour

It is documented that at 10:50am a consultant visited Sarah and Jack and offered condolences, and that the consultant was notified of Harriet's death at 06:00am but had decided not to visit Sarah sooner as she was requiring pain relief. However, contrary to the record, Sarah and Jack do not recall meeting the consultant until they were admitted to theatre.

Contractions at this time were 2:10, the cervix was fully dilated and there was thick meconium liquor draining. A plan was made for a syntocinon infusion, and to commence active pushing in 30 minutes. A plan was made for a catheter to be indwelling for twenty-four to forty-eight hours following birth.

It is difficult to know when a consultant became involved. But whether it was at 10:50am or at delivery, the Review Team feel this was wholly unacceptable. Sarah was in the second stage of labour, with a newly diagnosed intrapartum stillbirth; the Review Team would expect immediate review and confirmation of findings by ultrasound scan following the initial diagnosis, condolences and a plan for labour to be made in a timely fashion. From the record it appears likely that there was poor communication between consultants and failure to secure good oversight, which may reflect a poor culture of hierarchy within the medical team.

This leads the Review Team to record some of the Staff voices concerning the obstetric consultant team at this time:

Staff member (2016-2020): *"Midwives on labour ward were scared of core team, coordinators formed a dominant clique. Trainee doctors frightened of them. Queens Medical Centre much better, felt supported by midwives and obstetric colleagues. Undermining behaviours by consultants have reduced, new younger consultants are more aware and more supportive. OD consultant working to give staff tools to challenge undermining behaviours. Still juniors talk of gas lighting by older consultants. Now it is unusual for me to see a junior doctor or midwife in tears whereas a few years ago it was routine."*

Staff member (current): *"Did not feel on equal footing with obstetricians. Consultants more aligned to labour ward coordinators who did their bidding and would not challenge them. Some consultants aggressive and rude, hierarchical and no respect for midwives if you weren't in the clique. CNST compliance in 2018, found evidence was not available, told by obstetricians...'too honest' just tick the boxes. Refused to put incorrect evidence in and we failed CNST."*

Staff member (to 2022): *"A group of obstetricians that you could not escalate to. Left because incidents were brushed under the carpet. Believe governance midwives did all the work then at the rapid review meetings obstetricians would decide whether to proceed - generally they would close things down at that stage. Believe maternity incentive scheme was falsified. Aware of major incident where baby died and woman had bowel removed, obstetricians said this was NOT an SI. Belief they had done nothing wrong and outcomes would be the same anywhere."*

Staff member (current): *"Culture has improved. As a trainee felt intimidated and unsupported, now rapid reviews are done in MDT fashion. Historically real problems in disseminating information got so many emails couldn't read or process them all."*

Prolonged Second Stage of Labour

Syntocinon was commenced at 11:00am and increased every thirty minutes. There was minimal documentation of support offered to Sarah during this time. Sarah had been actively pushing at home on the 16th with an obstructed labour, due to intense involuntary urges. At 11:30am on the 17th Sarah was advised to commence active pushing once more. At 12:00pm there was a note to document that Sarah was contracting three times in ten minutes and that they were strong contractions. Sarah's heart rate was 118bpm, and her blood pressure was 153/73mmHg and an escalation was documented. There was no documentation of the outcome of the escalation. At 01:30pm, a Staff Member performed a vaginal examination. This examination found Sarah's cervix to be fully dilated and Harriet to be left occipital posterior. Attempts to manually rotate Harriet were unsuccessful. A plan was made to transfer Sarah to theatre for a trial of forceps, and possibly a caesarean section if they were unable deliver Harriet vaginally.

During the second stage of labour there was a lack of evidence of compassionate, kind care towards Sarah and Jack, who had received the most devastating news imaginable and needed a gold standard of emotional support to get them through labour. The record bears minimal information regarding Sarah's and Jack's emotional wellbeing. There was nothing noted with regards to maternal position, uterine resting tone, maternal efficiency of pushing given Sarah was exhausted, reassurance, or evidence of discussions

with the family. To the extent this may to some extent have been because a relatively inexperienced midwife was allocated this highlights a lack of psychological safety and compassion for the midwife caring for Sarah, which may have been reflected in the care provided to Sarah and Jack during this stage.

Birth of Harriet Hawkins

At 2:25pm Sarah arrived in theatre. The Review Team found there to be a lack of documentation of the clinical findings and management decisions made in maternity theatre at the time of birth. After arriving into theatre, the next documentation is at 2:48pm when an episiotomy was performed. At 2:58pm there was delivery of a stillborn baby girl, baby Harriet. Sarah was finally able to give birth to Harriet with episiotomy alone, and without forceps placement.

Forceps delivery for a baby that has died in-utero is a very challenging procedure that can cause disfiguring harm to the baby's facial skin, scalp and underlying bones, that may have already lost tissue integrity following demise. Forceps deliveries also carry significant added risk to the mother of extended perineal tears, anal sphincter injury, pelvic and bladder trauma. The effects of prolonged second stage of labour results in oedema and fragility of the pelvic tissues. For these reasons, the achievement of an unassisted vaginal birth in this context could be seen as a good outcome. The Review remains concerned by the lack of documentation, lack of explanation at the time, and events leading to the extreme length of the second stage of labour, especially given the labour dystocia in the first stage.

The next documentation is that at 03:15pm baby Harriet was transferred to labour ward as requested by Jack and Sarah, who wished to see their baby. Harriet weighed 3.08kg.

Sarah gave birth with an epidural top up. Anaesthetic care was in line with standard practice and she was stable throughout. Appropriate antibiotics, uterotonics, antiemetics and analgesia were administered.

A post-delivery plan was recorded in the operation notes with specific instructions about bladder care due to Sarah's over-distended bladder with 2000ml of urine before delivery and a prolonged 2nd stage. There was no evidence of placental abruption. The episiotomy was repaired and a perineal repair proforma was completed. Following this Harriet was transferred to labour ward to spend time with both parents. A review at 08:30 pm documents that the parents were informed that there was no obvious cause for Harriet's death. A plan was made for initial postnatal care and it was agreed that a post mortem examination (PM) would be discussed the following day.

Poor Bladder Management

Bladder management was poor throughout Sarah's labour, with little evidence of professional curiosity or concern when Sarah could not provide a urine sample. Urinary retention was evident when Sarah was admitted with an abnormally shaped abdomen and an indwelling catheter should have been prioritised when Sarah drained 1500-2000mls. Risk factors for urinary retention include the length of latent phase of labour over many days, pain and poly-opiate use. In the long-term bladder function and retention appears to be normal, but the notes are incomplete.

Postnatal Care

These events and the birth were discussed with Sarah and Jack at 8:30pm on 17 April 2016. A Staff Member told them there was no sign of abruption or knot in the cord. During the visit Jack and Sarah remember hearing *'I know you are upset but so are the staff'*. This remark alongside others has remained with Sarah and Jack in their grief and ongoing trauma. The Review Team find it difficult to comment with certainty on this without being there and hearing the tone in which it was delivered. The staff were not Sarah and Jack's concern, it was their pain for their daughter who had died. The Review Team consider that the staff member was perhaps trying to show care and compassion during this moment, but it is perhaps unsurprising that by this stage Sarah and Jack were not amenable to this, and that this comment has stayed with them.

There is no record that the anaesthetic team conducted a follow-up review of Sarah's epidural prior to her discharge. The 2012 RCoA 'Raising the Standard: A Compendium of Audit Recipes' 8.12, (2012)[60] advocates for anaesthetic follow-up for all women who have undergone anaesthetic intervention during childbirth. While widely accepted as best practice, it is not mandatory and not always achievable, as many women leave hospital prior to follow-up and service capacity may hinder consistent implementation.

Sarah required antibiotics for an infected episiotomy wound on day 4 and needed to get these via the out of hours GP rather than hospital. Jack called the maternity unit to ask them to help and they said no, that they had to attend the out of hours GP. This is often a challenge with commissioning and it is not known what the commissioning arrangements were in relation to this at the time but it is acknowledged as being an ongoing challenge for women in the postnatal period.

The postnatal visit chart shows Sarah receiving postnatal checks on days 1, 4 and 8. Sarah was discharged from midwifery care on 10 May with her last midwifery visit occurring on 25 April, which was day 8.

A Staff Member visited Sarah and Jack at home on 26 April to provide bereavement support, and Sarah and Jack consented to a post-mortem. The bereavement midwife recommended Sarah and Jack complete a list of questions which could feed into the investigation. On 5 May the bereavement midwife informed them that the post-mortem was complete, that they could proceed to arrange Harriet's funeral when they were ready, and that a follow up meeting with the consultant would be offered at 12 weeks. Over the next few weeks Sarah and Jack chased this appointment as they wished to discuss concerns around the care they had received, and the bereavement midwife responded to say she would arrange an appointment with the consultant.

Right Foot Review and Ongoing Bladder Management

On 19 April Sarah attended the labour ward with Jack - it was documented that condolences were expressed. Sarah's catheter was removed at 4:30 pm. First urine 100mls (70ml residual) and 2nd urine 600mls (106ml residual via a bladder scan). Sarah was advised to remain for a further void but she preferred to leave. There was a plan to measure urine output overnight and return the following day for assessment and to see Harriet. However the mortuary was unable to facilitate a visit to see Harriet when Sarah and Jack asked, as it was closed.

Sarah also reported "pins and needles" and reduced sensation in her left foot during the admission on 19 April. A Staff Member reviewed Sarah at 07:30pm. The clinical impression was that the symptoms were unrelated to the epidural, but an MRI was requested to investigate further. The plan was handed over to the resident obstetric anaesthetist and the consultant on call. Sarah had the MRI that evening, but was discharged before the results were available. This was not unreasonable considering there were no red flags.

A follow-up face to face review was conducted the next day where MRI findings were discussed with Sarah. She was reassured that there was no evidence of nerve damage from the epidural, but that there was a coincidental finding of a possible perineural cyst in the spine. It was explained that further, non-urgent, investigation of this might include a further scan with contrast. Sarah requested that this be carried out a later date, which was agreed to. She was advised to follow up with the obstetric team for any ongoing concerns, which was an appropriate course of action.

Later that day, Sarah was reviewed again. This time she was told that as her symptoms were affecting her foot, there was a chance that this was due to the epidural. This contrasting statement may have contributed to unnecessary distress and confusion for Sarah and her family.

On 9 June, a Staff Member confirmed the outcome of the imaging. She explained that follow up of women

60 Makin, R., Moores, L. & Twiddy, H. (2012). Audit of Pain Management Programmes. In: Raising the Standard: A Compendium of Audit Recipes. 3rd edn. London: Royal College of Anaesthetists.

with ongoing neurology usually takes place in a clinic in the antenatal clinic "which would not seem the most appropriate place to see you". She offered the opportunity to have an appointment in an alternative location if Sarah wished, which she declined.

The Review Team's Assessment

The Review Team considers that an intrapartum stillbirth should have triggered a Serious Incident review and the processes attached to this, as set out by NHS Improvement/England and that it should have been reported to the Clinical Commissioning Group, the Trust Board, the STEIS system and regulators.

In summary, Harriet's death was a serious incident. It was clear that a number of factors may have contributed. Harriet was a term intrapartum stillbirth of a clinically well grown baby and a clinically well mother; Sarah had no obstetric antenatal risk factors. Sarah's latent phase of labour and first and second stage of labour were very poorly managed. Baby Harriet likely died at some point within the 24 hours before medical encounter in the Sanctuary Birth Unit. Whilst the third and final post-mortem hypothesised Harriet might have died from a sudden hypoxic event at the time of Sarah's membranes rupturing, based on clinical information that Harriet's heartbeat was heard shortly prior to this, Sarah and Jack dispute that this was Harriet's heartbeat as it was the same as Sarah's pulse.

Sarah had received a high dose of opiate and was eminently suitable to be offered augmentation of her labour by amniotomy rather than being discharged home. Management of the prolonged latent phase of labour has been a highly discussed issue over the past decade in maternity. Sarah did not receive personalised, holistic or well-informed medical opinion during the final 24 hours prior to birth. There was a failure to risk assess, a failure to take a thorough history on fetal movements, and a failure to monitor Sarah and Harriet in labour, including bladder care, progress and to monitor for signs of hypoxia. Sarah's pain requirements were not met, there was a lack of empathy and understanding and an inability to see the possibility of an alternative, safer and kinder management plan (amniotomy, continuous monitoring, one to one care and epidural) rather than a constant attempt to normalise a 6 day latent phase without a break in contractions and to dismiss Sarah's pain, exhaustion and desperation over the telephone. There was a complete failure to archive conversations of concern and advice given.

Chronology of Investigations Following the Death of Harriet Hawkins

Sarah and Jack were clear that Harriet's death needed to be investigated as a Serious Incident, which triggers a particular investigative process, and they said so to the bereavement midwife. In June 2016, 2 months after Harriet's death, they contacted the Medical Director, requesting information, an explanation of Harriet's post-mortem results, and that the incident be declared a Serious Incident. They were offered an appointment with a consultant and with the Head of the Midwifery service.

Initial Feedback from NUH Internal Review

On 13 July there was a meeting to discuss the findings of the post-mortem and clinical investigations into Harriet's death.

A letter summarising the meeting (dated 26 July) records that Sarah and Jack were advised that there was evidence of acute chorioamnionitis and vasculitis which indicated infection, with additional evidence of hypoxia. It was also recorded in the letter that Jack found it difficult to accept infection as a cause for Harriet's death when there was no specific organism isolated and Sarah was well. An explanation was given that where bacteria ascend through the vagina a specific organism may not be isolated but this does not mean that there was no infection, especially if the histopathology showed infection response.

The root cause analysis process used by NUH for parents who have experienced the loss of a baby was explained to Sarah and Jack, also that this process had been completed and no issues with the care were identified.

At this stage NUH stood firm in its belief that Harriet's death was unavoidable and that ascending infection may have been a causation. It also found no failings in the management of the latent phase of labour nor the assessment and recommendations of multiple Staff Members when giving advice by telephone; nor did it identify any learning points.

However the investigation completed by NUH did not include Sarah and Jack's accounts of events, because they had not been made aware that they could contributed questions to the review process. The NUH internal incident Review Team were also made aware of Sarah's concerns relating to her care on 16 April, in particular her repeated calls to triage, and the need for multiple administrations of opioids to address her pain prior to being sent home. The NUH team were informed that Sarah was advised she would be invited back in straight away if she did go home, but in actuality she was not allowed back into hospital and her requests to come back in were declined. The NUH team were also aware that there was no hospital record of these triage calls. The NUH team were made aware that Harriet's heart rate was documented as 'normal' at 130bpm, but the parents believed they had heard a heart rate of 90bpm which was similar to Sarah's. For all these reasons it was accepted that Sarah and Jack were not satisfied with the investigation process and that this needed to be reviewed.

After the meeting on13 July, there was an email advising Sarah and Jack to think about the burial of Harriet, and they report being told by phone call *"It's time for you to start looking after Harriet".* Sarah and Jack were understandably very upset by this, as they felt there were still many questions unanswered around Harriet's death, and so they felt unable to move forward with a funeral until they had answers. Sarah and Jack were under the impression at this point that Harriet was being kept in a preserved condition, meaning further investigations could be performed as necessary. However this was not the case.

External Review

It was agreed at Sarah and Jack's request that an external review would be undertaken by a Head of Midwifery from another non-local trust, assisted by a consultant from within the trust but from a different speciality.

This review recommended that Harriet's death be upgraded to a Serious Incident, and it took into account information provided by Sarah and Jack. It highlighted a number of failings within the care of Sarah but did not challenge the original finding that Harriet's death was unavoidable due to an infection. On 21 December 2016, a draft was shared with Sarah and Jack for their comment to ensure factual accuracy. The report was finalised on 23 January 2017.

Sarah and Jack were concerned to find that the final version watered down the findings in the draft that linked substandard care to Harriet's death. The reasons for the changes remained in contention and in February 2023 NUH commissioned an external review of these events by a legal firm, Browne Jacobson.

Browne Jacobson found it was not possible to give a definitive conclusion about why the report was edited in the way that it was. However, their overall conclusion was that the trust did extensively edit the draft report, including the conclusions reached on contributory factors, and that the way in which this was done was not consistent with the intention that the Review was external. Their overall view was that the conclusions reached were influenced by the trust, undermining the intention as to the independent nature of the Review. Since some of the staff involved had left NUH, NUH decided not pursue this further.

Request for Inquest from Her Majesty's Coroner

In September 2016, Sarah and Jack requested Harriet's death be referred to Her Majesty's Coroner for an investigation into Harriet's death, which they felt was unexplained. In April 2017 the coroner met with Sarah and Jack and explained that they were unable to perform an investigation, as stillbirths fall outside their remit.

Report to StEIS

On 12 September 2016 NUH entered Harriet's death in labour retrospectively on StEIS (Strategic Executive information System) as a Serious Incident. StEIS was the primary database used by the NHS in England for reporting and monitoring Serious Incidents (SIs). During this period, its use was governed by the Serious Incident Framework (March 2015), which remained the active standard throughout 2016. Its primary purposes in 2016 were:

- Notification: To alert relevant parties (such as commissioners and NHS England) that a Serious Incident had occurred.
- Management: To track the progress of investigations and ensure they were completed within mandated timelines (typically 60 working days).
- Oversight: To provide a high-level managerial overview of safety issues, including 'Never Events' and other significant risks like major data loss or security breaches.

Under the 2015 Framework active in 2016, an incident was reportable on StEIS if it was an event where the potential for learning was so great, or the consequences so significant, that they warranted a comprehensive response. Key criteria included:

- Unexpected or avoidable death of one or more people.
- Unexpected or avoidable injury resulting in permanent harm or requiring treatment to prevent death.
- A Never Event – all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death
- Incidents preventing an organisation's ability to deliver healthcare, such as major IT failures, failures in security, systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services).
- Actual or alleged abuse where the healthcare system failed to take appropriate safeguarding action.

Post-mortem Dispute

In October 2016 Sarah and Jack formally disputed the findings of the post-mortem, not accepting the cause of death to be infection.

Review by Local Supervisory Authority Midwifery Officers

In January 2017, following a review by the Clinical Commission Group (CCG) of serious incidents at the trust, concerns regarding practice related to Harriet's death were communicated to the Local Supervising Authority (LSA). The LSA served as a regional regulatory body overseeing midwifery support and practice, particularly during trust-level investigations into incidents. At the time of Harriet's birth statutory supervision of midwives was undergoing transition, prompted by doubts about its efficacy in safeguarding the public due to conflicts of interest: the same midwives who were investigating midwives needing to also support them in practice.

These concerns were highlighted by the Morecambe Bay Investigation,[61] with a subsequent recommendation to remove this regulatory tier made by the Parliamentary and Health Service Ombudsman (PHSO). This mechanism was formally removed in March 2017 with the enactment of new legislation (Nursing and Midwifery (Amendment) Order 2017), which separated supervisory and regulatory functions, retaining supportive mechanisms at a trust level, while the regulatory function reverted wholly to the NMC. Upon dissolution, all records maintained by the LSA and Supervisors of Midwives (SoMs) were uploaded to the LSA Midwifery Forum Portal and are believed to be archived by NHSE.

61 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. London: The Stationery Office

During this transition period, supervisors of midwives were required to document and review all significant incidents related to midwifery practice utilising the LSA's 'Decision-making Tool'. This tool served to identify any issues in midwifery practice that might have contributed to adverse outcomes. Upon completion, the findings were uploaded to the LSA database, ensuring a comprehensive audit trail for midwifery oversight.

If indicated by the decision-making tool, a comprehensive supervisory investigation would be initiated. These investigations evaluated midwifery care in relation to the standards outlined in The Code: Standards of Conduct, Performance and Ethics (2015)[62] and the Midwives Rules and Standards (2012).[63] Although oversight was provided by the Local Supervising Authority Midwifery Officer (LSAMO), the actual investigations were typically conducted by Supervisors of Midwives (SoM) employed within the same trust, a practice that has been noted as a point of criticism by the PHSO.

Recommendations arising from such investigations addressed not only individual practice concerns but could also highlight service-level or systemic issues that had influenced decision-making. Possible individual recommendations included: no further action; implementation of a local action plan for learning (LAP); development of an LSAMO action plan for learning (LSAP); or direct referral to the NMC, particularly in cases involving behavioural concerns deemed irremediable. Supervisory practice programmes established competency standards aligned with the standards of proficiency expected of midwives at registration, with achievement overseen by a mentor assessor in practice. Failure to meet these standards would result in a Fitness to Practice (FtP) referral to the NMC.

Initially, NUH did not declare this case as a Serious Incident (SI), which meant that aspects of midwifery regulation were not activated until the CCG review. The supervisory investigation was conducted by an external SoM team, whose report identified multiple system-level care deficiencies, as well as shortcomings by Staff Members.

The supervisors highlighted issues such as inadequate communication and history-taking, insufficient handovers between individuals and sites, and an over-reliance on guidance.

NUH maternity service received recommendations to enhance communication across sites, strengthen governance and case investigation processes, review and update guidance on the management of the latent phase, implement logging for telephone triage, and clarify as well as reinforce the responsibilities of Band 7 labour ward coordinators.

In July 2017 the CEO of the Clinical Commissioning Group formally requested assurance from the CEO of NUH regarding the advancement of these recommendations.

The Clinical Commissioning Group (CCG) advice for independent review

Clinical Commissioning Groups (CCGs) were NHS bodies in England, led by GPs, other clinicians and lay members. CCGs were responsible for commissioning, planning and overseeing local health services; they replaced primary care trusts in 2013 until their abolition in July 2022, when they were replaced by larger Integrated Care Systems (ICSs) under the Health and Care Act 2022 to create more joined-up health and care provision across wider regions. Essentially, CCGs were the local planning authorities for most NHS services.

As a consequence of Sarah and Jack Hawkins' concerns the CCG arranged a panel to review the care delivered which included listening to the parent's concerns and NUH feedback separately. The panel was held on 23 February 2017 and consisted of representatives from South Nottinghamshire CCG Quality Team, Nottingham City CCG (as the CCG where the parents were registered), NHS England and NHS Improvement. It was agreed that a CCG commissioned External Independent Review was required. The authors of the Review were to be two consultant obstetricians and a risk midwife, all independent from NUH.

62 Nursing and Midwifery Council (2015) The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. London: NMC.

63 Nursing and Midwifery Council (2012) The Nursing and Midwifery Council (Midwives) Rules Order of Council. London. NMC

CCG escalation to NHS England

In March 2017 the CCG escalated to NHS England North Midlands its concerns regarding emerging themes at NUH. These included:

i) a lack of assurance surrounding decision making in NUH when determining a Serious Investigation (prompted by a significant reduction in SI reporting).

ii) the poor quality internal investigation of Harriet's death and the subsequent poor handling of parental concerns by the trust.

iii) the number of active Local Supervisory Authority referrals/ investigations which had been notified to the CCG by NHS England, and

iv) the lack of alignment of maternity governance with corporate governance at NUH, noting that under reporting can be a sign of transparency issues and a failure to learn.

Further CCG measures

In April, 2017 the CEO of the CCG wrote to Sarah and Jack to update them on measures which the CCG was undertaking to improve the standards of investigations into care and consistency in reporting, and to achieve ongoing improvements to care.

They were told that NUH had undertaken a governance review of maternity and were now looking back at historical incidents which had been under reported. This had resulted in 12 further incidents being entered onto the national reporting system (STEIS). Maternity Serious Incidents at NUH were to be reviewed by a panel consisting of members of the Clinical Maternity Network and dates for the panels had been arranged every month (commencing in early May 2017).

A further measure was to be escalation and review by a multi-organisational panel to review the recommendations of the CCG panel established on 23 February (see above) and plan further action required. An independent panel review of the care that was delivered to Sarah, Jack and Harriet was being arranged as planned by the Chair of the Clinical Maternity Network with colleagues from the network.

In July 2017, the CCG Independent Investigation Team appointed a team of two obstetric consultants and a risk midwife, as planned, and agreed a methodology for reviewing the documentation. Rather than re-interviewing staff, the team planned to review the maternity records for Sarah, including the entire labour record, review statements, and memory capture documents collected after Harriet's death. Also to be considered was information used by NUH's initial investigation, its conclusions and its recommendations.

This included but was not limited to: all interview records, all meeting notes, the analytical timeline constructed by the appointed internal investigators, any research documents reviewed and utilised, any NICE guidance reviewed and utilised, and local policies and procedures that applied to the safe and effective management of Sarah's labour and Harriet's birth..

The Independent Investigation team also interviewed Sarah and Jack to learn what had happened in the clinical care, to learn their concerns, and to develop a tabular timeline to capture where there were differences between NUH and the parents.

On 18 October 2017 Sarah, Jack and NUH received a final draft version of the Independent Investigation for factual accuracy checks. The overall conclusion was 'that the death of baby H was almost certainly preventable'

This report had an entirely different conclusion to that of the internal review and the previous external review, stating: *'Baby Harriet Hawkins died from a sudden hypoxic event when she was already susceptible due to prolonged labour and early signs of infection. Multiple missed opportunities for intervention and appropriate monitoring. Had they been taken and monitoring occurred labour would have been shortened and therefore intrauterine fetal death would not have occurred.'*

This report identified:

1. A lack of recording of all phone calls to maternity
2. Missing information on Antenatal Advice Sheet
3. Administration of opiates in the latent phase of labour and not recognising prolonged latent phase/ dysfunctional labour
4. Not following the local Latent Phase of Labour Guideline
5. Admission to low-risk Birth Centre despite possibility of cord prolapse
6. Delay in applying appropriate fetal monitoring
7. Delay in administration of epidural
8. Delay in obstetric review and management plan
9. Significantly prolonged second stage of labour
10. Failure to follow the Risk Management Policy for maternity
11. Misinterpretation of Post Mortem findings and failure to make appropriate clinical pathological correlation.

The report included 10 actions for improvement for NUH. Sarah and Jack finally felt this report and findings made sense. The final version of this report was issued on the 13 December 2017, 19 months after Harriet had died.

Second Post-mortem Results

Going back, in March 2017 NUH shared with Sarah and Jack the results of a second post-mortem which they had not consented to or been made aware was going to take place. The Trust had sent slides to an external pathologist in Birmingham. Sarah and Jack only found out that Harriet's body had been moved from NUH when they received a letter from NUH describing the findings of the post mortem. They were horrified to further learn that NUH felt it was not its responsibility to retrieve Harriet from Birmingham Hospital.

In May 2017 Sarah and Jack contacted the Human Tissue Authority (HTA) to complain regarding the commissioning of a second post mortem of Harriet without their consent.

In August 2017 the HTA concluded that NUH did not breach the Human Tissue Act in relation to consent by performing a second post mortem, as NUH had assumed consent given that there had been discussions about the likelihood of a second post mortem. They did however find that NUH had not followed the HTA Code of Practice (2014)[64] with regards to communication. The HTA wrote to NUH in August 2017 and NUH accepted full responsibility for failures in communication.

The HTA sought additional assurance of learning from NUH and requested evidence that the trust had updated its policies and procedures. These were sent to the HTA in January 2018 by NUH.

Wider CCG Review of Maternity Services

In May 2017 the CCG and partner organisations including the Healthcare Safety Investigation Branch (HSIB) conducted a wider review of maternity services.

This culminated in a risk review meeting which was held on 15 May 2017. The purpose of the meeting was to enable all partners to share current information about the quality and safety of the maternity service at NUH, including actions already taken and those planned. The conclusion of the Review was that, based on

64 Human Tissue Authority (2014) Code of practice, Code B, HTA.

available intelligence, the Commissioners believed that whilst the current service was not yet of the quality, they would aspire to, it was fundamentally safe. The CCG committed to continue to work with NUH and partners to support improvements and to monitor maternity services.

Apology from NUH

Following the final report of the Review commissioned by the CCG in December 2017 NUH wrote to Sarah and Jack apologising to them and accepting what it described as 'shortcomings' in their care and accepting recommendations made by the CCG.

Also, in December 2017 Jack called NUH Maternity unit in distress. Unknown to Jack, this phone call was recorded and later replayed at a maternity management meeting in April 2018. This did not come to light until 2024 during a staff interview for this Review, and is being treated as 'whistleblowing' under the NHS England Freedom To Speak Up policy.

There is no legitimate reason for NUH to have made the recording, or to have played it back, which displays a marked lack of empathy, kindness and respect. Donna Ockenden raised this with the NUH Chief Executive. In December 2024, Chief Executive Anthony May met with and then wrote to Jack and Sarah to express his sincere apologies and commit to an investigation. NUH commissioned Sarah Crowther KC to conduct a review, which is ongoing.

NHS England Independent Thematic Review

Since 2018 Jack and Sarah were focused on the need for a wider, systematic review of NUH maternity services to address long-standing and multiple failings.

In 2021 NHS England commissioned such a review. However, on 6 April 2022 more than 100 individuals from families affected by maternity services at NUH wrote an open letter to the Secretary of State, the Rt Hon Sajid Javid MP requesting that the Review be closed and that Donna Ockenden be appointed to lead a new independent review.

Within their open letter the families described losing confidence with the ongoing review due to various issues around how the Review was being undertaken. The families highlight in their letter that the past 6 months had seen changing processes and methodologies, a lack of engagement with the families, and a lack of engagement with staff who had worked at Nottingham prior to the past 12 months.

The families shared concerns within their open letter as to a lack of professionalism and judgement from the current Review Team. They were also concerned that the Review was insufficiently staffed to be able to obtain the qualitative evidence required to understand and address deep rooted issues. The families feared re-traumatisation through a continued lack of validation of their experiences. A request was made by the families for a robust open book review to understand why NUH was failing to learn from incidents and failing to listen to families.

The 'Independent Thematic Review' was disbanded by the Rt Hon Sajid Javid, and this Review was commissioned in its place.

Family Experiences and Wider Maternity Experiences

1. Introduction

Families were and remain the driving force behind the Independent Review of Maternity Services at Nottingham University Hospitals (NUH). Through extraordinary courage, determination, and persistence, their voices transformed what began as a locally arranged review into the largest maternity inquiry in NHS history. Their courage ensured that the experiences of mothers, fathers, babies, and families would not be overlooked, and that what happened to them will help shape meaningful change.

At the heart of this review are the voices of women and families. Their experiences – shared with honesty, bravery, and profound generosity – are central to understanding what happened and, importantly, to ensuring that maternity care becomes safer, kinder, and more compassionate for those who follow. Listening to women is not simply an important principle of maternity care; it is its foundation. When women's voices are heard, valued, and acted upon, services are better able to provide personalised, respectful, safe, high-quality care across the entire maternity journey. The Ockenden Team places immense value on hearing directly from those who have experienced maternity services. Their testimonies provide vital insight, illuminate where care must improve, and guide the changes needed to strengthen safety and quality for future families.

We dedicate this chapter to the families who so courageously and generously shared their accounts with our Team. It brings together the voices and experiences of women and families who received care at NUH, and honours the powerful role their voices play in shaping a safer future for maternity care. Bringing together two sources of evidence will enable us to inform learning, assurance and system understanding in relation to maternity services at NUH.

Section A: 'Family Experiences of Maternity Care', represents the primary dataset of cases that met the formal Terms of Reference (ToR) for inclusion within the Ockenden Review.

Section B: 'Maternity Experiences of Women and Families'. While these accounts are not formally assessed within the Review's core dataset, they provide important insight into cultural norms, communication practices, system behaviours and continuity of experience across a wider timeframe.

Section A: Family Experiences of Maternity Care

This section presents feedback from families, analysed from a patient representative perspective, to understand how maternity services were experienced in practice. Women's and families' voices are represented through a selection of accounts, supported by discussion around the impact of particular experiences of maternity services on the families concerned.

Understanding how maternity services are experienced by families is a key component of delivering safe, person-centred and equitable care. Family feedback provides insight into how policies, pathways and professional practices are experienced in practice and where improvement must be made.

2. Methodology

2.1 Purpose and Scope

The purpose of the analysis within this chapter was to understand how maternity services were experienced by families and to identify recurring themes across the patient journey.

The analysis focused on experiential evidence and did not seek to:

- Assess clinical decision-making or care quality
- Review individual cases or outcomes
- Make judgements against professional standards

2.2 Role of the Patient Representative

The analysis was undertaken by an experienced patient representative, bringing an independent, non-clinical perspective. This role ensured that analysis prioritised families' own description of care and how services were experienced.

The patient representative:

- Did not interpret feedback clinically
- Focused on patterns of experience rather than individual cases
- Complemented, rather than replaced, clinical and operational review

2.3 Analytical Framework: Patient Journey Approach

Feedback was analysed in relation to the maternity journey, enabling experience to be understood in context and across transitions in care.

Feedback was considered across:

- Antenatal care (including fetal medicine and early pregnancy care)
- Intrapartum care (labour and birth)
- Postnatal care
- Neonatal care, where applicable
- Bereavement care
- Experiences of raising a concern or complaint
- Impact of experiences

2.4 Data Familiarisation, Coding and Thematic Development

All feedback was reviewed in full to ensure familiarity with the range, tone and depth of experiences shared. Initial analysis identified recurring issues, concerns and positive experiences using families' own language. Feedback relating to concerns and complaints was also reviewed to understand accessibility, responsiveness and emotional impact. Themes were refined iteratively to reflect patterns of experience rather than prevalence.

2.5 Equality and Inclusion Considerations

An equality and inclusion lens was applied throughout, considering how experiences may differ for families with protected characteristics and for those from seldom-heard groups. The analysis does not assume homogeneity within groups but highlights recurring themes where potential patterns of inequality were identified.

2.6 Limitations

- Findings reflect experiential feedback rather than clinical assessment
- Feedback does not indicate prevalence or causality
- Views represent those who participated in interviews

3. Lived Experiences

This chapter draws predominantly on excerpts from interviews with families to reflect their experiences of maternity care across the pathway, in their own words. The use of direct family voices supports a person-centred approach and enables the Review to capture the complexity, emotional impact and cumulative nature of experiences that are not always evident through high-level thematic analysis alone.

Family voice excerpts are not presented as representative in isolation; rather, when considered collectively, they illustrate recurring issues, patterns and variations in experiences across the system. Where multiple accounts described similar experiences, evidence has been synthesised to preserve a collective voice while reducing repetition.

4. Experiences across the Maternity Pathway

Across the maternity pathway, families described experiences that were strongly influenced by:

- Quality of communication
- Consistency of care and information
- Feeling listened to and believed
- Involvement in decisions
- How concerns were responded to.

Where these elements were present, families reported feeling reassured and supported. Where they were absent, experiences were often described as confusing, distressing or disempowering.

4.1 The Antenatal Journey

4.1.1 Routine Antenatal Care

Across accounts of routine antenatal care, women described continuity and the quality of listening as critical determinants of confidence, feeling safe and emotional safety. Where women experienced a consistent midwife or team, they described being reassured and supported. This is often the first encounter with NHS services for many women and where first experiences can influence a woman's entire maternity journey.

Over a prolonged period of time, many women reported seeing different clinicians at each appointment, which they described as unnerving, particularly for first-time mothers. Women experienced that staff often did not know them, did not consistently carry forward prior discussions, and that key information was missed or inconsistently recorded. In these accounts, the impact of fragmented care was cumulative: women described repeatedly retelling their history, receiving variable advice, and losing opportunities for early reassurance or escalation.

"*...it started with not having any consistent midwife...every time I had a midwife appointment, I'd see somebody different...as a first-time mum, that's quite unnerving. I never had that opportunity to build a relationship… every time I had a new midwife, things that had been discussed weren't on file. It was really frustrating... that whole (lack of) consistency of midwife was a big problem. Never being able to develop that relationship and it also meant that things I'd said had been missed, so not documented properly or misinterpreted..."* (2013)

A recurrent pattern was women describing that their instincts or concerns were minimised or reframed as anxiety. Women reported feeling told off, blamed or judged when raising concerns, including when they raised concerns about fetal movements. These experiences reduced women's confidence to raise concerns and increased the risk that important symptoms were not escalated or acted upon.

"I told her that my baby hardly ever moved… she – she gave the impression that she thought I was just busy and anxious and that it was my fault… [crying] He hardly ever moves….. because it was my first baby, I didn't know what was normal" (2013)

These accounts illustrate how fragmented antenatal care, where women are not listened to, can undermine their confidence, reduce opportunities for escalation, and weaken trust. This therefore was found throughout the entire period of the Review,.

4.1.2 Specialist Antenatal Care: Fetal Medicine

Families' experiences of specialist antenatal services were shaped by the quality of communication, emotional sensitivity and respect for autonomy. Where care was coordinated, unhurried and compassionate, families described feeling reassured and supported, even in circumstances involving uncertainty or poor prognosis.

"...they would always see you immediately if there was a problem…. the care from the staff, the understanding... The way they talk to the dads particularly is just fantastic" (2022)

National guidance emphasises informed consent, the importance of decision-making and culturally sensitive care. Ockenden principles stress listening to women and respecting values and preferences, particularly in situations involving complex antenatal decision-making.

4.2 Intrapartum Care

4.2.1 Early Labour and Telephone Triage

Across multiple accounts and over many years, women and families described significant difficulty accessing timely assessment in early labour. Telephone triage interactions were frequently experienced as dismissive, with advice perceived as driven by capacity rather than clinical concern.

Women described feeling doubted, patronised or not believed, particularly first-time mothers and those whose labour did not follow expected patterns. Partners also described feeling excluded from conversations or dismissed when advocating for assessment. In several cases, families reported making repeated calls before attending in person, often against advice, only to discover they were in established or advanced labour.

For women with known risk factors, families described a lack of continuity between antenatal risk identification and intrapartum triage, with telephone responders appearing unaware of individual clinical histories. This created a perception that women were required to prove the legitimacy of their concerns before being seen. The cumulative impact was anxiety, distress and erosion of trust at a critical point in the pathway.

"They were very dismissive... 'is this your first baby?'...take some paracetamol...and have a hot bath.. and the only way we went to hospital was by just not even listening to them...we just turned up..." (2019)

4.2.2 Labour, Consent and Intervention

Women described labour as physically intense and felt emotionally vulnerable, with experiences strongly shaped by whether they felt listened to, respected and involved in decisions. While some women described supportive care, others reported feeling that their bodily cues, preferences and expressed concerns were overridden and disregarded.

Several accounts over many years described interventions occurring rapidly, with limited explanation or opportunity for discussion. Where changes to birth plans were required, women reported distress when deviations were not clearly communicated or when consent felt implied rather than actively sought. In these accounts, inadequate pain relief and dismissive language intensified fear, loss of control and trauma.

"…there was no pain relief… it felt brutal… traumatic… they were screaming at me… 'you need to pull yourself together'…" (2014)

Professional standards and national policy emphasise the need for informed consent, respect for autonomy, and trauma-informed care. They also emphasise that failure to listen, poor communication and disregard for consent can be recurring contributors to harm.

4.3 Postnatal Care

Postnatal care was described as a period of heightened vulnerability, shaped by staff visibility, communication and responsiveness to individual needs. Many women described long periods without contact from staff following birth, in theatre, or during transfer from recovery, which contributed to feelings of abandonment, fear and uncertainty. Difficulties accessing timely pain relief, assistance with mobility, and basic care needs were frequently reported, particularly during night shifts and staff changeovers.

Inconsistency of information between clinicians was also a recurring theme, with women describing conflicting messages about recovery, prognosis or care plans. For women who had experienced traumatic births or significant complications, postnatal care was often perceived as failing to recognise or adapt to their specific needs.

Feeding support emerged as a particularly sensitive area. Women described feeling overwhelmed by conflicting advice and, in some cases, pressured or judged when breastfeeding was difficult or not established. Several women described significant emotional distress, including symptoms consistent with trauma and postnatal depression, which they felt were minimised or normalised rather than explored or escalated.

"We were put in basically an office in a bed… we had nobody come and visit us for at least 3 hours… Nobody came to check on me. Nobody came to check on baby" (2017)

"I was having flashbacks...nightmares...I kept telling the midwives...all they would focus on was the breastfeeding...I felt like I was a machine to produce milk...." (2020)

Where babies required neonatal care, separation compounded postnatal distress. Families described delays in communication and a lack of proactive support to help them understand their baby's condition and feeding needs, further undermining confidence at an already vulnerable time.

Overall, these experiences highlight that how postnatal care is delivered – including kindness, compassion, tone, responsiveness and recognition of emotional need – has a significant impact on women's recovery, wellbeing and early parenting experiences.

5. Neonatal Care

Families whose babies required neonatal care described this as one of the most emotionally intense and vulnerable periods of their maternity journey. Experiences were shaped by communication, visibility of staff, involvement in decisions, and the physical and emotional impact of separation from their baby.

Across accounts, parents described feeling excluded from information-sharing and care planning, particularly during emergency transfers to neonatal units. Several families reported not being told where their baby had been taken, the reason for transfer, or what the immediate plan of care was. This lack of timely communication intensified fear, helplessness and distress.

Parents also described practical and emotional challenges associated with accessing neonatal units, including difficulties navigating hospital layouts, lack of clear guidance on visiting arrangements, and limited emotional support following traumatic births or emergency interventions.

"They took her and that was it...we didn't get to see her again until gone 4:00 in the afternoon. Nobody told us where she was or what was happening" (2017)

"…as soon as they put me on monitoring it was emergency...people running down the corridor...then suddenly my baby was gone and I didn't know where they'd taken them" (2017)

"I was having flashbacks and nightmares and then my baby was taken to the unit...I felt completely numb. Nobody explained what would happen next" (2020)

These accounts highlight the compounded trauma experienced when neonatal admission follows a difficult or traumatic birth. The absence of clear, compassionate communication at the point of separation undermines parents' sense of safety and control.

6. Bereavement Care

Where families sadly experienced bereavement, they described the care received as a defining and deeply sensitive part of their maternity journey. Experiences were shaped by how well care aligned with bereavement pathways, particularly in relation to compassion, communication, dignity, choice and continuity.

A number of families felt that their loss was recognised with kindness and respect, supported by sensitivity, with staff taking time to acknowledge the significance of their experience.

"Aftercare, couldn't have asked for more. The bereavement midwife was amazing. The consultant visited a lot and we had the room, the Serenity room was perfect." (2019)

"The chaplain came in...and just the support received there from [the consultant] as well but equally then, the bereavement midwife...you wish you never met them but they were just so understanding and so kind. In fact, they just messaged me the other day because it was (baby's) birthday...the exceptional level of care really to be given as a family in that situation made all the difference, really...I always wish I could have thanked them then because I know that they'd done everything that they could, but obviously, I was in no fit state to do anything really and I'm sure they would have liked to have come and said things to me but they were very respectful and gave me that space." (2022)

"They were trying to help us through it and when they gave us that memory box, we brought stuff in, they took a lock of her hair as well, as well as the footprints. It was those little gestures I found really nice, which is why when I was talking to them, that's why I've got a valued opinion of them because of the stuff like the charity box and the chats and stuff, I thought considering the traumatic circumstances, those things did help us along the way and it's nice to have all that stuff to remember her by. I found it really sweet that they had all that to give to us. We didn't have to go out and get it ourselves, they issued it to us and that's why I was very grateful for them". (2023)

Other families however described a lack of recognition of their loss.

"It felt like it was as soon as they knew -- there was no heartbeat there, it was like, all right, let's just get you in, get this baby delivered and then get rid, and we just moved on. If anything, the only time we actually felt like somebody cared and was looking after us was the funeral home that dealt with baby." (2012)

"...the way I see it is once they knew that (baby) had gone, they kind of just left my mum, do you get what I mean? I know sometimes, they might think that's right but as well as that, to them, I feel like it seemed it didn't matter as much because the baby had already died, ...So I feel like they kind of brushed my mum under the carpet and went to help other people." (2023)

Where families described lack of recognition of loss or bereavement, this was often compounded by a lack of privacy and dignity, particularly immediately following loss, when families were placed in environments that they found completely inappropriate.

"They said to us that the bereavement room...Serenity Suite...it was being done up so there was nowhere for us to go. Even if we went into a side room in a completely different ward, that would have been so much better than sitting in the labour ward, listening to women giving birth and newborn babies crying when our daughter was laid there lifeless and it was just...it was the most horrific experience." (2017)

"You've got babies being born, and you've got people celebrating, and maybe they should have a separate area. It was the same room as I had labour in...they just cleaned the room up quickly, and they had that room set up for me again when I came back. So I was in the same room." (2018)

Bereaved mothers emphasised the importance of being able to care for and spend time with their deceased baby. They described distress where there was no recognition or sensitivity in caring for their deceased baby, or limited access to appropriate facilities, such as 'cold cots', to support this.

"They were constantly coming in my room asking me if my baby had kept me awake at night...because I looked tired...I had to constantly tell them 'He's died, he's not alive'. I asked if I could have him with me, they brought him in a doll's Moses basket...with no handles or anything….and for the stand, he was put on the bin...He was brought in a little doll's Moses basket that looked like it had seen better days and placed on a bin because there was no stand for it." (2013)

"They didn't put her on a cold bed... the nurse explained to me what normally happens is once they have done whatever they need to do to the baby, they have this cold mattress that they put the baby onto and unfortunately, my baby didn't get that cold mattress... I was like, 'I don't know what a cold mattress is, but why wasn't she on one?' and they went -- she turned around and said, 'It was faulty'. I was like, 'The least you could have done is make sure your cold mattress was working, that the baby in the operating theatre and the baby in my room looked the same'. Afterwards, I did a lot of reading (about) cold mattresses... I literally swallowed an encyclopedia to try and figure out what the hell happened to my baby from Google, not that it worked, but at least I got a better understanding of what the cold mattress is, what it does and how it works basically because Google explained that to me. The nurse just failed to explain that." (2017)

Families shared feedback about the quality of care they received, highlighting the significant impact of staff behaviours and attitudes, leaving families feeling unsupported, ignored and rushed through processes that required care and time.

"After she died, we had a room and family came to visit. I can remember one of the (staff)...she may not have meant it, she probably didn't, but when I said, 'I think we're going to go home, we've been here all day with her' and she said, 'Yes, I think that's time now, you need to give her back'...a nurse took her off us and said, 'Yes, I think you do; I think you've had enough time with her now'...and she can't help it but it sticks in my head, I had another doctor come, heavily pregnant, stand at the end of my bed saying, 'I'm really sorry what's happened. Next time we'll do extra checks on you'... We were left to walk... down to the car park on our own. I had to stand outside the maternity unit where everybody else was leaving and I just stood there while my husband went to get the car, nobody with us, so that was awful." (2010)

"The bereavement midwife, I was really shocked by her reaction. She walked in the bedroom, in the labour room just dead jolly, kind of thing, like, you've just told me you're the bereavement midwife and you're coming into my room like, 'Congratulations, how are you?' And I was like, 'Pardon? Congratulations?' She went, 'Oh, maybe I said the wrong things.'" (2017)

"They kind of said to my mum, and the vicar, 'When are they going?' like they said that. They forgot about me at one point when they didn't come and feed me...They didn't change the bins, they didn't actually look after me. The bereavement midwife, I seen her once. I didn't see her again. I got put on a waiting list for my mental health and I was in a really bad way then." (2019)

A number of families told the Review Team that they did not receive any bereavement care, including the absence of a named or allocated bereavement midwife to support them through this period.

"...it would have been lovely to have a bereavement midwife, and lovely for them to say, oh, here's a phone number or – or, you know, do you want to come back in a month and just have a chat about it. You know, there was – there was nothing." (2013)

"There was no bereavement midwife available and no follow up care. No counselling, or even a phone call to check we were okay...one thing that was painful is, we'd been referred to...a research study through the hospital about whether it was better to induce older mothers..., they obviously hadn't been told that [baby] had died, so they rung me and said, oh, just wondered, you know, are you still on for this research? I was like, my – I've had a stillbirth." (2013)

Where families received dedicated bereavement care or a named bereavement midwife, we heard on occasion of the invaluable support provided.

"The lady who did the pictures, I've forgotten what it's called, she did it quite quickly and left quickly, in a good way. She wasn't rude, she wasn't abrupt, she took some photos. She did it, got it up, let me know how it was going to work on the disks and how I get them etc, etc. and she left. I appreciated that because she wasn't intrusive, she asked the right questions about what pictures do I want? Do I want to hold him? Do I want this? She let us do what we were doing around the room and just took pictures and it was nice." (2016)

"My consultant at the hospital who I probably met a couple of times, he was lovely. He was fantastic. He kept in touch afterwards a couple of times to check in and, 'How are you?'...he was genuinely lovely. He was considerate, he had good empathy, not sympathy, which I really appreciated and just kept in touch. But yes, he was one of the decent ones." (2016)

However, several families told us of challenges with communication, unclear explanations and a breakdown in continuity of care, particularly from bereavement midwives, often leaving a family feeling unsupported, distressed and confused.

"I had a bereavement midwife; I saw her twice throughout the whole lot. Once when I went through the stillbirth, and the second time when she brought me some photos of him round to the house and she was just checking to make sure that I was healing properly, because he did tear me. And that was it. Never had any counselling, never got offered counselling". (2014)

"Initially, there was support but I think after the funeral and things like that, I suppose it was just left up to us to get in contact with them. There was no sort of conversation to say, 'We'll check up on you in this time and see how you're getting on' or, 'If you feel you want more support, I'll call and we can go from there' sort of thing...it was just left to us...I think a bit further on, it sort of would have been nice to have someone get in touch to say, 'Do you need some further support or do you feel you're okay at the moment?'" (2015)

Following discharge, many families reported a lack of consistent follow-up and clear signposting to emotional and practical support, highlighting gaps in the later stages of bereavement pathways.

"[Bereavement Counselling]...I didn't go through with it anymore because it was a different person every week. So it was like I had to go – explain the situation, tell them about, 'All right, well come back next week

and we'll talk about it.' Then I had – it was somebody different, so then I had to explain the situation again, but it was so very raw, it was I didn't want to talk about it. I wanted to move on from it and get -- do you know what I mean?...I had five different people in that counselling session and I just thought, 'Oh, what's the point in them?' because I just -- I wasn't getting anywhere, I just keep telling the same story and the next week I'm going to have somebody different, do you know what I mean? So that was how it was." (2013)

7. Experiences of Raising a Concern or Complaint

Families' experiences of raising concerns were shaped by accessibility of processes, staff responses, and perceptions of whether their voices were valued or dismissed. While some families described being listened to and receiving compassionate responses, many reported encountering defensiveness, delay or lack of clarity about how to escalate issues.

Many families described raising concerns in the immediate aftermath of traumatic experiences, including emergency births, neonatal admissions or bereavement. In these circumstances, families reported feeling emotionally vulnerable and ill-equipped to navigate the formal complaints systems.

Families' confidence in complaints processes is closely linked to whether they feel believed and respected. Defensive or procedural responses can compound trauma and deter future engagement.

8. Equality and Inclusion – Extended Cross-Cutting Analysis

Across the maternity pathway, some families described additional barriers related to cultural, linguistic and social factors. These experiences intersected with communication, consent and access to care, shaping how safe and supported families felt.

Women from minority ethnic backgrounds and those with specific cultural or faith needs often described feeling stereotyped, misunderstood or required to repeatedly justify their preferences.

"We had to keep saying, 'respect our wishes'...it felt like they just didn't hear us." (2018)

The experiences described here reflect the importance of embedding cultural competence and inclusive communication across all services.

9. Overall Impact on Families

The cumulative impact of experiences across the maternity pathway was profound for many families. Women and partners described long-term emotional, psychological and relational consequences that extended well beyond the immediate postnatal period.

Some families described avoidance of future pregnancies, loss of trust in healthcare services, and persistent symptoms of anxiety, depression or post-traumatic stress. For others, positive experiences with individual staff members provided moments of reassurance and gratitude, highlighting the powerful influence of compassionate care.

"Twenty-five years on I am still traumatised. I still think about it." (2020)

"Without them my baby would have died. They were incredible." (2022)

These contrasting accounts demonstrate how individual interactions can have lasting positive or negative effects. However, the prevalence of trauma-related narratives suggests that system-level issues, in addition to isolated incidents, have played a major role in shaping long-term outcomes for families at NUH.

Section B: Maternity Experiences of Women and Families – Outside Terms of Reference

This section presents experiential evidence from women and families whose cases did not meet the formal Terms of Reference for inclusion within the Ockenden Review. The timeline for these experiences is women who accessed/received maternity care at Nottingham University Hospitals between 2011–2024. These women and families provided information via email and letter of their experiences of receiving maternity care at NUH.

1. Introduction

This report presents a comprehensive thematic analysis of 520 women's and families' accounts describing maternity care experiences at Nottingham University Hospitals NHS Trust (NUH) between 2011 and 2024. These narratives were voluntarily submitted by service users who wished to contribute to the broader understanding of the culture, safety, and quality of care within the NUH maternity service. While these accounts fall outside the formal evidence base of the Ockenden Review, they nonetheless provide significant contextual insight into the conditions, behaviours, and systemic issues that shaped women's experiences at NUH over more than a decade.

The NUH maternity service has been subject to prolonged scrutiny, including regulatory intervention by the Care Quality Commission (CQC), media reporting, coronial inquests, and parliamentary interest. Against this backdrop, the 520 accounts analysed here represent an important qualitative dataset that captures the experiences of women and families across a wide timeframe, encompassing changes in leadership, staffing, service configuration, and national policy.

The narratives span antenatal, intrapartum, postnatal, and neonatal care. They include experiences of both positive and highly traumatic births, elective and emergency caesarean sections, community and hospital-based care, and situations involving complex medical and safeguarding needs. Although the participants are self-selecting and not demographically representative, the sample size and consistency of themes provide a reliable indicator of recurring patterns in care and are consistent over time.

2. Methodology

This section outlines the analytical approach used to examine the 520 women's and families' accounts submitted regarding maternity care at NUH between 2011 and 2024. The aim was to ensure that the analysis was rigorous, transparent, and aligned with recognised qualitative inquiry standards.

2.1 Dataset and Source Material

The dataset comprises 520 anonymised accounts, each representing an individual woman's or family's experience of maternity care. These accounts are typically detailed narratives written in first-person voice and submitted voluntarily. They include experiences across:

- Antenatal care
- Intrapartum care (labour and birth)
- Postnatal care
- Neonatal care
- Community-based midwifery care

The time range spanned 2011-2024, enabling the identification of persistent themes across periods of changing leadership, policy, staffing levels, and wider NHS maternity reforms. The narrators varied in parity, mode of birth, clinical complexity, and demographic background.

The dataset is self-selecting so is not statistically representative. However, as noted in similar inquiries large-scale qualitative submissions from service users often reflect significant patterns of concern, especially when themes are consistent and recurrent.

2.2 Analytical Framework

A qualitative thematic analysis approach was applied and adapted for the context of maternity safety reviews. This method is widely used in national inquiries to identify patterns across large bodies of narrative evidence.

The analysis followed six stages:

Familiarisation

All 520 accounts were read in full. Initial notes were taken, focusing on issues relating to safety, communication, consent, staffing, emotional impact, and clinical care.

Initial Coding

Each account was coded line-by-line against emergent concepts. Over 90 initial codes were generated, including for example ‘ignored escalation’, ‘unsupported postnatal recovery’, ‘delayed pain relief’, ‘loss of dignity’, and ‘positive midwife behaviour’.

Theme Development

Codes were grouped into broader thematic categories. Through iterative refinement, these formed 11 major themes and three sub-themes, consistent with patterns commonly observed in national maternity reports.

Integration of Accounts

Representative anonymised excerpts were selected to illustrate each theme. These are cited internally using the date their experience. These excerpts preserve the detail of the narrative while maintaining confidentiality.

2.3 Ensuring Rigour and Trustworthiness

To maintain the quality of the analysis, the following measures were taken:

- Transparency in coding through maintenance of an ongoing coding document and trail
- Anonymisation of all identifying information, in line with inquiry standards
- Neutral narrative tone to avoid judgement and maintain objectivity

Saturation assessment demonstrated that after approximately 300 accounts, no new major themes were emerging – indicating a high degree of thematic consistency.

2.4 Limitations

The analysis acknowledges the following limitations:

- Self-selection bias: Individuals with negative experiences may be more likely to submit testimonies, although notable positive accounts were also present
- Lack of demographic completeness: Not all accounts included details of age, ethnicity, socioeconomic background, or clinical risk status

- Absence of staff perspectives: This dataset reflects the experiences of service users only, staff perspectives are reported in a separate chapter within this report
- Potential for recall bias, especially in retrospective accounts spanning up to a decade

These limitations do not diminish the value of the dataset for systemic analysis. As demonstrated in previous national inquiries, large-scale qualitative submissions can illuminate systemic cultural patterns, especially when themes are consistent over time.

2.5 Ethical Considerations

All accounts were anonymised.

No clinical verification of individual events was undertaken, in keeping with an inquiry-scoping methodology.

The purpose of the analysis was to identify themes through records of experiences. It was not the purpose of this work to determine the accuracy of individual cases or assign blame.

All women and families involved in the Review were offered access to psychological support.

3. Thematic Analysis

This section presents the full extended thematic analysis, using a neutral inquiry tone, integrating multiple accounts.

Each subsection includes:

- A description of the theme
- Supporting evidence from the 520 accounts (with incident dates)
- Analytical commentary

3.1 Autonomy, Information and Choice

A dominant theme across the dataset was the erosion of women's autonomy in pregnancy and birth. Women frequently reported that they were not given meaningful choice or enabled to make informed decisions, that their preferences were dismissed, or that interventions were carried out without appropriate consent.

Many accounts describe situations where women felt coerced into changes to their care pathway, such as transfers, induction, or specific interventions, often framed as non-negotiable due to 'policy', 'staffing', or 'protocol', rather than medical necessity.

Experiences

"My waters were broken against my will" (2020)

"Consent was never taken… I was told I would have to 'explain myself' if I declined repeat HIV and syphilis tests, even though I had recent IVF results." (2021)

"I felt I did not really have a choice and that my birth of choice was taken away from me – and not for any medical reason...QMC was closed because they were so busy, so despite living far from City I had to get out of the pool at home, leave my safe space and be blue lighted across town while pushing." (2022)

"I was told not to use the birthing pool because it would 'slow down labour' even though that wasn't true." (2022)

Across diverse experiences, the accounts consistently describe a culture of control and paternalism in maternity care. Women reported interventions being performed without adequate explanation, an absence of genuine shared decision-making, and situations where options were presented as instructions.

The recurring nature of such accounts at NUH suggests a systemic issue, not isolated events. The frequency and consistency of autonomy-related concerns across 2011–2024 indicate long-standing cultural patterns within NUH, echoing national concerns about paternalistic care and the failure of maternity systems to deliver truly woman-centred care.

3.2 Staffing and Systemic Constraints

Chronic understaffing was one of the most pervasive themes in the dataset. Women repeatedly described environments where midwives and doctors were overstretched, exhausted, and unable to respond promptly to requests for help.

Experiences:

"They didn't give me my prescribed thyroid medication for my entire stay. It was a good job I took my own." (2016)

"There was one midwife to cover the whole ward" (2017)

"My drip machine wasn't working...they said they were too busy. Hours later I was told 'it's too late now.'" (2019)

"Buzzers weren't answered for hours...we heard staff saying they were dangerously understaffed." (2021)

"My midwife said she didn't come into the profession to care for three women (in labour) at once." (2021)

Women's experiences reflect a maternity service operating under chronic resource pressure. The accounts describe:

- long waits for essential medication,
- delays in responding to emergencies,
- missed observations,
- inability to provide basic care,
- overwhelmed staff expressing distress.

This aligns with national findings. The Royal College of Midwives (1) has repeatedly reported severe workforce shortages, and the CQC (2) identified understaffing as a major driver of maternity safety concerns in England.

The Ockenden Report (3) identified workforce deficits as 'fundamental contributors to unsafe care', while Kirkup (4) concluded that staffing shortages contributed to compromised decision-making and avoidable harm.

The experiences at NUH mirror these findings, suggesting systemic pressures persisted for more than a decade. The accounts demonstrate that staffing issues were not episodic but chronic and entrenched, impacting every stage of maternity care. This has deep implications for safety, emotional wellbeing, and confidence in the service.

3.3 Continuity and Handover

Disrupted continuity of care was widely reported, with women seeing numerous midwives antenatally, intrapartum, and postnatally. Poor handover between midwives, shifts, and hospitals contributed to confusion, inconsistency, and feelings of insecurity.

Experiences:

"Midwives gave conflicting advice constantly." (2020)

"I saw many different midwives – none knew my plan and I had to explain myself over and over." (2022)

"The midwife team didn't know I'd had my baby." (2022)

Continuity of care is internationally recognised as a protective factor for both safety and emotional wellbeing (5). Its absence creates fragmented care, contradictory messages, and logistical failures.

National reports, including Better Births (6), emphasise the essential role of continuity in promoting positive experiences and reducing intervention rates.

At NUH, the lack of continuity appears systemic and long-standing, and may have been exacerbated by staffing shortages.

Fragmented care undermines trust, increases risk of error, and contributes to avoidable emotional distress.

3.4 Emotional Safety and Trauma

A substantial proportion of narratives described experiences of fear, abandonment, and trauma, including long-term psychological impact.

Experiences:

"25 years on I still feel traumatised...I felt suicidal." (1996)

"I have PTSD five years later." (2018)

"I was left alone and terrified. It felt totally traumatising." (2022)

The emotional impact described in these experiences is significant and enduring. Research demonstrates that traumatic birth experiences can contribute to postnatal depression, PTSD, impaired bonding, and avoidance of future pregnancies (7).

National investigations consistently recognise that maternity trauma is frequently caused not by clinical events alone, but by how women are treated during those events (2), (4). The number of trauma-related accounts in this dataset indicates systemic cultural issues around communication, compassion, and emotional safety.

3.5 Intrapartum Care and Pain Relief

Many women reported poor management of pain relief, delays, dismissive attitudes, or denial of pain relief requests.

Experiences:

"I received no pain relief and gave birth alone." (2016)

"I begged for an epidural… I was told it was coming but it never did." (2019)

"I was sneered at for asking for pain relief." (2023)

Inadequate pain management is associated with poor psychological outcomes, reduced satisfaction, and increased risk of trauma. National inquiries have repeatedly identified dismissive attitudes toward women's pain as a cultural problem in maternity care. The frequency of these reports suggests a cultural pattern of minimising women's pain, a known driver of trauma and adverse experience.

3.6 Postnatal Care and Support

The postnatal period was one of the most distressing areas of care described.

Experiences:

"I didn't receive food or water for hours." (2020)

"I had to call the hospital switchboard because no one came." (2021)

"I couldn't reach my baby and the buzzer didn't work." (2023)

Women described profound neglect: lack of hydration, dirty wards, lack of assistance with basic mobility after surgery, and delayed help with feeding. Poor postnatal care is consistently associated with increased readmissions, poorer maternal mental health, and reduced breastfeeding rates (10). The testimonies provide evidence of systemic postnatal care failure over more than a decade.

3.7 Communication, Professionalism and Compassion

A significant number of women described unkind, disrespectful, or dismissive communication over a prolonged timescale.

Experiences:

"If you don't like it, you should have gone somewhere else." (2012)

"Staff laughed about a miscarriage." (2012)

"The midwife told my partner to put his hand over my mouth." (2016)

Communication deficits are consistently linked to preventable harm in maternity services. The East Kent inquiry described a culture of 'unprofessional behaviour and callousness' (4), closely mirroring accounts in this dataset. These behaviours represent breaches of fundamental standards of dignity, respect, and professionalism.

3.8 Breastfeeding Support and Baby Feeding

Women commonly reported inconsistent, coercive, or rough handling during breastfeeding support.

Experiences:

"A nurse shoved my boob in his mouth and walked out." (2011)

"I was told I wouldn't be able to breastfeed because of my nipple shape." (2022)

Poor breastfeeding support and inconsistent advice undermine maternal confidence and contribute to early cessation (11). Staff shortages also impact feeding support quality. Inconsistent and harmful infant feeding support reflects training deficits and systemic pressure.

3.9 Safety, Basic Care and Observations

Women described missed observations, delayed test results, dirty clinical environments, and lack of basic care.

Experiences:

"The room was filthy, blood on the toilet seat, and no cleaner came." (2019)

"Repeat bloods were requested at 9am; they were taken at 7pm." (2021)

Failure to meet fundamental care standards breaches national safety expectations (6). Missed observations are a known contributor to avoidable morbidity (7). These failures indicate systemic governance weaknesses.

3.10 Value of Individual Staff Members

Despite systemic issues, women consistently praised individual midwives, doctors, and neonatal teams.

"The team saved my baby's life. They were incredible." (2019)

Positive deviance demonstrates compassionate and skilled practice is possible even under pressure. Leadership should focus on enabling and expanding the conditions that allow such practice to flourish.

4. Discussion

This section synthesises the thematic findings from the 520 NUH maternity experiences with national evidence, inquiry reports, and academic research. The purpose is to contextualise the patterns emerging from the local dataset within the established body of knowledge on maternity safety, culture, and system performance in England.

The discussion is structured around five domains, reflecting recurrent findings across Ockenden (3), the Morecambe Bay Investigation (12), the East Kent Maternity Inquiry (4), and relevant peer-reviewed literature:

- Communication, Listening and Respect
- Workforce and System Pressures
- Clinical Safety and Escalation
- Leadership, Governance and Culture
- Psychological Safety and Trauma

4.1 Communication, Listening and Respect

Summary of NUH Findings

The dataset shows pervasive issues concerning:

- Women not being listened to
- Dismissive or contemptuous language
- Poor explanations of procedures
- Coercive or paternalistic behaviour
- Inconsistency and contradictions between staff messages

These findings closely align with national inquiry conclusions.

National Context

Across all major maternity inquiries, a common foundational failure is not listening to women. Ockenden (3) described ‘repeated failures to listen to families’ and noted that parents often needed to ‘fight’ for safe care.

The East Kent report (3) found ‘callousness and unprofessional behaviours’, mirroring NUH experiences describing staff laughing, mocking, or ignoring women during critical moments. The Morecambe Bay report (12) reported that a lack of compassionate communication contributed directly to avoidable harm. Academic evidence supports these findings. Research demonstrates that women’s perception of being ignored or silenced is strongly predictive of birth trauma (7) and can result in lasting psychological harm.

The prominence of communication failures in the NUH dataset suggests a deeply embedded cultural issue. Such behaviours:

- undermine clinical safety,
- damage trust,
- increase anxiety and fear, and
- contribute to avoidable trauma.

4.2 Workforce and System Pressures

Accounts repeatedly describe dangerously low staffing levels and delays in medication and reviews. There are reports of unmonitored patients, exhausted staff unable to provide one-to-one care and service closures due to capacity issues.

Staffing deficits have been identified as a major concern in:

- RCM reports (1)
- CQC maternity inspections
- Ockenden (3)
- NHS England (13) workforce modelling

The East Kent Inquiry reported that staff shortages contributed directly to poor decision-making, inadequate monitoring, and preventable harm. The staffing shortages at NUH likely led to missed escalation opportunities, inconsistent care, demoralised staff, inadequate supervision of high-risk women and compromised emotional care.

The alignment with national patterns indicates systemic rather than isolated operational failures.

4.3 Clinical Safety and Escalation

Recurring patterns include:

- missed or delayed observations
- poor fetal monitoring
- failure to escalate concerns
- medication errors
- delayed transfer to theatre
- unclean clinical environments

Failures of escalation are repeatedly identified as critical contributors to harm:

The Shrewsbury and Telford reports (3) identified delayed escalation as central to avoidable injuries and deaths.

The report into East Kent (3) noted ‘catastrophic failures of basic clinical checks’.

Safe and high quality care requires timely observations and investigation of concerning symptoms; yet NUH experiences highlight hours-long delays.

Academic evidence shows that delayed maternal observations increase risk of sepsis, haemorrhage, and eclampsia (9). Poor fetal monitoring contributes to hypoxic injury (14). NUH accounts demonstrate that basic safety processes were inconsistently followed over a prolonged period, placing women and babies at avoidable risk.

4.4 Leadership, Governance and Culture

Multiple accounts describe fear of speaking up, dismissive attitudes becoming normalised, defensive behaviour from staff, families feeling ‘gaslit’ or blamed and staff expressing distress at their working conditions.

All major inquiries conclude that leadership failings and dysfunctional organisational cultures are key drivers of unsafe maternity care.

- Ockenden (3) cites ‘cultural failings over many years’.
- Kirkup (4) found that ‘a culture of denial and defensiveness’ prevented improvements.
- CQC (2) identifies culture as a core determinant of maternity safety.

The NUH dataset suggests a weak safety culture, inadequate oversight, normalisation of deviance and inconsistent accountability mechanisms. These conditions allow unsafe practices to persist over time.

4.5 Psychological Safety and Trauma

A large proportion of testimonies include:

- fear and panic
- humiliation or loss of dignity
- long-term PTSD
- postpartum depression
- avoidance of future pregnancies

Research shows that traumatic birth is often rooted not in the clinical event itself, but how women were spoken to, whether their concerns were acknowledged, and whether they felt safe (7).

National investigations echo this, East Kent and Shrewsbury families reported lifelong psychological consequences linked to poor communication and dismissiveness.

The prevalence of trauma across accounts indicates significant emotional harm, with long-term implications for maternal mental health, family wellbeing and future childbearing, alongside inadequate emotional safety within the NUH maternity environment

Overall Interpretation

This dataset reveals patterns that are highly consistent with findings of multiple national maternity inquiries. This convergence strengthens confidence in the themes identified and indicates that NUH challenges were systemic, recurrent, and long-standing.

The accounts illustrate a maternity service where:

- staffing constraints impaired safety
- communication failures undermined trust
- culture hindered openness
- basic care was inconsistent
- trauma was a foreseeable consequence of the system itself

These themes echo national learning and demonstrate the importance of compassionate, well-led maternity services that prioritise both emotional and clinical safety.

5. Conclusion

The analysis of women's and families' accounts of maternity care at Nottingham University Hospitals (NUH) reveals a persistent, systemic pattern of cultural, operational, and clinical failings. These findings echo the themes identified in major national investigations – Shrewsbury and Telford (3), Morecambe Bay (12), and East Kent (4) – and align with the concerns raised by the CQC (2) and academic literature on maternity safety, continuity of care, and psychological wellbeing.

Across the dataset, women described experiences shaped by loss of autonomy, inadequate communication, poor emotional and psychological safety, understaffing, delayed or missing observations, and failures in escalation. These issues span more than a decade, suggesting that challenges were deeply embedded and not limited to individual staff members, isolated events, or short-term operational pressures.

While positive accounts of compassionate, skilled staff demonstrate that high-quality care is possible, they were heavily outweighed by experiences indicating systemic fragility. The juxtaposition of some excellent individual practice against a background of structural dysfunction underscores the significance of leadership, oversight, and culture in shaping the conditions for safe and respectful maternity care.

Critically, the experiences describe not only incidents of clinical concern but also profound emotional harm, including reports of panic, fear, humiliation, PTSD, and enduring mental health difficulties. The toll on women and families, psychologically, emotionally, relationally, and on their confidence in the health system is a central finding of this analysis.

In conclusion, the testimonies provide compelling evidence of long-standing issues across NUH maternity services, consistent with national learning in maternity safety. The patterns identified within this dataset reflect system-wide shortcomings in leadership, staffing, communication, escalation, cultural competence, and postnatal support. These findings, taken together, illuminate a maternity care environment where both clinical and emotional safety were frequently compromised, contributing to trauma and loss of trust among women and families across Nottinghamshire.

The Psychological Impacts of Birth and Suboptimal Care

Post-traumatic stress disorder (PTSD) is a clinically recognised mental health condition, defined by the Diagnostic and Statistical Manual of Mental Orders as exposure to actual or threatened death, serious injury or sexual violence either directly, as a witness or hearing about the incident happening to a close friend or family member. The diagnosis is distinguished by symptoms including intrusive distressing memories or dreams, dissociative reactions (flashbacks), intense or prolonged psychological distress when exposed to certain triggers associated with the experience and avoidance of potential stimulus[65]. Within the birth environment, this encompasses direct birth supporters, family members and friends who are not present, as well as staff. These individuals are collectively referred to as 'second victims'[66].

Studies indicate that 4-5% of women develop PTSD following childbirth. A Report by The All-Party Parliamentary Group on Birth Trauma (APPG) found that approximately one in three women report experiencing aspects of their birth as traumatic[67]. While not everyone in this group may meet the criteria for a PTSD diagnosis, their perinatal experiences can still cause lasting psychological distress. Acknowledging these challenges and providing appropriate professional support can be highly advantageous and avoid the ongoing sequelae associated with this phenomenon.

The Review Team observed this situation not only among numerous families who have shared what happened to them, much of which was deeply distressing, but also among clinicians involved in traumatic births. It is also important to acknowledge that some NUH clinicians coming forward to the Review were also families within the Review.

Additionally, giving or having given birth, as well as providing care, within a Trust subject to the scrutiny of an external review may be associated with specific psychological effects. Media coverage and reports of distressing incidents can prompt families who previously felt they had come to terms with their birth experiences to re-examine and evaluate the quality of care they received.

During the period covered by the Review's Terms of Reference, NUH recorded over 116,000 births. Statistically, given the findings of the APPG, this suggests that more than 38,000 women may have experienced their birth as traumatic. Indeed, the Review has included testimonies from numerous families who reported significant psychological impacts following childbirth, as is reflected in the 'Family and Maternity Experiences' chapter. In some circumstances, these impacts were considered so severe that it was felt the threshold for 'severe maternal harm' had been met and cases were formally reviewed under this category within the Terms of Reference.

Rationale Behind This Chapter

Psychological harm associated with birth is not solely attributable to inadequate care or negative outcomes; rather, it can also arise from an individual's interpretation of the event and their personal perspective on childbirth. It is therefore challenging to ascertain whether aspects of care have influenced this perception, as experiences are shaped by a wide range of psychosocial factors. These factors may include family attitudes and experiences related to birth, as well as the individual's own childhood experiences. For instance, some individuals view birth as inherently traumatic and distressing, whereas others perceive it as a positive physiological process and a meaningful life event. Consequently, individuals may perceive birth

65 CSAT. (2014, Accessed Feb 2026). Understanding the Impact of Trauma. Retrieved from National Library of Medicine: www.ncbi.nlm.nih.gov/books/NBK207191/

66 Wu, A. (2000). Medical Error; The second victim. BMJ, 726-727.

67 APPG. (2024). Listen to Mums: Ending the postcode lottery on perinatal care. All-Party Parliamentary Group.

complications as traumatic events, despite these outcomes being regarded by healthcare professionals as routine or commonly occurring. Pre-existing mental health conditions and exposure to adverse childhood experiences can also result in perceptions of childbirth as inherently traumatic.

Experiences such as witnessing one's newborn baby requiring resuscitation, having one's partner experience a haemorrhage or being rushed away to theatre leaving partners behind, can contribute to the perceived threats associated with potential post-traumatic stress responses. Each of these events has the potential to trigger a PTSD response independently. If such circumstances are coupled with feelings of helplessness, poor communication, lack of control, being disregarded, or experiencing harsh communication, it is reasonable to conclude that these factors may exacerbate psychological effects. Although this aspect of care is not recorded in clinical documentation, its presence is demonstrated within the Family Voices and Experiences chapter.

"I don't think they did them wrong [the medical things]...it wasn't done very nicely...Only 2 or 3 midwives were compassionate, understanding – the rest were not compassionate, they were dismissive and impatient... one staff member had no sense of empathy...He's horrible but he's technically skilled." (2010)

Effective communication, maintaining composed urgency, and providing timely opportunities to discuss experiences and associated emotions are essential for evaluating and addressing the aftermath of complex births.

In some circumstances interventions may be deemed appropriate 'given the situation' which nevertheless cause unintended psychological harm. For example, it may be considered that prompt intervention is necessary to prevent potential stillbirth or brain injury due to concerns for fetal wellbeing. The consequential measures taken to safeguard the infant can cause trauma for the mother and her birth partners. For instance, the need to expedite the birth when the baby is no longer coping with labour might necessitate an urgent instrumental birth (ventouse or forceps); the urgency might restrict optimal analgesia administration, and the necessity for the procedure would certainly be significantly 'fear inducing'.

Clinician misunderstandings regarding consent and capacity in such situations remain a significant concern. A common misconception is that severe pain, emotional distress, or medication administered during labour impairs a woman's legal capacity to make decisions. However, judicial rulings consistently affirm that women in labour maintain decision-making capacity even under considerable physical stress[68]. The consequences of misinterpreting these facts are substantial, and have led some women to experience lasting trauma.

Consequential Impacts of Birth Trauma

The MBRRACE report[69] continues to identify mental health as the primary cause of late maternal death in 2025.

*In **2022**, shortly after having a termination resulting from severe tokophobia, a woman died by suicide a short time after her partner had raised concerns as to her well-being, which were neither acknowledged nor addressed.* (2022)

Birth trauma can have severe consequences and should not be viewed as an unavoidable aspect of childbirth. Supporting mental health is essential for improving the quality of maternity care and warrants substantial attention as a pivotal element in preventing maternal mortality.

Several mothers interviewed by the Review reported deciding against expanding their families after experiencing a traumatic birth, despite earlier intentions to have more children.

"I have been treated for PTSD, but we haven't had any more children, and that is why we haven't had any more children, and I just don't want to go through that again." (2017)

68 Birthrights. (2021). Birthrights.org.uk. Retrieved from Birthrights: https:://birthrights.org.uk/factsheets/consenting-to-treatment/, (Accessed 28 February 2028)

69 MBRRACE-UK. (2025). Saving Lives, Improving Mothers' Care 2025 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. NPEU.

Some mothers who have lost trust and confidence in maternity services due to experiencing traumatic births have chosen to deliver their subsequent babies in settings that fall outside recommended medical guidelines, seeking greater autonomy over their birth environment.

"Due to all that had happened before, I was very anxious during my second pregnancy, even experiencing anxiety attacks for the very first time. I chose to have a home birth as that's what my preference had always been, but this time I also didn't trust medical staff, and the hospital environment led me to believe I wouldn't be respected and heard." (2019)

Literature documents cases in which women have opted for freebirth or have been assisted by untrained birth attendants to birth at home, sometimes resulting in catastrophic outcomes[70]. Evidence received from mothers interviewed by the Review suggests that the maternity service must take significant steps to restore trust and confidence in its capacity to deliver care that is both physically and psychologically safe for all stakeholders.

In addition to the immediate individual psychological effects, investing in this area yields broader societal advantages. A report by the Office for National Statistics explores the financial impact of pregnancy events on family income. Between the years April 2014 to December 2022, they found that following a pregnancy loss or neonatal death, earnings were substantially lower for at least 5 years compared with the year before the event and that employment probability was reduced for up to 2 years post event. Consequently, it can be asserted that this issue extends beyond the immediate impact on bereaved and affected families, representing a concern for society at large.

Psychological Effects on Front line Clinicians

In clinical environments, such as obstetrics, interaction between healthcare providers and families is intrinsic, and is linked to outcomes; the professional conduct and demeanour of clinicians significantly influence the overall patient experience and family outcomes. Cultivating a supportive professional environment that prioritises the psychological well-being of clinicians is fundamental to ensuring the delivery of compassionate, high-quality care to create good patient experiences and achieve good family outcomes.

A staff member told the Review:

"In a harsh working environment you survive by becoming hard, the bullying culture is a way of managing your own helplessness... Short staffing meant disappointing women on every shift, I never left work feeling like I had done a good job..." (2023)

and reports leaving the Trust 'broken'.

Recent research indicates that nearly two-thirds of surveyed obstetrics and gynaecology physicians have encountered traumatic work-related incidents, with 18% demonstrating clinically significant PTSD symptoms[71]. The risk of being unable to prevent maternal or neonatal harm; especially in acute situations where clinicians hold direct responsibility; can have a negative influence on their behaviour and communication, sometimes presenting as diminished empathy or attentiveness. The culture of a workplace can significantly affect psychological safety and performance.

Psychological safety in the workplace is described as having four pillars.[72]

- **Stage 1:** Inclusion Safety is the basic human need to connect and belong allowing you to 'be yourself' without fear of being excluded

70 The Guardian (2025) Death of Irish mother in 'free birth' reveals how poor maternity care is pushing women towards extreme influencers. Available from: https://www.theguardian.com/lifeandstyle/ng-interactive/2025/dec/03/death-of-irish-mother-in-free-birth-reveals-how-poor-maternity-care-is-pushing-women-towards-extreme-influencers

71 Slade P, B. K. (2020). Work-related post traumatic stress symptoms in obstetricians and gynaecologists: findings from INDIGO, a mixed methods study with a cross-sectional survey and in-depth interviews. BJOG, 600-625.

72 Clarke, T. R. (2020). The 4 Stages of Psychological Safety: Defining the Path to Inclusion and Innovation. Berrett-Koehler Publishers.

- **Stage 2:** Learner Safety is the ability to ask questions, give advice and make mistakes as part of the learning process. During the final part of this stage, close supervision and support in a healthcare setting are essential to mitigate risks and keep patients safe
- **Stage 3:** Contributor Safety addresses the need for individuals to make meaningful contributions. This stage involves feeling secure in applying one's skills and expertise to actively participate as a team member, free from concerns about embarrassment or ridicule
- **Stage 4:** Challenger Safety is the highest level of safety, which allows for the challenging of the status quo. It means feeling safe to speak up, dissent, and offer alternative ideas to improve processes or products, fostering innovation

Each stage is dependent on the previous one; if someone lacks inclusion (Stage 1), they're unlikely to challenge the status quo or progress further.

When this is put into context and consider, for example, services that operate in a blame-oriented culture, with poor senior clinical support and where workload is excessive, it can be seen just how relevant the work environment is and how it can impact negatively on families' experience of care. Any previous traumatic experiences that have not been managed well can negatively affect clinical judgment, emergency response, and reporting willingness. Slade's study also highlighted outcomes including depersonalisation and emotional exhaustion, which can then impact on safe staffing levels and expertise.

Findings from the Review of Cases Involving Maternal Harm Through Psychological Trauma

There were 59 cases included in the Review under the cohort of 'severe maternal harm, severe psychological trauma/PTSD'. Although it is not possible to ascertain whether the quality of care directly influenced the psychological trauma observed, our assessment was that in 75% of those cases there was suboptimal clinical care.

Key Themes Identified

1. Inadequate Pain Relief and Analgesia

   Many accounts over a prolonged period of time describe insufficient pain management during various stages of labour, instrumental deliveries, caesarean sections, and postnatal procedures. Several women reported not being offered timely or effective analgesia, resulting in significant physical and psychological distress. Instances include unmanaged pain during forceps delivery, interoperative pain during caesarean section, and lack of pain relief during procedures such as manual removal of placenta (MROP).

   "It was unbearable pain. It took them hours to give me an epidural. I asked for an epidural. It took hours..." (2010)

2. Poor Communication and Lack of Agency

   A recurrent theme is ineffective or dismissive communication from healthcare professionals. Patients frequently felt ignored, not listened to, coerced into procedures (e.g., membrane sweep, syntocinon induction), and inadequately informed about their care options. Several narratives mention that consent was not properly sought, and decisions were made without the patient's full understanding or agreement.

   "Despite having a document that detailed my preferences, during my stay at City Hospital I felt coerced to do several things I didn't agree with. I was pressured to accept CTG monitoring, and later pressured to accept an oxytocin drip, both things I had researched and knew I didn't want, having looked into the evidence behind them. I agreed to an internal examination, but during this exam the midwife performed a membrane sweep without notice or consent." (2019)

3. Documentation and Transparency Issues

Numerous accounts point to discrepancies between patient and family accounts and medical records, with some events not documented at all. Concerns about missing or conflicting information in medical notes, lack of transparency in postnatal reviews, and poor documentation of procedures (e.g., suturing, pain relief) were highlighted.

"...they then spent 12 hours not believing me that I was in labour, denying me of pain relief, leaving me completely alone with no partner throughout, on a ward, not conducting adequate checks, lying in my medical notes to cover their backs….and then did not openly and honestly investigate my complaint." (2020)

4. Clinical Mismanagement and Delays

Participants described mismanagement during various labour stages, including delayed escalation in emergencies, failure to follow guidelines, and inadequate monitoring (e.g., not recognising progression in first-time mothers, delays in transfusion for postpartum haemorrhage). Some cases involved a chaotic or disorganised birth environment.

"...and I remember my mum was timing them, they were coming so fast. We kept ringing up..., numerous attempts and there was no evidence of the phone calls that my mum was making. They kept saying, 'Because this is your first baby, this is normal to happen'...My mum at the time nearly had to deliver my daughter and then we had to wait an hour for the ambulance to come because there was an accident at the time. Thankfully, they arrived and helped me give birth to my daughter." (2017)

5. Emotional Trauma and Psychological Impact

Emotional and psychological harm features prominently, with accounts of trauma, anxiety, depression, PTSD, and a lasting sense of betrayal or distress following the birth experience. The psychological impact sometimes overshadowed physical outcomes, with some patients linking birth trauma to subsequent mental health difficulties.

6. Lack of Compassion and Postnatal Support

Several women reported feeling unsupported, abandoned, or treated unkindly by staff, particularly during the postnatal period. Inadequate debriefing, poor emotional support, and lack of follow-up contributed to negative experiences and hindered recovery.

"And a midwife came up to me and was asking me if I was okay, and I was like, 'She's taken him somewhere [her baby] and I don't know where'. And I said, 'She's being really horrible to me'. And the midwife – all that midwife said is, 'She can be a bit like that'." (2024)

7. Safeguarding and Recognition of Vulnerability

Some accounts reveal failures in recognising and responding to vulnerable patients, including those with histories of domestic violence, mental health problems, or language barriers. There were significant missed opportunities for safeguarding and individualised support.

8. Physical Trauma and Long-Term Health Consequences

Physical injuries such as bladder damage, cervical trauma, perineal tears, incontinence, and nerve damage were reported, often with long-term repercussions. These outcomes were sometimes attributed to mismanagement and poor technique.

9. Impact on Family and Future Choices

Birth experiences influenced future reproductive decisions and family wellbeing. Some women chose not to have more children, while others described the impact on their child's health or family mental health (e.g., child with autism, parental anxiety).

"So much so that when I discovered I was pregnant with my second child, my immediate reaction was to terminate the pregnancy because I was too frightened to go through the experience I did with my daughter...Having been desperate to have any children this speaks volumes about the level of trauma I experienced in my first childbirth experience." (2014)

10. Positive Aspects and Appropriate Care

While most accounts focus on negative experiences, a few mention reasonable management and prompt attendance for procedures, although often these were contrasted with shortcomings elsewhere in care.

Conclusion

Many families described severe distress even when clinical actions were judged appropriate, while others experienced compounding trauma in the context of suboptimal care. This highlights an important limitation in relying on clinical documentation alone to evaluate experience, communication, and consent – factors that can determine whether an emergency is remembered as frightening but supported, or frightening and violating. Recognising this gap is not an academic exercise; it has direct implications for how services listen, learn, apologise, and provide timely help. A renewed focus on psychological harm, alongside clinical safety, is essential if maternity services are to rebuild trust and improve outcomes for future families.

"As someone who now helps women recover from birth trauma and helps pregnant women prepare for birth, I hope this review and the many testimonies will help improve things. I hope you can help make maternity staff more trauma aware and help them get the support they need in terms of compassion burnout and their own mental health and trauma treatment, as I am sure there will be very few staff who haven't had their share of vicarious and organisational trauma, including moral injury. I don't believe any of them set out to hurt people, but the system is not fit for purpose for either birthing people or birth professionals." (2019)

Current Provision of Psychological Support Services for Bereaved and Affected Families

Until recently, NUH was able to refer families to services such as Petals, Talking Therapies, Be U Notts, and Perinatal Trauma and Bereavement Service for psychological support. In Spring 2025, the Integrated Care Board discontinued funding for the Petals service, which is a dedicated support service for mothers who have experienced pregnancy or baby loss. This decision has adversely affected the local pregnancy and baby loss community, as Petals was the sole specialised service available for referrals related to pregnancy or baby loss.

Numerous local and regional charities throughout Nottinghamshire offer bereavement support to families by providing complimentary counselling sessions. Following the closure of the Petals service, these organisations responded by delivering specialised assistance to families affected by loss. Reports indicate that staff at the Trust were hesitant to refer families to alternative services, as they believed those options might not adequately address the specific needs of the individuals under their care.

In addition, many current mainstream services are limited to supporting only mothers, resulting in life partners, birthing partners, children, and extended family members often lacking appropriate assistance despite being affected by the birthing experience. Many of these services offer only a restricted number of sessions or require a formal mental health diagnosis from a healthcare professional, such as tokophobia, before a referral can be made. Such requirements reduce accessibility for families seeking support. Those without a formal diagnosis may remain unsupported until their condition worsens and they meet criteria for professional intervention. Furthermore, waiting times for some programmes differ across the country, with reports indicating that certain individuals face delays exceeding twelve months before receiving treatment.

It was reported that some staff referred families to local and regional organisations offering counselling services. These referrals were made without prior discussion between the Trust and the organisations, resulting in missed opportunities to assess each organisation's capacity to accept new clients. Consequently, some local charities closed their waiting lists to manage the increased volume of referrals. This development

adversely affected a number of charitable organisations, as denying assistance to these families conflicted with their foundational principles, values, and the original mission of their services.

The Review is facilitating closer collaboration between these charities and the Trust to help sustain this important resource.

Psychological Support throughout the Ockenden Maternity Review in Nottingham

The need for psychological and emotional support for those affected by the Review, either in relation to the experiences that led to them being involved with the Review or the impact of being involved with the Review process, was identified from the earliest stage. A Family Psychological Support Service (FPSS) was introduced to support those affected. The service is available for the whole family: mothers, partners, siblings, grandparents and any other individuals linked to the birth experience.

The FPSS utilised a new role, the 'Wellbeing Navigator'. The aim of this role was to provide a primary point of contact for each person who was referred to the service and guide them through the FPSS support offer. First contact with FPSS was not a formal assessment but an opportunity for a Wellbeing Navigator to explore individual needs, what support was needed, and the person's current circumstances and therapeutic readiness. This allowed time for service users to develop trust, make informed decisions about their treatment or support package, and ensure they were able to engage at a time that was right for them. This later point was particularly important as a proportion of service users were pregnant and were looking to resolve specific problems prior to further maternity experience.

The Wellbeing Navigator was able to hold cases where trust needed to be built, where individuals were looking to be heard instead of entering into formal treatment, where emotional support was needed to engage with the Review process, or to support preparation for treatment readiness. The Wellbeing Navigators referred on to a wide array of support and treatment options dependent on patient need. These have included the internal team within FPSS of trauma-informed CBT[73] therapists, EMDR[74] therapists, integrative therapists, Internal Family Systems[75] therapists and psychosexual therapists, as well as having close links with local charities and practitioners offering group support and alternative therapies, such as trauma-informed yoga. This has allowed for a truly patient-led service offer, without wait times or a fixed service offer.

FPSS has gained high levels of positive feedback from families within the Review, as well as evidencing strong clinical improvement outcome data. Working in partnership with the Review Team, with the ICB as commissioners, and with service user groups for codesign, FPSS has continued to develop throughout the duration of the Review to meet emerging needs and to deliver a service focused on the requirements of the families affected.

This support will remain in place for some time following publication of findings and reporting back to the families. As discussed, it is likely that some families who have experienced significant psychological harm will be informed that their 'clinical' care was appropriate when benchmarked against expected practice. Conversely there may be families who have not questioned the care they received but may be informed that it was in fact sub-standard. This does not distract from the 'care' provided in terms of emotional support, kindness, compassion and humanity that cannot be assessed via the clinical notes.

Throughout the Review process, staff and team members were provided with the opportunity to receive psychological support, recognising that listening to families describe numerous traumatic experiences could have a significant effect on them.

73 Cognitive Behavioural Therapy (CBT) is a structured, goal-oriented talking therapy that helps individuals manage mental health problems, such as anxiety and depression, by identifying and changing harmful thinking patterns and behaviours.

74 Eye Movement Desensitisation and Reprocessing (EMDR) is an evidence-based psychotherapy that helps individuals process and heal from traumatic memories, PTSD and other distressing life experiences.

75 Internal Family Systems (IFS) therapy is an evidence-based approach that views the mind as a system of distinct "parts", each with its own perspective and role, guided by a core, undamaged self.

Staff Voices

Introduction

In this chapter former and current Nottingham University Hospitals NHS Trust (NUH) staff tell us, in their own words what it was and is like to work at NUH. Staff engagement in this Review has been central to trying to understand the link between patient outcomes and experiences and the way that the service was organised, managed and led.

Most staff, past and present, working in NUH's maternity, neonatal and associated services share the values and motivation of NHS staff throughout the country: to serve, to provide high quality care, and to support women and their families to have the best outcomes and experiences possible in their maternity journey. Time and again we have heard stories of staff who have gone above and beyond, working beyond their contracted hours, raising money for service improvements and eager for innovation. And yet, overwhelmingly, the experience of staff members who contacted the Review is of a challenging and demanding working environment. Whilst we recognise that our sample is self-selecting, our results are in line, not just with the NHS Staff Survey, but specifically with five external culture reviews undertaken in NUH maternity over the last ten years, (see chapter 'Corporate Governance and Leadership' for more detail).

This staff voices chapter provides some context to the broader findings of this Review. Good morale and motivation are essential both for a healthy workforce and for productive and effective delivery of care. Most importantly they also have positive effects on patient care. Staff are the most significant element of NHS expenditure and its most important asset in providing safe high-quality care for NHS patients. NUH maternity staff describe their lived experience of systemic underinvestment in staffing levels, as well as their experience of the management, leadership and culture which determined the working environment.

SECTION 1: Who We Spoke To

1. Numbers

838 members of staff past and present contacted the Review, of those 715 completed our online survey and 139 staff also asked to be interviewed as part of the Review and we were able to arrange interviews with 133 of them. We also met groups of resident doctors in obstetrics, gynaecology and neonatology.

2. Methodology

The participants in both our online survey and our one-to-one interviews were very largely self-selecting. Senior staff and stakeholders who we asked for interviews were free to decline.

The staff survey was open from August 2022 to April 2025 and was advertised and promoted through local mainstream media, the Trust and Review websites and through social media, as well as during Review Team visits to the units. The survey was designed using an online survey platform and participants could complete as many or as few of our questions as they wished. The response rate for individual questions ranged from 53%-85%. The survey was anonymous, but we offered participants the opportunity to identify themselves if they wished to take part in a follow up face to face interview. We collected some limited demographic details and asked about job role, place of work and length of service. The full quantitative results of the survey are presented at Appendix 1. We asked survey respondents about their experiences of working at NUH and in particular, the safety culture of maternity and neonatal services. For all questions in the survey, we offered a free text box for comments, evidence and reactions.

The face-to-face interviews with staff comprised those who had completed the online survey and requested a follow up interview, plus other current and former staff who contacted the Review Team. These were largely conducted over the 'Zoom' video-conference application, but some took place in person; almost all included two members of the Review Team with a standard template of questions to prompt a free-flowing conversation. Most interviews lasted about one hour and were transcribed; the transcripts were provided to participants, who were given the opportunity to amend or change their responses. We did not collect demographic details about our interviewees, but we recorded job role and length of service. The evidence collected in these interviews is used to illustrate the findings throughout this chapter.

In addition, the Review Team was able to identify some stakeholders, key leaders and senior staff who could help us understand the issues raised in the case reviews and staff feedback, and with our analysis of corporate governance documents. This group included those with managerial, leadership and accountability roles over the period covered by the Review. Interviews were undertaken almost exclusively online by senior members of the Review Team with direct experience of operating at Board level. All interviews were transcribed and transcripts were reviewed and approved by interviewees.

Thematic analysis was used across the survey and interview datasets, including key word searches to provide a structured yet flexible framework for identifying, analysing, and interpreting patterns of meaning within the transcripts. Key words were selected from the existing literature on staffing, management, leadership and quality in the NHS. Initial theme codes were identified, refined iteratively, and validated with colleagues conducting the clinical reviews.

3. Demographics

The age, gender and ethnicity profile of our survey respondents was broadly aligned with the workforce profile of NUH's maternity and neonatal service. Most of the respondents were from a white ethnic background, female and between 40 and 66 years of age. 15.5% of survey responders had more than 21 years' service at NUH.

4. Professions and Roles

Staff who responded to our survey and were interviewed represented the full spectrum of professions and roles involved in maternity and neonatal care. Our sample included senior midwives and consultants, as well as front line staff, student midwives and resident doctors, general managers, and a mix of other corporate roles.

Table 1: Survey responses and interviews by staff group as a percentage of total participants

ROLE/PROFESSION	SURVEY N=388	INTERVIEWS N=131
Midwives	51%	53%
Nurses	2%	9%
Obstetricians	17%	21%
Anaesthetists	9%	7%
Clinical Staff	5%	5%
Other	16%	5%

Of the 131 members of staff interviewed

- 70 were still working at the Trust
- 9 had left the Trust since the beginning of 2023

- 36 had left between January 2017 and December 2022
- 7 had left before 2017
- 9 it was unclear when they left the organisation

SECTION 2: Positive Things Staff Say About Working at NUH

Many staff described pride in their service and the care they provide, as well as positive working relationships with colleagues.

58% of respondents to our survey agreed or strongly agreed that people support each other and that they work as a team; with 54% agreeing and strongly agreeing that staff are actively doing things to improve safety. Whilst 39% of our survey responders say they enjoy coming to work, this is considerably lower than the national NHS staff survey average, where 54% report looking forward to coming to work and 68% are enthusiastic about their job.

"I could not imagine working at another trust. I have had my babies here. I recommend our services to friends and family. We are a great team throughout the QMC site with some tricky members but that is human nature. Overall, we do work well as a team although it feels quite fragmented at present and we could be more united. I am proud to work at NUH and care dearly for my colleagues. We all want the best for our women and fight for the best." (2024)

"I absolutely loved and enjoyed working here. Staff were dedicated to deliver high standard of patient care but this was bound to be compromised with staff shortage and therefore balancing workload" (2024)

"Day to day experience is a friendly organisation with good team working on the labour suite, joined up handovers and ward rounds and cooperation between professional groups. There are a lot of good people at NUH and a lot of people passionate about patient safety and a lot of people motivated to improve things for patients, for staff and for the whole organisation. I worked with so many people who were kind and decent." (2024)

"Great working relationships with trainees. Obstetricians and midwives pop into our office for a chat - good collaborative communications. Feels like it is a good team no incivility or rudeness - anaesthetists are a pretty cheery group." (2024)

And some staff members told us:

"Team is great, professional, caring and supportive. No issues of workplace unpleasantness." (2024)

"Enjoy working at NUH. Have never been or witnessed bullying. Have found it a supportive place to work, have always been able to approach seniors. Good relations with Drs." (2024)

STAND OUT AREAS

2.1 Professional Midwifery Advocates

In 2017 statutory supervision of midwives was abolished and replaced with a system of employer-led supervision through Professional Midwifery Advocates (PMAs). The national framework for PMAs aims to support a culture of improvement, build personal and professional resilience and support midwives as they prepare for appraisals and revalidation.

Over the course of this review the PMA function has been one that midwives have reported to be approachable and supportive, in ways that in many cases local management has not. Staff reported that the PMAs provided support after clinical incidents and maintained a visible presence, with one individual mentioned repeatedly by name in the responses.

A staff member at the Trust told us:

"Our PMA team, they're another standout for amazing, especially that [XXX], who's probably our most experienced PMA. They're amazing, really good. I think their support of staff is really good. I feel like then obviously they wouldn't ever break anyone's confidentiality, but they'll come to you with themes." (2024)

2.2 Multidisciplinary Working

The provision of maternity services is a team endeavour. Midwives and obstetricians rely on anaesthetic, neonatal and paediatric colleagues as well as nurses, radiographers and maternity support workers. In addition, other specialists contribute to the care of women with pre-existing medical conditions and those who become very unwell during pregnancy.

Whilst there are many reports in our interviews and survey of an historically hierarchical and medically dominant team culture, we also heard of good collaborative working relations between doctors and midwives in more recent years, particularly since 2022. Stronger links across the wider trust and other specialities have become the norm, including regular MDT meetings and problems being discussed openly. There is also growing recognition and respect of the multidisciplinary team with full involvement in daily handovers, safety briefings and training, more double checking of decisions, and inclusive investigations to identify issues.

"In an emergency all colleagues pull together and support, intensivists are very collaborative, excellent CCOT (Critical Care Outreach) team. Made to feel an integral part of the obstetric and midwifery team. Proud of the working relationship across the MDT, collaborative and mutually supportive." (2024)

"MDT PROMPT and CTG training now is excellent focus on improvement, shared learning is solidifying team working since 2021/22. Learning from Morbidity and Mortality meetings and emails from Quality Risk and Safety team ensure feedback and shared learning." (2024)

2.3 Anaesthetics

Without exception, members of the anaesthetic team who contacted us were positive about their working environment, style and experience. Midwives and obstetricians also highlighted the support and camaraderie emanating from the anaesthetic and obstetric anaesthetists' teams. Some respondents put this down to being well staffed, others to good management and leadership.

"Very long happy working experience at NUH. A strong, cohesive team, good MDT connections even though busy there are regular handovers, safety huddles and formal meetings." (2024)

SECTION 3: The Challenges

3.1 Staffing

Of the negative experiences of working at NUH, appropriate staffing is experienced as the most serious and pressing issue, with only 11% of our survey respondents reporting there are sufficient staff for the workload and 59% reporting that staff regularly work longer hours than is best for service quality. Of significant concern, 73% of staff reported that they regularly feel they are working in crisis mode, staying late and working beyond their rostered hours because they believe this will ensure patient safety. These figures are higher than those found within the broader NHS community. According to the 2024 NHS Staff Survey 34% of respondents believe they have enough staff to do their job properly and 47% say they can meet all the conflicting demands made during work time.

As a theme, the pressures and consequences of short staffing received the largest number of comments in our survey and interviews from staff working across all disciplines, regardless of whether they were still

working at the Trust or not. Staff told the Review Team that short staffing continues to be experienced in all clinical areas and within all professional groups, and staff believe that it compromises patient safety. A particular concern repeatedly expressed was the recent reliance on agency and locum staff and, more recently, internationally recruited midwives, to routinely cover gaps. Whilst much needed, staff raised concerns that these staff members are unfamiliar with policies, processes and guidelines. Staff told the Review Team that insufficient staffing is at the heart of unsafe practice, with insufficient time to train, to review cases, to complete observations, to listen to women and to learn. Moreover, staff all agree that senior and executive managers have been routinely made aware of these challenges over many years, but have either ignored or have been unable to respond to the concerns being raised. We heard many accounts of the historic pressure to keep units open despite lack of staff, cancellation of mandatory training, and active discouragement of escalation of concerns about staff levels.

2006-2016

A staff member who left the organisation in 2016 recalled:

"Worked 12-hour shifts with no breaks. Didn't feel able to care for women properly. Caring for 2 women in labour at the same time with no support." (2024)

Another said:

"Up to 2016 no strategic planning for the number of women or the level of need. Instead pressure to keep the doors open. No acknowledgement of pressure service was under. 2012-2022 just massive lack of resources, staff shortages, focus just on filling shifts, nobody had headspace to think of anything else, people were just frazzled, staff permanently tired. Many staff welcomed CQC report 2020 and rating inadequate because they felt someone was finally listening." (2024)

2017-2022

A staff member who left in 2017 told us:

"Terrible staff shortages on ante/postnatal wards – except for the day CQC came so I called it out and was told if I told them anything else I would be sacked. Short staffing meant disappointing women on every shift, never left work feeling like I had done a good job. There was a ban on agency staffing. No protected time for learning - all my mandatory training out of date." (2024)

Another recalled (and this was commonly reported):

"WhatsApp group calling for people to cover shortages caused stress and pressure. Very little staff rotation meant staff not confident to cover labour ward and this caused conflict." (2024)

In 2018, fears of the impact of staffing on safety led to 50 maternity staff from the QMC site putting their names to a letter which they sent to the Chair of the Board. This letter was well known by staff throughout the unit, and the lack of any meaningful response only reinforced the disconnect between midwives and the Board. We heard from many that they felt 'fobbed-off'.

One staff member recalls:

"Staff involved did not feel they got a satisfactory response, as Drs we agreed with it, we could see the short staffing and the way midwifery was organised was poor. There are now a lot more midwives but problem is many junior midwives so skill mix is often difficult. High use of agency staff, can be good if it's the same people, but difficult at nights when many people who are unfamiliar with the unit. After CQC rated service inadequate (2020) a scoping need of obstetric-need found we were 14 consultants short. 6 new posts were advertised in 2020/21. Still feels like many gaps especially as amount of obstetric activity has increased. High rates of stress, sickness, high workload, investigations and GMC referrals." (2024)

Another told the Review Team:

"Risk register c2019 was not properly processed. Midwifery staffing was a Divisional risk but then got subsumed within nurse staffing as a trust wide risk and never got properly dealt with. c2021 Trust tried to down grade the risk. Seemed to be no will to solve it. Historically no budget to backfill for maternity leave. Feeling that Trust does not properly control its own finances. Aware of midwives anonymous letter 2018, no consultants signed it. Did not see anything really change subsequently." (2024)

We heard many accounts of favouritism and cronyism within the service over this period and preferential treatment for extra shifts or being moved to different areas, as a way for power and influence to be exerted. Many of the past and current Band 6 midwives told us of their camaraderie and support for each other during short-staffed shifts, but their frustration at the lack of support and the perceived pointlessness of escalating.

Short staffing has two elements, firstly whether the funded establishment is sufficient for the workload (this is measured by the NICE-endorsed Birthrate Plus tool) and secondly whether amongst employed staff there are sufficient able to work to cover shifts when vacancies, sickness, training and holiday and maternity leave are taken into account. We have seen Board and Divisional papers show that. Executives within NUH were aware of both types of shortage over the period of the Review. One staff member who left in 2021 told us:

"BR+ showed a gap of 61.8 midwives, but to deliver Continuity of Care would need additional 73 midwives." (2024)

"Staff shortages common demonstrated by 2018 letter [to Chair]. Perception is Trust was more concerned with finance. 2020 CQC report emphasises impact of short staffing. Perception is that CNO surprised by CQC findings" (2024)

Another staff member explained:

"Staff shortages meant constant juggling, high use of agency, NHSP, constant recruitment, nurses came onto wards to help. Good daily meetings to assess all risks and make appropriate challenges. Training regularly cancelled. Escalated concerns re staffing to MD and CNO – no action." (2024)

2023 to present

Short staffing is most visible in hospital environments, but we heard from many staff that community midwifery was systematically denuded of staff. This staff member who left in 2023 told us:

"Witnessed huge decline in community midwifery over 2000s, not enough staff, expected to work beyond shift/additional hours, meant unable to provide continuity in the community; clinics always being cancelled to cover each other. Matron sent an email saying you are not working hard enough, need to see more women in a day. Since digital booking, only allowed 20 mins per woman and 1 hr. for booking. Home birth service launched recently but not enough staff and always asking for people to cover on-calls. Constantly calling people to come in on their day off, junior staff feel unable to say no – emotional blackmail. A lot of agency midwives and locum doctors, cut rates for NHSP so own staff won't pick up extra shifts." (2024)

In recent years, it is obstetric staffing which has become the greater challenge and many of those who spoke to us reflected the impact of consultants covering resident doctors' shifts, of inappropriate pay for on-calls and insufficient time for essential non-clinical work. Throughout 2024 obstetric staffing was escalated to the Board with reassurance that mitigation through additional shifts and locums was keeping the service safe.

One staff member told us:

"Concerns were raised by consultant body in 2015 about capacity – approached Freedom to Speak Up Guardian in Aug. 2017 re inadequate staffing, relationships, lack of continuity and approached again in

2021. Didn't feel like anything changed after any of these. In 2021 they were 13 consultants short. After the CQC report in 2022 consultants started having regular meetings with Medical Director. Huge resistance to closing due to inadequate medical staffing if there are sufficient midwives." (2024)

The Review Team sensed a high degree of anxiety amongst current staff members, and were told:

"Currently: rota gap and terrible sickness rates mean 4 or 5 out of hours shifts a week have no registrar or senior registrar, so consultants must be resident on-call. Not a good process for managing workload between electives and emergencies. Sense is it's getting worse. Have raised this with Trust Executives and not believed - they were defensive. Few juniors work full-time. Have created lots of fellowships and research posts to encourage people to stay but they don't work clinically much - so a lot of locums. WhatsApp group puts pressure to pick up additional shifts. One or other site ends up closing because not enough doctors that puts huge pressure on the other. Seems to be a process for stopping things like inductions if there are not enough midwives- but not if there are not enough doctors quite a few obstetricians do not work on labour ward and don't do on-calls." (2024)

The impact of short staffing in obstetrics is further commented on by midwives and anaesthetists, who see that contingency plans become normalised, and that whilst a shortage of midwives can lead to unit diverts or closures this is rarely the case when there are insufficient obstetricians. One staff member told us:

"Anaesthetic staffing is rarely/never a serious problem, not under pressure, but for obstetricians and midwives there's always someone missing and we are constantly aware of shortages. Hear from obstetricians and midwives that when they escalate shortages nothing happens and people no longer want to do extra shifts because they are burnt out. Neonates v often short staffed." (2024)

It is clear that the scale of the staffing challenge is now more openly recognised and staff who have been in the organisation for a number of years are starting to see some changes. The introduction of the "Flow Coordinator" to respond on an hour-by-hour, day-by-day basis to staffing pressures across wards and sites is appreciated so that across teams and across the city, colleagues can support each other.

"Service remains short staffed today (doctors and midwives) but at least people listen. Lots of agency staff especially at night. QMC v badly staffed and skill mix is challenging many NQMs and many international recruits who come with a lot of skills but need help especially with CTG. Band 5 midwives end up caring for women with complex needs." (2024)

3.2 Organisational Culture

3.2.1 Bullying

Problems with bullying, undermining and harassment are unfortunately common within the NHS. They can relate to individuals, organisational culture or both, and are often accompanied by a fear of reporting the behaviour. According to the NHS Staff Council, 17.6% of all NHS staff experienced bullying or harassment in 2024 and 98% experienced incivility[76]. The impact of bullying is serious for the individual, for the organisation and most importantly for patient care. Research has demonstrated that bullying is associated with[77]:

- Anxiety and depression
- Disengagement and isolation
- Taking feelings home
- Reduced confidence
- Greater risk of human error

76 NHS Staff Council. Tackling bullying and harassment in the NHS;2025. Available from: https://www.nhsemployers.org/articles/tackling-bullying-nhs-infographic

77 Illing JC, Carter M, Thompson NJ, Crampton PES, Morrow GM, Howse JH, et al. Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS. Final report. NIHR Service Delivery and Organisation programme; 2013.

- Poorer patient care
- Lower morale
- Increased absenteeism
- Reduced productivity and teamwork

A bullying and toxic culture has been a long-running theme in NUH's maternity services. 64% of our survey respondents completed questions relating to bullying and of these, 38% had either witnessed or personally experienced bullying. Of the staff we interviewed, 44% recounted examples of experiencing or witnessing bullying by managers or other colleagues as a regular part of the working environment. These figures are higher than those reported in the 2024 NHS Staff Survey where 25% reported bullying by patients, 9% by managers and 18% by other colleagues.

External reviews and consultants were engaged in 2015, 2018 and 2022 to explore issues around poor culture, behaviours and leadership in NUH's maternity care. These are explored in more detail in the 'Corporate Governance & Leadership' chapter. The Reviews highlighted a number of ongoing concerns, for example, during 2018/2019 labour ward co-ordinators were observed writing derogatory terms such as 'idiot' on the board when allocating midwives, instead of using the midwives' given names. This issue has also been at the heart of more recent reviews by CQC and others.

There are many comments from those whose working time at NUH spanned the earlier years of this Review c2012-2022, regarding experiences of bullying and disrespect, especially by the labour ward co-ordinators. A recurring theme of cliques that were/are well known, but not confronted or challenged, is illustrated by a number of midwives and resident doctors who have left the Trust and some who have left their profession, due to anxiety and fear. One third of those face-to-face interviewees who no longer work at NUH, described in often harrowing detail the personal cost of their experience and some describe leaving NUH 'broken'. Medical students, student midwives, newly qualified midwives and bank midwives described being disrespected, unsupported, being treated with contempt, and described a toxic environment not conducive to learning or training.

From staff still working at NUH comments suggest bullying and undermining behaviours are still present and that the complex role of labour ward co-ordinator is frequently seen as an unsympathetic role.

2006-2016

Reviews into failings such as those at Mid Staffordshire[78] have previously shown how bullying cultures can impact negatively on patient outcomes, as well as having devastating effects on the individuals concerned. This member of staff left NUH in 2016, three years after Sir Robert Francis's report had been published and supposedly widely adopted across the NHS. They said:

"Stress caused people to behave badly to each other, Band 7s would bully Band 6s, we started to turn on each other. In I witnessed poor culture, bad behaviour. Overwork was not being addressed when escalated. One individual was very powerful and everyone was frightened of her. At City saw cliques, the core Band 7 team on labour ward worked very closely with doctors, the bullying culture came from them. Some matrons tried to raise concerns with CNO but were ignored." (2024)

Poor organisational cultures may lead to environments where bullying can thrive, especially where there is a focus on targets over patient outcomes and where staff concerns are not listened to. The Review Team were told of examples of extreme behaviour such as threatening letters, urine thrown over someone's office, police being called to deal with vandalism, theft of drugs, falsification of off-duty; the common factor was a failure of management and HR processes to deal with the known perpetrators of these incidents.

Amongst the medical team, examples of undermining behaviour were described frequently by juniors and trainees. This is mentioned in GMC surveys of trainees in 2016 and 2017. Obstetricians still working at NUH recognise that this was an issue at the time with some 'fiery personalities', a lack of kindness when giving feedback, and an inability to raise concerns.

78 Francis, R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Vol 1-3, London: The Stationary Office; 2013.

2017-2022

A staff member captured many of the issues raised by colleagues. They only worked at NUH for 1 year in this period, they believe bad behaviour and toxic culture was normalised, and people didn't even recognise it. Their experience was that anyone who came from outside was challenged, and they told us that on their second day they were informed by colleagues that they would 'break her'. (2024)

Specific examples of bullying behaviour came up time and again in interviews, these included:

- Senior/experienced midwives not responding to requests for help and support from B5 and B6 midwives
- Labour ward co-ordinators assigning 'difficult/complex' labours to relatively inexperienced staff whilst allocating 'easy/uncomplicated' labours to their friends
- Refusal by senior/experienced midwives to rotate through clinical areas

And this staff member who left the Trust years later told us almost the same thing:

"Ward midwives were not pleasant people, trying to get people to move around areas really challenging. Oct 2020, staff did not believe CQC had got it right, in denial of problems. I was appointed with a brief of ending the bullying culture. Coordinators were challenging, real problem with some doctors who were aggressive and hierarchical – high degree of incivility. Senior management seemed incapable of stopping it." (2024)

2023 - present

Despite recent work to address culture, some patterns of behaviour have continued. This staff member told us:

"Culture where no one trusted each other, cliques, bitching night shift coords worst for bullying. Band 5s left with the most complex cases whilst friends got easy shifts. PMA group overwhelmed by their workload. I recognise now that there was no training for people moving into management, they just copied the poor experience they'd witnessed. Poor cultures and bullying perpetuated through changes in management." (2024)

And amongst staff members still working in the Trust we heard:

"Culture has always been very difficult, from very intimidating sisters/matrons to no respect for Band 7s and Band 8s. Gone from too strict to too friendly. If I escalate concerns about a colleague, it doesn't get acted on, trying to protect people's feelings, nobody wants conflict." (2024)

Happily, more recent education quality reviews have found that resident doctors spoke positively about the working environment and consultants were described as supportive and approachable. An NHS England Review in November 2024 found 'measurable improvements in culture'.4[79] One positive development, mentioned by a significant number of doctors and midwives, has been the engagement of an Organisational Development consultant to work with teams on cultures and behaviours. This staff member told us:

"...seen a lot of positive changes in last 2 years in obstetric team working, consultants more approachable and accessible. Culture has improved less incivility and unprofessional behaviour. Organisational Development consultant has been amazing working on the way people talk to each other, to women and how not escalate concerns and psychological safety. People seem happier. Obstetric anaesthetists are amazing and supportive to everyone. More staff open to honest conversations reflecting on good and bad experiences, learning and not so defensive...people more likely to feel able to raise concerns – feel more empowered." (2024)

79 NHS England. Education Quality Review: Nottingham University Hospital; Available from: https://www.england.nhs.uk/long-read/education-quality-review-nottingham-university-hospitals-nhs-trust-3/; 2024.

And another staff member confirmed:

"now: very supportive culture at City. OD consultant working with team on culture change, has given staff freedom to speak up and get engaged in improvements. Bringing the team together to challenge poor behaviour and attitudes, focus on kindness at work. Bitchiness being confronted, people not frightened of each other anymore, hierarchy is flattened." (2024)

3.2.2 Racism & Discrimination

The NHS is a microcosm of society, with racism, harassment and discrimination remaining all too prevalent, both in relation to the care of patients, but also the employment of staff. The annual NHS Staff Survey repeatedly shows that the global majority of staff do not feel safe to work in the NHS, they are more likely to experience bullying, be disciplined, sanctioned or referred to professional regulators. Research has outlined the impact racism and a lack of diversity in leadership has on the NHS's ability to deliver safe care[80]. A 2022 survey by the British Medical Association found that 76% of respondents said they had been subjected to at least one incident of racist behaviour in the previous two years.[81]

Nottingham is a multi-cultural city. According to the Workforce Race Equality Standard data, NUH's global majority workforce is slightly greater than the 2023 Midlands average (26.4% compared to 25.7%).[82] More recent NUH data indicates 29% of staff identify themselves as having a global majority background. This contrasts with 17% of Obstetrics and Gynaecology staff and 13% of the nursing and midwifery workforce. In 2025, the Director of Midwifery reported to the Board that whilst 34% of obstetric staff are from a global majority background, only 8% of midwives are. Internationally recruited nurses and midwives comprise 7% of the total NUH workforce and are more likely to report bullying and harassment by both patients and staff than UK born colleagues.

Note: Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is a mandatory NHS England tool introduced in 2015 to ensure NHS employees from Black and Minority Ethnic (BME) backgrounds receive fair treatment and have equal access to career opportunities compared to white colleagues. It uses nine specific metrics to identify and address inequalities, aiming to improve patient care and workplace experience.

National Workforce Race Equality Standard data indicates that staff with a global majority background report limited access to career opportunities, higher levels of harassment bullying and discrimination, are more likely to enter formal disciplinary processes and are less likely to access non-mandatory training and Continuing Professional Development. Staff from the global majority are known to experience discrimination and harassment, and to experience unconscious bias in their working lives.

Of Nottingham's population, 42.7% are from a global majority background, with people with an Asian ethnic background comprising 14.9% of the total[83]. In December 2021, 25% of women and birthing people attending a midwifery booking appointment with NUH were from a global majority background. 3% of Nottingham's population have limited English proficiency, including 0.4% who cannot speak English. In Nottingham, 8.9% of households have no members for whom English is the main language. Whilst English is the main language spoken in Nottingham, Polish is the second most common and Urdu the third[84].

The 2025 MBRRACE-UK reports into maternal and perinatal mortality shows worse than average outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. Black women are 2.3 times more likely to die in childbirth than white women, those from mixed backgrounds are

80 Kline, R. Beyond the Snowy White Peaks of the NHS, A Race Equality Foundation Briefing Paper. London: Race Equality Foundation; 2015. Available from: https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/Health-Briefing-39-_Final.pdf

81 BMA. Racism in Medicine; 2022. Available from: https://www.bma.org.uk/media/5746/bma-racism-in-medicine-survey-report-15-june-2022.pdf

82 NHS England. NHS Workforce Race Equality Standard 2023 data analysis; 2024. Available from: https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/

83 Office of National Statistics. How life has changed in Nottingham: Census 2021; 2023. Available from: https://www.ons.gov.uk/visualisations/censusareachanges/E06000018/

84 Nottingham and Nottinghamshire Local Maternity and Neonatal system (LMNS). Maternity Equity Strategy: Our local high-level plan v0.3; 2023

1.8 times more likely and those from Asian backgrounds are 1.3 times as likely.[85]

As well as reaching out to seek the voices of black and brown staff, we were also very interested to hear from staff across the service about whether and how maternity care meets the needs of Nottingham's global majority population.

Very few of the staff who engaged with the Review raised issues relating to personal experiences or witnessing racism within the working environment, and this would mirror the NHS staff survey results with 97% of NUH Obstetrics and Gynaecology staff agreeing that they had not experienced racial discrimination in their work.

We spoke to a staff member who believed her bullying was related to being a woman of colour. (2024)

A staff member who saw student midwives treated differently depending on race, an anaesthetist who was concerned that overseas doctors were deliberately kept on one year rolling contracts to save money and that this was not good for patient safety because these staff felt psychologically unsafe to raise concerns. (2024)

One staff member told us they had seen international medical graduates being treated differently by midwives who did not have confidence in them, and another told us they were aware that female black/Asian registrars had been bullied, but rather than complain they had left. This staff member believed racist behaviours were a result of inadequate resources, inadequate leadership, poor structures and no responsibility. They witnessed international doctors targeted and undermined because their approach to care is very traditional medically driven. (2024)

Most of the staff we interviewed who no longer work at NUH offered little commentary or insight into providing culturally specific care. Very few had anything to say when asked about caring for women from global majority backgrounds and some expressed the view that there was no racism in the way women were treated. Those who did respond to questions about tailoring care to meet cultural needs spoke only about women for whom English was not their first language. The commonly held view amongst respondents was that community midwives would try, and usually succeed in booking interpreters, but that in the hospital environment this was difficult to achieve. Whilst most staff would rely on the NUH-contracted interpreting service, a few also mentioned using family members and staff who spoke community languages. Despite this, a small minority of respondents were alert to racism and discrimination in the way services were delivered:

"Saw patients treated differently dependent on race. Saw traveller/gypsy/Roma women treated appallingly. Covert racism to black/brown women but overt racism to Eastern Europeans. Translation service poorly used and poorly accessed." (2024)

"Language Line was not always available, used picture cards. Experienced racism, toxic blame culture if you did not fit in. Not many black midwives employed. Saw racist attitudes to black women labelled too loud, too demanding." (2024)

"Witnessed poor care of women whose first language was not English. DATIXed the incident and it was not followed up." (2024)

Prior to 2022, it appears that various initiatives were launched but were not sustained. We heard that a specialist midwife role for women with a global majority background was not continued. Similarly, we heard of research commissioned into interpreting services where the recommendations were ignored and that attempts to actively engage with women of colour living in deprivation were made but abandoned. This staff member told us:

"Interpreters were not used on labour wards except for planned sections. Vulnerable women were not being heard or listened to. Digital appointments don't work for them and yet we had an increase in online information instead of leaflets in languages." (2024)

85 Felker A, Patel R, Kotnis R, Kenyon S, Knight M (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2025. DOI: 10.5287/ora-4javr692x

Another member of staff:

"...saw staff lacking in confidence on working with translators and interpreters so didn't use them." (2024)

However, in more recent times, staff reported a change in approach and we heard several accounts of real change and improvement including proactive outreach with Polish, Muslim and Roma communities; expansion of materials in community languages and a new app to aid translation as well as increased awareness and training on vulnerabilities and safeguarding.

"Trying to move an FGM clinic into the community to reduce DNAs at hospital clinic. Been working with local charity to understand the women at risk, but only 1 midwife qualified to assess FGM. Moved an obstetric clinic into the community aimed at non-English speaking women – dr speaks Romanian. one community clinic has permanent translators available with Urdu and Romanian, but for all other languages get an interpreter. struggle with some languages to get face to face interpreters. Other option is telephone translators, this is not ideal. Trialing a new app. when using translators/interpreters have to have longer appointment times, difficult to schedule that on appointments system. Actively dissuade women from bringing family members as translators." (2024)

"Now have a matron for inclusion. Role came about because of Ockenden review. 43% of population from global majority. Committed to supporting diversity in leadership and supporting non-black colleagues to feel comfortable with issues. Bespoke antenatal classes for Urdu speakers and for Afro-Caribbean women. Confident service is speaking to these women but not sure it's always listening to what they say. Been working really hard to engage with Roma community. Still a long way to go to have robust interpreting services. Organising for black history month themes – diabetes and sickle cell" (2024)

"In community we have interpreter led clinics, specialist midwives and increased MSW network to support BAME and disadvantaged women. In hospital can book an interpreter for known appointments started using CARD MEDIC, working well but at night too easy to use Google translate and family. A lot of work recently about tapping into other resources, auditing 3-way telephone calls on maternity advice line." (2024)

3.2.3 Obstetric Morale

Several staff members have described the pressures they feel under, most specifically because of short staffing, but also because of the intense scrutiny they feel under:

"A lot of the day-to-day care of women on our wards is undertaken by the day's consultant. We have an allocated consultant, so there's no longer the system where each team goes and sees their team's patients in the morning which would have been the team consultant, registrar or senior registrar. Now, we have an allocated consultant to go around and see all the antenatal and postnatal patients every day. We don't really work in teams anymore because of the junior doctors' rotas and because people have very different job plans. It brings its own share of problems; continuity of care is really difficult if you're seeing a different consultant every day and not necessarily the consultant who knows you very well." (2024)

Others say:

"I know we have quite a few people who aren't fully working. We have a number of people off sick. We have quite a few people who don't do labour ward work now. They went off sick and have come back and because of the stress of working on our labour wards, currently don't. We have a number of people who don't do nights, so we're not fully staffed, even allowing for that. We have some locums in place but even if we were fully staffed, in theory, because a lot of people don't do a full on-call, we're not fully staffed. There are gaps, and there are multiple gaps at senior registrar level as well, so staffing in the unit at the moment, I would say, is currently the biggest concern and medical staffing." (2024)

"18 months ago, you wouldn't dream of a consultant being asked to be the senior registrar on an hour's notice on a gap which has been present for three months, I mean it was unheard of. It would be someone was sick at the last minute, of course, we all think, 'Okay, I'm going to have to be the senior registrar on the floor tonight.' It's now a regular occurrence that you have to stay in because there isn't [a resident doctor]. Sometimes it's sickness, a lot of the times it's rota gaps and that's really difficult." (2024)

Multiple staff members reported issues with obstetric staffing

"Unfortunately, a lot of the current myriad of new appointees seem to be off with stress or sickness of one sort or other. And what does, week-by-week, seem very hard to believe is the paucity of obstetric input that they are forever short of consultant obstetricians to cover labour suite, the wards, the clinic. And despite the appointment of consultants with a notional remit for the rota, they just seem to find it very difficult to cover everywhere and have an idea prospectively that come Thursday there is going to be few – a shortage here or there and they do always seem to be run ragged, and there seems to be a bit of crisis management, rather than planned cohesive staffing." (2024)

Multiple staff members have told the Review Team of pressures facing their obstetric colleagues and said:

"...my gut feeling now, is the consultants are more vulnerable now than they were then. I had an on-call where one of the consultants that was on for labour suite was just beside themself, bereft, and said, 'I'm walking out, I'm going. I'm going home, I can't do it.' They're really, yes, struggling. And they don't seem to have anywhere to go for support." (2024)

A staff member can see many improvements since 2022, especially in relation to midwifery staffing, but identifies the main current pressure point as medical staffing:

"...junior doctors, people who can do a caesarean and stuff like that because like yesterday, they had three ladies waiting for [a] procedure. I didn't understand what it was, but they couldn't be performed by a junior doctor and there was nobody available for the next 24 hours." (2024)

3.2.4 Impact of Review and External Scrutiny

Some current NUH staff expressed concern that the impact of this Review and the scrutiny the service has been under for a number of years is having a negative impact on staff morale and retention. This was not accompanied by denials that problems exist, rather it highlights that the cost of poor services is also felt by those who work in the service. Respondents expressed mixed views about whether the current executive and Board leadership are truly supportive of their staff and the changes that need to be made. Some expressed that recent moves to look at systemic safety issues are being jeopardised by the return to a blame culture, when staff involved in cases under review are not given the opportunity to contribute. Some staff members described being 'thrown-under-a-bus' by executives who they say are privileging unsubstantiated patient stories.

We have been told that the Review, media, police and public scrutiny has made staff fearful and anxious, facing criticism from their local communities, unwilling to admit where they work and leading to an increase in the number of people approaching the Freedom to Speak Up Guardian. Incidents of abuse and threatening behaviours to staff from patients have reportedly increased. At the same time some staff believe it has an impact on women's confidence and trust in professionals, with a corresponding rise in free birthing and births outside guidance. The Review Team were told this itself leads to defensive practice with staff focused on documenting everything at the expense of talking and listening to women, or depleting antenatal and postnatal wards in order to evidence safe staffing on labour wards. The following quotes are illustrative of the impact of external scrutiny on staff.

"I feel that the investigation at NUH has resulted in many experienced staff leaving, resulting in a more inexperienced workforce, with high levels of stress and burnout. The obstetric team, especially trainees appear broken. In the 5 years that I have worked in the unit, I have seen many positive changes made but all of these cannot keep up with the pressure on the service." (2024)

"Negative press reports have been hugely distressing for all staff, medical staff in particular have had zero support from the trust leadership – I'm coming towards the end of my training and the attitude of senior management makes me think twice about working here as a consultant. The overwhelming majority of staff are providing excellent care and their goodwill only stretches so far." (2024)

"It is not the lack of care, far from it. As a team we desperately want to give every service user the best possible experience but the conditions, particularly chronic staffing [shortages] and constant negative media coverage make this really difficult. So many positive changes have been made but we are not able to showcase this. In the last couple of years, we have had major changes to our senior leadership team who more than ever are approachable, friendly and are really engaged with the team to maintain safety. Prior to this we had a leadership team who were unapproachable, rude, dismissive and who dismissed many concerns raised to them. There was a very autocratic hierarchy and people were frightened of them. Those currently in post are nothing like this and I feel they fully support the whole maternity team with kind compassionate and inclusive leadership. There are still problems within the teams due to lack of rotation which has caused territorial behaviours and a lack of team working, but this is a problem being addressed with the new leadership and I can see improvements with team relationships all the time." (2024)

3.3 Leadership and Management

In 2022, the Messenger Review: Leadership for a Collaborative and Inclusive Future[86] was published. It was the latest in a long line of external reviews into NHS management and leadership stretching back over 40 years. The Messenger Review acknowledges the very real difference that first rate leadership makes to patient care, whilst also recognising that for too long the NHS has experienced institutional inadequacy in the way that managers and leaders are trained, developed and valued. Rather than blaming historic or existing leadership teams or their staff, the Messenger Review notes the wider contributory factors which can lead to poor behaviour in the workplace:

"They are a result of a combination of factors over many years; some structural, some cultural, some emanating from behaviours at the top, including politicians, some born of complex inter-professional and status issues in the workplace." (2022)

Like reports that preceded it, the Messenger Review links positive organisational culture to high quality of care, emphasising the importance of clear goals and values, implementing leadership development programmes, and embedding inclusive leadership and equity principles to ensure a positive work environment for all staff. In addition, the Review acknowledges the importance of effective recruitment and development of non-executive directors to bring independent perspectives and challenge the board when required.

In this Review, survey and interview respondents were critical of both historic and more recent senior midwifery and obstetric management within NUH's maternity service. Staff expressed that they were out of touch, did not listen to staff, were unsupportive and lacked compassion. Our staff voices confirm the combination of factors identified by the Messenger Review. Of the staff interviewed for the Review, 57% made explicitly negative comments about leadership and management and only 14% had positive things to say.

The top concerns raised about maternity/obstetric management were that 'Management' was:

- Invisible, unapproachable and unresponsive
- with concerns raised being ignored and the inability to accept challenge
- staff described the presence of bullying managers who were rude and aggressive and lacked kindness
- Rapid turnover leading to overwhelmed and ineffectual managers
- The presence of favouritism and cliques

Equally, senior and corporate management, including the Board, have until recently been perceived as disinterested, unsupportive and preoccupied with other priorities. This was perceived as resulting in a lack of scrutiny and accountability.

86 Messenger, G. and Pollard, L. Leadership for a Collaborative and Inclusive Future. London: Department of Health and Social Care; 2022. Available from: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

A staff member who is no longer employed by NUH told us:

"Management was impenetrable, nothing ever got through to them, they took no responsibility. I raised concerns to management to the Board, to the media and MPs. Management on call handled through labour suite, very much an us and them culture - no support for other areas. Never any Band 7s available at night in antenatal or postnatal areas. No kindness from management. When a staff member was sacked for stealing controlled drugs, we were told not to talk about it. Poisoned pen letters were sent, we were all interviewed by the police, we never heard any outcomes." (2024)

Pezaro et al. conducted an international appreciative inquiry of over 400 participants from 76 countries to identify the essential characteristics of strong midwifery leaders.[87] This provides a useful framework to summarise this staff voices initiative and benchmark NUH performance. These qualities can be applied not just to midwifery leaders, but to their clinical colleagues and indeed the entire Trust.

In contrast to the essential characteristics of midwifery leaders outlined in the table above, many staff told us managers were unsupportive towards staff, which affected their wellbeing.

"As a [XXX] asked to do HR investigation in maternity - saw culture of bullying, poor attitudes and rude and aggressive managers who were unsupportive of their staff and dismissive of staff with health needs" (2024)

"In 2015 a new [XXX] was appointed, they were very unsupportive and hostile to staff. I made a mistake in supervising a staff member and felt it was handled very badly, affected my mental health, took a long time to investigate the incident." (2024)

Concerningly, staff told the Review Team managers were not responsive to patient safety concerns.

"Raised serious safety concerns with manager – but these were ignored. Consultants would over-ride incident investigation at an un-minuted meeting after case review meetings." (2024)

"Approached [senior managers] with concerns told I was a trouble maker and was inappropriately whistleblowing." (2024)

"Staff used DATIX because too scared to escalate to their managers. 2015-2018 experienced a lot of new managers who were out of their depth, they got no support and it resulted in high levels of sickness". (2024)

A recurring theme is the rapid turnover of senior managers within the maternity service. Over the course of the Review there were six different Directors of Midwifery, some staying for only a very short period. More unsettling for staff was the fact that managers would often 'disappear' without explanation and with the underlying issues that prompted their exit unacknowledged and unresolved. A member of staff who left remembered:

"*Between 2010-2022 I had 12 different line managers, leadership and management was always difficult. Between 2016-2022 nobody seemed to want to take responsibility for gynaecology, it was very difficult to collaborate with maternity we were side-lined. Could not get Staff Members to engage especially with patient feedback."* (2024)

This staff member echoed many interviewees in pointing to the years between 2016 and 2020 as the most challenging and unsettling:

"No continuity of senior midwifery management, seen ups and downs with ever changing maternity leaders each changing direction and priorities. Always trying to do service improvements without stopping doing anything, the day job continues. Trust's processes and systems have not supported maternity over the years, disconnect from Trust Board. From 2016-18 saw many senior people who were not supportive this impacted on the ability to do the job well and people were left fearful and defensive, still have that legacy. Conflict between labour ward and other inpatient areas. Know of coordinators who never went into the labour rooms and would not support." (2024)

87 Pezaro S, Zarbiv, G., Jones, J., Feika, M.L., Fitzgerald, L., Lukhele, S. et al. Characteristics of Strong Midwifery Leaders: An International Appreciative Inquiry, Midwifery, Vol 132; 2024. DOI: 10.1016/j.midw.2024.103982

Table 2: Benchmarking NUH staff voices against essential characteristics of midwifery leaders identified by Pezaro et al. 2024s

ESSENTIAL CHARACTERISTICS OF MIDWIFERY LEADERS	NUH PERFORMANCE
MEDIATOR: strong leaders must be able to engage in effective conflict resolution with fairness and impartiality.	We did not hear evidence that staff had confidence this had existed in the past. Staff report feeling encouraged by recent changes.
DEDICATED TO THE PROFESSION: love for and dedication to the maternity professions is seen as an essential characteristic of the strong maternity leader.	With few notable exceptions we heard no criticism of maternity leaders' core values and beliefs.
EVIDENCE-BASED PRACTITIONER: strong maternity leaders are those who are constantly learning and improving.	It is notable that many staff told us of recurring issues and problems in maternity at NUH which seemingly could not be solved. We heard of reluctance to adopt many national guidelines (OASI and SBLCB) and to change practice.
EFFECTIVE DECISION MAKER: good leaders remain calm and collected under pressure, think critically, and involve the team throughout.	Staff told us this did not exist historically and is only now in 2025/2026 becoming the de facto way of working.
ROLE MODEL: staff should see their leaders and managers as professional or inspiring.	Staff told us this was not the case at NUH historically. We were told that managers acted in a dictatorial rather than collaborative way and staff repeatedly questioned their honesty, integrity, and attitude. Staff now report seeing an improvement.
ADVOCATE: effective leaders are the voice of the service, patients and staff, speaking truth to power.	From listening to staff voices and our consideration of minutes of executive and other leadership meetings, there is little historical evidence of maternity leaders advocating for the maternity department or for those they care for. Instead, we heard many examples of false reassurance and problem minimization.
VISIONARY: being able to tell a compelling and inspiring story about the journey of improvement is a key leadership strength.	The external reviews of 2015 and 2018 point to maternity leaders' lack of vision, and this is certainly confirmed by 'staff voices' who did not see their leaders planning, implementing, and championing changes that would improve maternity services.
RESILIENT: leaders must be able to cope with problems, setbacks and challenges.	The rapid turnover of management grade staff and comments from former staff suggest the working environment at NUH overwhelmed the resilience of maternity leaders
EMPATHETIC: more than compassion, strong leaders demonstrate understanding and a sense of fellow feeling	Staff voices suggest empathy has been lacking within the organisation historically, especially amongst midwifery leaders. We heard many examples of staff views, concerns and suggestions being ignored, disregarded and disrespected in the years preceding this Review
COMPASSIONATE: perhaps more than anything, compassionate care depends on compassionate leadership.	We heard that historically, staff experienced their line and senior managers, especially in midwifery, as unfriendly and insensitive to the emotional, social, and cultural needs of their teams and reports. Staff told us this was exacerbated by the experience of HR staff who were seen as unsupportive, unprofessional and often vindictive.

"So much churn in the senior management team, many senior people 'disappeared' overnight, not held to account. Churn in B7/8s due to micromanagement, lack of support, overloaded with work. People were set up to fail. Attended away day for senior managers, [XXX] very angry aggressive and dismissed suggestions from staff. People got promoted into unsuitable roles without support, relationship between [senior staff members] fraught." (2024)

We also heard from several staff who had sought adjustments to their working patterns for either family or health reasons, often advised by Occupational Health. These staff reported that management remained obstructive and more significantly that HR were unsupportive.

"Management unsupportive when life changes meant needed adjusted shifts - had to fight to stop doing long days and night shifts. In 2016 applied for a job, got offered it and then it was withdrawn. Lack of management support when sick. We got to the point where we hated each other because we weren't being led properly." (2024)

We heard worrying reports of bullying, poor behaviour and in-fighting amongst managers. This staff member, who left witnessed:

"A staff member came into the unit in October 2020 unit saying CQC will shut it down [prevention of future death notice]. This was very destabilising and increased pressure on ward managers. Witnessed a staff member being belittled by [XXX] - she went off sick. Difficult to manage midwives put into triage. Experienced senior managers as bullying, unsupportive and unintelligent." (2024)

This staff member who left NUH shared a disturbing account:

"Clinical leaders were not visible. I was bullied by a senior [colleague] and complained about them it was investigated and she was moved from QMC to City - she was hated there and received threatening letters and excrement left in her office. Raised issues with CEO, felt dismissed." (2024)

The stories we heard of ineffective management and leadership extended beyond the maternity service. Over the period of this Review, the NUH Board and Executive received two separate critical 'well-led' reviews. This staff member who worked at the organisation was critical of the NUH Board.

"Leaders were not held to account. Being normalised that things were difficult in maternity and there were unfavourable outcomes. Lack of ability to engage with complex problems and to effect change. Attempts to change midwifery structures seemed disruptive and unproductive. There was a Chief Exec brought in who really should not have been appointed, as not experienced. Medical Director did not have respect of all consultants, tried to create a structure for dealing with concerns about consultant performance but it never took off. People unable to challenge each other." (2024)

Since 2021 NUH's maternity service has received significant external and internal scrutiny, investment and support. Building a strong midwifery leadership will undoubtedly take time.

"Historically difficult relations with managers, escalations from staff body dismissed and leadership disappointing. Never saw senior midwives, no engagement especially following incidents or public reports. Now much more approachable more shared info, more engagement more proactive management. Senior team seem more happy, more engaging more willing to listen than in the past when staff concerns at DATIX were ignored and no feedback." (2024)

A medical colleague told the Review:

"Seen a big and positive change in midwifery management. Flow coordinator has made a big difference. Younger more enthusiastic people into managerial posts they are liked and respected and more open to collaboration. Making it easier to make improvements" (2024)

and another

"2019 saw disconnect at managerial level between midwifery and obstetric leadership which hadn't seen on shop floor. Tried to bridge that by introduction of more joint meetings and forums. Efforts made more

difficult when [colleague in leadership role] off long term sick. Since CQC and Maternity Improvement Programme significant change in maternity leadership, work really closely with [XXX], real change for the better. Really developing leadership through entire perinatal team." (2024)

"Now: much improved management: accessible, accountable senior management team, willing to listen. All matrons approachable. Really supportive of students. Funding available for diploma to degree top ups. Strong MDT working recognise co-dependency implementing SBLCBv3. Manager on-call rota working well everyone supports each other." (2024)

3.4 Clinical Governance

Clinical Governance was first placed centre stage in the 1998 Labour Government's health reforms with an aspiration to create a joined-up approach to nationally agreed guidelines, nationally conducted inspections and scrutiny, formalised incident reporting investigation and learning, and duties of patient involvement and engagement. Over the last 25 years expectations and competency in clinical governance have evolved. There is now a greater understanding of fundamental components required to facilitate the delivery of quality care: a no-blame learning culture, excellent leadership, and a work environment where staff are valued and can build therapeutic partnerships with patients.[88]

Whilst safety and a compassionate, enriching experience are undoubtedly everyone's ambitions for maternity, mistakes can and will happen and that poor experiences and adverse outcomes will never be wholly eradicated. In its 2023 report 'Broken Trust: making patient safety more than just a promise'[89], the Health Services Ombudsman concluded *"The National Health Service is suffering from a deficit of accountability and compassion for patients and their families when things go wrong"*. After reviewing more than 400 serious health complaints from the previous three years the Ombudsman recommended: *"the NHS must do more to accept accountability and learn from mistakes, particularly when there is serious harm or, worse, loss of life. When concerns are raised after such incidents they are too often met with a defensive attitude. This makes things even worse for a grieving family trying to get answers. It also places unnecessary pressures on staff, creating a barrier to learning and a gateway to making the same mistakes".*

Within this staff voices work, there is a running theme of poor governance within maternity going back to 2012, including Serious Incidents not investigated and reported in a timely manner and failure to learn and change after incidents. At the same time a consistently high number of maternity related incidents were reported to the Trust's Quality Assurance Committee. Amongst 715 staff members who completed our online survey, 376 answered questions relating to the way the Trust investigates, supports and learns from incidents, mistakes and poor outcomes. Amongst these, 165 (44%) told us they had personally been involved in investigations, giving us good data on how staff experienced governance. Of these, 17% told us that potential patient incidents that could harm a patient were rarely or never reported, and 43% reported that staff concerns were rarely or never dealt with appropriately. On the one hand, staff reported a culture of organisational denial, where poor outcomes were regularly dismissed as 'known complications'. On the other hand, staff perceived there was a deliberate failure to support individuals, particularly those attending HM Coroners' courts, with more junior staff feeling that they were scapegoated for the omissions of more senior staff or the system. We have commonly heard that after an initial flurry of activity following a clinical incident, staff, even those involved, might hear nothing more and even HSSIB reports were not proactively shared.

Family accounts of their experiences highlight that grief, pain and mistrust have often been compounded by the way the Trust investigated, reported and communicated adverse incidents, poor outcomes or errors in care and decision making. This is mirrored by staff experiences of these processes.

88 Halligan, A. and Donaldson, L. Implementing clinical governance: turning vision into reality, BMJ; 2001. DOI: 10.1136/bmj.322.7299.1413.

89 PHSO. Broken Trust: making patient safety more than just a promise; 2023. Available from: https://www.ombudsman.org.uk/publications/broken-trust-making-patient-safety-more-just-promise-0

"I have been involved in many incidents including HSSIB investigated cases. It is very rare for the reports to be shared; often this occurs by accident or when a colleague states that..."oh have you seen the report for... etc.". There was a recent coroner's case where I was the consultant throughout the patient's care and I wasn't even made aware of any of the findings or outcomes, despite having a helicopter view of the entire situation as it progressed as the day went along. I only knew it was even at coroners [inquest] when I put two and two together and joined the dots to work out it was that case. When I saw the HSSIB report I was shocked as I could have given input to many of the areas commented upon and clarified things. I don't think the governance teams take the opinions/views of (my profession) seriously - they don't seem to appreciate the role we have on labour suite and the often unique perspective we can see things." (2024)

3.4.1 Structures and Processes

Staff who have worked at NUH for many years told us of historic inadequacies in the maternity governance team and the way it worked. The team was experienced as being very disconnected from the operational teams and there appeared to be little trust between them. Staff say they experienced little learning from incidents, and that there was a blame culture. Concerns voiced to us included: decisions not to investigate were opaque; there was seemingly no accountability for those deciding whether an incident met the criteria for a Serious Incident, and action plans were not implemented. A good deal of this is explained by understaffing, poor management and a lack of training for those working in governance roles.

We also heard from staff spanning several years and roles that culturally, the obstetric leadership team did not recognise mistakes or errors. For example, in 2017 the Clinical Commissioning Group were informed by one of the governance team of 15 cases that had been reviewed internally but not declared as Serious Incidents (SIs) despite meeting the criteria. A member of the governance team told the Review Team told us:

"Left because clinical incidents were brushed under the carpet, whilst governance midwives did the work, rapid review meetings run by obstetricians would decide whether to investigate and more often than not would close the thing down at that stage. For example, a major incident, baby died and mother had [major harm] and this was not declared an SI. Experienced governance team as dysfunctional, leadership ever changing not supportive, under resourced and over ruled by consultants." (2024)

A former staff member told the Review Team:

"Massive emphasis on 'avoidability' anything deemed 'unavoidable' was not investigated." (2024)

"Most time spent conducting rapid reviews, did not talk to anyone involved only used notes, then presented to consultant body and more often than not decisions were overturned and cases closed." (2024)

This staff member said:

"Midwives and doctors historically very reluctant to come to case review meetings, felt bullied and intimidated by the obstetric consultants." (2024)

Other colleagues told the Review Team:

"Pre-2015 many SIs were downgraded as High-Level Incidents. In the past not good at identifying avoidable harm, if things were deemed unavoidable, they weren't investigated at all regardless of how serious the consequences. Historically experienced Trust risk committee as blocking and downgrading SIs." (2024)

More recently, staff told us they had seen significant improvements. The Review Team were told that a member of staff was brought into the maternity governance team in 2022 to bring some additional capacity and capability. Their first project was to establish an accurate database of all live SIs and their status, because there was no central record and the backlog of SIs at that time stretched back 2 to 3 years. The Review Team were told that at that point the team had no standard operating procedure, processes or policies for incident management, and that it was cut off and operating very differently to the wider corporate governance team. Staff say that prior to 2022 they saw no evidence of practice changing due to incidents and experienced the then maternity management team as very blasé about SIs.

The Review Team have been informed that maternity governance has now been brought in line with the corporate approach to governance and that it is well run and is unrecognisable compared to its former self. We understand that incident investigations are now happening in a more timely fashion.

3.4.2 Support for and Involvement of Families

There are compelling moral and logical arguments for engaging with those affected by a patient safety incident and involving them in a learning response; primarily to assess, support and meet the needs of those who have been affected in a compassionate way, but secondly to improve understanding of what happened and potentially prevent a similar incident occurring again, through the insights of those affected.[90]

Few of the staff who spoke to us had anything to say about the involvement of families in investigations or in wider governance processes or in the care and support for families after adverse clinical incidents. A small number told us families were not involved in investigations after a prolonged period of time and some believed they had been deliberately excluded. This view also came from a member of staff who used to be involved in patient liaison:

"Families deliberately closed down. Duty of Candour (DoC) processes unfit for purpose, including letters sent 6 months after incident, serious issues such as baby death not meeting threshold for DoC." (2024)

A staff member told the Review Team:

"In the past investigations were done without input from families. Muddle between management action, HSSIB, supervisor action, SI investigation - didn't talk to each other delayed taking action. More recently seen a much more open approach to investigations" (2024)

Staff told the Review Team that in the past, neither the maternity department nor the wider Trust had engaged well with families following a patient safety incident, but significant changes in approach and expectations were now becoming embedded:

"Have not been good at closing feedback loop with families, but getting better at that. Communications with families is often a struggle, many do not speak good English and many not well educated. We're not good at exploring things in an accessible way, use of Language Line is not ideal." (2024)

"Our problem has been a failure to look after people who have had a bad experience/outcome. Historically Duty of Candour managed centrally. In last 4 years things have greatly improved." (2024)

"Family involvement in complaints has got much better but many do not trust us think we will cover up. Invited a family to a PMRT. There are more families wanting support and debrief post birth, there is a good birth reflections team but they are overworked and the waiting list to access is long." (2024)

"Big theme in incidents is communication - it hasn't been good enough at time of incident or after. A lot of work to improve communication. Centralising the process for women to get a consultant debrief which has been separate to birth reflection service. Long waits and disconnect. A consultant and a matron are bringing this all together. Do acknowledge there were families who were not listened to." (2024)

3.4.3 Support for Staff

Staff involved in patient safety incidents may experience emotional distress and moral injury.[91] In the staff voices survey, 44% of respondents had personal experience of a serious clinical incident, more than 40% of these told us they did not receive support during the investigation and that they did not receive feedback after.

90 HSIB/NHS England. Patient Safety Incident Response Framework supporting guidance Engaging and involving patients, families and staff following a patient safety incident; 2022. Available from: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

91 HSSIB. Support for staff following patient safety incidents; 2021. Available from: https://www.hssib.org.uk/patient-safety-investigations/support-for-staff-following-patient-safety-incidents/

This staff member who left in 2016 told us:

"Following bad outcomes there was no support, just expected to come back into work the next day. For a high-profile investigation an external [investigator] brought in, she interviewed all the midwives involved and every one of them came out crying because of the way they were treated." (2024)

This staff member who left in 2019 said :

"involved in a neonatal death/homebirth gave a statement but then never involved in the investigation." (2024)

This staff member who left in 2022 said:

"Peripherally involved in 1 clinical incident, didn't even know it was being investigated until 10 months later, then told [I] might have to go to court, never heard anything more. Junior staff did not feel protected - one [staff member] was named in the press and got no support from seniors." (2024)

A number of staff recounted that the PMAs were involved in supporting staff through incidents and investigations, both those conducted internally and externally, such as by HSSIB. However, we also heard repeatedly that staff did not feel supported by senior staff and management through coronial cases and concerningly, staff who raised safety concerns experienced bullying and victimisation. This was confirmed by staff external to maternity services who worked as Freedom to Speak Up Guardians:

"People did not want to listen to me and did not respond well to concerns raised by staff. Investigation process ineffective with poor involvement of HR processes, saw 3 separate midwifery investigations which resulted in midwives leaving broken by the experience. Midwife who raised concerns were shut down by managers. Whistle blowing was put within HR, no separation or impartiality. Felt like my role was totally toothless, nothing happened after I raised things. Deputy Director of HR said things were being blown out of proportion, defensive, unwilling to listen." (2024)

As with the other elements of governance, we heard that support for staff has improved significantly in recent years, with staff reporting they feel more able to escalate concerns and that they receive good support and feedback after incidents:

"Since the Review has started staff feel much better supported through clinical incidents - not afraid to speak up" (2024)

"Since 2024 a cultural team within NUH looking to support staff and support staff called for HSSIB interviews." (2024)

"In the last few years NUH has really clear and robust way of supporting students who witness or are involved in clinical incidents, they are also informed at the uni so they can provide support too. Students have access to PMAS, personal tutor and practise supervisors." (2024)

4. LEARNING AND CHANGE

In its 2025 Exploratory Review, the Health Services Safety Investigations Body,[92] identified failure to learn and make appropriate changes within organisations as the key issues requiring further understanding. It also highlighted the disconnect between organisations in sharing learning which results in repeated incidents of poor care.

Staff voices told the Review Team that historically there was little opportunity for learning, development and change within the NUH maternity service, but those staff still working have experienced tangible change in the last 2 years.

The historic examples include:

- **Inadequate support for mandatory training.** We heard repeatedly of staff being pulled from mandatory training due to staff shortages. Indeed, this is a subject that was experienced across the

92 HSSIB. Summary report: An exploratory review of maternity and neonatal services; 2025. Available from: https://www.hssib.org.uk/patient-safety-investigations/an-exploratory-review-of-maternity-and-neonatal-services/summary-report/

whole Trust and was discussed at Board level on numerous occasions with the Trust failing to meet its performance targets.

- **Lack of support for wider development.** We heard that the prioritisation of achieving MAGNET status (a marker of quality and innovation in nursing, which excludes midwifery) meant that there was little interest within the Division for supporting research and learning in midwifery
- **A dominant obstetric culture that resisted adopting national guidelines.** For example, it is clear from minutes of operational meetings that the service was aware of higher-than-average rates of 3rd and 4th degree tears and PPHs and yet over several years, clinical leaders seemed powerless to change practice. At the same time, we heard from several staff that there was opposition to national safety bundles, particularly Saving Babies' Lives Care Bundle (SBLCB) and Obstetric Anal Sphincter Injury (OASI).
- **A closed culture in relation to sharing information about clinical incidents.** Not only was there a defensive culture which denied the need to investigate many clinical incidents, those that were investigated were not shared in a proactive and engaging way.
- **Short staffing had an impact on the time available for learning and reflecting.** We heard of important communications, updates and guidance languishing unread in emails.
- **Detailed action plans following clinical incidents not implemented and not followed up.** Over a third of our survey respondents disagreed that changes to improve patients' safety were evaluated or embedded.

This staff member who no longer works at NUH told us:

"Created maternity governance newsletter to cascade learning and information and things that could be improved. Instigated meetings with Staff Members regarding themes in investigations but then realised this information was not being used. Staff did not read the newsletter or emails so didn't know of policy updates." (2024)

More recently, it is clear that senior clinicians are now setting an example and encouraging openness and honesty in reporting adverse incidents and near misses. At the same time we heard that more is being done to foster a culture of learning and improvement. This staff member told us:

"Historically no learning from clinical incidents, no sharing of action plans. Now very different, get feedback on everything. Now families can come in and share experiences with staff." (2024)

Other staff confirmed this, although they recognised the ongoing challenge of protecting time and space for learning:

"Prior to Maternity Improvement Programme there did not appear to be a system for cascading info from governance. In last 18 months it feels very different, things are improving." (2024)

"Now we have good feedback from incidents and investigations. Number of newsletters, ten at ten, share learning in clinical forums, divisional meetings. Trying to open up communications." (2024)

In addition to learning from clinical incidents, staff have experienced improvements in the support for their ongoing training and development. Since the introduction and commitment to the SBCLB, there has been a stronger focus on mandatory and multi-disciplinary training. Midwives, obstetricians and anaesthetists all gave us positive feedback:

"Challenge to accommodate mandatory training within community work plans without disrupting continuity. But there is a lot of support for training and development." (2024)

"PROMPT training excellent focus on experience and trauma. Genuine desire amongst current staff to improve and be the best service we can be. Police investigation etc. causes stress and anxiety." (2024)

"MDT PROMPT and CTG training now is excellent focus on improvement, shared learning is solidifying team working since 2021/22. Learning from M and M meetings and emails from QRS team ensure feedback and shared learning." (2024)

SECTION 4: Looking to the Future

Amongst staff still working in the Trust there is a strong theme of commitment to improvement and some optimism that this time things can change.

"I feel like there has been tangible changes made in maternity and for the better. Midwifery staffing seems better although obstetric staffing still needs to be improved. Triage seems much more organised. I feel like staff really want to provide high quality care for their patients." (2024)

"I care a lot about the families using our service, and I want them all to have a good experience of pregnancy, birth and having a newborn. I want to be someone who helps make that time a positive time they will remember forever. I want to continue to get better at my job and I want the Trust I work at to have a justified reputation for excellent care. If the Review can help achieve these things, I am definitely on board with that." (2024)

"Procedures and systems have definitely let us down in the past but there has been so much positive change directed from the learning from incidents that moving forward I feel we are in a much better position. There is always room for improvement and I feel our team are happy to embrace change for the better provision of safe care. However, the vast amount of change in an incredibly short time has been overwhelming, unsustainable and difficult to embed appropriately. I truly believe that chronic staff shortages is our biggest barrier at the moment. The enthusiasm for improving patient experience continues regardless. We absolutely as team want to make things better but the conditions we are working in doesn't accommodate this." (2024)

In 2021 NUH established a Maternity Improvement Programme, with Executive level oversight. Its Terms of Reference included:

- Working together creatively, respectfully and collaboratively to support the development of a culture of continuous improvement which is positive and inclusive;
- Overseeing the adequacy and effectiveness of the systems of risk and control, relating to agreed objectives and programmes of work within the Maternity Improvement Plan and Programme;
- Overseeing and providing assurance that the delivery of the Maternity Improvement Plan is developing, building and embedding the conditions required to create a positive and open reporting and continuous improvement culture within maternity services

Staff who are still working in the service were optimistic that this change really is happening:

"New cadre of labour ward coordinators don't carry baggage of last 10 years and are having a positive impact and are accepting of change. Until [XXX] Director of Midwifery appointed a revolving door or midwifery leaders, they were invisible, nobody had a good relationship with them. [XXX] has energised midwives and they feel listened to. The two deputy HoMS are a joy to work with." (2024)

"Seen a big and positive change in midwifery management. Flow coordinator has made a big difference. Younger more enthusiastic people into managerial posts, they are liked and respected and more open to collaboration. Making it easier to make improvements" (2024)

"Prior to maternity Improvement Programme there did not appear to be a system for cascading info from governance. In last 18 months it feels very different, things are improving." (2024)

SECTION 5: Conclusions

The testimonies presented here provide consistent and credible insight into the lived experience of current and former NUH staff across maternity and neonatal services over an extended period. While individual accounts are subjective, the strength of this dataset lies in the convergence of themes across professions, timeframes and data sources, including alignment with national NHS staff survey findings and previous organisational reviews. Taken together, these accounts should not be interpreted as isolated experiences but as indicators of systemic organisational pressures, particularly in relation to staffing, culture and leadership.

For more than 20 years the NHS has run an annual staff survey. Its rich data source has been analysed by numerous academics, policy makers and practitioners and their findings consistently point to the predictors of high quality and safe patient care. The most important of these is staff engagement, encompassing the pride staff feel in their role, service and organisation; their engagement in their work, and their involvement in decision-making.[93] Staff engagement is underpinned by compassionate and supportive leadership, with good team working, agreeable collegiate relationships and minimal hierarchy. How staff feel and are treated is therefore a major factor in how patients and their families receive care. Open, inclusive and positive cultures result in staff feeling valued and patients are more likely to be treated with compassion and civility. In contrast, burn out, stress and work overload are associated with poor performance and low staff satisfaction. Put simply, the more pressured staff feel, the worse the quality of care received by patients.

The impact on patient care is clear from these testimonies: when NUH staff describe working in sustained ‘crisis mode’, feeling unable to escalate concerns, or experiencing bullying and fatigue, the conditions required for safe, compassionate maternity care are compromised. The experience of NUH staff is therefore not a peripheral workforce issue but is central to the patient safety concerns reported throughout this Review.

The evidence within this chapter demonstrates a direct relationship between workforce experience and the reliability of care delivery. Chronic understaffing, skill mix challenges and the normalisation of contingency working all reduce the capacity for reflective practice, multidisciplinary learning and proactive risk management. These conditions increase the likelihood of missed observations, delayed escalation, reduced continuity and defensive practice.

In maternity services, where deterioration can be rapid and consequences severe, the margin for error is small. A workforce that is exhausted, unsupported or fearful is less able to provide the vigilance, compassion and collaborative decision-making required to maintain safety. The staff voices initiative therefore describe not only the experience of working in the service, but the operating conditions within which adverse outcomes can occur.

A recurring theme across these staff narratives is the perceived disconnect between front line concerns and organisational response. This represents a governance issue rather than solely a cultural one. When staff repeatedly report unsafe staffing, bullying or ineffective processes without visible action, confidence in leadership and formal escalation routes deteriorates. Over time this contributes to a cycle of under-reporting, disengagement and loss of organisational learning.

For Boards and executive leaders, the implications should be clear: staff voice is a critical component of safety intelligence. Where concerns are minimised, delayed or fragmented across governance structures, opportunities to intervene early are missed. Effective maternity governance therefore depends on leaders who actively seek, hear and respond to workforce intelligence with pace, transparency and accountability.

Although individual accounts illustrate the emotional and professional impact of working conditions, the consistency of themes across hundreds of staff indicate structural rather than interpersonal causes. The central issues of staffing gaps, skill mix pressures, limited psychological safety, inconsistent management

93 West, M. and Wallbank, S. What does the NHS staff survey 2024 really tell us? Kings Fund Blog; 2025. Available from: https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-staff-survey-2024-tell-us

response and variable multidisciplinary functioning interact to create an environment where risk becomes normalised. This synthesis suggests that improvement cannot rely on isolated initiatives or leadership changes alone. Sustainable improvement requires coordinated action across workforce planning, leadership development, culture, governance and resource allocation.

This chapter demonstrates that staff experience is inseparable from patient experience and outcomes. The testimonies presented are not solely reflections of morale but indicators of how the service functions under pressure. Addressing the issues described – staffing, culture, leadership and governance – is therefore not optional or aspirational; it is fundamental to improving safety, restoring trust and delivering the standards of maternity care expected by women, families and the public.

Antenatal Care

1. Introduction

This chapter focuses on the quality of care provided throughout the antenatal period, examining over 2000 sets of medical records of women who accessed maternity services at Nottingham University Hospitals (NUH) in line with the Terms of Reference for the Review. Intelligence and thematic findings were derived from case reviews, family accounts, data analysis and local quality metrics. This information was benchmarked against local and national guidance and expert clinical advice to form key lines of enquiry and develop a rich understanding of practice over the years.

Instrumental to understanding the culture and delivery of care are the voices of the families and staff who came forward to share their experiences. At the centre of this Review are the women, their partners, families and their babies and children.

Antenatal care should be person-centred, personalised and reflect shared decision-making and collaborative care planning, in line with best practice. This approach recognises the woman as an active partner in her care, ensuring that information is provided in an accessible, unbiased way, considering all barriers to support informed choice. A relationship that is based on trust, continuity, and mutual understanding is fundamental to good care and should be established from the initial contact with the midwifery service.

Risk assessment must be comprehensive: incorporating medical, obstetric, and social factors as part of a holistic assessment of need, in line with National Institute for Health and Care Excellence (NICE) and local recommendations. Early identification of risk, appropriate pathway allocation, and timely referral to specialist services are integral to ensuring the provision of safe, effective, and timely care and intervention. For many women, care is shared across the obstetric and midwifery professions, with input from health and social care professionals, as required. Good relationships and communication amongst the multidisciplinary team have never been more important in the safe planning of maternity care.

Antenatal management is the cornerstone of a mother's maternity journey. It must be meticulous in health promotion, risk identification, and preventive measures to improve outcomes for mothers and babies.

The Trust should be commended for numerous examples in which care was planned and delivered in accordance with best practice and national guidance. However, the Review also identified missed opportunities to listen to and act upon the views of women and their families, which in some cases resulted in reduced trust, limited collaborative working, and poor physical and psychological outcomes.

The antenatal review identifies long-standing, systemic weaknesses across the pathway: from booking and initial risk assessment, through continuity and surveillance, to communication, documentation, and cross-boundary working. Families repeatedly described not receiving clear explanations, feeling unheard when raising concerns (especially reduced fetal movements), and experiencing delays in assessment and escalation. These experiences coincided with frequent gaps in ultrasound provision, growth surveillance, documentation, and referral to specialist services; contributing to missed opportunities for earlier intervention and avoidable harm. At the same time, there are clear examples of compassionate, well-coordinated antenatal care and effective multidisciplinary working within NUH, demonstrating that safer, more consistent practice is achievable.

It is imperative that maternity services and systems work collectively with service users to align with best practice. The Review aims to indicate opportunities for learning, allowing providers to consider the safer planning and delivery of maternity care in the future.

2. Community Antenatal Care

2.1 Background and Context

Community antenatal care provides accessible, holistic support throughout pregnancy within local settings such as GP surgeries, community clinics and homes. It focuses on initial risk assessment for charting the pathway of care, promoting physical and emotional wellbeing, offering health education, and building trusting relationships between midwives and pregnant women and their families.

NICE guidance *(Antenatal Care, 2021)*[94] provides a framework for the delivery of antenatal care with a schedule of minimum expected maternity appointments for women. First-time mothers and those where complexity is identified follow an enhanced schedule of care, whereas low risk mothers in second and subsequent pregnancies are routinely offered a reduced schedule.

A low-risk pathway is for women whose pregnancy is progressing normally with no medical, obstetric or social complications and they are generally expected to remain under midwifery care throughout the antenatal period unless complications arise. In response to complications, timely referral to specialist/ obstetric services is made. High-risk pathways involve shared or consultant-led care due to medical, obstetric or social factors that increase potential complications. These women typically receive additional appointments and enhanced monitoring, specialist input, and are usually seen within antenatal clinics in the hospital in addition to community care.

A detailed review of clinical notes and the feedback heard from women, reveals large variation in experience of community antenatal care provided by NUH. A consistent theme was that women felt unheard when raising concerns due to staff providing false reassurance, normalising abnormal findings, and the fragmentation of care. The Review has found clinical consequences, including the missed detection of complications and delayed action. The families have voiced the psychological impact of this in the form of anxiety, trauma and grief.

2.2 Booking and Risk Assessment

The booking appointment is the first full appointment, usually before 10 weeks' gestation and is the first full meeting with a midwife. It gathers information about the woman's health and helps her plan the most appropriate care, whether on a low or high-risk pathway. The Review has encountered the inconsistent application of risk assessments and national guidance with reoccurring patterns of: misclassification of high-risk as low-risk; missed escalation of abnormal booking results (e.g. low PAPPA, hypertension); missed referrals to obstetric and specialist teams; incomplete documentation of risk factors; and divergence from guidance (e.g. aspirin prophylaxis) with downstream effects on surveillance and prevention.

In several cases, early pregnancy vulnerabilities, including teenage pregnancy, additional social needs, or language barriers were not captured or responded to during booking. This resulted in women being placed on pathways that did not always match their level of risk. The absence of structured follow-up, continuity of care, and clear documentation further amplified these gaps, leaving families describing repeatedly how they had the feeling of being 'left to decide for themselves' when or whether to seek care.

On review of the clinical records, several cases over a long period of time have highlighted missed opportunities to ensure women had the correct plan of care in relation to their primary risk assessment. These were found from the earliest days of the Review to the very latest.

*In **2012** there was a failure to perform an adequate pregnancy risk assessment at the booking visit and the consequent failure to provide an individualised pregnancy management plan for the mother. The mother's previous obstetric history of a small for gestation age baby was not considered. Accordingly, she did*

94 National Institute for Health and Care Excellence (NICE). Antenatal care (NICE guideline NG201). London: NICE; 2021. Available from: https://www.nice.org.uk/guidance/ng201

not have the recommended serial third trimester obstetric growth scans commencing at 28-30 weeks' gestation (depending on the local unit policy). This led to the baby's small size and the abnormalities in placental blood flow no being identified. Therefore, IOL was not considered and the baby was born at 41 weeks by caesarean section in poor condition. (2012)

Families also described concerns about their care, not least the cumulative effect of unclear information at the outset and assumptions about ethnicity, 'small babies are normal'. There were missed opportunities to embed enhanced care for those women with social or clinical risk, leaving them uncertain about their next steps and escalation thresholds.

After experiencing blood loss from 20 weeks, a mother felt isolated and unsupported. Her concerns were not escalated and she was left to make decisions about when to seek care.

The mother explained to the Review Team:

"I received supportive and definitive care in my next pregnancy which leaves me feeling distraught in comparison to the shocking care and dismissive attitude from my complications before. I also believe my heritage as a Black Caribbean woman has unfortunately signalled the disparity within the Nottingham Trust." (2015)

The Review also identified examples where early booking processes were undertaken appropriately, risks were recognised promptly, and care pathways were implemented as intended. These cases demonstrate that safe and reliable antenatal booking practice was achievable within the service, providing a useful contrast to the challenges described above.

2.3 Management of co-morbidities

The effective management of medical comorbidities such as hypertension or diabetes is a cornerstone of safe antenatal care, given their strong association with maternal and fetal morbidity. Across the review period, cases highlighted how inappropriate risk assessment and pathway allocation have led to inconsistent escalation and specialist involvement, resulting in avoidable deterioration, delayed interventions, and missed opportunities for prevention. National guidance has long emphasised the need for clear pathways, timely investigation, and proactive management of chronic and pregnancy-related conditions. However, the evidence in this Review shows that variation in adherence, documentation, and follow-through directly impacted women's safety, particularly where early signs were normalised or referrals were incomplete.

An example of this is found in the following case where Aspirin prophylaxis and the inadequate management of hypertension at the booking stage resulted in poor care:

2.4 Cross-boundary care and use of electronic patient records

Where women received care across Trust boundaries or systems - for example, where community care and place of birth were provided by different organisations - the Review found that maternity records were often incomplete, fragmented or had not been transferred in a timely manner. This resulted in unclear ownership of information, repeated requests for historical details, and gaps in clinical understanding at key points in care - including surveillance, safeguarding, and care planning. Families described having repeatedly to recount their history, with important information being missed or disputed, thus undermining their confidence in the continuity of care.

The use of electronic patient records within maternity services has the potential to support continuity of care, improve information sharing across teams and organisations, and provide a comprehensive longitudinal record of a woman's pregnancy when used consistently and as intended. Where electronic records are completed fully and contemporaneously by all clinicians involved in the mother's care, they can support shared situational awareness, timely identification of risk, and coordinated decision-making across community, obstetric, and specialist services.

However, the Review identified that the effectiveness of electronic records was highly variable and dependent on individual user practice. Inconsistent data entry, partial documentation, and variation in how and where information was recorded across systems did result in fragmented records that did not reliably reflect the full clinical picture of women receiving antenatal care. In some cases, critical information was absent, duplicated or held in parallel systems, undermining the purpose of electronic records and leading to repeated history-taking, missed surveillance triggers, and delays in care planning. As a result, the presence of electronic records alone did not guarantee improved continuity or safety and, in some cases, mirrored or compounded existing communication failures rather than resolved them.

These findings are reflected in the experiences of the following two families.

*In November **2023,** a mother booked to have her second baby. She had had a previous vaginal birth with some confusion as to whether she had a third-degree tear at a different Trust. The notes were requested, but this was not received until after she had given birth (this was later found to be a 2nd degree tear). She also had a missed PAPP-A result and therefore did not receive Aspirin, but she did already have serial growth scans in place. This mother then moved care to Kingsmill Hospital (KMH) as she was not happy with the missed result and care at NUH. However, she continued some community care with City Midwives as her address was on the border of the catchment areas of NUH and KMH and therefore her local clinic had NUH midwives. She later proceeded to develop pre-eclampsia and had a normal birth at KMH.*

The mother described how incomplete and disputed information from previous care affected clinical understanding and confidence in decision-making, explaining:

"I explained that to my midwife, so that's why my midwife had put down that it was a third-degree tear. The consultant basically disregarded that and said, 'it can't possibly have been a third-degree tear'…it just felt like I was fobbed off a little bit and not kind of taken very seriously." (2023)

This family's previous maternity records were requested but not received until after birth, contributing to uncertainty regarding previous perineal trauma and antenatal risk factors.

Another family highlighted the impact of fragmented electronic records following the transition to a new maternity system, describing how:

"We've been told multiple times that if it's not recorded, it doesn't happen… Some conversations would go on to BadgerNet, some conversations wouldn't. Some bloods wouldn't, so it's inconsistent as to who entered it." (2023)

This inconsistency in recording and transfer of information led to families repeating explanations and clinicians missing results, and thus reduced confidence that those providing care had access to a complete and accurate history.

2.5 Ongoing risk assessment

Ongoing risk assessment to review each woman's medical, psychological, and social needs throughout pregnancy is important to ensure timely identification of any emerging concerns and the appropriate adjustment of her care pathway. This involves both clinical assessment but also listening and responding to women's concerns. Families described feeling dismissed or unsupported when concerns were minimised, or the follow-up was inconsistent. Conversely, when community midwives listened, acted promptly and coordinated effectively with hospital services, the Review found that care was safer and more reassuring.

A consistent theme was that women felt unheard when raising concerns such as reduced fetal movements, hypertension, swelling and pain. Families described being told that symptoms were 'normal and later questioning whether earlier escalation of concerns would have changed their outcomes.

*In **2021** a mother was booked with a raised BMI and history of anxiety-related hypertension. From 24 weeks, swelling and visual disturbances were noted. At 27+3 weeks they attended triage due to headaches, visual disturbances and flashing lights. Labetalol was commenced and she remained an inpatient and was delivered by caesarean section at 28+1 weeks due to uncontrollable blood pressure.*

The mother recalls feeling unwell and not being listened to:

"I felt fobbed off. At about week 22, I'm sure I rang my midwife and went in to see the on-call midwife at my local team because I had concerns….I was waking up with swollen hands and swollen feet. I noticed that I was getting more headaches and I was also worried that I was having some flashes with my vision. There was a midwife and a student. I'd never met them before. The student dipped my urine and didn't really wait for it to come back. The midwife from across the room glanced at it and said, 'Yes, that's fine' and just discarded it. They checked my blood pressure, which was a bit raised - I think it was about 140 at the time - and the response was, 'Well, it is a bit raised and it is a bit, you have got a bit of protein but it could be other things'… I went to see that midwife (at the next visit). She was also concerned that my blood pressure was raised." (2021)

*In **2014**, a mother booked for her first pregnancy and was allocated to a consultant-led pathway. There was an attendance for reduced fetal movements at 30+6 weeks. The assessment was normal. They were seen by the community midwife at 39 weeks for routine appointment. However, only one fetal movement was felt that day and the midwife was unable to find the fetal heartbeat. Fetal death was confirmed on attendance at the hospital. The mother recalls:*

"I think I was about 32 weeks when I had my first reduced movements, and all they did was put me on the heartbeat monitor. At my 37-week appointment I said to her I was still concerned because his movements weren't as active as what they had been in the past, and she just said, 'because he's moving, they're not concerned about that.'"

During the Review of this case, it was also found that the symphyseal fundal height was not consistently measured and recorded. Similarly, the fetal heart was not auscultated at 24, 28 and 37 weeks as would be expected for routine care. (2014)

2.6 Fragmented care and inconsistent information sharing

Fragmentation across community and hospital settings meant many families saw different staff at each contact, with inconsistent documentation and advice. Women reporting clear concerning symptoms, in some cases at several visits (e.g., reduced fetal movements, headaches with visual disturbance) and described receiving reassurance from staff rather than being invited to attend for a review. Examples can be seen across numerous cases where families express their concerns.

*In **2012,** a multiparous mother was booked for her third pregnancy. A glucose tolerance test was indicated but there was no evidence that this was completed. Ongoing routine antenatal care was good and no concerns were noted. At 41 weeks, the mother raised concerns that she had been experiencing reduced fetal movements with a midwife for one week, but with no fetal movements in the last 2 days. On arrival, the CTG was difficult to interpret due to loss of contact. She was admitted with a plan for induction of labour the next day. Four hours later no fetal heartbeat could be heard as her baby had died.*

The mother told the Review that she had twice phoned community midwives prior to going to hospital and was told not to worry and that she would be seen at her next appointment:

"I went to the next appointment, and I told her that he'd stopped moving. Like, there was virtually nothing and that was not normal to me. She said not to worry, she did his heartbeat. She said his heartbeat was fine. She said 'it's probably because he was a big baby'. I phoned the midwife, and I said to her, look, something's not right, it's been since Tuesday night and he's literally stopped moving altogether. Like, I've had no movement. She said, try a bubble bath, try drinking cold fluids. Relax, you're coming in on Tuesday anyway for your sweep, so, everything should be fine." (2012)

*In **2012**, a mother was booked for her fourth pregnancy. She reported smoking with a history of asthma and pre-eclampsia in a previous pregnancy. At 26 weeks the mother was seen with headaches and it was thought she was anxious about developing pre-eclampsia. At 35 weeks she presented with Braxton Hicks and reduced movements and no fetal heartbeat was found. There were missed opportunities to*

implement closer fetal surveillance by uterine artery doppler and serial growth scans given the history of pre-eclampsia and current risks associated with low BMI and smoking. Her birth weight was on the 1st centile for her age and growth restriction was missed. Fundal height monitoring did not show a concern.

"I didn't have the same midwife all the way through. I was seeing a different locum midwife every time I had a check-up. They would take my blood pressure and go, 'That's normal'." (2012)

*In **2013** a mother was booked with her first pregnancy. From 28 weeks her fundal height measurements accelerated beyond the 90th centile. A routine induction was booked at 41+5 weeks, and with a ventouse birth (undertaken for concern for fetal wellbeing) she sustained a 4th degree tear. The infant weighed 4.65kg. No episiotomy was undertaken. There had been no acknowledgement of larger-than-expected size that ought to have led to a discussion with the woman about the associated implications and uncertainties.*

"So, as a first-time mum, that's quite unnerving. I never had that opportunity to build a relationship; I suppose, and I think every time I had a new midwife, things that had been discussed weren't on file…. So obviously, they said I was going to have a normal-sized baby - it was all fine." (2013)

*In **2013** a mother booked her pregnancy at 9 weeks' gestation. She had routine antenatal care with no concerns about fetal growth or size, although she was seen at 20 weeks for suspected ruptured membranes – not confirmed. However, she attended at 26 weeks with reduced fetal movements and no fetal heartbeat was found.*

"My care was quite inconsistent throughout my pregnancy….I never saw the same member of staff twice and I didn't feel that they knew me. At my final midwife appointment, which was at 25 weeks - so, that's a week before Benjamin was dead - I told her that my baby hardly ever moved. And I was worried about movements. And she said to me, 'you need to make sure you sit down and make time to feel the baby move…'. She gave the impression that she thought I was just busy and anxious and that it was my fault I wasn't feeling the baby move. And I was trying to tell her, he hardly ever moves." (2013)

Several families told the Review Team that they saw a different midwife each time in their antenatal care, often never seeing the same midwife twice. They felt that changes in their pregnancy were missed, telling the same story repeatedly, having to chase their own investigations, and finding out their results by chance.

2.7 Interpreter use and accessible communication

The Review Team found another recurring theme in the lack of adequate communication support. This included reliance on family members to interpret, the absence of professional interpreters during complex fetal medicine consultations, booking appointments conducted without language support, and missed opportunities to ensure informed consent.

Such practices fall below national standards and place women at substantial risk and disadvantage, particularly when discussing abnormalities, procedures or decisions requiring clear understanding. These gaps raise concerns about equity, safeguarding, and the ability of services to meet the needs of diverse populations. Nottingham City is highly diverse with about 42.7% identifying as from the Global Majority, compared to around 15% nationally. It is reported that 29 different languages are used in their maternity units that require interpreter services. The availability of interpreter services seems to differ between community clinics and those in the hospital-based antenatal clinics.

Throughout the period of review, the team found some clear examples of when families with limited English proficiency faced risks where professional interpreting was not provided.

*In **2015** oligohydramnios was found in a woman who was 21 weeks pregnant. She received complex counselling about the options available for her continued pregnancy without an interpreter. There are no other references to interpreting services except that she does not speak English throughout her notes. None of the notes from her other antenatal, counselling, admissions, postnatal or even debrief appointments signal whether an interpreter had been present or requested.* (2015)

*In **2014** a mother booked her second pregnancy with limited English and no interpreter was used. It was noted within the antenatal appointments that she had a family member present each time to translate for her. There are no further details to suggest whether an interpreter was ever sought for antenatal appointments. This mother also had several antenatal admissions with complexities and there is no documentation to suggest an interpreter was present. She went on to have a 4th degree tear and there seems to have been no interpreter used to support the woman during the repair of this trauma, her postnatal or follow-up care.* (2014)

*In **2015**, a woman had a monochorionic diamniotic twin pregnancy which required close monitoring and more frequent appointments. English was not her first language. There were additional complications during the pregnancy with twin-to-twin transfusion syndrome (TTTS) and sadly, one baby died shortly following birth because of the effects of TTTS, prematurity and sepsis. It appears that there was some misunderstanding following some of the discussion with the family during what would have been very difficult conversations in which complex information would have been shared. The family told the Review Team that the first time they had access to interpreters was after the birth when deciding care for their child.* (2015)

Staff acknowledged that:

"Interpreting services especially in emergency situations is always a challenge. Some people query the independence of interpreters and don't trust them, they like it when the workforce speaks the language." (2020)

One current staff member spoke about how:

"The Matron for inclusion role has supported bespoke antenatal classes for Urdu speakers and for Afro-Caribbean women... but there is still a long way to go to have robust interpreting services." (2024)

2.8 Care of vulnerable women, equity and bias

Across the antenatal pathways, the Review found that women with additional social or demographic vulnerabilities including teenage pregnancy, language needs, social complexity and Global Majority ethnic backgrounds were particularly exposed to gaps in care. System-level pressures, inconsistent application of guidance, and variation in staff confidence in managing complex needs meant that those requiring enhanced support often received care that was fragmented, delayed or not aligned with national standards. These patterns reveal how inequitable outcomes across the service have been provided over a prolonged period of time from at least 2013 to 2021.

Families described stereotyping and assumptions, missed safeguarding opportunities, and gaps in enhanced pathways.

While some cases demonstrate exemplary multidisciplinary engagement, others show missed opportunities in escalating safeguarding concerns, initiating enhanced support pathways, coordinating effective social care, or making reasonable adjustments such as home visits with appropriate equipment.

This theme highlights variation in the system's ability to provide continuity and personalised care for vulnerable groups, with outcomes strongly affected by the quality of multidisciplinary collaboration.

Teenage mothers described feeling judged and dismissed, with their concerns minimised and their needs overlooked during both antenatal appointments and acute events.

*In **2023** a teenage mother with a complex social background did not receive appropriate teenage midwifery team input. She was later found to have a low-lying placenta. She was reviewed at 38 weeks with reduced fetal movements but no abnormalities were found and she was discharged and sent home. She later presented with PV bleeding and had an abruption, which resulted in a caesarean section and a baby born in poor condition.* (2023)

*In **2019**, a first-time mother booked in the community setting for care at 25 years of age. At booking, she had a social concern highlighted as she was a recent migrant to the country, but it was reported that she*

spoke good English and had declined translation services. No further referrals or investigations were made. Although this did not have a direct effect on the outcome, referring social concerns is a key part of safe and compassionate maternity care. Migrant women may face extra challenges that can affect their health, their baby's health, and their ability to access support. (2019)

*In **2023** a teenage mother booked her first pregnancy and was suitably assigned to consultant-led care, multiple medical risk factors having been identified. Throughout pregnancy the mother raised several concerns relating to her ability to access notes effectively, the provision of counselling, the availability of screening results and feeling unheard. The mother spontaneously laboured at 34 weeks, and the infant was born in an unexpectedly poor condition – later diagnosed with an hypoxic insult. The family told the Review Team that the mother was treated with a lack of respect due to her age and that her concerns were dismissed.* (2023)

2.9 Antenatal education

Throughout the Review, there was minimal recorded evidence of an offer of, or participation in antenatal education, including classes, digital resources, structured preparation. This suggests not only low attendance but also a lack of consistent provision, signposting or follow-up by services. As a result, the Review Team heard from many women who felt they approached pregnancy, labour, and decision-making junctures without the foundational knowledge required to recognise warning symptoms, understand care pathways, or feel confident navigating maternity services. The lack of antenatal education is likely to have contributed to confusion, delay in seeking help, heightened anxiety and a sense of being unprepared or unsupported.

Gaps in antenatal education ranged from a limited explanation of fetal abnormalities, care pathways and induction of labour (IOL) processes to a lack of clarity about symptoms that warrant urgent assessment. This lack of understanding often contributed to delays in seeking help, heightened anxiety and feelings of exclusion from decision-making.

*In **2022** a mother facing the option of termination due to fetal abnormalities felt rushed, pressured, and poorly informed, receiving minimal emotional support or opportunity to understand her options.* (2022)

Others reported not knowing the significance of reduced fetal movements, rupture of membranes, diabetes or pre-eclampsia symptoms which affected their ability to advocate for themselves and their babies. These accounts show that when antenatal education is inconsistent or insufficient, families are unable to make informed decisions, are vulnerable, unsupported, and unable to participate fully in safe and informed maternity care.

3. Fetal Growth Assessment and Management

3.1 Background and Context

The risk assessment for fetal growth restriction (FGR), monitoring of fetal growth and the management of the small and growth-restricted fetus is one of the most important elements of safe and effective antenatal care. There is a strong association between abnormalities in fetal growth and poor perinatal outcomes including stillbirth, neonatal death and perinatal morbidity. Element 2 of the NHS England Saving Babies' Lives Care Bundle (SBLCB) has provided a framework for providers and commissioners of maternity care across England to structure their antenatal care with the aim of reducing perinatal mortality from FGR.[95]

95 NHS England. Saving Babies' Lives: a care bundle for reducing stillbirth (Version 1). London: NHS England; 2016 Mar 21. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

Prior to the SBLCB the Royal College of Obstetricians and Gynaecologists (RCOG) Green-Top Guideline for *The Investigation and Management of the Small-for-Gestational-Age Fetus*[96] (2002, 2013) and NICE[97] (2003, 2008) provided guidance to maternity units on how to risk-assess women, monitor fetal growth and manage the small-for-gestational-age fetus. There has been variation in the guidance over time and considerable variation in its implementation across England. The implementation of SBLCB has been evaluated over time and the SBLCB version 3[98] (2023) and the 2024 RCOG guidance[99] provide the latest national guidance focusing on detection of the growth-restricted fetus, rather than small-for-gestational-age fetus and avoiding unnecessary early-term delivery. NICE Guidance[100] (2021) recommends a risk assessment for FGR at booking and due consideration of RCOG or SBLCB guidance.

There remains variation nationally on the risk assessment pathways, use of customised charts or population-based charts for symphyseal-fundal height (SFH) or ultrasound estimated fetal weight (EFW), and variation within those categories of chart. Current RCOG guidance recommends using the Hadlock formula for calculating EFW on ultrasound, which NUH are currently using. Current national guidance does not specify specific EFW centile charts to choose, although a recent direct communication from NHS England has recommended avoiding intergrowth charts for the EFW centile calculation and recommended one of four formulae (one of which, the Hadlock centile chart, is currently used by NUH). The SBLCB recognises that *'there remains a range of expert opinions on some interventions' for risk assessment and monitoring of fetal growth and 'allows some flexibility in the choice of pathways*[101]*'*. Alternative pathways can be chosen by maternity units if agreed with their local Integrated Care Boards (ICBs).

To comply with Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), trusts are required to provide assurance to their trust board and ICB that they are on track to achieve compliance with all six elements of SBLCB through annual submissions of data.

3.2 Overview of local and national guidance

During the early stages of the Review timeframe (from 2012 until 2017), NUH were using the Cardiff SFH chart to monitor fetal growth during pregnancy. The chart was widely used nationally and has been frequently placed in the National Maternity notes. The RCOG Green-top Guideline for *The Investigation and Management of the Small-for-Gestational-Age Fetus* (2002) was the guidance employed until 2013 and recommended the use of customised SFH charts, although many maternity units in the UK did not adopt their use. Therefore, NUH was not an outlier in this practise and NICE Antenatal Care Guidance (2008) did not support the use of customised charts. From 2017 onwards NUH implemented the Intergrowth SFH chart which is now the most widely used non-customised SFH chart in the UK.

The first local guideline reported to the Review Team on fetal growth monitoring was the *Guideline for Ultrasound procedures performed in Family Health by the midwife sonographer services*, implemented in June 2015. This includes a booking risk assessment of who should be referred for a growth scan. This was similar to RCOG 2013 guidance and detailed a clear pathway for low-risk women having SFH monitoring and referral if the SFH was less than the 5th centile (notably different from the 10th centile recommended in the 2013 RCOG guideline) or crossing centiles.

96 Royal College of Obstetricians and Gynaecologists (RCOG). SmallforGestationalAge Fetus and a GrowthRestricted Fetus: Investigation and Care (Greentop Guideline No. 31). London: RCOG; 2013. Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/small-for-gestational-age-fetus-and-a-growth-restricted-fetus-investigation-and-care-green-top-guideline-no-31/

97 National Institute for Health and Care Excellence (NICE). Antenatal care for uncomplicated pregnancies (Clinical Guideline CG62). London: NICE; 2008. Available from: https://www.nice.org.uk/guidance/cg62

98 NHS England. Saving babies' lives: a care bundle for reducing perinatal mortality (version 3). London: NHS England; 2023. Available from: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

99 Morris RK, et al. Investigation and care of a small for gestational age fetus and a growthrestricted fetus (Greentop Guideline No. 31). BJOG. 2024. Available from: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.17814

100 National Institute for Health and Care Excellence (NICE). Antenatal care (NICE Guideline NG201). London: NICE; 2021. Available from: https://www.nice.org.uk/guidance/ng201

101 Widdows K, Roberts SA, Camacho EM, Heazell AEP. Evaluation of the implementation of the Saving Babies' Lives Care Bundle in early adopter NHS Trusts in England. Manchester: Maternal and Fetal Health Research Centre, University of Manchester; 2018. Available from: https://www.e-lfh.org.uk/wp-content/uploads/2020/02/SPiRE-evaluation.pdf

The first small-for-gestational age (SGA) guidelines for all clinical staff was ratified in December 2017: *Guideline for the screening and management of the small for gestational age fetus.* This was based on the RCOG 2013 Green-top guideline and SBLCB version 1 (2016) and included a risk assessment for who should be recommended for serial scans, a pathway of care for low, moderate and high-risk women, and guidance for management of the small-for-gestation and growth-restricted fetus. There were updates to this guideline in 2018, 2021 and 2023 ensuring compliance with SBLCB version 2 (2019) by April 2023. The quarterly compliance with element 2 (for FGR) of SBLCB reported by the Trust was 27-33% in 2022 and rising to 95-100% compliance in 2025.

NUH currently uses, and historically used, non-customised charts for SFH and ultrasound measurements, as do many other maternity units in the UK and the Review Team felt that the local NUH guidance was overall not an outlier nationally in their use of non-customised charts and was complaint with NICE guidance. Local NUH Guidance prior to 2017 was outside RCOG guidance in a number of areas in that it recommended:

- Serial growth scans if BMI >40 (RCOG guidance BMI >35)
- Smoking at booking managed with SFH measurement (not growth scans)
- Recommend growth scan referral if SFH <5th centile (RCOG guidance < 10th centile)

The first fetal growth surveillance guideline (December 2017) following the SBLCB recommendations was implemented over 21 months after the publication. However, the Review Team felt that this was not unusual given the extensive planning, organisation and ultrasound capacity changes it required. A 'small baby' clinic was running at the City campus by 2014 and at the Queen's Medical Centre (QMC) site by 2021 and many of the pregnancies where the baby was suspected to be small would have been managed in these clinics.

The Review Team's examination of the obstetric ultrasound service found that there was a diverse range of healthcare professionals performing ultrasound examinations. Furthermore, it found the ultrasound scans to be of good quality, with a reasonable amount of time allowed to perform and complete the scans and reports. The NUH ultrasound reports did not always indicate the job title of an ultrasound practitioner, which would be best practise and did not always clearly state who was the supervising practitioner when a trainee was performing the ultrasound. On growth-scan reports, the documentation of fetal measurement and EFW centiles were inconsistent depending on the department in which the ultrasound had been performed. This is essential for abdominal circumference and EFW measurements when clinical decisions are made based on these values. The SBLCB (version 2) published in 2019 recommended displaying reference charts with 3rd and 10th centile lines for EFW and this was inconsistently found in ultrasound reports of the cases reviewed.[102]

3.3 Summary of Care and Themes at NUH

The Review Team reviewed the risk assessment pathway, ultrasounds performed, and management of fetuses with suspected FGR and which were SGA during the period defined for the Review. There were many cases of good quality care but there were some instances where care was below standard. These failures were evident across the review period and care settings, suggesting not isolated omissions but long-standing gaps in practice, training and clinical oversight.

The following themes were found:

- SFH not plotted after 24 weeks on the SFH growth chart
- SFH incorrectly plotted on the SFH growth chart
- failure to correctly identify women at risk of SGA
- fetal ultrasound measurements not plotted on a growth chart resulting in slowing growth/SGA not being identified correctly

102 NHS England. Saving babies' lives version two: a care bundle for reducing perinatal mortality. London: NHS England; 2019. Available from: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

- not acting on abnormalities of the fetal growth assessment
- adverse outcomes in pregnancies where there was SGA and English was not the mother's first language

3.3.1 SFH not plotted from 24 weeks on the SFH growth chart

There were multiple occurrences over the period of the Review where at least one of the SFH measurements were taken and documented but not plotted on the SFH charts in accordance with local guidance. In most cases this would not have affected the outcome. Some of these errors were highlighted in the Trust's risk incident reviews:

*In **2013**, a woman had a stillbirth at 39 weeks following episodes of recurrent reduced fetal movements in 2013. SFH measurements were taken and documented throughout the pregnancy but were not plotted on a SFH chart. An ultrasound was performed within a few days prior to her stillbirth and was normal, as was the birth weight on the 30th centile and therefore this was not thought to have affected the outcome.* (2013)

3.3.2 SFH incorrectly plotted on the SFH growth charts

In some cases, the SFH was measured but plotted incorrectly resulting in the wrong management, false reassurance and in some cases leading to tragic consequences.

I*n **2021**, a mother booked and had serial SFH measurements taken and plotted on the SFH chart. At 34 weeks the SFH measurement was incorrectly plotted. If it had been correctly plotted then the next SFH would have shown the drop in centiles and should have triggered a growth scan. At 38 weeks the community midwife was unable to detect a fetal heart rate and an intrauterine death was diagnosed. The infant was born less than the 1st centile.* (2021)

3.3.3 Failure to Correctly Identify Women at Risk of SGA

The Review Team found several cases where women with risk factors for SGA, such as previous SGA, low PAPP-A and hypertension were not identified and therefore serial scans were not arranged. The Review Team noted that before the NUH Fetal Growth Surveillance Guideline in 2017, smoking at booking and a BMI of 35-40 were not used as risk factors for growth concerns:

*In **2012**, a mother with a history of a previous SGA infant, low BMI and a current smoker booked in 2012. These were not recognised as risk factors for SGA that warranted serial scans for growth. SFH measurements were taken instead and documented, but not plotted on an SFH chart (which was not necessarily standard practice in 2012 prior to the RCOG 2013 Guidance). An intrauterine death was diagnosed at 35 weeks. The placenta was small with changes indicative of pre-eclampsia which did not show until after the in-utero death had been diagnosed. The birth weight was on the first centile for gestational age.* (2012)

*In **2017** there was a failure to adhere to national or local guidance when a low PAPP-A in the first trimester was recognised as a risk factor for SGA. Instead, a growth scan at 32 weeks (rather than serial scans) was arranged. At 39 weeks the small SFH measurement should have triggered referral for a scan. The pregnancy ended in stillbirth at 39 weeks and the infant was on the 1st centile.* (2017)

The NUH Guideline for 'Ultrasound procedures performed in Family Health by the midwife sonographer services' (2015) recommended serial scans for a low PAPP-A found in the first trimester.

*A woman booked at NUH in **2017** with recognised risk factors requiring closer surveillance. Concerns including reduced symphysis-fundal height growth were identified at 28 weeks and a scan referral was made; however, fetal heart auscultation had not been performed at prior antenatal appointments despite maternal request. Two days later the mother was admitted with an intrauterine death. The infant was on the 2nd centile.* (2017)

*In **2017** a mother with a BMI of 33 and a current smoker booked. The official guideline ratified two months prior to her booking, 'Guideline for the screening and management of the small for gestational age fetus', did recommend serial growth scans for a woman who was a current smoker at booking. However, this was not implemented until December 2017. There was an episode of RFM and vaginal bleeding at 28*

weeks and an ultrasound scan was normal. Serial SFH measurements were taken, but no further scans performed and a stillbirth was diagnosed at 37 weeks. The infant was very small at 1.7kg. (2017)

This case highlights the delay that can occur between the ratification and implementation of guidelines and the importance of considering multiple risk factors in individual pregnancies.

*In **2018** a mother booked her pregnancy at NUH. There was a failure to recognise that maternal age of 40 years at booking should have triggered serial growth scans in the third trimester. There were two episodes of RFM at 34 and 36 weeks and no ultrasound scan was requested. The Trust investigation acknowledged both referrals were recommended in local guidance, but did not make appropriate recommendation to prevent recurrence. The infant was admitted to NNU with Hypoxic-Ischaemic Encephalopathy (HIE) following preterm labour and APH at 36 weeks. The infant was small, weighing 2250g.* (2018)

3.3.4. Fetal Ultrasound Measurements not Clearly Documented or Plotted on Growth Chart Resulting in Slowing Growth/SGA not Being Identified Correctly

The Review Team found that there appeared to be a wide variation in the documentation of the EFW value and centiles of the individual fetal measurements and EFW on the ultrasound reports. This varied depending on who was performing the scan and where it was performed and became more consistently documented during the period of the Review. The documentation of the centiles on the report and plotting on the charts is essential to allow the clinician reading the report to interpret the scan findings in the clinical context and make a management plan, given that recent guidance is based on an abdominal circumference or EFW less than the 3rd or 10th centile or drop in centiles over time.

*In **2012** an infant died at three days of age from multiple organ failure and HIE. There was a failure in the pregnancy risk assessment to identify the risk factor for FGR (previous SGA). A growth scan was undertaken at 36 weeks due to a small SFH. The growth parameters were recorded within the normal range, but with an estimated weight 2342g, which equates to the 5th centile. There was subsequent slow growth by SFH and a second scan was undertaken. Growth at 38 weeks was recorded as normal but the umbilical artery dopplers were raised and the EFW was on the 4th centile (2594g). This was not plotted on a centile chart as the system that generates the reports did not have this, nor was it reflected in comments in the report or the subsequent clinic review. The mother subsequently attended in early labour at 40+1 weeks and was risk assessed. There was acknowledgement of a small fundal height but two 'normal' scans. A CTG was commenced, was pathological, and an emergency caesarean was swiftly undertaken. The baby's birthweight was 2160g. This provides evidence of some of the challenges of using ultrasound to assess growth, in interpreting the results, and the margins of error that are possible.* (2012)

*In **2017** a mother with a history of previous pregnancy loss had serial growth scans in the third trimester. At the 36-week growth scan the EFW was on the 8th centile. This was documented on the ultrasound report but there was no reference to the drop in centiles and the EFW was not plotted on the EFW chart. Clinical review of the scan documented it as normal. Consideration should have been given for induction of labour at 37-38 weeks or a repeat scan. Review at 38 weeks did not acknowledge the SGA on scan. The woman had an intrapartum stillbirth at 38 weeks and the infant was on the 4th centile at birth.* (2017)

3.3.5. Not acting on abnormalities of the growth assessment

In some cases, an ultrasound scan reported abnormalities in growth such as a drop in growth or no growth but this did not prompt action, again resulting in some cases having poor outcomes:

*In **2024**, In 2024 a mother had a stillbirth at 41 weeks. There was static growth in the SFH between 38 and 40 weeks and an ultrasound scan was booked the following day. The scan was reported as normal. However, the amniotic fluid index (AFI) was on the 5th centile. Induction of labour was booked at 41+ weeks. The finding of static growth was not escalated to the medical team and there was a loss of situational awareness in a post-dated pregnancy and a lack of recognition of the risk posed by static growth. The Perinatal Mortality Review Tool (PMRT) recommended a referral for obstetric opinion following a sonographer or midwifery scan beyond 39 weeks and highlighted that the Fetal Growth Surveillance*

guideline did not provide a strategy for suspected or confirmed SGA from 39 weeks, when delivery rather than referral to the Small Baby clinic should have been recommended. (2024)

3.3.6. Adverse outcomes in pregnancies where there was SGA and English was not the mother's preferred language.

In a significant majority of pregnancies where there was SGA and an adverse outcome, English was not the mother's preferred language. These women are known to be at higher risk of FGR and stillbirth. The Review Team felt it was essential, however, to highlight these cases to ensure that the Trust must have a robust policy to ensure these women have access to skilled interpretation and understand their care pathway. This is a significant means by which health inequalities in healthcare might be reduced.

*In **2021** a mother had FGR diagnosed on scan at 40 weeks following an episode of RFM. English was not her preferred language and there appears to have been good use of translation services throughout, although occasionally her husband was used to translate. She was admitted for IOL but had an emergency caesarean section due to CTG concerns. The infant's weight was on the 2nd centile and was admitted to NNU.* (2021)

3.3.7. Concluding reflections on pregnancies affected by SGA and FGR

The themes found by the Review Team when reviewing pregnancies affected by SGA and FGR reflect the challenges experienced in all maternity units in the UK in screening for, monitoring of, and managing the small and growth-restricted fetus. The tools to screen and monitor growth have inherent inaccuracies and there is acknowledgment that not all growth-restricted fetuses can be diagnosed antenatally. However, the current SBLCB framework provides a structure to reduce the perinatal morbidity and mortality associated with fetal growth restriction and the themes found here demonstrate some areas where care could be improved.

The Review acknowledges that current national guidance has inevitably increased the number of scans for fetal growth that are recommended not just at NUH but also across England. For many maternity ultrasound departments this has led to capacity issues in ultrasound machines and sonographer hours when ensuring compliance with the national recommended pathways for serial growth scans. The SBLCB (version 1) evaluation report (SPIRE)9 found that Trusts that implemented the care bundle had a 20% reduction in stillbirths and 58% antenatal detection of SGA over the period of implementation. However, the implementation led to a 19.4% increase in IOL and a 9.4% increase in caesarean section and a 25% increase in the number of ultrasound scans performed.

The SBLCB (version 2) evaluation report (EVOLVE)[103] highlighted:

- The challenge of continuously ensuring women are referred for scans when risks are identified
- The importance of continuity in SFH measurements
- The importance of standardisation of scan referral guidelines
- Ultrasound capacity remains a challenge with the need for more trained sonographers
- Inherent false positives and concerns over scan inaccuracy in the detection of SGA babies
- The importance of review by a trained professional immediately followed identification of a small baby on a scan
- Recording antenatal detection rates for SGA babies remains a challenge for many Trusts

103 Widdows K, Reid H, Smith DM, Camacho EM, Roberts SA, Heazell AEP. Evaluation of the Saving Babies' Lives Care Bundle Version 2. Manchester: Maternal and Fetal Health Research Centre, University of Manchester; 2024. Available from: https://pure.manchester.ac.uk/ws/files/1563310720/SBL2_Evaluation_Report_NHSE_V1.0_Complete.pdf

4. Fetal Medicine and Ultrasound

4.1 Background and Context

The Trust provides a dedicated ultrasound service for women booked for maternity care in the Trust and a regional fetal medicine service receiving referrals from across the East Midlands with a dedicated Fetal Medicine Unit at the QMC site and a Fetal Care Unit at the Nottingham City site. The Review Team examined the structure and functioning of these services, including: the quality of ultrasound; the handling of complex fetal conditions; the multidisciplinary pathways in place and the experience of families accessing specialist care.

4.2 Ultrasound

The maternity ultrasound service is predominantly provided by sonographers and midwife sonographers, with ultrasound scans being performed in a variety of locations on both sites. The Review Team found evidence that the NUH screening team complied with national governance guidance for antenatal screening. There was evidence of bi-annual submission of Down Syndrome Screening Quality Assurance Support Service data and an annual report for the Antenatal and Newborn Screening programme which included the Fetal Anomaly Screening Programme (FASP) with detailed analysis of the data and recommendations made annually.

The Team reviewed ultrasound scan images and reports for relevant cases within the Review, where available. Overall, the majority of the scans reviewed were performed to a good standard. All anomaly scans reviewed were compliant with FASP guidance. There were multiple occasions where the sonographer had taken additional time to perform the anomaly scans. For a few cases the scans appeared not to be compliant with NUH local protocol, in terms of images stored. However, it is not clear whether all the images were made available for review by the Review Team. Of note, the local protocol has recently been updated to align with FASP for images that are recommended to be stored. In a minority of scans, it was observed that the technical quality could have been of a superior standard or that the scan time was too brief.

Not all fetal abnormalities can be detected on ultrasound and although most scans were performed to a high standard there were a few scans where static images reviewed suggest possible fetal abnormality and a fetal medicine review should have been triggered. The process of reviewing fetal abnormalities diagnosed postnatally within the Trust was not clear to the Review Team.

There were a number of cases reviewed where scan images had not been stored electronically. The Review Team acknowledged that it is not always possible to store images due to problems with connection to the server or scans performed on a portable ultrasound machine due to the circumstances of the scan.

The NUH ultrasound reports were generally of a high standard. There were, however, occasions where the job title of an ultrasound practitioner was not included on the report or that the name of a sonographer supervising a trainee was not included. In addition, the documentation of the fetal measurement and EFW centiles was inconsistent as discussed in the growth assessment section above.

The ultrasound protocols were reviewed by the Review Team. A theme raised by sonography staff was that there were often multiple versions of guidance authored by different groups and this contributed to uncertainty. Communication between obstetric and sonography teams about protocol changes and learning from incidents was consequently not always effective.

The sonographer team from NUH reported to the Staff Voices initiative that they felt well supported in the department, worked well in their team, and were trained to a high standard.

4.3 Fetal Medicine Service

The Fetal Medicine Service is provided by obstetricians who are sub-specialists in Fetal Medicine working with specialist midwives. Review of cases demonstrated involvement of a wide multidisciplinary team including neonatology, genetics, cardiology, paediatric surgery and other specialist services within NUH - across the East Midlands and beyond, as required.

4.4 Themes and Summary of Care

The Review Team reviewed multiple cases where there was excellent fetal medicine care demonstrated with multidisciplinary involvement, personalised and compassionate counselling, and excellent documentation of discussions relating to birth planning. Families were empowered to participate in decision-making, with risks and options explained in a balanced and thoughtful way. The approach was collaborative, respecting family values and preferences.

There were cases where fetal abnormalities were not diagnosed during the pregnancy. However, review of the care demonstrated that it had been appropriate and that it is acknowledged that not all abnormalities can be diagnosed antenatally. Examples of good practice included:

*In **2014** the Fetal Medicine Unit at NUH cared for a mother whose baby had a complex abnormality diagnosed during her pregnancy. The mother was aware of the diagnosis before birth and required close monitoring and specialist input. She described her antenatal care as excellent, specifically praising the fetal medicine consultant. The mother felt well-informed and supported throughout the pregnancy, with clear explanations and a proactive approach from the team. The continuity of care helped the family prepare for the birth and potential complications.* (2014)

*In **2017** a mother booked at NUH with Monochorionic Diamniotic twins and a complex medical history. The pregnancy was complicated by Twin-to-Twin Transfusion syndrome and there was extensive input from the fetal medicine team and referral onto the tertiary centre in Birmingham. The Review Team assessed that she received high quality antenatal and fetal medicine care with good communication between the NUH fetal medicine team, tertiary centre, obstetric, anaesthetic, neonatology and specialist medical teams and good planning for the birth.* (2017)

*In **2018** a woman was referred to the Fetal Care Unit following the diagnosis of significant fetal abnormalities at the anomaly scan. Antenatal care was of a very good standard, with appropriate information sharing. There was kind and compassionate care when it was identified that her baby infant had anomalies incompatible with life. The parents were supported in their choice to end their pregnancy. Maternity postnatal care and care provided by the bereavement midwife were both of a good standard. Memory-making was compassionate, and there was evidence of good support for the parents.* (2018)

*For another family in **2020**, multiple abnormalities were diagnosed at the anomaly scan. A chromosomal abnormality was suspected and the parents had excellent multi-professional care at NUH and with the fetal cardiology team in Leicester. Their baby was born by caesarean section due to CTG concerns at 34 weeks. Following admission to the NNU their baby was managed according to the parent's wishes with comfort-based palliative care and the baby died on day 2 of life. This case demonstrated excellent counselling and multi-professional involvement and empathetic bereavement care.* (2020)

In addition, the Review Team heard positive colleague feedback through the Staff Voices initiative describing the Fetal Medicine Team:

A staff member wrote:

"The Fetal Care Teams hold themselves to very high standards and my observation is that they provide good patient-centred care. Maternity services have been particularly hard hit when it comes to recruitment and retention of staff, but Fetal Medicine seem to have maintained safer staffing than some other parts of maternity services. I have always found them to be professional and extremely helpful with our shared patients." (2024)

And:

"I work very closely with the fetal medicine team. I see regularly that they all care deeply about their patients and will do their best for them / go above and beyond...I would recommend the fetal care teams to any friend or family." (2024)

By far the majority of fetal medicine care was assessed as excellent. There were, however, a small number of cases where the Review Team received feedback from families where they felt that their care could have been better. These cases involved:

- Delayed referral to fetal medicine;
- lack of clear explanations regarding ultrasound findings or options for management; and,
- families feeling pressured and rushed into decisions to terminate their pregnancy

*In **2012** a mother booked with monochorionic diamniotic twins at another hospital in the East Midlands. Twin to twin transfusion was diagnosed at 20 weeks following review by the Fetal medicine team at NUH. A laser ablation was performed at 20 weeks in Birmingham and there was an intrauterine death of one of the twins one week later. The second twin developed a significant issue at 25 weeks secondary to the complications of the laser ablation and death of their co-twin. The parents made the difficult decision to progress to termination of pregnancy at 26 weeks. The Review Team assessed that the fetal medicine care was good, that this was a known complication of monochorionic twins and the recommended treatment was discussed and undertaken. The offer of termination of pregnancy was appropriate. The family fed back that they felt under pressure to terminate the pregnancy, felt not listened to, and that care was delivered in an insensitive environment. This case highlights the importance of good quality, detailed, unhurried and compassionate counselling in situations such as this, and how the quality of communication can dramatically affect the experience for parents when faced with making the decision to end a pregnancy.* (2012)

*A mother booked in **2022** and abnormalities were diagnosed in the first trimester. The pregnancy was monitored by the fetal medicine team and further abnormalities were diagnosed as the pregnancy progressed. The parents were counselled regarding the uncertainty of the prognosis for their baby and involved the genetics and specialist paediatric teams and further investigations were performed. When further abnormalities were diagnosed at 25 weeks, the mother described how she felt pressured and rushed into a decision to terminate the pregnancy. She felt that there were poor explanations of options and a lack of emotional support. One of the final MRI results were discussed over the phone whilst she was in a shop. The Review Team assessed that fetal medicine care was good and that it was appropriate to discuss termination of pregnancy given the multiple abnormalities. This was a complex pregnancy that illustrates that not all abnormalities can be diagnosed at the anomaly scan, that the prognosis can be difficult to predict, and can evolve as the pregnancy progresses. It demonstrates the importance of detailed information, time to make decisions and support for parents when significant fetal abnormalities are diagnosed.* (2022)

*In **2024** a mother booked and had preterm rupture of membranes at 16 weeks. There was a delay in referral to fetal medicine until 25 weeks. The fetal medicine care was good and she was appropriately counselled of the high chance of a poor prognosis in this situation. The family fed back that they felt pressured to terminate the pregnancy. The Review Team felt it was appropriate to offer a termination of pregnancy in this situation and it is likely that the delay in referral to the fetal medicine team contributed to their experience and lack of clarity of the risks and prognosis in this case.* (2024)

Medical termination of pregnancy for fetal reasons is highly sensitive and emotionally complex, and this Review highlights that some women reported felt rushed through the process, even when all the appropriate information had been provided. The perception does not necessary reflect a failure of the fetal medicine specialist, but rather the inherent emotional burden, time pressures and distress associated with the situation. The findings emphasise the importance of providing additional time for discussion, checking

understanding and offering reassurance and emotional support to help women feel heard, supported and able to process information in a highly stressful period.

The Review Team also identified cases where there was a lack of candour when care did not proceed as expected during the pregnancy or perinatal period. In some instances, this was compounded by delays in undertaking incident reviews. Together, these factors significantly affected families' experiences of grief, prolonging uncertainty and delaying their understanding of why their baby died or why a fetal abnormality occurred. The findings highlight the need for timely, transparent communication and prompt review processes to support families in reaching clarity and beginning to process their loss.

5. Maternal Medicine

5.1 Specialist Antenatal Care

NICE 1 recommends that all women who are identified with medical concerns at booking, or who receive unexpected results from examinations or investigations during their pregnancy, should be offered referral to an obstetrician or other relevant specialist for shared care. During care, clear and informed discussions should be carried out and documented when offering any assessment, intervention or procedure. NUH provides dedicated maternal medicine clinics for women booked for maternity care including obstetric haematology, renal medicine, diabetes and endocrinology, epilepsy and abnormally invasive placental conditions.

5.2 Identification and Referral

The Review found many incidences of good practice of specialist antenatal care, demonstrating high-quality person-centred care and multidisciplinary input when caring for women with additional antenatal complications. The Review Team noted:

*In **2023** a mother who had experienced multiple vulnerabilities had received good antenatal care, including consistent engagement and continuity of staff.* (2023)

This approach results in women feeling fully informed, well supported and encourages a trusting relationship with their healthcare provider – directly leading to better outcomes and improved care experiences. For example:

*In **2023** a primiparous mother with a very strong family history of venous thrombus embolism (VTE) developed a deep vein thrombosis early in pregnancy. She received prompt multidisciplinary care with early specialist input from the haematology teams to optimise her wellbeing during pregnancy.* (2023)

The Review also identified some cases where risk assessment and clear management planning was not always in evidence. When this occurs, preventable harm and errors are more likely. For example:

*In **2014** a multiparous woman was referred for shared care for her ongoing medical and pregnancy conditions, which included a history of epilepsy. Specialist epilepsy input was not provided until 20 weeks of pregnancy, which resulted in a missed early opportunity to review her medication options and the management of epilepsy in pregnancy. When she was seen, it was apparent that she had stopped her anti-epileptic medication at 5-weeks pregnant due to concerning media coverage on epilepsy medication. The medication the mother had stopped was not the medication described in the media coverage. Following discussions, she restarted them and the dosing was monitored and adjusted.* (2014)

*In **2022** a multiparous woman did not receive a complete VTE assessment despite a history of multiple risk factors, which led to delay in recommending antenatal prophylaxis. There was then a further week before it was prescribed and treatment was commenced. Fortunately, there were no adverse outcomes in this*

instance but appropriately prompt care provision would have reduced the woman's risk of developing a VTE during the peripartum period. (2022)

The Review Team received feedback from families who felt that their care could have been improved. Some families described inconsistent care, including a lack of continuity of care provider and conflicting advice. Others described an awareness of staff shortages and rushed care that led to them feeling unsafe:

*In **2015** a woman reported that she had received inconsistent advice about her birth options and felt dismissed when phoning the hospital in pain.* (2015)

*In **2023** another woman felt that she had not been monitored regularly throughout her pregnancy: she had been referred to an epilepsy nurse, but no appointment was received and she felt that she had not been informed of the reasons for the screening of various infections during pregnancy. Her consultant appointments were cancelled, and she reported that the midwife was unable to access/use the BadgerNet records. Her midwife would write notes on paper and then transfer them to BadgerNet and she felt these were not a full record of the events.* (2023)

6. Multiple Pregnancy

6.1 Background and Context

Multiple pregnancy occurs in approximately 1 in 60 pregnancies and these pregnancies carry an increased risk of preterm birth, FGR, pre-eclampsia, maternal pregnancy symptoms and postpartum haemorrhage (RCOG).[104] Early ultrasound assessment is vital to define the gestational age, chorionicity and amnionicity, since these factors guide surveillance and management. National guidance emphasises the importance of regular training and audit of those undertaking scans to ensure accuracy in determining chorionicity and structural assessment. Women with multiple pregnancies require more frequent antenatal appointments, serial ultrasound assessments and multidisciplinary planning.

Across the review period, NUH cared for between 111-179 multiple pregnancies per year and the Review Team found consistent evidence that women with multiple pregnancies at NUH were generally identified appropriately and referred for specialist input. Most women received enhanced surveillance and management aligned with national standards.

6.2 Identification and referral

Women expecting twins or higher order multiples should be counselled about the increased risks of this type of pregnancy and all screening should be discussed in detail. The Review found many examples of high quality management, including robust care planning, timely referral, and good interprofessional communication. For example:

*In **2017** a woman planned a caesarean birth for her twins due to the leading twin being in a breech presentation. There was a desire to aim for a vaginal birth and the mother's wishes and the obstetric recommendations were fully discussed. She presented in labour at 32 weeks and a caesarean section was organised.* (2017)

*In **2024** a primiparous woman booked with a DCDA twin pregnancy and her referrals for consultant-led care were completed appropriately. Her preference for vaginal birth was explored early at 21 weeks. Subsequently she had vaginal bleeding at 25 weeks and threatened preterm labour, both babies were facing head down. Both were born vaginally three days later with appropriate optimisation.* (2024)

104 Royal College of Obstetricians and Gynaecologists (RCOG). Management of monochorionic twin pregnancy (Greentop Guideline No. 51; 2024 partial update). London: RCOG; 2024. Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-monochorionic-twin-pregnancy-green-top-guideline-no-51/

By contrast, there were cases which gave cause for concern:

*In **2014** a primiparous woman booked for induction of labour at 37 weeks had minimal documentation of discussions around mode of birth and maternal choice. During induction, CTG concerns and maternal pyrexia led to a caesarean section. Better antenatal counselling may have supported more informed decision-making.* (2014)

The Review Team received feedback from families where they felt that their care could have been improved. Some families described a lack of information and advice provision during their care. As a result, they felt insufficiently informed or supported. For example:

*In **2016** a woman with a complex early pregnancy described difficulty understanding the explanations given, despite numerous appointments and scans. This was a very complex pregnancy with early doppler and growth concerns and many appointments and scans.* (2016)

*In **2016** a woman who had a twin pregnancy reflected on whether more detailed antenatal education about multiple pregnancy could have helped her anticipate what to expect, rather than what was just 'normal'.* (2016)

*In **2020**, another family described having their concerns dismissed and insensitive care following the intrauterine death of a twin during pregnancy. The woman recalled the midwife using a broken doppler when trying to locate the second twin's heartbeat, and despite identifying the damaged equipment, the same scenario played out again four hours later when they used the same doppler:*

"Following admission to labour ward, a doppler scan was performed and the midwife told me that she was sorry but that she could no longer find a heartbeat for the surviving twin. After telling me that my baby's heart was no longer beating, she realised whilst packing the machine away that it was in fact making no noise at all and that it might actually be broken. She said she would get another machine to double check and found a strong heartbeat.....the same broken doppler was then used a second time later that evening by a different midwife and I was told for a second time that my surviving baby had died. Whilst waiting for an ultrasound scan to confirm, the midwife was told to try another doppler in case it was the 'broken one'." (2020)

This case underlines the importance of reliable equipment, clear communication and compassionate practice following adverse events.

7. Management of Diabetes in Pregnancy

7.1 Background and context

Women with pre-existing diabetes and those who develop gestational diabetes are at greater risk of pregnancy complications and require specialist antenatal care to manage their pregnancies. National documents from NICE (2020)12 set out clear pathways of care for women with diabetes. The Review Team found that there was evidence that these pathways were being followed and women had access to the correct specialists during their pregnancy which included endocrinologists, diabetes nurses and midwives as well as dieticians.

Importantly, the Review saw clear evidence of collaborative multi-disciplinary care. This meant that women were being seen jointly by all specialists rather than being managed in isolation. The Review recognised that women had access to additional scans in pregnancy in accordance with national guidance and that discussions regarding the risks of pregnancy and diabetes were usually shared with women and their families. For example:

*In **2020** a primiparous woman booked her pregnancy with a history of pre-existing Type 1 diabetes. She was appropriately referred to the diabetic clinic and seen early. She began the recommended prophylactic aspirin and maintained good glycaemic control throughout her pregnancy. She received the appropriate schedule of growth ultrasound scans as recommended and a planned caesarean birth was performed at 38 weeks in line with guidance after appropriate counselling. (*2020)

7.2 Pre-existing diabetes mellitus

It should be noted that women with pre-existing diabetes have a much greater chance of having a pregnancy with a poor outcome, such as stillbirth. National data suggests that the risk of stillbirth is five times greater in this population (NICE, 2020)[105] and it is for this reason that women receive enhanced antenatal assessment and sometimes an earlier birth needs to be considered. Whilst the Review Team often saw cases of women being correctly advised of planned delivery at the appropriate gestation, there were cases where clinicians failed to advise earlier birth for high-risk pregnancies, not least when diabetes was combined with additional obstetric risks. This did lead to cases of stillbirth. For example:

*In **2016,** a multiparous woman was risk assessed for consultant-led care due to her pre-existing insulin-dependent diabetes and other risk factors. She had a high HbA1C identified at booking, which was repeated a further four times during the pregnancy and a rise at 28 weeks did not prompt a change in her management. The contact received was not in line with NICE guidance, which suggests assessment of blood glucose levels every 1-2 weeks throughout pregnancy.* (2016)

*In **2016**, a woman should have been offered earlier birth prior to 37 weeks due to uncontrolled Type I diabetes mellitus and concern of a large-for-gestational-age baby. If a caesarean section had been performed between 34 and 36 weeks following the antenatal steroids, it is likely the baby would have been born alive.* (2016)

8. Hypertension Management in Pregnancy

8.1 Identification of hypertension

The Review clearly demonstrates that, overall, effective procedures are in place for diagnosing and managing hypertension during pregnancy. In the majority of cases, women were appropriately assessed at their initial booking appointment, and risks were identified early in the process. Timely referrals were made to consultant-led care, and women received detailed care plans and management. Good standards of monitoring were observed for women experiencing any form of pregnancy related hypertension. Notably, cases of severe pre-eclampsia were managed in line with best practice recommendations, with a multidisciplinary team approach and clear communication; care providers took the time to explain concerns, events and management plans to the women and families involved.

In addition to such examples of good practice, reviewers highlighted some concerns. One significant issue was the delay in aligning the NUH aspirin risk assessment with the 2010 recommendations from the RCOG and NICE[106]. NUH did not update its policy until November 2014, resulting in women not receiving aspirin, even when they met the national criteria.

*In **2012**, a woman who had a risk factor of hypertension in a previous pregnancy – listed in the 2010 NICE guidelines but not in local NUH policy – but was not prescribed aspirin and subsequently developed severe pre-eclampsia later in her pregnancy. Provision of aspirin would likely have reduced the chance of this occurring.* (2012)

105 National Institute for Health and Care Excellence (NICE). Diabetes in pregnancy: management from preconception to the postnatal period (NICE Guideline NG3). London: NICE; 2015 Feb 25. Updated 2020. Available from: https://www.nice.org.uk/guidance/ng3

106 National Institute for Health and Clinical Excellence (NICE). Hypertension in pregnancy: the management of hypertensive disorders during pregnancy (Clinical Guideline CG107). London: NICE; 2010. Available from: https://www.nice.org.uk/guidance/cg107

8.2 Medical management of hypertension

Reviewers also identified shortcomings in fluid management for women with pre-eclampsia:

*In **2018** a woman admitted with severe pre-eclampsia and pulmonary oedema did not have her fluid balance appropriately measured or restricted until 35 hours after admission. When fluid restriction was eventually implemented, it was set at 100mls/hour (not the recommended 80mls/hour), which may have worsened her pulmonary oedema. It is important to note, however, that local governance in this case was robust; the department acknowledged these errors and implemented widespread teaching to address them.* (2018)

8.3 Complications of hypertension

There were also instances where delays in responding to abnormal observations led to the progression of the condition. For instance:

*In **2013** one woman was sent to hospital from the community antenatal clinic by ambulance taxi rather than a hospital ambulance - contrary to local protocol - after presenting with a severe headache and significantly elevated blood pressure. An Early Warning Score was not initiated despite significant blood pressures ranging between 187-159/ 118-104 for over an hour. As this was not escalated, a senior team review was undertaken two hours after admission. This resulted in a delay in controlling her hypertension and starting magnesium sulphate, and she suffered an eclamptic fit just five minutes after the senior doctors arrived - despite being in hospital for two hours.* (2013)

*In **2013**, a diagnosis of pre-eclampsia was made, but the bloods were not reviewed, raised liver function test results were missing, and a low platelet count of 69 was recorded. These results were only reviewed three days after issue, which was after delivery with a spinal anaesthetic. Although no harm was caused in this instance, there was no postnatal debrief, investigation, or demonstration of candour in the records submitted to the Review.* (2013)

The Review also highlighted a lack of holistic, patient-centred care in some instances:

9. Maternity Triage

9.1 Background and context

Maternity triage acts as a gateway to access unplanned or emergency care during, and in the immediate weeks, following pregnancy. Historically, there was an absence of national direction relating to how maternity providers deliver triage services. Therefore, Trusts were providing these vital emergency services without guidance or the appropriate governance, infrastructure, staffing or resources which led to a lack of appropriate oversight and inevitable harm.

National evidence (*The Ockenden Review (2020))*[107] and *Black Maternal Healthcare and Mortality* report (2021)[108] has highlighted inconsistencies in access to care and care standards, largely due to a lack of effective processes and systems. In response, the 2021 UK Government and Parliament[109] petition called for a review of NHS maternity triage, specifically challenging the practice of assessing women over the phone.

107 Ockenden D. Ockenden report: emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. London: Department of Health and Social Care; 2020. Available from: https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockenden-report.pdf

108 House of Commons Library. Black maternal healthcare and mortality (Debate Pack CDP20210055). London: UK Parliament; 2021. Available from: https://researchbriefings.files.parliament.uk/documents/CDP-2021-0055/CDP-2021-0055.pdf

109 UK Government and Parliament Petitions. Review triage procedures used by NHS maternity wards (Petition 330264). London: UK Parliament; petition closed 202. Available from: https://petition.parliament.uk/petitions/330264

In response the RCOG released its Good Practice Paper on Maternity Triage in December 2023.[110] To ensure appropriate, timely review, underpinned by the systematic use of pathways, this paper recommended a national mandate to implement the standardised Birmingham Symptom-specific Obstetric Triage System (BSOTS). NUH were early adopters of this triage system, with the Trust implementing this model of triage care in April 2022.

To deliver BSOTS successfully, NUH created standalone triage services, separating day services which provide scheduled observation for conditions of pregnancy. The division of these services has demonstrated improved outcomes for mothers accessing unplanned care. Nottingham City Hospital has a dedicated five-bedded triage unit whilst QMC has a triage area, with a three-bedded room and separate assessment room that can accommodate two further patients.

9.2 Maternity Advice Line

The Review Team expressed concerns over the 24-hour Maternity Advice Line (MAL), covered by a team of midwives, that is run from NUH. The MAL is accessible for women at all stages of pregnancy, up until and including the sixth complete postnatal week. The service takes on average 1000 calls per week. Call volumes and supportive data is collected via Trust software to identify peak flow and aid effective workforce planning. Data demonstrates varying compliance with answering incoming calls, which at times has demonstrated excellence at 97%. However, there are inconsistencies where incoming calls are unanswered, with figures as low as 82%. The Review Team heard staff report continued poor staffing levels in triage, impacting their ability to answer calls effectively and conduct appropriate risk assessments:

Staff told the Review Team:

"We received feedback from women and families about how it felt they were 'fobbed off' or they were told they would get a call back, and they ultimately didn't get a call back. It was through experiences obtained out of incidents we saw issues around being told they were in latent phase, but when they wanted to ring back to say that they feel that they're going into labour, or they're not coping, they couldn't get through." (2024)

"Triage staffing is currently very poor; advice line is short-staffed and women often can't get through. This was due to significant and sustained staffing shortages." (2025)

The introduction of BSOTS and the Trust electronic patient record (2022) has, over a long period of time supported the effective storage and centralisation of patient information. Historically, triage at NUH was inconsistent in its coverage, the handling of calls, and the effectiveness of recording patient interactions and clinical assessments. Staff told us:

*"Pre **2021** it was chaotic…calls went all over the place, labour ward, triage, different pathways at QMC and City, paper based, no standard protocols for what to advise -women could be cared for anywhere."* (2024)

The Review Team found many examples of poor telephone risk assessments and/or missing documentation, demonstrating reduced oversight and ineffective clinical history-taking. Combined with a lack of professional curiosity, this led to a cascade of poor experiences and outcomes. Mothers described not being heard, often making multiple calls before receiving an invitation to a clinical review. Whilst the Review found significant improvement following the introduction of BSOTS, concerns remain in relation to the advice given and accessibility of triage for mothers.

*In **2016** a mother in her first pregnancy made five telephone calls to triage with continued abdominal pain. Concerns were not heard and a call was made to the GP for support. The fetal heart rate was not detectable.* (2016)

110 Royal College of Obstetricians and Gynaecologists (RCOG). Maternity triage (Good Practice Paper No. 17). London: RCOG; 2023. Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/good-practice-papers/maternity-triage-good-practice-paper-no-17/

*In **2018**, a nulliparous mother called the triage line for the second time in 48 hours when she experienced uterine activity and reduced fetal movements, following abdominal pain two days beforehand. Her symptoms were explored, yet concerns were denied and there was no further consideration of her symptoms. A third call was made the following day and the mother was invited to a review; an intrauterine fetal death was diagnosed.* (2018)

*In **2022** a mother called maternity triage in her first pregnancy with two episodes of watery loss preceded by the initiation of uterine activity. These signs were not recognised as symptoms of ruptured membranes. A prolonged rupture of membranes was diagnosed three days later, resulting in an extended inpatient stay following birth, with the infant requiring five days of intravenous antibiotics for confirmed infection.* (2022)

Mothers continue to report resistance to offering in-person reviews when calling maternity triage with concerns. This is further supported by staff interviews, where a negative and uncaring culture on the labour ward is often cited by both staff and mothers as the reason for keeping mothers at home:

*In **2013**, a primiparous mother who was booked for a homebirth made three calls to the out-of-hours midwife and hospital with concerns about reduced fetal movements. Her concerns were not heard and non-evidenced based advice was shared. She was not invited into the hospital. The mother self-presented the following day where an intrauterine fetal death was confirmed:*

"You kind of feel like you're going like a little bit mad. You're like, no, because your midwife has told you, only ring at this point. So, you wait till that point and then told, 'no, no, no, don't come in'. And then, you're like, but I need to come in and …. It's almost like you're not believed, like, you're not believed to know what your body is doing".' (2014)

Staff interviews report a concerning approach to the effective triaging of mothers. Toxic cultures and poor behaviours demonstrated by senior staff is thematic across the whole period of this Review. Midwives detailed entrenched ways of behaving that were unprofessional and cruel to women. There were poor behaviours that were witnessed and escalated, yet not acted upon. The staff told the Review that:

"There was a focus on always keeping the unit open despite staffing challenges." (2021)

There are multiple references to those leading the labour ward influencing triage decision-making, encouraging staff to delay admission, or keeping mothers at home:

*In **2013** a mother called triage at 38+ weeks reporting reduced fetal movements. Initially, she was advised that the earliest appointment was in five hours. The mother phoned back later and was offered an appointment two hours later. An intrauterine fetal death was diagnosed upon admission.* (2013)

*In **2015** a mother described how she made calls to maternity triage but was not invited into the hospital for in-person care:*

"I don't feel baby's movement. My family rang the hospital for me at 2pm to ask to be seen and they said, 'No, because sometimes, baby is resting. Just lie down' and things like that. They gave me an appointment at 7pm that night."

An intrauterine death was confirmed when the family later attended. (2015)

*In **2018** a high-risk mother, already known to have lost one twin, called triage at 29+2 weeks of pregnancy due to vaginal bleeding, a tender abdomen, and possible ruptured membranes. She was informed to attend 1 hour and 45 minutes later. Her significant risk factors, vulnerabilities, and presenting symptoms, were overlooked.* (2018)

A family told us how:

"…when you phone up and you do need to speak to somebody… they do play God…it was almost like I was too much trouble….like the department would be quieter if all these women weren't causing them a problem. That's how I feel and I'd still feel almost if I shouted …I got the care and I did get the care and I delivered my baby safely, which is paramount in my mind…I think women have to shout for their care and they shouldn't have to. They shouldn't have to." (2014)

There was evidence of poor telephone risk assessment throughout the continuum of the Review. Systemic failings were identified across many pathways, but particularly in the management of women who called triage with symptoms of labour and with the ongoing care provided upon admission. Often, when calls were made, pain was minimised or ignored, and mothers were not invited in for review. The 'latent phase' was the clinical conclusion over the telephone without appropriate exploration or consideration for assessment. Many women made several calls before they were given access to the unit. There is an abundance of evidence within maternity notes, and importantly directly from mothers, who were left feeling scared and vulnerable at home. The latent phase of labour is explored in detail within the intrapartum chapter.

9.4 Clinical Assessment and Decision-making

The Review Team has identified variability in the quality of clinical assessment of those mothers who attended in person for review. This includes time taken for clinical assessment and the onward recognition of risk factors that dictate investigations and treatment. The use of BSOTS has significantly improved timely and methodical clinical assessment, with the Trust now reporting over 90% compliance with the initial 15-minute review. Whilst there is not a nationally expected compliance rate, this figure is widely accepted as positive. The Review identified multiple examples however, where care was delayed and did not follow this local guidance. The failure to perform risk assessments and undertake the expected examinations has, over time, caused physical and psychological harm.

Despite attempts to align triage to national 'best practice' standards, there is a lack of national guidance to support maternity units in providing consistent advice, deliver education, and safely quality-check outcomes. Case reviews, which only account for a fraction of attendances to triage services, provided evidence of inadequate risk assessments and poor recognition of pathology resulting in delayed or missed opportunities to escalate cases to senior review. Staff report that:

"Triage continues to be understaffed, making it feel unsafe despite improvements" (2025)

Cases of poor care are exemplified by these testimonies:

*In **2021** a mother presented to triage for review. The midwife failed to escalate appropriately when she had significant risk factors including raised blood pressure, active vaginal bleeding and reduced fetal movements. A CTG was completed and ran for 20 minutes. It was abnormal but not recognised. The delayed recognition contributed and led to severe hypoxia and harm.* (2021)

*In **2025** there was a triage admission at 21.00, at 27+1 weeks' gestation. The mother presented with brown loss, abdominal and back pain. Maternal observations were performed, but no fetal heart rate was documented. A CTG was commenced at 2310 and classified as abnormal. Transfer to the labour ward was not completed until 0200 with her baby born 8 hours later.* (2025)

10. Antenatal Inpatient Care

10.1 Background and context

NUH Trust has antenatal inpatient services at both Nottingham City Hospital and the QMC sites. Antenatal inpatient care refers to hospital admission during pregnancy prior to the onset of established labour, typically for complications such as: hypertension, antepartum bleeding, reduced fetal movements, symptoms of preterm labour, the need for enhanced monitoring in high risk pregnancies and admission for induction of labour.

At Nottingham City Hospital, Bonnington and Lawrence wards are similar 27-bedded mixed antenatal and postnatal wards, with a dedicated 4-bedded bay for IOL. The labour ward is situated on a different floor to

the inpatient wards. At QMC there is a dedicated 18-bedded antenatal ward called B26. The labour ward is based on the same floor as B26 and hosts an IOL area.

Inpatient care aims to optimise maternal wellbeing, fetal health, and pregnancy outcomes through appropriate assessment, diagnosis, intervention, and coordinated multidisciplinary management. Although there is no standalone national guideline dedicated to antenatal inpatient care, national frameworks such as the NICE Antenatal care guideline[111] (NICE, 2021) are used to recommend antenatal care expectations and management of common pregnancy complications. Routine maternal observations, ongoing assessment of fetal wellbeing, and individualised care planning form the core of inpatient management, as reflected in hospital-level policies and fetal monitoring guidelines.

10.2 Cardiotocography (CTG) Management

Fetal wellbeing assessment is a crucial aspect of IOL, where continuous or intermittent CTG monitoring is required for early recognition of fetal distress. Any delay in responding to abnormalities, or misinterpretation of the CTG during IOL, can lead to adverse fetal outcomes.

Prior to commencing IOL, all women should undergo a CTG to establish baseline fetal wellbeing and identify any pre-existing concerns. A normal CTG demonstrating an appropriate baseline rate, variability, and accelerations provides reassurance of fetal wellbeing and an intact autonomic nervous system prior to starting any intervention. NICE emphasises that monitoring and managing contraction frequency during IOL is key to reducing intrapartum hypoxia (*Fetal Monitoring in Labour,*[112] NICE, 2025).

The current policy at NUH is explicit that a computerised CTG should be undertaken prior to IOL for at least 20 minutes and that it should be normal before any induction agent is administered. If the CTG is abnormal it should not be administered and the woman should be reviewed by a senior obstetrician. If a Propess® induction agent is administered, then a CTG should be undertaken for 30 minutes following insertion and again at 6 hours post-insertion with review of maternal and fetal wellbeing. This would include a set of maternal observations, recorded on the Obstetric Early Warning Score tool (OEWS), assessing fetal movements, uterine activity and vaginal blood-loss.

Numerous cases have been identified by the Review Team regarding poor CTG monitoring and interpretation pertinent to women during IOL.

*In **2011,** a mother attended for IOL at 41+5 weeks. A CTG was interpreted as normal and Propess administered. However, the Review determined that the CTG had in fact been abnormal during the antenatal period and therefore Propess should not have been given. The mother felt some reduced fetal movements a few hours later and was having painful contractions, but there was no assessment of the fetal heart or of the contractions. 6 hours after the use of Propess, the mother's cervix was found to be 2-3cm dilated and the Propess was removed. However, there was still no assessment of the fetal heart rate. A CTG was commenced 30 minutes later, which was suspicious, and following a bradycardia a further hour later, the fetal heart was difficult to monitor and there was thick meconium in the waters indicating distress. A category 1 caesarean was performed. However, the infant was born with no heartbeat and the resuscitation attempt was unsuccessful.* (2011)

*In **2017** a mother presented with reduced fetal movements at 41 weeks' gestation. The CTG was not recognised as abnormal and she underwent induction of labour with Propess. The CTG was later recognised as abnormal, the mother underwent a category 1 caesarean, and the infant was delivered without signs of life. Although the resuscitation was successful, the infant spent the first 5 weeks of life on the neonatal unit with a diagnosis of HIE Grade 3.* (2017)

111 National Institute for Health and Care Excellence (NICE). Antenatal care (NICE Guideline NG201). London: NICE; 2021. Available from: https://www.nice.org.uk/guidance/ng201

112 National Institute for Health and Care Excellence (NICE). Fetal monitoring in labour (NICE Guideline NG229). London: NICE; 2022 Dec 14. Updated 2025 Nov 12. Available from: https://www.nice.org.uk/guidance/ng229

10.3 Midwifery Autonomy and Escalation for Medical Review

There is substantial evidence that delays in care can arise when midwives are not enabled to undertake timely autonomous assessment, especially in the context of suspected preterm labour. Speculum examination is a key component of preterm labour assessment because it allows inspection of the cervix, identification of cervical change, assessment of membranes, and collection of diagnostic specimens. NICE guidance on preterm labour[113] (NICE, 2022) emphasises early and accurate assessment to reduce delays and ensure timely diagnosis, intervention, and transfer if required.

There are numerous cases in the Review where there was a delay in care due to the postponement of speculum examination below 37 weeks' gestation while awaiting medical review – despite this procedure being within the recognised scope and competence of autonomous midwifery practice[114]. Many examples of NHS trust-endorsed guidance agree that midwives may perform speculum examinations at any gestation, including under 37 weeks, provided they are competent and have received the appropriate training.

*In **2015**, there was a clear example of delay in recognition of advanced preterm labour in the antenatal ward setting when a mother attended at 34 weeks and 2 days' gestation, with a history of SROM and contractions. Following assessment, this was confirmed and it was stated that she was not labouring at this time. Despite requiring regular analgesia to manage her pain, there was a reluctance from midwives to examine her. When there was then a delay in obstetric review, there was inadequate support and lack of appropriate care. The mother had escalated her concerns about signs of labour and these were not investigated effectively. She said it made her feel uncomfortable and her concerns not heard.* (2015)

*In **2018** a mother attended in her 4th pregnancy at 33 weeks and 4 days' gestation with left-sided abdominal pain. She was admitted over the weekend and was not seen by a consultant. Her blood results showed that her haemoglobin level had dropped to 87gd/L but there was no suspicion of bleeding. However, the CTG was abnormal and not escalated. Her observations deteriorated, her pain became unmanageable, with her abdomen tender and the CTG becoming pathological. A decision was made for a category 1 caesarean section. This was complicated by a classical incision, haematoma and bowel adhesions, requiring a general surgical repair. The infant was born with poor cord gases and the mother had a PPH of 1900mls.* (2018)

*In **2021** a mother had poor antenatal management on the ward following admission with premature PROM at 27 weeks' gestation. There was good inpatient care until 29 weeks when she had blood-stained waters and started to experience pain. The registrar was alerted but was unable to attend immediately, so she was reviewed by a more junior doctor. There was no further exploration of the mother's concerns after this and she was left to labour unattended on the ward until she had an urge to push and there was difficulty in finding the fetal heart rate. The Review Team find this to be sub-optimal practice. There was a lack of autonomy by the midwifery team to examine in the absence of a doctor and missed opportunities to raise concerns with the labour ward. This resulted in an unidentified labour and a failure to arrange timely and safe transfer to the labour ward for pre term optimisation, suggestive of a poor culture.* (2021)

10.4 Delayed transfer and communication with labour ward

There were other examples that demonstrated a reluctance to escalate concerns by communicating with senior midwives on the labour wards and thus missing opportunities to transfer women from the antenatal ward areas. This can be explored through the case reviews but is also very clearly illustrated in the information provided in staff interviews.

The Staff Voices interviews have highlighted a culture of 'us and them' in relation to the inpatient ward areas and the labour ward, with a reported sense of elitism in the labour environments:

113 National Institute for Health and Care Excellence (NICE). Preterm labour and birth (NICE Guideline NG25). London: NICE; 2015 Nov 20. Updated 2022. Available from: https://www.nice.org.uk/guidance/ng25

114 Nursing and Midwifery Council (NMC). Standards of proficiency for midwives. London: NMC; 2024. Available from: https://www.nmc.org.uk/globalassets/sitedocuments/standards/2024/standards-of-proficiency-for-midwives.pdf

"…there was, absolutely, a culture of - if you were on the antenatal ward - you weren't seen as being at the same level as a labour-ward midwife. Absolutely, I would 100% say that. They felt they were in a league of their own." (2024)

"There was a real 'us and them' between the wards upstairs and the labour suite downstairs...I did experience some actual scary Band 7s." (2024)

"There were three of us, and, as well as being in charge, I had my full complement of patients to look after. And we had a lady 28/29 weeks pregnant and it looked like she was going into early labour, and they wanted me to put an Atosiban infusion on the antenatal ward. And I was horrified. And I said, 'No, no.'.. And one sister came round… she was shaking, she was clearly annoyed but nervous, and she was in the public area, [where] there was patients walking up and down, [saying]: 'Are you refusing, are you refusing? You're putting this woman's baby's life at risk, you know, they're going to die, the baby'. And I said, 'Yes, I'm refusing'. And she stormed off." (2024)

Family feedback indicates that women were aware of the challenges that staff were facing in relation to this:

"It took a while for them to transfer me to the labour suite." (2015)

"The midwife that was with her was doing everything to try and help. She was very good but I got the impression that she was trying to convince people higher up that something was wrong but nobody was really paying attention to her..." (2017)

"I was already admitted on the antenatal ward when I started to feel that something wasn't right. Over nearly eight hours, I asked for help several times. I was seen by a junior doctor twice and a registrar once. Each time, I asked if they needed to examine me, and each time I was told it wasn't necessary.

Between around 6pm and 1am, I wasn't examined at all. I felt like my concerns weren't being taken seriously, and my previous pregnancy history wasn't considered. There didn't seem to be clear communication or handover between staff.

Because I was already on the ward, it felt like I was being overlooked—'out of sight, out of mind'. Other women coming in were taken straight to labour ward, while I felt pushed to the back of the queue.

It wasn't until I pressed the emergency buzzer, after more than seven hours, that things were taken seriously. By then, everything became urgent and chaotic.

I believe that if I had been examined earlier, things could have been different. Instead, there was a long delay, and the consequences were devastating – I lost my daughter" (2021)

Cases that the Review Team identified reflected the comments of the staff in relation to communication difficulties and delayed transfer include:

*In **2019,** during admission for induction of labour, a mother had a delay in transfer to the labour ward after her waters broke. The pain relief was not adequate in the antenatal ward and the coordinator declined a transfer as there was no capacity on the labour ward. The mother and her partner were very distressed by this and the CTG became uninterpretable due to the maternal distress. 30 minutes later her partner really wanted a transfer to the labour ward and made a further request, at which point the coordinator agreed.* (2019)

11. Conclusion

This Review demonstrates that antenatal care at NUH has been characterised by a combination of committed, high-quality clinical practice and long-standing systemic weaknesses that have affected consistency, safety and experience. While there are clear examples of excellent multidisciplinary care – particularly within fetal medicine, maternal medicine and specialist pathways - the findings show that

these standards were not reliably delivered across the wider antenatal pathway. Instead, variation in risk assessment, surveillance, documentation, communication and escalation has been persistent over time, contributing to missed opportunities for earlier intervention and avoidable harm.

A central theme across this chapter is the fragmentation of care and its consequences. Inconsistent application of national guidance, gaps in continuity, variable use of electronic records, and failures in communication - both between professionals and with families - have undermined the delivery of person-centred care. Women and families repeatedly described feeling unheard, inadequately informed, or unsupported when raising concerns, particularly in relation to reduced fetal movements, emerging medical complications, and complex decision-making. These experiences were further compounded for vulnerable groups, including those with language needs, social complexity or from Global Majority backgrounds, highlighting persistent inequities in access to safe and responsive care.

The Review therefore concludes that improvement requires not only adherence to clinical guidance, but a fundamental strengthening of culture, leadership, communication and system reliability. This includes robust and consistent risk assessment, timely escalation and review, accurate and shared documentation, and equitable access to interpretation and support services. Just as importantly, services must prioritise listening to women, ensuring that concerns are taken seriously, and that care is delivered with transparency, compassion and continuity. Addressing these areas will be critical to restoring trust, improving outcomes, and ensuring that antenatal care is consistently safe, personalised and responsive to the needs of all women and their families.

Intrapartum Care

1. Introduction

This chapter focuses on the safety and quality of care provision during the intrapartum period at Nottingham University Hospitals NHS Trust. In keeping with the Terms of Reference for the Review, family cases have been analysed from the 1 April 2012 until 31 May 2025. All completed case reviews graded 2 and 3 were analysed and recurring intrapartum themes extracted from the data. Building on this, further searches were undertaken to identify recurring themes across all case gradings, ensuring a comprehensive understanding of systemic patterns. Data was collated and analysed within multi-professional teams and benchmarked against the national, professional and local guidance in place at the time of the incident/case.

Intrapartum care provision encompasses not only clinical interventions but also the wider organisational context, incorporating the systems and processes in place, culture, communication and emotional support that is paramount for safe, person-centred care provision. Data extracted from the case reviews was analysed in conjunction with information obtained from the Staff Voices and accounts from women and families to ensure any learning also encompassed themes identified within the experience of families and staff members. Further contextual information – such as intrapartum forum minutes, clinical dashboards, training records and risk registers – was also considered during the final analysis of themes to ensure a holistic analysis of care provision and its wider organisational context was provided.

The findings from this Review have been synthesised into a thematic narrative that shows areas for improvement to inform future quality improvement and learning. Whilst intrapartum planning commences during the antenatal period, intrapartum care commences from the onset of labour and incorporates the first, second and third stages of labour. The first stage of labour includes both the latent and active phase of labour.

The Review Team found several themes were prevalent throughout the stages of labour which are presented in the sections below. Fetal monitoring was a predominant theme identified as a key area for improvement within the Trust and consideration has been given to the wider issues associated with fetal monitoring to provide context for the findings of this Review and support for future learning. There is evidence from many individual cases where intrapartum monitoring was demonstrably substandard. These cases detailed below illustrate how unsafe care occurs when multiple system defences fail simultaneously, including breakdowns in escalation pathways, dilution of professional accountability, normalisation of deviance, and erosion of situational awareness under pressure. Understanding how vulnerabilities within maternity systems align to permit harm can be achieved through the examination of individual cases and is essential to show how these failures might be anticipated and mitigated in future practice.

2. Fetal Monitoring

2.1 Background and Context

Intrapartum fetal monitoring remains a central component of maternity care and a recurrent focus of recent national reviews of adverse outcomes, including the Royal College of Obstetricians and Gynaecologists (RCOG) *Each Baby Counts* 2020 final progress report,[1] the *Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*[115] and the independent maternity review of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust, *Reading the Signals*.[116]

115 Royal College of Obstetricians and Gynaecologists (RCOG). (2015). Each Baby Counts: Full Report 2015. RCOG. 2 Ockenden, 3 Kirkup

116 Kirkup, B. (2022) Reading the signals: Maternity and neonatal services in East Kent – the report of the Independent Investigation. London: Department of Health and Social Care.

Such reviews have identified instances of misclassification or delayed recognition of evolving fetal compromise on the cardiotocograph (CTG). Electronic fetal monitoring using a continuous CTG is offered to many women and current national guidance outlines 29 reasons where a CTG would be recommended because of the increased potential for the baby to be compromised during the labour, for example if the baby is smaller than expected or there are signs of an infection.[117] If a mother is considered to have none of the known risk factors in labour, she is offered intermittent auscultation. However all mothers should be given a choice on which monitoring they wish to have in labour.[4]

Findings of reviews must be interpreted cautiously, as reviews are conducted with the benefit of hindsight, where outcomes are already known and thus risk overstating the apparent clarity of CTG abnormalities when compared with the uncertainty, competing demands and cognitive load present during real-time clinical decision-making. Moreover, these recurrent findings sit within a well-established evidence base demonstrating that a CTG has not been shown to reduce perinatal mortality or long-term neurological morbidity when compared with intermittent auscultation – despite its widespread use and perceived role in preventing harm.[118]

Rather than reflecting simple failures of individual interpretation, growing evidence suggests that intrapartum fetal monitoring is best understood as a complex sociotechnical practice, shaped by system design, workload, team dynamics, guideline variability and organisational culture.[119] Continuous CTG itself has well-recognised limitations, including poor specificity for predicting long-term neonatal outcomes and substantial inter- and intra-observer variation in interpretation.[5] Reviews of intrapartum care are therefore unavoidably influenced by retrospective bias, with greater apparent clarity afforded by knowledge of the outcome than was available to clinicians at the time.

However, despite this, a sociotechnical understanding does not negate the importance of examining individual cases in which intrapartum monitoring was demonstrably substandard. National inquiries and confidential reviews repeatedly describe cases involving sustained failure to recognise pathological fetal heart-rate patterns, delayed escalation despite repeated triggers, and missed opportunities for timely intervention. [2,3,120,121] These cases cannot be explained solely by the inherent limitations of CTG or by hindsight bias.

2.2 Incorrect Interpretation of CTG

The Review Team identified multiple instances of misclassification of the CTG. Failure to recognise and escalate an abnormal CTG resulted in poor neonatal outcomes for families whose babies subsequently sustained Hypoxic-Ischaemic Encephalopathy (HIE) in cases reviewed between 2013 and 2019.

Chronic hypoxia means the baby is not getting enough oxygen for a duration of time as their placenta is no longer able to deliver the required amount. There are multiple reasons why this might happen and not all are entirely understood. This can be suggested on a CTG with a particular pattern of changes/deviations from normal. For example, a loss of accelerations in the antenatal period, decelerations, reduced variability, and a rise in the baseline rate. There is no national guideline for antenatal fetal monitoring, which leaves potential for misinterpretation and subsequent harm to occur, given that CTGs are used frequently in the antenatal period. *Saving Babies Lives (version 2)*[122] recommends the antepartum use of computerised CTG over and above visualised CTG due to the potential to reduce the risks of human error. Regions have adopted their own guidance but there is no national guidance from National Institute for Clinical

117 National Institute for Health and Care Excellence (NICE) (2022, updated 2025) Fetal monitoring in labour (NG229). Available at: https://www.nice.org.uk/guidance/ng229

118 Alfirevic, Z., Gyte, G.M.L., Cuthbert, A. and Devane, D. (2017) 'Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour', Cochrane Database of Systematic Reviews, 2, CD006066. https://doi.org/10.1002/14651858.CD006066.pub3

119 Lamé, G. et al. (2024) 'Why is safety in intrapartum electronic fetal monitoring so hard? A qualitative study combining human factors/ergonomics and social science analysis', BMJ Quality & Safety, 33(4), pp. 246–256. https://doi.org/10.1136/bmjqs-2023-016144

120 Kirkup, B. (2015) The report of the Morecambe Bay Investigation. London: The Stationery Office.

121 NHS Resolution (2017) Ten years of maternity claims: An analysis of NHS Resolution data. London: NHS Resolution.

122 NHS England (2019) Saving Babies' Lives Care Bundle Version Two. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf

Excellence (NICE), the RCOG or international guidance from The International Federation of Gynaecology and Obstetrics.

*In **2022** a mother was commenced on oxytocin for augmentation of labour when there was no indication for this as her contractions were already frequent at 4 in 10 minutes. The use of oxytocin led to hyperstimulation. The CTG was not correctly classified as pathological and there was opportunity for the baby to be delivered at a much earlier interval. The correct classification of a CTG and subsequent intervention would have avoided the outcome of severe acidosis and neonatal admission at birth.* (2022)

Evidence was found of a general lack of recognition regarding the commencement of induction of labour on women who had abnormal CTGs. This is discussed within the Antenatal chapter.

2.3 Use of Oxytocin

The Review Team found that oxytocin was not always used with the necessary clinical caution and CTGs were often misclassified in these cases which resulted in staff not necessarily appreciating the risks associated with oxytocin use for the baby at the time. The Review Team found situations of tachysystole, hyperstimulation or pathological CTG without a subsequent reduction in the rate of oxytocin infusion, with oxytocin being continued or even increased. This resulted in various degrees of harm from Hypoxic-Ischaemic Encephalopathy (HIE) grade 1 to intrapartum stillbirth, as demonstrated in the vignettes below:

*In **2006**, a mother was commenced on oxytocin, starting 3 hours into the second stage of labour, when there was already good progress in labour with regular contractions up to 4-5 in 10 minutes and no indication to start oxytocin. Oxytocin was commenced on a higher starting dose than was recommended nationally or in Trust guidelines and it was titrated faster than guidelines dictated at the time. Despite the very abnormal CTG – indicating hypoxia for the baby – the oxytocin continued to be increased even when there was evidence of hyperstimulation resulting in a term intrapartum stillbirth.* (2006)

*In one instance in **2018**, oxytocin was increased during a fetal bradycardia during a high-risk pregnancy with dichorionic diamniotic (DCDA) twins at 33+6 weeks. The woman was in her second pregnancy with DCDA twins following IVF and with a history of a previous emergency caesarean section. The mother's cervix was fully dilated and the CTG was uninterpretable. In the presence of a fetal bradycardia that was confirmed with an ultrasound scan (USS), the oxytocin continued to be increased resulting in a diagnosis of HIE grade 3 for the baby.* (2018)

*In **2019,** there was an inappropriate use of oxytocin for a mother with a pathological CTG in the 2nd stage of labour which was not recognised and resulted in the baby being diagnosed with HIE.* (2019)

*Also in **2019**, a mother received inappropriate commencement and continuation of oxytocin for a 34+1 weeks' gestation pregnancy. The subsequent failure appropriately to interpret and act upon the CTG abnormality, combined with delays in getting to theatre due to unit capacity, resulted in her baby being diagnosed with HIE.* (2019)

2.4 Documentation

The Review Team found a lack of documentation on CTG monitoring. It was observed that following the 2014 NICE guideline update there was no amendment made to local CTG stickers (used to assist with documenting CTG interpretation) to reflect the guideline's language and categorisation.[123] The Review Team noted CTG stickers were not always used and CTG reviews were not always completed hourly, as expected. The 'fresh eyes' tool was not consistently applied, often being performed every 2-3 hours rather than hourly as advised by local and national guidance. There was often a lack of full and holistic CTG review.

123 National Institute for Health and Care Excellence (NICE) (2014) Intrapartum care for healthy women and babies (CG190). Available at: https://www.nice.org.uk/guidance/cg190

Saving Babies' Lives Care Bundle (SBLCB) (version 3)[124] describes the elements required for effective fetal monitoring during labour. This includes a structured risk assessment that informs the clinician's recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review. The Nottingham University Hospitals NHS Trust (NUH) audit in 2024 showed that this documented risk level for fetal monitoring at the start of labour did not occur in the majority (n=95%) of cases and a documented intrapartum risk assessment was completed in only 63% of cases.

2.5 Fetal Scalp Electrode

The Review Team identified a consistent failure by the Trust to use fetal scalp electrodes (FSE) in situations where they were clearly indicated. A well-placed FSE allows direct recording of the fetal heart rate into the CTG machine though a clip that attaches to the fetal scalp through the vagina and open cervix instead of using an external ultrasound probe. It can improve the quality of a CTG recording and therefore the ability to interpret it. Term women experiencing repeated loss of contact on the cardiotocograph (CTG), or cases where staff were unable to confidently interpret the trace, were not escalated to FSE use despite national guidance supporting this intervention.

Maternity and Newborn Safety Investigations (MNSI) have also fed this back to NUH and advised the Trust to increase training to midwives to support the application of FSEs. On some occasions staff reported that they attempted to apply a fetal scalp electrode but were unable to locate the correct attachment, exposing a fundamental lack of equipment availability and organisational oversight.

*In **2021**, there was no escalation documented when the CTG was not recording or uninterpretable in labour. There was a failure to consider a FSE, despite performing an artifical rupture of the membranes that was not warranted. The woman also had a history of a previous baby requiring treatment for GBS meningitis.* (2021)

This represents a significant systems failure. The inability to access basic fetal monitoring equipment suggests inadequate stock management, poor labour ward preparedness, and weak accountability structures. As a result, staff were unable to deliver safe, timely intrapartum fetal monitoring, and likely lost confidence with attaching this monitoring over time. These avoidable gaps in infrastructure directly contributed to delays in assessment and decision-making, heightening the risk of preventable harm to babies. The long-term challenges relating to fetal monitoring equipment were further evidenced in Staff Voices feedback, with staff reporting the need to share CTG monitors.

2.6 Lack of Coordinator Documentation and Oversight

The Review Team identified a consistent absence of documented oversight from the labour ward coordinator midwife, following escalation. Where escalation occurred, documentation was frequently completed by the midwife providing direct care rather than by the shift coordinator, or there was no documented evidence of coordinator review at all. In many cases, where the coordinator was reportedly informed or asked to attend, a medical review took place instead, with the plan and documentation authored by the doctor. This pattern suggests that escalation pathways were often linear rather than collaborative, with either midwifery or medical input occurring in isolation rather than through coordinated multidisciplinary review.

Following a targeted data extraction it was found that approximately only one third of cases demonstrated clear, documented evidence of coordinator review and support. Most cases reflected either an absence of coordinator involvement, or involvement that was not documented. Escalation entries such as 'coordinator informed' were common, but frequently lacked any accompanying outcome, plan or evidence of senior midwifery oversight. Several reviews between 2012-2024 explicitly highlighted the absence of coordinator review with reviewers repeatedly questioning 'where was the coordinator?'.

124 NHS England (2023, updated 2025) Saving Babies' Lives Care Bundle Version Three. Available at: https://www.england.nhs.uk

*In **2024**, a mother with a low-risk pregnancy was in labour at 41+6 weeks gestation. The CTG was suspicious with a rising baseline rate becoming pathological. The mother was pyrexial with a temperature of 38.3 degree Celsius, respirations 23 per minute and pulse of 91 beats per minute. The doctor was informed but the escalation was not expedited and there was no review until over 90 minutes later. It appears that the urgency of the situation was not recognised, leading the reviewer to question the location of the lead member of staff.* (2024)

These findings are consistent with wider evidence that intrapartum fetal monitoring, including CTG review and escalation, is not an individual technical task but a complex sociotechnical process requiring coordinated interaction between people, roles, documentation systems, communication practices and organisational culture. Lamé et al[6] demonstrated that CTG interpretation and escalation are inherently collective activities, dependent on clear role delineation, shared situational awareness, effective communication, and reliable systems for seeking and recording second opinions. Failures in documentation and visible senior oversight therefore represent system-level vulnerabilities rather than isolated individual omissions.

The apparent substitution of coordinator review with medical review also risks undermining the distributed safety function of the labour ward coordinator role. Patient safety frameworks emphasise that safety in complex systems relies on multiple, overlapping layers of review and sense-making, rather than a single professional perspective.[125] When senior midwifery oversight is absent, undocumented, or bypassed, opportunities for challenge, contextual judgement and early risk mitigation may be lost.

Importantly, staff narratives suggest that these documentation and escalation gaps may reflect deeper cultural and psychological safety issues that have persisted over a prolonged period. Multiple staff described a toxic culture associated with some Band 7 coordinators, including bullying behaviours, fear of escalation, and lack of supportive engagement with junior staff. Reports that newly qualified midwives were allocated the most complex cases to 'see if they would sink or swim', and that Band 6 midwives felt intimidated or unsupported, are particularly concerning. This is demonstrated within the following vignettes from the Staff Voices:

"Band 7s on the labour ward who did not rotate created an 'us and them' culture. Other midwives did not want to come onto the labour ward, especially on night shift. Junior staff members were given the most complex/demanding cases and they were too scared to escalate or challenge." (2017)

"The Band 7s on labour ward were all challenging, would not engage…would allocate complex cases to junior staff members and simple cases to their friends. Juniors were too scared to escalate and too scared to provide evidence of bullying and harassment." (2018)

"On shift when a major incident happened, coordinators were toxic." (2018)

The staff member mentioned a staff member regularly shopping online on night shifts, stating that she saw nepotism and cronyism in relation to promotions which was why she left:

"Band 6s were brilliant and supportive. [There was a] clique amongst Band 7s all coming up to retirement, who were not trusted or unapproachable. City had a reputation for bullying and harassment – [I] would not go to work there." (2018)

"Bad behaviours and toxic culture were normalised; people didn't even recognise it. Anyone who comes from outside is challenged. [I was] told on my second day they would break me. [There were] entrenched ways of behaving that were unprofessional and cruel to women on labour ward. New [staff members] who joined and newly qualified [staff members] saw this behaviour, accepted it and continued…They did have staffing challenges. However, that was the least of the issues. Their behaviours and culture were damaging to women, babies and anyone who went to work there. I once had an interaction with a [staff member]

125 NHS England (2022) Patient Safety Incident Response Framework. Available at: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

from Queen's. She screamed at me down the phone because I asked her to do something. Screaming and shouting and threatening is a deeply embedded theme there." (2018)

"[Lead staff members] at night did shopping on the internet and gave all the junior staff members 2 or 3 women each." (2025)

Psychological safety is a critical prerequisite for effective escalation, shared decision-making, and learning in high-risk clinical environments. Where staff fear negative consequences for speaking up, escalation may become performative ('coordinator informed') rather than meaningful, and documentation may serve as defensive record-keeping rather than an account of collaborative clinical reasoning.

This aligns with broader safety science evidence demonstrating that poor psychological safety is associated with breakdowns in communication, failure to challenge authority gradients, and increased risk of adverse outcomes.[126,127] In the context of CTG monitoring, Lamé et al highlight that the ability to communicate concerns freely, seek challenge, and mobilise coordinated responses is as important as technical competence in trace interpretation.[6] Where senior roles are perceived as punitive or unapproachable, the sociotechnical system underpinning fetal monitoring is weakened.

Overall, the absence of documented coordinator oversight should not be interpreted solely as a documentation failure. Rather, it appears to reflect interacting issues of role clarity, workflow design, professional relationships, and psychological safety. Addressing these gaps will require more than reminders about documentation; it necessitates attention to leadership culture, supportive senior presence, clear expectations of collaborative MDT working, and system designs that make senior midwifery review both visible and routine within escalation pathways.

2.7 Poor Escalation

There were multiple occasions when the Review Team noted delayed escalation, or failed escalation. Multiple reviews between 2006 - 2022 identified that the birth was delayed, which in some cases is likely to have made a difference to the outcome. This was due to failures to recognise, acknowledge or escalate the significance of the situation, and, at times, the inability of the labour ward or maternity theatres to accept patients because of acuity or staffing pressures, which contributed to delays. This is demonstrated in the vignettes included below:

*In **2019**, a mother arrived in triage in established labour at 34+1 weeks' gestation. On examination, the mother's cervix was 9cm dilated. Oxytocin was commenced inappropriately as there was inadequate fetal monitoring of the fetal heart and regular maternal contractions 4 in 10 minutes. The oxytocin continued to be increased despite a suspicious CTG trace and poor-quality monitoring of the fetal heart rate on the CTG. Progress was slow during the second stage of labour and a plan was made for a trial of forceps in theatre. This was delayed due to an emergency and the oxytocin was stopped. However, the mother continued to push. There was no CTG analysis for a period of over one hour at this point resulting in a category-1 caesarean section due to a fetal bradycardia. The baby required resuscitation and intubation at birth and was transferred to the neonatal unit and cooling therapy. A later MRI showed HIE grade 1.* (2019)

*In **2022**, a mother arrived on Labour Ward at 41+3 weeks' gestation for a planned induction of labour and already in established labour. Oxytocin was commenced when the maternal cervix was 9cm dilated with no clear indication which may have caused the subsequent uterine hyperstimulation and subsequent pathological CTG trace. There was a delay in stopping the oxytocin and transferring to theatre once the decision for a caesarean section had been made with no reason documented for the delay. The Review Team agreed that birth should have been expedited earlier which may have affected the outcome. The baby required resuscitation at birth, was intubated and taken for cooling therapy.* (2022)

126 Liberati, E.G. et al. (2019) 'How to be a very safe maternity unit: an ethnographic study', Social Science & Medicine, 223, pp. 64-72.

127 Liberati, E.G. et al. (2020) 'Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation', BMJ Quality & Safety. Available at: https://qualitysafety.bmj.com/content/early/2020/09/25/bmjqs-2020-010988

2.8 Fetal Blood Sample (FBS) Use

*In **2012**, a family had multiple FBS samples taken throughout their labour with normal results but these were not then performed nearer birth (or within the few hours prior to birth, despite a worsening CTG), resulting in a hypoxic baby at birth.* (2012)

Sometimes an FBS was performed when expediting the birth was required. Equally, previous guidance recommended a suspicious CTG with meconium-stained liquor warranted an FBS and this was not always considered. There is evidence that FBS was incorrectly performed in clear cases of infection and chorioamnionitis and staff were falsely reassured by these results. FBS is undertaken to assess the presence and severity of fetal acidosis during labour although there has been a sharp decrease in its use in recent years and the most recent national guidelines no longer recommend its use due to increased training in CTG interpretation and alternative, less invasive, methods.[4]

2.9 Fetal Monitoring Training

There is no documented evidence of fetal monitoring training at NUH before 2010. The teaching then became part of the emergency study day presented by a clinical educator. Evidence presented by NUH shows that the same PowerPoint presentation was used in 2013, 2014 and 2016 – with no updates beyond the date being changed on the first slide.

The most noticeable development was a fetal monitoring full training day in 2023, led by a fetal monitoring lead midwife and obstetrician which appears to align with current guidance,[11] and focuses on learning from incidents and fetal physiology. Embedded fetal monitoring 'learning events' also take place every week led by the fetal monitoring leads.

Feedback from Staff Voices reveals that staff were regularly pulled away from mandatory training to fill staff shortages, even to the extent of being instructed to take their uniforms into training days. This meant the Trust had poor compliance with mandatory training and particularly with CTG training. Staff have reported little support or sympathy from management when training was cancelled and a culture that tried to minimise the significance of poor training compliance. However, there appears from Staff Voices to have been a positive shift in more recent years:

"As a newly qualified [staff member] on QMC labour suite you would get no help or response when escalating concerns to [obstetric colleagues] and senior [staff members]. [Staff members] were rude, unsympathetic and bullying. [Staff members were] fearful of pulling emergency buzzer. Staffing shortages meant staff often got pulled from mandatory training and regularly work 2-3 hours overtime. Pre-2021 agency staff were rarely used" (2022)

"MDT PROMPT and CTG training now is excellent with a focus on improvement. Shared learning is solidifying team working since 2021/22. Learning from morbidity and mortality meetings ensures feedback and shared learning." (2022)

"Service remains short staffed today but at least people listen. Lots of agency staff, especially at night. QMC is very badly staffed and the skill mix is challenging with many [junior staff members] and many international recruits who come with a lot of skills but need help especially with CTG. The [junior staff members] end up caring for women with complex needs." (2022)

Importantly, more recently, there appears to have been a noticeable reduction in the number of harm cases at NUH which may be associated with a change in their content of fetal monitor training additionally with the oversight of the Care Quality Commission (CQC). This suggests better training may be contributing to a positive impact on outcomes. Examining individual cases is essential to understand how vulnerabilities within maternity systems align to permit harm, and how these failures might be anticipated and mitigated in future practice.

3. The Latent Phase of Labour

3.1 Background and Context

The concept of the latent phase of labour was formally introduced in the 1950s and its definition and management have since evolved, moving from a rigid, short timeframe to a more flexible, individualised approach that recognises its natural variability. There is a lack of a universal, standard definition for the precise start and end of the latent phase, and experiences can vary widely among women. According to the World Health Organization (WHO), respectful, woman-centred care during this time should prioritise emotional support, reassurance, clear communication, and the provision of information to reduce anxiety and promote a positive labour experience.[128]

Clinical guidelines from bodies such as NICE emphasise providing woman-centred, supportive care and encouraging women to remain at home during the latent phase if they are coping and there are no complications.[15] This approach aims to reduce unnecessary medical interventions. However, this depends on a comprehensive, holistic risk assessment undertaken by the midwife and on the mother's understanding of when to recontact the unit, with the option of earlier attendance if preferred.

Evidence has suggested that some women felt unsupported and experienced more anxiety when sent home during this phase of labour.[129,130] Another report found that some mothers may not have known when to come back to hospital if asked to return 'when labour is established' as they thought they were in labour already.[131]

More widely, the Health Services Safety Investigations Body (HSSIB) has highlighted that a significant number of investigations found emphasis on advising mothers to remain at home, with mothers not being invited into the clinical setting during what was perceived as 'early labour' without a full assessment of the clinical picture being undertaken.[18] *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK* (MBRRACE-UK) highlighted that inadequate care during the latent phase of labour is a significant issue contributing to adverse outcomes and recommended that national guidance be developed for care during this period.[132]

National guidance defines the latent phase of labour as a timeframe, not necessarily continuous, when there are contractions with some cervical change which includes cervical position, consistency, effacement and dilatation up to 4cm.[15] The quality of care during the latent phase significantly shapes a woman's overall childbirth experience and this stage is highly sensitive to external influences and interactions with healthcare providers.[20,133]

The mismanagement of the latent phase of labour was a theme found by the Review Team. There is evidence that despite the failings identified following the review of the Signature Case (2016) there continues to be mismanagement of the latent phase of labour.

3.2 Communication and Language used During the Latent Phase

Concerns were identified by the Review Team with the communication and language used in the latent phase of labour at NUH. MBRRACE[19] has emphasised the importance of using positive communication

128 World Health Organization (WHO) (2018) WHO recommendations: intrapartum care for a positive childbirth experience. Available at: https://www.who.int

129 Williams, C. and Thompson, J. (2017) 'Discharge during early labor: Impact on maternal anxiety and perceptions of care', Journal of Obstetric, Gynecologic & Neonatal Nursing, 46(2), pp. 134-142.

130 Bauer, A. (2012) 'A qualitative study exploring women's experiences of early labor and the impact of home discharge on emotional well-being', Midwifery, 28(3), pp. 324-330.

131 Healthcare Safety Investigation Branch (HSIB) (2020) Summary of themes arising from the maternity programme. Available at: https://www.hsib.org.uk

132 Draper, E.S., Kurinczuk, J.J. and Kenyon, S. (eds.) (2017) MBRRACE-UK perinatal confidential enquiry. Leicester: University of Leicester.

133 NHS Wales (2024) Latent phase of labour guideline. Available at: https://wisdom.nhs.wales

and stipulates that midwives should adopt encouraging and affirming language, avoiding negative phrases like 'you are not in labour' or 'only 2cm dilated', which can devalue the woman's experience and increase anxiety.

The Review Team found evidence of a lack of compassion and women being advised to stay at home and not being invited to attend the unit when an inpatient visit would have been clinically appropriate. Often, when calls were made, pain was minimised or ignored, and women were not invited in for review. Many women made several calls to NUH staff before they were given access to the unit. There is an abundance of evidence within maternity records, and importantly directly from women, who were left feeling scared and vulnerable at home. Similarly, there are multiple acknowledgements of labour ward coordinators discouraging attendance and encouraging women to remain at home within Staff Voices.

This is demonstrated in the examples below:

*In **2014**, a mother rang the hospital three times from home following spontaneous rupture of membranes and reporting being in a lot of pain which was continuous. The family report having their concerns dismissed on the phone and told to 'calm down' and 'take some paracetamol' as it would 'probably be another 24 hours before the baby was born. The mother was given an appointment for a check later that day after the second phone call. The mother rang a third time to say they did not feel right and were coming into the hospital but were dismissed and asked why they were coming in when they had an appointment booked for later. On arrival at the hospital the mother was placed in a waiting room while a bed was sorted for them and when they were finally examined, the woman's cervix was nearly fully dilated and the fetal heartbeat was slow and difficult to determine from the mother's. An emergency caesarean was called for. However, in theatre it was found that the mother's cervix was fully dilated, but her baby was not in a position to enable the birth to occur safely with forceps. There was still a slow heartbeat. This resulted in an emergency caesarean section and the baby born in poor condition and was cooled sustaining HIE.* (2014)

*In **2021,** a mother telephoned maternity triage twice and was told by a staff member that she wasn't in labour because she was able to have a conversation for 18 minutes on the phone which she would not be able to do if she were in labour. The woman told staff she was coming in as she was high risk due to maternal age and previous pregnancy with Turner's Syndrome and gestational diabetes mellitus. On arrival, the mother's cervix was 6cm dilated and the CTG was suspicious. The CTG became pathological and the mother tachycardic with a heart rate of 130-140bpm. There was a delay in further escalation to the obstetrician and the baby was born in poor condition following signs of shoulder dystocia and a 4-minute delay between the head delivery and the delivery of the baby. The baby suffered seizures from 10 hours of age although causation of the seizures is uncertain.* (2021)

3.3 Documentation of the Latent Phase

The Review Team found evidence of triage phone calls not always being documented. The Trust audit report for the period 2023-4 states that the latent phase of labour audit was paused because it was difficult to ascertain a sample on BadgerNet and, when analysed, only 10% of advice calls were relevant. The audit highlighted poor documentation which impacted upon the ability to identify women who were receiving care during the latent phase. A reduction in compliance with the first set of observations being performed since 2023 was also found, with the report stating that these were commonly missed. Initial observations performed are fundamental to undertaking a holistic assessment and subsequent decision-making about care provision.

A lack of guidance and standards for the latent phase, alongside significant national variation in guidelines, was highlighted in the audit report, which recommended that the audit be reinstated once such guidance was in place. The Review Team found that detailed local guidance for the latent phase of the first stage of labour was already published in February 2022.[134] This provides clear guidance regarding latent phase

134 Nottingham University Hospitals NHS Trust (2022) Intrapartum care guideline (3381).

management, including the importance of documentation in the notes and Maternity Medway (Medway was the Trust's digital record system during this time). There was reference to the development of further guidelines and funding to incorporate the Maternity and Newborn Safety Investigations (MNSI) recommendations in October 2023 but the Review Team were unable to find further evidence of this development.

3.4 Intrapartum Guidelines

Overall, the intrapartum group within the Review Team found a lack of consistency and clarity with guideline amendments and updates. This made it difficult to understand what the changes were when guidelines were updated. Earlier guidelines on the latent phase of labour, published in January 2014, advised that women should be invited to attend the unit on their third call.[135] These stipulated that the decision for admission for maternal and fetal assessment at the third call should be discussed with the labour ward coordinator. A further amendment in September 2014 stated that there should be a low threshold for admitting women to the unit for maternal and fetal assessment, with a documented rationale required if a woman was not invited to attend. This guidance was removed in 2018 and further guidance was made available from August 2020.[136]

3.5 Staff Voices

Staff Voices feedback reflects that there was a culture of keeping women at home in early labour, particularly before 2017. Some described it as a tick-box exercise and the decision to invite women into the unit was based on acuity. There was pressure to send women home and labour ward coordinators were described by staff as acting as gatekeepers to access to the unit in early labour. This reflects a wider culture of care which may also have been influenced by staffing pressures and acuity.

"The focus was on always keeping the unit open. Latterly, awareness of staff shortages did improve, and the use of agency [staff], manager of the day and bank shifts has made improvements. Because there was not the capacity on [the] labour ward, it was accepted practice to get women in the latent phase of labour to stay at home. [This was] not about ideology, just not enough [staff members]." (2021)

"We did send/encourage women home in the latent phase of labour often without risk assessment so there were missed opportunities. Most came back in when labour advanced but mostly everything was OK. In 2016-18 we didn't have overnight triage, and were hugely understaffed and overrun." (2020)

On triage, a staff member commented:

*"Since **2021** I have been operating an Advice Line, 4 desks away from clinical area staffed by 2x B6 [staff members], 1 x community [staff member] and 1 x [staff member] [who] undertake telephone triage according to clear protocols. [They] RAG rate them…[and] colour determines place/priority of care. Pre-2021 it was chaotic calls [which] went all over the place – labour ward, triage, different pathways at QMC and City. [It was] paper based, no standard protocols for what to advise…women could be cared for anywhere."* (2023)

It is reported by staff that there was a focus on the latent phase of labour around 2019/20, with guidelines produced and training provided.

"Management of latent phase of labour and triage [has] greatly improved in recent years." (2023)

"…excessive workload still feels unsafe despite improvements. High use of [agency staff members]. In triage too there is too much work because [you are] also covering day assessment unit. It is rare these days for staff to be pulled off mandatory training. In triage BSOT was introduced and we are now managing to achieve time restrictions – [it] has significantly improved. Some leaflets in triage are in community languages, and there is the use of telephone translation [and] specialist teams for vulnerable women.

135 Nottingham University Hospitals NHS Trust (2014) Latent phase of labour guideline (2174).

136 Nottingham University Hospitals NHS Trust (2020) The latent phase of labour (3163).

There is a new app to look at support where there is a language barrier – haven't used it. Telephone translators are good if you can get one." (2025)

Staff also mention that the introduction of the flow coordinator role has made a positive difference, with a single point for escalation although they are sometimes called away from their role to work clinically, meaning that this oversight as flow coordinator is lost.

"Flow Coord[inator] Role on each shift is a [staff member] whose job [it is] to look at workload and staffing and then move staff around, check on staff wellbeing, put out call for extra shifts on NHSP – [it] provides a single point for escalation. Very busy in triage and difficult to get doctor reviews." (2025)

3.6 Mismanagement of the Latent Phase

The MBRRACE-UK (2020) report[20] identified that issues in care prior to the establishment of labour, including during the latent phase, could contribute to potentially preventable deaths. Specific problems identified included delays in induction or transfer to an obstetric unit, failure to recognise progression from latent phase to established labour, inadequate fetal monitoring, and fragmented care with poor communication and documentation.

The Each Baby Counts guidance[137] had previously acknowledged the difficulty in assessing the transition between the latent phase and established first stage of labour, and variance in practice may be attributed to the limited guidance available. The Review Team found numerous cases of inappropriate management of the latent phase of labour over a prolonged period of time which is demonstrated within the vignettes below:

*In **2014**, a mother presented with a spontaneous rupture of membranes and there was a failure to escalate blood-stained liquor to an obstetrician for review prior to subsequent discharge home. A second opportunity was missed to escalate the cases for review when the woman reattended with contractions and ongoing blood-stained liquor. A vaginal examination showed the mother's cervix to be 3cm dilated with irregular uterine activity and a diagnosis of the latent phase was made with admission to the antenatal ward. Whilst this assessment was appropriate, the ongoing management plan to reassess in 4 hours was not. It is likely that an earlier diagnosis of established labour would have ensured regular maternal and fetal observations which would have highlighted abnormal findings with the maternal pulse and temperature and evolving pathological CTG. The baby sustained a neonatal brain injury, HIE grade 2.* (2014)

Heavily blood-stained liquor can be a sign of placental abruption and it is recommended there is continued electronic fetal monitoring if encountered. NICE guidance[10] stated that mothers who have any vaginal blood loss other than a mucous show should be transferred to consultant-led care. A review would therefore have been undertaken by an obstetrician with a documented plan in the above case. The Review Team found discrepancies in the interpretation of blood-stained liquor during the latent phase and widespread reference to 'pink' liquor when reviewing maternity notes. Staff commentary is that the presence of 'pink' liquor is 'normal' during labour. However, an earlier HSIB review[138] highlighted that 'pink liquor' is not acknowledged as a category. HSIB found that, in several investigations, 'pink liquor' had been normalised, and the classification of mothers as low risk contributed to ongoing bleeding not being recognised.

MBRRACE-UK highlights the importance of risk recognition, noting that midwives should identify women who move from low to high risk during this phase and seek support from appropriate medical staff if they deviate from their original care pathway.[20]

*In **2016**, a mother received a very brief labour assessment lasting 20 minutes when she first presented to triage in the latent phase of labour despite a history of a previous precipitate birth. The woman was sent home to await events following spontaneous rupture of membranes and proceeded to labour rapidly at*

137 Royal College of Obstetricians and Gynaecologists (RCOG) (2015) Each Baby Counts. Available at: https://www.rcog.org.uk/media/3fopwy41/each-baby-counts-2015-full-report.pdf

138 Healthcare Safety Investigation Branch (HSIB) (2022) Maternity investigation programme year in review 2021/22. Available at: https://www.hsib.org.uk

home with an undiagnosed breech presentation. Overall, the care provided and subsequent discharge home to await events was suboptimal and suggestive of an inadequate level of basic midwifery care. The mother lived 45-50 minutes' distance from the unit, which also posed a risk of being unable to return to hospital if needed. This was not acknowledged or considered in this case. The mother proceeded to an unplanned vaginal breech birth at home and the baby died. (2016)

*In **2018**, there was a failure to recognise and act upon established preterm labour at 34+2 weeks' gestation for a mother despite regular contractions on the CTG and signs of an abnormal CTG. In view of this, intrapartum care was minimal as active labour was not recognised and steroids were not administered at appropriate intervals.* (2018)

*In **2019**, a woman had been experiencing uterine contractions at home and there was a reluctance to admit the woman to QMC as an assumption was made that she was experiencing the latent phase of labour. On admission to the alongside birth centre the mother received suboptimal care, was left alone for long periods, and did not have her concerns listened to. There was a failure to recognise all the risk factors present and ensure adequate maternal and fetal monitoring during the latent phase and established labour. The CTG recording showed abnormal features which were not recognised by the team following transfer to the labour ward. Staff shortages were also not escalated appropriately. Earlier birth would have likely prevented the subsequent neonatal death.* (2019)

*In **2019**, there were multiple opportunities to examine and determine the stage of labour and diagnose ruptured membranes. There were several entries of paracetamol, codeine and oramorph without fetal assessment or further exploration. The mother did not receive appropriate intrapartum care as signs of established labour were ignored. There were 36 hours of contractions with no examination and advanced labour on the antenatal ward before transfer for one-to-one care.* (2019)

*In **2021**, a mother was receiving 'latent phase care' on the midwife led unit, Sanctuary, and due to staffing the staff member was advised to send her home as 'admitting her may increase the risk of intervention and iatrogenic harm'. Without examination, the message was relayed to the mother – she politely declined. An examination a short while after found that the mother's cervix to be almost fully dilated. There was no offer of analgesia or one to one care and there was inadequate fetal monitoring.* (2021)

4. Oxytocin

The neuropeptide oxytocin acts as a hormone and a neuromodulator that mediates the onset and progress of labour. Synthetic oxytocin (for example, Syntocinon) is a drug used to induce or strengthen contractions during labour and prevent postpartum haemorrhage. Administered intravenously via a controlled pump, it acts on the uterus to mimic natural oxytocin, often shortening labour, but it requires careful monitoring to avoid uterine hyperstimulation. Through their review of intrapartum fetal monitoring cases, the Review Team found significant evidence of inappropriate use of oxytocin.

4.1 Oxytocin Use

A thematic review was undertaken of family cases in which substandard oxytocin use was identified as contributing to poor neonatal outcomes. These concerns were highlighted by case reviewers during case review completion, interprofessional conversations and through the fetal monitoring chapter review. The cases span a 16-year period (2006–2022) and fifteen cases were examined in detail. Consistent with the fetal monitoring findings, most incidents occurred at City Hospital (73%) compared with QMC (27%). While the number of cases is small relative to the total number of reviews, the following areas for improvement were identified.

4.2 Inappropriate Commencement of Oxytocin

Several cases demonstrate oxytocin being initiated despite the presence of an abnormal or pathological CTG. Both local and national guidance state that oxytocin should only be commenced when fetal wellbeing is confirmed and the CTG is normal. Key issues identified include failure to classify or misclassification of the CTG resulting in oxytocin being commenced when contraindicated and/or the continuation or increase of oxytocin despite recognised fetal deterioration evident on the CTG. In all reviewed cases, this was associated with adverse neonatal outcomes.

*In **2015**, oxytocin augmentation was commenced by a staff member, despite them having concerns and it being an hour since the obstetric team's decision was made to start it. The oxytocin was commenced without maternal consent and in the middle of an already deteriorating situation with clear signs of fetal hypoxia. The baby required resuscitation, cooling therapy, sustained HIE grade 3 and was discharged home on a palliative care pathway.* (2015)

4.3 Oxytocin Initiated in the Second Stage of Labour

The Review Team found several cases that involved the inappropriate initiation of oxytocin during the second stage of labour. These cases highlight significant deviations from guidance and a lack of situational awareness regarding the fetal condition in the second stage.

*In **2006**, following rapid progress to full dilatation and effective contractions, oxytocin was started after an hour of active pushing. The infusion was commenced at a higher rate and titrated more rapidly than protocol allows. Poor-quality CTG monitoring meant fetal wellbeing could not be reliably assessed, contributing to an intrapartum stillbirth.* (2006)

*In **2013**, earlier recognition of malpresentation and delay in the second stage of labour should have resulted in faster transfer to the consultant unit. Oxytocin was not appropriate in the multiparous mother who had been pushing greater than 2 hours with a brow presentation.* (2013)

*In **2018**, a mother with a previous caesarean section and in labour with 33+5 DCDA twins had oxytocin increased in the second stage of labour despite no further descent with pushing and a fetal bradycardia for 6 minutes which recovered and was followed by two further episodes of bradycardia. The oxytocin infusion was also maintained when it should have been stopped when the decision for a category-1 caesarean section had been made. This resulted in lifelong severe disability for the infant. The parents recall at the time a 'blasé attitude' of the staff caring for them and there was never any sense of urgency that something serious was unfolding.* (2018)

*In **2022**, oxytocin was commenced due to perceived slowing of contractions, without a vaginal examination to exclude obstruction or delay. Although discussed with a consultant, the decision did not align with recommended practice.* (2022)

National audits and investigations have highlighted that oxytocin use must follow a 'holistic review' when delay is diagnosed in the second stage of labour and a recurring theme of delays in intervention once fetal compromise (often linked to oxytocin-induced hyperstimulation) was suspected.

4.4 Failure to Reduce or Stop Oxytocin in the Presence of Hyperstimulation

Another recurrent theme was the failure to respond appropriately to uterine hyperstimulation, even when clinically recognised; the Review Team identified multiple cases where no action was taken. MBRRACE-UK has previously linked substandard care in the administration of oxytocin – specifically failure to recognise and act on hyperstimulation – to poor outcomes, including intrapartum stillbirth and brain injury.[139]

Ongoing assessment of evolving factors that may impact the clinical situation and pose additional risks to the mother and baby is an integral element of intrapartum care and has been highlighted in numerous national

139 Knight, M. et al. (eds.) (2023) Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland 201921. Oxford: National Perinatal Epidemiology Unit.

reports and investigations. Fundamental components of clinical assessment include abdominal examination to determine symphysis-fundal height, lie, presentation, position and station; vaginal examination to assess cervical change, dilation and confirm fetal position; and palpation of uterine contractions to evaluate their frequency, duration and strength. Together, these elements contribute to a holistic clinical picture, which should be considered alongside individual factors and maternal preferences. The Review Team identified evidence of wider cultural influences that may have impacted clinical decision-making.

The following examples illustrate failures to reduce or discontinue oxytocin, alongside inadequate fetal monitoring, often associated with persistent loss of contact and delayed or omitted use of a fetal scalp electrode.

*In **2019**, the CTG became abnormal shortly after 23:00 and was pathological by 23:30. At this stage, there was an opportunity to discontinue oxytocin and consider terbutaline in the presence of continued abnormalities with frequent contractions, particularly where delivery could not be expedited due to unit acuity. There was a significant delay in discontinuing oxytocin, after which the CTG appeared to improve. However, from 01:30, the CTG became markedly abnormal, with a rising baseline and very deep decelerations, indicating the need for urgent delivery. In this case, there was an opportunity to expedite delivery more than two hours prior to birth, which would likely have altered the outcome of HIE.* (2019)

*In **2020**, despite a history of previous caesarean section and contractions occurring at 5 in 10, oxytocin was continued as contractions were perceived to be 'short.' A staff member documented reluctance to reduce the infusion for fear that contractions would fall below 4 in 10. This resulted in uterine rupture and neonatal HIE.* (2020)

Whilst Staff Voices feedback did not specifically reference oxytocin use, the Review Team identified recurring themes of escalation, culture, and fetal monitoring competence across multiple cases. These included delayed or absent escalation, failure to recognise emerging concerns, and variable fetal monitoring competence, including misclassification, failure to recognise deterioration, and failure to appropriately adjust or discontinue oxytocin. In addition, there was an inadequate response to poor-quality CTG traces. Collectively, these factors contributed to unsafe management of labour involving oxytocin.

5. Aromatherapy in Labour

Aromatherapy was introduced into maternity services at NUH as a well-intentioned, holistic addition to care and quickly became embedded in midwifery culture. Staff described its early adoption as driven by a small number of enthusiastic practitioners who created local guidance, delivered a single day of training, and maintained the supply/provision of oils. Many midwives valued the sense of calm and personalised care it offered, particularly within the birth centre, where it became part of the identity of the service. However, limited training, infrequent updates, and a lack of organisational oversight created conditions in which practice drifted over time.

As aromatherapy became normalised, its use expanded informally across clinical areas and into community settings. Diffusers were used widely, sometimes for personal preference rather than clinical indication, and community midwives were issued kits without consistent instruction. Several midwives acknowledged uncertainty about safe blending or prescribing of oils but continued because aromatherapy had become culturally embedded. Essential oils were often treated as harmless despite their recognised pharmacological effects on uterine activity, blood pressure, respiratory function, and neuroendocrine responses.

5.1 The Governance and Safety Implications of Aromatherapy Use

Documentation was frequently absent or superficial, with little recording of oil type, dosage, dilution, rationale, or monitoring. The guideline lacked contraindications, risk assessment requirements, and restrictions for high-risk settings, and there was no audit or leadership oversight to identify unsafe practice.

Over time, aromatherapy was used in high-risk pregnancies, induction and augmentation, VBAC labour, obstetric emergencies, and in women with significant medical conditions. Oxytocic oils such as clary sage were used in clinically dangerous contexts, including attempts to deliver retained placentas and alongside syntocinon infusions. In several cases, aromatherapy appeared to replace evidence-based care, delaying escalation or timely intervention.

Unsafe methods and boundary breaches were also evident, including the use of diffusers in clinical areas contrary to COSHH standards and the administration of oils to partners and family members. Staff reflected that while aromatherapy symbolised kindness and personalised care, its withdrawal in 2022 was necessary given the extent of unsafe and unregulated practice that had developed.

6. Third Stage of Labour

The third stage of labour is defined as the period immediately following the birth of the baby until the complete expulsion of the placenta and membranes. Midwifery care during this stage includes monitoring maternal and neonatal wellbeing, promoting maternal-infant bonding, minimising risks such as postpartum haemorrhage (PPH), and responding appropriately to any complications.

6.1 Postpartum Haemorrhage

Excessive bleeding after childbirth, known as postpartum haemorrhage (PPH), remains a leading cause of maternal mortality worldwide.[140] Whilst mortality due to haemorrhage is rare in the United Kingdom (UK), MBRRACE-UK highlights that the number of women dying from obstetric haemorrhage is not decreasing, with deaths, particularly among women with abnormally invasive placentation, remaining significant despite recent changes in service configuration.

Recurring themes identified by MBRRACE-UK[28] in the care of women who died following haemorrhage include failure to recognise the clinical signs of significant blood loss, delays in treatment associated with system pressures, and the need for improved situational awareness and senior leadership.

The RCOG *Prevention and Management of Postpartum Haemorrhage* (Green-top Guideline No. 52)[28] provides evidence-based recommendations for clinical practice. The guidelines emphasise a structured, multidisciplinary approach, including immediate resuscitation, prompt identification and management of the underlying cause, and timely escalation of interventions in cases of severe bleeding.

The Review Team identified multiple cases between 2012 and 2023 demonstrating suboptimal recognition, management and documentation of postpartum haemorrhage (PPH).

NUH Intrapartum Forum minutes from 2024 identified PPH as a Patient Safety Incident Response Framework (PSIRF) priority, with a 12-month improvement plan and the establishment of a PPH Group task force (currently in progress).[141] The Review Team was also provided with slides from five serious incidents in which women experienced blood loss exceeding two litres, however it was not clear how learning from these incidents had been translated into improvements in care.[142]

Review of Intrapartum Forum minutes indicated that questions raised were not consistently followed through with clearly documented actions, creating a risk that oversight and key learning could be missed. In 2024, five of the twelve scheduled monthly meetings were cancelled, potentially delaying both the completion of actions and the dissemination of learning.

140 World Health Organization (WHO) (2023) A roadmap to combat postpartum haemorrhage between 2023 and 2030. Available at: https://www.who.int/publications/i/item/9789240081802

141 NUH Intrapartum Forum minutes, March 2024 [internal document]

142 Mavrides, E., Allard, S., Chandraharan, E., Collins, P., Green, L., Hunt, B.J., Riris, S. and Thomson, A.J. on behalf of the Royal College of Obstetricians and Gynaecologists (2016) 'Prevention and management of postpartum haemorrhage', BJOG: An International Journal of Obstetrics & Gynaecology, 124(5), pp. e106–e149. Available at: https://doi.org/10.1111/1471-0528.14178

For example, a query regarding the use of intravenous oxytocin for women with a BMI over 40 and tranexamic acid for instrumental birth was delegated to two clinicians to align PPH management across both sites. However, this was not recorded as a formal action within the minutes and was not referenced in subsequent meetings of the Forum, indicating a lack of a robust audit trail for actions arising from these forums in 2024.

6.2 PPH Guidelines

The Review Team identified a lack of consistency and clarity in guideline amendments and updates, making it difficult for staff to readily identify the most current version of and determine which guideline was most applicable in practice.

Review of NUH guidance relating to postpartum haemorrhage (PPH) demonstrated overlap across multiple documents.[143] While the most detailed guidance is contained within *Management of Primary and Secondary Postpartum Haemorrhage*[144], additional detail PPH-related guidance is also included within *Intrapartum Care Guideline: Care for Healthy Women and Babies* (Guideline 3381, version 2, review date 01/02/25).[145]

This intrapartum guideline is a 132-page document covering a wide range of clinical topics, including PPH, and is authored separately from Guideline 1720. It does not include a contents page, making navigation difficult and creating a barrier to accessing relevant sections in a timely manner.

This overlap, combined with a variation in structure and accessibility, introduces a risk of confusion among staff regarding which guideline should be followed, potentially impacting consistency in care delivery.

'Staff Voices highlight concerns about under-reporting of PPHs and lack of trust between the governance team and staff, with the governance team being poorly led and managed resulting in cases that were deemed 'unavoidable' cases dismissed, with no learning.' (2019)

NUH was aware of inconsistencies in its guideline framework, as highlighted in its 2024 Datix listing report. This report identified risks associated with inaccurate or outdated guidance in clinical practice, with the potential to cause harm. It also highlighted the absence of a robust audit trail, particularly where document footers and identification numbers were inaccurate, limiting effective scrutiny by external and professional regulators.

The report further noted a lack of clarity regarding which documents were in circulation during specified time periods, particularly when reviewing patient safety incidents.

6.3 Recognition and Escalation of Postpartum Haemorrhage (PPH)

The Review Team identified multiple cases in which there was a failure to recognise and respond appropriately to signs and symptoms of PPH. In many instances, earlier intervention would likely have improved outcomes. The majority of these cases occurred after 2016. Illustrative examples are provided in following vignettes:

*In **2016**, there was a failure to recognise the extent of the blood loss and act appropriately. Blood loss was estimated rather than measured, and required maternity observations were not completed in a timely manner. There was also a delay in the administration of appropriate oxytocic drugs and escalation to the medical team. This resulted in severe maternal harm and unexpected admission to intensive care.* (2016)

*In **2016**, there were multiple lapses in the standard of care provided by the midwife. Blood loss was neither measured nor adequately estimated, and concerns regarding ongoing trickling of blood were not communicated to the senior staff members. The first postnatal observation was delayed and only undertaken*

143 Homebirth current guideline; Intrapartum care guideline; Management of women declining blood products during pregnancy and labour; Postnatal haemorrhage care; Management of women undergoing caesarean section review; Placenta praevia review 2030 [NUH Guideline, internal document]

144 NUH Guideline 1720; Management of Primary and Secondary Postpartum Haemorrhage

145 NUH Guideline 3381; Intrapartum Care Guideline: Care for Healthy Women and Babies

when the mother was approaching clinical collapse. There was no evidence of MEWS scoring, observation or fluid balance charts, and no indication that the significance of the situation had been recognised by the staff member. Contemporaneous documentation from the staff member following the birth was absent, and retrospective records were insufficient given the severity of the events. If this emergency had occurred in the home or a birth centre the outcome may have been very different as the mother's estimated blood loss was 3.5 litres. (2016)

*In **2016**, the delayed recognition and inadequate response to major obstetric haemorrhage were identified as a Grade 2 concern. This reflected failures in timely escalation, deviation from established protocols and gaps in documentation. Blood loss was not quantified, postpartum haemorrhage was not identified promptly, and transfer to theatre did not occur despite a third-degree tear. In addition, key interventions were not documented, including uterine massage, administration of second-line uterotonics, alongside bimanual compression and delayed escalation to the multidisciplinary team.* (2016)

Clinicians should be aware that the visual estimation of peripartum blood loss is unreliable, and that clinical signs and symptoms must be incorporated into the assessment of PPH.32 MBRRACE-UK30 reports that in a clinically well woman, blood pressure and pulse may be maintained until 30% of circulating blood volume has been lost, underscoring the importance of prompt recognition, and timely intervention to prevent adverse outcomes.

*In **2018**, the management of the PPH was suboptimal, with poor compliance with post-PPH observations and delays in obstetric review following escalation. Although initial measures to control bleeding were appropriate, subsequent management lacked a structured and systematic approach, and documentation was limited.* (2018)

6.4 Activating Major Obstetric Haemorrhage (MoH) Protocol

Major Obstetric Haemorrhage (MOH) is associated with significant morbidity across all healthcare settings, including multi-organ failure, postpartum hysterectomy, and long-term psychological trauma.[146] A structured protocol is essential in the management of both PPH and MOH to support prompt, coordinated action and reduce the risk of severe morbidity and mortality.[30,32]

The RCOG stipulates that an MOH protocol should be activated when blood loss is 1000ml and ongoing, or where there are clinical signs of shock (e.g. hypotension, tachycardia), irrespective of the volume of blood loss.[30] Early transfer to theatre is critical to enable timely surgical control of bleeding and to prevent rapid progression to hypovolemic shock, coagulopathy, and death. National guidance emphasises the importance of immediate resuscitation, senior clinical decision-making, and a coordinated multidisciplinary response.

The Review Team identified delays in activating the MOH protocol and in transferring women to theatre while actively bleeding.

*In **2013**, no MOH protocol was activated despite a blood loss of 2 litres PPH in a woman with a BMI of 19, who was resuscitated well after being in a state of hypovolaemic collapse. This was secondary to a failure in securing the uterine angles at primary caesarean. Had the caesarean been completed to the highest standard, the secondary bleed is unlikely to have occurred. Had MOH been activated originally, blood products would have been immediately available in the recovery area.* (2013)

*In **2017**, following induction of labour for post-maturity and an otherwise straight forward assisted birth for delay in the second stage, there was difficulty delivering the placenta. As the epidural was effective and the woman showed signs of hypovolaemic shock, a manual removal of the placenta (MROP) was performed in the room. Bleeding continued due to uterine atony, trauma, and retained placental tissue. The mother lost 3.2 litres of blood prior to transfer to theatre for examination under anaesthesia, with a total estimated blood loss of 3.5 litres.* (2017)

146 Drew, T. and Carvalho, J.C.A. (2022) 'Major obstetric haemorrhage', BJA Education, 22(6), pp. 238244.

*In **2019**, there was suboptimal management of another PPH and delay in activating a MOH call with an estimated blood loss of 2.9 litres. Controlled cord traction (CCT) was applied during initial physiological management of the third stage, and there was a delay in transfer to theatre.* (2019)

More recently, the Review Team found evidence of wider cultural issues influencing decision-making around MOH protocol activation.

*In **2022**, there was failure to activate MOH policy and gaps in the documentation following a twin birth resulting in a 4.2-litre major obstetric haemorrhage. A staff member had documented that the medical team did not wish to activate the MOH protocol, despite blood loss reaching 1624ml, and concerns were escalated to the senior team.*

The obstetric notes for this family also describe a disagreement between the obstetric team regarding the need to activate the MOH protocol, with a staff member advising that the activation was not required. This contributed to a delay in escalation, despite ongoing blood loss. The situation was unstable and blood loss exceeded 1500 ml within 12 minutes. The major haemorrhage call should have been activated in line with NUH major obstetric haemorrhage guidance at this time but was not commenced until the EBL had reached 4.6 litres. (2022)

*Again in **2022**, there was a delay in both activating the MOH call and commencing a syntocinon infusion, despite blood loss exceeding 4 litres. The mother had two identified risk factors for PPH; however, the Review Team was unable to identify documented evidence of formal risk assessment. Whilst elements of third-stage management were appropriate, including intravenous access, blood sampling, assessment of trauma and placenta, bladder emptying, administration of tranexamic acid (TXA), as well as two blood pressure and pulse recordings, the MOH proforma was incomplete. This made it difficult to determine exactly the sequence and timing of interventions. Key measures, including rubbing up a contraction or bimanual compression, were not documented.* (2022)

The CQC national review of maternity services in England (2022-2024) report found that potentially serious incidents, including massive obstetric haemorrhage, were at times normalised by many services where care was perceived to have followed guidance.[147] The Review also identified that incident investigation did not always translate into learning or measurable improvement, including reductions in PPH rates.

*In **2022**, a woman sustained a PPH following induction of labour and active management of the third stage. A staff member undertook appropriate postnatal observations and recognised, documented and responded to the initial blood loss. However, there was a delay in obtaining additional support being provided and transferring the woman to theatre. There was no evidence that a MOH protocol was activated, despite ongoing bleeding, with a total EBL of 2.5 litres and a subsequent haemoglobin of 77g/L.* (2022)

Staff Voices feedback to the Review Team suggest that a reluctance to activate the MOH protocol may reflect wider cultural and system-related factors on the labour ward. Several staff described challenges with emergency escalation systems, including concerns raised about the replacement of tannoy systems with emergency buzzers, with reports that these were either unreliable or not used consistently:

"The emergency buzzers in labouring rooms were not working and escalated to [senior management] and, via DATIX, [we] received no support to fix it". (2016)

"[There were] tannoy systems in labour rooms rather than emergency buzzers. These were replaced, but the [staff members] were too scared to use [them] and escalate. The [staff members] would not leave their desks". (2018)

"[Staff were] fearful of pulling the emergency buzzer. Staff shortages meant that staff were pulled from mandatory training". (2019)

147 Care Quality Commission (CQC) (2024) National review of maternity services in England 2022 to 2024. Available at: https://www.cqc.org.uk

Staffing pressures may contribute to a culture in which staff feel unable to speak up or raise concerns. Evidence from the 2024 Trust Intrapartum Forum indicates that resident obstetric doctors have reported feeling under pressure and vulnerable, and that midwives are encouraged to escalate concerns via the flow coordinator rather than directly medical staff, in an effort to manage workload.

6.5 Documentation

The Review Team identified multiple cases in which documentation was incomplete or key information was missing in the management of PPH and MOH. Inadequate documentation limits the ability to establish what interventions were undertaken and when, thereby impacting upon audit processes, organisational learning, and the provision of meaningful feedback to families. This was a consistent theme across all aspects of intrapartum care.

*In **2022**, a mother underwent induction of labour for post-maturity and had a spontaneous vaginal birth. Subsequently she experienced a MOH due to uterine atony and retained products, requiring examination under anaesthesia in theatre under general anaesthetic, with estimated blood loss of 3700ml. Whilst the clinical management of labour appeared appropriate and in line with guidance, documentation of the PPH was suboptimal, with no completed PPH proforma or audit documentation.* (2022)

6.6 Assessment of Risk Factors

Identification of risk factors for PPH enables implementation of preventative measures, including active management of the third stage of labour, appropriate planning of place of birth, and optimisation of modifiable factors such as anaemia. Effective risk assessment also facilitates timely involvement of the multidisciplinary team, which is recognised as a key factor in reducing maternal morbidity and mortality. The Review Team found that risk assessment was often omitted or not clearly documented, and was not consistently discussed with families to inform shared decision-making.

*In **2019**, a mother with a history of postpartum haemorrhage in her first pregnancy (estimated 1.1 litres) was admitted for induction of labour at 39 weeks for maternal request. Following artificial rupture of membranes, she was transferred to the Midwifery-Led Unit. There was no documented evidence that place of birth had been risk assessed or discussed, and the intrapartum risk assessment section of the notes was incomplete. Recognition and management of PPH was delayed, chaotic and did not follow Trust guidance. The emergency buzzer was not activated, and there was no cannula in situ, which would have been expected due to the mother's history of PPH and a group and save sample had not been taken. Consequently, the mother received un-cross-matched blood and the MOH protocol was not activated until transfer to theatre. There was an initial EBL of 500ml, however no cumulative total was maintained, and maternal observations were not documented following ongoing bleeding and prior to transfer. The total estimated blood loss reached 4.9 litres and subsequently the woman described believing she was going to die.* (2019)

This is contrary to NUH guidance, which recommends planned birth on a labour ward for women with risk factors including PPH requiring additional treatment or blood transfusion, and those undergoing induction of labour. The Review Team identified a lack of situational awareness and failure to consider fundamental elements of care in the following case:

*In **2017**, a mother with a previous forceps birth complicated by an intrapartum placental abruption and PPH had an uncomplicated subsequent pregnancy and a spontaneous vaginal birth with a second-degree perineal tear. Initial estimated blood loss following suturing was 200ml, however the placenta was documented as possibly incomplete, with a cotyledon missing. Approximately one hour later, the mother reported rectal pain and became hypotensive. A review identified a developing haematoma and she was transferred to theatre. During surgical management, there was uncertainty regarding the source of the bleeding. There was no clear evidence in the records that the possibility of retained placental tissue was considered as a contributing factor.* (2017)

Further evidence of failure to identify and act upon established risk factors is outlined below:

*In **2020,** a mother with multiple risk factors for PPH had no documented recognition of her elevated risk, nor evidence of preventative planning or precautions. Documentation was limited, with a 13-minute gap between delivery of the baby and recording of an estimated blood loss of 1800ml. There was no documentation of escalation, clinical planning, personnel in attendance, or activation of a MOH protocol. The placenta was delivered 19 minutes after birth, during which time the bleeding continued despite administration of uterotonic agents. Given the ongoing haemorrhage, immediate transfer to theatre for management of MOH and consideration of manual removal of the placenta (MROP) would have been appropriate at, or prior to, this stage. Instead, a decision was made to proceed with suturing in the room, despite documented poor uterine tone. During this time, blood loss increased to 3050ml. Transfer to theatre occurred only after administration of tranexamic acid and carboprost.* (2020)

*In **2022**, there was a delay in activating the MOH protocol and commencing a syntocinon infusion, despite blood loss exceeding 4 litres. The woman had two risk factors for PPH but the Review Team was unable to identify documented evidence of a formal assessment. Management of the third stage appeared appropriate.* (2022)

*In **2023**, a woman with a history of PPH of 1400ml in 2020, requiring a two-unit blood transfusion, was not identified as high risk at booking. She was not referred for consultant-led care. During labour, she was transferred to theatre for examination under anaesthesia, where placental tissue was removed, with an estimated blood loss of 1789ml.* (2023)

Improving the management of PPH has been a stated focus of senior clinical staff, as reflected in the NUH Intrapartum Forum minutes. Actions included raising awareness of PPH proformas through PROMPT training, review of pharmacological management, and the introduction of whiteboards in theatre to support accurate recording of cumulative blood loss.[148]

However, variation in practice between both sites was evident. Concerns were raised about delays in accessing Group O rhesus-negative blood during major obstetric haemorrhage (MOH), with reported delays of up to 25 minutes. Clinical staff have highlighted the absence of a blood fridge on the labour ward at QMC, which would enable more rapid access to emergency blood products.[149]

Whilst PPH remains a recurring focus within Forum discussions, there is evidence that implementation of changes has been slow. For example, agreement and rollout of the PPH proforma took over six months, indicating delays in translating identified issues into operational improvements.[150]

148 NUH, Intrapartum Forum Meeting Feb 2024 [internal document]

149 NUH Intrapartum Forum Meeting 12th March 2024 [internal document]

150 NUH Intrapartum Forum Meeting September 2024 [internal document]

Obstetric Anaesthesia

Introduction

Obstetric anaesthesia is a fundamental component of safe and effective maternity care. Anaesthetists play a critical role across the maternity pathway, including the provision of timely and effective labour analgesia, safe anaesthesia for operative birth, the management of obstetric emergencies and the care of the critically unwell woman. High-quality obstetric anaesthetic services are essential to support multidisciplinary working and the optimisation of outcomes for women and their babies.

The terms of reference for anaesthetic review were as follows:

- Severe pre-eclampsia (PET), HELLP syndrome, and/or eclampsia
- Major haemorrhage (>3500ml)
- Significant pre-existing maternal medical conditions
- Unexpected Intensive Care Unit (ICU) admission requiring ventilatory support
- Peripartum hysterectomy
- Concerns regarding anaesthetic management, including, but not limited to:
  - High spinal or epidural block
  - Failed intubation or unrecognised oesophageal intubation
  - Post-dural puncture headache (PDPH)
  - Neurological damage associated with anaesthetic interventions
  - Intraoperative conversion to general anaesthesia (GA)
  - Accidental awareness under GA
  - Significant intraoperative pain
  - Suboptimal management of labour analgesia following anaesthetist review request

In addition, further cases were reviewed where concerns were identified regarding a woman's anaesthetic or intensive care management, or where women reported poor maternal experience directly related to labour analgesia, anaesthesia, or care received in theatre or critical care settings.

It is important to recognise that some of the terms of reference for anaesthetic review may, by their nature, appear to represent adverse outcomes. In practice, however, such events may reflect appropriate, timely and safe clinical decision-making in the best interests of women and babies. For example, admission to critical care, conversion to general anaesthesia, or peripartum hysterectomy may represent timely, safe care which are indicators of high-quality practice rather than suboptimal care.

By focusing on a defined set of outcomes to trigger case review of care, the scope of this Review has inevitably been limited. While this approach was necessary within the methodological constraints of the process, it has restricted the ability to examine the full breadth of anaesthetic care, including the many occasions where care was delivered safely and outcomes were as expected or even better than expected. A full understanding of a complex system such as maternity care requires consideration of the entire spectrum of practice – both where care has fallen short and where it has worked well. Learning solely from adverse outcomes offers only a partial view, so equal emphasis must be placed on understanding the conditions, processes, and behaviours that enable safe, effective, and compassionate care. This ensures that these aspects can be identified, strengthened, and replicated across services. This approach aligns with contemporary Safety II principles and would support a more balanced, system-wide understanding of quality and safety in maternity care.

Gradings of Anaesthetic and ICU Care

381 cases were reviewed by the anaesthetic/ICU Review Team. The gradings were as follows:

GRADE OF ANAESTHETIC CARE	NUMBERS (PERCENTAGE)	SUMMATION
Grade 0	199 (52.2%)	Total grade 0 and 1 = 91.6%
Grade 1	150 (39.4%)	
Grade 2	30 (7.9%)	Total grade 2 and 3 = 8.4%
Grade 3	2 (0.5%)	
Total	**381**	

Overall, the anaesthetic care provided at Nottingham University Hospitals NHS Trust (NUH) was assessed to be of a high standard, with very good quality care delivered for the vast majority of women and their families. In 91% of cases reviewed, care was graded 0 or 1, reflecting practice where there were either no concerns – often with elements of excellent care – or only minor concerns that did not impact on clinical outcomes.

A smaller proportion of cases raised concerns. Thirty-two cases were graded as 2 or 3 (30 graded 2 and 2 graded 3). Although limited in number, these cases were examined in detail to identify recurring themes and opportunities for learning. Areas identified included suboptimal management of epidural analgesia in labour, including instances of intra-operative pain, alongside challenges in the management of major obstetric haemorrhage. In addition, there were occasions where escalation to senior support was delayed, and where recognition of the deteriorating woman could have been improved.

Importantly, while these findings highlight areas for improvement, the issues identified were not considered unique to NUH. Rather, they reflect challenges that are recognised across maternity services more widely within the NHS. This reinforces the importance of shared learning, system-wide improvement, and continued focus on early recognition, escalation, and optimisation of care to further enhance outcomes for women and their babies.

Both of the cases graded 3 related to medication errors occurring in theatre. The impact on women and their families was significant. These events highlight the reality that, within complex clinical environments, medication administration carries an inherent risk of error. Again, these safety challenges are not confined to NUH alone; they represent a persistent risk within anaesthesia practice on a global scale.

Whilst these incidents are deeply regrettable, the Review Team recognises that they occurred despite the best intentions of skilled professionals working within complex and high-pressure clinical environments. These cases illustrate the potential for harm where medication preparation and administration processes are vulnerable to both human and system factors. This highlights the need for continued focus on medicines safety across anaesthesia, particularly within obstetric practice. Strengthening safety systems remains essential. This includes the consistent use of standardised syringe labelling, clear separation of high-risk medications, minimising advance preparation of drugs, and the use of prefilled syringes where appropriate. Importantly, there remains a need to foster a psychologically safe culture that enables open reporting, reflection and learning from incidents and near misses.

Anaesthetic Service and Workforce

Over the period covered by this Review, maternity services nationally have been the subject of scrutiny and multiple independent inquiries, leading to substantial changes in clinical practice, governance arrangements and ways of working. Anaesthetic services at NUH have evolved commendably in response to these recommendations, with notable changes to systems, processes and workforce models over time.

At the time of this Review, the obstetric anaesthetic service at NUH met the Royal College of Anaesthetists' *Guidelines for the Provision of Anaesthetic Services* (GPAS): *Obstetric Anaesthesia* standards for

consultant presence on the labour ward. In addition to daytime provision, dedicated consultant cover is available during the evening, supporting timely senior decision-making and strengthening multidisciplinary input during evening ward rounds.

Dedicated consultant on-call rotas are in place for obstetric anaesthesia, with consultants also undertaking weekend morning ward rounds. The service provides a weekly antenatal anaesthetic clinic and a fortnightly postnatal follow-up clinic, promoting continuity of care, review of outcomes, and opportunities for learning. Many of these developments have been introduced in response to recommendations arising from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust and demonstrate a commendable and sustained commitment to improving the safety, quality and experience of care for women and their families.

The NUH multi-disciplinary team consistently highlighted the visible and continuous presence of consultant anaesthetists on the labour ward, noting its positive impact on fostering a supportive and less hierarchical working environment. This approach was seen to empower resident doctors, midwives, and other team members to raise concerns, seek advice, and escalate issues promptly. Many staff praised the anaesthetic team's approachability and the reliable, consistent staffing, which included timely consultant attendance when needed. This aligns with the growing emphasis on the importance of teamwork, compassionate, inclusive and approachable leadership, and the growth of civil and psychologically safe cultures, which are vital in ensuring safe care and improving outcomes for women and babies.

"Anaesthetic colleagues are really good, their staffing is good, and they always support." (2024)

"Good relations with anaesthetists, can call doctors in the middle of the night with no anxiety." (2024)

"Obstetric anaesthetists are amazing and supportive to everyone." (2024)

"The anaesthetic team is very supportive and helped build my confidence. There are generally good working relations between anaesthetists, obstetricians, and midwives." (2024)

"The obstetric anaesthetic leadership is very positive, proactive, and supportive. I felt confident in escalating clinical concerns." (2024)

"I've had a very long, happy working experience at NUH…The team is strong and cohesive. Even though it's busy, there are regular handovers, safety huddles, and formal meetings." (2024)

Although anaesthetic staffing levels met national standards, the team described increasing pressure on the service arising from increasing caesarean birth rates and growing requirement for epidural analgesia. Within this context, particular concerns were raised regarding the planning and day-to-day management of elective caesarean birth lists, with staff reporting that current arrangements contribute to inefficiencies in service delivery and adversely affect both women's care pathways and staff morale. As caesarean birth rates continue to rise nationally, there is an increasing need for consideration of clearer operational separation between elective and emergency activity to protect safety, support effective patient flow, and maintain the quality and timeliness of care for women and babies.

"There are challenges with managing elective caesarean birth list and insufficient staff causes inefficiencies: this clogs up labour suite, people get stressed and it's a mental burden." (2024)

"Planning and scheduling of elective lists is not organised or logical and not resourced properly." (2024)

The Trust's aspiration to offer elective caesarean birth lists staffed exclusively by female staff was viewed as a positive and compassionate initiative. However, staff expressed some uncertainty about how this model could operate in practice and whether it can be delivered consistently alongside existing service pressures:

"Women have been promised single-sex care, but logistically this just doesn't work." (2024)

"The Trust wants all-female elective list staffing, but this is not practical and I don't feel confident to raise that with Director of Midwifery." (2024)

Staffing shortages and increased staff turnover within the wider multidisciplinary team (MDT), particularly the lack of senior experienced midwives, were noted to impact anaesthetic care delivery. Several anaesthetists raised concerns about high turnover and insufficient support for critical care developments and other service innovation.

"High turnover of midwife managers means it's difficult to get buy-in for critical care developments". (2024)

"Worried about the introduction of midwife-led discharge by inexperienced midwives who've had no training for it." (2024)

Anaesthetists also frequently referenced the challenges within obstetric staffing and the impact this had on the wider team.

"Whilst the obstetric workforce has grown, many are currently off sick with stress, and there is always a shortage. They are always struggling to cover the rota. It feels like we're in crisis management all the time." (2024)

Anaesthetic Involvement in Antenatal Care

Anaesthetic involvement during the antenatal period is central to the assessment, counselling and care planning of women with identified risk factors, whether through dedicated antenatal anaesthetic clinics or review within the ward setting. Early anaesthetic input supports multidisciplinary management of complex pregnancies, facilitates anticipatory planning, and ensures that women receive clear information to enable informed, shared decision-making about their care.

The Review Team found consistent evidence that early anaesthetic involvement in complex cases led to effective senior-led multidisciplinary decision-making, improved care planning, enhanced safety, and a better experience for women at NUH. These benefits were evident across both clinic-based and inpatient care settings.

*In **2024**, a woman with a BMI of 80 had excellent MDT planning, which involved the maternal medicine network, manual handling teams, and consideration for transfer to a bariatric specialist hospital. She was seen by all members of the MDT antenatally and was extensively counselled and supported throughout her pregnancy.* (2024)

*In **2013**, a woman with sickle cell anaemia was invited to the anaesthetic clinic but did not attend. She later attended the labour ward when not in labour. The Consultant Anaesthetist covering labour ward took the opportunity to review her with her partner and mother. The consultation was extremely comprehensive and covered all potential aspects of her perinatal care and adhered to the Montgomery principles, providing clear, compassionate, and personalised communication of risk while addressing the woman's unique medical issues. The documentation was exemplary and reflected respectful, woman-centred care. The woman was grateful for the anaesthetist's time and thanked them at the end of the discussion.* (2013)

It is essential that clear and robust systems are in place to support the documentation of multidisciplinary team plans and decisions, ensuring that records are contemporaneous, comprehensive and readily accessible to all clinicians involved in a woman's care. This must extend to all members of the multidisciplinary team, including those providing care out of hours and colleagues from other specialties, such as emergency medicine.

There were instances where referral to the anaesthetic clinic was not made, or was delayed, despite the presence of clear risk factors. In some cases, this delay limited the opportunity for comprehensive antenatal planning, including timely involvement of the relevant specialties, appropriate allocation of clinical staff and preparation of the necessary equipment and environment for safe care. These findings highlight the importance of clear referral pathways, early identification of risk, and timely referral to specialist services to support coordinated multidisciplinary planning and ensure safe, well-planned, and woman-centred care.

*In **2017**, a woman with a known bicornuate uterus and suspected abnormally invasive placenta was not referred for antenatal anaesthetic assessment. At elective caesarean birth, she was found to have placenta*

percreta with an intra-abdominal pregnancy, resulting in a 6-litre postpartum haemorrhage and the need to convert to general anaesthesia. Mother and baby had good outcomes; however, earlier anaesthetic review could have supported improved counselling, consent and perioperative planning, including allocation of two anaesthetists and consideration of interventional radiology involvement. (2017)

Anaesthetic antenatal services have traditionally focused on managing and preparing for medical conditions during pregnancy and childbirth. However, there is increasing recognition that a woman's experience of care is crucial to achieving positive outcomes. The anaesthetic Review Team reviewed a number of women's accounts of trauma related to anaesthetic care, even when the care provided was of high quality.

*In **2020**, a woman with a significantly raised BMI and multiple risk factors for chronic pain was not reviewed in the antenatal anaesthetic clinic, likely due to service disruption during the COVID-19 pandemic. She later required an emergency caesarean birth, during which neuraxial anaesthesia was technically difficult and distressing for her, leading her to choose general anaesthesia. She has since developed chronic pain and significant disability, which she attributes to the anaesthetic intervention, although no organic cause has been identified. Antenatal anaesthetic review may have provided an opportunity to discuss the potential complexities of anaesthetic care in her case, including the challenges that might arise during emergency delivery, and to improve her understanding of possible events and interventions.* (2020)

The Review Team considers that some of the psychological harm described may have been mitigated had women been better prepared for their care, highlighting a potential need to strengthen antenatal education. Routine provision of clear, accessible and evidence-based information on anaesthesia and analgesia for birth as part of routine antenatal care may support women to understand their options and consider the potential risks and benefits. This is particularly important in the context of rising caesarean birth rates.

Anaesthetic Involvement in Intrapartum Care

a) Labour Analgesia

Over the review period, NUH implemented a number of system changes to improve the safety of epidural insertion. These changes include the introduction of two-practitioner checklists, a consent checklist, and structured documentation to encourage good practice and thorough recording of the insertion procedure.

Some women reported concerns relating to multiple attempts at epidural insertion or transient neurapraxia, which they associated with ongoing postnatal symptoms. The Review Team gave careful consideration to these accounts and found no evidence that poor epidural care at NUH was associated with persistent neurological injury or long-term neurological deficit.

Notwithstanding this, for a small number of women these experiences have had a significant impact on daily functioning and wellbeing. This reinforces the importance of clear, timely communication and follow-up, to support understanding, recovery, and confidence in care.

*In **2023**, a woman received an epidural for labour analgesia, which was effective throughout labour and delivery. In the postnatal period, she developed left-sided leg heaviness. She was promptly reviewed by an anaesthetist, who undertook and documented a comprehensive neurological examination, confirmed the absence of red flag features, and discussed the case with the consultant anaesthetist. Thereafter, she received daily review from the anaesthetic team alongside physiotherapy input. On the second postnatal day, she was assessed by the consultant anaesthetist, who found no clinical evidence of neuraxial complication but appropriately requested an MRI scan for reassurance, which was normal. Ongoing symptoms prompted further MRI imaging and review by several specialist teams, none of whom identified an organic cause. She has also been followed up in the anaesthetic outpatient clinic. Despite thorough multidisciplinary investigation and follow-up, she continues to experience significant functional disability related to her symptoms.* (2023)

Epidural analgesia does not always provide complete or consistent pain relief, and a proportion of women require review for further assessment and intervention, such as a top-up, catheter adjustment, or re-siting.

Where an anaesthetic review was requested, the Review Team found that responses were generally timely and that appropriate steps were taken to optimise analgesia. However, the Review identified variability in the quality of documentation relating to epidural reviews, particularly relating to recording of block assessment and interventions taken. Improving the consistency and clarity of documentation would support continuity of care, shared understanding within the multidisciplinary team, and reassurance for women receiving care.

*In **2018**, the anaesthetist clearly documented the consent process and insertion of the epidural. However, the woman's analgesia remained suboptimal, and midwifery records indicate that the anaesthetist administered three epidural top-ups in response. These additional doses were not documented in the anaesthetic record, nor were they prescribed on the drug chart or recorded on the epidural chart. There was also no documentation of sensory block assessment before or after these interventions.* (2018)

Inadequate labour analgesia is a recognised contributor to poor maternal experience. Timely recognition of a failing epidural is important in supporting both comfort and confidence during labour, but also safety if an operative delivery later becomes indicated. The Review Team identified instances where there appeared to be reluctance to offer re-siting of a failing epidural during labour. While it is important to consent women for the possibility that pain relief may not always be complete, repeated requirements for top-up doses should prompt consideration of senior involvement and evaluation of the need to offer to re-site the epidural.

*In **2024**, an epidural was inserted promptly following the woman's request, with clear documentation of both the consent process and the procedure itself. The anaesthetist was asked to attend multiple times due to a suboptimal block, but there was a significant delay in offering a re-site despite slow progress in early labour.* (2024)

There were also instances where problems with epidural analgesia were not escalated to the anaesthetic team when they should have been.

*In **2012**, a woman was induced for pre-eclampsia. She had an epidural inserted, but it was ineffective, and she continued to use Entonox throughout labour. The midwife did not communicate this to the anaesthetist, and the anaesthetist did not conduct a routine review. The woman was later taken to theatre for a forceps delivery which was done under epidural top up. She suffered a massive obstetric haemorrhage of 3.5L. Although the haemorrhage management was satisfactory, the woman reported pain throughout the procedure. Despite analgesia being administered, the documentation was poor. The only note made was that the woman was 'keen to avoid GA'. The woman recalled being told that pain was 'psychological'. This poor communication contributed significantly to her postnatal psychological morbidity.* (2012)

Cases of accidental dural puncture reviewed by the team were generally managed well.

*In **2024,** a woman developed a post-dural puncture headache following a seemingly straightforward epidural. Her baby was on NNU. She was thoroughly assessed and there was high-quality documentation. She was reviewed daily, sometimes in the NNU accommodation. Every time, the Review was thorough and of good standard. She was informed of her treatment options and provided with written information. There was evidence of safety netting and clarity about red flags. She was followed up on the phone and offered a postnatal anaesthetic appointment 2 months later, which she did not attend.* (2024)

b) Anaesthesia for Caesarean Birth and Assisted Vaginal Births

Rates of caesarean birth and obstetric intervention continue to rise nationally, with a corresponding increase in demand for anaesthetic input. At the same time, the obstetric population is becoming increasingly complex. More women are entering pregnancy with significant pre-existing conditions such as obesity, diabetes, cardiac disease, hypertension and mental health disorders. Maternal age is rising, bringing higher rates of co-morbidity, assisted conception and obstetric complication, while increasing numbers of women have complex surgical histories, including previous caesarean births, which raise the risks of adhesions, abnormal placentation and major haemorrhage. Advances in medicine also mean that more women with complex chronic conditions are now surviving into adulthood and pregnancy.

These changes create a maternity population with greater acuity, requiring more frequent senior anaesthetic involvement, more complex perioperative planning, and closer multidisciplinary coordination. This places growing pressure on maternity anaesthetic services and underlines the importance of well-designed systems, clear communication, and effective multidisciplinary working. Within the theatre environment, safe care depends on attention to human factors, strong clinical leadership, and collaborative teamworking delivered with professionalism and civility at all times.

Intra-operative pain remains a significant risk in obstetric anaesthesia and is recognised as a potential contributor to long-term psychological harm. The Review Team noted that women's experiences of pain may be compounded when they feel that their concerns are not listened to or believed. A number of cases were reviewed in which intra-operative pain was reported, many of which demonstrated good practice.

*In **2021**, assessment of neuraxial block adequacy was undertaken in accordance with accepted standards and indicated that surgery could proceed. Despite this, the woman reported pain once surgery had commenced. Her concerns were listened to, believed, and acted upon promptly. The surgical team was asked to stop, additional analgesia was administered, including alfentanil and paracetamol, and senior support was escalated without delay. Conversion to general anaesthesia was offered early, clearly documented, and undertaken safely with consultant involvement.* (2021)

The Review Team highlighted a small number of cases where intra-operative pain management was not as effective as it should have been. While such instances were rare, poor intra-operative pain management emerged as one of the most significant anaesthetic themes of the Review. In these cases, many women described profound distress and lasting psychological impact, with some reporting that the experience had influenced, or would influence, their decision about having further children.

*In **2015**, a woman reported pain during her caesarean birth and recalled being able to move her legs, consistent with the anaesthetic record. She was offered conversion to general anaesthesia but declined because she did not wish to miss the birth of her baby. She recalls also being offered ketamine, which she declined because she was concerned it might affect her memory of the birth; however, there is no documentation in the anaesthetic record to confirm that this option was discussed. She therefore remained awake and proceeded using Entonox alone, although this did not provide adequate pain relief. The anaesthetic record does not clearly document the full range of analgesic options offered, nor does it provide a contemporaneous account of the discussions held with the woman regarding her choices and decision-making. This case highlights the importance of clear communication, respect for maternal choice, and accurate documentation when managing pain during caesarean birth.* (2015)

Significant variation was identified in the assessment and management of pain during caesarean birth. Greater standardisation of practice, underpinned by clear clinical guidance and structured documentation, would support a more consistent, systematic and stepwise approach to care, particularly for less experienced anaesthetists. Documentation tools should incorporate explicit prompts for timely senior involvement, facilitating earlier escalation. Consideration should also be given to the routine measurement and recording of intraoperative pain, to improve recognition, response, and ongoing audit of women's experiences during caesarean birth.

Several cases of high neuraxial block were identified during the Review. In each instance, the complication was recognised promptly and managed safely, with care delivered in accordance with accepted clinical standards.

A review of cases requiring intra-operative conversion to general anaesthesia found that procedures were conducted safely and in line with established standards of obstetric anaesthetic practice.

A small number of cases involved challenging airway management, although no woman came to harm. These cases nevertheless underline the critical importance of thorough preparation, heightened vigilance, and effective multidisciplinary communication in the management of the obstetric airway. Safe care depends on anticipating potential airway difficulty, ensuring that clear management plans are agreed and communicated across the multidisciplinary team, and maintaining readiness to respond rapidly should

complications arise. Given the continuing evolution of airway equipment and techniques, updated national guidance specific to obstetric airway management would support greater standardisation of practice and help ensure consistent access to appropriate equipment and training across services.

Common Obstetric Presentations

a) Haemorrhage

Major obstetric haemorrhage was the most common reason for anaesthetic review. Many cases demonstrated high-quality, senior-led care with clear evidence of robust MDT working, timely escalation, and adherence to established major haemorrhage protocols.

*In **2017**, a grand multiparous woman was admitted at 26 weeks' gestation in spontaneous labour with suspected placenta accreta. As she was fully dilated, she was taken to theatre for a vaginal birth. Preparation included insertion of two large-bore cannulas and an arterial line. Following delivery, she developed brisk blood loss. A general anaesthetic was administered and a Swan sheath inserted. Despite removal of the placenta, bleeding continued, prompting timely attendance by interventional radiology and successful embolisation. The woman was extubated at the end of the procedure and discharged on postoperative day two. This case demonstrated strong senior MDT working, timely intervention, and careful attention to detail, resulting in maintained cardiovascular stability and early discharge.* (2017)

*In **2023**, an unanticipated MOH occurred during an elective caesarean birth for a previous caesarean birth. There was clear, contemporaneous documentation of updates provided to the woman and family, alongside early involvement of interventional radiology, gynaecology, and critical care. The woman remained awake and fully informed throughout the haemorrhage, transfer, and embolisation of a right uterine artery arteriovenous fistula, before returning to labour ward care supported by critical care nursing. Documentation, including structured proformas and free-text entries, was of an exceptionally high standard. There was clear evidence of high-quality clinical and pastoral care during an unexpected life-threatening emergency.* (2023)

*In **2014**, a woman developed DIC secondary to placental abruption, with thrombocytopenia, hypofibrinogenaemia, and prolonged APTT. This was recognised and treated promptly, enabling reversal of the coagulopathy. Additional good practice included active warming and calcium replacement. Documentation demonstrated careful attention to details including arterial blood gas results and clear recording of escalation and timings of senior support. The woman was managed in recovery while awaiting an ICU bed and subsequently received ICU care. She was supported to see her baby, with her partner present for much of her admission, and was discharged on day five following physiotherapy input.* (2014)

However, a small number of cases identified key areas for learning. These included delayed recognition of women at risk of bleeding, failure to promptly identify active bleeding, delays in assembling the team when bleeding was suspected, slow activation of the MOH protocol, and delays in the availability or administration of blood products. Addressing these gaps is vital to improving both response times and woman outcomes.

*In **2014**, a woman undergoing manual removal of placenta required anaesthesia in the context of ongoing haemorrhage. At the time of theatre transfer, she was already tachycardic and hypotensive, indicating significant physiological compromise. A spinal anaesthetic was administered; however, bleeding continued and her condition deteriorated further, with profound cardiovascular instability and a heart rate exceeding 160 beats per minute. Point-of-care haemoglobin testing subsequently revealed a critically low haemoglobin concentration of 4.5 g/dL. Despite these life-threatening findings, there was a delay in initiating a major obstetric haemorrhage call, and senior anaesthetic support was not sought in a timely manner. No documented postnatal follow-up was undertaken by the obstetric or anaesthetic team.* (2014)

*In **2011**, a woman underwent a category-2 caesarean birth for slow progress in labour. Despite a significant perioperative haemoglobin drop, tachycardia, and estimated blood loss of 1200 ml, she was discharged from recovery to the ward. She subsequently became hypotensive and required urgent return to theatre, where more than 5 litres of blood was found intra-abdominally. Although haemoglobin and coagulation were*

rapidly corrected, she developed transfusion associated circulatory overload and required ICU admission for non-invasive ventilation. (2011)

*In **2013**, a woman undergoing category-2 caesarean birth for brow presentation had a blood loss of 2 litres. Despite hypotension and tachycardia at the end of surgery, the MOH protocol was not activated and senior surgical review was not requested. Recovery staff appropriately recognised deterioration and escalated care, leading to timely return to theatre and definitive surgical management. The woman made a full recovery following ITU admission.* (2013)

In some cases, particularly where the anaesthetic team was less experienced, there was evidence of difficulty in recognising and treating coagulopathy, most notably hypofibrinogenaemia, in a timely manner. While near-patient testing offers rapid and clinically valuable information, its effectiveness is dependent on appropriate interpretation and timely action.

*In **2018**, a woman developed disseminated intravascular coagulation (DIC) following caesarean birth with a major obstetric haemorrhage. The most senior anaesthetist immediately present was an ST4 trainee, with no documented evidence of consultant anaesthetic involvement at this critical stage. Although the coagulopathy was ultimately recognised and managed, there were delays in key decision-making and missed opportunities for earlier intervention that may have limited progression of the DIC. Near-patient coagulation testing was undertaken; however, concerns were identified regarding both the frequency of testing and the interpretation of results. Laboratory investigations demonstrated critically low fibrinogen levels, which should have prompted earlier and more aggressive replacement therapy.* (2018)

In some cases, earlier involvement of the anaesthetic team may have facilitated more effective multidisciplinary planning, supported timelier coordinated decision-making, and enabled clearer, more proactive communication with women about the anticipated management of obstetric haemorrhage.

*In **2014**, a woman presented with IUD secondary to abruption. She was clinically stable. Antenatal bloods revealed DIC with a critically low fibrinogen. The haematology team were involved immediately, but the anaesthetic team were not. She was given FFP and cryoprecipitate but went on to have a 1000ml PPH after vaginal birth. The obstetrician was called, but the anaesthetic team were not. The woman stopped bleeding but opportunities to involve the anaesthetic team were missed threatening the safety of the mother (fibrinogen was 0.6 at the time of delivery).* (2014)

b) Severe PET or HELLP, Eclampsia

Women with severe pre-eclampsia or HELLP syndrome should receive prompt anaesthetic review, followed by timely multidisciplinary discussion to ensure coordinated and holistic management. Anaesthetists have a pivotal role in these cases, contributing specialist expertise to fluid balance, analgesia, haemodynamic stabilisation, blood pressure management, and the planning of safe perioperative and critical care pathways.

*In **2019**, a woman was diagnosed with intrauterine death complicated by HELLP. A senior anaesthetic review was conducted, and general anaesthesia was administered for a Category 2 caesarean birth due to coagulopathy. Throughout the perioperative period, there was effective multidisciplinary collaboration and communication. Postoperatively, the woman was transferred to ICU, sedated and ventilated to allow correction of metabolic and haematological abnormalities. Sedation and ventilation were successfully weaned the following day.* (2019)

However, there were also cases in which women received suboptimal care as a result of delayed or absent anaesthetic involvement, limiting opportunities for timely specialist assessment, multidisciplinary planning, and optimal management of complex clinical needs.

In most cases of eclampsia, the anaesthetic team had not been involved in the woman's care prior to the seizure, potentially indicating missed opportunities for earlier anaesthetic involvement and multidisciplinary planning in these high-risk pregnancies. Despite this, the emergency management of eclampsia was consistently of a high standard and aligned with accepted clinical practice. However, the Review identified cases in which earlier escalation by resident anaesthetists to consultant level would have been appropriate, reinforcing the importance of senior involvement in the management of these complex cases.

*In **2016**, a woman with a concealed pregnancy presented to ED with a seizure. Eclampsia was rapidly diagnosed and the obstetric and anaesthetic team attended promptly. The woman was transferred to the labour ward, where they were stabilised before undergoing a category-2 caesarean birth. An ST3 assessed the woman and elected to perform a GA despite normal platelets. No consultant was informed of the eclamptic seizure or involved in the decision-making/care in theatre. This woman could have been considered for a spinal as her platelets were normal. No harm resulted from the GA.* (2016)

*In **2020**, an anaesthetist responded promptly to an eclamptic seizure and coordinated the woman's subsequent transfer to theatre for emergency caesarean birth. Following delivery, she was appropriately managed in critical care and transferred for CT head as part of her ongoing assessment. The acute clinical management undertaken by the ST6 anaesthetist was timely and effective; however, there was no documented evidence of consultant discussion or escalation for additional senior support during this high-risk event. The absence of senior involvement may have contributed to shortcomings in contemporaneous documentation, which was notably limited throughout the acute episode.* (2020)

c) Significant Maternal Medical Disease and other High-Risk Pregnancies

The majority of cases demonstrated timely and appropriate anaesthetic involvement, which supported effective MDT communication, coordinated care, and woman-centred decision-making.

*In **2011**, a woman with a twin pregnancy was seen on labour ward by the anaesthetist. She was pre-emptively consented for neuraxial and general anaesthesia. She delivered twin 1 in the room but was taken to theatre for twin 2 due to bleeding and the presenting part was high. Several resident doctors failed to site the spinal anaesthetic in theatre. The consultant was called, who recommended a GA. At caesarean birth, there was evidence of abruption and MOH. This was treated expediently with uterotonics, tranexamic acid and blood products. In recovery, she desaturated and was reviewed by the anaesthetist. She was extensively investigated by cardiology and the anaesthetic team. The Critical Care outreach team also regularly reviewed. She gradually improved over the next 24 hours. Elements of good care relate to proactive decision-making, frequent and early consultation and excellent and thorough MDT working. Documentation was also excellent.* (2011)

However, the Review identified a small number of cases where earlier anaesthetic involvement may have been beneficial for women who were clearly unwell or at risk of requiring imminent operative intervention. These findings highlight missed opportunities to strengthen multidisciplinary team working and to ensure timely, proactive engagement of anaesthetic teams.

*In **2021**, a woman with overwhelming sepsis was tachycardic, hypotensive and febrile with a MEWS score of 10. The blood gas was highly abnormal. Despite this, the anaesthetist was not asked to review the woman for 70 minutes.* (2021)

*In **2022**, a woman developed severe pre-eclampsia at 26 weeks gestation necessitating consultant input from NICU, obstetrics and cardiology on labour ward. Emergency caesarean birth proceeded three days later after acute deterioration with hypoxia. The first documented anaesthetic review occurred at this point. Clinical and operative care was very good, although anaesthetics should have been included in the MDT care of the woman much sooner.* (2022)

Clear guidance on when consultant input should be sought can support staff in making timely and appropriate escalation decisions. This must be underpinned by a culture in which seeking senior advice is actively encouraged, valued and regarded as a fundamental component of safe clinical practice, reflective learning and high-quality patient care.

Anaesthetic Involvement in Postnatal Care

NUH demonstrated strong practice in the follow-up of women during their inpatient stay and, where required, through outpatient review clinics. When concerns relating to clinical care or maternal experience were identified prior to discharge, women and their birth partners were frequently offered consultant-led

debriefing before leaving hospital. These discussions were typically compassionate, open and honest, providing timely explanation, reassurance and an opportunity to address questions or concerns. In many cases, this early supportive engagement was of considerable value to women and reduced the need for further outpatient follow-up.

*In **2022**, a woman experienced a PPH following delivery of her third baby and was rapidly transferred to theatre, receiving blood, uterotonics, and general anaesthesia. A Bakri balloon was inserted expediently, successfully arresting the haemorrhage. She was extubated, managed on the labour ward, and discharged a few days later. She had been seen in the antenatal anaesthetic clinic due to raised BMI, had consultant presence during theatre, and was debriefed soon after by the anaesthetic consultant. The woman fed back:*

"from my perspective everyone acted with care, efficiency and skill during this delivery. The team were compassionate and comforting and did everything they possibly could to make me feel safe and aid my recovery" and *"I want to reiterate I think generally the care I got was excellent. The team during my third delivery, put simply, saved my life."* (2022)

Examples of good in-hospital follow-up demonstrate the value of early, coordinated, multidisciplinary care:

*In **2018**, a woman developed foot drop postnatally after an epidural with forceps delivery in lithotomy position. She was promptly and regularly reviewed by the anaesthetic team, with extensive neurological examinations documented. Neurologists confirmed a peroneal nerve neurapraxia due to positioning. She was appropriatly referred for occupational therapy, physiotherapy, and was seen in clinic three months postnatally. However, although she was seen soon by physiotherapy, the occupational therapy referral never materialised.* (2018)

*In **2024**, during an elective caesarean birth, two apparently uncomplicated spinal anaesthetics failed to achieve an adequate surgical block, necessitating conversion to general anaesthesia before surgery commenced. Following induction of general anaesthesia, the woman developed anaphylaxis, requiring urgent treatment and stabilisation.*

The subsequent care was notable for its high quality. Documentation from both the immediate and later postnatal period was clear, comprehensive and holistic, addressing acute clinical management as well as longer-term follow-up. This included coordinated planning for immunology investigation, psychological debriefing, and ongoing anaesthetic review. (2024)

The consultant-led postnatal anaesthetic clinic at NUH was identified as a strength. The clinic provides a space for reflection, explanation, and future pregnancy planning, with clear evidence that maternal wellbeing is prioritised. Documentation demonstrated thoughtful, individualised follow-up and clear communication.

*In **2016**, a woman who had a MOH and ICU admission during a previous pregnancy was identified as high risk in a subsequent pregnancy. She was referred to the anaesthetic clinic. This referral provided an opportunity for debriefing and significantly improved her experience in subsequent pregnancies.* (2016)

*In **2023**, a woman underwent caesarean birth for twins and developed significant haemorrhage in recovery, requiring urgent return to theatre. Prompt multidisciplinary team working enabled rapid stabilisation, coordinated emergency management, and timely transfer to critical care while awaiting interventional radiology. When the woman was unable to attend her planned postnatal follow-up appointment with the consultant anaesthetist, a comprehensive debrief letter was sent to her, clearly explaining the events of her care and providing an opportunity for ongoing understanding and follow-up.* (2023)

However, the Review Team also found instances where postnatal follow-up and debriefing were either inadequate or entirely absent, exposing a significant risk of women being left without vital explanation or support after complex or distressing care. The barriers to effective debriefing were multifaceted, including staffing pressures, a lack of visibility of cases requiring follow-up, and inconsistent handover processes that hindered comprehensive follow-up.

*In **2014**, a woman was induced for an intrauterine death. Her first epidural became dislodged. Re-siting the epidural was challenging; eventually an accidental intrathecal catheter was sited. Despite regular top-ups,*

analgesia was poor. The woman eventually opted for PCA but became increasingly distressed. After a vaginal birth, she had a 2L PPH. She received no outpatient follow-up. (2014)

Documentation

Anaesthetic documentation provides an important record of a mother's maternity experience, including assessments before and during labour, details of intra-operative status, drug administration, and post-operative instructions, visits, and debriefs.

Documentation has evolved significantly over the review period, both within NUH and nationally. At NUH, documentation, including the anaesthetic chart, has been deliberately designed to support safe clinical practice and ensure comprehensive, contemporaneous record-keeping. Structured prompts, such as recording the intra-operative log and 'time consultant called', reinforce the expectation of timely escalation and senior involvement, thereby embedding consistent standards of care and accountability. The Review Team considers this to be an example of positive and proactive practice development.

*In **2018**, a woman undergoing planned caesarean birth under general anaesthesia suffered anaphylaxis. There is evidence of high-quality clinical care, leadership, teamwork, documentation and follow up. The documentation in use by the Trust in 2024 was noted to actively promote quality care. This included the anaesthetic charts, obstetric critical care checklist, and intra-hospital transfer paperwork.* (2018)

Many earlier cases reviewed at NUH highlighted gaps in anaesthetic documentation, a pattern that may well be reflected nationally. While incomplete documentation does not necessarily indicate substandard care, it can reduce clarity in the woman's journey and limit communication across the multidisciplinary team.

*In **2017**, a woman had a category 1 caesarean birth under spinal for suspected abruption. She went on to have a 3.5L PPH and required a general anaesthetic. Despite a senior staff member being present, there was no documentation in the anaesthetic notes about the general anaesthetic, such as drugs used, timings and intubation. There was also no narrative documentation of symptoms reported or discussion with the woman. The outcome was good for the woman, but the lack of documentation was concerning.* (2017)

*In **2017**, a woman bled during caesarean birth. Whilst the maternal outcome was good, the anaesthetic documentation in this case is very poor. There was no documentation of pulse, urine output, temperature, blood loss, or blood results. Atropine and glycopyrrolate were also given, with no explanation as to why.* (2017)

There have been several occasions where anaesthetists' reviews were not properly documented; the only record often appears in midwifery notes.

*In **2020**, a woman had an epidural in labour. She required an epidural top up for an instrumental delivery in the room. The notes state that an anaesthetist attended and topped up the epidural, but there is no record of what was given and assessment of the block. The woman reports that she had a dangerously high block. The lack of documentation about the top-up made this case very difficult to assess.* (2020)

Anaesthetists who respond to emergency calls or bleeps frequently leave no documentation. Similarly, MDT discussions and ward rounds are sometimes undocumented, even though these may have important clinical implications. When a consultant is called, it is essential to document the time of the call, their arrival time, the assessment performed upon arrival, and any interventions, preferably in a narrative format.

The shift from paper to electronic record keeping has without doubt improved legibility and created clearer structures. This together with the redesign of anaesthetic charts, appears to have enhanced documentation quality, although occasional deficiencies persist. It remains essential that documentation accurately reflects factual events and relevant metrics, and just as importantly, woman interactions and conversations. Key aspects of anaesthetic care should be embedded in discharge summary documentation to ensure safe continuity of care based on events and risk factors experienced, and so that the discharge documentation reflects the woman's overall maternity experience.

Governance, Learning, Innovation and Improvement

Whilst maternity governance at NUH is considered elsewhere within this report, anaesthetic governance at the Trust currently sits outside the maternity governance framework. The Review Team heard from a number of staff that this separation of governance limits opportunities for multidisciplinary learning and shared oversight. In particular, concerns were raised that anaesthetists were not consistently informed of rapid reviews relating to maternity care. This has the potential to result in missed opportunities for shared reflection, dissemination of learning, and the alignment of improvement actions across professional groups.

"The separation of maternity governance from anaesthetic governance means some learning gets lost." (2024)

Despite the lack of full integration within the wider maternity governance framework, there was clear evidence of a strong commitment to learning and improvement within the anaesthetic team. The team demonstrated a proactive approach to reviewing incidents and adverse events and showed positive intent to promote a supportive culture that encourages escalation of concerns and reflective practice.

"There was good anaesthetic governance relating to maternity critical care admissions to share learning. The residents felt that there were good processes for learning and rectifying mistakes and did not see a blame culture, rather a good safety culture." (2024)

"We go through woman debriefs or complaints in an MDT forum which are a productive way of learning and improving." (2024)

There was also a strong desire to implement improvements to systems and processes. This commitment to learning was reflected not only in efforts to strengthen governance structures and operational processes, but also in the behaviours and professional practice observed within the team.

*In **2018**, a woman experienced a medication error during her care. The error was recognised promptly, appropriate immediate action was taken, and senior support was summoned without delay. As a consequence of the clinical deterioration that followed, an emergency category-1 caesarean birth under general anaesthesia was required.The response to this incident demonstrated good practice in both clinical management and duty of candour. The woman and her family were given timely, open and honest explanations by senior clinicians, with clear acknowledgement of the harm caused and multiple sincere apologies. She received regular senior review throughout her recovery. The subsequent governance response was robust, with thorough investigation of the incident and implementation of changes designed to reduce the risk of recurrence. A full debrief was provided, and the woman and her family were offered comprehensive ongoing support.* (2018)

*In **2022**, a woman received a high block after an unrecognised intrathecal catheter. There was excellent anaesthetic governance after this with updates to the obstetric epidural guidelines, improved induction, improvement of the obstetric anaesthetic handover to ensure it was structured, objective and specific supported with acronyms*. (2022)

However, the Review Team identified incidents where governance processes were inadequate:

*In **2020**, an epidural top-up was requested for a ventouse delivery in the room. A large dose of local anaesthetic was administered, without documented assessment of pre-existing block height. There was also no additional monitoring. After delivery, the woman experienced a high epidural block with vomiting and severe hypotension requiring vasopressors. The anaesthetic team attended. There was a delay in return to normal neurological function after delivery, requiring an MRI lumbar spine, which was normal. The incident review from this case took three years to occur, after significant personal effort by the woman seeking understanding of the events of her delivery. Reflection, learning and action from this case were deemed insufficient. The mother transferred her care to another trust for her next pregnancy.* (2020)

Women's Experience of Anaesthetic Care

Maternal experience lies at the heart of quality maternity care. For many women and families, childbirth is one of the most significant and emotional events of their lives. The anaesthetic team plays a pivotal role in

shaping this experience, not only through the delivery of safe and effective analgesia and anaesthesia, but also through the provision of compassionate, respectful and individualised care. Anaesthetists are often the clinician providing reassurance, explanation and continuity during surgery, frequently at moments of heightened fear and vulnerability. They may also act as a conduit for information about events in theatre, including neonatal care, supporting women and their partners at a time of profound uncertainty.

Compassion, kindness and respectful communication have been consistently identified in national maternity reports as fundamental to the delivery of safe, effective and woman-centred care. Although workforce pressures and service constraints can reduce the time available for staff to provide the level of care they would wish, this review found clear evidence that, within NUH, women's individual needs remained central to the delivery of anaesthetic care. Across the cases reviewed, staff demonstrated flexibility, empathy and professionalism, adapting their approach to support not only clinical safety but also the emotional and psychological wellbeing of women and their families. This reflects a strong commitment within the service to maintaining compassionate, woman-centred care even in challenging circumstances.

*In **2025**, a couple experienced an unexpected neonatal death. The baby was critically unwell at delivery. The anaesthetist was described as outstanding and very supportive, calm and reassuring throughout:*

"But he was very calm through the whole thing, talked us through it. He even talked us through what else was going on in the room to try and explain stuff to us because, as I said earlier, I've never had major surgery." (2025)

Maternal Critical Care

Although most women in the UK experience healthy pregnancies and safe childbirth, the landscape of maternal health is changing. Rising maternal age, increasing obesity rates, and a higher prevalence of chronic disease have contributed to a growing number of women becoming acutely unwell during pregnancy, delivery, or the postpartum period. Socioeconomic and racial inequalities further compound these risks.

Understanding the true burden of maternal morbidity remains difficult due to inconsistent terminology and fragmented data collection. Terms such as 'maternal critical care' and 'obstetric critical care' are often used interchangeably, yet each excludes important groups of women. Research suggests that for every maternal death, 70–90 women experience severe morbidity, and approximately 2.4 per 1,000 births result in a critical care admission (The National Maternity and Perinatal Audit Maternity Admissions study into intensive care in England, Wales and Scotland 2019[151] World Health Organization (WHO)[152]). However, these figures underestimate the true incidence, as many unwell women are managed outside traditional critical care settings and therefore not captured in national datasets, such as Intensive care national audit and research centre database.[153]

Definitions of maternal mortality also vary. The WHO limits the definition to deaths occurring during pregnancy or within 42 days of termination, whereas UK Maternal Confidential Enquiries extend this period to one year postpartum (a late maternal death being defined as one occurring between 42 days to 1 year after the pregnancy...). These inconsistencies hinder accurate surveillance and service planning (2,5).

Recognition of Critical Illness in Pregnant Women and Mothers

A recurring theme identified across the cases reviewed was delay in the recognition of the sick and deteriorating woman. This occurred across a range of clinical areas, including the labour ward, maternity wards, and other departments within the Trust.

151 Jardine J, NMPA Project Team: Maternity Admissions to Intensive Care in England, Wales and Scotland in 2015/16: A report from the National Maternity and perinatal Audit: London: RCOG;2019

152 World Health Organization. Sustainable Development Goals 3.1 Maternal mortality: by 2030 reduce the global maternity mortality ration to less than 70 per 100 000 live births. https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality
GHO- Indicator Metadata Registry list. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

153 Intensive Care National Audit and research Centre. Case Mix Programme. https://www.icnarc.org/Our-Audit/Audits/Cmp/About

Recognising clinical deterioration in pregnant and recently pregnant women presents particular challenges. The physiological adaptations of pregnancy, including increased heart rate, reduced systemic vascular resistance, and altered immune responses, may mask or mimic the early signs of serious illness. As a result, early warning systems developed for the general adult population may be inappropriate for use in maternity settings[154]. Despite NUH having an obstetric-specific early warning score (OEWS) and established guidelines for the management of sick and deteriorating maternity womans, the Review identified cases where care fell short of these standards:

- OEWS was not consistently used.
- Escalation pathways were not followed.
- Clinical deterioration continued without timely senior review.

These findings highlight gaps in adherence to established protocols, with potential implications for the timely recognition and management of serious maternal illness.

*In **2022**, a multiparous woman attended triage at 33 weeks with reduced fetal movements. EWS was 12 on arrival. A profound compensated metabolic acidosis on venous blood gas testing failed to trigger review or escalation to critical care. Inadequate resuscitation of the mother may have contributed to a poor CTG trace, which prompted a possibly avoidable emergency caesarean birth.* (2022)

To improve recognition of the deteriorating pregnant or recently pregnant woman, NUH developed a Maternal Critical Care Education Programme in 2023, in line with national recommendations[155]. All CCOT and critical care nurses now undertake maternity-specific competency training every three years, and a nurse with this training is rostered on every shift. This ensures that specialist knowledge is available at all times to support timely recognition and escalation of maternal deterioration.

Early multidisciplinary input is essential when maternal critical illness develops, ensuring timely, coordinated decision-making around maternal stabilisation and potential birth.

*In **2021**, a COVID-positive woman with multiple risk factors was managed by a multidisciplinary team including obstetrics, anaesthetics, respiratory medicine and critical care. Clear, coordinated plans were made for both maternal and neonatal care. Antenatal optimisation included administration of magnesium sulphate and corticosteroids in preparation for potential preterm birth. Regular MDT reviews ensured the plan was updated as the mother's condition evolved. As her clinical status continued to deteriorate, the decision was made to proceed with delivery at 30 weeks' gestation.* (2021)

However, other cases demonstrated fragmented communication, delayed involvement of key teams, and a failure to reconsider the diagnosis when women did not respond to treatment.

Pregnant and recently pregnant women can develop conditions unrelated to pregnancy. Maintaining a broad diagnostic perspective beyond pre-existing or pregnancy-specific conditions is essential to safeguarding maternal and fetal outcomes. The Review Team identified several cases where diagnostic fixation contributed to delays and suboptimal care.

*In **2012**, a woman with a history of occipital trigeminal neuralgia, presented to the ED twice, with worsening headache, photophobia, and a low-grade temperature. She was subsequently admitted with a diagnosis of meningitis, but was not started on antivirals. She subsequently had two seizures. The decision was made to proceed to an emergency caesarean birth under GA at 33+1 weeks of gestation.* (2012)

154 Gerry S, Bedford J, Redfern OC, Rutter H, Chester-Jones M, Knight M, Kelly T, Watkinson PJ. Development of a national maternity early warning score: centile-based score development and Delphi informed escalation pathways. BMJ Med. 2024 May 15;3(1):e000748. doi: 10.1136/bmjmed-2023-000748. PMID: 38756669; PMCID: PMC11097818.

155 Critical Care Outreach Practitioner Framework, including appendix 1 National Outreach Forum, Intensive Care Society and Critical Care Networks - National Nurse Leads (2022) http://cc3n.org.uk/uploads/9/8/4/2/98425184/critical_care_outreach_practitioner_framework.pdf. Intensive care society, critical care networks national nurse leads. Appendix1: enhanced critical care outreach competencies

Metabolic Acidosis

Any cause of metabolic acidosis should be promptly recognised and managed in order to avoid fetal acidaemia, hypoxia and even intrauterine death. Severe metabolic acidosis in pregnancy is usually secondary to diabetic ketosis, sepsis or rare metabolic conditions, but can be caused by starvation or poor nutrition. Metabolic changes in pregnancy make pregnant women more susceptible to starvation ketosis than non-pregnant women, and therefore a relatively short fasting period may provoke ketosis, especially in the 2nd and 3rd trimesters. Prompt recognition is critically important as it is easily treated with carbohydrate administration and consideration of an insulin infusion[156].

*In **2021** a woman was admitted with increasing shortness of breath at 37 weeks. She had tested positive for COVID. She had a high respiratory rate. The full MDT were involved and she was managed in the labour ward with an arterial line in situ. A blood gas showed a compensated metabolic acidosis with a raised ion gap. She had 4+ of ketones in her urine. This compensated metabolic acidosis was not recognised as a potential cause of her high work of breathing. She continued to deteriorate and had an emergency caesarean birth.* (2021)

There were several other cases of severe metabolic acidosis necessitating urgent caesarean birth and admission to critical care.

Location and Delivery of Maternal Critical Care

The principle underpinning maternal critical care is that women must be cared for by clinicians with the appropriate competencies, in the most suitable environment for their condition and gestation[5,157,158,159,160].

There are three main locations where these women can be cared for:

- labour ward
- critical care or high dependency units
- medical/surgical ward

Whilst all areas have inherent risks and benefits, proactive, collaborative and flexible MDT working can ensure provision of safe care in any of these locations. NUH does support enhanced maternity care on the labour ward, supported by ICU nurses when required (an example of excellent service provision). However, there were some cases that would have benefitted from this model but did not receive it.

*In **2017**, a woman presented in spontaneous labour. She had 2+ of ketones in her urine. She was advised to drink more. She subsequently developed hyponatraemia and hypochloraemia, which resulted in a seizure after birth. Her sodium was 114. Had the enhanced maternity care model been utilised, fluid balance and ketosis might have been better managed and she might not have had a seizure.* (2017)

Wherever care is delivered, the correct maternal observation chart must be used, and clear documentation should outline when and how to activate an obstetric emergency response. The NUH Maternal Critical Care Guideline (version 2) includes maternal safety alert posters and key contact information. The Review Team observed examples of excellent practice in the use of an obstetric checklist when women were admitted to critical care.

Admission to critical care represents a deeply distressing experience for women, often arising suddenly

156 Abraham L, Ning X, Whitlatch HB. Starvation Ketoacidosis in Pregnancy: An Unusual Presentation and Brief Literature Review. JCEM Case Rep. 2024 Aug 16;2(9):luae145. doi: 10.1210/jcemcr/luae145. PMID: 39156003; PMCID: PMC11327118.

157 Cranfield, K., Horner, D., Vasco, M., Victory, G. and Lucas, D.N. (2023), Current perspectives on maternity critical care. Anaesthesia, 78: 758-769. https://doi.org/10.1111/anae.15948

158 Royal College of Anaesthetists. Care of the critically ill woman in childbirth: enhanced maternal care. 2018. https://www.rcoa.ac.uk/media/6591

159 Critical care networks-national nurse leads, National Competency Framework for registered nurses in Adult Critical Care, Maternal Specialist Competencies. http:///www.cc3n.org.uk/uploads/9/8/4/2/98425184/maternal_comps_final.pdf, 2019

160 Enhanced Maternal Care Units: Guidance on development and implementation. The Intensive Care Society. September 2023. http://ics.ac.uk?resource/enhanced-maternal-care-units.html

and without warning. This starkly contrasts with their expectations of childbirth, plunging them into a reality marked by fear and uncertainty. The experience of maternal critical illness is not only physically traumatic but can also have profound emotional and psychological repercussions.

Women may face separation from their newborn and partner, exacerbating feelings of isolation. In some cases, the baby may also require neonatal intensive care, which adds to the emotional strain. Furthermore, disruption of early bonding can compound distress. As a result, women often experience a range of emotions, including shock, fear, frustration, disempowerment, anxiety, alienation, and, in some instances, post-traumatic stress symptoms such as flashbacks.

The Review Team identified several instances where families were supported in a manner that alleviated some of these psychological burdens. Notably, there were cases where partners and babies were actively encouraged and facilitated to remain present alongside the critically ill mother in the ICU. Additionally, in situations where the mother's condition stabilised, visits to the NICU were arranged, further promoting familial bonding during a challenging time.

These practices represent exemplary care, demonstrating a proactive approach to addressing the psychological and emotional needs of families in critical care settings. Despite the logistical challenges inherent in such arrangements, these efforts significantly mitigate the emotional and psychological impact of maternal critical illness, underscoring the importance of holistic and compassionate support.

Throughout the review period, NUH critical care teams increasingly prioritised holistic and compassionate care for pregnant women and mothers, ensuring that both their physical and emotional needs were recognised and supported during critical illness.

Post-ICU Care

The transition from critical care to a ward setting is a challenging process for many women and mothers. It signifies a shift from the high level of medical support and continuous monitoring provided in the ICU to a more standard ward environment. This can be daunting for women, both physically and emotionally, as they begin to face the realities of their illness and recovery.

The preferred step-down pathway for women following discharge from critical care is transfer to the labour ward, where enhanced monitoring and specialist maternity support can be most effectively provided. Data from NUH indicates that 70% of women were stepped down to either the labour ward or a high dependency setting after their critical care stay. However, this optimal pathway is not always achievable, owing to factors such as the woman's clinical condition and wider hospital capacity constraints. Feedback from women and families highlighted the challenges experienced when transfer to a high dependency environment was not possible, including reduced nursing-to-patient ratios, diminished levels of direct care and support, and an increased expectation on women to manage aspects of their own recovery at a time of significant physical and emotional vulnerability.

It is noteworthy, however, that the majority of women and mothers discharged from critical care were reviewed the following day by the CCOT irrespective of their location. This review process is a critical part of the discharge protocol, allowing critical care experts to assess the women's condition and progress and allow women and their families to ask questions regarding their ICU experience.

In more recent years, women and mothers discharged from critical care were routinely offered an outpatient follow-up appointment with the critical care team. While not all women elected to attend these appointments, the offer of structured follow-up represents an important component of recovery. Such appointments provide women with the opportunity to discuss their critical care admission, ask questions about the care they received, and gain a clearer understanding of the events surrounding their illness.

*In **2023**, a woman was admitted to the ICU following a category-1 caesarean birth complicated by a MOH. Ongoing concern regarding continued bleeding prompted a diagnosis of uterine artery aneurysm. This was successfully managed by uterine artery embolisation. The woman remained in ICU for four days before*

stepping down to ward-based care. She was subsequently reviewed in the critical care follow-up clinic and offered ongoing psychological support. (2023)

In a number of cases reviewed, maternity discharge summaries did not include reference to the woman's admission to critical care. The Review Team acknowledge that this reflects a national issue that is not unique to NUH. However, clear and comprehensive documentation remains essential to ensure that community healthcare professionals are fully informed of the care a woman has received in hospital and are able to provide safe and appropriate follow-up care after discharge.

Encouragingly, there was evidence of excellent documentation in cases where women had attended critical care follow-up clinics. In these instances, holistic summaries were provided that clearly described the critical care episode and addressed the physical and psychological aspects of recovery.

Neonatal

1. Introduction

In this chapter, the Review Team focuses on the clinical care provided by the neonatal team to babies born at the Trust. The majority of the care took place on the neonatal units (NNUs) at Queen's Medical Centre (QMC) and at Nottingham City Hospital (City). The neonatal team was also involved in resuscitation of babies in the labour ward as well as providing advice to midwives caring for babies on the postnatal and transitional care wards. Midwifery-led care of babies on the postnatal ward is addressed in the 'Postnatal Care' chapter.

The neonatal team at Nottingham University Hospitals NHS Trust (NUH) comprises neonatologists, resident doctors, Advanced Neonatal Nurse Practitioners (ANNPs), neonatal nurses and Allied Health Professionals (AHPs).

In line with the Terms of Reference for this Review, only a selected number of cases were examined – those involving adverse maternal or neonatal outcomes. The 2,505 cases reviewed represent approximately 2% of all births at the Trust between 2012 and 2024. Those receiving a specialist neonatal review represent just over 5% of all babies admitted to the two NNUs during this period. The Review Team has not examined the care of the many babies born at the Trust who had healthy outcomes. Where comparative data are available, The Trust's outcomes have been assessed against those of similar units nationally.

In addition to babies born at the Trust, the Review Team examined the clinical course of a smaller number of babies born elsewhere and subsequently transferred to QMC or City.

Overall, the neonatal care observed was in line with national expectations, with many clear examples of good and exceptional practice. Compassionate, family-centred care was evident throughout. The Review Team also identified a number of areas requiring improvement, which are set out in this chapter.

2. Background to the Organisation of Neonatal Services in Nottingham (2012-2026)

Neonatal services are commissioned in accordance with the Department of Health's Toolkit for High Quality Neonatal Services (2009, updated 2022), which divides neonatal care into three categories: Intensive Care, High Dependency Care and Special Care, together with Transitional Care, in which a parent or carer is resident with the baby. In 2022, the British Association of Perinatal Medicine (BAPM) published *Service and Quality Standards for Neonatal Care*,[161] defining neonatal units as Neonatal Intensive Care Units (NICUs), Local Neonatal Units (LNUs) and Special Care Units (SCUs). A NICU delivers all levels of care, including intensive care, and some also provide specialist neonatal surgical care. An LNU can deliver short-term intensive care and high dependency care; where longer-term intensive care is required, the baby should be transferred to a NICU.

Neonatal services in Nottingham have been based on two sites throughout the review period, serving the maternity units at Nottingham City Hospital and QMC. Both units were designated as small to medium-sized tertiary NICUs, delivering intensive, high dependency and special care to babies from Nottingham and across the East Midlands Network. The NICU at QMC additionally provided specialist paediatric surgical care and served as a supra-regional referral centre for neonatal renal and neurosurgical services. The two

161 British Association of Perinatal Medicine (2022) Service and quality standards for provision of neonatal care in the UK. [Online]. Available at: https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk (Accessed: 24 April 2026).

units operated as a single service, with shared guidelines, strategy and consultant cover across both sites out of hours, and shared leadership following the formation of NUH in 2006.

NICUs, LNUs and SCUs in England are organised into Operational Delivery Networks (ODNs) to ensure all levels of neonatal care are available across a geographical area. Both Nottingham units were part of the East Midlands Neonatal ODN (EMNODN) throughout the review period. The other East Midlands NICU is based in Leicester.

The Review Team heard from both the EMNODN and the Trust that significant cot capacity pressures existed throughout the review period. The limited size of the QMC unit meant that over 100 babies requiring specialist care were transferred out of the area each year, making Nottingham a net exporter of babies needing intensive care to adjoining networks. This was highlighted in nine EMNODN external reviews between 2006 and 2022, and in the 2020 GIRFT review.

Following the National Neonatal Critical Care Transformation Review (2019) and the GIRFT review (2020), the Trust secured funding to expand the neonatal unit at QMC, together with a BAPM-compliant workforce to support the increased number of cots. The expanded unit opened in December 2024 with an additional 21 cots, and is now the sole NICU for Nottingham. The City unit has been reclassified as an LNU, providing high dependency and special care and short-term intensive care only. The Review Team was informed that while capacity pressures remain, they have improved since the expansion.

3. Transport Arrangements

Babies should be delivered in the most appropriate setting for the postnatal care they are anticipated to need. In some cases, this will differ from what is expected, and transfer to another unit may be required – for example, for neonatal surgery or unplanned intensive care.

Neonatal transfers should be carried out by a centralised, dedicated team of specially trained staff. In Nottingham, transfers are undertaken by the CenTre transport team, which has provided a 24/7 service since 2010. The Review Team did not examine the care provided by the transport team; however, the following concerns were identified.

There is evidence that preterm babies transported in the early postnatal period are at higher risk of brain haemorrhage and death.[162] Where a baby is born in a perinatal unit with a NICU, they should remain there until sufficiently stable for repatriation or step-down to high dependency care. The Review Team found several examples of extremely preterm babies being transferred out of the two NICUs within the first days of life. These transfers were not for surgical review or escalation of care; a number were transfers to the other Nottingham NICU, almost certainly for capacity reasons. The Review Team found instances where babies were hypothermic prior to departure, and some were transported multiple times between the two units. One baby was transferred four times in a single week. Where capacity pressures necessitate transfer, it is essential that the most appropriate baby is selected for transfer, with clear advocacy from the referring unit, and that every effort is made to ensure the baby is normothermic before departure, provided this does not delay urgent care.

The Review Team found that the absence of advanced radiology services at City NICU resulted in several babies being transferred to QMC for investigations – including renal ultrasound and MRI – that would ordinarily be expected to be available within a NICU. These transfers placed additional demand on the transport team and exposed vulnerable babies to risk. Access to appropriate diagnostic services is essential to minimise transfers of this nature.

162 Mohamed, M.A. et al. (2010) 'Transport of premature infants is associated with increased risk for intraventricular haemorrhage', Archives of Disease in Childhood: Fetal and Neonatal Edition, 95(6), pp. F403–F407.

4. On Call and Working Patterns

4.1 Neonatal Consultants

The two acute trusts in Nottingham merged in 2006 to form NUH, and the neonatal service is managed as part of the Family Health Care Group. In 2012, there were 11 consultant neonatologists (9 whole-time equivalent, WTE) across the two units, each with a designated base site. By 2025 this had grown to 23 consultants (20 WTE), all of whom rotate between QMC and City, with some contributing to the CenTre transport service.

The long-term strategy of the neonatal service has been to consolidate onto a single site, co-located with the maternity service and children's hospital. This would have brought clear benefits for consultant cover and service quality. Despite repeated reviews over more than 25 years, various challenges prevented this from being achieved during the review period.

Consultant on-call arrangements evolved incrementally over the review period. In 2012, each NICU had two daytime consultants. From 5pm, a single consultant covered both units on call from home. Weekend daytime cover varied - on some weekends a consultant was available for each unit, but on others a single consultant conducted ward rounds and provided emergency cover across both sites. In 2015, separate daytime consultant cover at weekends was introduced, though a single consultant continued to cover both NICUs overnight. From 2019 to 2024, a single consultant was resident on one or other unit until 9pm on weekday evenings, on call for both sites; overnight, one consultant covered both units from home. At weekends, a resident daytime consultant was in place on each unit, with a single consultant on call overnight for both.

National guidance was clear on the inadequacy of these arrangements. In 2014, BAPM recommended that larger NICUs consider 24/7 resident consultant cover. Its 2022 *Service and Quality Standards*[163] stated that it is not appropriate for a consultant to provide out-of-hours cover to two geographically separate sites simultaneously. The BAPM Consultant Working Patterns document (2023)[164] is explicit that in-person attendance out of hours should always be achievable within 30 minutes. In 2024, HM Coroner in Brighton issued a Prevention of Future Deaths notice recommending that consultants cover only one unit and be more immediately available. The 2020 GIRFT report also identified the cross-site on-call arrangements in Nottingham as a concern (see Section 5.3).

The Review Team calculated that until 2024, a single consultant was responsible for emergency on-call cover across both NICUs for at least 50% of all hours in the week – including weekday nights and weekend days and nights. Both units were designated as full tertiary NICUs throughout this period. While split-site on-call arrangements were not unique to NUH, the Review Team is not aware of any other neonatal service in the UK where two tertiary NICUs were routinely covered by a single on-call consultant.

In the majority of cases reviewed, consultant input was well documented and of good or excellent quality, with a compassionate approach evident. However, the Review Team heard a small number of serious and concerning reports of consultants either declining to attend to support their team or stating they were unable to attend within 30 minutes when on call:

*In **2017,** a staff member declined to attend overnight to support the team despite a baby experiencing multiple episodes of cardiopulmonary resuscitation (CPR) and proving extremely difficult to intubate. Whether the cross-site on-call arrangement contributed to these difficulties could not be determined.* (2017)

The Review Team was informed that since January 2025, separate 24/7 consultant cover has been in place for each neonatal unit. The Review Team welcomes this development and considers it an important step in addressing the long-standing concerns about the timely availability of senior support.

163 NHS and Department of Health (2009) Toolkit for high quality neonatal services. [Online]. Available at: https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845 (Accessed: 24 April 2026).

164 British Association of Perinatal Medicine (2023) Consultant working patterns: a BAPM report. [Online]. Available at: https://www.bapm.org/resources/consultant-working-patterns-a-bapm-report (Accessed: 24 April 2026).

4.2 Nurse Staffing

Nursing staff work a rotational model, with arrangements varying by role and seniority. Band 5 and Band 6 nurses have a designated base site and rotate on a 9-month/3-month split, a model introduced in July 2025. Band 7 clinical nurses rotate between sites on a shift-by-shift basis. The senior nursing team – including the head of nursing, matrons, and leads for family care, education, critical care, homecare and quality – rotate across sites daily as part of their leadership responsibilities.

4.3 Resident Doctor and Advanced Neonatal Nurse Practitioners (ANNP) Staffing

Until August 2024, resident doctors were assigned to either City or QMC; they now rotate between both units. Rotas are compliant with BAPM standards and the resident doctor contract. The ANNP establishment has been expanded and ANNPs also rotate cross-site.

5. External Comparative Data

5.1 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)

The MBRRACE-UK perinatal surveillance programme[165] has provided comparison of perinatal and neonatal mortality rates across hospitals since 2013, using stabilised and adjusted rates that account for maternal age, socio-economic deprivation, baby's sex and ethnicity, multiplicity and gestational age at birth. In 2013, NUH had an adjusted mortality rate more than 10% higher than comparable NICUs with surgical provision. Rates remained up to 10% higher in 2014 and 2015. From 2016 to 2023, rates were within the average range for similar units. By 2024, NUH had an adjusted neonatal mortality rate more than 15% below that of comparable units – a significant improvement. NUH was also in the top third of perinatal centres in the UK by total number of births.

Mothers giving birth in Nottingham are considerably more likely to live in areas of high deprivation than those in most other trusts nationally. Since 2021, the proportion of babies from non-white ethnic backgrounds has been above the UK average. Deaths due to congenital anomalies were comparable to similar trusts. These demographic factors are likely to have contributed to the pressures experienced by the neonatal service and to the elevated risk of perinatal morbidity and mortality during the earlier part of the review period.

5.2 National Neonatal Audit Project (NNAP)

NNAP collects data from all neonatal units in England, Scotland and Wales on agreed quality improvement measures and enables benchmarking against other units.[166] All available NNAP data for the period 2012 to 2025 was reviewed.

The perinatal optimisation composite measures the proportion of preterm infants receiving all optimal perinatal care interventions: antenatal steroids, magnesium sulphate, delayed cord clamping, admission at a normal temperature and early breast milk. Between 2018 and 2025, both Nottingham units were consistently below the interquartile national range and well below the NICU-only average. Data completeness was poor between 2018 and 2021, affecting all units nationally, but from 2021 City Hospital's performance has been around the 25th percentile and QMC's between the 10th and 25th percentile, while other units have shown greater improvement. Antenatal corticosteroid and magnesium administration were comparable with other units, and admission hypothermia rates improved following quality improvement work. However, early administration of breast milk to preterm babies has remained below the national average and was rated

165 MBRRACE-UK (2025) Perinatal mortality surveillance reports. [Online]. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance (Accessed: 24 April 2026).

166 Royal College of Paediatrics and Child Health (2025) National Neonatal Audit Programme (NNAP) online dashboards. [Online]. Available at: https://www.rcpch.ac.uk/resources/NNAP-dashboards (Accessed: 24 April 2026).

red in the 2022 GIRFT report for QMC. Delayed cord clamping – shown to improve survival in preterm babies - was, as noted in the 2020 GIRFT report, being performed only for term babies at that time; it has since been introduced for preterm babies and performance is now in line with other trusts.

The NNAP online dashboard[6] shows that over the last seven years, fewer very preterm babies at both Nottingham units were discharged home free of serious complications of prematurity – including necrotising enterocolitis (NEC), bronchopulmonary dysplasia (BPD), serious brain injury and death – than the UK average. As a tertiary NICU, Nottingham would be expected to care for a higher proportion of preterm and acutely unwell babies than the national average; nonetheless, complication rates appear higher than those of comparable large NICUs in adjacent networks.

Breast milk administration is an important determinant of outcomes in preterm babies. NNAP data for the breast milk feeding composite – measuring administration of breast milk to babies born before 34 weeks at 14 days of age and at discharge – show QMC performing mostly within the national range between 2018 and 2025, though with a fall in 2025. City Hospital's data lie mostly below the national average.

Both units were well below the national average for documented parental conversations within 24 hours of admission between 2012 and 2020. This improved significantly from 2021 and has been around the national average since. The Review Team noted generally good documentation of conversations with parents in the clinical records. Parental presence on consultant-led ward rounds was above the national average between 2018 and 2024

Both units performed around the national average for retinopathy screening. Nurse staffing levels were broadly around the national average between 2018 and 2025, with a notable dip below average at QMC in 2022, suggesting that while staffing at Nottingham did not fully comply with BAPM guidance, it was broadly comparable to other NICUs nationally.

The Review Team found evidence of poor data quality for some NNAP measures – in 2019, only one baby had 100% data completeness. There is evidence that NNAP findings were reviewed in Trust audit meetings and that some areas of poor performance, including high admission hypothermia rates and low early breast milk administration, were subsequently addressed. However, the response to audit findings was inconsistent, and the Review Team found little evidence of joint audit activity with the maternity team.

The Review Team found that the Nottingham neonatal units were operating under significant capacity pressure throughout much of the review period, and that this is likely to have limited the resources and staffing available for quality improvement work. As two of the three NICUs within the East Midlands Neonatal ODN, the Nottingham units were well placed to lead quality improvement across the region; the Review Team found insufficient evidence that this opportunity was taken.

5.3 Getting It Right First Time (GIRFT)

GIRFT is a national, data-driven programme designed to improve the quality of care and patient outcomes by identifying and reducing unwarranted variation. It provides specific recommendations for trusts to implement. The neonatal services at NUH were subject to a GIRFT review in 2020, based on 2018 data, with a follow-up visit in 2022.

The 2020, the Review found that NUH generally achieved good neonatal outcomes despite significant capacity pressures, and was in the lowest quartile nationally for mortality and BPD. Research activity was well developed, and there was evidence of quality improvement work to reduce hospital-acquired infections. Infusion pump software had been shown to reduce errors and an upgrade was planned. Discharge processes were good and both units had achieved Bliss Baby Charter accreditation. Support and training for parents was well regarded, and psychology support was in place. Nurse numbers were close to BAPM standards and specialist nursing roles were supported, though the number of nurses Qualified in Speciality was below that of comparable units. Gaps in allied health professional provision were noted, particularly in pharmacy, speech and language therapy and physiotherapy. Despite these gaps, staffing compared favourably with many other neonatal units and retention was good. The Review heard that staff turnover has fallen further in the most recent year.

The 2020 GIRFT Review identified a serious patient safety concern: that NUH had the most significant capacity problems of any NICU in England, with a demonstrable negative impact on the quality of care and on mortality for high-risk babies born elsewhere in the network who could not access the service when needed. Occupancy at QMC was nearly 100% and at City just under 80%. QMC had five times the national NICU average of transfers out for non-clinical capacity reasons; City was in the upper quartile. Both units were in the lowest decile for preterm babies being born in a perinatal unit with a NICU. A significant number of babies were transferred out of the region entirely. Critically unwell babies born in LNUs and SCUs within the network could not be transferred to the Nottingham NICUs due to capacity constraints. City Hospital did not meet the recommended minimum activity threshold for a NICU, though combined activity across both units was above average, reflecting the extremely high turnover of intensive care babies at QMC.

GIRFT also noted that more than 50% of admissions on both sites were term babies – considerably above the national average – and that pulse oximetry screening of newborns, widely used in other units, was not in place at the Trust. Transcutaneous bilirubinometers were insufficient in number, resulting in an above-average rate of blood tests for jaundice. A higher than expected number of babies at City NICU required cardiac compressions and drugs during resuscitation. Less Invasive Surfactant Administration (LISA) – a technique that avoids the need for intubation – was not in use at the Trust.

The capacity problems were escalated to the specialised commissioning team, as the Trust had been unable to resolve them locally. GIRFT recommended consolidation onto a single site, prioritisation of the ATAIN workstream to reduce term admissions, and escalation of the single consultant cross-site cover arrangement as a formal risk.

The 2022 follow-up visit to QMC showed limited progress. Overall occupancy had reduced marginally to 90%, but ICU activity was running at 105% despite a fall in births. Capacity transfers remained in the top quartile.

In summary, the 2020 and 2022 GIRFT Reviews identified the Trust as a significant outlier in a number of areas, most notably capacity and the frequency of transfers of preterm and acutely unwell babies - both between the two Nottingham units and further afield. The Trust was a late adopter of LISA and delayed cord clamping in preterm babies, both of which are evidence-based interventions with demonstrated benefit. The expansion of QMC by 21 cots is expected to address many of the concerns raised, but insufficient time has elapsed for the Review Team to assess its impact.

5.4 Perinatal Culture and Leadership Programme (PCLP) and The General Medical Council (GMC Training Survey)

PCLP[167] is a national NHS initiative aimed at improving the safety and quality of maternity and neonatal care through cultural transformation. PCLP data showed high proportions of neonatal staff reporting burnout and low scores for emotional wellbeing. A good safety climate was reported by only 22% of neonatal nurses, 45% of resident doctors and 56% of consultants. These findings are consistent with the high occupancy and workload pressures described elsewhere in this chapter, and reflect the consequences of sustained under-resourcing. The results of the 2024 PCLP SCORE survey are discussed further in the 'Clinical Leadership' chapter.

The GMC conducts an annual national training survey of trainees and trainers to get detailed information about their experiences and to monitor the quality of postgraduate medical education and training[168]. Publicly available data for doctors working on the Nottingham neonatal units covers 2022 to 2025 and includes comparison with paediatric trainees across the UK. Resident doctors reported a consistently high workload and concerns about rota design affecting both their education and work-life balance - measures

167 NHS England (2024) The Perinatal Culture and Leadership Programme. [Online]. Available at: https://www.england.nhs.uk/culture/culture-leadership-programme/ (Accessed: 24 April 2026).

168 General Medical Council (2026) Education data tool. [Online]. Available at: https://edt.gmc-uk.org/ (Accessed: 24 April 2026).

on which NUH was a significant negative outlier throughout. Clinical supervision and out-of-hours senior support were below the national average in 2022, although these had improved to within range by 2025. Overall satisfaction, handover quality, adequacy of clinical experience, local teaching and supervision of educational progress all worsened over the period surveyed, with all remaining below average or as negative outliers. No measures at NUH were positive outliers across the period reviewed.

6. The Extended Neonatal Review

The Trust identified 256 admissions to the neonatal units at QMC and City that met the Terms of Reference for this Review in terms of neonatal outcomes, but where the babies had been born at other hospitals and transferred to Nottingham after birth. The parents of all 256 babies were contacted and offered the opportunity to opt out of the Review. No parent did so.

The discharge summaries of all 256 babies were evaluated where available, together with the governance records relating to their admissions. Where documented concerns or clinical issues appeared to merit further investigation, a full review of the clinical records was undertaken. The standard of care was graded using the same criteria applied across the maternity review. A detailed review of the transport of these babies was not within the scope of this element of the Review. All families will receive specific, individualised feedback on the care provided.

Nearly all 256 babies were born within hospitals in the current East Midlands Operational Delivery Network. Three quarters were admitted from three neighbouring trusts: 33% from University Hospitals of Derby and Burton NHS Trust (Royal Derby Hospital and Queen's Hospital Burton); 25% from United Lincolnshire Hospitals NHS Trust (Lincoln County Hospital and Boston Pilgrim Hospital); and 17% from Sherwood Forest Hospitals NHS Trust (King's Mill Hospital, Sutton-in-Ashfield). The majority of the remaining transfers were from hospitals within a 50-mile radius. Clinical records were unavailable for 11 babies: the records of six babies born in 2012 or 2013 had been destroyed by the Trust in accordance with its local policy, which was not consistent with national policy, and the records of a further five were not available for other reasons. Of the 256 babies in this cohort, 71 died. Full in-depth reviews were conducted for 16 babies who had been transferred into NUH after birth elsewhere.

Among the cases reviewed:

A case related to the prevention and management of skin breakdown associated with continuous positive airway pressure (CPAP). A third concerned endotracheal intubation practice.

Assessment of the care provided to these babies at their referring hospitals was outside the scope of this Review. On the basis of the information available, the Review Team's overall assessment was that the initial care offered at referring neonatal units was generally appropriate.

The Review Team noted that babies were commonly transferred from City to QMC for surgical review, MRI or surgical intervention. The opening of the new single NICU at QMC should reduce the need for these cross-city transfers, which place significant demands on the transport service and carry the risk of destabilising vulnerable babies.

7. Resuscitation and Stabilisation at Birth

Although most babies are born healthy, some can be predicted to require additional stabilisation after birth, and a smaller number may be so unwell at delivery – not breathing, or with a low or absent heart rate – as to require immediate resuscitation. This is not always foreseeable, and all attending midwives and neonatal specialists must be proficient in basic life support. Within the perinatal team, appropriately trained personnel and functioning equipment must be immediately available to deliver advanced resuscitation at all times. Throughout the review period, the resuscitation of newborns in the UK has been guided

by Resuscitation Council UK algorithms, and all professionals attending newborns are expected to have completed the Newborn Life Support (NLS) course.

The Review Team examined the resuscitation of all babies in the Review cohort where records were available. In the majority of cases, the neonatal team responded promptly and followed national guidance. Resuscitation was generally well documented on a dedicated newborn resuscitation sheet, and senior support was present at the outset or arrived promptly.

However, the Review Team identified a number of cases in which care did not accord with national guidance. These included babies who received advanced airway interventions, including intubation, before any attempt at lung inflation via a mask, and cases where there was significant delay in establishing intravenous access because the umbilical route was either not available or not attempted. In a small but important number of cases, equipment – including suction devices and face masks of the correct size – was documented as missing or not functioning, causing delays in treatment. This represents a failure of equipment preparedness and checking. GIRFT data for 2016 to 2019 noted that significantly more very preterm babies at the Trust were intubated than expected nationally, and that significantly more preterm babies required CPR at birth.

The Review Team found that the Trust's guideline for newborn resuscitation did not fully align with the Resuscitation Council UK national algorithm. In particular, the guideline described a period of observation – 'wait for a minute or so' – before giving artificial breaths to babies who were blue or not breathing. This is not consistent with national NLS guidance and has the potential to cause harmful delay.

On a small number of occasions, there was a delay in obtaining senior consultant support. This occurred most commonly when babies were delivered out of hours and the consultant was on call from home. On one occasion, a member of staff who was present in the hospital chose to remain in their office after being informed of the imminent delivery of an extremely preterm baby. The Review Team considered this to represent a serious failure to provide appropriate support to the team.

The Review Team identified several cases in which babies were born severely anaemic following acute blood loss, and in which there was significant delay in the administration of emergency Group O negative blood. This occurred in some cases despite explicit handover from the obstetrician that the baby was pale and likely to require transfusion. Unlike most maternity units, O negative blood was not stored on the labour ward but in an adjacent area. The Trust's guideline at the time also appeared to under-emphasise the importance of rapid emergency blood transfusion. These issues are discussed in detail in Section 8.

In 2021 the Trust undertook a thematic review of 24 incidents classified as neonatal emergencies and complications, covering just over two years of data. Approximately half of the cases were investigated by the same individual. Mild or moderate harm was identified in 46% of cases and no harm in 54%. While 92% of incidents were reported promptly, four cases had no completed investigation. The Review Team found limited evidence of meaningful learning from this process.

The Review Team emphasises that in the majority of cases examined, resuscitation and stabilisation was carried out effectively by a competent team of doctors, neonatal nurses and ANNPs.

8. Blood Products and Transfusion Delays

Newborn babies may occasionally be born severely anaemic, either as a result of acute blood loss or other causes. Where acute blood loss has occurred, babies are typically also hypovolaemic, with signs of circulatory insufficiency and shock, including hypotension, prolonged capillary refill time and metabolic acidosis. National guidance recommends that where acute severe blood loss is suspected, or where a baby does not respond to resuscitation, an immediate bolus of Group O negative blood or isotonic

crystalloid fluid should be administered, followed by blood transfusion to restore oxygen-carrying capacity. Emergency stocks of Group O negative blood should be immediately available at the point of care. It is important to note that oxygen saturation measurements can be falsely reassuring in this context, remaining within normal range despite severe anaemia and critically inadequate oxygen delivery to the vital organs.

During the course of this Review, a number of cases were identified in which there was clear evidence of significant antenatal bleeding, including massive maternal antepartum haemorrhage (APH) or placental abruption – and in which the baby was observed at delivery to be pale, shocked and showing clear signs of hypovolaemia. Despite these findings being documented, it often took several hours for blood to be administered.

*In **2021**, a baby was delivered by emergency caesarean section at 36 weeks for fetal bradycardia and a large APH. The baby was noted immediately to be pale, and the possibility of transfusion was raised at that point. The neonatal team documented concerns about low circulating volume, and the baby was repeatedly noted to be very pale despite breathing with normal oxygen saturations – a pattern consistent with severe anaemia. The baby had an unrecordable pH with a rising lactate. It took over two hours for any blood to be administered, and the second transfusion was given very slowly. The baby subsequently died of multi-organ failure.* (2021)

The Review Team found that the Trust's guideline at the time under-emphasised the importance of rapid emergency blood transfusion and placed excessive emphasis on the use of saline fluid boluses and cautious volume replacement. This is not consistent with national guidance. The Review Team also established that at one of the delivery units, emergency blood stocks were not stored on the delivery suite itself, but in an adjacent operating theatre corridor – an arrangement that is out of keeping with standard practice in most maternity units, where an emergency blood fridge is located within or immediately adjacent to the delivery suite and obstetric theatres.

When the Review Team raised these concerns with the Trust, it responded promptly: undertaking an immediate review of practice, revising the guideline and auditing further cases. That audit found that the majority of babies in those cases had received emergency blood within one hour of birth. The Review Team welcomes the Trust's responsiveness to these findings.

9. Hypoxic-Ischaemic Encephalopathy (HIE) Management and Cooling

HIE is a serious condition arising when a newborn baby's brain is deprived of adequate oxygen and blood flow around the time of birth. HIE is a significant cause of neonatal death and of longer-term morbidity, including cerebral palsy, learning difficulties and epilepsy. Because brain injury can continue to evolve after the initial hypoxic insult, early recognition and treatment are essential.

Therapeutic hypothermia is the established treatment for moderate to severe HIE[169]. It involves carefully reducing the baby's core body temperature, typically for 72 hours, and works by slowing the inflammatory and cellular processes that drive ongoing brain injury.

The Review Team examined cases of babies who received therapeutic hypothermia at NUH. The Trust had a robust guideline and screening protocol for eligibility, in line with national guidance. Babies meeting the criteria for assessment were evaluated using a dedicated Neonatal Encephalopathy Record, retained in the clinical notes throughout the assessment period. The Review Team found this to be an example of good practice, supporting thorough and transparent documentation of clinical decision-making. In the majority of cases reviewed, the standard of care was good and consistent with national guidelines.

However, the Review Team identified a recurrent pattern of concern relating to the use of passive cooling. Passive cooling - achieved by turning off heating devices rather than using a servo-controlled cooling

169 British Association of Perinatal Medicine (2020) Therapeutic hypothermia for neonatal encephalopathy: a BAPM framework for practice. [Online]. Available at: https://www.bapm.org/resources/237-therapeutic-hypothermia-for-neonatal-encephalopathy (Accessed: 24 April 2026)

machine - intended for use during transport or while awaiting transfer to a NICU; it is not standard practice within a NICU where active cooling equipment is readily available. Active cooling machines achieve target temperatures within 30 to 60 minutes and allow precise temperature control. The Trust's guideline stated that if no features of encephalopathy were identified by six hours of age, the baby could be rewarmed. The Review Team found that passive cooling was routinely being continued until six hours of age in babies being assessed within the NICU itself – a practice not in keeping with national guidance and one that risks impairing the neurological assessment of these babies during a critical window.

Specific deviations from the cooling pathway were identified in a number of cases.

*In **2024**, a baby was passively cooled for six hours in the NICU and, following a period of rewarming, was subsequently commenced on active cooling at ten hours of age – well beyond the recommended target of reaching 33.5°C by six hours.* (2024)

*A further baby in **2020** received cooling for only 24 hours before rewarming was commenced.* (2020)

*In **2015**, passive cooling continued until six hours and active cooling was not initiated until seven hours of age.* (2015)

The Review Team also identified a pattern in which babies who were assessed for active cooling but did not ultimately meet the criteria – due to rapid neurological improvement – were nonetheless kept in passive cooling until six hours of age before rewarming was initiated. This is not consistent with accepted practice.

*In two cases in **2015** and **2018,** there was a delay in commencing Cerebral Function Monitoring (CFM); in one instance this was attributable to a lack of available equipment. These were isolated occurrences, and CFM was initiated promptly in the great majority of cases in which babies were assessed for therapeutic hypothermia.* (2015, 2018)

*In one case in **2017**, the Review Team found concerns regarding the monitoring and management of coagulation abnormalities in a cooled baby. The Review Team considered that a different management approach may have altered the outcome and could potentially have prevented extension of an intracranial haemorrhage.* (2017)

The Review Team found that follow-up of babies who had received cooling therapy was well organised and appropriately multidisciplinary. The Trust operated a passport scheme for babies diagnosed with moderate or severe HIE, providing structured follow-up, multidisciplinary input and neurodevelopmental assessment until two and a half years of age, and facilitating clear communication between all professionals involved in the baby's ongoing care. The Review Team regarded this as good practice.

10. Airway Management

Preterm or unwell term babies may require respiratory support, ranging from non-invasive measures such as CPAP or High Flow Nasal Therapy (HFNT) to endotracheal intubation. Intubation involves passing a breathing tube into the trachea via the nose or mouth, usually following administration of premedication. It is a technically demanding procedure that requires experience to perform safely and confidently, and it is recognised nationally that opportunities to acquire and maintain these skills are becoming more limited. BAPM has published Neonatal Airway Safety Standards[170] to support the availability of these skills across all neonatal units.

When performed correctly, neonatal intubation should be atraumatic, with the endotracheal (ET) tube placed in the correct position at the first attempt and secured so that the tip remains at the appropriate

170 British Association of Perinatal Medicine (2024) Neonatal airway safety standard: a BAPM framework for practice. [Online]. Available at: https://www.bapm.org/resources/BAPM-Neonatal-Airway-Safety-Standard (Accessed: 24 April 2026).

depth. Unplanned or accidental extubation should be uncommon and is, in most cases, preventable. Many neonatal services have undertaken quality improvement work to reduce unplanned extubation rates, and a national improvement project was underway in 2025.

The Review Team found that a significant number of babies in the cohort had experienced multiple reintubations, frequently within the first days of life. In some cases, babies underwent eight to ten intubation attempts by a variety of practitioners. The rate of unsuccessful attempts was higher than the Review would expect in a large tertiary NICU. In addition, many babies experienced repeated unplanned extubations requiring reintubation, sometimes within hours of each other. Repeated instrumentation of the neonatal airway carries a risk of trauma and longer-term complications. In some cases, babies collapsed during attempted reintubation and required CPR.

During the earlier part of the review period, NUH used pre-cut ET tubes, trimmed to an estimated optimal length based on the baby's predicted or actual size and secured using a fixator attached to a hat. The Review Team found cases in which the pre-cut tube, when fully inserted, proved too short and had to be removed and replaced with a longer tube. This exposed babies to repeated high-risk procedures unnecessarily. Standard practice in most other units at the time was to use a full-length tube and trim it at the external end only after the tip position had been confirmed - a safer approach that the Trust was slow to adopt.

Most neonatal units now secure ET tubes using a clip or plastic fixation device fastened to the baby's cheeks. NUH undertook several audits and quality improvement projects in this area and has now adopted a clip fixator. While the Review Team acknowledges the audit and improvement work undertaken, it is clear that this change was made later than in many comparable NICUs.

The Review Team considers the failure to follow an established airway plan in a baby with a known difficult airway to be a serious and avoidable failing.

The Review Team found that NUH had no routine system, such as cot-side signage or alerts to identify babies with known difficult airways and ensure that the most senior available clinician performed or directly supervised intubation in those cases.

A difficult airway guideline had been in place since 2019, but the escalation pathway to a neonatal consultant or anaesthetist was not consistently clear. The Review Team found, through evidence presented at a Coroner's inquest, that BAPM difficult airway guidance was not formally adopted by the Trust, and video-laryngoscopy equipment procured and escalation pathways clarified, until 2024.

The Review Team acknowledges that changes have now been made and that the Trust's airway practices are more closely aligned with national standards. However, the Review Team is clear that a number of these changes could and should have been implemented sooner, and that the delay had consequences for the safety of babies in the Trust's care.

11. Hypoglycaemia

Hypoglycaemia is very common in newborn babies, and severe hypoglycaemia is a significant and preventable risk. Risk factors are well established and national guidance has been issued to help guide management and prevent harm[171]. Severe hypoglycaemia (blood glucose below 1.0 mmol/L) or persistent hypoglycaemia (more than two blood glucose measurements below 2.0 mmol/L in the first 48 hours after birth, or blood glucose below 2.6 mmol/L with symptoms) always requires urgent medical review and investigation.

171 British Association of Perinatal Medicine (2024) Identification and management of neonatal hypoglycaemia in the full-term infant (birth–72 hours): a BAPM framework for practice. [Online]. Available at: https://www.bapm.org/resources/identification-and-management-of-neonatal-hypoglycaemia-in-the-full-term-infant-birth-72-hours (Accessed: 24 April 2026).

The Review Team identified a number of cases in which there were serious concerns about the prevention, recognition and management of hypoglycaemia in newborn babies. In many of these cases, clear risk factors were present but were not acted upon in a timely manner. Each case identified was avoidable. While workload pressures may have been a contributing factor in some instances, these cases occurred across the full timescale of the Review, and the Review Team is clear that the underlying issues should have been identified and addressed far earlier.

*One infant in **2014** experienced two episodes of hypoglycaemia following the discontinuation of intravenous fluid infusions for reasons that were not clearly documented. On one occasion the blood glucose fell to 1.3 mmol/L, attributed in the notes to 'a delivery issue.' On another, 20% dextrose was placed on standby and the blood glucose dropped to 0.8 mmol/L. These episodes were preventable.* (2014)

*Three babies in **2017, 2018 and 2021** were born to mothers prescribed labetalol, an antihypertensive medication that can impair a baby's physiological response to low blood glucose, placing them at recognised risk of hypoglycaemia. Two were also preterm, an additional independent risk factor. In all three cases there was either a significant delay in, or a complete failure to perform, blood glucose monitoring. One baby collapsed on the postnatal ward with a blood glucose of 0.5 mmol/L.* (2017, 2018 and 2021)

*Three infants in **2008, 2013 and 2018** experienced unacceptable delays before an initial or repeat blood glucose measurement was taken. One preterm baby had no blood glucose measurement for two hours, at which point it was found to be critically low at 0.2 mmol/L. A glucose bolus was administered but no infusion was commenced - an inadequate response. A term baby born in poor condition with significant brain injury had a blood glucose of 1.4 mmol/L on the first day; it was not rechecked for over eight hours, at which point it remained very low at 1.3 mmol/L. A third infant with hypoxic brain injury had a blood glucose of 1.6 mmol/L on admission to the NICU; treatment was started 30 minutes later, but a repeat measurement was not taken for a further two hours, at which point the blood glucose remained at 1.6 mmol/L. National guidance recommends rechecking within one hour of commencing treatment. The prolonged period of hypoglycaemia in this case may have compounded the baby's existing brain injury.* (2008, 2013 and 2018)

The Review Team considers the failure to follow up this baby, in the context of documented feeding difficulties and known risk factors, to be a serious and avoidable failure in community postnatal care.

*One infant in **2007** was noted on day three to be jaundiced and unwell. A neonatal review was requested by the midwifery team but did not take place for three and a half hours. On admission, the baby's blood glucose was 0 mmol/L.* (2007)

*One infant in **2016** was noted on the postnatal ward to be excessively sleepy and not waking for feeds. Blood tests for a septic screen were taken but no blood glucose was measured. The following day the baby had two episodes of cyanosis on the postnatal ward, was admitted to the neonatal unit and began to have seizures. Blood glucose at that point was 0 mmol/L.* (2016)

Across these cases, the Review Team identified a consistent pattern of failures, including: failure to follow local guidelines for babies at recognised risk of hypoglycaemia; failure to identify babies born to mothers prescribed labetalol as being at increased risk; failure to monitor blood glucose in at-risk babies following discharge into the community; failure to measure blood glucose in a timely manner in babies admitted to the neonatal unit; and failure to monitor blood glucose with sufficient frequency in babies receiving intravenous dextrose.

Many of these cases were subject to local investigation. The Review Team found that in a significant number of instances, no care delivery problem was identified and there was little or no evidence of learning from the incident. This is of serious concern.

12. Postnatal Collapse and the 'Reluctant Feeder'

One of the key challenges in neonatal care is identifying babies who are becoming seriously ill. Many clinical signs and behaviours that may indicate significant illness are, in the majority of babies, transient and benign. Local guidelines, typically based on national or international evidence, play an important role in supporting clinical decision-making in this context. However, the Review Team found that guidelines can, in some circumstances, inadvertently provide false reassurance.

In Nottingham, one such guideline concerns babies under 48 hours of age who appear to mothers and maternity staff to be feeding inadequately. The guideline, titled *Guideline to Support Women with Newborn Feeding and the Reluctant Feeder* (2014), is broadly representative of similar guidance used across many UK maternity services, generally reflecting the principles of the UNICEF Baby Friendly Initiative (BFI).[172]

The Review Team identified a number of concerns about the framing of this guideline. Although it includes advice to refer to the neonatal team as indicated, its stated purpose is to support women rather than to assess the baby. The use of the word 'reluctant' – widely adopted across the UK – implies an element of choice or recalcitrance on the part of the baby, when the reality may be a medically-based inability to feed. This distinction matters: a feeding difficulty may itself be the primary indicator that a baby requires urgent medical assessment, rather than continued feeding support. The guideline's focus on avoiding blood glucose testing – framed around minimising a painful procedure in an otherwise well baby – risks obscuring this. Its Active Feeding Plan concludes with the recommendation that if the baby remains reluctant to feed at 48 hours, referral to the neonatal team should be considered. While this may be appropriate for the majority of babies, in a small number of cases such a delay risks serious deterioration in babies with underlying medical conditions.

The Review Team identified a number of babies who showed abnormal feeding patterns and who would have benefitted from earlier medical review. The Review Team recognises the inherent difficulty in capturing, within a written guideline, the full range of subtle and nuanced clinical features that may indicate the need for more detailed assessment. The quality of care in this area will ultimately be determined by the standard of education and training of front line staff, and by a culture in which all professionals, regardless of background or seniority, feel empowered to seek advice when uncertain.

There is an important balance to be struck in the design of maternity and neonatal guidelines: between avoiding unnecessary interventions in the majority of well babies, and ensuring that the small number of babies at genuine risk of serious illness are identified and assessed without delay. The Review Team recommends that the framing and language of the Reluctant Feeder guideline, and similar guidelines used nationally, be reviewed to ensure that the assessment of the baby's clinical condition is given appropriate primacy alongside the support of the mother.

13. Infection Prevention and Control (IPC) and Antimicrobials

IPC is essential in a critical care area. This is particularly so when very vulnerable preterm and sick infants are cared for.

13.1 Physical Environment

The Review Team received multiple concerns about the physical environment at both sites, with particular concern about conditions at QMC. Staff and families reported overcrowding and poor hygiene. The 2022 Ibex Gale review, commissioned by the Trust, recorded the following account from a member of staff:

"Queen's is cramped, but it is also untidy, especially the nurses' area which is very small. The toilet was blocked for the whole 6 weeks we were there for our training. They were not cleaned often, and it was not addressed. The environment is not the best and comfortable place". (2022)

172 UNICEF UK (2026) The Baby Friendly Initiative. [Online]. Available at: https://www.unicef.org.uk/babyfriendly/ (Accessed: 24 April 2026).

The Review identified numerous examples of poor cot spacing and an inability to isolate babies when required. City NICU had no isolation rooms throughout the review period. Both overcrowding and the absence of isolation facilities are recognised risk factors for infection outbreaks and are known to make outbreaks harder to contain once established.

One family reported that the parents' bedrooms (where parents with babies on the NICU can stay overnight) were frequently dirty with unclean sheets, dirty fridges and in one example silverfish in the bed:

"So, when you say bugs, tell me about the bugs. Were they….?'…'We have pictures and movies of it. It's these long things that go on the floor'…'Oh, like silverfish?'...'Yes, but they were also in the bed." (Parents who wished to remain anonymous)

13.2 IPC Practices

The Review Team heard from multiple families about concerns regarding IPC practices on the neonatal units, with hand hygiene cited most frequently. The accounts below are representative of what the Review Team heard:

'Putting your gloves on, and then you're going out of the bay to go and get your PN bags or whatever, you come in and get a pen from your pocket, picking up your mobile phone with your gloves on and then touching everything. I've got my gloves on, so I'm allowed to go in your incubator. But your gloves are dirty. You've touched the drip stands, the screens that I've been pressing too, you know, change the monitor, the alarms and stuff'. (Parents who wished to remain anonymous)

The Review Team found evidence that staff were observed entering incubators wearing watches and jewellery, contrary to infection control policy. One mother told the Review Team:

"...you are not meant to have watches and jewellery and stuff on, but there were people going into the incubator with watches on, and it was normally [staff members], so the people higher up, were the ones flouting the rules." (Parents who wished to remain anonymous)

The Review Team considers the routine failure to clean incubators in accordance with manufacturer guidance to be unacceptable, and notes that capacity pressures – an insufficient number of incubators to allow rotation for cleaning – were a direct contributory factor.

13.3 Infection Outbreaks

Between 2012 and 2025, there were eight outbreaks of hospital-acquired infection on the Nottingham neonatal units: four of Pseudomonas aeruginosa, three of MRSA and one of Klebsiella. Outbreaks of this nature do occur in other neonatal units; however, they carry significant risk of morbidity and mortality in vulnerable neonatal patients, place additional pressure on capacity and staffing, and cause considerable distress to families. The absence of source isolation facilities – particularly at City, which had no isolation rooms – and the chronic overcrowding on both units are recognised factors that increase both the risk of outbreaks and the difficulty of containing them. Several babies died of Pseudomonas sepsis during the review period.

Considerable work was undertaken to reduce the risk of Pseudomonas outbreaks through improvements to water safety, including education on water-safe practices. However, the Review Team found that the impact of this work was not consistently reflected in the environment or in the experiences reported by families.

The Review Team found a serious and recurring failure to implement the recommendations of outbreak investigations. In 2019, a Pseudomonas outbreak report at City identified that the milk kitchen was cramped, with water residue on surfaces, and that the environment was not conducive to effective cleaning or decontamination of equipment. Five years later, the report on the 2024 Pseudomonas outbreak at the same unit recorded that the milk kitchen remained on the risk register and that only planning work for renovation had been undertaken. The same deficiency, identified as a significant infection risk in 2019, had

not been remedied by 2024. The Review Team considers this an unacceptable failure to act on a known and serious patient safety risk.

The Review Team acknowledges that the opening of the new expanded NICU at QMC should address many of the long-standing environmental concerns and reduce the risk of future outbreaks.

13.4 Antimicrobial Stewardship

National Institute for Health and Care Excellence (NICE) published guidance on the management of early-onset neonatal sepsis in 2012, and all neonatal units should have been working towards full compliance from that point. The Trust's guidance broadly follows NICE recommendations and, in general, sepsis was recognised and managed appropriately.

Good antimicrobial stewardship is essential to preserve the effectiveness of antibiotics, limit the development of resistance, protect public health and minimise harm to individual patients. There is growing evidence of the importance of a healthy neonatal microbiome to long-term health, behavioural and neurodevelopmental outcomes, reinforcing the importance of prescribing the right antibiotic, at the right time, for the shortest necessary duration.

However, the Review Team found that clinical practice at NUH did not consistently follow its own guidance or national recommendations. While first-line treatment with benzylpenicillin and gentamicin was in line with NICE guidance, the Review Team found a recurrent pattern of additional antibiotics being added to, rather than substituted for, the first-line regimen, without documented clinical rationale. There was also evidence of inconsistency between consultants in the planned duration of antibiotic treatment.

*In **2016**, a preterm baby was correctly commenced on benzylpenicillin and gentamicin at admission. Cefotaxime was added without documented explanation a few hours later – benzylpenicillin and cefotaxime should not routinely be prescribed concurrently. A five-day course was planned but eight days were administered. On the day the course was stopped, three antibiotics were commenced – two of which the baby had just completed. A fourth was added the following day. Two were subsequently stopped, but another full course of broad-spectrum antibiotics was then prescribed with no evidence of sepsis on investigation.* (2016)

The Review Team identified this pattern of poorly justified, escalating antibiotic use repeatedly across multiple babies' records.

NICE guidance advises lumbar puncture (LP) if there are concerns regarding meningitis. LP is an invasive investigation that carries risks. LPs were undertaken very frequently at NUH. Sometimes this was for a baby documented as clinically well and before any other results were available or despite negative infection markers. This does not comply with national guidance. Many babies had multiple attempts at LP, which were not always justified – one baby had 18 attempts over the first two weeks of life.

14. Pressure Sores and Skin Wounds

Extremely preterm babies frequently require prolonged respiratory support, and the devices used to deliver that support – including endotracheal tubes and CPAP and BiPAP interfaces – carry a risk of pressure injury, particularly to the delicate skin and cartilage of the ears, nose and face. The Review Team identified a number of babies who sustained severe pressure injuries associated with the fixation of respiratory support devices.

The neonatal units maintained extensive documentation requirements for skin integrity, with assessments recorded in up to six separate places. Despite this, the Review Team found that monitoring systems did not consistently prevent harm. A recurring pattern was identified in which pressure injuries were checked regularly, found, photographed, documented and referred to the Trust's Tissue Viability team – but without

adequate action thereafter to prevent further damage or escalate care. The Review Team found evidence of a cultural acceptance that pressure injuries of this kind were an inevitable consequence of caring for small, preterm babies. They are not. The units were slow to change the fixation devices in use, despite evidence of harm.

While appropriate actions were taken once the injury was identified, the response was reactive rather than preventive. This case represents serious iatrogenic harm that was not an inevitable consequence of the baby's underlying condition and should have been prevented.

*In a further case in **2022**, a very preterm twin sustained ear injuries from CPAP fixation straps, requiring an additional period of endotracheal intubation and ventilation to allow healing. This caused significant distress to the family and may have contributed to the baby developing bronchopulmonary dysplasia (BPD)*. (2022)

The Review Team also found that in some cases, families were not informed of pressure injuries in a timely manner – a failure of communication that compounded the harm already caused.

Across the cases reviewed, the Review Team found a consistent disconnect between the processes in place for monitoring skin integrity and the reality of care delivered. Documentation was extensive, but documentation alone did not protect babies from harm. Opportunities for prevention and timely escalation were missed, in some cases resulting in serious and permanent injury. The Review Team is clear that pressure injuries associated with respiratory support fixation are largely preventable, and that the Trust's response to identified injuries was too often reactive rather than preventive. Simplified monitoring systems, unambiguous accountability and a stronger organisational focus on prevention are required.

15. Family-Centred Care

15.1 Communication and Documentation

The Review Team found that the quality of documentation of conversations with families in the neonatal units and labour wards was generally good. Records were frequently comprehensive and detailed, and this was particularly evident in cases involving end-of-life care, where discussions about care planning, emotional support and clinical decision-making were thoroughly recorded.

The Review Team found good evidence of family-centred practice in antenatal and postnatal counselling, with the needs of the wider family unit considered and parental concerns incorporated into ward round discussions. A family care nurse was available to support families across both units. However, the documentation of daily medical reviews did not consistently reflect a high level of parental involvement.

The Review Team noted a recurring discrepancy between the standard of documented communication and the experience reported by families in interviews. Despite generally detailed records, some parents felt they were not kept informed, that their concerns were not acted upon, and that they were not told about planned procedures, including LPs before they were carried out. The Review Team was unable to determine the cause of this disconnect from the available evidence and recommends that this be explored through further national research. The introduction of shared communication records, accessible to parents at the cot-side or via an online platform, may help to address this gap.

15.2 End-of-Life Care

End-of-life care at both sites was of a high standard. The emphasis placed on memory-making was a particular strength, providing families with lasting and meaningful memories of their babies. Dedicated bereavement support staff were identified as a valuable resource in numerous cases, and the Review Team heard consistently positive accounts of the compassionate care provided at the most difficult times.

*One family in **2021** whose baby had a life-limiting condition commended the care provided by most staff but described rude behaviour and poor communication from a small number of individuals, and felt that some staff had not read the care plan or demonstrated the standard of compassionate care that the circumstances demanded. The Review notes this as a reminder that the quality of end-of-life care is only as consistent as the least well-prepared member of the team.* (2021)

15.3 Listening to Families

The majority of families reported feeling listened to and involved in their baby's care. However, the Review Team identified cases in which parental concerns were not adequately heard or acted upon, with serious consequences. Specific cases included:

*In **2019**, parents raised concerns about their baby, who was jaundiced and had not fed well since birth. The baby subsequently collapsed at home. The parents' concerns were not recorded in the clinical notes, and there is no evidence that they were acted upon.* (2019)

These cases illustrate the critical importance of listening to and acting on parental concerns.

15.4 Separation from Babies

Parents are not visitors to their babies on NICU; they are essential carers. The Review Team found a number of cases in which families were prevented from or significantly delayed in accessing their babies, causing lasting distress.

During the early phase of the COVID-19 pandemic, visiting restrictions were widespread across NHS maternity and neonatal services. The Review Team recognises the extraordinary circumstances of that period. Nevertheless, the consequences for families were severe.

*In **2020**, a father was unable to visit his baby who had been transferred to another hospital.* (2020)

*In **2022**, a mother who had tested positive for COVID-19 and had given birth to twins at 27 weeks' gestation was not permitted to see her babies for 10 days - a restriction that, by that point in the pandemic, was not being applied in other hospitals.* (2022)

Separation was not limited to the pandemic period.

*In **2014,** a father was unable to see his baby, who had been born with a congenital diaphragmatic hernia, for 18 hours.* (2014)

*In **2022,** a father experienced significant unexplained delays in accessing his baby.* (2022)

The Review Team also heard that opportunities for parents to hold their babies in the delivery room were not always offered or facilitated, although this appears to have improved in more recent years.

Consistent national policies are needed to ensure that families are never unnecessarily separated from their babies and that the principle of parents as essential carers – not visitors – is embedded in practice across all neonatal units.

15.5 Family Inclusion in Patient Safety Investigations

The Review Team identified a consistent theme of families feeling excluded from patient safety investigations into the care of their babies. Families frequently reported that they were not kept informed of the progress or findings of investigations, and did not feel that their perspectives had been sought or valued.

The Review Team is clear that this must change. Families should be active participants in investigations from the outset, kept informed at every stage, and provided with the findings and any resulting actions. This is not only a matter of transparency and respect, it is essential to ensuring that investigations are as thorough and as accurate as possible, and that learning is shared with those most affected.

16. Overall Summary

In the majority of cases examined, the neonatal care provided at the Trust was good or excellent, and in line with national guidance and best practice. In some cases, care could have been improved but would not have altered the outcome. In a small but important number of cases, the Review Team found that care had contributed, or was likely to have contributed, to adverse outcomes for babies.

The most significant structural finding of this Review Team is that Nottingham operated a split-site neonatal service under severe and sustained capacity pressure for the entirety of the review period. This had direct consequences for patient safety. Too many babies were unable to receive intensive care close to home. Too many babies, including extremely preterm infants in the first days of life, were transported between units, exposing them to avoidable risk. The chronic capacity pressures, compounded by what the Review Team considers to have been a prolonged period of under-investment in the service, meant that separate consultant on-call cover for each unit – a basic requirement for two tertiary NICUs caring for the most vulnerable babies in the region – was not achieved until January 2025. Radiology provision at City NICU was insufficient for a unit of its designation throughout the review period.

Both units, and QMC in particular, were overcrowded, with cot spacing below the standard expected of a modern neonatal unit. This created conditions that increased the risk of hospital-acquired infection and placed staff under sustained and unreasonable pressure. Staff described strong team spirit and commitment, but also described working under constant pressure with high patient acuity and a significant risk of burnout. The Review Team is clear that working conditions of this kind increase the risk of patient safety incidents and are not acceptable in units caring for the most vulnerable patients.

The neonatal service was research active and maintained an extensive portfolio of guidelines. However, the Review Team found that a number of those guidelines were not consistent with national recommendations or with established practice elsewhere, and that the Trust was a late adopter of several widely accepted, evidence-based interventions – including HFNT, LISA, postnatal oxygen saturation screening, and more reliable methods for the preparation and fixation of ET tubes and nasal CPAP. The rates of reintubation and LP observed across the Review cohort were higher than the Review Team would expect in a tertiary NICU.

The Review Team found many examples of compassionate, family-centred care, with the neonatal team providing strong support to families at times of critical illness and at the end of life. Documentation of follow-up care was generally of a high standard. However, the Review Team also heard from families who felt they had not been listened to, had not been kept informed about their baby's condition or the procedures being carried out, and had been excluded from patient safety investigations into their child's care. These experiences reflect failures that go beyond individual interactions and point to the need for sustained cultural and systemic change.

The expansion of the QMC neonatal unit and the achievement of 24/7 single-site consultant cover are significant and welcome developments. The Review Team urges the Trust to ensure that the momentum of recent improvement is maintained, and that the lessons of this review period are embedded in the culture and practice of the service going forward.

Postnatal Care

1. Introduction

Over the review period (2012-2025), more than 115,000 mothers gave birth under the care of the Nottingham University Hospitals NHS Trust (NUH). The majority received their inpatient and community postnatal care from NUH maternity staff; a smaller number had their inpatient postnatal care with other Trusts but received their community postnatal care with NUH midwives. The postnatal care provided by Trust staff was reviewed in 2,200 cases. In the majority of cases the care provided was considered appropriate. However, in a proportion of cases the Review Team identified failures in care, the nature and extent of which are set out in this chapter.

2. Postnatal Inpatient Midwifery Care

The Review identified failures in postnatal blood pressure monitoring and management across the review period, including failures to escalate concerns appropriately.

*In **2013**, doses of antihypertensive medication were omitted without escalation.* (2013)

*In **2014**, three further cases demonstrated inadequate postnatal observations in hypertensive mothers, including one in which staff members did not follow the documented medical plan for blood pressure monitoring*. (2014)

The Review also identified failures in the assessment and management of venous thromboembolism (VTE) risk across the review period.

*In **2015**, a mother received an inappropriately low dose of thromboprophylaxis because her weight had not been taken into account.* (2015)

*In **2016**, inaccurate completion of VTE risk assessments resulted in two mothers not receiving thromboprophylaxis; one subsequently developed a pulmonary embolus (PE).* (2016)

*In **2017**, a mother who had declined antenatal thromboprophylaxis did not receive a postnatal VTE risk assessment or any counselling regarding her increased postnatal thrombotic risk*. (2017)

*In **2018**, a mother who had been taking antenatal thromboprophylaxis left the ward before her postnatal prescription was dispensed; no attempt was made to ensure she received her medication, and she later developed a PE*. (2018)

Failures in VTE risk assessment continued into 2022 and 2023, with incorrect postnatal assessments resulting in thromboprophylaxis not being prescribed in three further cases; in one, the mother developed a PE on day four postnatally.

The Review identified a number of concerns relating to the standard of care on the postnatal ward.

*In **2017**, following a postpartum haemorrhage, there was no evidence of regular maternal observations.* (2017)

*In **2022**, a mother described confusion regarding the management of her intravenous iron infusion and, in 2023, a mother with a history of renal problems reported that urine samples were misplaced during her inpatient postnatal stay.* (2022)

Some mothers reported unacceptable delays in receiving pain relief.

*In **2012**, medication doses were missed on night shifts due to severely low staffing levels.* (2012)

*In **2016**, a mother waited five hours for analgesia and was told she would need to self-discharge if she wished to take her own paracetamol.* (2016)

*In **2021**, similar difficulties in obtaining timely pain relief were reported.* (2021)

Inadequate support with infant feeding and baby care was reported across the review period. Poor breastfeeding support was reported in 2012, 2016, 2017 and 2019, with one mother describing the advice she received as 'just stick him on'. Concerns in the same vein were raised in 2021.

*In **2022**, a mother reported receiving no assistance with caring for her baby on the ward.* (2022)

The Review identified instances in which family members were asked to interpret for mothers rather than professional interpreter services being used. In some cases this occurred when serious clinical information about a baby's condition was being communicated, compounding family distress.

Concerns regarding staff attitudes were raised across the review period:

*In **2013**, a young mother reported perceiving poor staff attitude related to her age.* (2013)

*In **2019,** a mother similarly described dismissive attitudes from staff members.* (2019)

One mother told the Review:

"Whenever I pressed the buzzer for some support I was made to feel like an inconvenience. No member of staff introduced themselves when they came in, either with their name or their role." (2021)

Several families reported missed meals or inadequate food provision during postnatal admissions. In 2012, one mother told the Review:

"I was told that mothers should carry their babies to the food trolley and collect their own food. I could not do this with 2 [babies] and with visitors flooding in and out of the unit unchecked and was too anxious to leave them unattended. I continued not to eat and was in significant pain." (2012)

*In **2022**, one mother noted that when meals were missed she felt uncomfortable drawing attention to it and her husband would purchase food from the hospital café on her behalf.* (2022)

3. Identification and Management of Poor Feeding and Unwell Babies on the Postnatal Ward

The Review identified failures in the recognition and management of poor feeding and clinical deterioration in babies on the postnatal ward across a number of years.

*Also in **2007**, a failure to monitor blood glucose in a low-birth-weight baby who was reported as 'jittery' resulted in readmission with profound hypoglycaemia.* (2007)

*In **2011**, a 36-week baby had inadequate blood sugar monitoring and management and required admission to the neonatal unit with hypoglycaemia.* (2011)

*In **2012**, a mother who had received multiple doses of oral morphine following a caesarean birth of twins was observed breastfeeding Twin 1 but was not observed with Twin 2 after the baby had initially latched. By the time the staff member returned, Twin 2 was unresponsive and required resuscitation and admission to the neonatal unit.* (2012)

*In **2014**, a mother with a history of prolonged rupture of membranes reported that her baby was unwell and had not fed for seven hours; these concerns were not acted upon and the baby was subsequently admitted to the neonatal unit with sepsis.* (2014)

*In **2017**, Trust guidelines for blood glucose monitoring in infants of mothers prescribing labetalol were not followed. At 53 hours of age the baby displayed signs of agitation, bradycardia and low oxygen saturation; blood glucose was not checked until transfer to the neonatal unit, where severe hypoglycaemia was identified, with long-term effects.* (2017)

*In **2019**, midwives proceeded with discharge despite being aware that the baby had not fed, providing advice on hand expressing and formula 'top-ups' in lieu of further assessment. The baby subsequently collapsed at home and resuscitation was unsuccessful.* (2019)

*In **2020**, a low-birth-weight baby was discharged without blood glucose monitoring. On the day of discharge the baby was found at home to be blue and lifeless; resuscitation was unsuccessful and blood glucose was unrecordable.* (2020)

4. Postnatal Communication

4.1 Communication Between Clinical Teams

The Review Team identified failures in communication between clinical teams across the review period with direct consequences for the care received by mothers and their families.

*In **2013**, a staff member attended a mother who had been discharged following a stillbirth for what was recorded as a routine postnatal visit, unaware that the mother had not had a livebirth.* (2013)

*In **2018**, ineffective communication between the postnatal ward and the neonatal unit affected feeding plans for twins receiving transitional care.* (2018)

4.2 Discharge Communication to GPs and Community Teams

In several cases, discharge communication to GPs was incomplete or absent, with direct clinical consequences;

*In **2012**, neither the GP nor community midwives were informed that a mother had been discharged home on antihypertensive medication, and a discharge summary failed to record an ICU admission or required follow-up investigations.* (2012)

*In **2013**, a mother with chronic hypertension was discharged following a stillbirth without an appropriate plan for blood pressure monitoring being communicated to her GP.* (2013)

*In **2019**, a failure to request GP continuation of postnatal thromboprophylaxis resulted in a mother not completing her treatment and subsequently developing a pulmonary embolus.* (2019)

*In **2020**, a GP was not informed of intrapartum findings requiring caesarean birth in all future pregnancies, nor of the mother's gestational diabetes.* (2020)

*In **2021**, a similar deficiency was identified, where a discharge summary lacked critical information regarding hypertension management and follow-up.* (2021)

5. Recognition and Escalation of Medical Concerns

The Review Team identified failures to recognise and escalate clinical concerns to medical staff across the review period.

*In **2014**, maternal hypertension was not escalated to medical staff.* (2014)

*Also in **2014**, hypotension with poor urine output following caesarean birth was not appropriately assessed, leading to delayed recognition of intra-abdominal bleeding that required return to theatre.* (2014)

*In **2016**, persistent wound oozing was documented on multiple occasions but not escalated; it was only brought to medical attention when the mother was being prepared for discharge, by which point her discharge was delayed. In the same year, repeated episodes of hypertension were not escalated to the obstetric team.* (2016)

*In **2017**, a mother reported rectal bleeding following a third-degree tear; this was not escalated resulting in a delayed recognition of an anal fistula requiring surgical management. (2017)*

The Review Team also identified cases in which escalation occurred but was directed inappropriately;

*In **2018**, a mother with persistent hypertension following caesarean birth was referred only to the anaesthetic team, without obstetric involvement.* (2018)

*In **2019**, repeated episodes of vaginal bleeding following caesarean birth were not escalated to the obstetric team, delaying appropriate assessment and management.* (2019)

6. Recognition and Management of the Deteriorating Mother

6.1 Failure to escalate to senior clinicians

The Review Team identified cases in which clinical deterioration was not recognised or escalated to senior clinicians in a timely manner, resulting in delayed diagnosis and management.

In 2010, haemodynamic instability following vaginal birth after caesarean was not recognised, leading to a 24-hour delay before laparotomy, at which point uterine rupture was identified. The mother told the Review:

"I complained about the pain in my abdomen still being there – when I say I complained, I mean I screamed at the staff about the stabbing feeling in my stomach." (2010)

*In **2012**, a mother reported leg pain two days before discharge; a staff member assessed this as clinically unlikely to represent deep vein thrombosis and did not arrange investigations. The mother subsequently presented with a pulmonary embolus.* (2012)

*In **2013**, persistent postnatal hypertension was not managed with regular antihypertensive medication for several days owing to a lack of senior input and poor care planning.* (2013)

*In **2017** and **2022**, persistent hypotension following caesarean birth was not escalated in two separate cases, leading to delayed recognition of ongoing bleeding requiring surgical management.* (2017, 2022)

*In **2024**, no escalation occurred despite a mother reporting shoulder tip pain with a distended abdomen and deteriorating observations following caesarean birth; this resulted in a delay of more than ten hours before she returned to theatre. The mother told the Review Team:*

"I felt so much pain. They offered me more painkillers and said it is normal but it was not." (2024)

6.2 Failure to recognise deterioration during senior review

The Review Team also identified cases in which ongoing bleeding, deteriorating observations, or worsening blood results were not recognised even when mothers were being reviewed by senior clinicians.

*In **2013**, a mother with unrecognised HELLP Syndrome and continuing bleeding following caesarean birth was not adequately assessed despite ongoing review on the labour ward, ultimately resulting in delayed return to theatre and hysterectomy.* (2013)

*In **2014**, despite multiple multidisciplinary reviews, the documented post-caesarean management plan for a mother with severe pre-eclampsia was not followed, resulting in avoidable deterioration.* (2014)

*In **2017**, although intraoperative management of an abnormally invasive placenta was appropriate, postnatal observations and reviews in recovery were inadequate, leading to delayed recognition of bleeding that required return to theatre.* (2017)

*In **2023**, significant pain and an elevated pulse rate following caesarean birth were not acted upon by the anaesthetic and obstetric teams; there was no holistic MDT, and the mother required further surgery for ongoing internal bleeding.* (2023)

7. 4th Degree Tears

7.1 Clinical Management

During the review period (Jan 2012-May 2025), according to records provided by NUH, there were 145 4th degree tears and nine buttonhole tears without sphincter damage. By the RCOG definition, only buttonhole tears that involve the anal sphincter complex should be classified as 4th degree tears, but all tears involving the anorectal mucosa can lead to the development of an anovaginal fistula.[173] Therefore, the discussion below relates to 4th degree and buttonhole tears.

During the review period 116,261 mothers had their babies under the care of NUH, of whom 70.1% had vaginal births[174]. The NUH rates of 4th degree tears appears to be high at 1.76 per 1000 vaginal births for the review period (range: 1.20-2.37 per 1000 vaginal births per year). It is not possible to directly compare the Trust's rates with other maternity units as there are no national figures available solely for 4th degree tears. All reports, including the National Maternity Dashboard, quote rates of obstetric anal sphincter injuries (OASI) which include all 3rd and 4th degree tears.[175] The RCOG guideline (2015)[1] quotes the overall incidence of OASI in the UK as 2.9% (range 0-8%). The NUH maternity dashboards for which the data on 3rd and 4th degree tears has been documented (Jan 2014-December 2024) indicate that the overall rate of these tears in women who have delivered vaginally is within the expected range at 3.8%. In those years for which the data is documented on the maternity dashboards (Jan 2017-Dec 2024) the rate of OASI for all assisted vaginal births (ventouse and forceps) was 7.9%.[2]

With regards to mode of birth, the overall distribution of 4th degree tears is as follows:

MODE OF BIRTH	NUMBER
Unassisted vaginal birth	69
Waterbirth	4
Birth assisted by ventouse	17
Birth assisted by forceps	55
Total	**145**

Despite local and national guidance that an episiotomy should be performed during assisted births, 16 forceps births and six ventouse births that culminated in 4th degree tears were performed without episiotomy. Of these seven, three forceps and four ventouse without episiotomy occurred after the RCOG guidance changed to: 'In the absence of robust evidence to support either routine or restrictive use of episiotomy at assisted vaginal birth, the decision should be tailored to the circumstances at the time and the preferences of the woman'.

In all 16 forceps births that occurred without episiotomy the documentation indicated the head delivery was precipitate, not that there had been an assessment that episiotomy was not required. When a birth is assisted by forceps, the delivery of the head should be controlled by the obstetrician. Controlled birth of the head, and/or episiotomy may have prevented the 4th degree tear for some of these women. In all 16 cases this was the mother's first vaginal birth, when episiotomy for a forceps delivery is usually indicated. The Trust highlighted the lack of episiotomy during instrumental birth through a local audit in June 2015. However, the Review Team were unable to find evidence of embedded learning as, after the presentation of the audit, a further 12 4th degree tears occurred following forceps births without an episiotomy.

173 https://www.rcog.org.uk/media/5jeb5hzu/gtg-29.pdf

174 Local maternity dashboards (NUH)

175 https://app.powerbi.com/view?r=eyJrIjoiOTg1YTkzNWQtNTM1NS00YmE0LWEzNTktMWQ3ZTRlNWM5ZmUyIiwidCI6IjM3YzM1NGIyLTg1YjAt-NDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9

In five of the six births where a 4th degree tear occurred after a ventouse delivery without episiotomy, the documentation indicated that assessment had been made during the delivery that episiotomy was not required.

The Trust's perineal guideline from 2012-2024 indicated that repair of 3rd and 4th degree tears should only be performed by staff who have completed training and competency assessments. From 2017 there was also additional advice to 'consider calling a consultant for help' with the repair of a buttonhole tear. The Review Team found that senior clinician presence for the repair was mostly appropriate. In 12 cases the colorectal or general surgeons performed either a primary repair (two buttonhole tears and two 4th degree tears) or a defunctioning colostomy (eight 4th degree tears). Three of the 4th degree tear repairs by a consultant surgeon included an external anal sphincter repair using figure-of-eight sutures, which is contrary to the 2015 RCOG guideline which specifically advises that such sutures should be 'avoided during the repair of OASI because they are haemostatic in nature and may cause tissue ischaemia'.

Of the remaining four cases where a primary repair was performed by a colorectal surgeon, two women were counselled by the surgeon and chose primary repair alone. In one case the surgeon decided against colostomy in theatre after repairing a buttonhole tear and noting that the sphincters were intact, but in the last case there is no documentation of surgical review or counselling before transfer to theatre. In this case, the repair of the 4th degree tear was completed by the obstetric team, and the surgical notes indicate that the colorectal team repaired the rectum and sphincter.

In 77 cases, the repair was performed by an obstetric consultant or post-CCT Fellow, and in 57 cases the repair was performed by a senior registrar or ST6/7 trainee. In only three cases was the repair performed by a more junior registrar. However, all these cases occurred between 2014 and 2017. The Review Team were unable to determine whether these registrars were appropriately trained to repair 4th degree tears without direct senior supervision.

There was a multidisciplinary morbidity and mortality (M&M) meeting in October 2019, attended by consultant obstetricians and consultant colorectal surgeons, where three buttonhole tears, with sphincter damage, were discussed. Two had been managed with a defunctioning colostomy, and one with a primary repair alone. The surgeon's views documented at this meeting was that all rectal damage should be managed with a colostomy to avoid fistula formation, but there was acknowledgement that 'we do not have current data regarding outcomes of 3rd and 4th degree tear repair', which is true both at NUH and nationally. The actions agreed from this meeting were:

- There should be an audit of 4th degree tears at NUH including medium/long term outcomes of repairs.
- If an appropriately trained obstetrician is comfortable and confident to suture a 4th degree tear then they should proceed to do so as per the existing guidelines.
- If the obstetric consultant has concerns about a particularly large or difficult tear, particularly a buttonhole tear, then the consultant colorectal surgeon should be contacted to review the woman on either City or Queen's Medical Centre (QMC) campus.
- The colorectal surgeons will inform all the colorectal consultants about this plan.
- If a defunctioning colostomy is being considered, then fully informed consent should be taken by the colorectal surgeon.

The Trust 'Guideline for the management of perineal trauma and breakdown' was not amended to reflect these actions until 2024. The 2024 guideline indicated that a consultant should be asked to attend for all 3rd degree, 4th degree and buttonhole tear repairs, also noting that if the consultant has any concerns about the repair, a colorectal surgeon should be asked to review.

There was an audit of 3rd and 4th degree tears undertaken in 2022, but only 6 months were audited (June-November 2022) during which time there were 2342 vaginal births (data from NUH maternity dashboards). The audit identified 80 3rd/4th degree tears during this time period, but there were only three 4th degree tears, and no buttonhole tears (data from cases reported to this Review by the Trust). This audit was therefore of poor value with regard to the aims noted at the October 2019 M&M meeting as, with such

small numbers, it could not address outcomes after 4th degree tear repair. The audit did indicate that 5% of the 19 women who had undergone 3rd/4th degree tear repair who reported symptoms at their follow up appointment had undergone repair of a 4th degree tear, but it did not separately indicate what proportion of women with a 4th degree tear this applied to. Similarly, the audit reported that 13% of women had a 'defunctional stoma', but did not identify what proportion of these women had 4th degree tears. The Review Team felt that there was no evidence of learning from this audit, and that a much more robust audit would have been required to address the issue of medium/long term outcomes after 4th degree tear repairs.

7.2 Follow-up Care

The Trust has a dedicated Perineum after Pregnancy (PAP) clinic. The Review Team were able to find evidence that 79.9% of women who had experienced 4th degree or buttonhole tears had appropriate follow-up in this clinic (123 of the 154 women). This was usually around three months after the birth. Of the remaining 31 women, 17 did not attend the arranged appointments, but in 13 cases the Review Team could not find any evidence that a clinic appointment was offered. In one case it was appropriate that a follow-up appointment was not arranged as the mother was discharged from the postnatal ward to her new home in the North East of England, in this case a consultant wrote a clear letter outlining the events surrounding her delivery, and asked that the GP refer her locally for follow-up. This evidences personalised management.

It is clear from the Trust guidance and this data, that the current national guideline for the management of 3rd and 4th degree perineal tears is being followed with regards to follow-up care. There was evidence in most cases that maternity staff had requested follow up (there is a copy of the request form in maternal notes), but in some cases it did not occur, which may have been because the woman did not attend. However, this was not recorded in the notes, or may have been because she was never sent an appointment.

Whilst it was clear that women who have suffered a 4th degree or buttonhole tear are offered appropriate follow up, it is less clear that those who reported symptoms such as faecal urgency or incontinence always had appropriate ongoing care. At follow-up, 61% (75 of 123) of the women reported no symptoms, the remainder did report some symptoms, and in a number of cases more than one symptom. Ten women reported urinary symptoms, four women reported perineal problems, seven women reported problems with intercourse and three women reported anxiety. The Review Team acknowledge that symptoms may have been under-reported due to recognised social stigma relating to women's pelvic health issues.[176]

Of the 19 women (15.5% of all women followed up after 4th degree or buttonhole tears) who reported bowel control symptoms, such as faecal urgency and/or incontinence, seven were appropriately discharged from the PAP clinic because they reported historical symptoms that had now resolved or they reported minimal symptoms. Five women had appropriate ongoing follow up either in the PAP clinic, or with the colorectal team. However, four of the women were discharged from the PAP clinic, or given open appointments, despite ongoing significant symptoms. The two women with ongoing symptoms who were given 'open' appointments did not contact the hospital requesting further appointments, but later documentation indicates that their symptoms persisted. This demonstrates that offering an open appointment is not an effective way of ensuring follow-up care if symptoms persist, possibly because the women avoided requesting help for their symptoms due to fear of embarrassment.

*In one case in **2013**, a woman was followed up in the PAP clinic until she was 6 months postnatal, but then discharged, despite reporting ongoing faecal incontinence. The letter from the PAP clinic asked her GP to refer her to the colorectal team.* (2013)

At the time of follow-up, usually three months following birth, seven women had a colostomy and four had rectovaginal fistulae. One woman still had her colostomy four years after the birth, as the colorectal surgeons declined to reverse it until her weight was below 100kg.

Of the women with rectovaginal fistulae, two had a 4th degree tear without a buttonhole tear, and had their primary repair by the obstetric team. One woman had a 4th degree tear with a buttonhole tear, which

176 https://pureunityhealth.co.uk/resources/blog/addressing-the-womens-health-gap-in-the-nhs/#:~:text=Government%20Policies%20and%20Their%20Role,%25%20(DHSC,%202023).

was repaired by the surgical team without a colostomy, and the final woman had a primary repair and defunctioning colostomy by the surgical team (this fistula was not diagnosed until 11 months after the birth). Whilst these numbers are small, they do appear to reflect the lack of evidence on the best initial management of 4th degree tears, for which there are currently no national guidelines. The Review Team understands that the RCOG is currently updating guidance for the management of 3rd and 4th degree perineal tears.

It was clear that on-call surgical teams attend promptly when asked to review a woman for a 4th degree or buttonhole tear, and readily advise the women and perform their surgery. However, there is little evidence of MDT management, which is especially evident in the follow-up of these women.

Of the 13 women in whom the primary repair (five cases) or a defunctioning colostomy (eight cases) was performed by the colorectal team, all but one (a primary repair of a buttonhole tear without sphincter damage) had follow-up care by the colorectal team. In general these women also had PAP clinic follow up, and often a debrief appointment with their own obstetric consultant.

There was no evidence of any coordination of these appointments, and in one case in 2019 a woman had all three appointments within a five week period, which may have been particularly challenging with a young baby.

Another reflection of the lack of MDT working with regards to follow-up care, is that the consultant responsible for the PAP clinic was unable to arrange endo-anal ultrasound, or physiology studies in women reporting ongoing bowel dysfunction. This inevitably delayed ongoing care in symptomatic women. The Review Team also found evidence where a referral for physiology studies from the colorectal specialist nurse was rejected until a written request was received from a colorectal consultant.

There is no national guidance on who should repair 4th degree tears, apart from indicating that they should have undertaken appropriate training, nor whether a defunctioning colostomy along with the repair should be advised. The most recent RCOG guideline (updated 2019) simply notes ‘Involvement of a colorectal surgeon will be dependent on local protocols’. The guideline does indicate appropriate suture materials and techniques for the repair of the anorectal mucosa, and specifically advises that ‘figure-of-eight sutures should be avoided during the repair of OASI because they are haemostatic in nature and may cause tissue ischaemia’ specifically noting that this applies to the repair of the anorectal mucosa and the sphincter. However, the Review Team found evidence that this technique was used in NUH for several years after this guidance was issued.

Clinical governance management was found to be variable. Not all 4th degree tears were reported via DATIX. Of those that were, the harm levels varied between, no harm, minor harm, moderate harm and severe harm.

One case involved a birth assisted by forceps with no episiotomy; it was reported as minor harm and the investigation stated:

“Known complication of childbirth. No suboptimal care.” (2019)

*A further incident in **2021** also involving a forceps birth with no episiotomy was similarly reported as minor harm. This incident was closed as part of a wider thematic review of all incidents with no individual learning nor case review identified.* (2021)

7.3 Women’s Experiences of their Care and the Impact upon their Health

Although there has been investment in women’s pelvic health in recent years, there are significant short and long-term effects for women who sustain a 4th degree or buttonhole tear during childbirth. Many women reported long-lasting physical symptoms such as pain, mobility limitations, prolapse, dyspareunia, urgency and incontinence of flatus and/or faeces.

“We went for a walk and I made it to the bottom of the road, but then I was in so much pain that I had to turn around…” (2020)

Women also described psychological symptoms such as flashbacks, nightmares and post-traumatic stress disorder related symptoms. Some women reported long-term feelings of inadequacy, shame, guilt and emotional withdrawal.

"I suffered with postnatal depression…I felt like I was inadequate…" (2020)

The Review Team found a common theme of poor communication with regards to immediate and ongoing clinical care. Many reported no updates for partners whilst women were in theatre, inadequate explanation about injuries and unclear recovery guidance. There were reports of suboptimal clinical follow-up, leaflet-only care, no wound checks and insufficient access to physiotherapy.

"But all they gave me... was a booklet on a 4th degree tear to tell me what had happened and what I'd done. Not how to look after myself, not how to take care of what I should and shouldn't be doing. I would have loved to have another child but I have not. I don't want to go and see a doctor about it because it terrifies me in case I end up in a worse position than what I am… I suffer from anxiety now." (2012)

"He's got a screaming child for two hours while he doesn't know what is happening to his wife. I also remember wondering if I was going to die because I didn't know what was happening. I didn't know I could use my legs because nobody has told me. I remember there being a lot of blood ...I was completely broken physically and mentally and had no idea what was happening I'm assuming it was the [staff member], it was someone who came around with leaflets about a third and 4th degree tear...because you've had a fourth-degree tear, you can have a C-Section next time…" (2018)

The resultant impact on women's daily life was palpable. Some women described how it was difficult to leave the house due to poor access to a toilet, some women required spare clothing in case of incontinence, and some women were unable to continue with their careers after maternity leave due to ongoing physical symptoms. Many women made lifestyle adjustments to help with their physical and psychological symptoms. However, there were sadly reports of relationship challenges, difficulties with bonding and some women informed the Review Team there were times when they were unable to care for their baby at all. Future pregnancies were difficult to discuss with some families choosing to become 'one-child families' out of fear of further physical trauma alongside the collective impact and strain such complications may have upon their relationship.

The impact upon women from a physical, psychological and social perspective cannot be underestimated. It is imperative that maternity services and the wider healthcare system ensure women can access care to support/treat all of their symptoms to optimise their initial healing and ongoing physical and mental health recovery.

7.4 4th Degree Tears Conclusion

In summary, there were 145 4th degree tears and nine buttonhole tears at the Trust during the review period. National comparison is difficult because no national data exists for 4th degree tears alone. The Trust's combined OASI rate for vaginal births was 3.8%, which is within the expected national range. The Review Team highlighted concern regarding the lack of use of an episiotomy for forceps births. Although this was highlighted as an issue through clinical audit, there was no evidence of learning and improvement as further similar cases occurred. Further audit was undertaken, but the time interval between audits was prolonged and there was no evidence that previous recommendations were revisited.

The Review Team felt that the majority of surgical repairs were undertaken with recognised techniques by an appropriately trained professional. However, there was evidence of some poor practice including the use of 'figure-of-eight' sutures which was contradicted by RCOG guidance at the time the repair occurred. Follow-up care was reported by women to be of a variable standard with symptom management inconsistent. Many women reported significant physical, psychological and social consequences due to their severe perineal trauma. Although there has been development within women's pelvic health services in recent years, further investment is urgently required to improve the care and support available during the initial postnatal period, and beyond for women who sustain an obstetric anal sphincter injury.

8. Postnatal Care Planning

The Review Team identified failures in postnatal care planning across the review period, particularly following transfer to the postnatal ward.

In several cases spanning 2013 and 2014, there was no clear plan for the monitoring and management of hypertension either during the inpatient stay or following discharge into the community;

*In **2013**, a mother who required abdominal surgery 20 days after birth did not have thromboprophylaxis considered during her admission despite obstetric input; she subsequently presented with pulmonary emboli.* (2013)

*In **2014**, a mother with pre-eclampsia and HELLP Syndrome received fragmented care compounded by the absence of a holistic obstetric review of her overall clinical situation, which contributed to avoidable deterioration in her management.* (2014)

9. Consultant Involvement in Postnatal Management

The Review Team identified limited consultant involvement in postnatal management, particularly following transfer to the postnatal ward, including in cases of significant clinical complexity.

*In **2012**, a critically unwell postnatal mother required prolonged admission to non-maternity wards. She received only two midwifery reviews and one obstetric review during a four-day ICU stay, and no maternity input during a subsequent four-week ward admission.* (2012)

*In **2017**, a mother with a complicated caesarean wound infection was managed for five days by junior staff without senior review.* (2017)

10. Postnatal Fluid Management

The Review Team identified failures in fluid balance monitoring and fluid administration across the Review period, particularly in mothers with pre-eclampsia or other complex medical conditions;

*In **2013**, inadequate fluid monitoring in a mother with a sickle cell crisis complicated by pneumonia resulted in fluid overload, further complicating her clinical management*. (2013)

*In **2014**, fluid overload occurred in two mothers despite clear documented indications for fluid restriction, contributing to pulmonary oedema in both cases.* (2014)

*In **2017**, excessive oral fluid intake during labour was not monitored, resulting in hyponatraemia, postnatal seizure, and admission to the ITU.* (2017)

*In **2024**, a further case of fluid overload despite documented indications for restriction was identified.* (2024)

11. Inappropriate Care Settings

The Review Team identified cases in which the care setting did not match the clinical needs of the mother. Three distinct patterns were identified: premature transfer from critical care to the postnatal ward; premature transfer from recovery or the labour ward to the postnatal ward; and failure to transfer to critical care when clinically indicated.

11.1 Premature Transfer from Critical Care to the Postnatal Ward

Some mothers were transferred directly from high-dependency or critical care settings to the postnatal ward despite requiring ongoing intermediate-level care.

Trust data indicates that during the review period, 630 maternity patients were admitted to an adult critical care area, the majority of whom are likely to have been postnatal mothers. Of these, 319 were transferred to an obstetrics area on discharge from critical care and 177 were transferred to a general ward, which in some cases was a postnatal ward. The Trust's own 2022 Maternal Critical Care Guideline acknowledged that the care environment must match the woman's immediate clinical need. Nevertheless, for mothers who had previously required one-to-one care and who may have been separated from their baby, transfer to a postnatal ward where nursing support is limited and independent infant care is expected can represent a significant and potentially unsafe step down.

11.2 Premature Transfer to the Postnatal Ward

Other cases involved transfer to the postnatal ward before the mother's clinical condition warranted it:

*In **2013**, a mother with HELLP Syndrome was transferred to the postnatal ward before her condition had stabilised.* (2013)

*In **2015**, a mother was transferred to the ward after only 47 minutes in recovery following caesarean birth with a postpartum haemorrhage; she subsequently returned to theatre for management of persistent bleeding.* (2015)

*In **2023**, a mother was transferred to the postnatal ward whilst still requiring one-to-one care. She told the Review Team:*

"I was transferred back up to the ward despite me being in extreme pain and my stomach swelling without any explanation of the sudden move and sudden rush."

She returned to the labour ward four hours later for further care. She described feeling let down, not listened to, and vulnerable. (2023)

11.3 Failure to Transfer to Critical Care

The Review Team also identified cases in which mothers who required critical care were not transferred to an appropriate setting in a timely manner.

*In **2013**, a mother with heavy intraoperative bleeding and unrecognised HELLP Syndrome was managed on the labour ward rather than in critical care; transfer was not arranged until ten hours after delivery.* (2013)

*In **2015**, a mother with severe pre-eclampsia following a very preterm caesarean birth was managed on the labour ward for several days. When she deteriorated, continuous ECG monitoring was advised but was unavailable on the labour ward and was not commenced for a further 24 hours, by which time she had developed a new oxygen requirement and required transfer to ICU.* (2015)

12. Discharge from the Postnatal Ward Despite Ongoing Symptoms

The Review Team identified instances in which mothers were discharged from the postnatal ward without adequate consideration of the clinical picture or of concerns raised by mothers themselves;

*In **2014**, a mother was discharged on antibiotics seven days after caesarean birth, having been transferred from the labour ward only hours earlier following management of colonic pseudo-obstruction (Ogilvie's syndrome) without full multidisciplinary involvement. Records indicated that her pain had been intermittent in the preceding days, although it had improved at the time of discharge. She was readmitted two days*

later with severe pain; laparotomy identified a bowel perforation that had occurred prior to readmission. (2014)

*In **2022**, a mother was discharged with persistent mild tachycardia without prior investigation. She was subsequently diagnosed with a pulmonary embolus.* (2022)

13. Management Following Postnatal Readmission

The Review Team identified delays in medical review following postnatal readmission across the review period, resulting in delayed initiation of treatment;

*In **2008**, a mother readmitted with infection waited more than two hours for medical review, delaying initiation of the sepsis management pathway.* (2008)

*In **2018**, a mother readmitted with probable sepsis did not receive a first medical review until more than three hours after admission, resulting in delayed antibiotic treatment.* (2018)

*In **2023**, a mother who re-presented in an unwell condition with leaking from her caesarean wound waited almost two hours for medical review following admission; there was a further six-day delay in escalating antibiotic therapy despite microbiology advice.* (2023)

In some cases, definitive management was deferred because outpatient treatment was advised at initial presentation despite concerning symptoms;

*In **2009**, a mother who re-presented eight days after caesarean birth with fever, pain, wound discharge, diarrhoea, and vomiting was discharged home on oral antibiotics without senior medical review. She re-presented on day 24 with an open discharging wound and a pelvic abscess requiring surgical management.* (2009)

*In **2023**, a mother who presented to triage with heavy vaginal bleeding seven days after caesarean birth was discharged and readmitted six hours later with very heavy bleeding requiring operative management.* (2023)

In other cases, management plans were appropriate but were not implemented in a timely manner;

*In **2022**, a mother readmitted with a necrotic open caesarean wound did not receive a plastic surgery review until the day after admission. This delayed the wound debridement she required.* (2022)

14. Maternal Mental Health during Postnatal Readmission

The Review Team found that consideration of the impact of postnatal readmission on maternal mental health was not consistently prioritised, particularly in cases involving prolonged admissions or separation from the newborn.

*In **2020**, a mother readmitted on day 18 with a significant wound infection remained in hospital for almost three months, requiring multiple returns to theatre and intensive input from the tissue viability team. Despite the length and complexity of her admission, opportunities for perinatal mental health were not taken.* (2020)

*In **2022**, a mother who experienced repeated postnatal readmissions with serious complications told the Review Team:*

“I thought I was going to die and no one wants to think they’re going to die when they’ve got newborn children.”

Despite repeated documentation of anxiety in the clinical records, a referral for mental health support was not made until one month after the birth. (2022)

15. Postnatal Ward Staffing

Both families and staff consistently reported inadequate staffing levels on the postnatal ward to the Review Team. This was exacerbated by the redeployment of midwives to the labour ward to maintain one-to-one intrapartum care, reducing the support available to mothers in the postnatal period.

Staff described significant concerns regarding safety, morale and the quality of care they were able to provide. One member of staff told the Review:

"I have serious concerns about the safety and oversight of transitional care which I have raised repeatedly and no changes have been made." (2024)

A staff member who left the Trust because of concerns about staffing reported severe shortages on the antenatal and postnatal wards, adding that these were not apparent on the day of CQC inspection. They told the Review Team:

"I never left work feeling like I had done a good job… disappointing women on every shift" (2024)

Other staff members reported the same pattern, describing the postnatal ward as consistently short-staffed. Families acknowledged that individual staff did their best in difficult circumstances, but reported feeling unsafe as a result of insufficient staffing levels. Families described the stark contrast between the level of care they had received in the ICU and the limited support available on the postnatal ward.

16. Community Postnatal Care

The Review Team identified cases of inadequate or absent community postnatal follow-up across the review period, particularly following stillbirth, maternal medical complications, and neonatal feeding concerns.

Postnatal care following stillbirth was frequently limited to a single visit or was absent entirely, with inadequate emotional and physical support documented across multiple years, including cases identified in 2012, 2015, 2016, and 2019. Inadequate blood pressure monitoring in the community following discharge of women with known hypertension or pre-eclampsia was also identified in several cases spanning 2013 to 2020.

Lack of timely face-to-face review had significant consequences for babies on a number of occasions;

*In **2013**, a mother made several calls to report that her baby was not feeding well; none resulted in a face-to-face review. When she subsequently reported that the baby had not fed for many hours and was feeling cold, emergency transfer was neither suggested nor arranged. The baby was later diagnosed with an infection.* (2013)

*In **2016**, during a postnatal home visit, a staff member did not recognise the significance of chest tightness reported by a mother with known VTE risk factors. No maternal observations were taken and the mother was advised only to contact her GP if the symptoms persisted. She presented later that day with a pulmonary embolus.* (2016)

*In **2020**, a staff member gave inappropriate feeding advice by telephone when a mother reported that her baby had not fed for several hours; the baby was admitted hours later with profound hypoglycaemia.* (2020)

Inadequate wound assessment in the community was identified across several years;

*In **2020**, following discharge for conservative management of a caesarean wound haematoma, wound checks were not performed during multiple community visits; on day 22 the mother required surgical debridement of an open wound.* (2020)

*In **2022,** a caesarean wound was not assessed for several days in a mother at known risk of wound infection; she required readmission for wound management.* (2022)

*In **2023**, following a two-week inpatient admission for wound infection, the only community follow-up provided was by telephone, which was inappropriate given the clinical history.* (2023)

*In **2024**, a staff member advised a mother who reported abdominal pain, feeling unwell, and shivering four days after caesarean birth to take analgesia and call 111. A planned home visit on day six subsequently showed normal findings; however, this visit only took place after the mother contacted the team herself to report that no one had attended. Although no harm resulted in this instance, the care provided fell below the standard expected.* (2024)

17. Community Postnatal Feeding Support

The Review Team identified deficiencies in community postnatal feeding support across the Review period, with direct consequences for neonatal wellbeing.

*In **2013**, a pre-term breastfed baby was discharged after thirteen days in the neonatal unit. Community reviews occurred only on days 14 and 18; by day 18 the baby had lost 20% of birth weight and required readmission.* (2013)

*In **2022**, a mother raised breastfeeding concerns on day 3; the baby was not weighed until day 5, when an 11% weight loss was recorded, but no feeding plan was established. The baby required hospital admission on day 8, by which point weight loss had reached 14.3% of birth weight.* (2022)

During the COVID-19 pandemic, face-to-face review of babies in whom feeding difficulties or jaundice had been identified was significantly limited, with serious consequences in a number of cases.

18. Maternity Support Workers (MSW): Communication and Governance

The Review Team identified a number of cases in which concerns identified by MSWs were not escalated to a midwife, or in which escalation was ineffective, with consequent harm to babies. The Trust provided evidence of MSW training in the recognition of unwell babies but was unable to provide the Review Team with a community escalation guideline or Standard Operating Procedure (SOP). It was also unable to provide a SOP indicating when a community visit should be allocated to an MSW rather than to a registered midwife.

*In **2019**, jaundice was identified in a baby on day 3 was followed up by visits on days 4 and 5. The jaundice was not resolving but was not escalated; on day 7 the baby was found to have significant jaundice requiring intensive phototherapy.* (2019)

*In **2021**, jaundice identified by a staff member on day 2 was followed up on day 3. The jaundice persisted but was not escalated; by day 4 the baby required admission for intensive phototherapy.*

*Also in **2021**, following discharge on day 1 and a telephone review on day 2, subsequent contacts were made at home. The mother reported concerns about poor waking for feeds; no further information was sought and there was no escalation. A home visit did not occur until day 5, at which point the baby required admission with significant jaundice.* (2021)

*In **2023**, following a complex birth, a mother was seen by a staff member on days 3 and 5 but missed her day 11 visit. No further contact occurred until an unanswered staff member call on day 20, which was not escalated. Midwifery care was transferred to the health visitor on day 35 without further review having taken place.* (2023)

*Also in **2023**, breastfeeding concerns on day 4 prompted a visit the same day. The staff member had concerns but did not perform observations, and did not escalate; a member of the paediatric team who was contacted did not arrange hospital review. When a different staff member visited the following day, a weight loss of 19.8% was identified and the baby was admitted. This case was subsequently included in the Trust's Infant Feeding Thematic Review published in 2025; however, that review did not address the failure of escalation.* (2023)

Across these cases, a consistent pattern was identified: concerns raised with or observed by MSWs were not escalated and clinical deterioration in the baby resulted in each instance. This pattern, combined with the absence of a governance framework for MSW visit allocation and escalation, represents a systemic risk that requires immediate and sustained attention by the Trust.

19. Inappropriate Postnatal Review by Telephone

During the COVID-19 pandemic, postnatal telephone reviews became the default model for community follow-up after discharge, with face-to-face visits reserved for clinically essential situations. Following the withdrawal of restrictions, many hospitals continued to provide postnatal contact predominantly by telephone. While telephone follow-up can be appropriate in some circumstances, the Review Team identified a significant number of occasions on which it was used inappropriately at NUH.

The Trust's 2022 Postnatal Guideline states that the first community postnatal visit for all mothers should be a face-to-face midwife review within 36 hours of discharge, consistent with the NICE Postnatal Care guideline (2021). However, it provides no guidance on when subsequent telephone contact is appropriate or inappropriate. Neither national nor local guidance defines the circumstances in which a telephone review may substitute for a face-to-face visit. The Review Team also noted that telephone contacts are documented by NUH staff as 'wellbeing calls', a framing that risks creating an assumption that the mother and baby are well before the call has taken place, introducing the potential for confirmation bias.

19.1 Language Barriers and Telephone Follow-up

The Review identified occasions on which mothers who did not speak English received postnatal telephone follow-up with family members acting as interpreters rather than professional interpreter services being used.

*In **2024**, only a telephone bereavement care call was provided despite a documented language barrier. The use of telephone follow-up in conjunction with informal interpretation compounds the risk of clinical information being missed or misunderstood.* (2024)

19.2 Maternal Assessment Conducted by Telephone

Physical assessment cannot be conducted by telephone, yet reviews requiring examination were conducted in this way on a number of occasions identified by the Review Team.

*In **2014**, a hypertensive mother following stillbirth did not receive any face-to-face community visit, bereavement care, or blood pressure check until day 11.* (2014)

*In **2023**, following a two-week inpatient stay for wound infection, the only community follow-up was a single telephone call nine days after discharge.* (2023)

*Again in **2023**, following a 4th degree tear repair, only one face-to-face visit occurred; all subsequent contacts were by telephone.* (2023)

*Also in **2023**, a mother was discharged from community midwifery care by telephone on day 16, having had no face-to-face review since day 6, when superficial perineal breakdown had been noted by a staff member.* (2023)

Women with prolonged inpatient stays were also frequently followed up predominantly by telephone.

*In **2024**, following a seven-day inpatient stay for maternal complications, no face-to-face review occurred until day 19 despite several interim wellbeing calls.* (2024)

*In **2025**, a mother discharged on day 10 following a complex postnatal course received initial follow-up by telephone; when seen on day 13, readmission was required*. (2025)

19.3 Neonatal Concerns followed up by Telephone

Babies cannot be assessed remotely, yet neonatal concerns were frequently followed up by telephone rather than face-to-face review, with serious consequences in a number of cases;

During COVID-19 restrictions in 2021, several cases were identified in which earlier face-to-face review, rather than telephone follow-up, would likely have improved neonatal management.

*In two cases in **2021**, mothers received daily telephone calls because feeding concerns had been identified; neither received a face-to-face visit until day 5, at which point one baby had a 22% weight loss requiring intensive phototherapy and the second also required admission for intensive phototherapy.* (2021)

*In a third case in **2021**, jaundice noted by a staff member at a face-to-face visit on day 3 was followed up by telephone the next day and when the baby was seen again on day 5, she required admission with a 17.4% weight loss, jaundice, and hypothermia.* (2021)

*In a fourth case in **2021**, jaundice and unsettled behaviour noted on day 2, alongside maternal reports of feeding difficulties, were followed up by telephone; the baby required admission on day 5 with dehydration and a 17% weight loss.* (2021)

*In **2023**, a mother with breastfeeding concerns received only telephone contact; by day 5 the baby had lost 19.8% of birth weight and required admission.* (2023)

19.4 Other Failures in Telephone Follow-up

The Review Team also identified occasions on which families were asked to conduct clinical assessments remotely.

*In **2021**, a partner was asked to check the mother's pulse, temperature, and respiratory rate after reporting that she was unwell, which is not an appropriate use of remote contact.* (2021)

The Review further noted that missed calls were not consistently followed up.

*In **2023**, following a face-to-face visit on day 5, the Trust failed to re-establish contact after calls went unanswered, and the mother was transferred to health visitor care on day 35 without further midwifery review having taken place.* (2023)

20. Postnatal Follow-up Following Delivery at Another Trust or Site

The Review Team identified reluctance and inconsistency in arranging postnatal follow-up for women who had delivered at another Trust or at the Trust's other maternity site.

*In **2022**, postnatal care following caesarean birth and early neonatal death at another Trust was poorly coordinated, with a lack of continuity of care. Staff members asked the parents about the baby and about breastfeeding, which was inappropriate and distressing given the circumstances of the neonatal death and the family's need to repeatedly recount their history. The mother subsequently experienced difficulty accessing treatment for a wound infection.* (2022)

*In **2024**, following an emergency caesarean birth and neonatal cooling, no community midwifery visits took place until day 19. Despite the mother reporting leg swelling, she was redirected between NUH sites on the basis that her baby had been transferred to the neonatal unit at the other site; midwife review was not arranged until day 24, at the mother's request.* (2024)

These cases indicate that organisational boundaries between sites and between Trusts should not be a barrier to the timely and appropriate provision of postnatal care.

21. Postnatal Management Following Complex Home Birth

*In **2013**, a mother experienced a postpartum haemorrhage of 600ml at home birth, with the placenta delivered piecemeal. A staff member did not report the complex birth or arrange admission for observation. Four hours after the birth, the mother was bleeding heavily. The ambulance was directed to the emergency department rather than the maternity unit, delaying appropriate management. The only uterotonic drug available in the emergency department was Syntometrine, and no escalation was made for senior staff member attendance. The mother was subsequently transferred to the labour ward, where she was appropriately managed with uterotonics and examination under anaesthesia for removal of retained placental tissue. Her total blood loss was three litres.* (2013)

This case illustrates how a series of sequential failures in community decision-making, ambulance destination, drug availability and escalation can compound the harm arising from a single initial lapse in governance. Each failure created the conditions for the next.

22. Failures in Compassionate Care

The Review Team identified instances across the review period in which families reported care that lacked compassion.

*In **2013**, a mother whose baby was on the neonatal unit asked 17 times to be taken to see her daughter. Due to insufficient staffing on the postnatal ward, she was not assisted until her baby was being transferred to theatre, where she died.* (2013)

*Also in **2013**, a mother asked for the curtains around her bed to be drawn; her request was refused despite there being no clinical reason for them to remain open.* (2013)

*In **2016**, a mother who had undergone caesarean hysterectomy and was being discharged with a urinary catheter requested a wheelchair to reach the main entrance. She was told by a staff member that she would not be permitted to go home if she could not walk the distance herself, despite having been assessed as fit for discharge.* (2016)

*In **2018**, a mother who asked for postnatal analgesia was told by a staff member:*

"You have to wait your turn, you're not important, there's other women here." (2018)

*In **2020**, a mother who attended triage on multiple occasions reported that staff were 'rude, unhelpful and dismissive' and that their attitude was 'absolutely appalling.'* (2020)

She was eventually admitted and treated for infection.

23. Insensitive or Unsupportive Bereavement Care

Although many families received compassionate bereavement care, the Review Team identified cases of insensitive or unsupportive care across the review period. Notably, such cases were identified even after the appointment of NUH's first specialist bereavement midwife in September 2013, indicating that the structural improvement did not consistently translate into improved experience for families.

*In **2010**, a mother reported that when she and her partner said they needed to go home, a neonatal nurse took the baby from them and said:*

"Yes, I think you do; I think you've had enough time with her now." (2010)

*In **2012,** a mother admitted to ITU following a stillbirth received limited bereavement support; there was no evidence of any further input beyond the first few days of her admission.* (2012)

*In **2013**, a mother described feeling abandoned following a stillbirth, telling the Review Team:*

"I didn't feel like I had the support, and it left me feeling a little bit like, wow, I'm on my own." (2013)

*In **2015**, three separate cases were identified. A mother received no face-to-face visits for nineteen days following a stillbirth, during which time she received only three telephone calls. A mother received insensitive contact from the hospital while her family had taken her baby home for palliative care. A third family, following a stillbirth, reported needing support but being given leaflets:*

'with no follow-up or discussion' (2015)

*In **2016**, a family waited five hours for Anti-D (a medication to protect a baby when a pregnant woman and her baby have different blood types) following confirmation that their baby had died before birth. No consideration was given to the option of Anti-D administration at home. The family told the Review Team:*

"We'd just learnt what had happened and, to be honest, all [the mother] wanted to do was get home and away from there." (2016)

24. Bereavement Processes and Information Sharing

The Review Team identified failures in bereavement administrative processes across the review period, with incomplete or inaccurate paperwork identified in a number of cases spanning 2012 to 2018 – on occasions causing delays before families were able to register the births and deaths of their babies.

The Review Team identified failures in post-mortem processes that caused additional and serious distress to families;

The Review Team also identified cases in which bereaved families were not provided with adequate information or signposting to support;

*In **2012**, parents were not given relevant information from the stillbirth and neonatal death charity (SANDS) following the intrauterine death of their baby, which they stated would have been of assistance.* (2012)

*In **2016**, a mother reported feeling abandoned by the bereavement team, telling the Review Team she felt she had been left to:*

'Sink or swim.' (2016)

*In **2019**, a mother received no signposting to external support organisations following her stillbirth* (2019)

25. Community Bereavement Care

NUH's first specialist bereavement midwife was not in post until September 2013. The Review Team identified cases in which bereaved families received limited or no community support following discharge, including cases identified in 2015, 2017, 2018, and 2020 in which there was no evidence of any bereavement support having been provided after the family left hospital.

In several cases, mothers with known mental health needs did not receive community bereavement support;

*In **2019**, a mother with known mental health difficulties who had experienced a stillbirth received limited bereavement follow-up despite her partner raising concerns on multiple occasions.* (2019)

Communication failures between clinical teams affected the provision of community bereavement care in a number of cases;

*In **2012**, a mother who had been transferred critically unwell to NUH from another Trust, where her preterm baby was stillborn, was subsequently transferred to the City Hospital in Nottingham; inadequate*

bereavement support resulted from a failure of communication between the two hospitals. (2012)

*In **2014**, the bereavement team did not make contact with a mother because they had not been informed of her discharge.* (2014)

*In **2024**, similar failure occurred, where communication breakdowns between the community and bereavement teams meant a mother received no bereavement support at home between day 2 and day 11.* (2024)

These cases demonstrate that community bereavement care was vulnerable to systemic failures in communication and information sharing. Where a mother is known to have experienced a stillbirth or neonatal death, the responsibility for ensuring that community bereavement support is offered and received must be clearly allocated and cannot be dependent on information flowing reliably between teams.

26. Postnatal Debrief and Counselling: Good Practice

Across the review period, the Review Team identified many cases in which obstetric and fetal medicine debriefing and counselling were of a high standard, demonstrating kindness, compassion, clear explanation, and well-defined plans for the management of future pregnancies. Such cases were identified in each year of the Review period. Families frequently acknowledged this high-quality support. A family reported excellent support following a very preterm birth and ITU admission with severe pre-eclampsia. A further family reported receiving open and honest feedback following a medication error. These are representative of a consistent pattern of positive family experience across the review period.

*In **2019**, following the loss of a baby with severe abnormalities, the genetics team sent three compassionate letters to the family, using the baby's name throughout and acknowledging the upcoming funeral.* (2019)

The Review Team noted that in a small number of cases, families remained dissatisfied despite documentation indicating that explanations had been comprehensive, open and honest. The Review Team considered the documented explanations in these cases to have been of a good standard; the dissatisfaction appeared to reflect the profound difficulty of the circumstances rather than a failure in the quality of the clinical communication.

The Review Team also identified a number of cases in which the Trust arranged more than one debrief meeting to ensure that all of a family's questions were fully addressed. These included a mother who attended several debrief sessions following a return to theatre for bleeding after caesarean birth, was well supported throughout, and was referred to psychological services due to probable PTSD. They also included a family who, following their second pregnancy loss, were offered an additional counselling appointment to establish a clear plan for future pregnancies, and a family who after two debrief appointments were sent a detailed letter addressing more than 50 questions they had raised following their stillbirth.

*In **2013**, a staff member wrote proactively to a family following a stillbirth where fetal abnormalities had been identified, outlining a plan for early contact with the fetal medicine unit in any future pregnancy; the family had declined a post-mortem and felt unable to attend the debrief appointment that had been offered, and the letter ensured they nonetheless received the clinical information they needed.* (2013)

27. Failures in Open and Honest Debrief Communication

The Review Team found that in the majority of cases families were provided with open and honest explanations of events, including identified failings. However, in a small number of cases the explanations provided fell short of this standard;

*In **2010**, following a complicated caesarean birth, parents were not provided with full details of the hospital investigation into their care.* (2010)

*In **2016**, a mother who had reported abdominal pain but had not been advised to attend hospital presented 24 hours later with reduced fetal movements; her baby was stillborn. At the subsequent debrief, the parents were told it was likely that monitoring would have been normal at the time the pain was first reported, on the basis that the mother had still been feeling fetal movements. As the mother had not been reviewed at that time, it was not possible to determine what fetal monitoring would have shown. The explanation given to the parents at debrief therefore went beyond what the clinical record could support.* (2016)

*In **2022**, a mother who required return to theatre for intra-abdominal bleeding following an elective caesarean birth was informed at debrief that no cause for the bleeding had been identified. The Trust's own patient safety report, however, documented a surgical error in which the uterine angle had not been secured. The explanation given to the mother was not consistent with the Trust's internal findings.* (2022)

28. Debrief Appointments: Failures in Timeliness and Organisation

The Review Team identified failures in the timeliness, organisation, and in some cases the conduct of debrief appointments across the review period;

*In **2016**, an infant was delivered unexpectedly in critical condition, necessitating immediate therapeutic cooling. Although medical records indicate that the mother was deeply traumatised and that clinical staff engaged in extensive discussions with her, she presented with numerous unresolved questions during the subsequent debriefing appointment. Despite assurances that a formal follow-up would be conducted, no further communication or action transpired.* (2016)

*In **2017**, a family attended a scheduled debrief appointment to find the staff member was unavailable, requiring them to attend on a further occasion.* (2017)

*Also in **2018**, a family contacted the bereavement midwife three months after their stillbirth to request a debrief appointment, as one had not been offered.* (2018)

*In **2019**, a debrief did not take place until ten months after a stillbirth.* (2019)

*In **2020**, a debrief appointment was not arranged until five months after a stillbirth, in part owing to the COVID-19 pandemic, and only following intervention by the family's GP on their behalf. The subsequent written communication to the family incorrectly stated that the delay had been caused by waiting for a post-mortem report; the family had in fact declined a post-mortem examination.* (2020)

*In **2022**, a mother who had been informed she would receive a formal debrief following return to theatre for intra-abdominal bleeding after caesarean birth had to contact the Trust herself to arrange it.* (2022)

*In **2023**, a family were not offered a formal debrief following their stillbirth, despite their concerns having been addressed through the Trust's complaint response and the Perinatal Mortality Review Tool (PMRT) process.* (2023)

*Also in **2023**, a mother waited five months for a debrief appointment following a MOH requiring ITU admission. When the appointment did take place, it was of a good standard and multidisciplinary.* (2023)

Across these cases, a consistent pattern emerges: debrief appointments were not arranged proactively, families were required to request them, and in several cases significant delays occurred. Where a debrief is indicated following stillbirth, neonatal death, or a major unexpected maternal complication it should be considered routine. The responsibility for arranging it rests with the clinical team, not with the family.

29. Written Communication Following Debrief Appointments

The Review Team identified a number of instances in which written communication following debrief appointments lacked appropriate compassion, clarity, or both.

Several letters were found to lack compassion;

*In **2013**, a letter offering a debrief appointment following a stillbirth was written on a standard proforma; while it clearly set out the time, location, and clinician involved, it contained no expression of condolence.* (2013)

*In **2014**, a debrief letter following a birth at 25 weeks where the baby did not survive resuscitation was found to lack compassion.* (2014)

*In **2015**, a debrief letter following a stillbirth was factually accurate but written in highly medicalised language and conveyed no sympathy.* (2015)

Other letters raised more serious concerns:

*In **2013**, a letter following a debrief appointment after fetal medicine care and termination of pregnancy appeared to attribute responsibility to the mother for the congenital abnormalities identified, despite no cause having been established.* (2013)

*In **2015**, a debrief letter following a caesarean hysterectomy did not include an apology and described the event as an 'unfortunate incident of having an emergency hysterectomy.' Although there was no evidence of suboptimal clinical care, the inclusion of this phrase was experienced by the family as defensive and insensitive, adding to their distress.* (2015)

*In **2020**, a detailed debrief letter lacked clarity regarding the intended management plan for a future pregnancy, leaving the family without the practical guidance the debrief was intended to provide.* (2020)

30. Absence of Debrief Following Significant Maternal Events

The Review Team identified cases in which outpatient debrief appointments were not offered following significant and unexpected maternal events.

*In **2013**, a mother received excellent and timely inpatient debriefs following a MOH but was not offered a subsequent outpatient debrief appointment.* (2013)

*In **2014**, a mother did not receive a follow-up appointment following laparotomy for delayed complications after caesarean birth. An appointment was only arranged after she made a formal complaint to the Trust. When the meeting took place, the mother told the Review Team:*

"I felt stupid like the way I went to that meeting… everything which they were telling me it was like mocking… like brushing me off, putting things down, like maybe I don't know what I was doing… I don't feel like they treated me as they're supposed to be." (2014)

*In **2015**, no debrief appointment was arranged for a mother who had experienced very heavy bleeding requiring hysterectomy, followed by return to theatre to drain a pelvic haematoma.* (2015)

*In **2017**, a mother who had a prolonged postnatal admission following caesarean birth complicated by renal failure and a conservatively managed ileus attended a debrief appointment; however, this was conducted without obstetric involvement, which was inadequate given the clinical complexity of her case.* (2017)

*In **2021**, there was no documentation to indicate that a debrief appointment had been offered to a mother whose postnatal course included pre-eclampsia, caesarean birth, massive haemorrhage with return to theatre, ITU care, and paralytic ileus.* (2021)

*In **2024**, a mother who underwent a peripartum hysterectomy did not have a postnatal outpatient debrief appointment arranged. The Review Team notes, however, that the hysterectomy had been anticipated and the mother had been fully counselled antenatally regarding this possibility; documentation indicates she was debriefed on several occasions by staff members during her postnatal inpatient stay.* (2024)

The absence of a formal outpatient appointment in this case is therefore of a different nature from the failures identified in the cases above.

31. Effective Communication and Multidisciplinary Working: Good Practice

While the Review Team identified failures in a number of aspects of postnatal care, evidence of good practice was identified in many cases, and in a significant proportion of the cases reviewed care was of a high standard. There was consistent evidence of effective postnatal care supported by robust communication and multidisciplinary working between hospital and community services. Appropriate use of professional interpreter services was also identified, enabling effective communication with women and families where English was not their first language.

*In **2012**, following a stillbirth in a mother with hypertension, effective communication between the hospital team, the GP, and the community midwifery service enabled safe blood pressure management within the community.* (2012)

*Also in **2012**, a staff member on the postnatal ward identified neonatal seizures at an early stage despite very subtle clinical signs and communicated her concerns to the neonatal team, facilitating timely management.* (2012)

*In **2013**, a mother with a complex medical and psychosocial history, including significant mental health needs, received coordinated multidisciplinary support, with effective engagement of safeguarding services and extended postnatal midwifery input.* (2013)

*In **2017**, a mother who gave birth to a stillborn baby at home and subsequently suffered a stroke received comprehensive postnatal care, with community and bereavement staff members liaising effectively with the stroke rehabilitation team throughout her inpatient admission.* (2017)

*Also in **2017**, following an unexpected stillbirth at home with ongoing bleeding, care was coordinated effectively between obstetricians, midwives, anaesthetists, and haematology services in the emergency department and the mother expressed appreciation for the care provided.* (2017)

*In **2020**, a mother who developed sudden onset, severe pre-eclampsia resulting in placental abruption and stillbirth received high-standard inpatient hypertension management, with emotional support maintained throughout despite COVID-19 restrictions, and effective communication between hospital and community services ensuring appropriate blood pressure monitoring following discharge.* (2020)

*Also in **2020**, timely attendance from home and well-coordinated intraoperative communication characterised exemplary multidisciplinary management of an ongoing postpartum haemorrhage following spontaneous vaginal birth.* (2020)

*In **2023,** a mother with a complex history including a pre-existing mental health condition, gestational diabetes, gestational hypertension, deranged liver function, resulting in a preterm caesarean birth received excellent multidisciplinary postnatal care, remaining on the postnatal ward for 25 days with daily medical reviews and regular mental health team input.* (2023)

*In **2024**, a mother with complex medical and surgical needs received effective multidisciplinary care, with each speciality contributing to an individualised and holistic plan of care.* (2024)

32. Cultural and Spiritual Care: Good Practice

The Review Team identified a number of cases in which cultural and spiritual care was responsive, sensitive, and of a high standard. For families whose cultural or religious practices require prompt action following bereavement – including arrangements for early burial – the responsiveness of staff to these needs was particularly significant.

*In **2014**, parents were supported in their choice to arrange a same-day burial with the involvement of their religious leader.* (2014)

*In **2016**, a mother who lost both of her extremely premature twins told the Review:*

"The chaplaincy service was involved and, actually, one of the chaplains led the funeral for the twins because he was involved more or less from [the babies] deaths." (2016)

*In **2022**, following a stillbirth, staff members facilitated early burial in accordance with the mother's cultural and religious beliefs. The family reported that this had a positive impact on the mother's psychological recovery in the postnatal period.* (2022)

*In **2024**, postnatal care in one case was delivered in a responsive and individualised manner, with clear evidence of staff sensitivity to the mother's cultural needs and beliefs.* (2024)

*Also in **2024**, the hospital chaplain facilitated the washing and shrouding of a baby, and the family's imam was involved in early burial arrangements.* (2024)

*In **2025**, staff members on the postnatal ward worked promptly to complete the required documentation to enable a family to arrange an early burial in line with their cultural practices.* (2025)

The Review Team also noted that bereavement team members attended funerals at families' request on a number of occasions across the review period, including cases identified in 2016, 2017, and 2024, providing personal emotional support at a significant moment for the families concerned.

33. Emotional and Psychological Support: Good Practice

The Review Team identified many cases in which emotional and psychological support was provided to a high standard across the review period.

*In **2012**, documentation from the postnatal ward for a mother who had experienced a traumatic birth reflected care that was kind and compassionate throughout.* (2012)

*Also in **2016**, a staff member who was concerned about a mother traumatised by her birth experience spent additional time reassuring her, telephoning later that day to check on her wellbeing, offered to return if needed, and continued to provide ongoing supportive care.* (2016)

*In **2018**, a mother who was an asylum seeker and did not speak English received attentive and inclusive support from staff members following a preterm twin birth.* (2018)

*In **2020**, a staff member took time to build a supportive and caring relationship with a mother with complex mental health needs. The mother told the Review Team:*

"I remember looking towards the door as I heard it open, listening to the [staff member] and thinking, I'm so glad she is here – now she'll get to meet my baby." (2020)

*In **2021**, a mother who required emergency caesarean birth and ITU admission with COVID-19 was supported by a staff member following discharge who, concerned about the mother's mental health, ensured appropriate escalation for crisis team assessment.* (2021)

*Also in **2021**, a mother who experienced a mental health crisis in the postnatal period received an urgent perinatal mental health referral and ongoing emotional support. Despite COVID-19 visiting restrictions, arrangements were made for enhanced partner visiting.* (2021)

*In **2024**, a mother with a complex history received consistent midwifery support while her baby was receiving care in the neonatal intensive care unit; following the baby's death, arrangements were made for an extended hospital stay in recognition of her limited social support, enabling time for bonding and memory-making.* (2024)

Many families received excellent bereavement care across the review period, with high-quality cases identified in every year from 2011 to 2024. The following examples illustrate the standard of care provided;

*In **2013**, a mother who had previously experienced a pregnancy loss received compassionate bereavement care following a stillbirth at 36 weeks, with staff explicitly acknowledging her previous loss.* (2013)

*In **2015**, parents of a baby with a severe fetal congenital anomaly received antenatal home visits from the bereavement team and excellent continuity of care throughout.* (2015)

*In **2019**, a staff member visited the baby in the chapel of rest several times at the mother's request, to establish the length of her baby and the colour of her eyes, and to support further memory-making.* (2019)

*Also in **2019**, a mother who was unwell on ICU had her baby brought to be with her regularly and was supported to take her daughter home.* (2019)

*Again in **2019**, following a debrief with parents who had lost their twins, a staff member stepped out of the room and observed a minute of silence in honour of the babies.* (2019)

*In **2024**, a mother and her extended family received compassionate care following a stillbirth that occurred while her brother was critically ill elsewhere in the hospital.* (2024)

*Also in **2024**, a staff member attended both the funeral care appointment and the Registrar appointment with a family at their request, liaising with external agencies on their behalf, and supported a father to request compassionate leave, contacting his employer on his behalf to explain the circumstances of their bereavement.* (2024)

*In **2025**, a mother who had given birth at another Trust received regular postnatal contact both in person and by telephone from a staff member whose care was noted by the Review Team as compassionate and kind.* (2025)

Families described the impact of this care in their own words;

*In **2015,** one mother told the Review Team of her relationship with the bereavement team:*

"It was positive, if you can use that word in this situation... we'd got a very close relationship and yeah, it was quite soothing in a way that I already knew the person and [they were] fantastic." (2015)

*In **2016**, a mother who had lost her twin babies told the Review Team that:*

"the bereavement [team] were really excellent" (2016)

*In **2021**, parents described the care received from two bereavement staff members as 'excellent', telling the Review Team:*

"They were empathetic, non-judgemental and completed tasks for us that we felt unable to do. For example, one staff member contacted my GP for me regarding my sick leave for work... We have a lovely memory box for our baby which we will treasure forever." (2021)

The Review Team identified a number of cases in which bereaved parents were supported to remain in hospital until they were ready to go home;

*In **2020**, parents were supported to spend as much time as they wished with their baby, and the mother was supported to trial a visit home before discharge owing to anxiety about leaving.* (2020)

*Also in **2021**, a mother's wish to remain in hospital longer was respected and encouraged.* (2021)

*In **2025**, a mother was encouraged to stay in hospital for as long as she wished. Staff members accompanied the parents to take their baby boy to the chapel of rest and subsequently conducted a joint support visit at home.* (2025)

The Review Team also identified cases in which families received extended and personalised bereavement support over many months.

*In **2015**, a mother received home visits until after the first anniversary of her baby's death.* (2015)

*Also in **2015**, a mother received regular visits and contact over many months, particularly around the time of the baby's funeral.* (2015)

*In **2020**, community bereavement care continued for four months and was of an excellent standard.* (2020)

Finally, the Review Team identified many cases in which memory-making support was provided in a way that involved the whole family, with specialist resources for siblings;

*In **2016**, a family received a book for the baby's sister to help her understand the loss, along with an additional set of hand and footprints and locks of hair for the extended family.* (2016)

*In **2017**, three separate cases demonstrated high-quality sibling support: one family received matching bears for the baby's siblings; another received a specific siblings memory box, book, and separate footprints; a third received an 'Aching Arms' bear, with additional contact from the team after Christmas to check on the family's wellbeing.* (2017)

34. Management of Postnatal Readmissions: Good Practice

The Review Team identified a number of cases of postnatal readmission in which care was delivered to a high standard;

*In **2009**, a mother readmitted with wound dehiscence was appropriately assessed and managed.* (2009)

*In **2017**, a mother who experienced a complicated postnatal recovery owing to a wound infection received care that the Review Team considered appropriate throughout, despite the clinical challenges involved.* (2017)

*Also in **2021**, a mother readmitted seven days after birth following a haemorrhage at home was promptly transferred to theatre; the Review Team considered care during this admission to have been timely and to have included a comprehensive post-operative discussion.* (2021)

*Also in **2021**, a mother diagnosed with pulmonary emboli on day 23 had all recommended VTE risk assessments completed and all relevant advice followed during both her pregnancy and the postnatal period; the Review Team considered her care to have been appropriate in all respects.* (2021)

*Also in **2022**, a mother was admitted with a pulmonary embolus ten days after birth despite having taken her prescribed daily thromboprophylaxis following completion of a postnatal thrombosis risk assessment.* (2022)

This case illustrates that venous thromboembolism can occur even when all recommended preventive steps have been taken and reinforces the importance of maintaining clinical vigilance for VTE symptoms in the postnatal period regardless of compliance with thromboprophylaxis.

Conclusion

The Review demonstrates that postnatal care at NUH was appropriate in the majority of the 2,200 cases examined, and in many instances was delivered with high levels of professionalism, compassion, and effective multidisciplinary working. The quality of bereavement care in particular, while variable, reached an exceptionally high standard in a significant number of cases, and the commitment of individual staff to families in the most difficult of circumstances was consistently evident.

However, the chapter also documents a pattern of recurring failures in core postnatal safety processes across a period of 13 years. These failures were not isolated incidents but recurred across the review period in both hospital and community settings. They include: failures in the monitoring and escalation of maternal hypertension and clinical deterioration; failures in VTE risk assessment and thromboprophylaxis; failures in the recognition and management of the unwell or poorly feeding baby; failures in discharge communication across hospital, community, and primary care; and failures in the provision of compassionate, culturally sensitive, and equitable care.

These themes were exacerbated by chronic workforce pressures on postnatal wards, variable consultant involvement following transfer from higher-dependency settings, an absence of governance around the role of MSWs in the community, and the inappropriate substitution of telephone contact for face-to-face clinical review. In several cases the consequences of these failures were severe and irreversible.

The chapter also identifies a recurring and serious failure in accountability to families: explanations that were incomplete or inconsistent with the clinical record, debrief appointments that were delayed or not offered, and written communication that lacked compassion or clarity. Where a family has experienced significant harm, the quality of the Trust's subsequent engagement with them is not a secondary concern; it is a fundamental component of the standard of care.

The findings set out in this chapter require sustained and system-wide action. Where a healthcare professional advises a mother to seek further review for herself or her baby, the responsibility for arranging that review rests with that professional. Signposting alone is not sufficient.

Maternal Deaths

The Impact of Maternal Deaths

The death of a woman during or after pregnancy - as a mother, partner, daughter, granddaughter, sister or friend - is catastrophic and life-changing. The impact of such a loss reaches far beyond the immediate family, rippling through wider family and friendship networks, as well as the broader community. Those who survive are faced with navigating profound grief and the expectation to adjust to a 'new normal' that is anything but, shaping their lives for years and decades to come.

"We will need to put on a brave, smiling, happy face to celebrate the birthday of our beautiful granddaughter, whilst deep inside we are full of hurt and grief for her mother whose death we mourn on the same day." (2014)

"It's changed all our lives immensely, both her sisters struggle with their mental health now and I suffer with flashbacks terribly and don't sleep anymore." (2018)

"She was not just my daughter, she was my best friend, my everything. We went everywhere together." (2021)

"I feel like we've been...just left... forgotten". (2021)

"Even today, the school are quite worried... they're trying to do therapy [with the surviving children]." (2021)

What is a 'Maternal Death'?

A maternal death, or the death of a mother, is defined by the World Health Organization (WHO) as occurring during pregnancy or within 42 days after its end. A late maternal death is defined as the death of a woman between 42 days and one year following birth or the end of pregnancy.[177] Maternal deaths are further sub-categorised as follows:

Direct: deaths resulting from obstetric complications during pregnancy, labour or the puerperium (see glossary)

Indirect: deaths resulting from previous existing disease, or disease that developed during pregnancy, which was aggravated by the physiological effects of pregnancy.

Coincidental: deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

Findings

There were 27 maternal deaths associated with maternity care provided at Nottingham University Hospitals (NUH) NHS Trust between 2006 and 2024. All the women who died included within this Review received part or all of their care at NUH. This includes women who gave birth elsewhere but were transferred to NUH for specialist services, as well as women who received antenatal care at NUH but gave birth or died elsewhere.

Each maternal death recorded here has been reviewed by members of a multidisciplinary team including midwives, obstetricians, anaesthetists and - where indicated - other clinical experts including specialists in neurosurgery, cardiology, perinatal mental health, obstetric medicine and haematology. In line with previous Ockenden reviews and reports, a holistic approach was undertaken, including using the maternal medical records, clinical governance records and information provided through family meetings and evidence.

In accordance with the Review methodology, scores were applied using the established care-grading system. Any concerns with care provided by another NHS organisation have not contributed to the final care-grading score. The care-grading score pertains only to care provided at NUH as set out in the Terms of

177 https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

Reference of the Review. Any concerns regarding management in other trusts have been directly reported to the relevant organisations. All of the families of the women who died will be given the opportunity to receive individual face-to-face feedback in Nottingham regarding their relative's care if so desired.

Of the 27 women included within this chapter, five did not meet the Terms of Reference of the Review. Four women received the majority of their care at different NHS Trusts and one woman died 46 days after giving birth. This latter case has already been the source of learning for the Trust and, recognising the complexity and risk that can be associated with cross-boundary working, it has felt appropriate to review all maternal deaths to ensure there are no missed opportunities for system-wide learning.

Of the 22 women who either received the majority of their maternity care at NUH and/or died at NUH during pregnancy or within 42 days following birth, their care was graded as follows:

CARE GRADING SCORE	DESCRIPTION	NUMBER OF WOMEN
0	Appropriate care in line with best practice at the time	7
1	Minor concerns, care could have been improved but different management would have made no difference to the outcome	7
2	Significant concerns, suboptimal care in which different management might have made a difference to the outcome	5
3	Major concerns, suboptimal care in which different management would reasonably be expected to have made a difference to the outcome	2
	Unable to Grade	2
	Total	**22**

The Review Team was unable to grade two cases as the medical records had been prematurely destroyed by the Trust. In accordance with the NHS Records Management Code of Practice, all maternity records have a minimum retention period of 25 years.[178] This is regardless of whether or not a live birth had been the outcome of the pregnancy. The Review Team escalated concerns regarding the missing records to the CEO of the Trust for investigation.

Of the women who died: 10 women died of direct causes; 16 women died of indirect causes; and one death was from a road-traffic collision.

The findings of the most recent MBRRACE-UK report identify the most common causes of maternal death as thromboembolism, COVID-19, cardiac disease, suicide, sepsis and other physical conditions[179]. The Review Team noted similar causes of death in the cohort examined.

Of the women who died, the deprivation quintiles were found to be as follows:

DEPRIVATION QUINTILE	1ST QUINTILE (most deprived)	2nd QUINTILE	3RD QUINTILE	4TH QUINTILE	5TH QUINTILE (least deprived)	NOT AVAILABLE	TOTAL
NUMBER OF WOMEN	11	4	4	1	5	2	**27**

178 https://transform.england.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice/#appendix-ii-retention-schedule

179 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023

National statistics detail how women living in areas with the highest levels of deprivation are at an increased risk of mortality.[3] In relation to Global Majority heritage groups, the medical records provided by NUH state that 14 women who died were from backgrounds defined as Asian or Asian British Pakistani, Asian or Asian British Indian, Black or Black British African, Black or Black British Caribbean and Any Other White. 13 women were recorded as White British.

The Review Team acknowledges that ethnicity is not always recorded accurately. Overall, statistical analysis of the maternal deaths is limited due to the number of cases. However, The Review Team felt the findings were representative of national findings.

Clinical Care

*In **2020** during the Covid-19 pandemic, a woman with a congenital cardiac condition died due to a thrombosed cardiac valve early in her pregnancy. Peak low molecular weight heparin levels were taken but not appropriately actioned in accordance with national guidance. The Review Team and the investigation by HSIB agreed that improved communication and multi-disciplinary team working might have contributed to a different outcome.* (2020)

During the Covid-19 pandemic, NHS Trusts reduced the frequency of face-to-face appointments between clinicians and patients. This woman's pregnancy was particularly high risk and the Review Team considered that both the pandemic and the subsequent delivery of care to the mother may have adversely affected the woman's outcome. This case reflects the importance of continuity of care by experienced clinicians in the management of high-risk pregnancies at all times.

One woman who her partner described being placed on a Covid ward (without having covid) had repeated tests were done that came back negative. When she was moved, she was left on her own, she had no idea what was going on, there was no plan, all her partner knew is that he couldn't help her, she was on her own and she was scared.

*In **2018**, a woman was identified as high-risk for venous thromboembolism (VTE) after the birth of her baby. She was discharged before her anti-coagulation medication (blood thinning injections) to take home was ready. A member of staff felt this was due to a 'bed-crisis'. The medication remained on the postnatal ward uncollected. The mother died 23 days after birth due to a pulmonary embolism.* (2018)

Pulmonary embolism is recognised as the leading cause of direct maternal death.[3] There have been significant local and national recommendations relating to risk assessment in order to ensure appropriate preventative treatment for women at increased risk of venous thrombo-embolism (VTE). In this case, the woman's prescription remained uncollected when she was discharged from the postnatal ward. The Trust's internal serious incident investigation recognised the suboptimal care. Venous thromboembolism is one of five elements of the recently launched Maternal Care Bundle which aims to reduce morbidity and mortality.[180]

*In **2024**, A woman died at an unknown gestation due to a ruptured ectopic pregnancy. There was a delay in the ambulance attending as there were no crews available. The clinical care provided to the woman upon her arrival at the Trust was found to be good. An external investigation by MNSI and the Coroner's Inquest found that ambulance crews were experiencing delays in handing over their patients at the Trust and this resulted in delayed response times.* (2024)

The Review Team found the care provided by the on-call gynaecology service and the emergency department was of a good standard. The delay in ambulance crews transferring patients to acute hospital trusts is recognised as a national issue.[181]

*In **2018** a woman of North African origin who had lived in Nottingham for many years and who spoke excellent English reported persistent headaches throughout her pregnancy. She also reported an episode of slurred speech and facial asymmetry alongside a headache. Her symptoms were wrongly attributed by hospital staff to 'hormones' and were not investigated. Her family sought advice from the hospital on a*

180 https://www.england.nhs.uk/long-read/the-maternal-care-bundle/

181 https://rcem.ac.uk/press-release/increased-ambulance-handover-delays-threatening-patient-safety-rcem-and-college-of-paramedics-warn/

number of occasions but their concerns were disregarded. After the birth of her baby, she began to have difficulty communicating and explaining her symptoms. She underwent an MRI scan which showed a large frontotemporal mass with appearance in keeping with a meningioma. The mother had a cardiac arrest whilst awaiting surgery. She was resuscitated and admitted to the intensive care unit where she later died. (2018)

The Review Team considered that there was a missed opportunity to investigate this woman's symptoms earlier in her pregnancy and had this occurred this would have changed the outcome.

*In **2013** a woman presented with headaches, confusion, disorientation and incontinence. Her symptoms were not treated but were attributed to mental-health concerns despite no previous mental-health history. Some of her behaviour was also attributed to a language barrier. Two weeks later she was admitted to hospital where she collapsed. She underwent surgery for what was later found to be a malignant brain tumour. She died five days after surgery.* (2013)

This mother's brain tumour was malignant and incurable. The mother's life expectancy would have been limited even with maximal surgical resection and adjuvant therapy. However, the Review Team found that an earlier diagnosis would most likely have enabled intervention that would have prevented the acute and irrecoverable deterioration. An internal investigation did not comment on the possibility of the earlier missed diagnosis. The importance of appropriate investigation for women with new neurological symptoms has been noted in previous MBRRACE-UK reports.6 Although not relevant in the care of the woman who died, the Review Team found evidence in other cases involving brain tumours where imaging was delayed due to concern of radiation exposure in pregnancy. The radiation risk from a CT head scan is negligible and, in the presence of concerning neurological symptoms, the mother's health should always be prioritised and imaging undertaken as soon as possible[182].

*In **2022** a woman died by suicide. Prior to her death, there were multiple 'red flags' relating to her deteriorating mental health, which were missed.* (2022)

The Trust reported the woman's death to MBRRACE-UK but, as she died abroad, her case was not accepted for review. Additionally, as she died by suicide her death did not meet the criteria for review by HSIB. An investigation was conducted by the mental healthcare provider. However, the Review Team was unable to find evidence that NUH had contributed to the investigation. The care provided by NUH was found to be suboptimal and the Review Team felt there were a number of missed opportunities for wider multi-disciplinary team working. At the time of publication of this report, NUH have still not undertaken any investigation into the death of this mother.

*In **2014** a woman with a history of previous caesarean births died after a freebirth at home where she had a major obstetric haemorrhage.* (2014)

The Review Team found evidence that the mother had been informed of the risks associated with her birth choices or decisions taken in opposition to medical advice. They noted a missed opportunity for further discussion on informed decision-making with senior midwifery and obstetric clinicians and believe that more senior staff should have engaged directly with the mother. This concern was also recognised in the Trust's serious incident investigation. However, it remained unclear whether the involvement of more senior individuals would have altered the outcome.

Clinical Governance

Most maternal deaths are unexpected and therefore require investigation to determine the cause of death and identify any learning for service improvements. Prior to the introduction of HSIB – now MNSI – in 2017, it was standard practice for a Trust to investigate deaths in pregnancy in accordance with clinical governance frameworks of the period. Trusts are now required to refer maternal deaths up to 42 days after

182 Felker, A., Patel, R., Kotnis, R., Kenyon, S. & Knight, M. (eds.) on behalf of MBRRACEUK (2024) Saving Lives, Improving Mothers' Care: Compiled Report – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020–22. Oxford: National Perinatal Epidemiology Unit, University of Oxford. ISBN 9781068791307.

birth for external investigation. The Review Team found that all cases were appropriately referred to external bodies (HSIB/MNSI), where indicated. Two families withdrew their consent for external investigation.

There were two maternal deaths where the Review Team could not find any evidence of an internal or external investigation. One woman died in 2009 and all her notes had been destroyed by the Trust; the Review Team concluded that there would have been valuable learning from an investigation.

The second woman was transferred to NUH for specialist care when she became unwell after the birth of her baby. The Review Team identified concerns with the care provided by two external organisations, concluding that the care had been suboptimal and that different management would, in all likelihood, have prevented the mother's death. There were no concerns with the care provided at NUH. None the less, it was felt there was a missed opportunity for a multi-organisation investigation into the mother's death. The concerns identified were fed back to the chief executives of the relevant organisations by the Review Chair.

Bereavement Care and Support

Bereavement care for the families of the women who died was reported as variable by families. The Review Team found examples of good care, including ensuring continuity of carer by the bereavement midwife or another known clinician. There were also examples where the Trust supported families with complexities such as parental responsibility following a maternal death. The Review Team found that when women died outside of the maternity unit, midwifery care was not always continuous and there were thus missed opportunities to ensure provision that was family-centred and trauma-informed.

Despite the vast majority of cases having formal investigations through internal and external governance processes, many families still had questions regarding the deceased mother's care. Some families informed the Review Team that they did not understand the investigation reports or their findings. Additionally, there were multiple accounts of insufficient support and a strong sense of being 'left' to navigate the early weeks and months alone. The Review Team acknowledge that they were unable to review undocumented communication. Notably, suboptimal support was reported not only by families whose experiences had raised concerns for the Review, but also by those who had received care and governance considered appropriate. This might be recognised in part as a response to grief, but it is also symptomatic of a gap in support where lives have been forever changed by the catastrophic loss of a relative.

Grief is recognised to have a profound physical, psychological, emotional and social impact.[183] Additionally, families report many other interrelated complexities associated with a maternal death that vary considerably depending upon individual circumstances. There may be a motherless newborn infant who may have been born prematurely and thus requiring neonatal care. There may be other children grieving in the family home. Some families reported significant financial challenges including funeral costs, changes to household income and difficulty managing childcare and continuing in their pre-existing careers as an unexpected newly single-parent family. Overall, families described a complete lack of preparedness for, and support during, the days, weeks, months and years which followed a maternal death. They report minimal, if any, psychological support available, not least for children whose mothers have died.

The introduction of the government bereavement-support payment and statutory parental bereavement leave and pay affords some support to bereaved families.[184] However, many families told us they would benefit from tailored support whilst navigating such a unique and multifaceted loss. Most organisations such as acute NHS Trusts and investigatory bodies are not adequately resourced to provide the level, complexity and duration of support required by families following a maternal death.

There are many national, regional and local charities that offer dedicated ongoing support for families following the loss or death of their baby. However, there are no charities offering specific support for when a mother dies during or after pregnancy. It is well recognised that many health-related charities 'bridge the gap' by providing support to communities experiencing various conditions or situations. Many baby-loss

183 https://www.inquest.org.uk/

184 https://www.cruse.org.uk/understanding-grief/effects-of-grief/

charities aim to ensure support for complex emotions, placing families at the centre of their work – validating their thoughts and feelings and actively working with the psychological effects of the loss.[8,185,186]

Charitable services tend naturally to create communities with unparallelled strength made up of those with lived experience of similar trauma. To be able to connect to others with a mutual understanding of child-loss and its attendant grief creates a lifeline to families in reducing isolation and signposting access to practical help, thus enabling a family gradually to adjust to the 'new normal'. Similar service provision is urgently required to fill the void in support for families where there has been a maternal death. In the absence of charitable provision, the Review Team recommends that all organisations including, but not limited to, health, social care, education and investigatory bodies should review their support systems for bereaved families. This will ensure they are trauma-informed and capable of recognising that the impact of a maternal death is lifelong and extends far beyond the remit of maternity care.

Following the conclusion of the Review, Donna Ockenden pledges to create a charity dedicated to supporting families where there has been a maternal death.

Summary/Conclusion

There were 27 maternal deaths included within the Review. Due to the number of cases and their individual clinical presentations, careful statistical analysis has not been possible. Despite this, the findings broadly reflected the national maternal mortality picture. The key conclusions were:

1. The importance of listening to families and acting appropriately upon any concerns in a timely manner.
2. The importance of 'safety-netting': ensuring women can access services and treatment, know how to seek help if they or their families have concerns, and receive timely, safe maternity care. Barriers are often multifaceted, including limited access to services due to location (for example, the former 'Sure Start' centres), difficulties in interpreting information, inadequate transport infrastructure, and living in conditions of deprivation.
3. The importance of continuity of care for women, in particular those with additional medical or social complexities.
4. The importance of robust clinical governance processes, including information sharing between organisations to enable wider system improvement.
5. The importance of implementing trauma-informed, family-centred bereavement support across all relevant services.
6. The importance of timely imaging in women with concerning neurological symptoms.

185 https://www.gov.uk/bereavement-support-payment
186 https://www.sands.org.uk/Sands-strategy-22-25

Post-Death Care

1. Introduction

Inpatient care does not end and must continue when a patient dies; they remain a patient until they are discharged from the hospital, usually by being released to the family's nominated funeral director, via the hospital's mortuary.

In his evidence to the public inquiry into the collision on the river Thames between the pleasure boat the 'Marchioness' and the dredger 'Bowbelle' chaired by Lord Justice Clarke, Charles Haddon-Cave QC said:

"The care with which our dead are treated is a mark of how civilised a society we are. Much goes on for understandable reasons behind closed doors. For this reason, there is a special responsibility placed on those entrusted with this work and the authorities who supervise it to ensure that the bodies of the dead are treated with the utmost care and respect. This is what bereaved and loved ones are entitled to expect and what society at large demands[187]".

Later, Lord Justice Clark laid out the following principles for professionals involved in the care of the deceased[188] (the report in which these principles were laid out was specifically concerned with identification processes following major accidents, but the principles are equally applicable to all mortuary operations):

- Provision of honest and as far as possible, accurate information at all times and at every stage
- Respect for the deceased and the bereaved
- A sympathetic and caring approach throughout
- The avoidance of mistaken identification

This chapter contains findings from the Review of eighteen cases at NUH where issues were identified with the post-death care given to babies and one adult who had died or to people who had been bereaved, as well as wider issues associated with the relevant services. All of the cases were within the Review as they met the Terms of Reference. Concerns were raised directly with the Review Team by families.

1. Care of the Deceased

1.1 Dignity of the Deceased

Dignity is one the four guiding principles of the Human Tissue Authority, the regulator of human tissue and organs, which has oversight of the majority of mortuary establishments in England and Wales ('all settings where deceased people are managed and cared for, unregulated and regulated, should consider how their practices ensure dignity and are respectful of diverse cultural and religious observances'[189]).

Dignity of the deceased was also at the heart of the Independent Inquiry into the Issues Raised by the David Fuller Case, which stated very clearly that *'people are entitled to be cared for securely and with dignity after death'*[190]. This is reflected in the breadth of Inquiry recommendations, which span nine settings in which deceased people are cared for; including NHS hospitals.

187 https://www.college.police.uk/app/civil-emergencies/disaster-victim-identification
188 Public Inquiry into the Identification of Victims Following Major Transport Accidents: Report of Lord Justice Clarke: No. 5012 (Command Paper)
189 https://www.hta.gov.uk/guidance-professionals/codes-practice-standards-and-legislation/guidance-those-responsible-dignity-and-care-deceased
190 https://assets.publishing.service.gov.uk/media/688258b96a7ea0e1ce1d3653/fuller-inquiry-phase-2-report-hc-1092-web-accessible.pdf

When there are shortcomings in the post-death care of patients, their dignity can be severely impacted. All of the cases reviewed for this chapter involved a loss of dignity to a greater or lesser extent.

2016: A baby was placed by a member of the portering staff into a mortuary space already occupied by an unknown and unrelated deceased adult patient. This error was corrected the following morning when mortuary staff arrived. Although this incident did not result in any physical harm to either patient, both suffered a loss of dignity. The family were not informed of this incident.

2019: One very early gestation baby was inadvertently disposed of as clinical waste by laboratory staff after her post mortem examination, resulting in a complete loss of dignity for the baby and significant distress to her parents, as it went against their express wishes (*"we didn't want the baby to be disposed of. That was the main thing we didn't want"*) and denied them the opportunity to have a ceremony to say goodbye to their daughter in the way they would have wanted.

A loss of dignity does not only arise from physical harm; several families told the Review that the language used by NUH staff to describe their baby, such as 'fetus', 'sample' and 'specimen', had a dehumanising effect *"our baby is just a foetus in the report but it was our baby, we planned to have that baby", "it goes into the system, doesn't it? He becomes a test that needs actioning rather than a little boy"* and reduced their baby to a lesser status.

2019: One grieving family unexpectedly received graphic colour photographs of their baby's post mortem examination, along with a breakdown of costs relating to the Emergency Department admission, after the documents were misfiled and then released in error as part of a Subject Access Request disclosure. The parents told the Review Team *"we weren't at home and we came home to it and opened it up and they'd sent me all of their records, post mortem imaging and even a costing of his death. Right down to the cost of someone coming and telling us that our son was dead".*

In their interview with the Review Team, a member of NUH staff recounted how there was *"a small bereavement room on the – on the labour suite at City, and they had a white normal domestic fridge in that room, and they used to wrap babies up and put them in the fridge on the shelf and keep them there for anywhere between 24 and 72 hours, just in case the parents wanted to come back and see the baby. I remember one day, with the bereavement midwife saying, I walked in there and I said, 'you can't keep a baby in a fridge in here'. 'Yes, I can. I've got the – I – I am the person responsible for the human tissue licence, I can keep a baby in here'. I said, 'okay, if the human tissue licence ticks a box and says, yes, okay, you can keep a baby in a domestic fridge, I really don't think it will personally, but if it does, then let's have some respect for the families'. What if a – what if a bereaved family is so distressed and you don't know, and they follow you into that room and they see you getting their baby out of a fridge. That is so disrespectful. We've got a mortuary; we can use that service".*

1.2 Storage of the Deceased

One of the key activities of a mortuary is the safe storage of the bodies of deceased patients, to prevent unnecessary deterioration. This is achieved by the use of refrigerated and freezer storage facilities. The HTA advises that deceased individuals *'should be moved into frozen storage after 30 days in refrigerated storage, or before, depending on the condition of the body'*, to *'check and document the condition of bodies upon arrival to the mortuary'*[191] and, *'following admittance, undertake regular condition checks to ensure optimal preservation of bodies whilst in storage. Document dates of condition checks and record actions taken to prevent deterioration'.*[192]

Whilst the QMC mortuary at NUH has procedures in place to manage the storage and condition of deceased patients, gaining praise in a 2016 regulatory inspection for its *'traffic light system that staff use to monitor*

191 The term 'body' to describe a deceased person is generally considered inappropriate within the post-death care field; however, as this is the terminology used in the Human Tissue Act 2004, it is the terminology the HTA are required to use.

192 https://www.hta.gov.uk/guidance-professionals/guidance-sector/post-mortem/guidance-body-storage

condition' [193] there have been severe problems with both the availability of freezer storage, as captured as a 'major shortfall' in a 2019 regulatory inspection,[194] and in the application of the procedures, which was again captured as a major shortfall in a later 2023 regulatory inspection.[195]

2016: The most serious of these failures affecting Harriet Hawkins is in a standalone chapter. With the consequence of these failures continuing to the current time in 2026.

2021: Another such case involved the death of a mother, an adult patient who died in mid July 2021 and was taken into the care of the nominated funeral director some 5 weeks later.

The deceased mother was kept in refrigerated storage whilst in the hospital mortuary and her own mother recalls that, initially, she was told that a viewing at the funeral director would be possible; however, she was subsequently contacted by the funeral director and advised not to visit due to the extent of the deterioration of her daughter's body.

The extent of the deterioration meant that the deceased could not be embalmed, or viewed or dressed by her family. This was a shock to her family, and caused them great distress (*"and I couldn't … you know what I mean, couldn't see her, it was horrible…she's wrapped up in swaddling…in the sheet… she was still in the hospital gown"*).

Information provided to the Review Team by NUH stated that 'in 2021, NUH policy did not require patients to be automatically transferred to freezer storage. Furthermore, there was very limited bariatric freezer space in NUH mortuaries at that time'.[196]

Whilst there was no defined time frame for when patients should be moved into freezer storage, this deceased mother had been identified as having issues with her condition when she was admitted into the mortuary, so a plan for her ongoing management, including whether or not to move her to freezer storage, ought to have been in place to ensure her dignity and to facilitate her family's wishes. If the family's plans and wishes had been ascertained at an early stage, this would have likely indicated the need for the after-death process to be expedited, where possible, and would have allowed a decision to be made by the family on how they wanted to proceed in light of their cultural preferences. Even if no options were available to shorten her stay in the mortuary, at least the family would have been fully aware of the situation at an early stage and been able to plan accordingly. Given NUH's answer, it would appear likely that a lack of bariatric freezer facilities was a factor in how her condition was managed.

2025: A baby born extremely prematurely died after a cardiorespiratory arrest. Her family spent time with her in the Snowdrop Bereavement Suite before she was transferred to the mortuary. She remained under NUH care for 37 days before being released to the funeral director. When viewed by family members in early February, she showed significant deterioration, causing considerable distress to the family who contacted the Review Team to raise concerns.

Five condition checks were recorded during this baby's mortuary admission. NUH state these checks are intended to identify deterioration from the condition at admission. However:

- The baseline condition was inaccurately recorded as *'no concerns'*, despite clinical notes documenting marked abdominal discolouration before the baby's death.
- This meant staff had no reliable baseline against which to assess deterioration.
- A check 2 days before the release to the funeral director recorded that she was *'oedematous and jaundiced but viewable'*, yet these findings were not recorded the day before or on a subsequent check two days later. NUH's explanation to the Review Team does not address this inconsistency.

193 https://www.hta.gov.uk/sites/default/files/2021-10/2016-08-09-16%2012258%20Queen%27s%20Medical%20Centre-FINAL.pdf

194 https://www.hta.gov.uk/sites/default/files/2021-10/2019-09-24%2012258%20Queens%20Medical%20Centre%20Inspection%20Report%20-%20Final.pdf

195 https://www.hta.gov.uk/sites/default/files/2024-05/2023-10-%2025-26%2012258%20Queen%27s%20Medical%20Centre%20Post%20Mortem%20inspection%20report%20Final.pdf

196 TC265b Response to Mortuary Enquiries, NUH, March 2026

- The final check stated *'no concerns'*, which is incompatible with the advanced deterioration seen by the family just a few days later.

Overall, the condition-check process of this little baby was inconsistent, poorly documented, and unreliable. While some deterioration was likely to be unavoidable given her clinical background and the long post mortem interval, the failures in documentation, monitoring, and communication meant that the family were not prepared for the condition in which they found her on arrival at the funeral directors. This distress was avoidable, and the mortuary condition-check process did not function as intended.

1.3 Post Mortem Examination of Non-Coroner's Cases

Consented (i.e. non-coronial) perinatal post mortems (PMs) at NUH are carried out in the Pathology Laboratory at Queen's Medical Centre (QMC), not in the mortuary. The laboratory takes a multi-phase approach to these PMs (preparation, PM, reconstruction, disposal).

The loss of the very early gestation baby disposed of as clinical waste by laboratory staff after post mortem was judged by the NUH Serious Incident (SI) Investigation Panel to most likely to have occurred at the reconstruction phase following the baby's postmortem.

Mortuaries are the appropriate location for perinatal postmortems to be carried out. This is because they are licensed by the HTA, contain appropriate facilities and equipment, are appropriately secure and private, are staffed by qualified Anatomical Pathology Technologists, and have well-embedded processes and procedures for the identification and traceability of patients' bodies and retained tissue samples/organs.

Reference is made in the NUH SI Report[197] to the fact that the mortuary at QMC *'does not have suitable equipment and there are a number of factors that could cause interruptions during a reconstruction'*, and that, therefore, *'the environment in which the reconstructions take place was identified as the better option by the team in the labs'*, however, it is unclear what *'suitable equipment'* the mortuary lacks, or what the specific factors are *'that could cause interruptions during a reconstruction'* (it should be noted that, also in the SI report, laboratory staff reported that there were *'disruptions within the lab environment – the staff members who carry out the reconstructions commented on how busy the area can be'*).

Conducting postmortems of babies of ≥24 weeks in the pathology laboratory is likely to present significant conflicts with Code B of the Human Tissue Authority (HTA)'s Codes of Practice[198], not least around the dignity of the deceased, and to do so is inappropriate when the Trust has access to the purpose-built mortuary facilities. It should also be noted that this practice is unlikely to comply with the recommendation of the Independent Inquiry into the Issues Raised by the David Fuller Case that '*all NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised'.*[199]

Laboratories such as the Pathology Laboratory at QMC are accredited by the United Kingdom Accreditation Service (UKAS) under the international standard ISO15189:2022 (Medical Laboratories – Requirements for Quality and Competence),[200] and the scope of QMC's accreditation includes the activity of *'paediatric pathology'.*[201]

Whilst this standard is entirely relevant to laboratory practice, including the parts of a perinatal PM involving the laboratory investigation of retained tissue, fluids and organs, it is not suited to practices related solely to the mortuary[202], as it refers to 'specimens' and 'samples', and not to 'patients'. This can have a dehumanising effect, as can be seen in the Datix and SI investigation report relating to this incident, where

197 759217_271396 SI report, NUH, 2019

198 https://www.hta.gov.uk/sites/default/files/2024-04/Code%20B%20-%20Post-mortem%20examination.pdf

199 Recommendation 5: https://assets.publishing.service.gov.uk/media/688258b96a7ea0e1ce1d3653/fuller-inquiry-phase-2-report-hc-1092-web-accessible.pdf

200 ISO15189:2022 Medical Laboratories - Requirements for Quality and Competence, International Standards Organization, 2022

201 https://www.ukas.com/download-schedule/8162/Medical/

202 Such as appropriate storage of the deceased's body and care of the deceased throughout their mortuary admission (including technical PM procedures such as evisceration and reconstruction).

the baby is referred to respectively as a 'specimen' and a 'sample'. Throughout other documents, she is referred to as 'the fetus'.

In its evidence to the Independent Inquiry into the Issues Raised by the David Fuller Case, UKAS stated that the ISO15189 standard *'contains requirements that support safeguarding the security and dignity of the deceased'*, however, the Inquiry report stated that '*the Inquiry has found no requirements in the standard that specifically support such safeguarding'* .[203]

Best practice is for the baby X-ray, postmortem and reconstruction to be carried out in as short a timeframe as possible. For late-gestation or full-term babies, this would ideally be as part of the same process, on one day.[204] A multi-phase process, undertaken over a week or more with multiple staff members, introduces an increased risk of error through the need for multiple, repeated checks as each phase begins. The practice of requiring checks to be made with only one individual, with no confirmatory checks, would have also increased the risk of error (note: two-person checks were introduced in response to this incident).

The practice of leaving babies unreconstructed for significant periods of time is undignified, disrespectful and inappropriate. If the examination involves the retention of organs and tissue that are required to be returned to the body, an interim reconstruction is acceptable, as long as it is of a sufficiently high standard to protect the dignity of the baby. It is unclear why babies at NUH are not appropriately reconstructed immediately after the pathologist has completed the PM.

It is unclear why a medical laboratory assistant has been trained to assist the pathologist and reconstruct following the PM, when NUH employs fully-qualified Anatomical Pathology Technologists, whose role it is to carry-out these tasks on a daily basis. The findings from the 2026 HTA regulatory inspection report underlines this concern...support staff working in this area did not have documented training or competency assessments in mortuary processes.[205]

Babies <24 weeks are considered in law to be the tissue of the mother and therefore tissue from the living. As a result, they are not in scope of Code B of the Human Tissue Authority (HTA)'s Codes of Practice[206]. Notwithstanding this fact, it is the strong opinion of the Review Team that the PM of all babies from 12 weeks to term should be carried out in the mortuary by qualified APT staff, not in the laboratory by Biomedical Scientists or Medical Laboratory Assistants.

2. Care of Bereaved People

2017: One family reported that after their baby had died, they requested to see her in the mortuary, but that they were left to wait in a corridor for an extended period of time with no information, because the member of mortuary staff who was going to conduct the viewing was on the other hospital site and had to travel back to meet them, despite an appointment having been booked. The family also report that they were taken on a long walk to the mortuary, through kitchen areas, which caused them distress and made them feel like they weren't being cared for.

Unfortunately, it is not unusual for hospitals that were designed and built in a similar period to QMC to have suboptimal arrangements for members of the public visiting the mortuary, including being located in areas that result in the public being brought into contact with inappropriate ancillary departments, such as kitchens and waste areas. Many hospitals, however, have recognised this and created alternative routes to support families and to try and minimise distress at such a difficult time.

More appropriate and compassionate practice would have been to arrange the family's appointment to see

203 https://assets.publishing.service.gov.uk/media/688258b96a7ea0e1ce1d3653/fuller-inquiry-phase-2-report-hc-1092-web-accessible.pdf

204 Early-gestation babies may require the body structures to be 'fixed' in preservative before they can be examined, which extends the time-line.

205 Draft inspection report on compliance with HTA licensing standards: Queen's Medical Centre, HTA, March 2026

206 https://www.hta.gov.uk/sites/default/files/2024-04/Code%20B%20-%20Post-mortem%20examination.pdf

their baby daughter, taking into account the travel time required for the member of mortuary staff to travel from the other site, so it is unclear why this does not appear to have happened. This resulted in a long wait for the family in an unsuitable hospital setting, causing them further distress.

2024: in another case, a family recounted having to pass through the Labour Ward to reach the Bereavement Suite (*"[you] have to be buzzed into the labour ward and walk past the place where your baby died – the reception area is part of the labour ward – to the bereavement rooms"*). They report that they found this profoundly distressing (*'have to be buzzed out – streaming with tears – the worst torture'*).

In response to questions from the Review Team relating to a deceased mother, who was permitted to deteriorate to such an extent that the family were unable to see her after her death. NUH stated 'In 2021, the Bereavement Team at NUH was not structured to provide comprehensive support to the families of women who had died. At that time, the team's core function primarily centred on supporting parents who had experienced the loss of a baby'.[207]

It is surprising and disappointing that as recently as 2021 there was no ability to provide 'structured' bereavement support to the families of mothers who had died at NUH. This would appear to be a significant gap in provision, and not in-keeping with bereavement services in other large acute trusts; however, there is confirmation that support was generally provided by the mortuary staff.

2020: In another case, a mother left hospital after the neonatal death of her early gestation baby, with the impression that the baby was a boy. The results of an external-only PM were available in late October 2020, but it was only after receiving the results of the PM five months later, that she found out the baby was a girl, having already buried the baby as a boy in a blue coffin. The mother had also given the baby a boy's name, which she had tattooed on her body.

This case was investigated by the Parliamentary and Health Service Ombudsman, who found that *'on the balance of probabilities, with contemporaneous medical mental health records suggesting [the mother] had been told the sex, we do think a conversation occurred. While it is not clear to what extent this happened, or exactly what was shared, it is clear [the mother] felt strongly her baby was a boy as a result'.*

The report concluded that *'overall, we know by the time both the death was registered and the burial took place, the Trust did know [the mother]'s baby was female. We have not seen evidence to suggest this was shared either by contacting (the mother) or by ensuring the local authority had the correct information. When [the mother] buried her baby, she still believed the sex to be male. We think this represents a failing in communication. The Trust had opportunities to share this information with [the mother], but we have seen no evidence to suggest it did so. If it had done so, we think this would have prevented the impact [the mother] has told us about'.*

3. Governance of Post-Death Care

3.1 Policy and Procedure

In 2016 (where a deceased baby was placed onto a body storage tray containing an unknown and unrelated deceased adult), staff completed a Datix incident report[208] and this was duly investigated; however, the findings and actions were limited to *'members of staff are to be retrained and team leaders are to do the task with the staff to make sure it has been done correctly'*, and *'member of staff have been seen and a file note has been done. Staff are to do more training within the mortuary'.*[209] This was not a sufficiently robust investigation to either identify the root cause of the incident, or to provide assurance that the risk of a recurrence was minimised.

207 TC265b Response to Mortuary Enquires, NUH, March 2026
208 Datix Ref. 180325, NUH, 2016
209 180325_Investigation Outcome, NUH, 2016

In early 2026, apparently in response to a notification received from officers working within Operation Perth that they were intending to *'inform the family of what they perceive to be a serious incident'* (NUH's words), the Trust undertook a second, in-depth investigation into the case relating to the baby and found the root cause of the incident to be *'a non-conformance with the SOP requirement to place the patient in an empty chamber. A factor in this is likely to have been the occupancy levels in the mortuary at the time of the incident. The incident could further have been compounded by the lack of clear instructions for portering staff to take if there was no available storage space'*, and noted that the corrective action taken at the time of the incident was '*to retrain the member of staff involved, for them to be observed by team leaders and for additional training to be accommodated within the mortuary'*.[210] The family was not informed of this situation for a further 10 years until 2026.

In addition to the identification of the root cause of the original incident, the 2026 investigation also identified gaps in the governance currently in place relating to access for untrained staff, insufficiently detailed procedural documents, a need to improve training, and a need to expand the scope of relevant audits. Actions were assigned to each issue identified to close the governance gaps.

The placing of a deceased baby onto a body storage tray containing an unknown and unrelated deceased adult patient fell significantly below the standards of care expected in 2016 (or in 2026). It is clear that the root cause of the incident was a lack of understanding by the staff member involved, contributed to by poor procedural guidance and training; therefore, it is concerning that the second investigation, ten years on from the original incident, revealed enduring procedural and training weaknesses, which were likely due to the insufficiency of the original investigation.

The 2026 investigation suggests that because a HTA Post-Mortem Examination Licensing Standards and Guidance document stating *'stacking bodies on the same fridge tray is not considered suitable practice'*25[211] as published close to the incident, it wasn't incorporated as a *'mandatory requirement within the SOP'*, which may have contributed to the original incident. However, even prior to this document being released (and certainly at the time of the incident in 2016), it was well embedded and accepted across the mortuary sector that placing two deceased individuals on the same body storage tray was unacceptable.

2022: A very serious incident involving the release of the wrong baby to a funeral director occurred.

Fortunately, the error was identified by the mortuary staff during a 'long stay patient check' before the 'wrong' baby was buried or cremated in the other baby's place, and the baby who had been released incorrectly was returned to the mortuary.

Information contained within the subsequent NUH investigation report[212] suggests an inappropriate focus on peripheral identifiers (such as fridge numbers, whiteboards, body bag labels and patient front sheets), when the only identifier that should be used for critical procedures, such as releasing a deceased person to a funeral director, is the ID wristband attached to the patient. This was not done.

In addition to the inappropriate focus on peripheral identifiers, there had long been recognition that the legibility of hand written ID wristbands originating from maternity services was known to be unreliable, and the member of staff releasing the baby admitted to not having carried out the checks required by the relevant SOP. If the mortuary had taken action to mitigate the risk they had identified regarding illegible handwritten ID wristbands, and the member of staff had followed the correct procedure, the incident is not likely to have occurred.

More concerning is reference to visual identification of the deceased in the incident report (*'both infants were in the late stages of the third trimester, and therefore similarly sized, and lacked definitive features. It is unlikely that they would be distinguishable by staff on visual inspection alone'* and '*infant patients are typically brought to the mortuary whilst wrapped in blankets. These blankets are provided by either*

210 HTARI Follow up report form CAS-78495-B7Q6 (Datix 180325) Signed, NUH, 2026

211 Code of Practice and Standards: Code B Post-Mortem Examination, Human Tissue Authority, 2016

212 382791_1177869_Final anonymised report, NUH, 2022

the child's parents or by the ward and can be very similar in appearance'. Relying on visual identification of either the deceased or items such as blankets in a mortuary context is entirely inappropriate, and its inclusion as a contributory factor in an incident report suggests a complete lack of understanding of standard mortuary practice on the part of the panel.

3.2 Number of Staff Groups Involved in Post-Death Care

A feature in multiple cases of cases of concern, across a long time span is the number of staff groups involved in many after-death processes at NUH. Professionals such as bereavement midwives, end-of-life officers, mortuary staff, and pathology specialist nurses all have parts to play in the post-death care processes; however, their roles and responsibilities appear to be often ill-defined, leading to (in these cases, at least) a loss of traceability and process-awareness. This has contributed in part to several families experiencing uncertainty over where their baby was and a number of post mortem examinations not being completed in line with families' wishes.

1. Statutory and Regulatory Compliance

Unlike other hospital staff groups, Anatomical Pathology Technologists are not regulated by statute. This means they have no protected title or scope of practice, and are only regulated by their local contract terms and conditions. Whilst the HTA regulates the post mortem sector, it is the establishment as a whole, not the individual staff, who are regulated. This leaves a significant regulatory gap when compared with other healthcare professionals.

There have been multiple failures at NUH to report incidents to the HTA within the parameters of the licensing conditions for mortuaries.[213]

There were serious failings in regulatory compliance in the case relating to Harriet Hawkins that are described in other sections of this report.

In a case occurring in 2016 an incident should have been reported to the Human Tissue Authority as an HTA Reportable Incident (HTARI) within 5 days of the incident occurring or being discovered, under the *'any incident not listed here that could result in adverse publicity that may lead to damage in public confidence'* category, but was not reported to the HTA until 2026, a gap of 10 years.

A governance review of the QMC mortuary,[214] commissioned by NUH and carried out in September 2025 by a reviewer from the Association of Anatomical Pathology Technology (AAPT), found a baby that had been in the mortuary for 772 days. Their condition was checked 31 days post-death and deterioration was found; however, the baby was not moved into freezer storage until 151 days post-death. This incident was not reported to the HTA until the report of the governance review was produced and disclosed to the Trust.

The AAPT governance review also found that *'there is no evidence of any other meetings taking place with interested departments such as the child bereavement team who arrange funerals for fetuses, babies and children and have contact with the parents'* and that *'the Child Bereavement Team are not available from Friday to Sunday and this can halt some processes such as family visiting the patient and handover of information'*.

Although areas of good practice were also noted, the governance review concluded that *'despite the incident that prompted this Review (Family 1), I believe that senior management – including the appointed Designated Individual – and other departments do not fully recognise the importance of making decisions that protect the dignity of the deceased, respect the family's grief, and uphold the Trust's reputation'.*

213 https://www.hta.gov.uk/guidance-professionals/guidance-sector/post-mortem/reportable-incidents-post-mortem-sector/post-mortem-hta-reportable-incidents-htaris

214 Nottingham Mortuary Assurance Review, Association of Anatomical Pathology Technology, September 2025

Since the Review's completion, NUH has presented a report to the Trust Quality Board, outlining the actions they are taking in response *('work is now moving into the implementation phase, where practical steps are being taken to translate these recommendations into measurable actions. This process includes assessing feasibility, allocating resources, engaging relevant stakeholders, and establishing clear timelines and accountability measures. Through this structured approach, we aim to ensure that the Review's findings lead to meaningful, sustainable improvements aligned with strategic objectives')*.[215]

In March 2026, the NUH mortuaries were subject to a no-notice regulatory inspection by the Human Tissue Authority. The inspection identified ten shortfalls (three critical, six major and one minor), against standards for Consent, Governance and Quality Systems, Traceability and Premises, Facilities and Equipment.[216]

Shortfalls were identified in most of the areas of concern highlighted by the Review:

The practice of conducting regulated activities, such as post mortem examinations, in a non-regulated area of the establishment:

- The team also observed that some perinatal post mortem examinations were not being conducted within the mortuary post mortem suite. Instead, they were transferred to a non-mortuary laboratory area that does not meet HTA standards. Consequently, support staff working in this area did not have documented training or competency assessments in mortuary processes.

Deterioration of bodies with insufficient condition checks and mitigation actions:

- *'During the body audit, the inspection team identified eight bodies that were showing advanced deterioration due to not being transferred to a freezer within a sufficient timeframe'.*

Insufficient provision for long-term storage:

- 'Both hospitals have insufficient long-term freezer storage to meet the needs of the mortuary service'.

Insufficient reporting HTA reportable incidents (HTARIs):

- Inspection staff completed an audit of incidents recorded on the Trust's internal systems over the past ten years. The inspection team identified a total of 719 internally recorded incidents. 145 of these incidents met the criteria to be reported to the HTA, of which 73 had not been reported.

Traceability of bodies and human tissue:

- *'Identification wristbands were not always checked when transferring bodies in hermetically sealed body bags into the care of funeral services…these seals are not opened at the point of release. As a result, identification is verified solely against accompanying documentation rather than by confirming the wristband on the deceased. This increases the risk of the wrong body being released to funeral services'.*

Shortfalls were also identified in the areas of equipment condition, maintenance and monitoring, security, risk assessment, consent, and contingency arrangements.

Shortfalls regarding insufficient provision for long-term storage and insufficient condition checks were also identified in a regulatory inspection the HTA carried out in 2019,[217] and inconsistencies in condition checks was also identified in a 2023 inspection.[218] Repeated, serious shortfalls over at least seven years demonstrates a failure by NUH to adhere to regulatory requirements, learn from incidents and invest in sufficient mortuary capacity. The lack of progress also suggests potential deficiencies in the HTA's regulatory inspection regime over the same period.

215 Item 5.1 Paper 3b NUH Response to AAPT review recommendations, 2026

216 Draft Inspection report on compliance with HTA licensing standards: Queen's Medical Centre, HTA, March 2026

217 https://www.hta.gov.uk/sites/default/files/2021-10/2019-09-24%2012258%20Queens%20Medical%20Centre%20Inspection%20Report%20-%20Final.pdf

218 https://www.hta.gov.uk/sites/default/files/2024-05/2023-10-%2025-26%2012258%20Queen%27s%20Medical%20Centre%20Post%20Mortem%20inspection%20report%20Final.pdf

Note: the Human Tissue Authority stated to the Review that, since 2016, they have implemented changes to their regulatory approach, such as issuing revised and updated Licensing Standards; introducing unannounced inspections as routine in the Post Mortem sector; introducing a more rigorous and documented process for checking appropriate storage arrangements, particularly for those held for lengthy periods, including babies and infants; and publishing revised guidance on body storage, managing capacity issues and reporting incidents. It should be noted that multiple examples of poor post-death practice were identified by the Review in the period after these changes were implemented.

NUH is currently embarking on a process of changing standard operating procedures, documenting operational and strategic risks and seeking funding to invest in additional body storage. This is positive, but raises the obvious question as to why this process only began once NUH started to come under significant external scrutiny. These changes should have occurred when concerns and regulatory shortfalls were first identified; this was a significant missed opportunity to prevent harm to deceased and bereaved people.

2008: In one case, one sister triplet was miscarried, whilst two of her sisters were born with signs of life and lived for a significant amount of time. The Trust, however, registered all three babies as miscarriages instead of neonatal deaths and, as a result, the babies were registered incorrectly, were not issued NHS numbers as they should have been and were not reported to HM Coroner.

The failure to register the births or deaths of Grace, Pippa and Lottie had a profound impact on the parents, including the fact that the mother was unable to take any maternity leave or claim any maternity benefits, despite being entitled to do so.

Following work by the Review Team, HM Senior Coroner for Nottinghamshire, the Senior Registrar for Nottingham, and the NUH Lead Medical Examiner, an application to the Registrar General was successfully made to register the babies' births and deaths. This has provided significant comfort to the parents of Grace, Pippa and Lottie more than 17 years after their deaths.

5. Organisational Culture

5.1 Communication

2018: A mother was shocked to learn by letter that her baby's requested post-mortem had not been performed. She was not contacted by the bereavement team during this time.

2018: In the case of this baby the failure to perform a post-mortem occurred when the appropriate paperwork was not transferred with the baby. The mother learned about the issue four months later during a postnatal consultant debrief. The baby's funeral had already taken place, denying parents the opportunity to have a post mortem examination.

2018: In one case, where the parents state that the hospital had 'lost' their baby, was due to poor communication and a lack of robust record keeping, relating to a failure of staff to follow arrangements put in place by the bereavement midwife whilst they were on leave (NUH state that they have been unable to determine why the arrangements put in place by the bereavement midwife whilst on leave were not adhered to).

The distress caused to the parents by this incident is significant (*"I was in a complete panic, I thought I lost him again"*).

2024: In another case, a baby was not taken to the mortuary following her stillbirth and she remained in refrigerated storage on the labour ward until the failure to transfer her to the mortuary was identified four days later. A Datix incident form was completed, which described the incident as *'baby found in fridge'* and the subsequent investigation identified a failure to follow *'agreed process'*. It is unknown if the 'agreed process' in question is a formal, documented process or practice that has developed over time.

As the baby remained in refrigerated storage, and the timeframe covered a bank holiday weekend, no harm to the baby and no delay to her subsequent after death care arose from this incident. This incident does, however, represent a significant failure of communication and a loss of traceability. During the investigation of the incident, it was noted that *'the midwife who discharged the woman purposefully kept the baby on the [labour ward] in order that her colleague on the night shift could take a tissue sample as had been consented for by the woman. The midwife who took the tissue sample was unaware that there was no plan in place to transfer the baby to the mortuary and imagined that this would happen as is usual on the day shift. However, she didn't tell anyone on the day shift that the baby was in the fridge believing that its presence would be picked up on review of the diary'*. Staff reported that two safeguards that used to be in place (checklist prompts to *'make a note in the [labour ward] diary that there is a baby in the fridge, soon after birth'* and to *'check the fridge daily as part of the daily checks'*) were no longer in place at the time of the incident. It is unclear why these two safeguards were no longer in place at the time of the incident.

2024: A further case, saw a baby's parents report being told that they would be informed as soon as the post mortem examination was completed, so that they could arrange his funeral, and that they would also be told when he was due to be discharged into the care of the funeral director.

It is unclear who told the family that they would be contacted at each of these important milestones (it must have been either someone from the funeral directors or someone from NUH), but they are absolutely certain and clear that they were told this. They are also certain that they were not told at either stage and were left both with uncertainty over what was happening with their baby son post mortem (and, therefore, his funeral), and the mistaken belief that he was still in the care of the mortuary at QMC when he had actually been discharged to the funeral director some days prior.

This lack of certainty over what was happening and where their son was to be found caused the parents considerable distress (*"I found that absolutely devastating, and it completely broke me because I thought, I've been thinking he's still at Queen's all this time. You imagine at night, when you go to sleep, where they are"*).

There are multiple potential sources of communication with the family described throughout the documentation – 'the hospital', 'the bereavement service', 'the mortuary', the 'bereavement midwives', 'the funeral directors'. This suggests that all of the services involved in providing support to bereaved parents are treated as separate entities, even though all but one of them are departments within NUH. This siloed way of working is highlighted throughout the explanations given to the parents by various individuals.

The response to the parents' complaint from NUH and the notes recorded by the NUH bereavement midwife present a confusing and contradictory picture – on one hand, in the response to their complaint, the parents are told that as a matter of course 'the hospital' would not contact families to inform them that the post mortem was completed or that their baby was ready for collection by the funeral directors; however, the notes made by the bereavement midwife clearly show that they at least intended to notify the parents of precisely those things by text (whether or not the text was actually sent is a matter of debate, and it is not possible for the reviewer to determine either way). The lack of a clear definition of who was responsible for each task, and a lack of effective coordination between them, made miscommunication much more likely.

Parents experiencing bereavement naturally find taking in and retaining information very difficult, which makes clear, compassionate, unequivocal and reliable communication extremely important.

2025: In another case , a mother requested to see her baby who had died and was informed that this would not be possible and to wait until baby was with the funeral directors. When the midwife on labour ward discussed this with the mortuary, they informed the midwife that the baby was in the freezer and *'would need to thaw'*. The mother was unaware that her baby had been frozen.

The baby was placed into freezer storage four days after being admitted to the mortuary, and on the same day authority was received to release baby to the family's nominated funeral director.

Moving a baby into freezer storage when they are exhibiting signs of deterioration is good practice, but not when authority for release has been given and baby is expected to be imminently collected by a Funeral

Director. The rationale for this decision is not clear.

Every time a decision is made that a patient needs to be moved into freezer storage, the family should be contacted, the reasoning should be explained to them in sensitive but clear terms, and they should be given the opportunity to comment and consider what impact this may have on their plans (e.g. to visit the baby). This clearly did not happen in this instance and the family were therefore denied the opportunity to see their baby.

5.2 Learning from Incidents

Many incidents involving poor post-death care share striking similarities, showing a marked lack of learning. Two in-depth reviews carried out into the post-death care of Harriet Hawkins[219,220] raised significant concerns regarding mortuary care, only for a similar case to be discovered during a subsequent review that was carried out at the recommendation of the first reviewer.[221]

5.3 Recognition of Religious and Cultural Needs

In two cases reviewed in 2019 and 2021, the families' cultural requirements were not met. One of the cases involved a lack of communication leading to a request to expedite a PM for religious reasons not being honoured, which delayed the funeral, and the other involved a family not being able to dress their daughter in traditional funeral clothes because of deterioration after a prolonged period of time in the mortuary.

6. Community Issues

6.1 Cemetery Care

In 2025, the Review Team received contact from a number of families who were distressed by the state that their local cemetery was in. The area was overgrown and unkept, littered with rubbish such as cans, broken benches, litter, and a stained mattress. Graves were unkept, damaged, and difficult to find.

In response, the Chair of the Review made contact with MPs and Nottingham City Council to share her concerns. The cemetery then began restoration work, and have since cut down the 'rewilding area' which hid many graves.

6.2 Locating Graves

Some families have told the Review Team that they are unable to locate their baby/babies' graves. For the most part, this relates to graves of those who had died at a time when hospitals generally took responsibility for burying babies. Review Team members have helped families locate graves by contacting local cemeteries, councils, and supporting parents with obtaining certificates of stillbirths or neonatal death which were frequently not provided to families at the time.

The Chair of the Review was contacted in October 2023 by a father whose daughter was stillborn in 1968 and whose son was stillborn in 1969.

The parents had waited for more than 40 years to locate them. Their mother had died without knowing where her babies were buried, as at the time the hospital took responsibility for burying babies and often did not tell families where their babies were located.

219 Independent Investigation into the After-Death Care of [Family 1] at Nottingham University Hospitals NHS Trust, Association of Anatomical Pathology Technology, March 2025

220 Independent Investigation into the After-Death Care of [Family 1] at Nottingham University Hospitals NHS Trust – Supplementary Report, Association of Anatomical Pathology Technology, April 2025

221 Nottingham Mortuary Assurance Review, Association of Anatomical Pathology Technology, September 2025

The father recounted how *"the babies were immediately removed when they were born with no explanation as to what was going to happen to them. No explanation was ever given and the only words of 'comfort' were 'you can try again'".*

Over the following months, at the request of the Review Chair, the Review Team worked with Nottingham City Council and the Nottingham Cemeteries to locate the burial plots of the babies, eventually locating them in Bulwell Cemetery – first the baby boy and then the baby girl, and then in February 2024, details of the babies' weights and exact dates of birth were also found.

The father told the Review that *"every little bit of information is precious and makes the babies' existence more real".*

The Review team sent the family SANDS memory boxes, for both babies, with baby wrist bands, baby blankets and birth cards.

The father of the babies said *"after 56 years of wondering what had happened to my daughter Eilean and 55 for my son John, I can now visit their resting place, which is of great comfort to me. I am in the process of having plaques made and laid on their graves. Thank you for all your diligence, for caring and all your help. I am forever grateful"*.

A family member said *"thank you seems so inadequate but we sincerely do so. Each little bit of information is gratefully received. Reading the information about the babies' birth brings the realisation of what might have been for* [the father]*. Even though it is quite emotional for him, and I do ask him if we should continue, there's never been a doubt in his mind that he needs and wants to get answers before it is too late for him. The only regret he has is that his late wife will never know".*

In October 2025, the Chair of the Review visited the Bulwell Cemetery, at the request of another family, and was able to locate the newly laid plaques for both babies.

6.3 Bereavement Boxes

The Review Team has worked closely with a number of charities including Sands and Aching Arms, charities that provide memory boxes to bereaved parents. The Review received contact from distressed families who had lost/didn't receive baby keepsakes. The Review Team helped families by organising personalised memory boxes to be sent to the parents.

6.4 Registering a Death

The Review Team have received requests from families asking how they can obtain proof of stillbirth or neonatal death. The Review Team have been able to advise families how they were able to do this with a step-by-step process involving support from The General Register Office (GRO).

Corporate Culture, Governance & Leadership

1. Introduction

Previous reviews of maternity services have highlighted the responsibility of Trust Boards for failings in service:

Kirkup said of Morecambe Bay in his 2015 Review[222]: *"When the dysfunctional nature of the maternity services became obvious, in 2008, the Trust's response was flawed and inadequate, and categorised for some years by instances of the same denial and cover-up that was evident in the maternity unit. At the time, the Trust was strongly focused on achieving Foundation Trust status, which both diverted capacity to manage day to day and surely fostered reluctance to disclose anything that may have jeopardised the bid".*

In her 2022 review of maternity services in Shrewsbury, Ockenden noted[223]; *"in late 2021 a member of staff reported how the Trust's board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services. The staff member told the Review Team: 'I don't think that the Board knew what was needed in maternity services. I was giving them information that they'd never had before".*

Kirkup diagnosed the following in relation to failings at East Kent[224]: *"The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation, as is evident from a great many instances within the NHS and much more widely. Many risk registers will identify reputational damage in several contexts as something to be mitigated."*

Most recently the 2025 Review of maternity services in Swansea found[225]: *"Between 2021 and 2024 there were significant weaknesses in governance. These related to a lack of challenge and scrutiny from Board members and poor visibility of issues relating to maternity and neonatal services"*.

In the Review it was important to understand whether and how the corporate culture, leadership and governance at Nottingham University Hospital NHS Trust (NUH) had impacted on and responded to the failings in maternity services; as well as assess whether changes made since 2022 are credible, embedded and sustainable. To do this we examined Board and other corporate minutes, reviewed external and stakeholder reports and interviewed a range of senior stakeholders who held positions of authority at both NUH and the then CCGs now ICBs over the period 2012 to present.

Engagement with this process proved extremely disappointing, of the 14 senior CCG/ICB colleagues contacted only four were interviewed (five came forward but one did not subsequently progress to interview). Overall engagement rate of 28.6%.

In relation to engagement from senior colleagues from NUH, 66 former and current colleagues were approached by the CEO of NUH. Many of which were contacted on multiple occasions. Of these 37 came forward and 35 were interviewed. Two colleagues missed the timescale for inclusion. This was an overall engagement of 53%.

In 2022 General Sir Gordon Messenger published what is the latest in a long line of national reviews and explorations of what it takes to provide good leadership and management in the NHS.[226] His findings and

222 Kirkup (2015) The Report of the Morecambe Bay Investigation, Department of Health, Stationary Office

223 Ockenden (2022) Findings, conclusions and essential actions from the Independent Review of maternity Services at Shrewsbury and Telford NHS Trust, House of Commons, London

224 Kirkup (2022) Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation

225 Chaffer (2025)Summary Report of: The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

226 Messenger (2022) Independent report: Leadership for a collaborative and inclusive future, Department of Health & Social Care

recommendations were widely accepted by politicians, policy makers and the NHS management and leadership communities, including trade unions. In summary his most acute observation was;

"That there has developed over time an institutional inadequacy in the way that leadership and management is trained, developed and valued. Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability. Very public external and internal pressures combine to generate stress in the workplace. The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. We experienced very little dissent on this characterisation; indeed, most have encouraged us to call it out for what it is."

Reflecting on the findings of the Messenger Review and guidance to leaders and Boards in the NHS, the Review Team searched for evidence relating to

- Effective oversight of quality and safety at Board, Divisional and service level
- Cultures and behaviours that across the organisation promoted psychological safety, speaking up and organisational learning
- Visible and credible leadership at corporate clinical and service levels
- Robust risk management and triangulation, including positive relationships with regulators and oversight
- Board competency in maternity and neonatal safety

2. Overview timeline of key events in NUH from 2012-2024

2012

Date	Event
Aug	A confidential and redacted external report on Board and Executive leadership and culture is discussed
Sept	Board Quality Committee expresses concern at Trust-wide backlog in resolving Serious Incidents
Dec	Midwifery LSAMO report highlights need to strengthen midwifery supervision

2013

Date	Event
April	CQC identifies the Trust as relatively high risk
May	Obstetric ventilation is added to significant risk register
June	Midwifery vacancies are flagged to the Board as a cause for concern
July	Board Quality Committee receives maternity dashboard and raises questions about maternity safety and consultant staffing
Aug	CQC alerts that NUH is on an outlier on maternal readmissions and PPHs. Obstetric leads provide assurance that this is not significant or of concern
Aug	National Berwick Safety Review highlights the main problems affecting patient safety across the NHS and makes recommendations to address them

2014

Date	Event
Jan	Changes introduced to the way community midwifery is organised/managed
Jan	Board Quality Committee receives results of maternity patient feedback and express concern that there is disconnect between assurances given by staff and women's experiences
Aug	A second whistle blower from radiology contacts CQC regarding safety and staffing
Oct	Internal audits and consultations across the Trust staff flag behaviours and culture as of concern

2015

Date	Event
Jan	Board Quality Committee receives details of several safety issues in maternity. However, the board are given assurance that these are not a cause for concern
Jan	Nursing vacancies at c200 met with a £4m investment in nursing staff
Feb	Board Quality Committee express lack of assurance regarding maternity dashboards and request quarterly reports
Mar	Kirkup Review into Maternity Care at Morecambe Bay is published. DoM assures Board 'no grounds for concern at NUH' and it 'reinforced appreciation of strong multi-disciplinary team working at NUH'. However raises financial risk associated with medical staffing recommendations
April	Maternity services awarded Baby Friendly status
April	A comprehensive review of management structures replaces directorates with fewer bigger divisions with delegated authority. Aim to save money and improve decision making. Also includes organisational review and Board development
June	NUH receives results of 2014 National Neonatal Survey. Issues raised include; mothers with babies in NICU on same wards as postnatal women; space to sit alongside cots; poor written information for parents; parents unprepared for discharge
Oct	Board Quality Committee receive additional confidential 0report into serious staffing issues uncovered on a maternity ward and alleged sabotage of CQC visit. An external review of maternity is commissioned led by an occupational psychologist. It will report in July 2016
Oct	Felicity Benyon experiences extreme injury during childbirth. In 2023 CEO will apologise for all failings in her care
Dec	Board Quality Committee express concern that High Level Incident Reporting log (process used for incidents not classified as SIs) is providing insufficient assurance particularly in relation to investigation of deaths

2016

Date	Event
Jan	DoH publishes proposals for changing the system of midwifery supervision in the UK
Feb	In response to Kirkup Inquiry, NHSE/I publishes Better Births a new vision for maternity services: for them to become safer, more personalised, kinder, professional and more family friendly
April	ED clinicians raise their concerns formally with the Board regarding stress and pressure, failure of clinical leadership and the support required
April	Baby Harriet Hawkins dies due to failures in care. Trust fails to investigate
July	Report of external review of maternity is reported. Despite its findings of poor culture and leadership, Board is given assurance: 'No problems with practice and clinical outcomes are good'. Action Plan received
July	Board Quality Committee receives Annual Maternity Incident Report which records: degree of harm incidents have reduced due to reclassification; targeted work to be done on PPH; 7 neonatal deaths reviewed and 6 had no sub optimal care. CS rate reported as significantly lower than national average
Aug	Maternity Never Event reported to Board
Oct	Chief Nurse gives Board assurance that midwifery has full establishment

2017

Date	Event
Jan	CEO & Chair announce resignation
Jan	Board receives critical 'Well led Review'
Jan	Board Quality Committee receives Maternity Quality Report. It records increase in deliveries; increase in unit diversions and closures; number and type of incidents stable; review of governance ongoing; reduction in stillbirths; midwifery staffing at establishment; 2 successful patient safety funding bid and increase in inductions
Mar	Board Quality Committee receives internal report on Maternity Unit Diversions & Closures. It provides assurance that rates at NUH are similar to neighbouring units. Reasons for diverts are mainly staffing, bed capacity and acuity. Incidents relating to diverts/closures in the main cause no harm, a small number cause harm and 2 investigations are underway. Patient complaints indicate has negative impact on their experience
April	Board Quality Committee receives report of Maternity Governance Review record only limited assurance
May	First mention at Board of maternity review that was undertaken in 2016
July	NHS Staff survey indicates NUH in bottom 20% for motivation and satisfaction at work
July	New CEO appointed
Aug	Notts CCG escalates its concerns about maternity at NUH to NHSE/I. It also commissions systematic review of maternity stillbirths and an independent review of the case of Harriet Hawkins
Nov	Board Quality Committee receives progress report on maternity aspects of CQC action plan
Nov	NHSE/I launches new National Maternity Strategy: setting out additional measures to drive improvement further and faster
Dec	Publication of External Report of Maternity Incident, the death of Harriet Hawkins. Trust has accepted findings and recommendations. CEO issued unreserved apology
Dec	NHSE/I sets out expectations for all maternity services to achieve Continuity of Carer by the end of 2020/21

2018

Date	Event
Jan	Board Quality Committee receive Quarterly Maternity Quality Report seek additional assurance. Recognise pressure on staff of media/public attention
Jan	Board updated on the baby H case. A working group has been established to discuss high profile cases
Feb	Board Quality Committee note that Trust-wide reporting of SIs remains a problem - timescales routinely breached. Lessons not being learnt quickly enough
April	Board Quality Committee receive Maternity Quarterly Quality Report, mostly positive, seek assurance re placenta storage and comment that reports fail to include any patient feedback
July	Board Quality Committee receive Maternity Quarterly Report. MBRRACE report shows significant improvement in perinatal mortality. CCG enhanced surveillance complete and normal surveillance resumed. Senior midwifery structure almost complete. 2 new O&G consultants appointed. Reduction in number of closures and diverts. Key risks: shortages of tier 2 and 3 medical staff, staffing shortages in governance team impacts on delays; service demand due to changes in guidelines impacts especially ultrasound. Research on maternity culture has been completed and a transformational work plan to include culture
July	Trust wide SI report; number of SIs increasing. Deterioration in timescales for investigating/ reporting. Duty of candour not 100%
July	External Review of Maternity Culture received in Division. It is not escalated to QuAC or Board. It is critical of leadership, culture and staffing. Follow up recommendations are not commissioned
Oct	Maternity Quarterly Review; full midwifery management structure in place, steady improvement reported by DoM. Incidents are better managed. Working on filling vacancies. Compliance with retention of placenta and equipment checking have been addressed and are regularly monitored, addressed differences in care on 2 sites for emergency CS. key risks: service demand due to guideline changes impacting on ultrasound and equipment shortages. positive impact of 24hr midwifery on-call rota. Staff engaging in culture work
Nov	50 midwives sign a letter to Chair of Trust Board expressing concerns at staffing and safety. This letter is not discussed at Board or QuAC. Response is from Divisional Director

2019

Date	Event
Jan	Saving babies Lives Care bundle v2 published
Jan	Trust Board informed
April	Board Quality Committee informed that Trust has failed to meet CNST standards
April	Board Quality Committee receive Maternity Biennial Quality Report. Reduction in Serious Incidents over last year. Staff shortages no longer recorded on DATIX. Insufficient evidence to meet 3/10 CNST standards, including significant shortage of midwives c50. Failure to meet CNST standards will cost Trust c£1m. Culture work supported externally and internally is continuing. Committee acknowledges that service is under pressure, revert to quarterly reporting
July	Board Quality Committee receive Family Health Divisional Quarterly Report. It indicates significant staffing issues in midwifery. Obstetric staffing described as 'fragile'. Maternity transformation pilot having an impact on service
July	Baby Kouper Needham dies 1 day postnatally due to failures in care
Aug	Trust wide SI reporting shows still a backlog, still taking too long to complete
Oct	Board Quality Committee receive Maternity Quarterly Report. Top 5 risks are driven by resources and national drivers. Improved vacancy position. 2 national outliers relate to PPHs and 3/4th degree tears. Higher than average stillbirth rates. Progress on implementing saving babies lives care bundle aim to be totally compliant by March 2020. New obstetric leadership team. SI include a maternal death. Family Liaison Officer taken up post to support patients after incidents.

2020

Date	Event
Mar	England enters first national COVID lockdown rules begin to relax in May
May	Low response to NHS staff survey and deteriorating position since 2018 survey. Allegations of bullying and harassment received via unions. A full investigation launched. Significant work on trust culture to commence
July	Board Quality Committee receive Maternity Quarterly Report – assurance of significant progress given
Aug	Maternity Safety Transformation Plan established because of significant safety concerns raised by HSIB including unexplained spike in stillbirths in April 2020, delays in responding to complaints and concerns about Duty of Candour. Executive team conclude concerns raise questions about culture of learning, new approach needed. Proposal shared with CQC commissioners and NHSI
Sept	Board considers Trust response to maternity inquest of baby who died Sept 2019. Chief Nurse says issues only came to light in Spring of 2020. The incident did not meet the threshold for reporting as an SI, therefore there were missed opportunities to identify concerns
Oct	Trust informed that CQC will rate maternity as inadequate
Oct	NUH commenced on NHSE Maternity Improvement Programme
Oct	Board Quality Committee receive Maternity quarterly quality report. Committee discuss their own failing in accepting past assurances and not acting quickly enough
Nov	England enters second national lockdown followed by regional lockdowns
Nov	Report to Trust Board from the Maternity Oversight Committee, chaired by the CEO and including reps from NHSI, CCG and an external critical friend. BR+ identified midwifery staffing establishment deficit is 73
Dec	Independent Review of Shrewsbury & Telford (first report) published

2021

Date	Event
Jan	England enters third national COVID lockdown - restrictions lifted in July
Jan	3 data breaches occurred in Family Health Division. 2 considered serious and flagged concerns around culture
Jan	Board consider maternity Never Event
Jan	Discussion by Board about racism and whether NUH is institutionally racist
Mar	CQC report rating NUH maternity inadequate is published
Mar	Business case to increase midwifery establishment by 61.8wte agreed
April	NUH Improvement Oversight & Assurance Group (IOAG) co-chaired by the Notts ICB and NHSE. Regional Perinatal Board
April	NICU staffing and problems with capacity are jeopardising retaining accreditation on both sites
April	Freedom to Speak Up Guardian reports themes around bullying, management style, perceived nepotism, especially prevalent in Family Division
May	Maternity Programme Oversight: SIs and staff engagement remain concerning. External visit to Trust raised concerns about culture - some staff not following guidelines and policies
June	A CQC visit to focus on surgery and emergency care. No inspection of maternity but progress of improvements will be monitored and re-inspected as required
July	Baby Quinn Studenski-Parker dies 1 day postnatally in neonatal unit due to failings in care
July	CQC undertakes Well Led Review of NUH Executive Team and Board concludes Board/ Executive not working effectively, disconnected from organisation, culture of bullying across the organisation and poor governance
July	Following Well Led Review NUH enters national recovery support programme. S29a notice served
Aug	Trust put under increased surveillance by CCG/ICS and a system maternity action plan developed. Identified a lack of pace and assurance and a lack of focus on impact and outcomes. No triangulation between Improvement Plan, maternity dashboard and challenges maternity faces. Noted service instability with 4 DoMs and 3 CNs in 8 months
Oct	CEO steps down
Nov	Finance Director becomes acting CEO
Dec	SIs (trust wide) up 30% demand for investigation panels has outstripped capacity. Increase in patient safety team planned

2022

Date	Event
Feb	Board Quality Committee note that maternity improvement is not happening at required pace. NHS Midlands Team has offered support for matrons on SIs. Home Birth service suspended in Dec 2020
Feb	NHS Improvement issues formal enforcement notice in respect of maternity
Mar	Ockenden Report: Final. Findings, conclusions and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust
Mar	CQC conducts unannounced inspection raises additional concerns regarding triage, and maternal observations on postnatal ward and issues an enforcement notice. Midwifery staffing remains below establishment: 37 additional posts required to meet BR+. Report on 19 historic maternity incidents that were never declared as SIs
April	NHS staff survey, FSUG and in house Big Conversation all highlight bullying culture across Trust. By end of year increase in reports to FSUG relating to inappropriate behaviours, incivility, and bullying
April	Actions and evidence of compliance with Ockenden 1 have been submitted including revising Maternity Improvement Plan. Concerns include: training compliance, BR+ acuity, impact of negative media on staff morale, SI themes, pathways and triage and referral to Trusts pre-term birth clinic
May	Announced that Donna Ockenden will lead an Independent Maternity Review of NUH
July	SIs across Trust remain a concern, large backlog and failure to meet deadlines. 9 never events between April 2021-Feb 2022 across whole trust - only partial assurance that learning has been disseminated
Aug	Anthony May appointed and announces his attention to develop a 100-day plan including 7 priorities - one of which is maternity. Also quality safety and patient experience
Sept	Implementation of PSIRF will commence Oct 2022. SI recovery plan (across Trust) is off track. Currently 60 outstanding maternity SIs. Not enough obstetric time to review SIs Lack of obstetric input in Mat Impov Plan due to staff shortages. Midwifery staffing remains an issue. Service unable to comply with CNST. Training continues to be a challenge. Triage data shows improvement
Sept	ICB notes that progress at NUH in relation to Ockenden IEAs is ‘nowhere near where we want it to be for local women’
Sept	New CEO attends first Board meeting. Apologises to families let down by maternity. Issues statement that there will be no toleration of bullying, racism. Reports to Board that his assessment is that staffing remains a challenge across Trust
Oct	Kirkup Report Reading the Signals. Maternity and neonatal services in East Kent – the report of the Independent Investigation is published
Nov	Trust receives findings of external review of neonatal services which is critical of culture, leadership, staffing
Nov	Inborn neonatal deaths increased in Sept 2022 although 4 babies had conditions incompatible with life. Staffing issues continue to impact on CTG audit compliance figures. Agency staff unable/unwilling to engage. Trust compliant with 4/10 NHS Resolution safety standards. Midwifery gap is 126wte. Not enough obstetricians to complete significant delays

2023

Date	Event
Jan	CEO attends prosecution re Wynter Andrews, pleads guilty to 2 charges, offers full and sincere apology
Feb	Anthony May publishes his 100-day plan: priorities are ED, recruitment and retention and leadership and culture. Concludes that The Trust has been slow in decision making and disengaged from clinical leadership. Nothing specific on Maternity
April	CQC inspection of maternity demonstrates some improvements
May	Delay in plans to rebuild QMC & City Hospitals
July	CEO acknowledges in letter to Sarah Andrews that maternity staff letter/response from 2018 were never discussed by Board. Accepts Trust's actions and response were inappropriate and inadequate and unsatisfactory
Oct	NUH announces Notts Maternity & Neonatal Review is a stop gap if the new build on one site cannot go ahead. Proposes rebuilding large areas of neonatology at QMC - to be opened 2024. Will change the way obstetrics works and has created more uncertainty whilst development underway

2024

Date	Event
Jan	Home birth service suspended
April	NHSE remove compliance notices for maternity and well led, but put in place a new one for financial controls
April	Operation Perth Police investigation begins
May	Freedom to Speak Up Guardian reports 62% increase in concerns being raised: incivility, inappropriate behaviour, bullying and harassment. FSUG service is expanding and actively engaging
May	18 international midwives join NUH
June	CQC inspection of maternity services following concerns raised by staff. Trust asked to submit an action plan
July	Appointment of new Medical Director
Sept	NUH home birth service relaunched
Sept	NUH launch family liaison service for women and families affected by maternity failings
Dec	New NICU at QMC opened

2025

Date	Event
Jan	Coroner inquest into the care of baby Teddy Martin. Trust admits liability for his death
Feb	Trust receives fine of £1.66 million after pleading guilty to failing to provide safe care and treatment to three mothers and their babies in 2021 following a CQC prosecution
Mar	CQC publish report following inspection of maternity in June and July 2024. 'Effective' category upgraded to 'Good' from 'Requires Improvement'. Maternity overall remains at Requires Improvement
Mar	John Pitchers (AAPT) report into the post death care of Harriet Hawkins
May	CQC inspection of maternity services
Sept	Amy Calder (AAPT) Nottingham Mortuary Assurance Review report

How was the Organisation Led in the Past 2012-2022

In 2006 Queens Medical Centre and Nottingham City Hospital merged to form Nottingham University Hospitals Trust. The merger created a maternity service based on two sites, with two neonatal units; however, community midwifery services remained organised and managed by the PCT until 2013.

From interviews with staff and leaders and from internal minutes, the merger was a challenge across the organisation, but specifically in maternity where obstetricians and midwives worked exclusively on one site, each with their own rotas, with different systems and their own approach to interpreting and using national guidance. The culture of the two units, whilst not hostile to each other was very much siloed, with little demonstration of collaboration, cooperation or consensus and a poorly functioning multidisciplinary team (MDT). As late as 2021 Executives and maternity leaders were reflecting the separation and cultural distance between the two units.

3.1 How the Board functioned 2012-2022

Over this 10-year period, the Trust struggled and largely failed to meet many nationally set performance targets across a range of metrics: primarily and most frequently the 4 hour target waits in A&E and cancer wait times. It regularly also failed to meet targets around staff appraisals and mandatory training. From 2017 onwards, performance declined in relation to elective waiting times, ambulance turn around, referral to treatment (RTT). The Board received a series of action plans, strategies and reorganisations aimed at addressing these, a number with external support from management consultants. These consumed a great deal of Board attention.

At the beginning of this period the Trust delivered its annual Cost Improvements of c£40m a year and managed to deliver a balanced end of year budget. However, by 2013/14 the Trust was increasingly struggling to control costs. Whilst for several years it continued to deliver required cost savings, its operating deficit grew year by year. Failure to control costs had an impact on the Trust's strategic ambitions: it did not achieve NHS Foundation Trust status; it also failed in taking on and merging with Sherwood Forest Trust. By the end of this period the Trust was in special measures given its on-going failure to meet its statutory responsibilities in relation to financial management. Whilst several senior stakeholders were anxious to inform the Review Team that lack of finance was not responsible for maternity's challenges, our evidence on staffing levels, problems with the estate and equipment and the dual costs of running on two sites could contradict this. Achieving financial controls through improved productivity and cost cutting were certainly key Board discussions over this period.

Several commercial or semi-commercial enterprises were attempted, but these failed to increase income and efficiency for the Trust. The outsourcing of Estates and Facilities Management in 2016 lasted less than two years and impacted on the long-term cleanliness and fitness for purpose of the NUH estate. The joint venture to create an arm's length pathology service by NUH and University Hospitals of Leicester Trust never worked successfully and eventually services had to be reintegrated into the parent Trusts. The first attempt to take over a privately run Independent Treatment Centre failed, although the second bid to win this contract was successful. Bids to create a helipad were abandoned in the face of financial pressures and the planned new hospital build was withdrawn by the Secretary of State in 2023. All these ventures consumed huge amounts of Executive and Non-Executive time and energy.

There is a clear pattern demonstrating the ambition of this Trust to be a leader in research, service innovation and NHS leadership. It's stated ambition and mission set in 2013 was to be the best acute teaching trust in England by 2016 and it set itself several KPIs to measure its trajectory. It regularly applied to be part of new national initiatives, pilots and programmes, only some of which were successful. It clearly aspired to be a Trust with a national reputation and sought to play a leading role within the local/regional NHS architecture and yet stakeholders report seeing it as insular, old fashioned and often adversarial. This ambition was often experienced by system partners and by incoming executives and non-executives as arrogance, a failure to pay attention to the basics and a firm belief in NUHs superiority.

Executives regularly reassured the Board that NUH was high performing. There was regular reassurance and confidence from executives, particularly the CEOs, Medical Directors and Directors of Strategy/ Improvement, to the Board that issues would be solved, that performance would be improved, that challenges were no greater here than elsewhere and that criticism from external agencies (Care Quality Commission (CQC), Healthcare Safety Investigation Branch (HSIB), NHSE/I etc) were largely unfounded and unfair.

The Trust twice received critical feedback from Well Led Reviews into the operation of the Executive team and Board. In both instances these coincided with a change of leadership. There did not appear to be any mechanisms for Board members to hold executives to account for recurring issues, rather challenge was not encouraged and executives appeared defensive. From 2018 onwards the Review Team were made aware of awkward relations between executives and non-executives, concerns raised being ignored and many items that were reported to the Board as problems, never returned with evidence of change/ improvement; instead, reassurance from Executives that issues were or would be dealt with.

There were red flags over several years that point to an enduring culture of bullying, racism, poor people management and low staff morale across the whole Trust. Known challenging behaviours amongst obstetric consultants were not dealt with and the Freedom to Speak Up Guardian role does not appear to have been effective or credible.

From Review Team interviews with senior stakeholders there appears to be a consensus that prior to 2017 the executive and Board provided strong, experienced and clear leadership in a challenging environment. Its weaknesses were a result of continuity of service that led to ‘group think’, with outsiders experiencing difficulty in challenging, particularly quality and clinical issues; the pride/arrogance associated with being a large prestigious and ambitious teaching hospital whose attention was not sufficiently on its own operational performance and a culture of “fixing issues” outside the Boardroom leading to reassurance not assurance.

In 2017 both the Chair and the Chief Executive were new. There is a strong theme from Review Team stakeholder interviews that the new Chief Executive was out of their depth, with leadership quickly fracturing under stress. The existing issues of an ‘old fashioned’ and insular corporate culture persisted, as did the adversarial relationships with other system players such as the CCG. The Review Team were told of a myriad of separate problems which cumulated in a poor ‘well led’ rating, these included: inexperienced NEDs unaware that information was not getting to them; a chair that ignored concerns raised by staff and executives, rapid turnover of leadership posts, inability to get a grip on key performance issues and continuing cultural dissonance between the two sites. Added into this mix was the existential challenge of providing health care during a pandemic from 2020 onwards.

3.2 Board oversight of maternity 2012-2022

Maternity did not feature as an item on the Trust Board in any substantive way until 2020, although it was regularly reported and discussed at the Board’s Quality Assurance Committee (QuAC). Indeed, key events in maternity, appear not to be escalated to the Board at the time they occurred, including: the death of Harriet Hawkins, a baby born to two members of NUH staff in 2016, a letter signed by 50 maternity staff expressing concern at the safety of services in 2018 or incidents that would later lead to the Trust being prosecuted by CQC for serious failures of care. From stakeholder interviews the Review Team received conflicting recollections of whether these issues were known by the Board. At best this points to a culture of denial, at worst one of cover up. When maternity issues were escalated to QuAC and to the Board itself, the Review Team observed a pattern of misleading reassurance being given by Executives and Divisional leaders.

In 2017 the CCG reported experiencing a disconnect between the governance processes within maternity and the Corporate governance team. Its view was that the Executive and Corporate governance team were unaware of the lack of escalation of concerns within maternity and the lack of conversion to SI in cases including that of baby Harriet Hawkins. Furthermore, at that time complex arrangements for commissioning in East Midlands meant teasing out operational working to monitor contractual and quality requirements of maternity across CCGs and NHSE (Specialised Commissioning/Screening teams) was challenging.

Following the 2019 CQC inspection of maternity the Chief Executive took direct control of a maternity improvement plan. Whilst senior oversight indicates the seriousness with which this issue was being taken, the feedback from senior stakeholders is that they did not have the expertise, experience or knowledge to effect the changes required. The maternity improvement plan rapidly grew in scale but with little evidence of improvement. After 2020 maternity gradually consumed an increasing amount of Board time, with regular reports of actions taken, progress made and new challenges discovered. Reports from Executives to the Board contain seeming frustration that it was the people (especially midwives and obstetricians) who were 'at fault' for failures in care. There appeared a constant hope that the next new leader would 'fix' the problem.

From 2021 onwards maternity was a major agenda item at almost all Open Board meetings. The focus was on the Trust's internal maternity improvement programme (MIP), it's plans to achieve the NHS Resolution safety standards to achieve CNST, it's response to CQC reports, actions to address historic under-reporting of SIs and plans to meet requirements to introduce Continuity of Care.

The first Ockenden report into Shrewsbury and Telford Hospitals NHS Trust (published December 2020) was discussed at the January 2021 Board meeting, including a status report on NUH performance against Ockenden actions and presentation of an action plan to ensure compliance, including timelines. It was also agreed that Ockenden actions would be incorporated within the existing NUH Maternity Improvement Plan. Progress was reported to the Board in April and July 2021.

The 2021 CQC report seems to have been a wake-up call for the Board and Executives, many of whom questioned why they were not made aware earlier of these issues. The answer was in part because they had not received full information, for example, clinical audits did not get submitted to the Board; maternity had not been flagged as an issue by HR and major incidents such as critical findings from HM Coroner were not reported. The Review Team would add that the Board demonstrated a lack of curiosity and challenge and was too quickly assured that actions reported would be implemented.

In March 2022 the Board was alerted to the Ockenden final report (published March 2022). In May it discussed a detailed report on NUH's response to the Ockenden report, the 22 Immediate and Essential Actions and the 136 actions, which would be incorporated within the MIP. At its July meeting the Board received an update on progress including a visit to SaTH. In November the Board were alerted to the Kirkup report into East Kent and received a detailed update on progress in achieving compliance with the Ockenden IEAs. However, these Reviews of other services should have come as no surprise to NUH which had commissioned at least 6 external maternity reviews between 2015 and 2022.

3.2.1 Response to previous reviews of NUH Maternity

It is clear that the challenges and weaknesses evident throughout this Review were known by service and corporate leaders as far back as 2015. The conclusions and recommendations of these previous reports are broadly similar to those found by the Review Team. It is a matter of great regret that had these reports been acted on, undoubtedly many families' experiences and outcomes would have been different.

2015: External Review: Culture at City Maternity Unit

In 2015, following receipt of threatening anonymous letters within the department, suspicious disruptive behaviour before a CQC visit by staff and the results of that CQC visit, an external Review by an occupational psychologist was commissioned by the Chief Nurse. The Review recommendations were shared with the Divisional Management Team and discussed at a workshop in May 2016. This work was reported to the Board Quality Committee (QuAC) in 2016 and reassurance was given that staff were involved in developing an action plan. The Committee was told that no problems existed with practice and clinical outcomes were good, rather that the issue was some unacceptable behaviours.

The progress of this work never formally came back to the Board, indeed in 2017 all reports relating to maternity presented to QuAC emphasised positive outcomes. There is no evidence of action to embed these recommendations being received. Rather, it seems from later notes and staff comments that this

work on developing a focus and vision all fell apart and when later challenged the CEO said they had assumed that the department would have carried on with it.

2017: Internal Review of Patient Safety & Governance in Maternity

This internal report was prompted by concerns about inconsistencies in the process of incident investigation and learning. It focused on 1 April 2015 to 1 December 2016. The outcomes of this Review were shared with QuAC in April 2017 and minutes reflect only limited assurance, in particular noting the findings relating to culture. It was agreed that the outcome of the maternity governance Review should be brought to the attention of the Board and indeed it is minuted in the Open Board minutes of April 2017 that the Board received and noted this under items for information. There was no Board discussion of this item. Implementation of the recommendations became subsumed within the Maternity Action Plan. In July 2018 QuAC recognised that the Division was taking positive steps forward in maternity, but could still derive only limited assurance and asked that the frequency of reporting to the committee be increased to quarterly so that it could monitor that the action plan was being delivered successfully. By July 2018 Executives reported to QuAC that staff shortages were leading to delays within the maternity governance team, whilst in February 2019 it was reported that the Family Service Division had put in place a new governance team.

2017: External Review of Baby Harriet Hawkins death

In December QuAC discussed the publication of the external report commissioned by the CCG into the death of baby Harriet Hawkins. This Review, contrary to two earlier internal investigations concluded that Baby Harriet died because of failings in her care and missed opportunities for effective monitoring and intervention. Minutes show the Trust had accepted the findings and recommendations in full, with the CEO issuing an unreserved apology. The minutes also reflect assurance taken from the Trust's openness and transparency and detailed action plan. In February 2018 QuAC received an update on progress in implementing recommendations from the Review and was assured of clear divisional oversight. Minutes noted the need for focus to move to the wider Maternity Action Plan.

2018: External Performance Audit by MSB Consulting

This Review was based on a series of one-to-one interviews, small group discussions and an anonymous survey including all maternity staff. The focus was to review culture and issues that had been highlighted in high profile clinical incidents, including problems between clinical staff and clinical managers. Interestingly, the authors of the Review reported that some staff called this process 'the last throw of the dice'. This Review identified poor leadership, culture and communications, noting that inappropriate behaviour was tolerated. It recommended that everything in the service should be focussed on quality and empowering individuals to make safe decisions.

The MSB report was reported to QuAC in July 2018 and it is minuted that a transformational work plan to ensure a healthy culture within the maternity service and maintenance of a safe service would commence. The Chair reiterated the need for robust action planning with clear ownership and accountability. However, there was no explicit report back to QuAC about progress in implementing this Review. The Review Team were informed that the Executive team did not believe that the specific interventions proposed by the consultancy company could be afforded and decided to undertake the work in-house instead.

2018: Pascal Maternity Safety Climate Review

Later in 2018, following the receipt of a signed letter to the Chairman of the NUH Board by more than 50 staff members raising concerns about staffing and safety, NUH used an independent national Safety Climate metric. NUH scored considerably lower than national NHS benchmarks in all domains. A discussion about this and the MSB Review took place at the Feb 2019 People and Culture Board subcommittee, where it was noted that maternity had had a difficult journey with a programme of work in place to address several issues. Assurance was given of a new senior leadership team in place, governance changes in maternity

and a new vision created by and for the Division. In December 2019 QuAC was also informed of an extensive work programme to develop and embed an improved safety culture in maternity.

2022: An independent review into the culture within the Neonatal Service within the Family Health Division at Nottingham University Hospitals NHS Trust: Report for Senior Managers by Ibex Gale

In August 2022, external OD consultants were commissioned to undertake a review into the culture and working environment within the Neonatal Service, at NUH. This was prompted by concerns raised in relation to poor behaviours, unfair treatment, career progression, leadership and change management. It paints a picture of a toxic culture, poor leadership, short staffing, lack of respect, hiding/containing the extent of the challenges/problems, all leading to poor adherence to standards and the handling of errors. It made 59 separate recommendations

This Review was discussed within the maternity Oversight Committee and reported to QuAC in December with an update received in January. QuAC was informed that the key issue was staffing levels and that business cases to address this were in preparation (these were later approved), the expansion of services at the QMC site was reported as key to long term improvement. In 2024 the Perinatal Improvement Assurance Oversight Group received an update on work to address cultural issues identified in the Review, including work with families and interventions on improving teamwork.

3.3 How the division functioned from 2012-2022

Maternity sat within the Family Services Division, led initially by a paediatrician and later by an ENT specialist, because, the Review Team were informed no one within the Division would take on the role. There was a rapid turnover of senior staff and no permanent general manager. In 2018 when new external staff were appointed within the maternity service, they did not receive the support of the Divisional team and things carried on the same. This should have been the forum for triangulating outcome data, with staff and women's experiences and escalating concerns to Board. A staff member reported to the Review Team:

"women's voices and staff voices are mostly saying the same things and if you put all the evidence side by side you've got the wealth of where your service is failing where it needs to be improved." (2024)

Instead the Review Team were told the Division was full of terrified people with no sense of direction, no sense of strategy and many senior staff totally out of their depth.

From minutes and dashboards it is evident that the Division was aware of the red flags in maternity: including the poor performance of governance and backlogs of SIs and failures in Duty of Candour compliance. Yet it seemed unable to mitigate safety risks such as the poor estate and equipment or address the toxic cultures and behaviours that undermined staff confidence. In 2018 maternity staff wrote a letter to the Board Chair expressing their concerns at safety, this was dismissed by Executive team members as fake and the Divisional Director's response merely repeated the list of actions in which staff had already expressed their lack of faith.

In the course this Review we discovered that clinical records for some babies in the Review who died had been destroyed by NUH. This was apparently done in accordance with NUH staff's understanding of relevant guidance on clinical records retention. This understanding was wrong and was not congruent with national policy, issued in 2016. More disappointing some of these records were destroyed after this Review had started, suggesting a lack of understanding of the need for transparency.

After the 2021 QCQ report the Division was charged with resolving the issues in maternity and established a number of working groups chaired by members of the executive team, but these still did not have support outside of the Division.

The conclusion is the Division failed:

- to create a unified cohesive service functioning across two sites
- to address the behaviours and cultures of some individual clinicians and midwives

3.4 How the Maternity and Neonatal Services Functioned

Throughout this report the Review Team has evidenced the failings in maternity services leadership and management, its clinical governance and staffing and the impact these had on enduring poor professional cultures and behaviours, often out-dated clinical practice (the Saving Babies Lives Care Bundle was not introduced until 2020 and failure to comply with requirements were flagged on the risk register until 2022), a lack of compassion or even the ability to listen to women and most importantly the failure to respond to numerous red flags or implement the recommendations of numerous internal and external reviews.

The maternity service at NUH was characterised by a high proportion of staff in the consultant body and amongst midwives who had worked there for a long time. 15% of our survey of over 800 staff past and present, was completed by people who had worked at NUH for more than 20 years. A stable workforce has many advantages, but can be accompanied by entrenched thinking and lack of insight that comes from fresh eyes. In NUH, the Review Team saw examples of out-dated clinical practice and evidence from the external reviews and from interviews that in both the obstetric consultant body and the midwifery body there were a cadre of long serving, powerful, dominating and some cases frightening individuals, who although not necessarily in managerially senior positions were ‘leaders’ and set the tone and culture. These individuals and their behaviours were known by their line managers and even by executives from 2015 onwards. Yet the Review Team found no evidence of this dysfunctional unit being an HR priority. Whilst the core staff group was stable, the midwifery leadership and management team were extremely unstable with a high turnover of senior posts, including 7 Directors of Midwifery in 7 years. As late as 15 years post-merger the Review Team were told of a leadership culture of acceptance of status quo and remaining massive divisions between City and QMC operating like two distinct hospitals, between obstetricians and midwives between maternity and neonates and between night and day staff with a number of personalities that needed to be dealt with and had not been.

The Review Team saw failures of clinical governance within the maternity service. Senior stakeholders confirmed that prior to 2021 there was no clear escalation to the Board, no visible Board Safety Champion, poor compliance with Duty of Candour and engagement with families and little by way of triangulation of incidents with complaints. With maternity governance and management sitting outside of the corporate team, there was no one to clearly advocate for what was needed to act on the external reviews or findings from CQC inspections. By 2020 the combined metrics: backlog of SIs, complaints, workforce data, stillbirths etc. meant both within the organisation and beyond in the CCG/ICB the scale of the problem was clear. The maternity service was known to be functioning in inadequate estate, was not digitally enabled and experienced poor multi-disciplinary working. Indeed at this stage the CCG did escalate their concerns to NHSE. The critical CQC report of 2021 was the catalyst for galvanising change, but there still remained capability and capacity issues to deal effectively with the number of concerns raised and the action plan was still not institutionally coordinated. The Review Team were told that at one stage the Maternity Improvement Plan had over 300 actions.

Throughout this time period, the Review Team saw evidence of staff shortages known by service and divisional managers. BR+ the only validated tool for measuring staff need in maternity showed that the funded establishment was inadequate for the workload, this was compounded by high vacancy rates, struggle to recruit and high use of agency staff together with poor skill mix, including staff appointed to roles without support, resources or training. And yet minutes and personal recollections show that reassurance was continually given that this was effectively being tackled. After the Ockenden Shrewsbury Report, NUH received an additional £4.2m in funding to address midwifery and obstetric staffing shortages and yet even at this point the Director of Midwifery and Executive colleagues were reassuring the Board that BR+ overstated the need.

National Alignment

A recent review of the Birthrate Plus® methodology, independently chaired by Birte Harlev-Lam, recognises the increasing complexity of modern midwifery practice and implications for safe staffing. The Safe Learning Environment Charter aims to strengthen the NHS workforce through supporting the development of positive safety cultures and continuous learning across NHS settings. The Charter sets out the supportive learning environment required to allow learners to become well-rounded professionals with the right skills and knowledge to provide safe and compassionate care of the highest quality. It was developed in response to healthcare learners' feedback on their clinical experiences in maternity services, set out in the Kirkup (2015 and 2022) and Ockenden (2020 and 2022) reports.

4. How is the organisation led now – since 2022

In 2022 a new Trust Chair was appointed followed by a new CEO. Over the following months several senior executives and NEDs also left the organisation. The unanimous feedback from staff voices and from the interviews with senior stakeholders and from the minutes of meetings is that the new CEO and Chair quickly established themselves as very present, very visible, with an openness and transparency about the problems of the past and the need for change across the Trust. This has resulted in a much improved, open and positive relationship between the Executive and Non-Executive teams. Stakeholders told the Review Team they saw a return to a high support, high challenge environment underpinned by strong views and beliefs. In 2022, the Trust also welcomed the appointment of Donna Ockenden to lead an Independent Review of Maternity Services and the evidence seen by the Review Team is that the whole Board supported this. The Review was told the organisation had experienced 'a catastrophic failure to understand where it was or what needed to be done' (staff member (2025) and had a 'history of arrogance that meant it took its eye off the basics' (staff member (2025). These stakeholders confirmed that the new CEO and Chair represented a marked change of open robust and empowering leaders.

4.1 How is the Board functioning

The new CEO embarked on a 100-day evidence gathering, stakeholder engagement exercise before presenting to the Board a new strategy to address the Trust's multiple problems in January 2023. These are:

- Quality Patient care
- Patient Flow
- Retention and Recruitment
- Culture and Leadership
- Financial Sustainability

To this list of priorities has been added maternity. Those in senior positions now describe a strong commitment to transparency. The Review Team were told NEDs are equipped to challenge and support in equal measure and have detailed oversight of both the Independent Review's progress and the improvement initiatives monitored by the Perinatal Improvement Oversight Group. Not only have there been significant improvements in governance, but also improved analysis and data quality. Everyone appreciates this is a 'risky' service in many different ways but it is reported to the Review Team that NUH is are now listening to families and have processes in place to respond quickly when things go wrong. Executives believe clinical leadership is much stronger and going in the right direction but acknowledge that progress is slow. The Review Team have heard that whilst maternity and neonates has so far been protected from Trust wide cost improvement programmes (CIP), further efficiencies Trust wide will be needed to maintain the level of investment in maternity. Most significantly there is an organisational commitment led from the Board Chair and Chief Executive, through the Board and cascading to the Division to win back the trust of families in a sustainable way going forward.

In January 2023 the CEO informed the Board that he had represented the Trust in court proceedings regarding Wynter Andrews where NUH pleaded guilty. At the same meeting the DoM provided an update on the MIP and a stocktake of all actions arising from reports from CQC/Ockenden/Kirkup/HSIB etc. A new accelerated development plan would focus on 4 areas:

- Communications and engagement
- Governance
- Clinical pathways (postnatal care)
- Badgernet implementation

During 2024 the Board continued to receive regular updates on progress including revised and robust Perinatal Surveillance reporting which showed improved midwifery staffing but ongoing challenges in obstetric staffing; concern at high levels of PPH, improvements in compliance with training, improved staff turnover, resumption of the homebirth service and a backlog in complaints due to lack of obstetric time. Throughout the year non-executives continued to engage colleagues in maternity with a series of meetings whilst the Board Safety Champion undertakes regular visits and triangulating.

The Review Team would conclude that maternity improvement is a recognisable Trust wide priority with a clear line of sight from 'Board to Ward' and a DoM able to advocate for the service at Board meetings. This is not to say that the Trust does not continue to be challenged in many ways. For example, in its 2024 Annual Report, external auditors noted:

Significant Weakness 1 – Governance

During the year a number of data breaches were reported in the media. These appear to be indicative of underlying behavioural issues at the Trust. While we understand that the Trust is trying to address these issues by investing in the Data Protection Office, improving monitoring and reporting, there is still evidence of operational staff not adhering or complying with policies or procedures. As such we consider this represents a significant weakness in the Trust's governance arrangements.

4.2 How is the Division functioning?

Within the Division, the DoM post now sits alongside the Director of Nursing, General Manager and Care Group Director and there are weekly meetings of the obstetric, neonatal and midwifery leads, monthly meetings of the Perinatal Improvement Oversight Assurance Group (PIOG) and weekly divisional governance meetings.

Staff say they are clear how information passes up through QRS to the Oversight Board and the Division. The Division/Care Group collates and reviews monthly data and reports upwards, progress of improvement and tracking. The PIOG is co-chaired by the Trusts Chief Nurse and Medical Director, its meetings always start with family voices.

The midwifery structure has been strengthened to include two HoMs and two Deputy HoMs together with a new suite of leadership programmes to develop future leaders and support succession planning. The Review Team have been told that the corporate team is actively encouraged to interact with clinical teams and management is less hierarchical more approachable and visible. Integrating midwifery into the rest of trust structures and processes means it is not so isolated. Team development is being supported and compliance with appraisals and mandatory training is greatly improved. clear line management structure and support to develop skills.

The change in culture is evident in senior staff who are able to describe getting appropriate challenge from the ICB and an external perspective from NHSE, instead of responding in a defensive manner.

We have previously highlighted the stress and pressure still facing the obstetric workforce (see staff voices chapter), this has resulted in many still unable/unwilling to engage directly with service improvement

and behaving defensively. As occurred previously no current NUH obstetrician has come forward to be appointed to take on the Clinical Director role. An experienced gynaecologist from London is currently providing 2 days a week leadership support, a mix of remotely and in person. This has to be flagged as a significant on-going risk.

4.3 How is the Maternity Service Functioning?

Whilst the CQC report of 2021 was the final trigger for organisational wide attention in maternity, the service continued to struggle to deliver on its action plan through to 2022.

The evidence of outcome and performance metrics together with feedback from staff clearly indicate that NUH's maternity and neonatal services are now on a trajectory of improvement.

The in-coming Director of Midwifery and Medical Director have clearly prioritised dealing with some of the long standing cultural and behavioural issues. A number of individuals known to be particularly challenging have now left the organisation and an OD consultant has been working intensively with the teams on roles and responsibilities, team development, and communication. A Freedom to Speak Up Guardian has been assigned to maternity and issues raised are now being dealt with and is reporting quarterly to the Board. Clinical psychologists have been employed to provide support to maternity and neonatal staff. Across the whole Trust there does remain a concern that unacceptable cultures and behaviours, particularly around racism do exist, but these are now clearly part of the Trust agenda and there has been a focus on inclusivity and engaging with local communities, with clear Executive leadership.

The investment in the midwifery management function has not only increased capacity, but also ensures new managers and promoted staff receive appropriate induction and orientation packages with regular updates and support for them. Both the Review Team staff voices and interviews with stakeholders indicate that the DoM is respected, accessible, fair and leading from the front.

Maternity Governance has changed substantially, with incidents, now investigated and reported in a robust way. The investment in the QRS team has greatly increased its capacity, given it clear reporting structures and the ability to engage with clinicians in a supportive way. MDT working and engagement in case reviews has improved as has engagement with families

The service has also invested time and resources into reaching out and earning back the trust and confidence of local families. The MNVP is actively involved in providing oversight and challenge, in participating in staff training and in designing processes such as family debriefs. Senior stakeholders say they can now see evidence of real collaboration and cooperation between the two hospital sites, stronger and more respectful MDTs and a culture of continuous improvement becoming embedded with a move from reassurance to assurance.

Remaining challenges include obstetric staffing levels that not only pose a risk to day-to-day quality and safety but are a brake on the ability to engage in service improvement and development; staff behaviours and cultures particularly amongst some labour ward coordinators continue to be a challenge and some clinical outcomes notably PPHs and 4th degree tears remain outliers.

5.Conclusions: A Constellation of Failings

The Theory of Active and Latent Failures was proposed by James Reason in his book, Human Error.[227] Today it is most commonly known as the 'Swiss cheese effect' whereby accidents within most complex systems, such as healthcare, are caused by a breakdown or absence of safety barriers across four levels within a sociotechnical system. These levels can best be described as Unsafe Acts, Preconditions for Unsafe Acts, Supervisory Factors, and Organisational Influences.

This Review of NUH from 2012 onwards has demonstrated that a number of known issues, challenges and failings were either sidelined and ignored, were deemed too difficult or of insufficient priority.

227 Reason, J. (1990). Human Error. Cambridge University Press Human Error | Cambridge Aspire website.

UNSAFE ACTS	PRECONDITIONS OF UNSAFE ACTS
• Professional arrogance • Estate not fit for purpose • Poor behaviours, bullying and lack of respect • Outdated clinical guidance and practice	• Two very busy units often understaffed over a long period • Focus on wider financial and performance failings • No effective patient voice
SUPERVISORY FACTORS	**ORGANISATIONAL INFLUENCES**
• Lack of clinical leadership and management in obstetrics and midwifery • Insufficient information/briefing to Board • Insufficient challenge from Board • Weak governance • Insufficient information/briefing to Executive	• Culture of two units markedly different • Too many senior people in post too long • Focus on reputation management • Weak HR oversight and support to known staffing challenges • Organisational arrogance

In conclusion the Review Team has identified multiple accounts and evidence that the NUH Board should have been fully aware that the culture of maternity was characterised by;

- Atomisation and tribalism – namely a divide between City and Queens hospital, between professional groups and within the managerial hierarchy, between Executives and non-executives
- Poor personal behaviours that were not addressed including incivility, racism, bullying with a weak HR function resulting in a known 'toxic culture'
- A lack of openness trust and transparency when things went wrong, failure to abide by Duty of Candour, backlogs of SIs, exclusion of families
- A lack of curiosity and challenge leading to inability/unwillingness to make changes, apply learning, recognise and accept weaknesses
- Continuing failure to listen to staff evident at every level – DATIX's ignored, FSUG impotent, the Executive team and NEDS described as unapproachable and invisible after a prolonged period of time.
- Arrogance: a sense of superiority that resulted in refusal to adopt national guidelines, a belief in the 'Nottingham-way', unwillingness to collaborate with stakeholders or to accept challenge or criticism

From the consideration of documentation and senior stakeholder accounts it seems that an inexperienced and overwhelmed Board was trying to keep a handle on issues but could not translate this into effective action or impact. The conclusion is that the Board and Executive, preoccupied by external issues such as achieving MAGNET status, the merger with Sherwood Forest etc, failed in three key respects:

- to understand the significance of a dysfunctional department with personality and cultural issues
- to recognise and support staff raising concerns
- to recognise and escalate safety and patient experience concerns

In particular:

- The Review Team demonstrated that there were a number of significant events over several years that were not referred to or discussed by the Trust Board
- It is clear that many individual Board members were aware of the problems in maternity services but failed to recognise the significance or failed to escalate their concerns

- The Review Team saw evidence of a culture where Board sub-committees were left to deal with significant operational challenges without reference to the Board
- Over some periods there were evidently tensions between executives and as a result the Review Team is concerned that clinical concerns were not elevated to a sufficient level or that they did not seek the support of the Board
- The Review Team has seen clear evidence of major dysfunctionality in the maternity department which was long-standing and probably stems from the merger in 2006, such that nobody from the service would take on a leadership role.
- With midwifery leaders not having direct access to the Board, the Review Team saw periods of a damaging disconnect between strategic direction and operational management
- The culture in the service was frequently described as ‘toxic’ and confirmed as well by local clinical leaders.
- Externally commissioned reviews from 2015 to 2022 were all extremely critical of the culture, consultant and departmental behaviour and overall governance of the service.

Clinical Governance

1. Introduction and Scope

This chapter examines long-standing and systemic failures in maternity governance at Nottingham University Hospitals (NUH) Trust. These were characterised by chronic under-resourcing, unclear leadership structures, ineffective governance processes, barriers to escalation, and a failure to learn in a timely way from incidents. The consequences were significant: investigations were delayed, similar incidents recurred, and families experienced prolonged uncertainty and avoidable harm. Staff described burnout, illness, and missed opportunities to improve quality and patient safety.

While there is evidence of some improvement in governance structures and culture in recent years – particularly after 2017 and again after 2021 – these changes followed an extended period of dysfunction during which safety, learning, and staff experience were compromised. Families were frequently promised that 'lessons would be learned', yet in many cases similar incidents were repeated.

In line with the Terms of Reference, this chapter analyses clinical governance, incident reporting and responses to families between 1 April 2012 and 31 May 2025. Over this period, national frameworks and expectations evolved significantly, with increasing emphasis on systematic learning and the involvement of patients and families in investigation processes. A useful infographic timeline of national patient safety events is available at Timeline-of-Patient-Safety-Events,-2020-2024.pdf

Over the period covered by this Review, national patient safety frameworks moved from development and revision of the Serious Incident Framework (2010-15), updates to the Never Events policy, the NHS Patient Safety Strategy (2019), and the introduction of the Patient Safety Incident Response Framework (PSIRF) in August 2022, with transition expected by autumn 2023.

In recognition of these changes, and in line with the Terms of Reference, this chapter is divided into two periods: 2012-2024 (pre-PSIRF) and 2024 to May 2025 (post-PSIRF, referred to as 'recent years'). A separate section considers cross-cutting governance challenges during the Covid-19 pandemic to distinguish the impact of this period from underlying organisational processes.

While there is some overlap to these phases, this structure enables earlier systemic failings to be distinguished from current practice, ensuring that recommendations are directed appropriately while recognising the impact of past harm on families.

2. Governance in the 'Early Years' (2012–2024, pre-PSIRF)

2.1. Overview of Governance Context and Expectations

This period of the Review covers years in which clinical governance across the NHS evolved from relatively inconsistent processes to more structured systems with clearer accountability, oversight, and national standardisation, including the Perinatal Mortality Review Tool (PMRT), Maternity and Neonatal Voice Partnership, MNSI investigations, and the Maternity Incentive Scheme. While expectations developed over time, the Review Team has considered NUH's governance arrangements within the contexts of the standards applicable at the time.

The Review Team found that many of the issues identified during this period were already known to the organisation. NUH commissioned, or was subject to, multiple internal and external reviews of maternity governance in response to concerns about the quality of incident investigations and failure to embed learning. These reviews consistently identified similar themes over an extended period.

Key findings from these reports are summarised below to demonstrate the extent to which opportunities for improvement were identified but not sustained.

2.2 Key Governance Review and Oversight

2.1.1 2015-2016 Review of Patient Safety and Governance

This internal Review, commissioned by the Chief Nurse and Medical Director and finalised in March 2017, examined maternity governance between 1 April 2015 and 1 December 2016 – a period during which significant clinical harm occurred.

Key findings included:

- Maternity services were reported as safe against national indicators, in line with comparable units and above-average Friends and Family Test results
- While clinicians were described as open and transparent with families, including meeting parents following bereavement, this was not consistently evidenced
- Midwifery leadership in patient safety required strengthening, with unclear governance roles and limited involvement of midwives in incident investigations, which were largely led by obstetric consultants
- Incident investigations were inconsistent in both quality and completion, with some not undertaken due to clinical workload. Where undertaken, significant variability and harm was frequently understated or downgraded, resulting in incidents not being investigated at the appropriate level
- Investigations focused on individual actions rather than systemic causes, with no evidence of effective thematic review. This contributed to a punitive culture and limited organisational learning
- Duty of Candour (DoC) requirements were not consistently met. There was a notable reduction of reported moderate harm incidents following its introduction, with cases often misclassified as low or no harm
- Thresholds for classifying Serious Incidents were inappropriately high, with delays in reporting to the Strategic Executive Information System (StEIS).
- Root Causes Analyses (RCAs) were weak, with limited exploration of underlying causes, over-reliance on low-impact actions, and insufficient follow-up
- Key national reports, including Morecambe Bay (2015) and Better Births (2016) did not feature in Divisional Governance discussion, despite assurances of compliance being reported to the Trust Board and commissioners

The report was presented at the Quality and Safety Trust subcommittee and made recommendations to strengthen the governance framework for incident investigations through more robust oversight models. Accountability for maternity services was delegated to the division, with strengthened Trust-level oversight through enhanced corporate challenge processes.

Further recommendations included increasing the midwifery leadership within Governance, clarifying and strengthening the role of the Governance Matron, and improving the quality of incident investigations and action plans through targeted training.

2.2.2 2017-2018 CCG Oversight and Quality Surveillance Processes

In March 2017, emerging concerns regarding maternity services and a decline in serious incident reporting were escalated to Nottingham North and East (NNE) Clinical Commissioning Governing (CCG) Body. These included concerns about the appropriate grading and escalation of harm, poor quality incident

investigations, high perinatal mortality rates (as identified by MBRRACE-UK), increasing Local Supervising Authority referrals, and a lack of alignment between maternity and corporate governance.

These concerns were escalated to the Derbyshire & Nottinghamshire Quality Surveillance Group, prompting a multi-agency Quality Risk Profiling (QRP) review in April 2017. Although a Risk Review meeting in 2017 concluded that progress had been made and the service was deemed safe, a Maternity Review Panel was established to provide ongoing external scrutiny of incidents through to December 2018.

Further scrutiny in September 2017 in a retrospective review of incidents (December 2015 - December 2016) resulted in 12 cases being reclassified as Serious Incidents (SI), having been previously been incorrectly graded. In response, the Trust reintroduced in January 2017 a 'trigger list' for automatic SI classification and implemented a revised Standard Operating Procedure to improve escalation processes.

A subsequent QRP review in December 2017 found that, despite some progress, key risks remained and recommended that maternity service continue under enhanced surveillance. This position was maintained into February 2018, with the CCG noting that improvements required longer to embed; ongoing concerns including medical leadership and engagement; the need to strengthen system-wide learning from incidents; and a continued focus on organisational rather than silenced improvement.

2.2.3 2018 MSB Cultural and Governance Review

In 2018, MSB Consultancy was commissioned to undertake qualitative work within maternity services; identifying significant concerns in relation to governance capacity, culture and the effectiveness of incident processes. Staff described limited support during investigations, a depleted Governance team, and pressure to complete processes in a transactional, 'tick-box' manner. Investigations were often rushed with limited learning, within a wider culture described as negative and, at times, blame-focused. There is limited evidence that the findings of this report were widely shared or acted upon.

The Review Team heard from a staff member who joined the Trust soon afterwards:

"Just before I arrived, they'd spent a lot of money on an external company to do some culture work. I don't know why but the report was never shared". (2024)

2.2.4 2020 Rapid Review of Maternity Governance

A further internal rapid review of governance was commissioned in 2020 following concerns about delays and incomplete actions from previous incident investigations. While the Review identified some strengths, including multidisciplinary attendance at meetings and commitment from senior clinicians, it again highlighted fundamental weaknesses in governance structures and processes.

Key issues included unclear and unratified governance frameworks, weak integration between governance and operational leadership, and the absence of clear accountability for embedding learning. Risk management processes were not aligned with Trust-wide systems, with significant risks not appropriately escalated. The rapid review also identified that those responsible for delivering care were not consistently involved in incident review, limiting the effectiveness of learning and improvement.

The rapid review recommended a 'root and branch' restructuring of governance arrangements. However, the Review Team found no evidence that this was undertaken, nor that recommendations from previous reviews had been systematically implemented. As in earlier findings, governance processes remained complex, under-resourced, and insufficiently coordinated to support effective learning and sustained improvement.

2.2.5 2021 Maternity Governance Review

The 2021 Maternity Governance Review was commissioned in response to escalating concerns raised by the Care Quality Commission (CQC) and the Healthcare Safety Investigation Branch, culminating in enforcement action in late 2020. Framed against the CQC Well-Led framework, it examined the

effectiveness of governance, divisional oversight, and escalation to Board level. It identified systemic weaknesses, fragmented structures, and a lack of clarity in accountability that impaired the Trust's ability to identify and respond to deteriorating safety.

A central finding was the absence of effective oversight. Senior leaders were unaware of the extent of governance failings within maternity services, reflecting a loss of line of sight from ward to Board. This was compounded by a lack of clarity in the delegation of accountability: while a Board Accountability framework existed, it did not clearly define how responsibilities were enacted below Board level, resulting in inconsistent governance practice and ineffective escalation.

The Review also identified a fundamental confusion between assurance and operational delivery. Committees received information that was either too detailed to provide assurance or too superficial to support management, leaving gaps in both oversight and operational control. As a result, the Board did not have reliable visibility of performance or risk within maternity services.

Within maternity services, governance processes were described as immature, inconsistent, and poorly coordinated. Meetings were cancelled, data was incomplete, and there was no functioning maternity dashboard. Multiple unaligned action plans arising from inquests and complaints were managed in parallel, with no thematic analysis. Consequently, similar issues recurred without sustained resolution.

Risk management processes were weak and poorly embedded. Risks were inconsistently recorded, not routinely reviewed, and not reliably escalated. The divisional risk register did not accurately reflect the Service's risk profile, further limiting organisational awareness and response. This lack of systematic risk oversight meant that the service did not have a reliable understanding of its risk profile, nor did it have effective mechanisms for mitigating or escalating concerns.

Incident management and organisational learning were similarly ineffective. Investigation capacity was insufficient, and the recurrence of similar serious incidents indicated that learning was not embedded. Patient experience and complaints data were not systematically integrated into governance processes, limiting the ability for triangulation and the identification of emerging concerns.

Divisional governance structures were found to be inconsistent and at times, ineffective. Attendance was variable, reporting was poor, and escalation to senior forums was unreliable. As the Trust relied heavily on divisional governance for assurance, these weaknesses created a significant gap between front line risk and Board oversight.

Overall, the Review concluded that governance structures existed in form but not in function. Data quality issues, fragmented reporting, and leadership instability contributed to a systemic lack of visibility, which further undermined the ability to identify and address safety concerns. The Board was therefore reliant on processes that were not functioning effectively, thereby creating a critical blind spot in the oversight of maternity services.

The Review sets out a comprehensive programme of required actions focused on strengthening accountability, improving data reporting, increasing governance capacity, and embedding effective learning from incidents. However, these actions reflect long-standing issues that had been identified in previous reviews.

2.2.6 Trust Oversight and Assurance

Across 2021, the NHSE/NHS Improvement review of maternity governance was formally acknowledged within a number of organisational forums, including Divisional Governance meetings, the Trust Board's Quality Assurance Committee (QuAC), the Executive Management Board, and the Maternity Oversight Committee (via agenda items). However, there is limited evidence that its findings were subject to sustained scrutiny or systematic oversight within these structures.

Development of the associated action plan appears to have been led primarily through senior leadership discussions, rather than embedded within formal governance processes. Although incorporated into the wider maternity improvement programme, which comprised almost 300 recommendations, this reduced the visibility and traceability of the governance review's specific recommendations. The Family Health Services monthly performance report confirms the existence of a defined Quality & Efficiency Project (No. 1388) focused on maternity governance and structure. This indicates that an action plan was developed and that both the Division and the Trust Board were aware of its existence.

Within Divisional Governance meetings, references to the Review were brief and did not progress into structured monitoring of implementation. Instead, discussions focussed on operational pressures, including staff redeployments, delays in incident management, and concerns that escalation processes were ineffective.

At Trust level, QuAC received updates on the Review and associated actions between April and July 2001, including the reclassification of serious incidents and the need for retrospective case review. However, there is no evidence that the action plan was reviewed in detail or that progress was consistently monitored through formal governance structures. Following July 2021, maternity governance did not feature in QuAC reports for the remainder of the year.

Although the Maternity Oversight Committee included a standing item on maternity governance, the absence of minutes limits assessment of the depth or effectiveness of discussions.

Overall, while the governance review was acknowledged across multiple forums, there was no coherent or sustained programme of oversight, monitoring or assurance. Implementation activity appears to have been fragmented, largely conducted outside formal structures, and constrained the organisation with competing operational pressures.

2.2.7 2021 LMNS Better Births Panel Review

In response concerns by the Care Quality Commission and HM Senior Coroner, the Local Maternity and Neonatal System (LMNS) commissioned an external independent review of 19 maternity cases (January 2019-August 2020) that potentially met the SI criteria but had not been reported as such.

The Review identified significant and systemic failures. Approximately 80% of cases met SI criteria but had not been reported or investigated accordingly, despite all cases having been reviewed at Trust-level panels. In many cases, opportunities for improved care were identified that may have led to altered outcomes for mother or baby.

The quality of investigations was consistently poor. Reports were descriptive rather than analytical, lacked clear methodology, and failed to identify contributory factors or recurring themes. Investigations were often incomplete, with key elements such as DoC and patient outcomes being omitted. The voices of women and families were frequently absent, and there was limited evidence of multidisciplinary involvement.

The Review Team's own findings strongly corroborate these conclusions. Across the period examined, there was consistent evidence of under-reporting and misclassification of incidents, failure to comply with DoC, inappropriate management of cases outside the SI framework, lack of effective leadership and governance oversight. Governance teams were frequently under-resourced, and staff described low morale and a culture in which concerns were not consistently heard or acted upon.

Taken together, these findings demonstrate a persistent failure to identify, investigate, and learn from incidents over an extended period, despite repeated opportunities to do so.

3. Core Governance Failures: Thematic Analysis

3.1 Incident Reporting Systems and Processes

Correct and effective incident reporting is a fundamental component of clinical governance, enabling organisations to identify risks, understand contributory factors, and prevent reoccurrence. Where reporting is inadequate, opportunities for learning are lost, and risks to patient safety increases.

The Review Team identified persistent and significant weaknesses in incident reporting at NUH through the period examined. These included under-reporting, incorrect grading of harm, and an inappropriate focus on avoidability when determining whether incidents should be recorded and investigated.

3.1.1 Under-Reporting of Incidents

Between 2012 and 2024, the Review Team examined 2,511 cases within scope. Of these, a high proportion would have been expected to have a corresponding incident report (Datix). However, the Review Team found that no incident was recorded in many cases.

Within these unreported cases, the Review Team found both significant concerns in care (grade 2) and major concerns in care (grade 3), where more effective management might reasonably have altered the outcome. In total, over 100 cases involving significant or major concerns were not reported or investigated.

This level of under-reporting by the Trust represents a substantial missed opportunity for organisational learning and risk identification, and is likely to have contributed to repeated incidents and an associated risk of avoidable harm to families.

The Review Team identified multiple examples where significant incidents were not reported.

Similar failures were observed across multiple cases throughout the period, including stillbirths and severe perineal trauma, where no incident reporting or investigation was conducted despite clear concerns in care. Staff consistently described a culture in which incident reporting was discouraged or perceived as punitive, with a lack of feedback following submission.

In 2015 one staff member noted that they:

“weren’t encouraged to put Datixes in, we weren’t encouraged to do that”. (2015)

This undermined confidence in the process and likely contributed to under-reporting. A number of staff also described a blame-focused culture, particularly affecting midwifery staff, which further discouraged reporting and openness.

This pattern of under-reporting, combined with the absence of systematic investigation, significantly limited the Trust’s ability to identify recurrent themes and implement effective improvements. Over time, this contributed to the normalisation of suboptimal practice and an increased risk of repeated harm to families.

3.1.2 Incorrect Grading of Harm

The accurate grading of harm is a critical component of incident reporting, as it determines the level of investigation, the application of DoC, and the organisation’s ability to identify patterns and learn from events. National guidance, including the National Reporting and Learning System (NRLS), has consistently defined harm according to the actual outcome for the patient, irrespective of whether care was considered appropriate.

Despite this, the Review Team identified persistent and significant issues in the grading of incidents at NUH. Harm was frequently assessed on the basis of perceived avoidability or the presence of suboptimal care, rather than the outcome experienced by the patient. This led to incidents being graded at a lower level than required and managed outside formal investigation processes.

These issues were compounded by limitations within the national framework. Under NRLS guidance, maternity incidents – particularly stillbirths and neonatal deaths – were treated differently from other patient safety events. The classification of harm as 'death' required consideration of whether an act or omission in case had contributed to the outcome, creating a departure from the principle of outcome-based grading applied elsewhere. This introduced ambiguity and inconsistency in the classification of maternity incidents in NUH. It is unclear to the Review Team why NRLS determined that stillbirths, intrauterine deaths and neonatal deaths required a review to determine if there was an omission in care before these incidents could be graded as 'death'.

While this complexity was recognised nationally, the Review Team found evidence of repeated and persistent misapplication at NUH. Incidents were frequently graded too low at the point of closure, contributing to the under-recognition of serious harm and limiting escalation to SI investigation.

For example, cases involving 3rd or 4th degree perineal trauma requiring surgical repair and often 'transfer to another area and often associated with long-term morbidity – were frequently graded as low harm.

In 2019, a woman who required a stoma following a 4th degree tear was classified as low harm. It should therefore be (and should always have been), classified as moderate harm. (2019)

Similarly, in a number of stillbirth cases where suboptimal care had been identified, incidents were graded as causing 'no harm'.

In one such case in 2012, a term stillbirth associated with mismanagement of maternal hypertension was investigated but recorded as no harm, despite evidence that different care may have altered the outcome. (2012)

These examples reflect a broader pattern in which the grading of harm did not align with either national guidance or the lived experience of patients or families. Staff accounts further highlight the impact of this approach, with catastrophic outcomes at times recorded as low or no harm, compounding distress and undermining confidence in governance processes.

Overall, the misclassification of harm significantly weakened the effectives of incident reporting at NUH. By reducing the number of incidents recognised as moderate or severe, it limited the application of DoC, reduced escalation to Serious Incident investigation, and impaired the organisation's ability to identify and respond to recurring risks.

3.1.3 Misapplication of Avoidability

As identified in earlier reviews, incident grading at NUH was frequently influenced by judgments about avoidability, rather than being based on the outcome experienced by the patient. This approach is inconsistent with national guidance, which requires that patient safety incidents are reported and graded regardless of whether they are considered preventable.5

The Review Team found that the concept of avoidability was often used as a determining factor in which incidents were reported, how harm was graded, and whether further investigation was undertaken. A staff member working in the Quality and Safety Team, reported a governance approach in which, if an outcome was deemed unavoidable, incidents were less likely to be formally reported or escalated, and opportunities for learning were curtailed.

While considerations of avoidability may appropriately inform decisions about the level of investigation for example, whether an incident meets the threshold for a SI, they should not influence whether an incident is recorded or how the level of harm is graded. The conflation of these principles was a consistent feature of governance processes at NUH.

This was evident in case review.

A similar pattern was identified in other cases. Staff described instances in which stillbirths, including those associated with missed opportunities in antenatal care, were not escalated or acted upon where the

outcome was deemed unavoidable. Concerns were raised about an ineffective paper-based system for requesting scans – where requests could be lost, but no action was taken.

These examples reflect a broader pattern in which the question of avoidability was allowed to override consideration of outcome and system learning. Staff Voices consistently reinforced this. Overall, the inappropriate application of avoidability significantly undermined incident reporting and governance processes at NUH. By conflating outcome with preventability, incidents were under-reported, harm was misclassified, and opportunities to identify systemic risks and prevent recurrence were lost.

3.2 Duty of Candour (DoC)

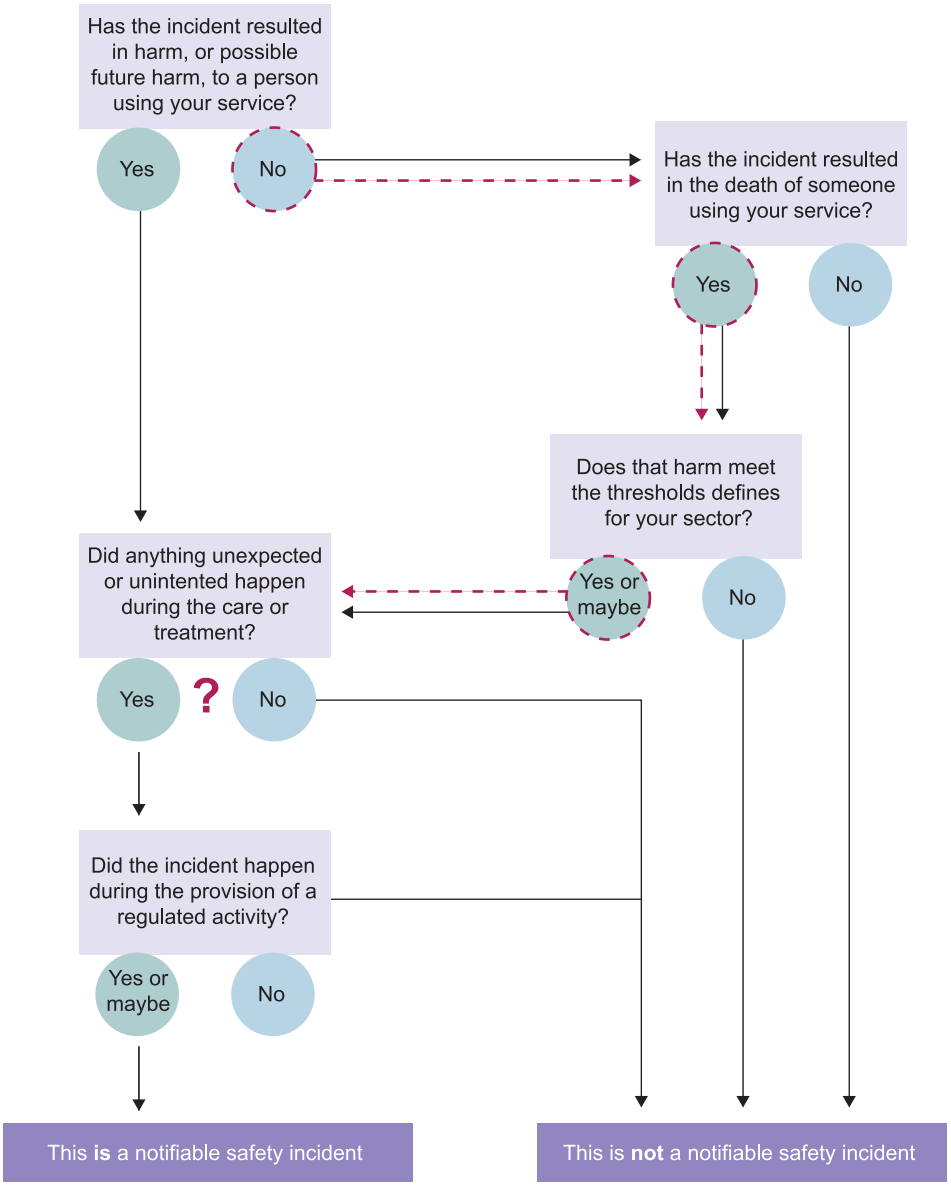
The statutory DoC, introduced in 2014 following the Francis Inquiry, requires healthcare organisations to be open and transparent with patients and families when a notifiable safety incident has occurred. In practice, this includes providing a timely explanation, offering an apology, and ensuring appropriate support, alongside accurate documentation of the process.

A notifiable safety incident is defined as an unintended or unexpected event occurring during the provision of regulated care which has resulted in, or could result in, death or moderate to severe harm, including psychological harm. Updated guidance in 2022 sought to align DoC more closely with national incident reporting systems, including NRLs and, subsequently, the Learn from Patient Safety Events (LFPSE) framework.

While the statutory framework is clear in principle, its application in practice is more complex. Incident grading focuses on the ‘outcome’ experienced by the patient, whereas the threshold for DoC requires consideration of whether the care or treatment itself was unintended or unexpected. This distinction introduces ambiguity for clinical governance teams, particularly in maternity care, where adverse outcomes may occur despite care being delivered in accordance with guidelines.

This flowchart (updated June 2022) is provided by CQC to help identify a notifiable safety incident.

Table 1



The Review Team found that this complexity has not been consistently understood or applied within NUH. In some cases, DoC was not undertaken where it should have been, particularly where incidents were graded at a lower level due to the perceived absence of suboptimal care. In others, the process was inconsistently applied, reflecting uncertainty about the relationship between harm grading and the statutory threshold for notification.

Earlier internal reviews had already notified concerns in this area, noting that DoC requirements were not reliably met and that there was a reduction in reported moderate harm incidents following its introduction. This raised concerns that incidents may have been downgraded, in part, to avoid triggering the statutory process.

*In **2017**, a woman experienced an eclamptic seizure followed missed opportunities to diagnose pre-eclampsia antenatally. NUH did not complete an investigation as it was felt that the woman had been seen immediately at the time of her seizure. Although follow-up care was provided, the woman was not informed of the earlier missed indicators that may have altered her management.* (2017)

*Similarly, in **2020** a case involving significant neonatal compromise followed delayed escalation in labour, the incident did not meet the threshold for a SI investigation and DoC was not undertaken, despite clear opportunities for shared learning.* (2020)

*Furthermore, in **2022** a baby was readmitted on day five of life to the emergency department having been seen by a maternity support worker and noted to have been pale with nearly 20% weight loss. On arrival to the emergency department the baby was floppy, quiet and pale with an unrecordable temperature and significant metabolic acidosis. The Rapid Review by the maternity service concluded that a 'Concise Serious Incident' investigation should be carried out, but this was later changed by the Trust risk management team to a 'Serious Incident Level 2 – Comprehensive' investigation. NUH did not complete this investigation and instead made the decision to incorporate this case into an infant feeding thematic review. The Review Team felt this was inappropriate after a decision had been made that a Serious Incident investigation was required. The family did not receive individual feedback on the care their baby had received.* (2022)

Overall, the Review Team found that failures in the application of DoC were closely linked to weaknesses in incident reporting and grading processes. Where incidents were under-reported or misclassified, the statutory duty was less likely to be triggered, further compounding the impact on affected families.

3.3 Serious Incidents (SIs)

3.3.1 National Context

The definition and management of SIs changed over the period of this Review. Earlier frameworks (2010-15) defined a SI as 'an incident' (an event or circumstance) that could have resulted, or did result in:

- Serious harm - all incidents graded as severe harm or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Unexpected or avoidable death of one or more patients
- Incidents included within the Never Events criteria. Never Events fall into defined categories where national, evidence-based safety barriers exist and should prevent the incident from occurring

The revised 2015 framework clarified that SIs included acts or omissions in care leading to unexpected or avoidable death or serious harm.

However, these frameworks provided limited specific guidance for maternity services, particularly in relation to stillbirth and neonatal deaths. This lack of clarity contributed to variation in how maternity incidents were classified and investigated across the NHS.

3.3.2 Application at NUH

The Review Team found consistent evidence that incidents at NUH which met the threshold for SI investigation were not escalated or reported as such. This was a recurrent finding across both internal and external reviews.

A retrospective review of maternity incidents undertaken in 2017 identified 12 cases that had previously been managed locally but should have been declared as SIs. In response, the Trust introduced a trigger list to support SI identification, including term stillbirths, neonatal deaths, maternal deaths, and cases involving significant harm or critical care admission.

Despite these measures, inconsistency in SI reporting persisted. Between 2017 and April 2024, 59 cases out of 1101 were identified by the Review Team as involving suboptimal care where different management would reasonably have been expected to alter the outcome. These cases would typically meet the threshold for SI investigation. However, escalation to formal SI processes was inconsistent, and in some cases did not occur.

This inconsistency was closely linked to issues identified in earlier sections, including the under-reporting of incidents, incorrect grading of harm, and the inappropriate use of avoidability as a determinant of escalation. Where harm was downgraded or outcomes were deemed unavoidable, incidents were less likely to meet the threshold for SI investigation, even where significant concerns in care were present.

The Review Team saw significant evidence that from 2021 onwards that incident grading had improved, with all incidents being recorded as moderate harm or above. However, there was still inconsistency as to whether a serious incident was escalated beyond maternity and to the divisional management team.

Case review provides further illustration:

*In **2017**, a woman who experienced an eclamptic seizure was not subject to a SI investigation on the basis that her acute management was timely, despite missed opportunities for earlier diagnosis; a missed urine test which measured proteinuria in her pregnancy that would have identified pre-eclampsia was not disclosed to her in her postnatal debrief.* (2017)

*In **2018,** a woman with significant obstetric haemorrhage and subsequent hysterectomy requiring critical care admission was not escalated as an SI, despite meeting local trigger criteria.* (2018)

Similarly, cases involving neonatal harm show evidence of failure to report an SI investigation.

*In **2018** a baby developed HIE after an emergency caesarean section for a fetal bradycardia. The local investigation identified that care 'was provided in line with guidance' and that there were no 'care delivery problems that would have altered the outcome.' The Datix was graded as low harm. The Review Team, however, noted that despite the baby being born 43 minutes after the first fetal bradycardia, the internal review downplayed this period and declared the 20-minute decision to delivery interval as appropriate - whilst not focusing on the 23-minute delay and the significant midwifery staffing gaps that contributed to the outcome.* (2018)

In all of these cases, opportunities to identify contributory factors and implement system-wide learning were limited.

Overall, the failure to consistently identify and escalate SIs significantly weakened governance processes at NUH. It reduced external scrutiny, limited the depth and quality of investigation, and contributed to a pattern in which serious concerns in care were not systematically recognised or addressed.

3.4 Investigation Processes and Governance Mechanisms

3.4.1 Use of High Level Investigations (HLI)

The Review Team identified that incidents which met the threshold for SI investigation were, in a number of cases, managed through local processes, including HLI, rather than being escalated through the formal SI framework.

From 2008, HLIs were intended to support local review; however, their use in this context often reduced the level of scrutiny applied to significant incidents. At this time, the first SI framework had yet to be released. As such, this was innovative and encouraged governance teams to provide a more robust investigation of cases, using a set structure although there is no single definitive document setting out the origins of the HLI and what cases were investigated in the early years. Over time, the purpose was to provide a structured process for reviewing incidents that did not meet the SI threshold and in March 2012, the HLI Review Group was formed to function as a dedicated forum for reviewing and approving HLI reports, which was chaired by the Deputy Medical Director. The initial process seems to have been thorough, but with a lack of national advice on how incidents should be investigated, many Trusts will have created their own internal investigations and processes. Cases that should have been subject to SI investigation; requiring external reporting, structured methodology, and independent oversight, were instead reviewed internally; limiting both transparency and the robustness of learning.

This was evident across a number of cases reviewed.

*In **2011**, a woman experienced an intrapartum stillbirth at 41+5 weeks. The Review Team have grave concerns, since induction of labour was started on an abnormal antenatal CTG and then stopped whilst still abnormal, only to find a preterminal trace when it was restarted many hours later. After making a formal complaint 8 weeks postpartum, the case was investigated as an HLI and it was investigated to an appropriate standard. The HLI was thorough but, noting the issues raised previously regarding grading of stillbirths, this should have been declared and investigated as a SI, as it resulted in an avoidable death.* (2011)

*In **2019**, a woman had a stillbirth at 41+2. This case was escalated as a SI by NUH, but it was downgraded to a local review. The Review Team did not feel that the investigation was thorough and the recommendations from their findings were considered to be weak.* (2019)

In August 2016, an HLI investigation into care of a patient within another service (non-maternity) led to concerns from a patient's family regarding the quality of the HLI process. This prompted escalation to a Level 3 SI investigation and a subsequent internal review of the robustness of HLIs as a mechanism for learning and assurance. In November 2016, the CCG reviewed a sample of HLI cases, removing 23 from the HLI log, of which 6 were reclassified as SIs.

The 2015-16 internal governance review (finalised March 2017) similarly identified that incidents were not being declared as Sis, noting that the Trust had set the threshold for classifying a maternity incident inappropriately high, with cases not being appropriately reported on StEIS. Minutes from the April 2017 Family Health Services Divisional Directorate meeting confirm that cases had not been investigated in line with the 2013 SI framework. In response, the Corporate Governance team proposed revising the policy to align with the national framework, introducing three levels of SI investigation and phasing out HLIs. The Trust aimed to implement this approach from June 2017, following policy approval – some four years after the national framework.

In April 2017, the HLI process was formally discontinued by the newly appointed Medical Director. At the same time, the Quality Assurance Committee (QuAC) minutes recorded a significant increase in maternity SIs, reflecting the addition of historic cases identified by a new Director of Midwifery. Minutes from the April 2017 Labour Ward Forum also confirm that a retrospective review of incidents over the preceding 18 months was underway to identify cases requiring more detailed investigation.

The use of HLIs appears initially to have been a local solution in the absence of clear national guidance. However, over time, their application in cases that met the threshold for SI investigation had the effect of avoiding external scrutiny and limiting transparency with families.

As one staff member described how: *"we didn't have to talk to the families…we only really spoke to them if they were serious incidents" reflecting a culture in which the classification of incidents directly influenced both escalation and openness with families".* (2024)

3.4.2. Multidisciplinary Imbalance and Leadership Issues

While governance structures evolved over the review period, consistent themes were identified across internal and external reviews. In earlier years (pre-2018), there was limited midwifery involvement in governance leadership and in the management of incident investigations. Staff described a culture in which obstetricians dominated discussions, influencing decisions on whether incidents were escalated as SIs

Midwives who had worked at the Trust for a number of years, described that 'governance was a difficult job, we had a lot of push back from, definitely [from] the obstetric team'. (2024)

This lack of multidisciplinary working persisted, with one staff member noting that collaboration felt conditional and that there:

"was no real teamworking…no multidisciplinary working that was comfortable." (2024)

Several staff described cases where concerns about incident severity were challenged or dismissed.

One recalled that incidents that required SI investigation were 'talked down', while another reported leaving the Trust because 'incidents were being brushed under the carpet', with obstetricians determining at review meetings whether cases would be escalated: 'No, it's not an SI, close it off'. (2024)

A number of staff also described reluctance among midwives and trainees to attend case review meetings due to intimidation and bullying by senior obstetric staff.

One account suggested active avoidance of escalation, with an obstetrician reportedly stating: "let's just downgrade it here and then we don't need to bother them about it". (2024)

At the same time, obstetric staff reported that SI decisions ultimately sat at Trust level. Multiple staff groups described incidents being submitted as moderate or severe harm but subsequently downgraded by the Executive team, indicating that these issues extended beyond the maternity service.

3.4.3 Incident Review Panel (IRP) and Downgrading of Incidents

Many staff described the Trust IRP as a key point at which escalation was prevented. The process required maternity teams to undertake an initial 72-hour review and propose a harm grading and level of investigation, which was then considered by the IRP, chaired by the Deputy Medical Director.

Staff described repeated attempts to escalate concerns that were dismissed.

One senior clinician reported the same concern on four occasions, including the Wynter Andrews case, only to be told it did not meet the threshold. (2018-19)

Case review supports these accounts.

*In **2019**, a woman received no maternity care after 31+5 weeks and was found to have suffered a stillbirth at 40+10. Although the local review identified learning, an SI was not declared until two years later, delaying external scrutiny.* (2019)

Staff accounts reinforce this pattern.

One individual described raising concerns about incident grading at IRP and being 'very quickly…closed down'. (2024)

Others described midwives being treated as though they were 'going looking for problems' and not taken seriously when escalating patient safety concerns. (2024)

The IRP was described as 'really intimidating' and 'very male-dominated', with perceptions that non-medical staff voices carried less weight. One midwife described presenting a case alone and being repeatedly told it did not meet SI threshold unless supported by a consultant: "Do a local investigation…all the time". (2024)

There is evidence that external mechanisms began to influence change. Staff reported that the introduction of HSIB made escalation more difficult to avoid, as certain cases required investigation under defined criteria. However, even where incidents were escalated, staff described obstruction by corporate patient safety teams.

Staff consistently described governance issues as Trust-wide rather than specific to maternity. One example from another division involved a patient being burned during surgery, which was reportedly not classified as an SI. One staff member reflected, "what do you have to do…to get it declared as a serious incident?". (2024)

Documentary evidence supports these concerns. A 2016 RCA acknowledged that the threshold for classifying maternity incidents as SIs had become 'inappropriately high'.

*In **2020**, a woman requiring a stoma followed a 4th degree tear was initially informed her case would be investigated, but six months later no investigation had taken place after IRP determined it was not serious enough. The patient was left without answers, describing the harm as clearly significant.* (2020)

Further evidence indicates that concerns raised by staff were sometimes actively suppressed.

One staff member identified approximately 19 undisclosed SIs within a cohort of moderate harm cases and reported that many had been downgraded at executive level. Attempts to escalate concerns were reportedly blocked. (2024)

These accounts demonstrate that, while maternity staff often recognised when escalation was required, decisions not to investigate were frequently made at Trust level. Over time, this appears to have led to a culture in which downgrading of incidents became normalised within the service as a form of learned helplessness.

3.5 Leadership, Capacity and Organisational Culture

Strong leadership is essential to effective governance because it creates the conditions in which safety, accountability and learning can function in practice rather than exist only on paper. Across staff accounts and commissioned reviews, the Review Team found repeated evidence of weak leadership, poor coordination, and ineffective governance processes. Three themes were especially clear: senior midwifery leadership not acting on front line concerns, chronic underinvestment in governance capacity, and the impact of these failures on staff morale and psychological wellbeing.

3.5.1 Leadership and escalation failures

In addition to concerns about incident downgrading at the IRP, the Review heard from numerous midwives who felt their concerns were not acted upon by senior midwifery leadership. Staff described reports being amended to reduce the apparent seriousness of concerns, a lack of trust between operational and governance teams, and senior leaders being absent from governance processes.

One senior staff member stated that the Director of Midwifery 'never once came to a governance meeting'. (2024)

A number of staff described having exhausted internal escalation routes without effect.

One staff member, after unsuccessfully escalating concerns through the director of midwifery, divisional clinical director, and governance channels, eventually raised concerns externally with the CQC, triggering external review. (2024)

Others reported being asked to amend papers or remove escalations before Board consideration.

One senior clinical colleague described Board papers being rewritten so that serious concerns were removed before reaching the Board. (2024)

While another said that a report they wrote on a rise in babies requiring therapeutic cooling and HSIB referrals was substantially altered because its contents 'upset doctors', although their name remained on the final version. (2024)

Other staff described similar experiences of being discouraged from escalating concerns.

One said that, when they recognised patterns resembling Morecambe Bay and tried to raise them, they were told it was 'not their role'. (2024)

Taken together, these accounts suggest that serious concerns were not only insufficiently heard, but in some cases actively diluted before reaching senior decision-makers.

3.5.2 Underinvestment in Governance Infrastructure

The Review Team heard repeatedly that long-standing clinical staffing shortages were mirrored in governance structures. Governance roles were described as chronically understaffed, under-resourced,

and lacking protected time, induction, standard operating procedures, and clear job descriptions. Staff often entered governance without prior experience or training, and the function was repeatedly portrayed as overwhelmed and reactive.

This underinvestment appears to have been long-standing.

*Staff described that prior to **2018**, delays in investigations and a lack of organisational commitment to governance, with one member of staff stating that "there was a lack of understanding and awareness and investment in governance at that time".* (2024)

*Another described governance between **2015** and **2018** as a place where staff were sent when unwell or difficult to place operationally.* (2024)

*Across the period **2012** to **2022**, staff described a 'massive lack of resource', with operational pressures focused almost entirely on staffing clinical areas rather than creating capacity for governance, quality improvement, or learning.* (2024)

Governance and improvement work were repeatedly described as secondary to immediate service pressures. One staff member said there was 'never really time to come up for air', and that quality improvement was treated as 'a luxury' rather than a core function. (2024)

The Review Team also heard that there was little structure within governance roles.

One staff member involved in clearing backlogs reported there were no job descriptions, no standard operating procedures, and no induction, with people simply being asked to 'do this'. (2024)

*One senior member of staff described the SI process in **2021** as effectively resting with 'one poor person'.* (2024)

While others noted that prior to 2021 there was little meaningful governance structure in place. This lack of capacity had operational consequences. In 2021, staff reported major midwifery shortages.

One account suggested that the vacancy position declared to the CQC did not accurately reflect the scale of the problem. (2024)

Temporary solutions included secondments to close low-level incidents because the service was so far behind.

Governance staff described their responsibilities as 'humungous for someone without formal governance experience'. (2024)

Even by 2022, staffing pressures affected the ability to convene panels for SI investigations,

One staff member stated that consultant obstetricians could not be released to form investigation panels. (2024)

The consequences of inadequate governance resource continued into later years.

*In **2023**, a maternal death following a significant postpartum haemorrhage was correctly identified as severe harm and an investigation commenced, but it took six months to appoint a panel, seven months for staff interviews to begin, and 12 months for the final report to be completed. Staff workload and absences within the governance team were recorded as contributors to delay.* (2023)

Overall, chronic underinvestment in governance staffing, skills, and leadership had significant effects on both patients and families. It contributed to delayed investigations, lack of transparency, weak learning, and repeated instability in governance arrangements. It also appears to have undermined the Trust's ability to sustain meaningful change over time.

3.5.3 Backlogs and Delays in Investigations

Throughout the earlier years of the Review, there were repeated backlogs in incident investigations, delays in closure, and slow completion of SI reports. SIs were often closed well beyond the 60-working-day target.

Staff described rapid reviews waiting weeks before even being declared as such. (2024)

Between 2019 and 2021, NUH employed a Patient and Family Liaison Lead, which the Review Team considered an innovative role with potential to improve families' understanding of governance processes.

However, a staff member reported that families were often informed of serious incidents 'six to nine months after the event', reopening trauma and causing additional distress. (2024)

The scale of backlog was also evident in the PMRT process.

*One staff member reported that, in January **2021**, there were still 30 open cases from 2018 and nine from 2019, and that senior leaders had effectively decided not to revisit earlier cases because the backlog was too large. In some instances, cases were reportedly signed off on Datix without full review*. (2024)

Specific family experience illustrates the human impact of delay.

*In **2023**, a family waited almost a year for a report and described feeling ignored despite repeated chasing, asking the Trust to 'show us you care'.* (2023)

*In **2025,** a woman reported possible neurological injury following repeated epidural attempts; the Trust investigation remained open more than a year later, and she had still not received answers.* (2025)

The Review Team also identified weaknesses in oversight of completed actions.

*In **2025**, following a maternal death after a post-feticide procedure in 2021, actions were reportedly completed in 2022 but not formally closed on the Trust action log until 2025, and only after a project to reduce overdue investigations. This remains a significant concern in relation to current governance oversight.* (2025)

3.5.4 Staff Experience and Moral Injury

The Review Team heard repeatedly from governance staff that chronic underinvestment and ineffective leadership caused significant emotional and moral injury. Staff described burnout, psychological distress and a toxic working culture that drove experienced people out of the organisation.

One staff member said they became 'very unwell working at NUH because of the culture… the bullying and everything'. (2024)

Another described a 'massive breakdown' after repeated requests for help were dismissed and said they became suicidal and eventually left the Trust, believing they might not still be a midwife had they stayed. (2024)

Others described governance work as having 'broke me', forcing them to leave without another job to go to. (2024)

Several staff described living in fear for their registration and reputation, and reported crying on the way home from work for months before eventually going off sick and resigning.

Governance meetings were described as 'brutal', with reports 'ripped to shreds' despite hours of preparation. (2024)

Staff also reported being pressured to declare compliance with national schemes when the evidence was not robust, and then being blamed when those declarations later proved unsound.

The Review Team also heard concerns from obstetric staff, including reports that some had been treated unfairly, with one leaving the organisation and another on long-term sickness absence. More recently, some staff expressed concern that, despite the promise of PSIRF and a more restorative culture, there had again been drift towards individual blame rather than systems thinking, with a consequent risk both to staff wellbeing and to families' ability to have concerns properly addressed.

The cumulative effect was the loss of experienced staff, repeated instability within governance teams, and reduced organisational memory and capability. This loss of expertise may help explain why sustained improvement did not take hold over time.

4. Recent Years (2024 – May 2025, post-PSIRF)

4.1 Introduction of Patient Safety Incident Response Framework (PSIRF) at NUH

On 16 August 2022, PSIRF was published by NHSE. Some Trusts had acted as early adopters from March 2020; NUH was not among them. The national expectation was that organisations would transition within 12 months of publication, with full implementation by Autumn 2023. Given the scale of the change required, this was an ambitious timetable. According to the Trust's Patient Safety Incident Response Plan (PSIRP), dated 1 April 2024, NUH began planning for transition in August 2022, working with internal and external stakeholders to review its safety profile. The plan covered all Trust services and was presented to the Quality and Assurance Committee in late 2022. The National Patient Safety Improvement Programme, including MatNeoSIP, formed part of this safety profiling alongside the local Maternity Improvement Programme.

It has not been possible to determine the exact date at which NUH transitioned to PSIRF. The Review Team saw evidence that incidents which ought to have been managed under the new framework were instead addressed through thematic reviews during 2022 and 2023, before publication of the PSIRP in April 2024. During this period the Trust was also dealing with a substantial backlog of SIs, and the focus appears to have been on closing historic cases, a process completed by September 2025.

As one staff member described, there were "like, 800 unresolved incidents at that time", with the Trust 'almost anticipating PSIRF really' by undertaking thematic reviews and trying to resolve large numbers of outstanding cases. (2024)

The PSIRP recognised that certain events would always require a Patient Safety Incident Investigation (PSII), including incidents meeting the criteria for Maternity and Newborn Safety Investigations (MNSI), and it identified local maternity triggers, particularly postpartum haemorrhage. The Review Team considered the PSIRP to have a broadly strong structure. However, additional detail is needed if staff are to engage with and interpret it consistently, particularly in maternity services where incidents are high in volume and often complex.

The wording of the Trust's Patient Safety Incident Response Policy (version 1) leaves room for interpretation. It could be read as implying that postpartum haemorrhage is the principal maternity event requiring investigation, while also offering the option of either a PSII or an alternative learning response without clear criteria for choosing between them. In practice, this places considerable responsibility on the Division to determine escalation, thereby limiting opportunities for wider scrutiny, independent challenge, and a 'critical friend' function from elsewhere in the Trust or at Board level.

There is also ambiguity in relation to nationally mandated reviews, particularly MNSI referrals. When an incident is referred to MNSI and subsequently declined, responsibility remains with the Trust to determine the appropriate local learning response. A declined referral does not remove the need for review. Rather, the incident should still be considered through the PSIRF framework to determine the most proportionate response – whether a full PSII, concise report, thematic review, or structured MDT debrief. This is important if families are to receive a transparent explanation, staff are to remain engaged in learning and the Trust is to retain oversight even where no external investigation takes place.

The Review Team was notified of ten incidents declared as PSIIs following publication of the PSIRP in April 2024. Nine were reviewed, as one family opted out. Of these, eight were referred to and reviewed by MNSI. Only one incident was declared outside MNSI criteria. From the experience of the Review Team, a typical maternity service would be expected to have a variety of incidents with some meeting MNSI criteria, some requiring full local investigation, and others needing thematic or proportionate learning responses. Having only one internally led investigation a year is not typical and may suggest:

- Under-recognition of incidents
- Over-reliance on MNSI
- Inconsistent understanding of PSIRF thresholds

- Limited staff confidence in declaring incidents
- Cultural or workload barriers to reporting

This is particularly notable given that the PSIRP itself states that each priority area can typically generate between three and six PSIIs per annum. That level has not been reached. Staff observations reflected this uncertainty.

One described the shift as having gone 'from nothing to everything' and then, under PSIRF, 'back to nothing', albeit with a recognition that the quality of the investigations themselves had improved. (2024)

Another described the process as short-lived and disorganised, with 'wrong dates, wrong notes, wrong cases… wrong everything'. (2024)

The Patient Safety Incident Response Policy and Plan was updated in July 2025 following an internal audit review of PSIRF 2024/25. The revised version places greater emphasis on minimum educational requirements and training needs analysis for PSIRF activity. However, The Review Team has seen no clear evidence that this training approach has been consistently implemented, nor assurance that all staff conducting investigations have the necessary skills and preparation.

Staff interviews also suggested that more work is needed to improve incident closure and the dissemination of learning. One member of staff commented that

"*there might not be a complete picture… you don't get a report actually, you have to ask for a report."* (2024)

Several staff also described the process as still too midwife-led, with insufficiently cohesive MDT involvement and other professional groups having to seek out information proactively. One trainee-related example described late or inaccurate meeting details and a continuing level of disorganisation, even where there had been attempts at inclusion.

Staff and family feedback also highlighted the need to strengthen the governance team structure. Although improvements have been noted, there remains a substantial risk that the service could again become overwhelmed by external pressures. The national maternity landscape has shifted significantly, with increasing demands arising from CNST, Saving Babies' Lives, MatNeoSIP, Ockenden, Kirkup, and the NHS England Three Year Delivery Plan. Maternity services are now required to evidence compliance with a wide range of national recommendations, and governance teams require sufficient staffing and expertise to manage this. As the Ockenden Review made clear, all Trusts must ensure that adequate resources are allocated to maternity governance teams.

A related issue raised by staff was the limited visibility of the governance team in clinical areas. Some felt that governance learning would carry greater credibility if those involved were seen in practice and contributing to in-situ teaching. As one staff member put it

'They aren't visible… being seen in clinical practice, doing teaching in practice off the back of incidents would be really welcomed.' (2024)

Although the updated PSIRP contains more detail about investigators and training, ambiguity remains about what should and should not be investigated. This is not unique to NUH. The one internally conducted PSII reviewed by the Review Team broadly followed PSIRF principles and DoC was applied, but it also exposed a number of weaknesses that would need addressing if this model were to become standard practice.

An After Action Review (AAR) was undertaken within five days of the incident and did identify learning, but arrangements for sharing that learning were still listed as 'to be discussed'. A clear proforma had been used, but it would have been strengthened by closer alignment with the four central AAR questions: what was supposed to happen; what actually happened; why there was a difference; and what would be learned and done differently next time. Staff also commented that AARs had not yet been sufficiently embedded and that training in their use remained limited.

Family engagement within that PSII was also incomplete. It was not clear whether the family had been invited to contribute their account or shape the terms of reference. Once the report was finalised, the Trust did not support the family to provide factual accuracy comments, and the delay in their feedback was not explored despite the obvious psychological impact of such reviews. The family were instead informed that the Review would progress and any comments would be added as an addendum. There was also a prolonged interval between the incident and approval of the report – three days short of a year – and it remains unclear what oversight was provided by the patient safety specialist. This is notable given Ockenden's requirement that every Trust should have a patient safety specialist specifically dedicated to maternity services; the Review Team has not been able to determine from the available evidence whether this requirement had been fully implemented at NUH.

The Review Team also identified no clear integration between patient safety and patient experience functions. In the PSII reviewed, a complaint made by the family was not addressed within the investigation despite being directly related to the incident.

Staff reflected similar concerns, stating that 'complaints were not consistently drawn back into governance processes and that learning gets lost.' (2024)

The actions arising from the report were also limited in scope. Many were administrative in nature rather than specific, measurable improvements capable of demonstrating meaningful change. Evidence of completion relied heavily on meeting minutes, which do not demonstrate impact or sustained improvement. Overall, the actions lacked the clarity, specificity, and outcome focus expected under PSIRF.

While PSIRF has value in principle, its current design does not sit neatly with the particular complexity of maternity services. This is evident not only in relation to patient and family engagement, but also in cases involving HM Coroner. These are recognised national challenges and are not unique to NUH. Similar concerns have been identified by the CQC, which found incidents going unreported because staff were overstretched, and by HSSIB, whose 2025 annual maternity review for NUH recorded that patients were experiencing compounded harm because of weaknesses in local investigations and the management of complaints and concerns.

The 2022 Ockenden report also warned that PSIRF's reliance on local determination of what to investigate could allow recurring problems to be downgraded or not fully investigated. The low number of PSIIs undertaken at NUH since introduction of PSIRF does little to dispel that concern. More than ever, Trusts now have discretion in determining which incidents receive the most rigorous investigative response. The Review Team identified evidence that some cases which should reasonably have progressed to a PSII did not do so.

For example, a woman sustained a ruptured uterus following VBAC, shoulder dystocia, a 3rd degree tear, and an 8.7L haemorrhage. She required extensive blood product support – including 10 units of red cells, platelets, cryoprecipitate, fresh frozen plasma, cell salvage, tranexamic acid, and nine litres of intravenous fluid – and remained an inpatient for eight days (2022). Despite the seriousness and complexity of the event, the case was managed as a multidisciplinary review and assessed as 'not meeting SI criteria'. Although it occurred after publication of the Trust's PSIRP, the old SI terminology continued to be used and the incident did not progress to a full investigation. It was graded as a moderate harm incident. This case illustrates the continuing risk that significant maternity incidents may not receive the level of investigation required, even within the post-PSIRF framework.

4.2 Implementation Challenges and Training

Prior to publication of the 2022 Ockenden report, the Review Team engaged with NHSE and received assurances that PSIRF would be effective for maternity services, with training in patient safety investigation and safety science forming a central component of national implementation. Despite the development of the NHS Patient Safety Syllabus and associated response standards, the Review Team identified significant challenges in implementation at NUH. These challenges are not unique and have been reported across multiple organisations.

A consistent finding was that the principal constraint on implementation is workforce capacity, particularly the availability of protected time. Staff require time not only to attend training, but also to undertake investigations, participate in learning responses, and embed reflective practice. In its absence, engagement is limited and implementation is compromised.

PSIRF represents a substantive shift away from traditional Root Cause Analysis towards a systems-based approach requiring multidisciplinary input, meaningful engagement with patients and families, and more complex analytical methods. These processes are inherently more resource-intensive and time-consuming. Without sufficient investment in staffing and training, there is a risk that these methodologies are implemented only superficially. This appears to be the case in some areas at NUH, particularly in relation to After Action Reviews (AARs), which staff described as not yet fully understood or embedded. As one staff member noted:

"we still haven't really got our head around after-action reviews… we're starting training… the majority… haven't really [had] SEIPS training." (2024)

The time required to complete PSIRF processes was also highlighted.

One family described a delay of approximately eleven months between an incident and receipt of AAR findings, with further delays in implementing learning. From incident to change in practice, the process could take up to two years. The family also questioned the quality of the AAR output, describing it as overly verbose but lacking clarity or meaningful conclusions, and expressed concern that the process felt 'like a tick box exercise' that provided 'more questions than answers' and limited accountability.

Staff similarly reported being asked to undertake new PSIRF methodologies, such as swarm huddles, without appropriate training or preparation. One described the current position as a 'hybrid' model in which AARs, swarm huddles and MDT reviews were not yet being delivered in line with PSIRF expectations.

These challenges are compounded by wider workforce pressures. Across maternity and acute services, staff are frequently redeployed to meet immediate clinical demand, limiting their ability to engage in training or undertake investigations. The result is a persistent gap between national expectations and local delivery.

The introduction of PSIRF was not accompanied by a dedicated funding stream. Trusts have therefore been required to absorb the costs of implementation within existing financial constraints. These include:

- Delivery of training programmes and provision of clinical backfill
- Development of governance systems to support PSIRF
- Recruitment or upskilling of patient safety specialists

National policy requires each Trust to appoint at least one Patient Safety Specialist and deliver functions aligned with the National Patient Safety Strategy. The Ockenden report further specified that such roles should be dedicated to maternity services. However, the Review Team has not been able to determine from the available evidence whether this requirement has been consistently met at NUH.

The Patient Safety Syllabus also requires staff to develop competence in complex domains including systems thinking, human factors, Safety II principles, SEIPS methodology, and proactive risk management. For many organisations, this represents a substantial educational shift. At NUH, as elsewhere, there remain insufficient numbers of trained investigators, limited access to specialist expertise, and variable confidence in applying just culture principles. In this context, there is a tendency to revert to more familiar, linear and, at times, blame-oriented approaches.

Although PSIRF emphasises the importance of separating error from blame, staff reported ongoing concerns about potential repercussions. Inconsistent application of just culture principles, combined with limited organisational capacity to support psychological safety, has slowed cultural change and reduced confidence in the framework.

While NHSE has described PSIRF as a 'significant shift' in how the NHS responds to patient safety incidents, there has been limited national direction on how organisations should operationalise training

requirements. Free resources are available, including e-learning modules and introductory training, but responsibility for ensuring staff attendance - including provision of backfill - rests with individual Trusts. More advanced training is limited in availability, often costly, and subject to waiting lists. Staff cannot reasonably be expected to undertake such training without appropriate resourcing and protected time.

Available training programmes often focus on the principles of PSIRF rather than the practicalities of implementation. Organisations require greater support in translating the framework into consistent operational practice. Improved access to training, protected time, and dedicated funding would significantly support more effective implementation.

PSIRF guidance also requires Trusts to maintain detailed training records and competency frameworks, ensuring staff undertake investigations appropriate to their level of responsibility (e.g. Learning Response Lead, Engagement Lead, Oversight Lead). Without adequate infrastructure to support this, compliance and consistency are difficult to sustain.

In summary, while PSIRF offers a progressive and system-focused model for patient safety, its effective implementation is dependent on workforce capacity, training and sustained investment. In the absence of these, implementation remains partial, and the intended cultural and organisational benefits are unlikely to be fully realised.

4.3 Recent improvements in Governance and Culture

The Review Team heard that support for staff has improved markedly in recent years. Staff reported feeling more able to escalate concerns and described receiving stronger support and clearer feedback following clinical incidents. As one member of staff noted:

"Since the Review began… staff feel a lot more supported… people do speak up now, they're not afraid to speak up anymore." (2024)

There is also evidence of a more structured approach to supporting students involved in clinical incidents. Universities are now informed where appropriate, and students have access to Professional Midwifery Advocates, personal tutors, and Practice Supervisors.

Senior clinicians were described as increasingly modelling openness and encouraging honesty in reporting adverse incidents and near misses. Staff reported a greater emphasis on learning and feedback. One midwife noted that, whereas previously feedback had been limited:

"now we get talked about absolutely everything… giving us feedback." (2024)

Communication mechanisms have also improved, including regular teaching sessions and divisional meetings where learning from incidents is shared across multidisciplinary teams.

The Review Team also heard that local leadership, particularly at labour ward level, has contributed to improved morale and a more positive culture. Staff described concerns being acted upon more consistently, increased encouragement of Datix reporting, and more regular feedback.

Structural changes appear to have supported this shift. Staff highlighted the impact of strengthened leadership arrangements, including dedicated governance roles within senior midwifery leadership, and greater engagement from the Trust Board. As one staff member observed:

"Our structure is… so much better… having two Heads of Midwifery, one with a governance remit… has made a difference." (2024)

Staff also described a move towards a more systems-based approach to investigations, with improved multidisciplinary working and greater focus on understanding what happened rather than attributing blame. Several accounts suggested that governance processes are now more robust, with one staff member stating that maternity governance is now:

"What I'd expect… well set up and well run." (2024)

These improvements are significant and should be recognised. However, they remain relatively recent, and it is not yet clear whether they have translated into consistent improvements in outcomes for families. The key test will be whether these cultural and structural changes result in timely, thorough investigations and meaningful engagement with families when harm occurs.

5. Cross-cutting Governance Issues

5.1 Impact of COVID-19 and Thematic Reviews

It is neither possible nor fair to fully assess how governance at NUH was affected during the COVID-19 pandemic. All Trusts experienced significant disruption, with many governance functions paused or reduced to prioritise front line care. A national timeline of events is available elsewhere.[228] While the Review Team did not specifically focus staff interviews on pandemic-related changes, some evidence was available regarding how incidents from this period were subsequently reviewed.

Following the pandemic, the Perinatal Care Directorate identified a long-standing backlog of open and overdue incident investigations, including some predating the pandemic. To address this, eight thematic reviews were undertaken, covering incidents between November 2019 and June 2021. However, these reviews were poorly structured: only one was dated, none had a named author, and they did not meet the standard expected of clinical thematic reviews.

The Reviews grouped incidents into eight categories:

1. Sharps incidents
2. Induction of labour
3. Provision of care
4. Transfusion and medication
5. Communication and documentation
6. Systems and staffing
7. Maternal emergencies and complications
8. Neonatal emergencies and complications

The Review Team found that these thematic reviews did not identify meaningful clinical themes or learning related to patient care. Instead, they focused largely on the investigative process itself and the reasons incidents had not been closed. There was little or no analysis of the care provided to women and babies within key categories, such as induction delays or obstetric emergencies, despite plans to use these reviews to justify closure of incidents en masse.

The themes identified by NUH largely reflected process failures rather than clinical insight:

- Incidents were reported but investigations were delayed or incomplete;
- Many investigations lacked a named lead;
- There was insufficient capacity to investigate incidents thoroughly; and,
- Grading of harm was inconsistent and frequently inaccurate.

Several reviews highlighted concerns about grading. For example, of 19 sharps incidents, 15 were classified as ‘no harm’, although the Review Team concluded they should have been graded at least ‘low harm’ in

228 https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

line with national standards. The maternity emergencies review noted long-standing under-reporting of key triggers, including major obstetric haemorrhage, and inconsistency in assigning harm. The systems and staffing review found that 92% of incidents were graded as no harm and 8% as low harm, concluding that this distribution was difficult to reconcile with the nature of the incidents described.

Despite these findings, the Review Team found no evidence that individual cases were revisited, regraded, or escalated for further investigation. Nor was there evidence that families received feedback. None of the thematic reviews recommended reviewing individual cases to determine whether a Serious Incident investigation was required.

One review acknowledged the pressures within the system, noting that staff often felt 'powerless to effect any change' due to time constraints or lack of capacity. This aligns with wider findings in the Review regarding chronic understaffing and limited governance resource. While the need to disseminate learning was recognised, there was also acknowledgement that this would be difficult in an already overloaded system. The Review Team did not identify evidence that learning from these reviews led to changes that would prevent recurrence of similar incidents.

Given the scale of backlog and limited capacity, the use of thematic reviews was not, in itself, inappropriate. However, their effectiveness depends on robust clinical analysis, clear identification of learning, and appropriate follow-up actions. In this case, the reviews were primarily process-focused and did not provide sufficient assurance that patient safety issues had been addressed. As noted elsewhere in this Review, thematic approaches were later adopted more effectively, but the underlying issues predated the pandemic and were not solely attributable to it.

It is particularly concerning that repeated findings across these reviews identified inaccurate grading of incidents without any clear plan to address this. For example, the neonatal review noted that only 8% of incidents were classified as moderate harm and acknowledged that, if categorised according to actual harm rather than intent, the proportion would likely have been significantly higher. Despite this, no systematic reclassification or escalation process was implemented.

The Review Team also identified ongoing issues with accountability and oversight. Incident investigation processes lacked clear ownership, with responsibilities diffused across teams – described by one account as 'everybody's job and nobody's job'. Incidents were often assigned to staff without dedicated time or training, contributing to delays and backlog. There appeared to be limited organisational recognition of the importance of governance as a core function underpinning safe clinical care.

Although some recommendations were included within the thematic reviews, these were often vague, lacked designated leads, and had no clear timescales for implementation. In some cases, reviews recommended further thematic analysis rather than prioritising detailed investigation of serious or complex incidents. It remains unclear why more in-depth clinical analysis was not undertaken at the outset, or whether such analysis was ever subsequently completed.

Overall, these thematic reviews did not provide sufficient assurance that incidents had been appropriately investigated, that learning had been identified, or that action had been taken to prevent recurrence. They reflect a system under significant pressure, but also highlight long-standing weaknesses in governance, including inadequate resource, poor oversight, and inconsistent application of incident investigation processes.

5.2 Reporting, Assurance and Progress Against National Maternity Requirements

As well as identifying the themes above, the Review Team examined governance documentation, meeting minutes, and reporting structures across maternity services, including PQSM reports, Trust Board papers, and committee records. Across this evidence, persistent weaknesses were identified in the clarity, consistency, and robustness of reporting relating to national maternity programmes and statutory requirements. These weaknesses directly affected the Trust's ability to demonstrate compliance, particularly in relation to the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

5.3 CNST Maternity Incentive Scheme Compliance

The Review Team found it difficult to track progress against national maternity initiatives through the governance structure. CNST requires regular, transparent reporting through internal processes and to the Trust Board, enabling Board-level assurance and confident self-declaration of compliance. However, documentation did not demonstrate a clear or consistent reporting pathway, nor did it provide sufficient evidence of progress against key programmes.

A particular area of concern was the Saving Babies' Lives Care Bundle (SBLCB). Since its introduction in 2016, with further iterations in 2019 and 2023, expectations for implementation and reporting have increased, and compliance forms part of CNST Safety Action 6. Despite this, the Review Team found limited evidence of structured reporting or demonstrable progress at NUH. The Trust was not compliant with Safety Action 6 in Year 5, following discrepancies between its self-assessment and LMNS review. While some documentation referenced use of MIS funding, for example to support smoking cessation services, there was no clear articulation of barriers to implementation or evidence of governance oversight.

Staff feedback supported these findings, describing delayed adoption of SBLCB elements, including GAP and reluctance to update guidelines in line with national standards. Although more recent accounts suggest improvement, this was not consistently reflected in formal reporting.

5.4 CQC Action Plan and Regularity Oversight

Following the October 2022 CQC inspection, the Trust developed an action plan to address identified concerns. While this plan was available, the Review Team found limited evidence of assurance regarding completion or sustained monitoring of actions. The absence of structured reporting limited the Trust's ability to demonstrate progress to the Board, LMNS, and regulators.

5.5 Governance Structures, Reporting Pathways and Board Assurance

The Trust's performance in the Maternity Incentive Scheme highlights further governance weaknesses. In Year 3, the Trust declared full compliance but was later required to return funding when evidence did not meet the required standard. In Years 4 and 5, compliance was declared for only five of the ten safety actions.

Staff accounts indicate that these issues were not solely technical but reflected cultural pressures. Multiple staff described pressure to declare compliance despite known gaps. One staff member reported that there was:

"a lot of pressure… to say we were compliant… to the point that it wasn't an option not to be compliant." (2024)

Others described the supporting evidence as lacking substance, with one noting:

"There was no evidence… it had no substance whatsoever." (2024)

A specific area of concern was MDT training, a key CNST requirement. Staff reported that the Trust was significantly below the required threshold but that definitions were adjusted to enable compliance. One staff member described being told that MDT training requirements could be met if a doctor delivered training, regardless of whether multidisciplinary participation occurred. When concerns were raised, they were discouraged, with one individual told they were

"Being a little bit too honest." (2024)

Another described how senior leadership redefined MDT training in order to meet requirements, despite this conflicting with national guidance, characterising the process as a farce.

This pattern persisted across years. One staff member described attempting to declare partial compliance

but having results up-marked by senior leaders, despite fundamental disagreement. Others reported pressure to declare compliance with SBLCB despite clear evidence to the contrary, and described a culture in which compliance had historically been asserted without sufficient scrutiny.

These accounts are consistent with the Review Team's finding of insufficient governance oversight and inadequate challenge of compliance declarations.

The Trust Board report from January 2024 acknowledged gaps in evidence, noting that maternity services could not provide assurance that PMRT reports had been consistently reviewed at executive or Board level. While changes to reporting structures were underway to support Year 6 compliance, the Review Team found limited evidence of comprehensive reporting for 2024, with only two PQSM reports available.

Across governance forums – including Board committees, oversight groups, and departmental meetings – the Review Team found inconsistent reporting of national maternity programmes and limited evidence of escalation or triangulation of risk.

Board-level Safety Champion activity was inconsistently documented, with limited evidence of structured engagement or feedback loops. Trust Board and departmental reports contained minimal information on progress against national programmes, restricting the Board's ability to gain meaningful assurance.

Staff feedback reinforced these findings, describing a disconnect between operational teams and governance structures, action plans that were not implemented, and a culture in which transparency regarding compliance was discouraged.

6. Summary

This chapter presents consistent evidence of staff who were committed, overstretched, and repeatedly raised concerns. Despite this, the failures in maternity governance were systemic, prolonged, and harmful. They were driven by chronic under-resourcing, weak structures and leadership, cultural barriers to escalation and a sustained failure to prioritise learning and patient safety. These governance failures appear to reflect wider organisational issues within the Trust. Of particular concern is that many of these issues were already known through multiple internal and external reviews over several years.

The consequences were significant: incidents were not appropriately reviewed, trends were not identified, investigations were delayed, and opportunities to prevent harm were repeatedly missed. This resulted in avoidable harm to families and considerable distress among staff.

The national governance landscape also contributed to these challenges. Evolving frameworks, inconsistent definitions, and a lack of maternity-specific guidance created ambiguity in incident grading and investigation processes. However, while these factors provide context, they do not fully account for the scale and persistence of the failures identified.

Overall, the Review Team found substantial weaknesses in reporting, monitoring, and assurance across national maternity programmes, including CNST requirements and CQC actions. Inconsistent governance processes, combined with cultural barriers, led to repeated failures to demonstrate compliance and limited the Trust Board's ability to exercise effective oversight.

Although recent improvements have been identified – particularly in relation to SBLCB implementation and Year 6 CNST reporting – these remain at an early stage. Sustained progress will require strengthened governance structures, transparent reporting, and robust assurance mechanisms. While there are signs of improvement, these follow a prolonged period of dysfunction that should have been identified and addressed earlier through sustained investment, leadership, and cultural change.

Clinical Leadership

1. Introduction

Compassionate, visible, and accountable leadership is fundamental to the provision of safe, high-quality maternity care. Evidence from several national inquiries, regulatory reviews, and local investigations have consistently demonstrated that failures in maternity services are often rooted in systemic and leadership shortcomings, rather than isolated clinical errors. Effective leadership promotes a culture in which staff feel supported, concerns are listened to and acted upon, learning is prioritised, and women and families are heard and receive safe compassionate care.

Multiple staff have told the Review that Nottingham University Hospitals (NUH), maternity services have experienced prolonged periods of leadership instability, fragmented governance arrangements and a workplace culture which has been characterised by fear, disengagement, and a lack of psychological safety.

Over the period of 13 years between 2012 and 2025 evidence drawn from local external reviews and the voices of staff reflect the long-standing and recurring leadership challenges faced by the Trust, as well as areas where progress has been made.

Findings from external reviews including; Care Quality Commission (CQC) inspections, internal and external maternity and neonatal culture reviews, and national maternity safety reviews, alongside staff testimony, indicate that clinical leadership challenges across all levels have had significant operational consequences. These challenges have affected day-to-day decision-making, staff wellbeing, professional practice and ultimately resulted in a lack of safe care for women, babies and families.

This chapter explores the theme of clinical leadership through analysis of changes in senior maternity clinical and operational leadership, including Directors of Midwifery (DoM), medical clinical directors, consultant leaders, matrons, and senior operational managers. It also considers the role of Trust-level executive leadership in supporting maternity services, particularly how senior organisational leaders influenced leadership stability, visibility, and the ability of clinical leaders to operate effectively. By examining available documentation alongside staff experiences, this chapter aims to understand how clinical leadership structures and practices have influenced the culture, safety, and quality of care at Nottingham University Hospitals NHS Trust.

National Learning and Historical Context

Evidence from national maternity reviews has consistently highlighted the critical role of leadership in ensuring safe, high-quality maternity care. Leadership visibility, integrity, and accountability underpin staff confidence, effective teamwork, and compassionate care, while deficits contribute to systemic failures.

The Ockenden Review (2020)[229] exposed widespread shortcomings in leadership and governance at the Shrewsbury and Telford Hospitals NHS Trust, noting that families and their own staff were often not heard, risks were ignored, and training was inconsistent. Subsequent national reviews have reinforced these themes. The East Kent Review (2022)[230] identified ongoing failures in compassion, professionalism, and collaborative working, highlighting the consequences of ineffective senior leadership and a persistent blame culture. The Messenger Review (2022)[231] broadened the focus to leadership across the NHS, advocating

229 Ockenden, D. (2022) Findings, conclusions and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

230 Kirkup, B. (2022) Reading the signals: maternity and neonatal services in East Kent – the report of the independent investigation. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

231 Messenger, G. and Pollard, L. (2022) Health and social care review: leadership for a collaborative and inclusive future. London: Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future (Accessed: 6 March 2026).

for distributed, inclusive leadership rooted in staff and patient experience, with mentorship and training for emerging leaders. The Swansea Bay Review (2023)[232] and the CQC State of Care report (2024)[233] further emphasised the importance of visible, consistent leadership, the impact of workforce instability, and the need for proactive support for staff wellbeing and retention.

This Review of NUH maternity services identified recurring issues in clinical leadership that mirror these national findings. Five key leadership themes emerge, reflecting both local experience and alignment with national evidence:

1. Leadership visibility and integrity – Leadership integrity is foundational to trust, safety, and staff engagement. Senior leaders must be present in clinical areas, actively listen and model compassion, and demonstrate accountable decision-making.
2. Workforce stability – Stable leadership supports workforce planning, morale, and retention. Persistent staffing shortages and high turnover undermine care quality, increase stress, and reduce continuity for both staff and families.
3. Culture and compassion – A culture of openness, psychological safety, and compassion is central to patient safety and staff wellbeing.
4. Training and development – Structured development programmes, multi-professional simulation, and mentorship equip staff and leaders with the skills and resilience required to manage complex services safely.
5. Learning and improvement – Continuous learning, effective incident review, and timely implementation of recommendations are critical to addressing systemic failures. Learning must be embedded at all levels and inform leadership decisions.

These themes demonstrate how local NUH experiences are reinforced by national reviews. They demonstrate that visible, compassionate, and accountable leadership are key factors in delivering safe, high-quality care, and reflect the leadership factors consistently identified as critical to the safety, culture, and quality of maternity services.[1,2]

This chapter examines the evidence from the Review, highlighting that many of the leadership challenges identified nationally including visibility and integrity, workforce stability, culture and compassion, structured training and development, and the capacity for learning and improvement have shaped the experiences of families and staff at NUH. The five key themes have been used to structure the evidence from the Review, with sub-themes to capture specific issues and examples.

Theme 1: Leadership stability and Visibility

1.1 Turnover in Midwifery Senior Leadership

Maternity services at Nottingham University Hospitals (NUH) have experienced sustained instability in senior midwifery leadership. Although the first Director of Midwifery (DoM) was appointed in 2017, there was significant turnover in the role, with five Directors of Midwifery in post between 2017 and 2021. This included a particularly unstable period between 2020 and 2021, during which three interim DoMs were appointed within a six-month timeframe.

232 Swansea Bay University Health Board (2023) Independent review of maternity and neonatal services. Swansea: Swansea Bay University Health Board. Available at: https://sbuhb.nhs.wales

233 Care Quality Commission (2024) The state of health care and adult social care in England 2023/24. London: Care Quality Commission. Available at: https://www.cqc.org.uk/publications/major-report/state-care/2023-2024 (Accessed: 6 March 2026).

The two permanent Directors of Midwifery each remained in post for less than two years, leaving at points when significant concerns were being raised regarding maternity safety, standards of care, and organisational culture. The scale of this instability was widely recognised within the service; one staff member reported being told during their interview that this would be

"The fifth DoM since she had been in post." (2021)

This highlights both the frequency and visibility of leadership turnover within the maternity service.

Recruiting permanent leadership during this period (2017–2021) proved challenging, particularly in the context of a maternity service which held an 'Inadequate' Care Quality Commission rating (2020–2022). This resulted in heightened scrutiny and reputational impact, both of which are known to affect the recruitment of experienced, senior leaders. As a consequence, the service experienced a prolonged period of leadership instability, with repeated reliance on interim appointments who, by their nature, were unable to provide the sustained leadership required to rebuild trust, embed improvement, or restore staff confidence.

In addition to this instability, staff feedback pointed to underlying cultural challenges within the service. Multiple staff described senior leadership behaviours as intimidating and, at times, lacking in professional respect, which negatively affected morale and psychological safety. Evidence from staff interviews and interim leadership experiences indicated that these factors contributed to the early departure of some leaders and hindered the establishment of stable, effective leadership.

Staff interviews suggested rapid promotions into senior roles, including internal promotions and interim leadership appointments, without adequate induction, mentoring, or structured support which further compounded instability. Some individuals gained pivotal positions without the infrastructure or guidance to succeed, exacerbating inconsistency in leadership. As one staff member reflected:

"People were promoted into roles they weren't ready for, with no support or mentoring." (2022)

Another staff member described the long-term impact:

"I had twelve different line managers over twelve years… very difficult to work in." (2022)

Staff also reflected that repeated turnover of senior maternity leaders undermined midwifery oversight and had negative effects across the wider multidisciplinary team (MDT). Staffing shortages, particularly the lack of senior midwives, were reported to affect clinical care. Several members of the medical team raised concerns that frequent changes in midwifery leadership made it difficult to implement critical care developments and other service innovations:

"High turnover of midwife managers means difficult to get buy-in for critical care developments." (2015)

In contrast, midwifery staff described the visible and continuous presence of consultant anaesthetists on the labour ward as contributing to a supportive working environment. This reliable presence enabled resident doctors, midwives, and other multidisciplinary team members to raise concerns, seek advice, and escalate issues promptly. One staff member observed:

"Anaesthetic colleagues are really good… they always support". (2013)

While another reflected on learning after serious incidents:

"I was involved in a maternal death and received tremendous support from colleagues throughout the investigation process." (2014)

Several MDT members highlighted the benefit of consistent anaesthetic staffing, including consultant attendance when requested:

"The City anaesthetic team is very supportive and helped build my confidence." (2023)

This stability and visibility acted as a positive counterpoint to the variability in senior midwifery leadership, demonstrating how consistent, relational leadership across the MDT can support escalation, learning, and patient safety.

National evidence reinforces the importance of stable, visible leadership, which the experiences at NUH illustrate vividly. The King's Fund report *The Courage of Compassion* (2020)[234] notes that instability in senior leadership undermines risk recognition, governance, and organisational performance across professions. Similarly, the CQC Maternity Review (2022-24)[235] highlights that leadership culture directly affects staff confidence and patient safety.

Between 2017 and 2021, the maternity service at NUH experienced frequent turnover of Directors of Midwifery and reliance on interim leaders, alongside rapid internal promotions without adequate induction or mentoring. This instability undermined midwifery leadership, disrupted team cohesion, and limited the service's ability to embed sustained improvements or support staff effectively. Since 2021, the appointment of a permanent Director of Midwifery has provided greater continuity, offering the potential to rebuild trust, strengthen leadership, and support sustained improvement across the service.

1.2 Senior team leadership and visibility

Leadership absences were particularly evident during periods of high pressure, leaving staff feeling unsupported. Senior midwives were often absent from clinical areas, with minimal engagement following incidents. Staff members told the Review Team that:

"We never saw senior midwives; no engagement followed incidents." (2016)

These leadership challenges pre-dated the COVID-19 pandemic, which created unprecedented system-wide pressures across the NHS including for maternity services. While the pandemic added further pressure, staff consistently reported feeling unsupported, citing a lack of recognition for extra efforts and the absence of practical help. In some cases, managers were perceived as unavailable or uninterested in concerns raised by staff, further undermining confidence in escalation pathways and leadership presence.

Key senior roles within maternity and neonatal services, such as matrons, were designed as 'front of house' clinical leaders responsible for the operational and day-to-day running of the service, including quality, safety, and staff support. The 2020 *Matron Handbook*[236] highlights their role in providing visible leadership, facilitating communication between front line staff and the Head of Midwifery (HoM) and DoM through to the executive team, and enabling the safe escalation of concerns.

Within the maternity and neonatal leadership structure at NUH, matrons are line-managed by the HoM, who oversees operational delivery across the service and supports the DoM in implementing service-wide policies and quality initiatives. The DoM holds overall professional accountability for midwifery services and reports to the Chief Nurse, who sits on the Trust executive team and Board and provides organisational oversight for nursing and midwifery standards, governance, and risk management across the Trust. This framework is intended to ensure that concerns raised at the ward level can be escalated efficiently and that matrons receive the guidance and support required to lead effectively.

Staff feedback, however, highlighted multiple barriers that prevented matrons from fully fulfilling this role. Frequent turnover in senior leadership, reliance on interim appointments, and inconsistent presence of senior midwives on wards disrupted established reporting lines and reduced the support available to matrons. As a result, opportunities for visible leadership, staff mentoring, and timely escalation of concerns were often compromised, limiting the ability to maintain safe, high-quality care and undermining confidence in leadership at multiple levels. This reflects findings from the CQC (2026), which reported that 'leaders weren't visible in the service and some staff told inspectors they weren't supportive'.

234 West, M., Bailey, S. and Williams, E. (2020) The courage of compassion: supporting nurses and midwives to deliver high-quality care. London: The King's Fund. Available at: https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives

235 Care Quality Commission (2022) National review of maternity services in England 2022–2024. London: Care Quality Commission. Available at: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/national-review-maternity-services

236 NHS England and NHS Improvement (2020) The Matron's handbook. London: NHS England and NHS Improvement. Available at: https://www.england.nhs.uk/publication/the-matrons-handbook

Newly appointed leaders often lacked formal induction, structured mentoring, or clear guidance about their responsibilities (Staff Members 2003 - current), leaving them without the support needed to undertake the role. Staff reported that many senior roles, including coordinators and matrons, were filled by inexperienced staff:

"They just don't know how to manage people, won't deal with conflict, don't deal with the escalations." (2013)

This led to inconsistent approaches and further uncertainty about leadership. Matrons described difficulties escalating concerns,

One reflected that when issues exceeded their remit, they faced significant barriers in engaging senior maternity colleagues. (2022)

Similar concerns were identified by the Care Quality Commission, which noted that

"Staff didn't always raise concerns as they felt neither the maternity leadership nor the trust would take any action" (CQC Press release March 2026)[237].

High turnover of staff, rapid promotions, intermittent presence in clinical areas weakened escalation pathways, contributed to confusion about expectations, and reinforced a culture of fear and reduced accountability. Staff observed:

"There was so much churn in the senior management team, people would just disappear overnight, and it never felt like anyone was held to account." (2024)

"Management was impenetrable before, they took no responsibility." (2024)

and

"They came, they went, somebody else came and I don't know, that's just the way that I felt it was." (2024)

Although some leaders were formally present on the wards, their inexperience and lack of support often meant that visible leadership failed to instil confidence or reassure staff. These experiences highlighted the effects of poor leadership on staff confidence in raising and escalating concerns.

1.2.1 Leadership Visibility

The concept of visible leadership has become a core recommendation across the UK maternity safety reports consistently linking with an improved safety culture and staff engagement and psychological safety (Ockenden 2022[1], Kirkup 2022[2], CQC 2022-24[7], NHS 2023[238]). Whilst widely acknowledged as essential, visibility can be either performative or meaningful in practice. Performative visibility refers to leaders being physically present without genuine engagement or follow-through, whereas meaningful visibility involves active listening, relational leadership, and demonstrable action in response to concerns raised. Visible leadership refers to leaders who are regularly present, accessible and actively engaged with women, families and front-line staff. It strengthens escalation pathways, enabling staff to raise concerns early and ensuring that emerging risks are recognised and addressed promptly. Box 1 demonstrates the elements to achieve meaningful visibility within services drawn from national reports.

237 https://www.cqc.org.uk/press-release/cqc-publishes-reports-maternity-services-run-nottingham-university-hospitals-nhs-0

238 3 year delivery plan – NHS England (2023) Three-year delivery plan for maternity and neonatal services. London: NHS England.

Box 1. Core components of meaningful leadership visibility across maternity and neonatal services

1. Physical presence in clinical areas: leaders need to be present in clinical settings, engaging directly with staff and observing care delivery and working conditions
2. Leaders build relationships with staff and services users: visible leadership involves relational leadership that supports psychological safety and seeks to understand the experience
3. Leaders listen to staff and act on concerns raised closing the loop: Leaders are approachable and accessible, actively seeking staff concerns and feedback. Concerns are not only heard but acted upon, and staff see evidence of change ("you said, we did"), reinforcing a culture of accountability and learning
4. Leaders provide presence and guidance during incidents and offer wellbeing support afterward, helping staff recover and learn from challenging events.
5. Leaders participate in activities that promote high-quality care, including audits, safety huddles, clinical governance, and quality improvement initiatives
6. Leaders model culture and behaviour: leaders influence culture through their behaviour, collective and compassionate leadership shows leaders shape organisational culture. Leadership visibility spans the multi-disciplinary team, working together to model safe, collaborative care

In practice, visible leadership is therefore not defined solely by presence in clinical areas, but by the extent to which leaders create psychological safety, support staff during periods of pressure, and ensure concerns raised by staff and families lead to action.

From 2021 onwards, NUH implemented deliberate measures to strengthen visible clinical leadership within maternity services, recognising that leadership presence and engagement were central to rebuilding trust and supporting staff. Consecutive inspection findings had identified leadership capacity challenges, noting recently that 'the leadership team didn't have enough capacity to spend time consulting on and implementing a maternity specific vision and strategy, as much of their time was taken up demonstrating assurance' (CQC 2026).[239]

Executive level engagement signalled organisational prioritisation of leadership and support for senior clinical staff, creating conditions for Clinical Directors, Directors of Midwifery, Heads of Midwifery, Matrons, and Senior Midwives to focus more consistently on ward presence, engagement with staff, and participation in safety huddles and incident learning forums.

Structured initiatives included quarterly Listening Forums, chaired by the Director of Midwifery, which provided staff with regular opportunities to raise concerns, ask questions, and offer feedback. A Maternity Safety Champion Network was also developed to empower staff to escalate safety issues, contribute to learning, and participate in quality improvement across the service. These initiatives were designed to enhance relational leadership, improve communication across clinical teams, and reinforce the professional role of matrons and senior midwives.

Staff feedback suggests that these initiatives contributed to a more supportive clinical environment, increasing the presence of senior leaders on wards and their engagement with staff in routine operational spaces. The initiatives provided formal and informal opportunities to raise concerns, seek guidance, and engage in service improvement, laying the foundation for the experiences and perceptions described by staff in subsequent reports and inspections. While CQC inspection findings do not attribute specific outcomes to these actions, subsequent reports noted improvements in leadership culture and staff confidence in raising concerns, providing external validation of progress in visible clinical leadership.

239 https://www.cqc.org.uk/press-release/cqc-publishes-reports-maternity-services-run-nottingham-university-hospitals-nhs

While visible leadership is widely promoted as a core component of safe maternity services, the practical realities of delivering it consistently are complex. Leaders operate within environments characterised by high regulatory oversight, performance monitoring, and organisational assurance demands, which often limit the time available for sustained engagement with front line clinical areas. National inquiries, including the Ockenden Review (2020, 2022) and Reading the Signals (2022) highlight the importance of visible, engaged leadership but also emphasise the multiple layers of responsibility across clinical, managerial, and organisational hierarchies.

This context demonstrates that the expectation for leaders to be consistently present, relationally engaged, and actively involved in safety and quality improvement must be understood alongside these operational constraints. Achieving effective visible leadership requires both individual leadership capability and supportive organisational conditions including balanced multidisciplinary accountability, protected time for relational engagement, and structures that enable leaders to prioritise safety-focused practice alongside system-level responsibilities.

Staff described the improvements in leadership practice, including the increased engagement from senior leaders and a shift towards behaviours more closely aligned with national expectations of the matron role. One staff member noted:

"Now, we see leaders engaging with staff and listening to concerns." (2024)

Others reported that the new DoM had energised midwives and fostered a sense of being heard. Senior midwives were also described as hosting a monthly forum, providing a regular opportunity for staff to raise questions and offer feedback.

Recent CQC inspections provide independent validation of these improvements. The 2023 Well-Led inspection reported 'significant progress in improving the culture' and noted that the executive team 'consistently led with integrity and were open and honest in their approach'. Subsequent inspections in 2024-2025 rated maternity services as 'Requires Improvement' for being well led, noting that while progress had been made, some staff were still 'not always confident they were taken seriously when they raised concerns' (CQC 2026) Although visibility has improved, staff experiences show that the deeper work of listening, acting on feedback, and closing the loop remains incomplete. Initiatives such as the 'manager of the day' model, often staffed by non-senior personnel, were sometimes experienced as alienating highlighting the ongoing importance of consistent, authentic senior leadership on the clinical floor.

1.3 Maternity Safety Champions

The importance of visible, empowered safety champions is reinforced by national guidance. Whilst the role has existed from 2015, it was strengthened by NHS Improvement in 2018 and the Ockenden Review (2022) mandated board-level and non-executive safety champions to ensure robust oversight, escalation of concerns, and independent challenge. Similarly, the Kirkup Report (2015)[240] emphasised visible leadership, multidisciplinary teamwork, and responsiveness to challenge as central to a strong safety culture. These reports provide a benchmark for the intended scope and function of safety champions.

240 Kirkup, B. (2015) The report of the Morecambe Bay Investigation. London: The Stationery Office. Available at: https://www.gov.uk/government/publications/morecambe-bay-investigation-report

Box 2. The role of the Safety Champions

Maternity safety champions are leaders across NHS trusts, regional, and national levels responsible for fostering a positive safety culture and implementing best practices to improve outcomes for mothers and babies. At provider level, they provide 'floor-to-Board' communication, bridging front line clinical staff and board-level management to ensure safety initiatives are implemented.

At front line level, every maternity provider is expected to nominate an obstetrician and a midwife who are jointly responsible for championing maternity safety locally whilst working collaboratively in their region.

Amid ongoing instability in senior leadership, the role of Maternity Safety Champions has become a critical mechanism for strengthening visible leadership, accountability, and the escalation of safety concerns within maternity and neonatal services as part of MIS safety action nine.

The Safety Champions were reportedly poorly embedded, which hindered the escalation of safety concerns from the clinical floor to the Board. Staff reflected on the limitations of early implementation:

"The safety champions, they hardly ever met… executives came down occasionally, but they weren't functioning as safety champions." (2024)

Safety Champions themselves described challenges engaging with staff:

"Sometimes, I'd turn up and say, 'I've got half an hour if anyone wants to talk to me,' and I'd perhaps have an empty room." (2024)

These experiences highlighted that early efforts were largely symbolic, with limited opportunities to influence practice or provide meaningful feedback for busy clinicians. The absence of a formal structure and consistent engagement contributed to weak escalation pathways, reducing the visibility of front line concerns at Board level.

Recent evidence confirms that Safety Champion meetings at NUH have been stood down at times, highlighting ongoing fragility in the role's implementation. However, the Trust appears to be actively strengthening the function through several targeted measures. Proposed actions include moving meetings to a bi-monthly schedule, avoiding school holiday periods, enforcing a deputising system to maintain consistent attendance, improving evidence logging (including minutes from walkarounds), and conducting a formal review of the terms of reference to align with the MIS toolkit and technical guidance. Collectively, these steps aim to ensure that Safety Champions provide the 'golden thread' linking bedside care to Board-level accountability, reinforcing staff engagement, formal escalation pathways, and the delivery of safer maternity services.

Staff reported that these changes improved engagement and confidence in escalation:

"We are starting to feel heard, and concerns are escalated appropriately." (2024)

Non-Executive Directors (NED) also observed the impact at board level:

"Now, we're maturing in that we've got structures in place at the right level with people dealing with the right level of detail, and then an escalation process that brings it up another level." (2024)

These measures are now beginning to embed the role of Maternity Safety Champions at NUH as a 'golden thread' linking bedside care to board-level oversight, providing a clearer escalation pathway, reinforcing accountability, and supporting continuous improvement.

Another key role through the Trust is the Freedom to Speak up Guardians, supporting staff with raising concerns if they do not feel safe to do so through traditional management structures. Accounts express concerns that maternity staff voices are still not heard by management whilst they did not feel able to escalate:

"… had no power to escalate, JD was to listen, support and then back off." (2024)

This demonstrates that whilst roles and positions exist to support staff, meaningful action is not guaranteed.

The evidence in this theme demonstrates that sustained leadership stability, visibility, clear role expectations, and effective oversight mechanisms are foundational to rebuilding trust and embedding improvement. Reducing turnover, enabling organisational conditions to support leaders to be visibly present, strengthening induction and mentoring for senior leaders, and Maternity Safety Champions operating as meaningful escalation and assurance mechanisms are therefore central to continued progress at NUH.

2.1 Workforce Pressures in Maternity Services

Alongside the prolonged instability in senior midwifery leadership, workforce shortages placed significant strain on maternity and obstetric services at NUH. Chronic understaffing, particularly on labour wards, meant staff were frequently required to manage multiple women in labour with limited support. This created sustained physical and emotional fatigue and left staff struggling to provide care safely and consistently.

The risk register demonstrates a sustained pattern of workforce pressure within maternity and obstetric services from 2017 onwards. While individual risks were periodically closed and re-opened under revised descriptions, this reflected an ongoing and recognised challenge rather than resolution. Clinical leaders were operating for prolonged periods within an environment of acknowledged staffing risk, with mitigations insufficient to deliver sustained improvement.

Staff members expressed:

"Up to 2016, no strategic planning for the number of women or the level of need… Staff were permanently tired. Many welcomed the CQC report in 2020 because they felt someone was finally listening." (2024)

Minuted discussions about midwifery shortages occurred, however, there was no clarity regarding escalation and if posts were recruited to:

"Risk register was not properly processed… midwifery staffing was a Divisional risk but then got subsumed within nurse staffing as a trust wide risk and never got properly dealt with… Seemed to be no will to solve it". (2024)

Staff accounts illustrate the human and professional impact of these pressures. Midwives described the emotional strain of delivering care in understaffed environments where competing demands were constant:

"We're still dealing with high stress and long hours. There are shifts where I don't feel like I can give patients the care they deserve because the team is stretched so thin. It's hard to stay positive when you're constantly short of staff and morale is low." (2024)

Reliance on temporary measures over a prolonged period of time including frequent use of agency staff, redeployment to other wards, and short-term was described as unsustainable and contributed to ongoing cycles of instability and pressure:

"Service is understaffed and skill mix is poor… now shifts are depleted every day, and there are requests for people to work extra shifts. Midwives are on their knees." (2024)

Accounts from families over a prolonged period of time illustrate the real-world consequences and impact of staff shortages, highlighting how inadequate staffing affected both their care experience and patient safety. Women described feeling left alone or neglected, sometimes left with a full urinary catheter bag and having to call out for help while staff were too busy to respond. One woman recalled:

"I remember being left with a catheter with a full bag. No one could relieve me of the burden of the catheter." (2013)

Others described feeling unwelcome or ignored because the unit was overstretched, leaving them to manage their own care while staff prioritised other urgent demands. Many women reported not being offered medication, not being assisted to the toilet after an epidural, and a sense that everything was out of control. One noted:

"No one helped me to the toilet, no one said that I needed to pass urine within a certain time otherwise I'd have my catheter put back in or anything like that." (2022)

Others described staff reactions as dismissive: "Like eye-rolling, huffing, very common… they seemed very inconvenienced by coming to me." (2023)

These reflections demonstrate the profound effect that workforce shortages have on the women and families receiving care, leaving them distressed, isolated, and unsupported throughout their maternity journey.

2.2 Workforce Pressures in Neonatal Services

Neonatal services at the Nottingham University Hospitals NHS Trust provide Level 3 neonatal care for babies requiring intensive, high dependency and special care. During the period of this Review services were provided across neonatal units at Queen's Medical Centre and Nottingham City Hospital. Since December 2024, neonatal intensive care has been centralised at Queen's Medical Centre, with City Hospital operating as a Local Neonatal Unit

Neonatal staff experienced similar workforce pressures to their maternity colleagues, particularly in intensive care units where high-acuity babies require one-to-one care. Chronic staffing shortages, combined with increasing clinical demands, created an environment in which staff were frequently forced to prioritise the most essential tasks over comprehensive care. Nurses reported that daily workloads often exceeded safe staffing levels:

"Most days we are under-staffed, and there is a strong urge to look after our patients' essential needs." (2022)

Others described raising concerns without meaningful resolution:

"We had 9 babies assigned to one nurse, I raised concerns through Datix, but nothing was done." (2022)

Another account captured the cumulative effect:

"It feels desperate down there, everyone is up against it all the time… we can't do quality care anymore, it just feels like extra work at this point." (2022)

These pressures were compounded by a long-term reliance on agency staff to maintain minimum staffing levels. While necessary, the issues regarding the employment of temporary staff are well known. They are often less familiar with local procedures and escalation pathways, creating additional risk. In the unit resident doctors frequently managed critical decisions without immediate on-site consultant support, particularly overnight. One staff member explained:

"You only have a SHO there as the consultant is on the phone, but not there overnight. They will come in if you need them. The support is not there physically compared to other units." (2022)

While most consultants were described as approachable and supportive when present, variability in availability and responsiveness (particularly out of hours), highlighted challenges in clinical leadership and oversight. On some occasions, consultants were unable or delayed in attending urgent situations, leaving junior staff to make critical decisions independently. These instances demonstrate that consistent senior presence and timely leadership input are essential to support junior staff, maintain confidence in decision-making, and provide effective clinical oversight, even when direct clinical intervention is ultimately required.

The emotional and physical toll of these pressures was profound. Staff described persistent fatigue, frustration, and professional strain:

"...but the workload is getting to such a level that people cannot do any more." (2022)

"We live on our nerves, it's not healthy." (2022)

Another observed:

"(Trainees are) getting burnt out and crying in the coffee room. They are not comfortable looking after babies out of hours with so much less support." (2022)

Persistent workforce shortages, coupled with inconsistent senior presence, contributed to ongoing risk and burnout, with staff continually stretched to meet safety and quality standards.

These experiences are reinforced by wider workforce and culture data. The National Perinatal Culture and Leadership Programme (PCLP) culture survey for NUH in March 2024 highlighted significant strain within neonatal teams. Improvement readiness was low, particularly among neonatal junior doctors (45%) and neonatal nurses (33%). Of those responding (42% of all staff), burnout was reported by 100% of neonatal junior doctors, 94% of nurses, and 88% of consultants, reflecting sustained workload pressure and limited capacity. Only 36% of junior doctors and 31% of nurses reported they were emotionally thriving, and perceptions of a positive safety climate were particularly low among nurses (22%), underscoring the impact of workforce strain on wellbeing and patient safety.

The General Medical Council (GMC, 2025) survey[241] data confirmed these pressures. Neonatal resident doctors at NUH consistently reported high workload and concerns about rota design affecting education and work-life balance, significantly below the national average. Clinical supervision and senior clinician support, particularly out of hours, scored below average in 2022. Although this measure returned to the national range by 2025, other indicators of satisfaction, handover quality, access to experience, and local teaching deteriorated with multiple outliers.

Taken together, staff testimony and national survey data present a consistent picture of neonatal services under sustained workforce pressure, characterised by staffing shortages, reliance on temporary cover, and variable senior presence. These conditions increased risk, placed disproportionate responsibility on junior staff, and contributed to widespread fatigue and burnout, highlighting the critical importance of robust staffing models, timely consultant input, and consistent support for front line teams.

2.3 Operational Leadership and Escalation

The Labour Ward Coordinator (LWC) is the senior midwife responsible for maintaining continuous oversight of the labour ward and, out of hours, acts as the senior maternity clinician on site with overall responsibility for coordinating the unit. The role is supernumerary and should be allocated in advance on the roster. It is designed to provide visible clinical leadership, support the multidisciplinary team, and maintain real-time situational awareness, with responsibility for escalating any clinical concerns to the wider MDT. While the LWC provides overall coordination across the maternity unit, including liaison with antenatal, postnatal, and neonatal areas, they do not have direct, continuous presence in every area simultaneously; instead, they oversee the service and ensure appropriate escalation and delegation to other senior staff as required.

At NUH, workforce shortages and high workload created significant challenges, as a result labour ward coordinators frequently lost supernumerary status and were drawn into direct clinical care, limiting their capacity to oversee the clinical activity, manage risk, and support junior staff. One former coordinator reflected: *“I would look around and with so much going on I would think I don’t really know how to manage this safely”.* (2017)

Staff further reported variability in labour ward coordinator’s behaviour. While some were supportive and approachable, others were described as intimidating, unapproachable, or inconsistent, with direct implications for escalation and patient safety:

“Some people aren’t willing or able to escalate concerns to coordinators as they are scared of them.” (2024)

During periods of high acuity, junior midwives and Band 5 staff reported to the Review Team they were frequently left to manage complex workloads without adequate support. A culture of hierarchy and superiority among some coordinators further limited psychological safety, discouraging escalation. Staff observed that outcomes for women and babies were directly affected by who was coordinating at the time, reinforcing the importance of consistent, capable leadership (also MSB Report 2018).

241 General Medical Council (GMC) National Training Survey 2025 (published 15 July 2025- could you add to the references and a number please

Matrons frequently described difficulties escalating concerns beyond their level of authority. One leader reflected that when issues exceeded their remit, they faced significant barriers in engaging senior maternity colleagues.

This mirrors the experiences of the Freedom to Speak Up Guardians and the staff themselves. These limitations created frustration and hindered timely responses to operational and safety issues, demonstrating ongoing challenges in relationships and communication within the maternity team, impacting culture.

In response to the 2020 Care Quality Commission (CQC) inspection findings and subsequent regulatory action, Nottingham University Hospitals NHS Trust implemented a maternity improvement programme to address staffing, leadership, and governance concerns. As part of this programme, initiatives introduced in 2021 aimed to support patient flow and staffing pressures across City Hospital and Queen's Medical Centre, including cross-site measures to improve coordination and oversight. Whilst subsequent inspections in 2022 and 2023 continued to highlight areas for improvement, inspectors did not explicitly attribute improvements to these initiatives.

Care Quality Commission inspections provide independent, external review of services across the five domains: Safe, Effective, Caring, Responsive, and Well-Led. Well-Led inspections in 2023 reported progress in leadership visibility, staffing review processes, and escalation mechanisms, and the overall rating for maternity services improved from Inadequate (2022) to Requires Improvement (2023). Midwifery Managers were observed actively monitoring workloads and adjusting skill mix to maintain safe care, reflecting strengthened operational oversight. (CQC, 2023)

However, despite these documented improvements, the CQC's most recent inspection (published 2026 following a 2025 inspection) continued to identify concerns relating to leadership visibility and support. Inspectors noted that leaders were not always visible or consistently supportive, learning from incidents was not always shared, and some staff did not feel confident that concerns would be acted upon. (CQC, 2026)

This aligns with staff feedback during this period, which indicate that challenges remain in leadership culture and behaviours, influencing the effectiveness of operational leadership and escalation processes. Reported themes included variability in leadership visibility, approachability, and responsiveness, alongside perceptions among some staff of hierarchical behaviours. These factors are recognised to affect psychological safety and can influence the extent to which staff feel able to escalate concerns or seek timely support.

Taken together, this evidence suggests that, although formal processes and oversight structures have improved, operational leadership and escalation have not consistently functioned as intended, indicating that further attention to leadership culture and behaviours is required as of the time of the most recent publication (CQC 2026).

In Spring 2024, the NUH Labour Ward Coordinator (LWC) Handbook was created in alignment with the principles of the NHS England Labour Ward Coordinator Framework (November 2023), and printed copies were made available on both labour wards. The LWC framework was launched at NUH in Summer 2024, with Labour Ward Coordinators participating in four structured development sessions designed to support implementation of the framework principles.

Sessions focused on knowledge development, operational management, quality and risk systems (QRS), and leadership, alongside an introductory session using SEIPS (Systems Engineering Initiative for Patient Safety) methodology to explore escalation and diversion processes, and support wider culture development linked to key competency areas. Self-assessments from the national framework pack were utilised to inform these sessions, structured around the six competency domains outlined within the framework.

Newly appointed LWCs receive four weeks of supernumerary practice on commencement of the role and attend monthly support meetings with the Matron during their first six months, to consolidate leadership, operational, and safety responsibilities. These initiatives reflect the standards set out within the framework,

which advocates for a standardised national approach for midwives coordinating delivery suites. The framework highlights the importance of clinical competence across complex maternity care, data-driven risk management, using tools such as maternity dashboards, continuous staff education and development, and clear multidisciplinary communication to support safe and effective care for women and families.

Despite these measures, the May 2025 inspection, published in March 2026, continued to rate the service as Requires Improvement for being well led, indicating that challenges in operational leadership and escalation persist. Staff described ongoing difficulties in raising concerns, particularly when issues exceeded their immediate remit, with limited confidence that their input would lead to meaningful change. These findings highlight the complexity of sustaining visible, relational, and responsive leadership within maternity services and Trusts, even when improvement initiatives are in place.

2.4 Medical Staffing and Obstetric Workforce

Operational leadership challenges were described from a medical perspective, particularly where staffing instability increased reliance on senior clinical decision-makers at short notice. Consultants reported being required to provide additional resident cover while simultaneously managing complex clinical risk, gap-filling, and escalation responsibilities. Anaesthetic colleagues highlighted the wider system impact of rota fragility and staff stress, emphasising that improving escalation and operational leadership requires consistent multi-professional leadership capacity, clear decision-making routes, and reliable follow-through across disciplines.

Across obstetric services at NUH, clinical demand exceeded available workforce capacity over several years up to and including 2024. Staff reported that temporary measures, including consultants covering resident shifts, agency doctors, and enhanced overtime rates were used to maintain service delivery, but these approaches were inconsistent, unsustainable, and often subsequently withdrawn, eroding goodwill and staff morale. Throughout 2024, obstetric staffing issues were repeatedly escalated to the Board, with reassurance that mitigation through additional shifts and locums was maintaining safety. These pressures were a persistent feature of day-to-day practice, shaping clinical leadership, decision-making, and risk management, and contributing to a sense of inevitability about working in a short-staffed environment and the long-term reduction in system resilience. One staff member told the Review Team;

“Midwives and doctors at NUH have known for as long as I have worked at this Trust that there are not enough staff… morale is low. We are tired of finding work incredibly stressful, not getting breaks, being rushed, being overwhelmed and having to compromise on the quality of care we would like to provide due to sheer workload and pressure to complete more tasks than are physically possible.” (2024)

Within obstetrics, rota gaps at consultant and middle-grade level were a recurrent feature, with direct implications for supervision, continuity, and senior decision-making at the point of risk.

“Currently: rota gap and terrible sickness rates mean 4 or 5 out of hours shifts a week have no registrar or senior registrar, so consultants must be resident on-call… It’s now a regular occurrence that you have to stay in because there isn’t one of your junior staff.” (2024)

Consultants described this pattern as ‘safety-net leadership’, where senior presence was used to manage immediate risks rather than supporting proactive workforce planning

Doctors of all grades described the impact of the reduction in the medical workforce, and the impact of the emotional and physical strain of managing multiple women on labour ward, traumatic clinical events, and significant clinical decision-making without sufficient staffing or senior support. Reliance on short-term staffing solutions proved insufficient to address cumulative pressure, contributing to staff fatigue, distress, and concern about patient safety:

“After the CQC rated the service inadequate… we were 14 consultants short. High rates of stress, sickness, workload and investigations persist.” … “There were times when I would have to manage multiple deliveries at once… You are constantly juggling, and that takes a toll… When staff are exhausted, the risk increases, and everyone feels it, especially the women we care for.” (2024)

Anaesthetic colleagues further highlighted the wider system impact on the obstetric workforce:

"Whilst the obstetric workforce has grown, many are currently off sick with stress, and there is always a shortage — always struggling to cover the rota. It feels like we're in crisis management all the time." (2024)

Staff described how this affected the care experienced by women and families, resulting in a lack of continuity, inconsistent advice, and reduced confidence in their care plan. One family described feeling

'pushed from pillar to post with locum consultants and different healthcare practitioners' and felt increasingly isolated as the pregnancy progressed: "…as the pregnancy progressed, I was just told, 'If there are any issues or problems, you make the decision to come to the hospital and you will be monitored'… once the blood loss started… I just felt very left and very isolated… I wasn't getting any answers… it wasn't enough, she wasn't there enough and a lot of the time, I just felt very isolated and left". (2015)

National surveys of resident doctors undertaken between 2022-24 by the GMC[242] showed areas of underperformance for NUH relative to the national picture in key areas including clinical supervision out of hours, supportive environment and reporting systems. These findings did not warrant enhanced monitoring from the GMC; however, they link to the key issues of culture and safety for those in learning position within the Trust.

Lengthy recruitment processes compounded these challenges. Staff described recruitment as slow, fragmented, and constrained by financial gatekeeping, making it difficult to appoint the required number of doctors and senior staff. Locum doctors were unfamiliar with local systems and pathways, which placed additional supervisory responsibilities and risk management burden on substantive staff. Communications regarding workforce planning, rota changes, and operational decisions were frequently described as poor and inconsistent.

Review Team leadership interviews and staff feedback both confirmed recognition of the importance of workforce establishment reviews, staffing calculations, and improved workforce modelling to reflect evolving service complexity. Risks were repeatedly formally escalated but not consistently resolved; this contributed to increasing disillusionment and reduced confidence that raising concerns would result in meaningful change. Workforce instability was not experienced solely as an operational challenge; multiple staff accounts indicate it was also shaped by leadership behaviours and decision-making processes, including how concerns were raised, prioritised, and acted upon. Collectively, this demonstrates that sustained obstetric and medical staffing shortages, coupled with inconsistent or absent senior leadership, affected the ability of teams to maintain safe, high-quality care, undermined staff confidence, and hindered timely escalation of clinical concerns.

2.5 Retention and Workforce Sustainability

As with many maternity units nationally, NUH has faced challenges not only in recruitment but increasingly in staff retention. Midwifery workforce recommendations arising from the Birthrate report produced in February 2023 have been fully implemented. National guidance recommends a full Birthrate Plus review is undertaken every three years; a review is currently underway. However, the national review report of Birthrate Plus, published this year (2026) highlighted significant areas of improvement for the tool to strengthen midwifery workforce planning in the current climate.

There is however a significant number of midwives leaving the profession with many experienced midwives retiring. In response, NUH introduced a range of initiatives aimed at improving workforce stability and retention. These included enhanced pastoral and mentorship support for midwives, the introduction of Professional Midwifery Advocate (PMA) roles, leadership development programmes aimed at mitigating burnout, flexible working arrangements, and role diversification to retain experienced staff, particularly those approaching retirement. The workforce matron role also focused on strengthening support for staff joining the service, including structured onboarding, enhanced preceptorship programmes, and additional preceptor capacity to support large cohorts of newly qualified Band 5 midwives.

242 General Medical Council (GMC) National Training Survey 2025 (published 15 July 2025

Staff reported improvements in organisational culture, leadership visibility, and involvement in decision-making:

"Seen a big and positive change in midwifery management… younger more enthusiastic people into managerial posts, they are liked and respected and more open to collaboration." (2024)

These initiatives aligned with CQC Well-Led recommendations that trusts should ensure sufficient staffing, support staff wellbeing, and maintain effective communication between teams and leadership. Despite these developments, staff turnover remains high, and the service is not always able to meet operational needs due to staffing shortages. The most recent CQC report (2026) noted that consultant vacancies were 20.91% and midwifery vacancies 13%. Although recruitment plans were in place, they were not fully implemented at the time of inspection, resulting in some gaps in skill mix and challenges in providing consistent supervision.

This finding is consistent with the NHS Staff Survey 2024 at Nottingham University Hospitals NHS Trust, where 82 per cent of staff reported that staffing was inadequate to ensure safety and 60 per cent reported regularly working beyond contracted hours. Staff testimony continued to illustrate sustained operational pressures. One midwife stated,

"Lack of staff is demoralising; it's been like that for six years." (2024)

Another reflected on the use of temporary staff, noting:

"We had quite a lot of agency staff in the past, but this has reduced recently; now there are only the occasional agency midwives, not as much as a year ago." (2024)

These experiences are consistent with CQC findings (2026), which observed that midwifery staffing was carefully monitored and supported, with bank and agency staff used as necessary, though reliance on temporary staff had decreased in recent months.

While there is evidence of progress and some improvements in leadership visibility, staff support, and organisational culture, persistent workforce instability continues to limit leadership capacity and shift the service into reactive management rather than sustained strategic improvement. Ongoing challenges in recruitment, retention of experienced staff, and succession planning compromised long-term stability and staff confidence. Protecting operational leadership roles, establishing a clear obstetric medical staffing resilience plan, and strengthening recruitment and onboarding processes are therefore necessary to restore resilience and reduce risk.

Theme 3: Culture and Compassion

3.1 The importance of culture in maternity and neonatal services

There is increasing evidence that the culture within a perinatal service is inseparable from the quality and safety of care. Culture is complex and multifaceted, shaped by shared values, beliefs, norms and behaviours and expressed through day-to-day interactions between staff and with the people they care for. It influences decision-making, psychological safety, learning and response to risk. Culture also originates from the wider organisation, aligning to the Trust values and strategy but also leadership behaviours. Evidence throughout this chapter highlights the wider organisational impact to local culture.

The 2024 CQC National Review of Maternity Services[243] references that a good and healthy culture in maternity services where staff feel supported and empowered can lead to improved staff retention and ensure high-quality, safe care for people. It draws attention to national reviews where poor culture has been identified including, defensiveness, failure to listen to staff and women, denial, hierarchy and poor team working (Ockenden 2022, Kirkup 2022).

243 https://www.cqc.org.uk/publications/maternity-services-2022-2024

Similar patterns of cultural and leadership challenges were observed at NUH during the review period. The trust sought to understand these challenges through a series of commissioned culture reviews, summarised in Box 3.

These reviews repeatedly highlighted negative behaviours, low morale, and limited staff support. Evidence of discussion and action plans at divisional level was noted, suggesting early attempts to address these issues.

Box 3. Culture reviews of NUH during The review period

- Brown (2016) External Review of Maternity Unit, City Hospital
- MSB Consultancy (2018) Performance Audit of Maternity services at NUH
- Pascal Metrics (2018) Safety Climate Survey
- Ibex Gale (2022) Independent review into the culture within the Neonatal service at NUH
- Safety, Communication, Operational Reliability, Engagement (SCORE) (2018, 2024) nationally supported culture survey of maternity services

These local report findings are corroborated by CQC inspections in 2020, 2023 and the most recent inspection of 2025 published in 2026, which noted ongoing challenges with leadership visibility, responsiveness and support, even as the overall culture was improving (CQC, 2026).

Due to the significant impact of culture on patient care specifically in relation to maternity services, NHS England delivered the Perinatal Culture and Leadership Programme (PCLP), which NUH undertook. Launched in 2022, the programme aimed to strengthen safety and quality in maternity and neonatal services by providing training for senior leadership ‘quads’ to foster psychologically safe, inclusive, and compassionate cultures. It also supported trusts to undertake a follow-up culture survey in 2024 which NUH undertook. While measurable impact is limited by the long-term nature of cultural change, the programme provided a structure and support for improving leadership behaviours and embedding a more positive safety culture across the trust.

3.2 Mergers of Units and the Impact on Culture

During the course of the NUH review, staff across maternity and neonatal services described experiences shaped by long-standing cultural challenges, including hierarchy, bullying, and poor psychological safety. Many attributed these issues to the 2006 organisational merger of the two maternity units, which brought together two very different services and cultures.

The challenges of bringing together two large maternity and neonatal services led to a perceived superiority complex for some staff working in more critical areas of the service. Staff described to the Review Team this persistent perception of superiority and entrenched interpersonal behaviours, as being known to senior Trust committees but with little or no action, resulting in undermined trust and cohesion.

Staff suggested the merger had a lasting human impact on the emotional experience of identity and belonging, and led to perceived power differences between sites. Some described the persistence and tribal identity of ‘team City’ and ‘team QMC’ and the sense that professional credibility and influence was unequal and dependent on where someone was based or trained.

“Historically culture at City very hierarchical and cliquey… People are either team City or team QMC.” (2024)

In that context, change was not only operational; it could be felt as loss of familiarity, anxiety about ‘being taken over’, and uncertainty about whose norms would become the standard. These under-recognised human dynamics help to explain why behaviours, escalation, and multidisciplinary trust were sometimes

fragile, particularly when workforce pressure intensified and teams were forced into cross-site working without the relational foundations that could have contributed to a safe integration of the two units.

The senior maternity team reportedly held a service vision but it was not widely disseminated. External feedback at several points during the review period recommended a clear vision and strategy be developed with policies on values and behaviours. The Local Maternity Neonatal System (LMNS) had a vision for maternity services which was aligned with the national priorities, however this was not replicated at NUH organisational level. The 2022 neonatal culture review of the service similarly highlighted the absence of a neonatal strategy, reinforcing that organisational culture and vision remained inconsistently embedded across perinatal services. There has since been collaborative work from this report across maternity and neonatal services with an action plan. Staff voices during the Review did not refer to or recognise a sense of shared vision and the team confirmed that this is still an outstanding action.

3.3 Embedded Negative Behaviours and Cultural Norms

NUH has undergone several external reviews (Box 3) over a prolonged period of time which found negative behaviours and unacceptable cultural norms, including persistent bullying, nepotism, aggressive behaviour, patterns inconsistent with professional values and compassionate perinatal care.

One external review of maternity services was commissioned to address issues between clinical staff and managers (MSB report 2018). This was described by staff as a 'last throw of the dice' as staff felt that this had been undertaken previously which 'did not lead to positive, lasting change' (MSB 2018, p4).

These concerns were expressed within the neonatal workforce through the external culture review which included 22% of the staff at the time (Neonatal culture review Ibex Gale 2022)[244]. These one-to-one interviews yielded vital insights. The report highlighted a lack of support for junior staff, inequitable managerial treatment, resulting in high sickness and turnover of staff. Themes around poor leadership and management behaviours (points 29.17,53.5, 55.6, 55.9, 2022), the need for belonging (points 45, 45.3, 46.6, 51.1 101.6 in report 2022) and to prove oneself clinically (46.6, 46.3, 2022) was very similar to concerns expressed by maternity staff to the Review and in external reports (box 3).

During this Review staff described 'tribes' and divisions between clinical areas, leading to poor collaboration and safety. Psychological safety has also been compromised, with staff feeling fearful of making mistakes or raising concerns. One previous staff member expressed:

"Work environment was terrible and scary… had no confidence concerns would be supported." (2024)

Staff described their experience whilst working on the labour ward, where Band 7 coordinators were described as dismissive, punitive, and unapproachable. This, created a culture of fear among both junior and senior midwives. Staff further reported unsafe allocations of clinical cases, including newly qualified staff being allocated complex midwifery cases without supervision. Staff referred to these behaviours as the 'Toxic Combo', linking them directly to compromised safety:

"People were scared of the coordinators… unfair caseloads and favourites. Raised bullying through DATIX – pressurised to withdraw". (2024)

Others described how

"Junior staff left to sink or swim". (2024)

The findings from the 2024 culture survey demonstrate a continued overarching negativity regarding the perinatal culture at NUH. These indicators of personal burnout, poor team working and safety alongside staff experience interviews are consistent with national patterns. A 2025 survey by the Nursing and Midwifery Council found that 70% of respondents reported bullying or harassment, with almost a third witnessing situations where patient safety or care was compromised.[245] This alignment highlights the long-term and widespread impact of culture on staff wellbeing and care quality, both locally and across the profession.

244 Ibex Gale Ltd 2022. Nottingham University Hospitals Trust Neonatal Culure Report; [Unpublished Report]

245 Nursing and Midwifery Council (2025) Spotlight on nursing and midwifery: insights from the NMC register and professionals survey. London: Nursing and Midwifery Council. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/insight-spotlight/2025/spotlight-report-2025.pdf

Staff also described not being able to provide appropriate care to the level expected by guidance and their own professional conduct, with many of those speaking to the Review having left the service. These examples demonstrate the interplay between organisational culture, staff wellbeing and care quality.

The culture is experienced by everyone, service users and those working within it. Some families that spoke to us over the course of the Review were very aware of the systemic culture issues at play through their own negative experience and outcome:

"…points to loads and loads of problems behind there which is the culture and which is systemic and the hardest thing to get which means it wasn't just us but was so deep rooted". (2019)

3.4 Compassion Fatigue and Impact on Patient Care

Compassion fatigue in maternity care has been described as a state of emotional, physical, and functional exhaustion among midwives, which is driven by high-stress, emotionally demanding environments and repeated exposure to traumatic childbirth or pregnancy loss. This in turn can lead to a reduction in empathy, leading to lower quality care and potential patient trauma, it can affect up to 77% of staff at moderate-to-severe levels (Liu et al 2025).[246]

Box 4. Key Aspects of Compassion Fatigue in Maternity[247]

- Symptoms: Emotional exhaustion, reduced empathy, 'zombie-like' detachment, and decreased job performance.
- Causes: High workload, emotional strain from 'energy-consuming' patients, fear of errors, and lack of support, particularly when managing traumatic births or loss.
- Impact on Care: Negatively impacts patient safety and quality of care, with 10% of women reporting negative, impersonal childbirth experiences.
- Consequences for Staff: High turnover rates, burnout, PTSD, and a desire to leave the profession.

A culture of compassion is fundamental to safe maternity care. Compassion fatigue, distinct from burnout and vicarious trauma, arises from repeated exposure to distress within caregiving relationships. Multiple staff accounts suggested emotional withdrawal, desensitisation, defensiveness or distress among staff, impacting on patient care and the experience of women:

"On my second day, a consultant joked to the co-ordinator about 'breaking me in' – and they just laughed. I remember thinking, what have I done?". (2024)

"A lot of people were frightened to speak up because they weren't sure they'd be supported and feared ending up with more work or responsibility. It felt defensive, but I understand it was due to exhaustion and being overworked." (2024)

Many of the service user voices express similar experiences and feelings around being 'a burden' and could see that the impact to them was less compassionate care. Others experienced this in intimate examination situations where withdrawal of consent was not acknowledged and procedures were not stopped. These interpersonal dynamics are known to impact the rates of birth trauma which currently sit at

246 Liu, S., Han, H., Athurupana, R., Yang, T. and Nakatsuka, M. (2025) 'Compassion fatigue and compassion satisfaction among nurses/midwives caring parents with pregnancy loss or infertility: a cross-sectional study', Frontiers in Public Health, 13, p. 1668647. doi: 10.3389/fpubh.2025.1668647.

247 Vandekerkhof S, Malisse L, Steegen S, D'haenens F, Kindermans H, Van Haeken S. Providing Compassionate Care: A Qualitative Study of Compassion Fatigue Among Midwives and Gynecologists. Healthcare (Basel). 2025 Nov 14;13(22):2908. doi: 10.3390/healthcare13222908. PMID: 41302296; PMCID: PMC12652111.

approximately one in three of all birthing people in the UK and a longer term post-traumatic stress disorder (PTSD) rate of 4%.[248,249]

3.5 Emerging Cultural Shifts

Work on changing and improving the culture within the maternity service is evident from 2021, when NUH implemented measures to strengthen listening, accountability, and staff engagement. These included regular review of Freedom to Speak Up reports, Datix insights, staff surveys, and quarterly Listening Forums led by the Director of Midwifery. This has resulted in staff reporting:

"A lot of positive changes in the last two years...consultants more approachable, less incivility. The Organisational Development (OD) consultant has been amazing". (2024)

The investment in OD support has been positively highlighted throughout the interviews with staff members and structures supported by national programmes such as the Perinatal Culture and Leadership Programme (PCLP) which have continued to strengthen the multi-professional leadership approach.

Since 2022, regional patient safety programmes have been available to support culture work including 'culture coach' and 'moments' training for the Trust. Of the senior midwifery and medical leaders, a total of 26 staff attended one or more of these offers. Measuring impact from this is difficult given the nature of culture, there was no overt data to review in relation to these programmes.

The forthcoming (expected 2026) national trauma-informed care (TIC) training programme from NHS England presents an opportunity to further embed psychologically safe, compassionate, and relational leadership practices across maternity and neonatal services.

While recent interventions are described as beginning to positively impact upon the culture, improving leadership visibility, listening, and civility, there is still improvements to be made as demonstrated by the CQC (2026), family and staff interviews and cases. The evidence across both maternity and neonatal services demonstrates that organisational culture is a key determinant of safe, compassionate care, and that where psychological safety is compromised, escalation, teamwork, learning, and compassion are weakened. Areas of significant negative culture within a Trust also correlate and indicate concerns about the wider organisational culture.

Continued focus on restorative practices, clear behavioural standards, strengthened routes for raising concerns, and visible leadership accountability for culture is therefore essential to achieving sustainable improvement.

Theme 4: Training, Mentorship and Development

4.1 Lack of Structured Development and Training Programmes for Leadership Preparation

A lack of structured leadership development was identified by staff within NUH maternity and neonatal services until very recently. Staff seeking to develop into leadership roles frequently faced limited or no access to mentorship and role models. Furthermore, career progression often relied more on personal networks than on formalised development initiatives with staff reportedly unclear on opportunities and processes.

Clinicians were promoted to managerial positions with limited clinical and leadership experience. Senior Midwifery roles, such as matrons and consultant midwives, did not receive any structured development or training programmes resulting in reliance for 'on-the-job' learning without sufficient support. This lack

248 Patterson, J., HollinsMartin, C. and Karatzias, T. (2019) 'Disempowered midwives and traumatised women: exploring interactions contributing to PTSD postchildbirth', Midwifery, 76, pp. 21–35. doi: 10.1016/j.midw.2019.05.010.

249 All Party Parliamentary Group on Birth Trauma (2024) Listen to Mums: Ending the postcode lottery on perinatal care. London: AllParty Parliamentary Group on Birth Trauma. Available at: https://www.theo-clarke.org.uk/birth-trauma-report

of formal leadership training left leaders unprepared when managing conflict, supporting team wellbeing, or cultivating a positive organisational culture. For many individuals, learning functioned primarily as an employment requirement rather than a developmental and safety process.

Despite this lack of organisational training and support there has been an increase in the number of senior and specialist roles. Since 2023 there has been specific organisational development (OD) involvement for maternity which has acted to develop and support staff from a leadership perspective, whilst there is now a corporate Trust leadership programme demonstrating the progress.

There has also been a reintroduction of mentorship structures to support emerging leaders within the workforce at the Trust. This is especially important for Band 7-8 staff, who often faced challenges in managing both the operational and interpersonal aspects of leadership. The mentorship programme, designed to help new leaders cultivate both clinical and emotional intelligence, will be crucial for developing compassionate leadership practices at all levels.

A senior leader reflected positively on the change:

"the introduction of mentorship has been a game-changer. Having someone to guide me through the challenges of leadership has been invaluable". (2024)

This programme marked a significant departure from previous years, when leadership roles were often filled without the necessary support for personal and professional growth. With a renewed focus on coaching, staff reported an increase in confidence, and a stronger culture of collective learning has begun to emerge. One midwife noted:

"I didn't feel alone anymore. I had someone to turn to for advice and support in the tough moments. That made all the difference in keeping my team together". (2024)

4.2 Mandatory Maternity Training and the Challenges

Mandatory maternity training for NHS staff includes essential, often annual, updates in clinical safety, safeguarding, infection control, and resuscitation to ensure patient safety and regulatory compliance. Key components include PROMPT training (Obstetric Emergencies), fetal monitoring and Neonatal Life Support (NLS) which are required as part of the Maternity Incentive Scheme (MIS) alongside other elements recommended for maternity staff but not mandated from the Core Competency Framework Version 2 (CCFV2)[250] from NHSE (2023).

During the initial stages of the review period until 2021 some staff perceived mandatory maternity training as part of a punitive culture rather than as a supportive mechanism for professional development, and so contributing to the safety of mothers and babies.

One staff member reflected:

"But it did feel like that was used as a stick to beat midwives with, and kind of, to absolve the Trust of liability. Quite often the message would be, well, you're up to date with your training, you know, you've had the information and you haven't used it… never put in those terms but that was the message that was being communicated". (2024)

The Maternity Incentive Scheme (MIS)[251] is a financial incentive programme designed to enhance maternity safety within NHS Trusts. It refunds the Maternity Incentive Scheme payment made to NHS Resolution for Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns. MIS compliance can be seen as a national indicator of leadership effectiveness.

250 NHSE 2023. Core competency framework version two: Minimum standards and stretch targets. https://www.england.nhs.uk/publication/core-competency-framework-version-two/

251 https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Despite being a mandatory requirement for maternity services and for submission of the (MIS) for Trusts, staff reported not being allocated time to undertake mandatory training which is safety action 8 of the MIS. A staff member, when talking about their fetal monitoring training stated:

"My K2 training was out of date for years. There was no protected time to do e-learning, so I did it when I could, but it was never prioritised". (2024)

There were suggestions that this was further linked to the lack of an established training and development team, which comprised one full time band 7 midwife and part-time practice educators to deliver and have oversight of the mandatory training programme. This led to the non-delivery of the MIS safety action 8 for NUH during three years of the scheme (years 1, 4 and 5):

"So it was undeliverable. We couldn't deliver the framework that we needed". (2024)

The emphasis on compliance over learning may have reinforced a culture in which curiosity, reflection, and shared learning were undervalued.

Staff were frequently recalled to clinical practice when attending a mandatory training day due to staff shortages, it is unclear if these were formal escalation processes, if there was senior involvement in decision-making, or strategies to ensure missed training was rebooked. This was confirmed by the CQC maternity inspection 2025 when inspectors found that not all staff had training in key skills.[252]

4.3 PROMPT & MDT Training

Practical Obstetric Multi-Professional Training (PROMPT) is a national initiative designed to enhance clinical skills, teamwork, and the safe management of obstetric emergencies. Initially efforts to introduce PROMPT to NUH were delayed due to challenges in securing funding from the Trust, as well as initial hesitancy within senior obstetrics and anaesthetic teams, with some senior medical colleagues advocating a locally developed programme. Due to the enthusiasm and drive by midwives who saw the benefits of multi-disciplinary training, it was implemented to good effect.

Staff report tangible improvements in teamwork and safety as a result of these initiatives. One obstetrician noted:

"When we started PROMPT, it was clear the teams didn't know how to work together in a crisis. Now, it's much better. We've had the opportunity to practice, and it has improved our response times and teamwork". (2024)

Feedback from midwives and doctors indicates that PROMPT has enhanced clinical skills, confidence in managing complex cases, and the ability to respond effectively to emergencies, including those outside the maternity unit in collaboration with the emergency department.

Compliance for training as required by MIS has continued to be difficult to attain and maintain with years 1,4 and 5 MIS unsuccessful. This has been largely acknowledged to be linked to resident obstetric rota gaps and periods of reduced workforce issues. The more recent appointment of an education matron has strengthen this programme of work and despite prior difficulties in maintaining a true MDT collaboration, there is awareness that this form a central part of the workforce development plan, reflecting a strengthened culture of learning and shared responsibility.

One of the main aims of MDT training is to become high-performing clinical teams, positively impacting clinical outcomes. Evaluations of team coaching interventions (similar to the PCLP programme) for clinical teams have shown positive impact to both team working and clinical outcomes.[253] This further highlights the need to invest in clinical teams and supports the Trust's investment in OD in recent years.

252 https://www.cqc.org.uk/press-release/cqc-publishes-reports-maternity-services-run-nottingham-university-hospitals-nhs
253 https://healthinnovationwessex.org.uk/img/insights/MatNeo-Coaching-Evaluation.pdf

4.4 Improvements and Developments

During the period of the Review, improvements have been made to strengthen education, training and leadership development within maternity services. The establishment of practice development teams across both sites increased the education team to ten staff under the leadership of an Education Matron with responsibility for practice and clinical education. This has strengthened the focus on professional development, mandatory training, and protected learning time for staff.

In Spring 2024, the NUH Labour Ward Coordinator (LWC) Handbook was introduced in alignment with the NHS England Labour Ward Coordinator Framework (2023), with printed copies available across both labour wards. The framework was implemented at NUH in Summer 2024 through a structured development programme for Labour Ward Coordinators, focusing on leadership, operational management, governance, and safety systems. Newly appointed coordinators receive four weeks of supernumerary practice and participate in regular support meetings with the Matron during their first six months to consolidate leadership and safety responsibilities. These developments reflect the national framework's emphasis on supernumerary leadership, oversight of patient flow and acuity, effective multidisciplinary communication, and strong clinical governance.

Further strengthening governance and learning systems, the Band 7 team at City Hospital are piloting development aligned with the Patient Safety Incident Response Framework (PSIRF).

While there is evidence of improvement in leadership visibility, organisational culture, and training provision, sustained progress depends on protected time and structured development. Ensuring consistent access to multidisciplinary training and safeguarding learning time are fundamental to embedding a culture of continuous learning.

5. Clinical Leadership and Learning

5.1 Missed Opportunities and Emerging Progress

Learning within maternity services depends on leaders who listen effectively, create psychological safety, and respond to concerns with curiosity rather than defensiveness. Throughout the period reviewed, staff and families described a learning environment where these core conditions were often absent. Instead, learning was experienced as inconsistent, fragile, and highly dependent on the behaviours of individual leaders rather than on a shared, embedded culture of quality improvement.

Historically, staff told the Review Team that learning mechanisms were unreliable. Training sessions were repeatedly cancelled due to operational pressure, and feedback after incidents, when given at all, lacked meaningful detail or actionable follow-through. This absence of consistent feedback meant that incidents became treated as isolated events rather than opportunities to understand patterns, learn lessons, and prevent recurrence. Staff described a situation where recurring issues such as communication failures, poor escalation, and dysfunctional teamwork were repeatedly identified but rarely addressed in a sustained way.

This lack of consistent leadership attention resulted in cycles of short-term improvement followed by drift. When teams changed or new initiatives were introduced, previous learning was not retained or built upon. Staff described a sense of "starting again" each time a new leader arrived or an external review took place. Without stable, visible leadership actively closing the learning loop, improvement efforts remained fragmented and reactive. The workforce became accustomed to raising the same concerns repeatedly without seeing tangible action.

Staff also described the emotional impact of working in an environment where psychological safety was limited:

"I feel treated like a number, not a person and I do not feel supported". (2024)

Staff told the Review that at points in the Review timeline escalation sometimes led to criticism, minimisation, or even threat. As one staff member expressed:

"With one Datix I did, I labelled it as high risk and I was told to never use that level of severity again, as it required an outside view, but the Nurse in Charge at the time had agreed with me what the level of severity should be at the time". (2024)

These accounts demonstrate how leadership behaviours directly shaped a climate in which raising concerns and learning was constrained by fear rather than supported by trust.

Families, too, were not consistently included in learning processes. Some reported that their accounts were altered or changed:

I think they tried to cover … there was a lot of things covered up…". (2024)

while others felt their experiences were minimised:

"He did the same as the other meetings, went through all the notes and told us we were talking crap". (2024)

Staff also reported similar concerns:

"MWs were raising concerns that investigations were thwarted or took too long, that families were dismissed". (2024)

This exclusion diminished opportunities to understand the full impact of harm and learn from women's and families' lived experience. However, learning was often unrecognised within the processes which is evident in this family account:

"There has been no learning and no consequence for the Nottingham way of doing things". (2024)

The Review identified gaps in embedding clinical expertise into learning and governance. The consultant midwife role is a key position within maternity service provision, designed to enhance care quality, improve outcomes for women and families, and lead evidence-based innovation and service transformation. Consultant midwives provide clinical leadership beyond traditional management, ensuring that midwifery expertise shapes practice, policy, education, research, and quality improvement. They are also positioned as system-wide influencers, bridging operational care with strategic improvements at local, regional, and national levels. NUH has had two consultant midwives for much of the period of the Review, and one prior to that, whose remit spanned wider strategic programmes, reflecting the wide variation of the role nationally.

The Review found that there was limited visibility and involvement of the consultant midwife role within case reviews, clinical documentation and governance processes. Whilst other senior midwifery managers were employed to lead in these processes, it remains a core function of a consultant midwife to bring clinical expertise, evidence-based care and safety agendas together to improve services and experiences. As a result, the potential for enhanced professional insight, constructive challenge, and a strong woman centred perspective within these processes may not have been fully achieved. The consultant midwife role is positioned as a key bridge between front line care and strategic leadership, ensuring that maternity services are safe, effective, equitable and centred on the needs and experiences of women and families (RCM 2026). This may reflect the way in which the role is being implemented at NUH as is seen across the broader NHS. With its pillars being delegated separately, the impact of the consultant midwife role can become diluted if task focused projects and back filling/supporting for managerial roles prevail.

Learning systems require accessible leadership, structured follow-through, and consistent and meaningful inclusion of staff and families. Strengthening feedback mechanisms after incidents and ensuring a strong clinical voice within governance processes are necessary to embed a durable learning culture.

6. Conclusion and Emerging Progress

NUH maternity services have made measurable progress in leadership, workforce development, culture, training, and learning. The most recent inspection published in 2026 recognised areas of improvement; however, further work is required to embed these changes and ensure they are sustained. While a range of initiatives have been implemented and positive changes are evident, ongoing challenges relating to leadership stability, workforce planning, and organisational culture continue to influence the consistency of care delivery and staff experience. Staff feedback during the review period reflects this mixed picture, describing improvements in leadership engagement and support in some areas, while also highlighting continuing variability in visibility, responsiveness, and confidence in escalation processes.

6.1 Leadership Visibility

Despite deliberate initiatives to strengthen leadership accessibility, variability remains across the service as of the current time. Some leaders are consistently visible, accessible and engaged, supporting staff and reinforcing accountability, while others are less present, limiting the impact of feedback and learning. Initiatives such as the establishment of Maternity Safety Champions, regular Listening Forums, and increased engagement from the Director of Midwifery and matrons have begun to embed a ‘floor-to-board’ line of sight, improving oversight, trust, and escalation pathways. Sustained attention is required to ensure these mechanisms consistently deliver the integrity, visibility, and support that underpin safe, high-quality maternity care.

6.2 Workforce Stability

Workforce stability remains an area of focus across maternity and neonatal services at NUH. Recent inspections published in 2026 recognised improvements in staffing levels, skill mix, and workforce planning, noting that leaders regularly review and adjust staffing to respond to demand and that services have moved forward from earlier inadequate ratings. However, the inspections also identified that further work is required to strengthen staffing arrangements and ensure improvements are sustained. Over a prolonged period, staffing pressures, turnover, and reliance on temporary cover have affected morale, continuity of care, and service resilience. Initiatives such as structured recruitment, enhanced mentorship and support roles, flexible working arrangements, and the establishment of a dedicated workforce matron have strengthened staff support, preceptorship, and retention efforts. Continued focus on recruitment, retention, succession planning, and visible multi-professional leadership will be important to support a stable and sustainable workforce capable of delivering consistently safe, high-quality maternity and neonatal care.

6.3 Culture and Compassion

Culture within NUH maternity and neonatal services has historically been characterised by poor psychological safety, entrenched hierarchical behaviours, and persistent bullying, with long-standing divisions between sites affecting trust, cohesion, and team functioning. These cultural challenges contributed to fear of raising concerns, inconsistent escalation, and impaired learning, while also increasing staff vulnerability to compassion fatigue, a phenomenon that directly impacts empathy, care quality, and staff wellbeing. Recognising these challenges, the Trust has implemented structured initiatives through incorporation of Organisational Development, which have strengthened leadership engagement, promoted psychological safety, and supported team development. While these interventions have begun to foster a more open, inclusive, and supportive culture, staff have told the Review Team that persistent systemic and behavioural issues remain. There is also cause to consider the wider organisational culture as the two are linked with clear reports of similar issues around escalating concerns and not being heard beyond maternity.

Culture is also something that relies on every member of the team, accountability and reflexivity is required alongside the foundations of workforce and time to lead. Continued investment in restorative practices, multi-professional leadership, and staff engagement is essential to embed a sustainable culture of compassion and to ensure safe, high-quality care for women, babies, and families.

6.4 Training and Development

Although notable progress has been made, the decline in confidence and skill development observed between 2017 and 2022 continues to have a lasting effect on the learning culture at NUH. Considerable improvements in team learning and cross-disciplinary training are evident; however, sustained leadership involvement remains essential to preserve dedicated training time develop processes and guarantee consistent mentorship opportunities. This will in turn support achievement of MIS safety action 6 and 8 linked to training.

There is increasing acknowledgement that ongoing investment in leadership development especially for mid-level leaders is vital to foster compassionate leadership practices at every level. This must include ensuring that Band 7-8 staff have access to appropriate training and mentorship to successfully manage both the operational and interpersonal dimensions of leadership and emerging talent programmes to support the identification of the next generation of leaders.

By continuing to invest in structured training, mentorship, and multidisciplinary collaboration, NUH has an opportunity to rebuild trust, improve team morale, and deliver the highest standards of care to women and families.

6.5 Learning and Improvement

Learning within NUH has historically been inconsistent and fragile, highly dependent on the behaviours of individual leaders rather than a shared, embedded culture of continuous improvement. Feedback mechanisms were often unreliable, training opportunities disrupted by operational pressures, and family experiences were not consistently incorporated into learning processes. This environment limited the organisation's ability to retain lessons from incidents, resulting in repeated challenges around communication, escalation, and teamwork. While initiatives such as the establishment of the Flow Coordinator role have strengthened communication and support during peak periods, staff report that gaps remain in embedding clinical expertise into governance and learning, particularly through the consultant midwife role. Opportunities to expand leadership roles, enhance mentorship, and ensure protected time for education and supervision are critical to consolidate improvements. Sustained progress in learning and improvement requires visible, accountable leadership that actively closes feedback loops, prioritises psychological safety, and ensures that lessons translate into enduring changes in practice and outcomes for women, babies, and staff.

NUH maternity services has laid the groundwork and foundations for improvement, but sustained progress relies on stable, visible, and accountable leadership, continued investment in workforce development, and embedding a culture of learning and compassion. Very long-term leadership gaps have had tangible impacts on clinical outcomes and family experiences, underscoring the importance of this work. While numerous local and national recommendations have been made, challenges remain in translating these into sustained change. Ultimately, long-term improvement depends on a secure foundation of workforce stability and structured leadership, upon which NUH can continue to develop safe and high-quality maternity services.

Since 2021, the service shows early signs of positive change. Staff report increased leadership visibility, greater transparency, and more consistent multidisciplinary learning. Incident reviews have become more structured, and cross-disciplinary discussions help teams identify recurring themes. While the service is no longer defined solely by short-term pressures, it remains in transition. For improvement to be embedded it requires sustained leadership presence, consistent follow-through, and a culture in which learning is seen as central and critical to be embedded in everyday practice. Progress is being made, but it must be consolidated over time to fully benefit staff and families.

Addressing Inequalities in Care

1. Introduction

Extensive evidence shows that women from Black, Asian, and other global majority groups, women living in deprivation, and women experiencing wider social and structural disadvantage face higher risks of adverse maternal and neonatal outcomes.[254,255,256,257] These disparities arise not from individual characteristics alone, but from the cumulative effects of structural inequality, differential access to care, baseline health disparities, and barriers to communication and continuity of services.

National surveillance and confidential enquiry data demonstrate persistent differences in outcomes: women from Black ethnic groups are almost three times more likely to die during pregnancy or up to six weeks postpartum compared with White women, while women from Asian ethnic groups experience approximately twice the risk.[1] Women from minoritised and marginalised populations frequently report racism, discrimination, unconscious bias, lack of poor culturally sensitive care, communication barriers, and unequal access to services.[258,259] Migrant women, particularly those with precarious immigration status and those with limited English proficiency face additional barriers relating to interpretation and fear of NHS charging, data sharing and immigration enforcement.[260]

Socioeconomic deprivation further compounds these risks: babies born to mothers living in deprivation areas are more likely to experience stillbirth, neonatal death, preterm birth, low birthweight, and neonatal unit admission, while women living in the 20% most deprived areas are nearly twice as likely to die during pregnancy or postpartum (Felker et al., 2025). These risks are amplified when deprivation intersects with pre-existing health conditions, substance use, housing insecurity, domestic abuse, poor nutrition, or limited social support.[2,261] MBRRACE-UK data show that over 90% of women who died in the UK between 2021-2023 faced multiple, intersecting disadvantages, highlighting how social determinants shape access to timely and effective maternity care.[9,262]

Professional bodies emphasise that maternity services must address the social and structural determinants that drive poor outcomes. Reflecting the latest MBRRACE report, the Royal College of Obstetricians and Gynaecologists[263,264] highlighted that women experiencing the worst outcomes often live within an ‘entangled web’ of disadvantage, including poverty, housing insecurity, pre-existing physical or mental health conditions, and limited social support. Similarly, the Royal College of Midwives stresses that

254 Felker A, Patel R, Kotnis R, Kenyon S, Knight M (Eds.) on behalf of MBRRACE-UK. 2025. Saving Lives, Improving Mothers’ Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. Oxford: National Perinatal Epidemiology Unit, University of Oxford. DOI: 10.5287/ora-4javr692x

255 Jardine, J., Walker, K., Gurol-Urganci, I., Webster, K., Muller, P., Hawdon, J., Khalil, A., Harris, T. and van der Meulen, J., 2021. Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study. The Lancet, 398(10314), pp.1905-1912.

256 Kapadia, D., Zhang, J., Salway, S et al., 2022. Ethnic Inequalities in Health-care: A Rapid Evidence Review. NHS Race and Health Observatory.

257 Rayment-Jones, H., Harris, J., Harden, A., Turienzo, C.F. and Sandall, J., 2023. Project20: Maternity care mechanisms that improve (or exacerbate) health inequalities. A realist evaluation. Women and Birth, 36(3), pp.e314-e327.

258 Abe C, Awe T, Peter M, et al. 2022. The black maternity experience report: a nationwide study of black women’s experiences of maternity services in the United Kingdom. https://fivexmore.org/blackmereport

259 MacLellan, J., Collins, S., Myatt, M., Pope, C., Knighton, W. and Rai, T., 2022. Black, Asian and minority ethnic women’s experiences of maternity services in the UK: A qualitative evidence synthesis. Journal of advanced nursing, 78(7), pp.2175-2190.

260 Office for National Statistics (ONS) 2021. Census-based statistics UK: 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/censusbasedstatisticsuk2021

261 Rayment-Jones, H., Burton, S., Dasgupta, T., Barry, Z., Easter, A. and Sandall, J., 2026b. The Role of Poverty-Related Social Determinants in Maternal and Perinatal Health Inequities: A cross-sectional study using the eLIXIR Born in South London, UK maternity-child data linkage.

262 Rayment-Jones, H., Burton, S., Bridle, L., et al., 2026a. The Role of Ethnicity and Migration in Perinatal Inequalities: A Retrospective Cohort Study. BJOG: An International Journal of Obstetrics & Gynaecology (2026): 1–13, https://doi.org/10.1111/1471-0528.70169.

263 Royal College of obstetricians and gynaecologists (RCOG). 2024a. Position statement: Poverty, deprivation and women’s health. https://www.rcog.org.uk/media/dirn0dfc/poverty-deprivation-and-womens-health.pdf

264 Royal College of obstetricians and gynaecologists (RCOG). 2024b. Position statement: Racial and ethnic equality in women’s health. https://www.rcog.org.uk/media/4xgeuz1d/racial-and-ethnic-equality-in-womens-health.pdf

systemic inequities, structural racism, and barriers to culturally safe care contribute to avoidable harm.[265] Both Colleges call for maternity systems to move beyond identifying elevated risk to actively redesigning services, improving cultural safety, workforce equity, and specialist support, and ensuring that a woman's ethnicity, migration status, or postcode does not determine her or her baby's safety.

Within this context, this chapter examines inequalities in care within Nottingham University Hospitals (NUH) maternity services as part of the Independent Review. It explores how women from Black, Asian, and other global majority groups, women living in deprivation, and other seldom-heard groups are represented in the Review cohort; whether differences in experiences or outcomes exist; and how care was designed to respond to social and structural determinants of risk. By combining population data, case review findings, and family voices, this chapter seeks to identify whether inequalities contributed to harm and to inform necessary actions for improving equity, safety, and outcomes.

2. The Nottingham Population and Review Case Mix

Nottingham is one of England's most demographically diverse and socio-economically deprived cities, with population characteristics that differ markedly from the surrounding county. Based on 2021 Census data,[8] approximately 80% of the Nottingham University Hospitals (NUH) maternity catchment population identifies as White British, but this aggregate figure masks substantial internal variation: within Nottingham City itself, around 57% of residents identify as White British, compared with approximately 85% in the wider Nottinghamshire County.

Nottingham City is also ranked 11th most deprived out of 317 local authorities in England according to the Index of Multiple Deprivation (IMD). Child poverty is high, life expectancy is below the national average, and many communities experience poorer health outcomes across the life course.[8] These characteristics are highly relevant to maternal and perinatal safety.

In Nottingham and Nottinghamshire, infant mortality rates among Black and Asian populations are substantially higher than among White populations.[266] Women from global majority backgrounds are also disproportionately represented in maternity Serious Incidents at NUH, despite accounting for a minority of births.[267] These local patterns mirror national findings, including persistently higher maternal mortality and morbidity among Black, Asian, and mixed-ethnicity women.

3. Reaching Seldom Heard Communities

To ensure that the perspectives of women and families most affected by inequality were included, the Review Team undertook targeted engagement over the entire period of The Review with seldom heard communities.

The term 'Seldom heard communities' refers to groups whose perspectives are often under-represented in service design, quality improvement, and formal review processes. This under-representation often results from structural and practical barriers such as language, disability, social isolation, mistrust of institutions, or previous negative experiences of care rather than lack of willingness to engage (Kapadia et al, 2022).

265 Royal College of Midwives (RCM). Position statement: Decolonising practice in midwifery. 2024. https://rcm.org.uk/wp-content/uploads/2024/10/RCM_Position-Statement_Decolonising_midwifery_8.pdf

266 Nottingham City Place Based Partnerhsip, 2024. Racial Helath Inequalities in Nottingham and Nottingamshire: Local Routes to Change. https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Race-Health-Inequality-Report-January-2024.pdf

267 Ibikunle R., 2023. Identifying and overcoming racial barriers to effective maternity care: Capturing the experiences of Black and brown skin maternity service users. Available at: https://collaboratoryresearchhub.ac.uk/identifying-and-overcoming-racial-barriers-to-effective-maternity-care/

Given Nottingham's demographic diversity and the known inequalities in maternity outcomes, The Review actively sought the perspectives of women and families from marginalised and disadvantaged groups. This included women from Black, Asian, and other global majority backgrounds, migrants and refugees, those with limited English proficiency, women experiencing poverty or homelessness, refugees, survivors of domestic abuse, and those with mental health or learning difficulties.

Engagement Strategy

A multi-faceted approach was used to facilitate participation and ensure inclusion:

- Community and faith engagement: Meetings with local faith leaders and organisations trusted within their communities, including majority Black-led churches, United Black Churches of Nottingham, the Nottingham Muslim Women's Network, and Baitul Hafeez Mosque, Sikh and Jewish Communities.
- Support groups and charities: Engagement with organisations supporting Roma women, refugees and asylum seekers, survivors of domestic abuse, bereaved families, and parents affected by neonatal harm or baby loss.
- Flexible participation: Sessions were offered individually or in groups or one to one sessions with support from an interpreter, recorded for wider access, with transport costs covered and crèche facilities provided where needed.
- Accessible communications: Information was shared via multiple channels, including radio, online platforms, and translated materials distributed across healthcare and community settings. YouTube videos were produced in six of the most commonly spoken languages in Nottingham.

This approach aimed not only to increase participation but also to ensure that the voices of those most affected by inequality were actively included in shaping The Review's findings. Families from seldom heard communities frequently described barriers to accessing care, communication difficulties, and experiences of not being listened to or believed; factors that can compound clinical risk and contribute to poorer outcomes.

By integrating quantitative analysis of The Review cohort with qualitative testimony, The Review sought to understand not only who was affected, but how inequalities were experienced within maternity care at NUH. This engagement provides critical context for interpreting the lived experiences presented in Section 6 and for understanding the mechanisms underlying the quantitative patterns described in Section 4.

Section 6: Family Voices – Experiences of Inequality

The Review ensured representation across ethnic groups including: 76% White British/Irish, 4% White non-British, 9% Black, 7% Asian, and 4% other/unknown. Families shared detailed accounts that illustrate how inequalities relating to ethnicity, social risk factors, and mental health intersect with systemic and structural barriers to shape experiences of care and outcomes.

From these narratives, five interconnected themes emerge:

1. Communication Failures
2. Not Being Believed
3. Cultural Misunderstanding
4. Fear, Mistrust, and Power Imbalance
5. Systemic Barriers

A recurring mechanism throughout these themes is the lack of continuity of care/carer, which can undermine trust, limit opportunities for escalation of concerns, and contribute to unsafe or inequitable care. Overall women reported not being heard or not being believed.

1. Communication Failures

Women frequently described receiving fragmented, inconsistent, or delayed information, leaving them anxious and uncertain. Encounters with multiple staff who did not know their individual circumstances exacerbated this, highlighting the importance of continuity of care.

- *"I approached the staff and was telling them that she's getting a lot of pain…they said, 'It's fine.'…I know now it was progressing quite quickly…we were shown very little kind of care at all really, not even common decency."* (2011)
- *"I was struggling with breastfeeding…I was trying so hard and they were just not helping me at all…we weren't even feeding her enough. They weren't telling us what to do."* (2018)

As recently as 2023, the Review Team have reports of mothers asking for information and then not having anyone come back to them… leaving many messages that they 'just didn't bother' to reply to.

Communication failures were amplified for women with social or mental health vulnerabilities, leaving them reluctant to disclose personal circumstances, less able to seek support, and less able to escalate concerns.

2. Not Being Believed

Closely linked to communication failures over a long period of time, women described being dismissed, ignored, or undermined, particularly when their sex-specific health needs, mental health concerns, or social risk factors were involved.

- *"Every day… I feel like I've failed as a mother…because of their neglect…this has contributed to what we have to go through as a family."* (2010)
- *"I was frightened because they were so dismissive of everything…I knew something wasn't right."* (2011)
- *"I spoke to the midwife, 'Can you check me because I've got a lot of swelling and pain?' She said, 'No, you're fine because you've had so many kids, that's probably why you have pain'".* (2015)

Again, as recently as 2023 a mother recalls being in a lot of pain and being told 'it's fine' and only being given paracetamol just minutes prior to giving birth.

When women are not believed, they may be less likely to disclose personal or social risks, or to advocate for themselves or their babies, increasing potential harm and reinforcing existing inequalities in care and outcomes.

3. Cultural Misunderstanding

Women from Black, Asian, and other global majority backgrounds, and those with diverse sexual orientations, reported experiences of stereotyping, assumptions, and lack of awareness of their cultural or social circumstances.

- *"…the doctor said, 'Why are you having another baby? You've had so many babies before.' And that made me depressed as well. Why did she say that to me?." (2015)*
- *"I'm in a same-sex relationship…they weren't aware that she was my wife…asked if we were sisters… it felt inappropriate." (2020)*
- *"…the nurse apologised that she didn't know what I was going through…she wasn't communicating well to me." (2020)*

Cultural misunderstanding intersected with communication breakdowns and lack of continuity of care/ carer, magnifying feelings of exclusion, isolation, and inequitable treatment.

4. Fear, Mistrust, and Power Imbalance

Families described feeling vulnerable, powerless, and anxious, especially when decision-making was limited or overridden and care was provided by multiple staff without continuity.

- *"I came out of the meeting and cried my eyes out…they didn't ask me what I wanted…trying to tell me what would happen."* (2019)
- *"…everyone was putting their hands in me, no one was asking me for consent…just the medical violation."* (2019)

Fear and mistrust could limit women's disclosure of social risks or mental health needs, further reducing safety and exacerbating existing inequalities in access, experience, and outcomes.

5. Systemic Barriers

Women reported organisational and structural challenges that compounded their experiences and limited their ability to access safe, supportive care. These included restricted partner or family support, gaps in postnatal care, COVID-19 visiting restrictions, and lack of continuity of care/carer.

These barriers did not affect all women equally. Women from Black, Asian, and other global majority backgrounds, those with limited English proficiency, and those experiencing mental health or social vulnerabilities were disproportionately impacted. For these groups, partners and family members often played a critical role in providing advocacy, supporting communication, and helping women navigate services. Restrictions on their presence therefore had a greater impact, reducing women's ability to express concerns, seek reassurance, and challenge decisions.

Gaps in postnatal care and limited continuity of care further compounded these inequalities. Women who were already vulnerable due to social or mental health factors described feeling isolated, unsupported, and less able to access timely review or escalation of concerns. Without consistent caregivers, opportunities to build trust, recognise individual needs, and identify cumulative or intersecting risk were reduced.

- *"They moved me back to labour ward but not once did anybody say how the baby was, even though he wasn't crying…nobody told my husband what was going on."* (2012)
- *"I needed my husband to stay…they said he couldn't…we only got a room once I insisted…we were in for a week."* (2018)

These systemic barriers intersected with the other themes identified in this section, reinforcing existing disadvantages. By limiting access to advocacy, reducing continuity, and increasing isolation, they disproportionately affected women already at higher risk, contributing to inequities in access, experience, and outcomes.

Fathers and Partners

Fathers and partners' experiences reinforce these themes. Lack of inclusion and communication compounded stress and limited their ability to support mothers:

"Not supported, not talked to, not told the truth of what was happening…I was sitting there alone for hours". (2010)

These experiences underline the importance of family-inclusive care and highlight the role of fathers in supporting communication, advocacy, and safety.

Linking Themes to Quantitative Patterns

The narratives reveal mechanisms through which inequalities may manifest:

- Delayed escalation due to fear, mistrust, or not being believed

- Reduced support for women with mental health or social vulnerabilities
- Inequitable access to culturally competent care
- Exclusion of fathers/partners, reducing advocacy and family support
- Lack of continuity of care/carer, compounding other themes

These mechanisms may underpin disparities observed in quantitative data, highlighting the need for interventions addressing both individual and systemic factors to reduce inequalities in care and outcomes.

6. NUH Approaches to Addressing Maternal Inequalities

Review of NUH Annual Trust Board Reports from 2012 onwards shows the organisation was aware of negative health experiences and outcomes for women and families from Black, Asian, and other global majority backgrounds, disadvantaged communities, and those with protected characteristics. Over the period of the Review, the Trust implemented community engagement initiatives, targeted projects, and staff development programmes to improve cultural competence, career progression for staff from minoritised backgrounds, and inclusion across services. Progress is now being made with women reporting positive differences in their care. There remains a significant amount to do.

6.1 Staff Ethnicity and Representation

Workforce diversity is essential to addressing inequalities. Women and families from minoritised backgrounds are more likely to engage with services and feel confident seeking help when staff reflect the communities they serve. A representative workforce also improves understanding of cultural norms, beliefs, and personal histories, enabling more sensitive, person-centred care.

NUH Workforce Race Equality Standard (WRES) Data

Table 6: Staff ethnicity data

Year	White (%)	Black, Asian & minoritised ethnicity (%)	Unknown (%)
2015	71.7	14.4	13.9
2024	64.1	26.3	9.5

Table 7: Midwifery Staff Ethnicity Data

Year	Total Midwives	White (%)	Black, Asian & minoritised ethnicity (%)	Unknown (%)
2015	423	83.2	4.72	12.05
2024	532	77.25	14.6	8.08

Despite improvements, gaps remain: midwifery and senior leadership roles remain predominantly White, and career progression opportunities for staff from minoritised backgrounds are limited.

6.2 Service Organisation Pre-2022

NUH established the first specialist community midwifery team for women experiencing social risk in 2015, supporting those affected by homelessness or domestic abuse. These services emphasised continuity of care and case-loading midwives, recognising that sustained relationships improve trust, engagement,

and safety for women facing multiple vulnerabilities. However, these specialist roles were inconsistently resourced and subject to staff turnover. Services such as interpreter support and culturally adapted materials were limited, and Labour Ward governance rarely addressed care for women from minoritised or socially disadvantaged backgrounds.

6.3 Inclusive Maternity Work Programme (2022 onwards)

In 2022, NUH launched the Inclusive Maternity Work Programme to address structural inequalities and improve care for women from Black, Asian, and other global majority backgrounds, and those experiencing social risk. Key objectives include:

1. Improving interpreting services and accessibility – launch of digital technologies, interpreter flowcharts, and bilingual antenatal classes.
2. Cultural awareness and competency training – Inclusive Maternity Study Day and staff development, mapped to core competencies.
3. Strengthening continuity and community-based care – expansion of specialist midwives supporting women with social risk, case-loading for continuity, relocation of clinics such as FGM services into local community settings to improve attendance and engagement.
4. Community engagement – partnerships with MNVP, Muslim Women's Network, Heya, Nottingham Women's Centre, refugee forums, and co-designed initiatives with local organisations to address inequalities.
5. Increasing workforce diversity – outreach, recruitment, and support for staff from minoritised backgrounds at all levels, alongside promotion of cultural awareness and inclusion throughout the Trust.

Staff feedback confirms that these initiatives are improving care in community clinics, interpreter-led appointments, and culturally sensitive engagement, though challenges remain in ensuring consistency, sustainability, and coverage across hospital services and languages.

6.4 Linking Workforce and Service Approaches to Observed Inequalities

Quantitative and qualitative findings from Sections 4 and 5 demonstrate inequalities in maternal outcomes and experiences related to ethnicity, deprivation, mental health, and other social determinants. NUH initiatives such as workforce diversification, cultural competence training, and specialist community-based midwifery must continue to directly address the underlying mechanisms through which these inequalities arise by:

- Improving communication and understanding for women from minoritised and socially disadvantaged backgrounds, addressing barriers related to language, cultural misunderstanding, and not being listened to or believed.
- Providing continuity of care through case-loaded midwives, enabling trust, advocacy, and timely escalation of concerns, particularly for women experiencing multiple or intersecting disadvantages.
- Reducing barriers to access caused by language, cultural misunderstandings, or structural obstacles, which disproportionately affect women from marginalised groups.
- Offering community-based services that are culturally and contextually tailored to women's needs, supporting engagement and attendance, and improving access for women who may otherwise be excluded from mainstream services.

Significant gaps persist. Workforce representation in senior roles is still limited, specialist posts are vulnerable to turnover, and inequalities in experience and outcomes remain evident. This indicates that, while current initiatives align with known drivers of inequality, their reach, consistency, and sustainability require further strengthening. Approaches should continue to draw on evidence-based, well-evaluated interventions to ensure improvements are sustainable, measurable, and directly aligned to the needs highlighted by quantitative and qualitative data.

Immediate and Essential Actions to Improve Care and Safety in Maternity Services Across England

There are 8 key headings for the Immediate and Essential Actions which must happen following publication of this Report.

1. Listening to Women & Families
2. Workforce Planning & Safe Staffing
3. Training & Multi-Professional Learning
4. Risk Assessment Throughout Pregnancy
5. Incident Investigation & Family Involvement
6. Governance & Board Accountability
7. Culture, Teamwork & Psychological Safety
8. Mothers Who Have Died and Post Death Care

What happened in maternity services following The Shrewsbury and Telford Hospital NHS Trust published on March 2022

Overview of progress on the Immediate and Essential Actions (IEAs) following the findings from the Independent Ockenden Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust published in December 2020 and in the Ockenden Report (2022), outlined 22 IEAs for maternity systems across England. NHS England (NHSE) devised a Maternity services assessment and assurance tool to support providers of maternity services to assess their current position against the IEAs and to provide assurance of effective implementation to their boards. The IEAs were cross referenced to the ten Maternity incentive scheme safety actions. However, it has become clear that many of these IEAs remain unactioned and may have become more challenging to implement given the changes which have occurred within maternity services over the past 4 years since publication of the second Ockenden report. For example, the Serious Incident Framework, being replaced by the NHS Patient Safety Incident Framework (PSIRF), which was published in March 2020 In addition there has been the publication of the Maternal Care Bundle (NHSE 2026).

Regional Teams at the time were tasked with reviewing the outputs of the self-assessment, however this was not reported or published nationally so it remains unclear how the 22 IEAs were implemented.

The Maternal Care Bundle – Background

The Maternal Care Bundle (MCB) (NHSE 2026) is a national framework published by NHS England in January 2026 to reduce maternity mortality, maternal morbidity and inequalities in outcomes across England. It sets out minimum best-practice standards that all NHS maternity providers must implement by March 2027

The reasons for the MCB introduction include:

- Maternal mortality has increased in the UK, with a 21% rise since 2009-11.
- Significant inequalities persist: Black women die at more than twice the rate of white women; women in deprived areas also experience worse outcomes.

- MBRRACE-UK (2025) reported that in 45% of maternal deaths, improvements in care may have changed the outcome.

Furthermore;

- The maternal population in England is becoming increasingly complex.
- More women are becoming pregnant who are living with obesity (Royal College of Physicians 2025).
- More women than ever before have underlying physical and mental health conditions.
- A high proportion of women who die have pre-existing conditions.
- Nationally the rate of caesarean births is increasing, associated with a higher risk of thrombosis and complications in successive births.
- For every woman who dies in pregnancy and in the 6 weeks after giving birth, it is estimated that more than 100 women will experience a severe adverse maternal outcome (MCB 2026).

The aim of the 'bundle' is to standardise care, reduce variation between trusts and ensure earlier recognition of maternal deterioration, providing co-ordinated multidisciplinary care. Ultimately this is what the following IEAs aim to achieve. In addition to this national policy must recognise that safe maternity care is dependent on a supported and sustainable workforce, psychologically safe cultures, voices of women and families being heard and leadership capable of translating staff and families' intelligence into action.

IEAs for Learning

This Review supports the IEAs from previous Ockenden reviews and reports and are clear that, at the centre of all the IEAs is listening to the voices of women and families and all staff working in perinatal services, and more importantly believe what they are saying. If a woman tells a member of staff that she has any concern regarding her own health and wellbeing or that of her unborn/born baby, those concerns must be recorded and appropriate and timely action taken.

Overarching Principle underpinning all IEAs

Where women, families or staff have ongoing concerns about a mother or baby, they must be able to seek an urgent additional clinical review using clear, accessible and responsive routes under the principles of Martha's Rule[268]. This must be available in both hospital and community settings.

1. Listening to Women & Families

IEA 1: Strengthening women-centred communication and informed choice

1. All women must be provided with clear, consistent, and accessible information throughout pregnancy to support informed decision-making. This should include information about labour and birth, pain relief options in labour, anaesthetic care for operative delivery, and the potential benefits and risks of different interventions. Information should be available in a range of formats and languages and signpost women to trusted resources, including Labour Pains.org, to support informed choices and shared decision-making.
2. By 28 weeks' gestation, all women must receive a minimum standard set of information on labour and birth, including pain relief options and information about anaesthesia for operative and instrumental delivery. This must include balanced discussions about interventions such as caesarean birth and epidural analgesia, ensuring women are fully informed, supported to make choices that reflect their preferences, and able to develop realistic expectations of their care.

268 Martha's Rule: Available from https://www.england.nhs.uk/patient-safety/marthas-rule/

3. Introduce a mandatory 'Listen to the Woman and consider her preferences' assessment field within triage and telephone triage documentation to ensure the woman's account is heard captured and informs clinical decision-making.
4. All Trusts must ensure women and families are listened to, acting appropriately upon any concerns within a timely manner.
5. Neonatal services should implement the principles set out in the BAPM Family Integrated Care Framework for Practice to ensure parents are recognised as partners in care, actively involved in decision-making and supported to participate in the care of their baby wherever clinically possible.
6. Communication with parents must be a priority. Documentation should be consistent and clearly reflect meaningful parental involvement in daily decision-making.
7. Regular, open conversations with parents, including use of translation where required, should be embedded into routine practice.

2. Workforce Planning & Safe Staffing

IEA 2: Support a nationally agreed perinatal workforce planning methodology as a critical enabler of perinatal improvement at pace and scale

1. Investment should be made in the development and implementation of a robust, evidence-based workforce planning tool across perinatal services. The tool should move beyond birth rates alone to reflect population complexity, including factors such as maternal age, co-morbidities, deprivation, acuity and service configuration.
    a. Obstetric sonographers must be included within workforce/staffing models, to reflect the increasing complexity of cases and increasing workload.
    b. Workforce planning should recognise the substantial out-of-hours obstetric workload and ensure that staffing arrangements provide sufficient dedicated anaesthetic capacity, resilience, and senior support to meet the needs of women and babies safely at all times. A long-term increase in anaesthetic training numbers and consultant posts will be required to respond to the growing demand on obstetric anaesthetic services. Workforce planning must also consider the availability of appropriately skilled anaesthetic support staff (ODPs and anaesthetic nurses) in order to deliver safe and timely care.

The methodology should be scalable across all maternity settings and sufficiently flexible to account for local variation in demand, whilst providing a nationally consistent framework for workforce planning, service design and investment decisions. It should also recognise the workforce capacity required for education and training, governance, quality improvement, leadership and patient safety activities, enabling a more accurate assessment of staffing requirements and helping ensure services are appropriately resourced to deliver safe, sustainable care.

2. Ensure staff models explicitly account for the provision of care to women presenting in early labour, including appropriate space and staffing to support assessment, monitoring, and ongoing care.
3. Postnatal wards must be appropriately staffed at all times. Postnatal staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward during the day and night for both mothers and babies. Newborn babies, on the postnatal ward, counted as individual patients.
4. When postnatal women are medically fit for 'step down' from critical care this must be to an appropriate maternity area, depending on their clinical needs. If step down directly to the postnatal ward is considered appropriate then additional support should be provided for at least the first 24 hours both to help the woman adjust to her changing circumstances, and to help her care for her

newborn baby. The expectation is that the additional support will generally be1:1 support which can be provided by a Maternity Support Worker (MSW) or Health Care Assistant (HCA).

5. All neonatal units must have adequate funded nursing and medical establishment and sufficient critical care equipment, including incubators, to be able to safely operate at 100% of planned capacity during peaks of activity, but must operate at an average of no more than 80% occupancy to allow for these surges of activity. Neonatal services should demonstrate compliance with BAPM Service and Quality Standards for Provision of Neonatal Care in the UK and relevant BAPM workforce standards.
6. Neonatal consultants must NEVER provide emergency cover to more than one hospital at the same time and, in-person attendance out of hours should always be within 30 minutes.
7. Immediate availability of consultants will be dependent on the experience of resident Tier 2 staff, particularly in relation to airway skills. This may require resident consultant models in some instances. (BAPM safety Alert 12.12.2024)[269]
8. All neonatal units must use national neonatal audit programme (NNAP) (RCPCH 2026) outcomes and GIRFT (NHSE 2026)[270] reviews to focus quality improvement work and drive improvements in those areas identified as negative outliers with an emphasis on close to real time quality surveillance alongside the use of audit data.
9. All maternity and neonatal services must ensure their resuscitation practice and guidelines fully align with Resuscitation Council UK (NLS) guidance (Fawke et al 2025)[271]. This includes prioritising emergency blood transfusion in severe acute blood loss and life-threatening severe anaemia.
10. National Neonatal Action
    a. All neonatal units must follow the recommendations in the BAPM Neonatal Airway Safety Standards[272] and audit their compliance with these airway competency standards.
    b All neonatal units must have immediate access to appropriate video laryngoscopy equipment.
    c. All NICUs and LNUs must collect data on their unplanned extubation rate per 100 ventilator days and consider quality improvements to reduce their rate.
    d. All neonatal units must follow and audit compliance with national and local infection control guidance including appropriate cot-spacing and appropriate hand hygiene measures.

3. Training & Multi-Professional Learning

IEA 3: National IEA for Labour Ward Coordinator Role

Implement a nationally recognised Labour Ward Coordinator (LWC) programme (NHS England (2023)) Labour ward coordinator framework. Available at: https://www.england.nhs.uk)[273] for all Band 7 LWC midwives undertaking the LWC role.

Provide structured opportunities and support to achieve the competencies and standards outlined across the six domains of the national LWC Framework.

269 British Association of Perinatal Medicine (BAPM), 2024. Safety Alert: On-call consultants. London: BAPM. Available at: bapm.org [Accessed 7 June 2026].

270 NHS England, 2026. Title of the specific GIRFT report/guide in italics. London: NHS England. Available at: <URL of the specific PDF/webpage> [Accessed 7 June 2026]

271 Journal Publication (ERC Guidelines 2025): Hogeveen, M., et al. (incl. J. Fawke). “European Resuscitation Council Guidelines 2025: Newborn Resuscitation and Support of Transition of Infants at Birth.” Resuscitation, 215, 110766.

272 British Association of Perinatal Medicine (BAPM), 2024. BAPM Neonatal Airway Safety Standard. London: BAPM. Available at: https://www.bapm.org/resources/BAPM-Neonatal-Airway-Safety-Standard [Accessed 7 June 2026]

273 NHS England (2023) Labour ward co-ordinator education and development framework. London: NHS England. Available at: https://www.england.nhs.uk/publication/labour-ward-co-ordinator-education-and-development-framework/ (Accessed: 7 June 2026).

Introduce 360-degree feedback for all LWCs to support reflection, performance development, and understanding of the impact of behaviour on the multidisciplinary team.

IEA 4: All trusts must support Training for Midwives in the use of Speculum Examination

1. All Trusts must ensure that midwives are supported to achieve local training competencies to perform speculum examinations for women at any gestation of pregnancy, with clear escalation pathways for women in pre term labour or those requiring immediate ongoing care.

IEA 5: Enhanced Maternal Care

1. All staff caring for pregnant women must receive regular, structured multidisciplinary training to ensure timely recognition and effective management of the deteriorating woman. Training must equip midwives, obstetricians, anaesthetists, critical care teams, and outreach services with the skills, knowledge, and confidence to deliver safe, high-quality enhanced maternal care. Insights from simulation and team-based training should directly inform the development and refinement of clinical systems, processes, and pathways. Dedicated training time must be protected and recognised as part of mandatory training requirements, and trainers themselves must be appropriately trained.
2. National education programmes must cover key areas of maternal care and include the recognition and management of lesser-known but clinically important conditions, such as maternal ketosis, to ensure consistent, safe, and excellent care across all maternity services.

4. Risk Assessment Throughout Pregnancy

IEA 6: Delivering Safe, Personalised and Equitable Maternity Care Through Early Risk Recognition, Coordinated Care and Responsive Services

1. All Trusts must ensure women receive the appropriate ‘safety-netting’ within their care, enabling them to access services and treatments, including the consideration of reducing barriers to enable to the provision of safe maternity care.
2. All Trusts must ensure continuity of care for women, in particular, those with additional medical or social complexities.
3. All Trusts must ensure robust processes for information sharing between organisations to enable accurate risk-assessments, ensuring safe maternity care.
4. All Trusts and services (health, social care and education) involved with the care of families who have experienced a maternal death, must ensure that service provision is trauma-informed and family-centred.
5. All Trusts must ensure that pregnant and postnatal women receive timely imaging in the presence of concerning neurological symptoms.
6. Ensure that, where additional risk factors for maternal or fetal compromise are present, a lower threshold for admission is applied, with senior clinical review and consideration of Electronic Fetal Monitoring (EFM).

IEA 7: National standard for standardisation and recording of fetal growth risk assessment

1. There must be standardisation of fetal growth risk assessment, management and audit across RCOG (1), SBLCB (2) and NICE (3) guidance, with clear concise recommendations on the choice of pathways and charts to ensure consistency of the approach to the reduction in stillbirth.
2. All practitioners performing ultrasound growth scans should have training to undertake and report examinations to meet the standardised methods used in the recommended charts.

IEA 8: There must be a national standard and documentation for maternity triage and record keeping in maternity care provision

1. Trusts must develop a robust method of training for midwives providing triage care. This must include minimum competency standards for telephone risk assessment, agreed pathways for mandatory attendance for review and a holistic review of physical, mental and social wellbeing assessment.
2. Trusts must implement local assurance processes to monitor compliance against action 3 with triage call lines being recorded for quality and assurance purposes.
3. Trusts must develop auditable standards for the care and advice provided to women who:
   a. Contact telephone triage during pregnancy.
   b. Attend triage during the latent phase of labour.
   c. Receive maternity care during the latent phase or in early labour with the ability to differentiate between the latent phase of labour and labour that has failed to progress or has become complex/ obstructed.
4. Suppliers of Electronic Patient Record (EPR) systems must ensure there is a standardised national maternity handover tool that addresses interoperability gaps between Trust systems. This tool must enable the consistent, real-time sharing of critical clinical information across organisational boundaries, particularly where women's care is being accessed outside of their maternity booking Trust.
5. All Trusts must implement the standardised national Maternity Early Warning System (MEWS)[274] with clearly defined escalation pathways wherever they are being cared for. This will ensure the timely recognition, escalation and management of women who are becoming unwell, with rapid access to senior clinical support.
6. Trusts should have a mechanism in place to record images and reports/findings from ultrasound examinations across all settings.

IEA 9: Support the development and implementation of a structured assessment framework for the latent phase of labour, ensuring clarity when the 'latent phase of labour' becomes abnormal requiring escalation

1. Develop and implement a structured assessment framework for the latent phase of labour, incorporating maternal and fetal wellbeing, the woman's preferences and narrative, social circumstances, potential barriers to accessing care (e.g. language or socioeconomic factors), time of day, and distance from the unit when determining the appropriateness of admission.

IEA 10: All Trusts must define criteria for the safe use of telephone postnatal follow-up, indicating when telephone follow-up is acceptable or when face-to-face follow-up is mandatory

1. The first risk assessment for this should be documented in the woman's notes in the antenatal period (by 34 weeks gestation), and the risk assessment reviewed before postnatal discharge from the hospital, and after every postnatal community visit.
2. Trusts must develop lists of circumstances in which **ALL** postnatal follow-up should be face to face.

Where a mother is advised to seek further medical review in relation to either maternal, or neonatal, care the responsibility for arranging appropriate follow-up lies with the healthcare professional providing that advice. Signposting alone is not sufficient.

274 NHS England, 2024. National Maternity Early Warning Score (MEWS) tool. London: NHS England. Available at: https://www.healthinnovationoxford.org/our-work/patient-safety/maternity-and-neonatal/national-maternity-early-warning-score-mews-tool/ [Accessed 7 June 2026].

Whilst it is no longer stipulated in the Midwives standards (Nursing and Midwifery Council) that mothers and babies remain under the care of maternity services up to 28 days postnatal, women and families must be able to contact their maternity provider during this time if they wish or need too.

IEA 11: National standard for obstetric anaesthetic record-keeping

All Trusts must introduce and use standardised approaches to key areas of maternity anaesthetic care to reduce variation and improve outcomes.

Recommended examples include[275]:

- management of inadequate epidural analgesia.
- intra-operative pain management and conversion to general anaesthesia.
- clear criteria for postnatal follow-up.

An agreed minimum standard for obstetric anaesthetic documentation must be implemented.[276] This should include routine recording of intra-operative pain scores and accompanying narrative log, particularly during unexpected or critical events, capturing:

- the woman's symptoms and clinical findings.
- information shared with the woman and her involvement in decision-making .
- time of escalation and arrival of senior clinicians.

This approach will ensure that both the quality of clinical care and the woman's experience are consistently and accurately documented, supporting safe and personalised care.

IEA 12: Safe, accessible and comprehensive maternity anaesthetic documentation

1. All Trusts must strengthen maternal anaesthetic and critical care documentation, ensuring it is clear, contemporaneous, and readily accessible, ideally within a single unified electronic patient record.
2. Documentation must capture all relevant multidisciplinary discussions and care plans, and be woman-centred, reflecting the woman's needs, preferences, and involvement in decisions.

This will support continuity of care, enhance safety, and enable personalised care across all clinical settings

IEA 13: DHSC/NHSE should introduce and support access to coordinated multidisciplinary debrief and psychological support

1. DHSC/NHSE must support Trusts to ensure that maternity services provide timely, accessible psychological support for women and families following traumatic events.
2. This must include clear referral pathways, adequately resourced specialist provision, and processes that proactively identify and respond to unmet emotional and psychological needs. Improvement must be demonstrated through increased and equitable uptake of support services, high-quality family-feedback data confirming that families feel supported and safe, and evidence that psychological care is embedded as a core component of the maternity safety response.
3. All women who experience complex, unexpected or traumatic care must be offered a single, coordinated multidisciplinary debrief in a timely manner (to be agreed with the women/mother).
4. This must include access to psychological support and aim to minimise repeated visits, supporting recovery and reducing the risk of long-term psychological harm.
5. Where babies have experienced life-limiting conditions, severe brain injury, neonatal death or

275 https://www.rcoa.ac.uk/gpas/chapter-9#section-2.4
276 https://theprsb.org/standards/obstetricanaestheticstandard/

withdrawal of intensive care, services should provide support consistent with BAPM's palliative care framework and bereavement guidance.

5. Incident Investigation & Family Involvement

IEA 14: Funding for implementation of Maternity Patient Safety Incident Reporting Framework (PSIRF)

1. DHSC/NHSE must provide adequate funding to address the systemic resource gap that prevents Trusts from operationalising new national policy, enabling women and families to experience safer, more consistent care, with improvement demonstrated through full implementation, audit compliance, and sustained delivery of required standards.

National guidance on maternity patient-safety incidents

2. DHSC/NHSE should develop clear maternity-specific definitions and guidance on patient-safety incidents to resolve national inconsistency in interpretation, ensuring women and families receive transparent and accurate reporting of harm, with improvement evidenced by nationally standardised grading and reliable national data.
3. Learning from neonatal PSIRF investigations should be considered alongside maternity investigations, recognising the opportunities for shared learning across perinatal services.
4. DHSC/NHSE must provide clear maternity-specific Duty of Candour guidance to address current uncertainty in applying DoC, ensuring families receive timely, accurate, and compassionate communication, with improvement measured through DoC compliance audits to standardise processes and reduce variation across Trusts.
5. DHSC/NHSE must develop to all staff at every level, the appropriate tier of PSIRF training aligned to their role to address current gaps in capability and confidence, so that women and families benefit from safer, more consistent learning responses, improvement demonstrated through role-specific training-compliance data, strengthened investigation quality, and clearer application of PSIRF principles across maternity services.
6. DHSC/NHSE should implement a nationally standardised, time-bound feedback framework within PSIRF to address current delays and inconsistency in post-investigation communication, ensuring that staff and families receive timely, clear, and compassionate updates that enhance trust and understanding, with improvement demonstrated through measurable reductions in feedback delays, strengthened family-reported experience, and evidence of learning being acted upon across providers.

Consistency and equitable quality of feedback provided to families following all forms of investigation

7. DHSC/NHSE should establish a national standard for the quality, depth, and format of investigation outputs across all maternity investigation pathways – ensuring that, irrespective of whether care is reviewed through MNSI, PMRT, or local PSIRF processes. This will ensure all families consistently receive a comprehensive, compassionate, and clearly reasoned report that explains what happened, why, and what will change, thereby eliminating current inequities in the information.

PSIRF training

8. Improve PSIRF implementation in Maternity Services Expand national training capacity in patient-safety science.
9. Embed PSIRF methodology in undergraduate and postgraduate curricula.

10. PSIRF methodology must be incorporated into medical, nursing, midwifery, RCOG, RCoA and NMC curricula to address the lack of foundational patient-safety education, ensuring future clinicians deliver safer care for women and families, with improvement demonstrated through curriculum adoption and competency assessments.

6. Governance & Board Accountability

IEA 15: Strengthened multidisciplinary governance and learning

All Trusts must ensure protected time for multidisciplinary governance, review and learning.

This must include learning from both adverse events and examples of good practice to support continuous improvement in the quality and safety of care provided to women. Learning from neonatal PSIRF investigations should be considered alongside maternity investigations, recognising the opportunities for shared learning across perinatal services.

7. Culture, Teamwork & Psychological Safety

IEA 16: Foster a compassionate, psychologically safe, and learning culture

All Trusts must actively foster a culture of safety, compassion, and respect across all maternity services. Staff must feel supported to speak up and raise concerns without fear of reprisal. Women must feel listened to, respected, and fully involved in decisions about their care.

Trusts must promote compassionate leadership, a civil and kind workplace, and the use of positive feedback as a tool to reinforce good practice and drive continuous improvement. A psychologically safe and learning culture is essential to improving clinical outcomes, supporting staff wellbeing, and enhancing the experiences of women and their families.

Appoint a maternity subject-matter specialist in every Trust

1. Every Trust must appoint a maternity subject-matter specialist with a nationally standardised role description to address inconsistent expertise and oversight, ensuring women receive safer, more consistent governance. The maternity subject-matter specialist will represent the views of the multidisciplinary maternity team (midwifery, obstetric, anaesthetic and neonatal) at trust board level. Improvement measured through compliance with Ockenden IEAs and other national review actions.

IEA 17: DHSC/NHSE should recommend and support recruitment processes and implement a consistent onboarding package for new starters

1. Trusts must streamline recruitment processes and implement a consistent onboarding package for all staff involved in the delivery of perinatal care with named supervision and support during initial shifts.[277,278]

277 https://www.rcoa.ac.uk/gpas/chapter-9#chapter-4

278 https://www.rcog.org.uk/media/tyrb4dfr/rcog-guidance-on-engagement-of-short-term-locums-in-maternity-care-august-2022.pdf https://www.rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

8. Mothers Who Have Died and Post Death Care

National IEAs:

IEA 18:

1. All Trusts to ensure compliance, audited annually, with the NHS Records Management Code of Practice (2023).

Post-Death Care

1. Cease the practice of conducting post mortem examinations anywhere except the mortuary.[279]
2. Ensure all deceased patients are fully – or if there is a valid technical reason, temporarily – reconstructed to a high standard immediately after their post mortem examination. If reconstruction must be delayed, the rationale for this decision should be recorded and referenced in subsequent condition checks of the deceased person, so there is a clear audit trail and timeline prior to final reconstruction.
3. Ensure all investigations or reviews into after-death care include an independent post-death care specialist
4. Formally review all staff roles involved in the delivery of post-death care to:
   a. Map post-death care roles, responsibilities and scope of practice for each staff group.
   b. Identify points of crossover or duplication between each staff group.
   c. Define robust communication pathways for each staff group, for each post-death care process.

National Action

1. Introduce statutory regulation of Anatomical Pathology Technologists.
2. Ensure that paediatric post mortems of babies >12 weeks gestation are only undertaken by qualified Anatomical Pathology Technologists, specifically trained and competent in paediatric evisceration and reconstruction techniques.

Local Actions for Learning (LAFL) for Nottingham University Hospitals NHS Trust (NUH)

1. The Trust must ensure Estimated Fetal Weight (EFW) calculation and EFW centiles are printed on the ultrasound report for all growth scans and that graphs that display growth velocity for fetal measurements and EFW are printed on the ultrasound report and include the 3rd/ 10th /90th /97th centile lines. This will ensure that clinical staff have clear information to plan appropriate management of a pregnancy.
2. The Trust must ensure a recalculation of risk at each contact with a referral to the appropriate specialist where risk categories change within the pregnancy, labour or postnatal pathway.
3. The Trust must develop and deliver training in the form of simulations, skills drills or case studies to support improved communication and actions for women requiring escalation/ transfer from triage/ the antenatal ward to labour ward.

279 Following the HTA regulatory inspection in March 2026, NUH have changed their procedure 'to allow the post mortem examination of babies and children over 24 weeks gestation and all neonatal deaths to be carried out in the NUH mortuaries'.

4. The Trust must ensure adequate training and strategies in place to encourage staff to escalate and speak up, supporting midwifery clinical judgement and advocacy.
5. The Trust must promote the role of Professional Midwifery Advocate (PMA) supported reflective practice and restorative clinical supervision to empower staff voice and confidence.
6. The Trust is required to create a SOP and structured communication tool to ensure that staff are supported to safely transfer women when there is concern that requires immediate escalation for urgent one to one care.

Postpartum Haemorrhage (PPH)

1. The Trust must: achieve timely identification, escalation, and management of PPH across all NUH sites in alignment with Maternity Care Bundle (NHS England (2026) The Maternity Care Bundle. Available at: https://www.england.nhs.uk).
2. Develop and implement a single, cross-site proforma for PPH to support consistent documentation.
3. Embed standardised escalation and reporting processes for PPH, aligned to local and national guidance.

Administration Support

4. The Trust must review administrative support capacity and processes to ensure sufficient resource to support timely development, review, and updating of clinical guidelines at NUH.
5. Establish patient safety related systems to track, monitor, and report progress against actions arising from meetings.

Communication and Guideline updates

6. The Trust must set clear, time-bound deadlines for actions, with defined accountability, and ensure structured dissemination of updates to guidelines.
7. Conduct focus groups with a range of perinatal staff across a range of roles and multi professional levels to identify the most effective methods of communicating updates.
8. Implement a standardised, multi-channel dissemination approach informed by staff feedback.

Neonatal Local Actions for Learning (LAfL)

1. The Trust must ensure that the neonatal resuscitation guideline is changed to align with the Resuscitation Council UK Neonatal Life Support (NLS) algorithm, in terms of timing of progression from stage to stage.
2. Endotracheal tubes must not be ‘pre-cut’ or shortened until the correct length of insertion has been confirmed. Fixation methods must allow appropriate adjustment of the ET tube length after insertion.
3. The NUH feeding guideline for newborns must ensure sufficient ‘safety netting’ to identify the baby who is becoming seriously unwell. The differential diagnosis of poor feeding includes sepsis and significant neonatal illness. There must be improvement in multi-disciplinary education and training on recognition of the sick infant in the immediate post-natal period, in the hospital and community setting.
4. Antimicrobial stewardship must be strengthened. Both neonatal units must have 24/7 access to microbiology advice and a system of regular antibiotic reviews to support safe and effective antimicrobial use.
5. NUH must begin to implement strategies such as ‘water free’ care to reduce the risk of hospital acquired infections being transmitted via sinks and water. A plan must be developed no later that the end of December 2026.

6. NUH must review their threshold for the use of lumbar punctures to investigate neonatal sepsis, ensuring that they are always indicated, safe and used in line with national guidance.
7. NUH must develop simplified, unified, neonatal skin integrity documentation with clear accountability for pressure injury prevention, with a culture that prioritises prevention as well as treatment.
8. NUH must undertake regular audit of all airway fixation devices (ET, CPAP and HFNT) and perform patient safety reviews for all cases of tissue damage associated with such devices.

Clinical Governance – Local Actions for Learning

Close outstanding governance actions

1. NUH must ensure all outstanding actions from previous governance reviews, including the 2021 NUH Maternity Governance Review, are converted into SMART actions and prioritised for closure to address repeated failures. This will ensure women and families experience safer, more reliable care, with improvement demonstrated through timely completion and governance assurance reporting.

PSIRF training for Trust's senior leaders – at Executive level and within Divisions

2. The Trust must ensure that senior executives, the medical director, and nursing director complete the required PSIRF training – and that all staff are funded, released, and supported to attend – so that women and families benefit from safer, better-informed leadership, with improvement measured through training-compliance data and strengthened oversight.

Strengthening perinatal governance capacity and processes

3. The Trust must develop the perinatal governance team and ensure adequate staffing, resources, and training to address any current capacity gaps.
4. This must include a comprehensive review and strengthening of governance processes, alongside structured team development, so that women receive timely, high-quality investigations, learning responses, and feedback. Improvement must be evidenced through reduced investigation backlogs, enhanced quality and consistency of reports, and clear demonstration that learning is being acted upon and embedded across maternity services.

Strengthening Escalation Pathways and Board-Level Oversight

5. The Trust must ensure that Maternity Safety Champions provide visible, regular, and in-person engagement with maternity services and establish clear, reliable escalation pathways that enable front line concerns to reach Board level without delay or dilution. This is essential to close the gap between what women, families, and staff are reporting and what the Board is hearing. Women and families must experience a transparent, responsive safety culture in which their voices are listened to and acted upon.
6. Improvement must be demonstrated through documented compliance with visits, timely and traceable escalation of concerns, Board-level scrutiny and action, and staff feedback confirming that their voices are being heard and responded to.
7. Improvement of incident-reporting accessibility and culture.

The Trust must ensure incident reporting is quick, simple, and actively encouraged to address under-reporting, enabling women and families to benefit from earlier identification of risks, with improvement measured through increased reporting rates and improved staff-survey feedback.

Families' experience inclusion in all investigations

8. The Trust must ensure that families' experiences are included in all learning responses to address gaps in understanding and improve the quality of investigations, so women and families feel heard

and respected, with improvement demonstrated through audit of family involvement and enhanced learning outputs. Parents and families should be offered the opportunity to be actively included in all patient safety investigations, with clear, timely, communication regarding the findings

Psychological Support After Traumatic Events

9. The Trust must ensure timely, accessible psychological support for both families and staff following traumatic events. Families must have clear referral pathways and specialist provision, and staff must have access to Health and Wellbeing services, including TRiM and Second Victim support. Improvement should be demonstrated through increased uptake of support services, and feedback and wellbeing metrics showing that families and staff feel supported and safe.

Development of clear maternity-specific criteria for PSII and learning responses

10. The Trust must develop clear, maternity-specific criteria for determining when a PSII to address inconsistency and ambiguity or alternative learning response is required – supported by structured escalation and independent scrutiny ensuring women and families receive proportionate, transparent investigations, with improvement measured through consistent application at Trust corporate level and Trust-wide review of borderline cases.

APPENDIX 1:

Overview of the GMC's Work to Support the Independent Maternity Review (IMR) of Nottingham University Hospitals (NUH) NHS Trust

1) Our Work with the IMR, Partners and the Affected Families

To engage constructively with affected families:

- We have established and maintained regular, structured engagement with families, including in-person and virtual family surgeries in Nottingham and ongoing engagement tailored to each family's preferences.
- Responding to feedback from affected families and the review team, we have ensured that GMC staff engaging with families have received trauma informed training. We have created single points of contact at the GMC to prevent families having to repeatedly recount traumatic experiences.
- We have introduced new ways of working with other organisations, such as the police, to minimise our ask of families when gathering evidence around potential fitness to practise concerns, and to optimise our trauma informed engagement with families.
- Senior GMC leaders have attended family events to hear experiences and concerns first-hand, listen and learn about systemic failings, and to explain the GMC's role and remit.
- We have shared contact information and routes to raise concerns via IMR channels as well as sent letters and actions plans directly to families.
- We worked with maternity charities and patient groups, Maternity and Neonatal Voices Partnerships (MNVPs), and Patient Advice and Liaison Services (PALS) in areas with known concerns, including Nottingham. This was in response to feedback from families on a lack of awareness of the GMC's role among families and front line partners and support better signposting of concerns to us.

To support the IMR, we have taken the following steps:

- Established and maintained regular engagement with the Review Chair and team, supporting the progress of the review and ensuring open dialogue and exchange of information.
- Responded to information requests and disclosures, securely sharing evidence and detailed responses to inform the Review's findings and thematic work.
- Undertaken systematic review of IMR case material, primarily through assessment of more than 300 draft case reports to identify potential fitness to practise (FtP) concerns, including repeat behaviours across multiple cases, and prioritise regulatory action.
- Worked closely with NMC, police, NUH Trust and coroner to share intelligence, coordinate regulatory action and avoid duplication.
- We have provided governance related support to the Responsible Officer/Medical Director through monthly meetings and have been involved in system oversight meetings where the Trust's ongoing position and improvement plans are discussed. We have also held periodic meetings with the Trust CEO, Responsible Officer/Medical Director, Chief Nurse and our General Counsel and Director of Fitness to Practise.

- Delivered targeted outreach with stakeholders to improve awareness of the GMC's role among families and front line partners and support better signposting of concerns to us, and a Trust-specific session with doctors specialising in obstetrics and gynaecology to explain our fitness to practise in order to support them to understand our processes and, importantly, how it relates to standards.

Other Lessons learned and improvements made:

- We have developed new public-facing resources, including joint GMC/NMC materials explaining our respective regulatory roles, as well as co-produced a leaflet - with charities and people with lived experience - on how to raise concerns about maternity or neonatal care.
- We have updated our website and public information to improve clarity about the GMC's role and processes.
- We have improved how we are able to identify, at the earliest opportunity, doctors where there are patterns of concerns across multiple family matters, as well as concerns arising from multiple Trusts.
- We have removed barriers by developing close joint working with partner organisations, such as the police and NUH, so that we don't ask that families identify doctors involved in their care, or to provide further information; we have minimised what we ask families to do in order that we can consider their concern.

2) Our Work on Maternity Care

To support wider efforts to improve maternity care, we have:

- In partnership with the Nursing and Midwifery Council (NMC), created a maternity-focused resource on the GMC ethical hub, reinforcing existing professional standards in the maternity context. The resource covers teamworking and multidisciplinary collaboration, communication with patients - including bereavement and sensitive care - and inequalities in perinatal care, alongside practical actions for professionals. We promoted the resource through a news announcement, digital channels and stakeholder engagement.
- At the Health Service Journal Patient Safety Forum 2025, we highlighted our wider work to support safer and more equitable maternity care, with a focus on professional behaviours, teamwork, speaking up and tackling inequalities in care and outcomes. The forum also provided an opportunity to engage with healthcare leaders and maternity professionals on shared patient safety challenges.
- Delivered GMC/NMC joint sessions for doctors and nurses in obstetrics and midwifery as part of our programme of work on professional behaviours and positive cultures, to support improvements in maternity and neonatal care. We have also jointly developed guidance on duty of candour and promoting early reporting of errors.
- Underlined with partners the focus in our updated standards, as set out in Good Medical Practice, on compassionate care and communication, teamworking and psychological safety, and leadership responsibility for culture and safety.

3) Data and Insights

To develop the evidence base for our regulatory work in relation to maternity care, we:

- Use shared data and intelligence, including with the NMC and Care Quality Commission, to identify emerging risks in maternity care, with combined metrics such as complaints, staff survey data, and referral patterns, to enable early identification of areas of concern and supporting coordinated system responses. We are also involved in several information sharing forums across the wider system which enable us to share and receive intelligence related to the safety and quality of maternity services.
- Draw on our internal intelligence structures such as the Patient Safety Intelligence Forum (PSIF) and participation in national and regional safety forums to identify patterns, escalate risks, and coordinate

action across the system, particularly where concerns relate to specific maternity services or training environments.

- Conduct – and publish the findings of – regular surveys of doctors, including doctors in training – which highlight systemic pressures in obstetrics and gynaecology, including high workload, burnout risk, rota gaps, bullying/undermining behaviours, and barriers to escalation.
- The evidence also indicates cultural and behavioural risks, including poor multidisciplinary working, weak psychological safety, and fear of speaking up, which can contribute to unsafe care and hinder learning from errors.
- Analyse the data on workforce experience and outcomes to better understand and address the role of inequalities and discrimination (for both staff and patients) as a driver of poorer experiences and outcomes in maternity care – and publish the findings.

4) Our Wider Work on Maternity Care

- We contribute to national maternity policy and review activity by providing evidence and addressing issues of patient safety. We will rigorously apply the learning from Nottingham to other maternity reviews and our regulatory work across the system.
- We recognise that improving maternity safety requires coordinated action across multiple parts of the health system. Our work reflects a broader approach that goes beyond the IMR to include standards, education, data, and system collaboration:
- We play a system-wide role through education and training oversight, including setting standards, approving curricula, and intervening where training environments are unsafe – linking the quality of training directly to safer maternity care.
- Our Future of Education and Career Development programme aims to strengthen patient safety, embed flexibility and inclusion, and ensure doctors are equipped to meet evolving needs in maternity and wider care.
- Regulatory oversight activity includes monitoring and intervention in training and service risks, including enhanced monitoring of Obstetrics and Gynaecology programmes and ongoing scrutiny of learning environments where concerns arise.

APPENDIX 2:

Glossary of Terms

Abnormally Adherent or Invasive Placenta	In some pregnancies, a placenta grows too deeply into, or through, the muscle layer of a mother's uterus and does not separate from the uterus after the birth of the baby. This is known as an abnormally invasive placenta (AIP) or placenta accreta spectrum.
Acidaemia	A condition of raised blood acidity.
Activated Partial Thromboplastin Time (APPT)	A blood test which measures how long it takes blood to clot.
Active Management of the Third Stage of Labour	Active management of the third stage of labour involves the administration of a uterotonic, cord clamping (usually in the first 5 minutes after the birth) and delivery of the placenta by controlled cord traction (NICE).
Acute Fatty Liver of Pregnancy (AFLP)	Is a very rare liver disease (about 1 in every 10,000 pregnancies) that develops suddenly, normally in the third trimester of pregnancy. It is usually serious and most mothers need urgent treatment and early delivery of their baby. (British Liver Trust)
Acute Fetal Bradycardia	Is defined as a single prolonged deceleration of the fetal heartbeat for three minutes or more. Help should be sought urgently and birth may be expedited. (NICE, 2017)
Advanced Neonatal Nurse Practitioners (ANNP)	Experienced neonatal nurses who have done an additional advanced practice qualification and usually provide medical and nursing care, providing expert specialist care for sick and premature babies, including management of babies in intensive care.
AKI	Acute Kidney Injury.
Allied Health Professionals (AHP)	Allied Health Professionals (AHPs) work in a variety of settings, including hospitals, patients' homes and in the community. Some examples are: Paramedics, physiotherapists, dieticians, therapeutic radiographers, operating department practitioners, speech and language therapists. (NHS)
Amniotic Fluid Index (AFI)	An estimate of the amniotic fluid volume (amount of liquor around the baby) as part of ultrasound assessment of fetal wellbeing in pregnancy. (RCOG)
Anaemia	Anaemia is a condition where the number of red blood cells or the amount of haemoglobin (Hb) in red blood cells is lower than normal.
Aneurism	A bulging, weakened area in the wall of a blood vessel (most often occurring in an artery) resulting in an abnormal widening or ballooning of the vessel's normal diameter (width). Untreated aneurysms can burst open, leading to

	internal bleeding. They can also cause blood clots that block the flow of blood in the artery, and can be life threatening.
Anhydramnios	When there is no measurable amniotic fluid (liquor) around the baby. (NHS)
Antepartum	The period of time from conception to before birth. (NHS)
Antepartum Haemorrhage (APH)	Antepartum haemorrhage (APH) is defined as bleeding from or in to the genital tract, occurring from 24+0 weeks of pregnancy and prior to the birth of the baby. (RCOG)
Antihypertensive Medication	Medication used to control high blood pressure.
Apgar Score	A method to assess newborn babies immediately after birth by evaluating the baby on five criteria Colour, Tone, Heart Rate, Breathing, , Response to stimulation) each on a scale from zero to two. The resulting score ranges from zero to ten, and is performed at 1 minute, 5 minutes and 10 minutes after birth. (NHS)
Aromatherapy	The administration of essential oils, extracted from plants, which can be administered by topical application via massage, inhalation or dispersed in water.
Artificial Rupture of the Membranes (ARM)	ARM, or amniotomy, is a procedure where a midwife or doctor uses a small plastic hook (amnihook) to intentionally break the amniotic sac (the waters around the baby) to initiate or accelerate labour.
Aspirin Prophylaxis	Mothers at greater risk of pre-eclampsia are recommended to be prescribed low dose aspirin each day (from 12 to 16 weeks) to reduce the risk of pre-eclampsia and help to increase the function and blood flow of the placenta (afterbirth).
ATAIN	'Avoiding Term Admissions Into Neonatal units' is an NHS England programme designed to reduce avoidable admissions of full-term babies (≥37 weeks) to neonatal units, aiming to prevent unnecessary separation of mothers and babies. (NHSE)
Atosiban Infusion	An intravenous medication (a tocolytic) used to suppress uterine contractions for mothers in threatened preterm labour.
Augmentation of Labour	Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/or artificial rupture of membranes.
BadgerNet®	An electronic healthcare record system.
Bakri® Balloon	A medical device inserted vaginally into the uterus (in an operating theatre) and inflated, to control major obstetric haemorrhage in mothers.
BAME	Black, Asian and minority ethnicity.

Berwick Safety Review	A safety review report in 2013 which highlighted the main problems affecting patient safety in the NHS and made recommendations to address them.
Beta hCG Test (bHCG)	A blood test which measures the level of human chorionic gonadotropin (hCG), a placental hormone during pregnancy.
Better Births	In 2016, the National Maternity Review's report, 'Better Births', set out a clear vision for maternity services across England to become safer and more personalised for families. (NHSE)
Bicornuate Uterus	Also known as a heart shaped uterus. Some mothers are born with a uterus in which the two sides did not completely fuse together resulting in two uterine cavities (or "horns") that are partially or completely separated.
Birmingham Symptom-specific Obstetric Triage System (BSOTS)	A standardised triage process developed to assess women presenting with unexpected pregnancy related problems or concerns, ensuring they are prioritised in order of clinical urgency. BSOTS is the recommended triage system in England and has been widely adopted in the UK in recent years. (RCOG)
Birthrate Plus® (BR+)	A safe staffing national toolkit that informs decisions about the number of midwifery staff needed to provide safe and high quality care in maternity units and the community.
BLISS	A charity for babies born premature or sick. Bliss launched the 'Bliss Baby Charter' in 2005 and has been closely involved in developing NHS neonatal policies.
Breech Presentation	When a baby is presenting in the uterus (womb) bottom or feet first: • Extended or frank breech – Bottom first, with thighs against the chest and feet by the ears. Most breech babies are in this position. • Flexed breech – Bottom first, with thighs against the chest and knees bent. • Footling breech – The baby's foot or feet are below the bottom. (NHS)
British Association of Perinatal Medicine (BAPM)	A multi-professional membership association, registered charity, and an affiliated specialist society of the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Obstetricians and Gynaecologists (RCOG). Publishes many of the national frameworks for perinatal care.
Bronchopulmonary Dysplasia (BPD)	Is a chronic lung disease that affects preterm newborns. Also known as Chronic Lung Disease of Prematurity. (NICE)
Brow Presentation	Brow presentation, a rare presentation for birth occurs when the baby's neck is extended and requires caesarean birth, as the larger diameter of the head prevents engagement in the pelvis for vaginal birth.
Cabergoline	A drug used to suppress lactation (milk production).
Caesarean Birth	A caesarean birth is a major surgical procedure used to deliver a baby through an incision in the woman's abdomen and uterus. (NICE)

Caesarean Birth (Categories)	**Category 1** Immediate threat to the life of the woman or fetus (within 30 minutes of making the decision) **Category 2** Maternal or fetal compromise which is not immediately life-threatening (in most situations within 75 minutes of making the decision) **Category 3** No maternal or fetal compromise but needs early birth. **Category 4** Birth timed to suit woman or healthcare provider (NICE)
Carboprost	A uterotonic drug used in post-partum haemorrhage to stop bleeding.
Cardiotocograph (CTG)	Is a continuous recording of the baby's heart rate (and uterine contractions) obtained via ultrasound transducers placed on the mother's abdomen in pregnancy.
Cardiovascular	Refers to the heart (cardio) and the blood vessels (vascular). (NHS)
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England.
Congenital Diaphragmatic Hernia (CDH)	A serious congenital anomaly in babies that develops during pregnancy. Organs from the baby's stomach pass through a hole in the sheet of muscle that separates the stomach from the chest, called the diaphragm. The lungs of babies with CDH are underdeveloped and this causes problems with breathing after birth and requires surgery. (NHS)
CenTre	The dedicated transport service specialising in transferring babies between hospitals in the East Midlands and beyond.
Cerebral Function Monitoring (CFM)	A non-invasive, bedside, and continuous monitoring device used to record electrical activity in the newborn's brain and can detect seizures. (NHS)
Cerebral Palsy	Cerebral palsy is the name for a group of lifelong conditions that affect movement and co-ordination. It's caused by a problem with the brain that may develop before, during or soon after birth, or in early childhood. In many cases, the exact cause is not clear.
Chorioamnionitis	Chorioamnionitis is a potentially serious infection in which the membranes that surround the fetus (baby) and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death. (NHS)
Chronic Hypertension	Chronic hypertension – hypertension (high blood pressure) that is present at, or prior to the antenatal booking visit, or before 20 weeks gestation. (NICE)
Classical Caesarean Section Incision	A surgical incision being made in a mother's uterus (womb) from just above the umbilicus to just above the bikini line.
Clinical Commissioning Groups (CCG)	Established as part of the Health and Social Care Act in 2012, and consisted of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population. (no longer in place)

Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums.
Clostridioides Difficile Infection	A bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics, and is very infectious. It can usually be treated with a different type of antibiotic (also known as Clostridium difficile, C. difficile or C. diff). (NHS)
CNO	Chief nursing officer.
Coagulopathy	A serious condition characterised by the blood's impaired ability to form clots, which may lead to excessive bleeding.
Compassion Fatigue	The profound physical, emotional and mental exhaustion that professionals or caregivers can develop from the chronic exposure to trauma and distress while helping others.
Computerised Cardiotocograph (cCTG)	Computerised fetal heart rate analysis systems have been developed to allow the automated evaluation of the CTG with the aim of bringing objectivity and reliability to CTG interpretation and applies 12 criteria, known as Dawes Redman (DR), to evaluate the CTG.
Consultant Led Unit	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum and postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team.
Continuous Fetal Monitoring	A cardiotocograph (CTG) monitors both the fetal heart and contraction frequency continuously to confirm fetal wellbeing, or monitor in labour.
Continuous Positive Airway Pressure (CPAP)	A type of non-invasive ventilation (NIV) or breathing support, delivered through nasal prongs or a mask.
Cord Blood Gases	Paired blood samples (venous and arterial), taken from the cord after birth provide an objective measurement of the newborn's condition at birth. Together, results provide information on possible oxygen deficiency of the baby.
Cord Prolapse	An emergency situation when the umbilical cord slips down in front of the baby into the vagina after the membranes (waters) have broken. (RCOG)
Corticosteroids (Steroids)	Mothers between 24+0 and 33+6 weeks of pregnancy, who are at risk of preterm birth should be offered a full course of antenatal steroids as part of antenatal optimisation for preterm birth to reduce the severity of lung disease of prematurity and of other associated complications for preterm babies (NICE). They can sometimes be used after birth to treat Bronchopulmonary Dysplasia (BPD).
CPR	Cardio pulmonary resuscitation (chest compressions and breaths).

Critical Care Outreach Team (CCOT)	A team of critical care specialists who identify and institute treatment in patients who are deteriorating within the hospital but outside of the ICU and help to prevent admission to ICU or ensure that admission to critical care happens promptly to ensure best outcome. (NICE)
CRP	C-reactive protein. A marker of infection or inflammation.
DATIX	A web-based incident reporting and risk management software used in many hospitals in the UK to report incidents.
Debridement	The medical or surgical removal of dead, damaged, or infected tissue to improve its ability to heal. (Wounds-UK)
Deep Vein Thrombosis (DVT)	The formation of a blood clot in a deep vein (usually in the legs, but sometimes in the pelvis, or arm), which partially or completely obstructs blood flow. (NICE)
Diamorphine	Diamorphine is a strong, effective painkiller, known as an Opioid.
Dichorionic Twins	Non-identical twins, each with their own placenta. They may have a separate amniotic sac (bag of waters around each baby), known as 'dichorionic diamniotic' (DCDA) twins, or one shared amniotic sac, known as 'dichorionic monoamniotic' (DCMA) twins. (NHS)
Disseminated Intravascular Coagulation (DIC)	A serious condition that causes abnormal blood clotting throughout the body's blood vessels, and can cause organ damage and uncontrollable bleeding.
DOM	Director of Midwifery
Diabetic Ketoacidosis (DKA)	A serious condition that can happen in people with diabetes. It's where a lack of insulin causes harmful substances called ketones to build up in the blood. It can be life threatening and needs urgent treatment in hospital.
Doppler Assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA).
Duty of Candour	Duty of Candour legislation is to ensure that providers are open and transparent with people who use services. It sets out specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. (GOV.UK)
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during labour at term (37+0 weeks and above). This improvement programme is now closed.
East Midlands Neonatal Operational Delivery Network (ODN)	Neonatal units in England are organised into Operational Delivery Clinical Networks (ODNs) so that across a geographical area, all levels of care can be provided to the population. The two Nottingham units were both part of the East Midlands Neonatal ODN for the entire review period.

EBL	Estimated blood loss
Eclampsia	Eclampsia is a very serious complication of pre-eclampsia with one or more seizures during pregnancy or in the postpartum period (Pre-eclampsia Foundation)
ECMO	Extracorporeal membrane oxygenation. (A therapy to oxygenate blood outside of the body, used in some critically unwell term babies).
Ectopic Pregnancy	Pregnancy in which the fetus (baby) develops outside the uterus, typically in a fallopian tube. This is a life threatening condition that requires early diagnosis and intervention, with the risk of ruptured fallopian tube, severe haemorrhage or death to the mother.
EFW	Estimated fetal weight.
Electrocardiogram (ECG)	A test that records the electrical activity of the heart, including the rate and rhythm. (NHS)
Electrolytes	Essential salts and minerals, such as sodium, potassium, chloride and bicarbonate, which are found in the blood. (NHS)
EMC	Enhanced maternity care.
Endometritis	Infection within the uterus (womb).
Episiotomy	A cut in the area between the vagina and anus (perineum) during childbirth to expedite birth of the baby. (NHS)
EPU	Early pregnancy unit.
EUA	Examination under anaesthetic (in theatre).
Extended Neonatal Review	A review of babies who were admitted to the NICUs in Nottingham, during the time frame of the Review, but were born outside Nottingham.
Extended Perinatal Death	A stillbirth or neonatal death before 28 completed days after birth. (MBRRACE-UK)
External Cephalic Version (ECV)	This is a procedure in pregnancy where a healthcare professional tries to turn a baby from breech presentation (bottom down), or transverse (lying sideways) into a head-down position in the uterus (womb) by applying firm pressure on the abdomen.
Extravasation	The inadvertent leakage of fluids or medication from a vein into the surrounding tissue. (NHS)
Extubation	Removal of an artificial breathing tube from the airway.
Fetal Blood Sampling (FBS)	A procedure to take a small amount of blood from the baby's scalp during labour to assess wellbeing and to determine whether birth needs to be expedited. (NICE)

Fetal Care Unit (FCU)	Mothers are referred to FCU for fetal wellbeing scans in pregnancy.
Fetal Growth Restriction (FGR)	A baby identified by ultrasound in pregnancy to have an estimated fetal weight of less than the 3rd centile for gestational age OR a baby born with a birth weight less than the 3rd centile.
Fetal Medicine Unit (FMU)	A team of subspecialist doctors providing advanced fetal ultrasound and fetal medicine, supporting diagnosis and treatment of complications which may arise in unborn babies, alongside specialist midwives. (NHS)
Fetal Scalp Electrode (FSE)	A small electrode (sometimes called a clip) attached to the baby's scalp (via the vagina) and connected to a monitor to enable accurate heart rate monitoring.
FFP	Fresh frozen plasma.
FGM	Female genital mutilation.
First Stage of Labour	The first stage of labour includes both the 'latent' (See **Latent Stage of Labour**) and 'active' stages of labour. The active or established first stage is when contractions are stronger and regular with cervical changes and dilatation, up until the cervix is fully dilated.
Fluid Balance	The balance of input and output of fluids in the body (NHS)
Fluid Overload	Too much fluid volume in the body.
Foot Drop	A rare, usually temporary, postoperative complication characterised by the inability to lift the front part of the foot.
Forceps Birth	Forceps are smooth metal instruments, used for assisted vaginal birth. The forceps are carefully positioned around the baby's head and joined together at the handles and they are gently pulled, whilst the mother pushes, to expedite birth.
Freebirth	When a mother chooses to give birth without a midwife or health professional present, also known as unassisted birth. (NHS)
Freedom to Speak up Guardians	Each NHS organisation has an FTSU guardian. They provide an additional route for staff to speak up when they feel that they are unable to do so by other routes. (CQC)
Fresh Eyes Assessment	A regular in-person review and independent categorisation of the cardiotocograph (CTG) by another clinician, providing "fresh eyes".
General Medical Council (GMC)	A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC work with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems.
Gestational Diabetes Mellitus (GDM)	A form of diabetes that develops in pregnancy. (RCOG)

GIRFT	The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing improvements. (GIRFT)
Group B Streptococcus (GBS)	Group B Streptococcus (GBS, group B Strep or Strep B) is a type of bacteria which lives in the intestines, rectum, or vagina of 2 to 4 in every ten women in the UK (20 to 40%). This is often referred to as 'carrying' or being 'colonised with' group B Strep. Most women carrying GBS will have no symptoms. Carrying GBS is not harmful to you, but there is a small chance it can affect your baby around the time of birth. GBS can occasionally cause serious infection in young babies and, very rarely, in babies before they are born. Carrying GBS can also sometimes lead to serious infections for pregnant women, though this is also rare. (https://gbss.org.uk/)
Group B Streptococcus (GBS) Meningitis	Group B streptococcus (GBS) meningitis is a rare but very serious infection that can cause death or long-term disability in a baby.
Guidelines for the Provision of Anaesthetic Services (GPAS)	Support anaesthetists with responsibilities for service delivery and healthcare managers to design and deliver high quality anaesthetic services. (RCoA)
HemoCue®	Point of care testing during obstetric emergencies (including major obstetric haemorrhage) to rapidly test for haemoglobin (Hb) levels, to determine what level of blood and blood product transfusion may be required.
Haematoma	A collection of blood which is located outside the blood vessels. (NHS)
Haematuria	Blood in urine.
Haemodynamic Instability	Abnormal or unstable blood flow when pulse and blood pressure are not stable.
Haemoperitoneum	Blood in the abdominal cavity, also known as intra-abdominal bleeding.
HDU	High Dependency Unit.
Health Services Safety Investigations Body (HSSIB)	An independent body of the Department of Health and Social Care, launched in 2023, who investigate patient safety concerns across England to improve NHS care at a national level. (HSSIB)
HOM	Head of Midwifery.
HELLP Syndrome	A rare, severe liver and blood clotting disorder that can affect pregnant and post-partum mothers. It is a severe form of pre-eclampsia. (NHS) (H) haemolysis (EL) elevated liver enzymes (LP) low platelets.
Herpes Simplex Virus (HSV)	Herpes simplex virus (HSV) is a virus that is spread by close contact or sexual activity. In newborn babies, HSV infections can spread rapidly if left untreated, causing death or brain injury. (BLISS)

Heya	A Nottingham based group for all Arab Women who have recently moved to the UK and lack personal and social networks, resulting in social isolation.
High Anaesthetic Block	A high anaesthetic block (or high neuraxial block) is a rare, serious complication of spinal or epidural anesthesia where local anesthetic spreads too high. It can cause severe hypotension (low blood pressure), breathing difficulties, and potential loss of consciousness, requiring immediate emergency intervention.
High Flow Nasal Therapy (HFNT)	A non-invasive way to administer humidified air and oxygen for breathing support in babies on the neonatal unit via nasal prongs.
Healthcare Safety Investigation Branch (HSIB)	A national programme which carried out independent safety investigations into NHS-funded maternity care across England from 2018 to 2023. The maternity investigations programme is now known as the Maternity and Newborn Safety Investigations (MNSI) programme, hosted by the CQC from 2023. (MNSI)
Human factors	Human Factors in healthcare involve enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings to improve safety. (NHSE)
Hyperstimulation (uterine)	Uterine hyperstimulation (which may reduce the oxygen flow to the baby), is defined as either: More than 5 contractions in ten minutes over a 30 minute period. OR Contractions lasting more than 2 minutes in duration AND resulting in fetal heart rate changes. (NHS)
Hypertension	High blood pressure.
Hypochloraemia	When the body has low levels of chloride in the blood, causing an imbalance in electrolytes.
Hypofibrinogenaemia	A coagulation disorder following trauma or surgery due to a reduced plasma fibrinogen concentration.
Hypoglycaemia	A lower than normal blood-glucose concentration (NICE)
Hyponatremia	Hyponatraemia is a low level of sodium in the blood. NHS
Hypotension	Low blood pressure.
Hypothermia	A dangerous drop in body temperature. (NHS)
Hypovolaemia	Low blood volume, usually secondary to blood loss.
Hypovolaemic Shock	Hypovolemic shock is a serious medical emergency that requires immediate treatment, and is caused by a large loss of blood or fluids preventing organs from getting oxygen and nutrients needed to function. This can lead to organ failure and can be fatal.

Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia).
Hypoxic-Ischaemic Encephalopathy (HIE)	A serious condition that occurs when a newborn baby's brain does not receive enough oxygen and blood around the time of birth. HIE is a major cause of neonatal death and long-term problems such as cerebral palsy, learning difficulties, and epilepsy. HIE is graded as mild (grade 1), moderate (grade 2) or severe (grade 3).
Hysterectomy	A surgical procedure to remove the uterus (womb). NHS
ICU	Intensive Care Unit.
Ileus **Also known as Paralytic Ileus or Functional Ileus**	An ileus occurs when there is a lack of movement of the bowel (sometimes following abdominal surgery). This stops the contents of the bowel moving through the body. Ileus results in abdominal distension, pain, nausea, vomiting, and an inability to pass stools or tolerate a solid diet. (NHS)
Index of Multiple Deprivation (IMD)	Indices of Multiple Deprivation measure relative levels of deprivation by postcode, and group individual areas into categories such as deprivation quintiles (1 to 5) or deciles (1 to 10), with 1 being the most deprived.
Instrumental Delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby.
Integrated Care Board (ICB)	Replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022 (NHS)
Intermittent auscultation (IA)	A technique to monitor fetal well-being in labour by listening to the baby's heart rate at set intervals using a Pinard stethoscope or handheld Doppler, focusing on the rate and patterns after contractions to detect potential hypoxia, allowing freedom of movement while enabling timely intervention if needed for low-risk pregnancies (NICE, 2025).
Interventional Radiology (IR)	A sub-specialty radiology service that involves performing a range of image-guided procedures, including embolisation (a procedure to stop severe bleeding during and following surgery). (Royal College of Radiologists RCR).
Intra-abdominal Ectopic Pregnancy	An intra-abdominal ectopic pregnancy is extremely rare (1% of all ectopic pregnancies) where the fertilised egg implants in the abdominal cavity outside of the female reproductive organs and unfortunately results in pregnancy loss.
Intrapartum	The time from the onset of a mother's labour to when a baby is born.
Intrathecal Catheter	A thin flexible tube used by the anaesthetist to inject anaesthetic into the space surrounding the spinal cord. This is used during siting a spinal anaesthetic.
Intravenous	Giving medicines or fluids through a needle or tube inserted into a vein.

Intravenous Iron Infusion	A procedure where iron is delivered directly into the bloodstream through a vein to rapidly treat iron deficiency anaemia.
Intrauterine Fetal Death (IUFD)	When a baby dies whilst they are inside their mother's uterus (womb).
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain, typically in premature babies.
Intubation (endotracheal)	Placing a breathing tube (endotracheal tube) into an airway to assist ventilation.
ITU	Intensive Therapy (care) Unit
IPC	Infection Prevention & Control.
Jaundice (Newborn)	Jaundice in newborn babies is common and usually harmless. It causes yellowing of the skin and the whites of the eyes. The medical term for jaundice in babies is neonatal jaundice. Treatment is usually only recommended if tests show very high levels of bilirubin in a baby's blood. (NHS)
Ketonuria	A high level of ketones in urine. It is commonly seen in people with diabetes. It can also happen during pregnancy when a mother is dehydrated due to pregnancy related nausea and vomiting.
Klebsiella	Klebsiella species are a Gram-negative bacteria and can cause a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis. (Gov.Uk)
Labetalol	A medication to treat high blood pressure (hypertension) of the mother in pregnancy. Babies, born of mothers treated with Labetalol in pregnancy require monitoring for potential side effects, including hypoglycemia, bradycardia, and hypotension.
Labour Ward Coordinator	A senior midwife who coordinates the clinical workload and activity on the labour ward and is normally supernumerary.
Laparotomy	A laparotomy (surgical opening of the abdomen) is a surgical procedure that involves an incision being made in the abdominal wall. This allows the surgeon access in order to identify and repair any emergency problems that may have occurred. (NHS)
Laryngoscope	An instrument to allow visualising of the airway to enable intubation.
Laser Ablation (Twins)	Intrauterine laser ablation of placental vessels is a treatment of twin-to-twin transfusion syndrome. This involves using a laser to seal off some of the blood vessels in the placenta so both babies receive a more equal amount of blood. (NICE / NHSE)
Latent Phase of Labour	The latent phase of labour (early labour) is a timeframe, not necessarily continuous, often over several days, when there are contractions with some

	cervical change which includes cervical position, consistency, effacement and dilatation up to 4cm (NICE)
Liquor	The water surrounding the baby in the womb.
Less Invasive Surfactant Administration (LISA)	A method of administering surfactant to newborn infant's lungs, reducing the need for mechanical ventilation during neonatal intensive care.
Level 3 Neonatal Unit	Neonatal units were graded 1-3, 3 being equipped to care for the most preterm and unwell infants requiring the highest levels of intensive care.
Local Authority	Refers to an organisation within local government who is responsible for public services and facilities.
Local Maternity and Neonatal System (LMNS)	The Local Maternity and Neonatal Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board.
Local Neonatal Unit (LNU)	(Formerly known as Level 2 Unit): An LNU can deliver very short term intensive care and high dependency care but if longer term intensive care is required, then the baby should be transferred to a NICU.
Local Supervising Authority Midwifery Officer (LSAMO)	A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was discontinued in 2017.
Local Supervisory Authority (LSA)	This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) who set rules and standards for nursing and midwifery.
Low Molecular Weight Heparin (LMWH)	An anticoagulant (blood thinner) derived from Unfractionated Heparin and is used to treat & prevent blood clots.
Low PAPP-A Low Pregnancy Associated Plasma Protein-A	PAPP-A is a hormone made by the placenta, is measured as part of the combined screening test in pregnancy. Low PAPP-A may be associated with an increased chance of pregnancy complications including a smaller for gestational age baby or preterm birth. (NHS)
Lumbar Puncture (LP)	A lumbar puncture (LP), sometimes called a spinal tap, is a medical procedure carried out to obtain a sample of cerebrospinal fluid (CSF).
Lymphoma	A type of blood cancer that affects the immune system (Blood Cancer UK)
Magnesium Sulphate (for neuroprotection of a baby's brain)	A medicine given by a vein to mothers to help to protect the brain of babies at risk of being born prematurely, and reduce the risk of cerebral palsy. (NHSE)

Magnesium sulphate (for severe pre-eclampsia / Eclampsia)	A medicine given by a vein to mothers with severe hypertension, severe pre-eclampsia, HELLP Syndrome, or eclampsia, to prevent maternal seizures. (NICE)
Major Obstetric Haemorrhage (MoH)	Major Obstetric Haemorrhage (MOH) may be defined as moderate (1000–2000 ml) or severe (≥2000 ml). Protocols should be in place to ensure a rapid and highly coordinated response, managed with multidisciplinary involvement including obstetrics, anaesthesia, midwifery, and transfusion medicine specialists (and others). RCOG
Managing Medical and Obstetric Emergencies and Trauma (mMOET)	Advance Life Support Group's (ALSG) clinical education & training programme provides a high-level structured approach to recognition, resuscitation and treatment of medical emergencies and trauma in those with the altered physiology and anatomy of pregnancy. (ALSG)
Manual Removal of Placenta (MROP)	A surgical procedure performed in theatre to extract the placenta from the uterus after birth, when it has not delivered vaginally. (NHS)
Maternal Death	The death of a woman in pregnancy or up to 42 days following birth or the end of pregnancy. A late maternal death is defined as the death of a woman between 42 days and one year following birth or the end of pregnancy. Direct – deaths resulting from obstetric complications during pregnancy, labour or the puerperium. Indirect – deaths resulting from previous existing disease, or disease that developed during pregnancy, which was aggravated by the physiological effects of pregnancy. Coincidental – deaths from unrelated causes which happen to occur in pregnancy or the puerperium. (WHO)
Maternal Medicine Network	Maternal medicine networks provide pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the postnatal period. (NHSE)
Maternity Advice Line (MAL)	NUH has a dedicated Maternity Advice Line (MAL) which is covered by a team of midwives.
Maternity and Neonatal Collaboration	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
Maternity and Newborn Safety Investigations programme (MNSI)	Part of a national strategy to improve maternity safety across the NHS in England, by performing independent maternity investigations Previously established in 2018 as part of the Healthcare Safety Investigation Branch (HSIB) and re launched in 2023 as MNSI hosted by the Care Quality Commission. (MNSI)
Maternity Dashboard	A tool used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of birth.

Maternity Incentive Scheme (MIS)	A financial incentive program, launched in 2018 with ten standardised safety actions designed to enhance maternity safety within NHS Trusts, who must evidence compliance annually. (NHSR)
Maternity Safety Champions	Maternity safety champions are leaders across NHS trusts, regional, and national levels responsible for fostering a positive safety culture from 'floor to board' and implementing best practices to improve outcomes for mothers and babies. (NHSE)
Maternity Safety Support Programme (MSSP)	Launched in April 2018, the Maternity Safety Support Programme aims to help maternity services achieve sustained improvement across the five CQC domains (safe, effective, caring, responsive to people's needs, well-led). (NHSE)
Maternity Transformation Programme	The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for mothers by ensuring that there is capacity in the workforce nationally. (NHS)
Maternity and Neonatal Voices Partnerships (MNVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. (NHS)
MBRRACE-UK	The main purpose of MBRRACE-UK is to conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. By investigating these deaths, MBRRACE-UK hopes to prevent similar deaths or serious complications in the future.
MDT	Multi-disciplinary Team
Meconium	The first bowel movement a baby has is called meconium.
Meconium Aspiration Syndrome (MAS)	Occurs when a newborn breathes a mixture of meconium and amniotic fluid into the lungs before delivery. Meconium aspiration syndrome is a serious complication, and a cause of severe illness in newborns. (NHS)
Meningioma	A meningioma is a primary central nervous system tumour. This means it begins in the brain or spinal cord.
Metabolic Acidosis	An often serious condition characterised by an accumulation of acid in the blood and a low blood pH. It is frequently linked to conditions such as sepsis, asphyxia, and respiratory failure.
Methotrexate	A cytotoxic drug used in medical management of ectopic pregnancy.
MEWS or MEOWS	An early warning score or guide, specific to pregnant or postnatal mothers based on vital signs to help identify deterioration in the mother and ensure appropriate early intervention. (RCOG)
Mifepristone	A drug that blocks progesterone, (the hormone that supports pregnancy), and is administered 36 to 48 hours prior to misoprostol, as part of the process of induction of labour following intrauterine fetal death. (NHS)

Misoprostol	Misoprostol is a synthetic prostaglandin medication used in conjunction with Mifepristone as part of the process of induction of labour following intrauterine fetal death, by stimulating contractions. Misoprostol is also used in managing post-partum haemorrhage (PPH). (NHS)
Molar Pregnancy	A molar pregnancy (sometimes called a hydatidiform mole) are rare and chromosomally abnormal pregnancies that have the potential to become malignant. A molar pregnancy is not viable.
Monochorionic Twins	Identical twins that share the same placenta. They may have a separate amniotic sac (bag of waters around each baby), known as 'monochorionic diamniotic' (MCDA) twins, or one shared amniotic sac, known as 'monochorionic monoamniotic' (MCMA) twins, which are rarer and carry a higher risk of complications.
Montgomery Principles	Precedents established through common law for valid consent mean that people with capacity to make decisions about their care and treatment must be thoroughly advised about their treatment options, and the risks associated with each option. (NHSE)
Morbidity and Mortality Meeting (M & M Meeting)	Structured, confidential clinical governance meetings held in healthcare settings to review patient deaths and severe complications. They promote learning, enhance patient safety, and identify system-based improvements, rather than assigning blame. They are crucial for training and professional development.
MRI Scan	Magnetic Resonance Imaging – a detailed scan.
MRSA	MRSA is a type of bacteria that usually lives harmlessly on the skin. But if it gets inside the body, it can cause a serious infection that needs immediate treatment with antibiotics. (NHS)
MSW	Maternity Support Worker.
Multiparous	A mother who has given birth before.
National Audit Projects (NAPs)	The National Audit Projects (NAPs) are internationally recognised as important reports with potentially significant impact on anaesthetic practice and patient outcome. (RCoA)
National Maternity Early Warning Score (MEWS)	The first national maternity early warning scoring tool for England, and the first based on population data. The new system is being rolled out across the English NHS, with an aim for completion in March 2026 to help healthcare providers in all settings to identify and respond to signs of deterioration in pregnant women. (NHS)
National Neonatal Audit Project (NNAP)	National audit of important neonatal outcomes, allowing comparison between providers.
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports.

NCH	Nottingham City Hospital.
Necrotising Enterocolitis	Necrotising enterocolitis (NEC) is a serious, life-threatening illness in newborns affecting the bowel. It is most common in very premature babies. (BLISS)
Neonatal	Refers to an infant in the first 28 days after birth.
Neonatal Data Analysis Unit (NDAU)	Collects and analyses neonatal data nationally.
Neonatal death	A baby who dies in the first 28 days of life: • Early neonatal death - a live born baby who died before 7 completed days after birth. • Late neonatal death - a live born baby who died after 7 completed days, but before 28 completed days after birth.
Neonatal Intensive Care Unit (NICU)	(Formerly known as Level 3 Unit): A NICU will deliver all types of care including intensive care. Some NICUs will also provide specialist neonatal surgical care.
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also knows as 'managed clinical networks' or 'operational delivery networks'.
Neonatal Transitional Care (NTC)	Neonatal Transitional Care (NTC) supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require to be in a neonatal unit (NNU). (BAPM)
Newborn Life Support (NLS)	Newborn Life Support Course (national training course).
NHS England and NHS Improvement (NHSE&I)	NHS Improvement and NHS England have worked together as a single organisation since 1 April 2019, to help improve care for patients and provide leadership and support to the wider NHS.
NHS England Labour Ward Coordinator Framework	This framework provides labour ward co-ordinators with a pathway of continuous development and supports the workforce to develop their skills and proficiencies to provide high-quality care.
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manage negligence and other claims against the NHS in England on behalf of its member organisations. Their aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff.
NHS Resolution	A body of the Department of Health and Social Care. They provide expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care.
NICE	National Institute for Health and Care Excellence.

NNU	Neonatal unit
Nuchal Translucency (NT)	Also called nuchal fold or nuchal thickness, it is a measurable area at the back of the fetal neck, examined using ultrasound as part of combined screening for Down's, Edward's and Patau's syndromes from 11 to 13 weeks and six days of pregnancy.
NUH	Nottingham University Hospitals NHS Trust.
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland.
Obstetric Anal Sphincter Injury (OASI)	A third or fourth-degree perineal tear (when a tear extends into the anus (back passage), occurring in approximately 3 in 100 women after a vaginal birth. (RCOG)
Obstructed Labour (labour dystocia)	Slow progress in labour despite adequate contractions, fetal malposition, reduced urine output and/or haematuria (blood in urine) and blood-stained liquor can all be signs of obstructed labour.
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour.
Oedema	Accumulation of fluid in bodily tissues
Oligohydramnios	When the amount of amniotic fluid (also referred to as liquor) surrounding the baby is lower than the expected normal range. (NHS)
Organisational Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations. These shared values, beliefs and norms create an environment where collaboration, communication, professionalism, respect for diversity, and innovation are critical components of day-to-day operations.
Organisational Development (OD)	Leading change, service improvement initiatives, engaging and motivating staff, developing their talents and improving potential of staff. Great OD is about understanding context and culture, taking a systems approach and enabling NHS staff to design and deliver great patient care. (NHS)
Oxytocin	A hormone commonly given intravenously for induction of labour, or in labour, to increase uterine contractions.
Paediatric	A branch of medicine that cares for infants, children and adolescents.
Parenteral Nutrition	Nutrients given directly into the bloodstream intravenously, bypassing the digestive system (NICE)
Parliamentary and Health Service Ombudsman (PHSO)	The PHSO look into, and make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other UK public organisations, and where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. (PHSO)

Patient Safety Incident Response Framework (PSIRF)	PSIRF, in 2024, replaced the Serious Incident Framework (2015) and forms part of the NHS patient safety strategy. It sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
PCA	Patient controlled analgesia.
Pelvis after pregnancy (PAP) Clinic	A clinic at QMC and NCH for mothers who sustain perineal complications following birth, including mothers who sustain a 3rd or 4th degree tear, postnatal bladder dysfunction and wound healing problems.
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth.
Perinatal Culture and Leadership Programme (PCLP)	A national NHS initiative designed to improve the safety and quality of maternity and neonatal care by transforming workplace culture. (NHS)
Perinatal Death	A stillbirth or early neonatal death (before 7 completed days after birth). MBRRACE-UK
Perinatal Mental Health (PNMH)	Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. (NHS)
Perinatal Optimisation	The process of evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes for babies, including: correct place of birth, antenatal steroids, magnesium, delayed cord clamping, admission with a normal temperature and early breast milk. (BAPM)
Perineal Tears	First-degree perineal tears are small tears affecting only the skin which usually heal quickly and without stitches. Second-degree perineal tears affect the muscle of the perineum and the skin. These usually require stitches. For some mothers (3.5 out of 100) Third or fourth degree tears, also known as obstetric anal sphincter injuries (OASI), extend into the muscle that controls the anus (anal sphincter). These deeper tears need repair in an operating theatre. Third degree tears involve partial anal sphincter involvement. Fourth degree tears involve a complete tear of the anal sphincter involving the bowel lining. (RCOG)
Perineum	The area between the anus and the vagina. (NHS)
Peripartum	The period during pregnancy, birth, and after giving birth. (NHS)
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it.
Placenta Accreta Spectrum	Placenta accreta is a spectrum disorder ranging from abnormally adherent to deeply invasive placental tissue (into the muscle of the uterus)

	Placenta accreta: the placenta firmly attaches to the superficial layers of the myometrium. Placenta increta: the placenta is more deeply embedded into the myometrium. Placenta percreta: the placenta passes through the myometrium and attaches to the outer layer of the uterus (serosa), and sometimes becomes attached to adjacent organs such as the bladder.
Placenta Praevia	When the placenta attaches in the lower part of your uterus (womb), sometimes completely covering the cervix (neck of the womb). This can cause heavy bleeding during pregnancy or at the time of birth. The baby will need to be born by caesarean birth. (RCOG)
Placental Abruption	The early separation of some, or all, of the placenta from the lining of the uterus (womb) in pregnancy or during labour and birth. It causes bleeding (sometimes concealed), and can be dangerous for the mother and the baby. (NHS)
Perinatal Mortality Review Tool (PMRT)	A national review tool launched in 2018 designed to support standardised perinatal mortality reviews (including late miscarriages, stillbirths, and neonatal deaths from 22 weeks) across NHS maternity and neonatal units in England, Scotland, Wales and Northern Ireland. (MBRRACE-UK)
Phototherapy (Newborn)	Phototherapy is treatment with a special type of blue light (not sunlight or ultra-violet) that is used to treat newborn jaundice by making it easier for a baby's liver to break down and remove excess bilirubin in blood. The baby will be placed under a light either in a cot or incubator. If the baby's jaundice does not improve, intensive phototherapy may be offered. This involves increasing the amount of light used or using another source of light, such as a light blanket, at the same time. (NHS)
Pneumonia	Pneumonia is inflammation of the lungs, usually caused by an infection. (NHS)
Pneumothorax (Tension)	Pneumothorax is the collection of air or gas in the space inside the chest around the lungs. When the accumulating air is under pressure a 'tension pneumothorax' results. This is an acutely life threatening situation and immediate drainage will be required.
Polyhydramnios	When there is too much amniotic fluid (the fluid that surrounds the baby in the womb) during pregnancy (NHS)
Post-dural puncture headache (PDPH)	A specific kind of severe headache which can only happen after an epidural or spinal injection (Risk 1 in 100 and 1 in 500 procedures). The brain and spinal cord are contained in a bag of fluid. The bag is called the dura and the fluid is called the cerebro-spinal fluid (CSF). If the needle passes through the dura, a small hole is made, through which CSF can leak out. A post dural puncture headache is frequently treated with an epidural blood patch in theatre. (RCoA)

Post-partum	The period immediately after birth to 6 weeks (40 days) after birth.
Post-partum Cardiomyopathy (PPCM)	PPCM is a rare type of heart muscle disease which occurs during the last part of, or in the first few months after, pregnancy. (Cardiomyopathy.UK)
Post-partum Haemorrhage (PPH)	Excessive blood loss that occurs within 24 hours of birth (primary PPH) or >24 hours and up to 12 weeks postpartum (secondary PPH) (RCOG)
Post-traumatic Stress Disorder (PTSD)	Post-traumatic stress disorder (PTSD) is a mental health diagnosis caused by traumatic, frightening or distressing events. The symptoms may include (for example) nightmares, flashbacks and trouble sleeping. (NHS)
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is born. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby.
Pre-labour Rupture of Membranes (PROM)	Pre-labour rupture of membranes (PROM) occurs in 8% of pregnancies and around 60% of these women will begin labour spontaneously within 24 hours (NICE)
Preterm Prelabour Rupture of membranes (P-PROM)	A woman is described as having P-PROM if she has ruptured membranes before 37+0 weeks of pregnancy but is not in established labour (NICE)
Prevent Future Deaths Report (PFD) (Regulation 28)	Following an inquest or investigation into a death, a coroner may issue a Regulation 28 Prevent Future Deaths (PFD) report to a person, organisation, local authority, government department or agency, where the coroner believes that action to address some of the identified concerns should be taken to prevent future deaths. (NHSE)
Primary Care Trust (PCT or PPT)	Were part of the NHS in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCG).
Primigravida	A mother who is pregnant for the first time.
Primiparous	A mother who has not given birth before.
Professional Midwifery Advocates (PMAs)	A nationally launched professional model, where midwives with extra training, aim to support and empower midwives to provide safe, high quality, kind, compassionate, care to mothers and their families. (NHS)
PROMPT (Practical Obstetric Multi-Professional Training)	A widely used, evidence-based mandatory training package in the NHS designed to improve maternity outcomes by training midwives, obstetricians, anaesthetists and other clinicians together in emergency scenarios. It reduces neonatal injury, reduces litigation costs, and enhances team communication. (PROMPT)

Propess®	A synthetic hormone (prostaglandin) which induces labour by encouraging the cervix to soften and shorten (ripening). It is like a very small tampon which is placed high into the vagina behind the cervix. It slowly releases prostaglandin over 24 hours. (NHS)
Prophylaxis	Procedures and treatments that are given to prevent something from happening, rather than treat it. For example medication.
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation).
Prostin®	A synthetic hormone (prostaglandin) inserted vaginally as a gel which induces labour by helping the cervix to soften and shorten (ripening).
Proteinuria	Protein detected in a urine sample which can be a symptom of pre-eclampsia.
Pseudomonas Aeruginosa	Gram-negative bacterium found in soil and water that rarely affects healthy people but poses a significant risk to hospital patients with weakened immune systems such as premature babies.
Psychological Safety	When you feel able to express your ideas and concerns openly, ask questions, recognise your mistakes, challenge others, including authority figures, without fear of negative consequences. (RCN)
Puerperium	The period of about six weeks after childbirth during which the mother's reproductive organs return to their original non-pregnant condition.
Pulmonary	Relating to the lungs.
Pulmonary Embolism (PE)	A pulmonary embolism is when a blood clot blocks a blood vessel in the lungs. It can be life-threatening if not treated quickly.
Pulmonary Oedema	Is a serious condition where an excess of fluids build up in the lungs, making it difficult to breathe.
Pulse Oximetry Screening (newborn)	A safe, quick, simple non-invasive test for detecting hypoxia and some critical congenital heart defects (CCHD) in newborn babies. (BAPM)
Pyrexia	High temperature.
QMC	Queen's Medical Centre.
Quick Reference Handbook for Obstetric Emergencies (Obs QRH)	A collection of action card guides for medical and resuscitation emergencies in hospitals. These guides are intended to help the multidisciplinary teams caring for mothers and their babies.
RCOG	Royal College of Obstetricians and Gynaecologists.
RCPCH	Royal College of Paediatrics and Child Health.

Reduced Fetal Movements (RFM)	A reduction or sudden alteration in fetal (baby) movements is a potentially important clinical sign and can be of concern. Reduced or absent fetal movements may be a warning sign of fetal compromise.
Renal	Relating to the kidneys.
Resident Doctor	Resident doctors are qualified doctors in clinical training. (BMA)
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs (surfactant deficiency).
Resuscitation Council UK (RCUK)	A leading charity and professional body established in 1983 that sets evidence-based, national guidelines and algorithms for cardiopulmonary resuscitation (CPR) and lifesaving techniques.
Retained Products of Conception (RPOC)	When pregnancy-related tissue (e.g. placental tissue or membranes) remain in the uterus (womb) after delivery of the placenta (afterbirth).
Retinopathy Screening (Newborn)	A diagnostic eye exam for premature babies to detect abnormal growth of blood vessels in the retina, which can lead to scarring or retinal detachment and cause blindness. (RCPCH)
Root Cause Analysis (RCA)	RCA is a systematic incident investigation method that can be used to identify the underlying systems factors that led to a patient safety incident. (NHSE)
Royal College of Anaesthetists (RCoA)	The professional body responsible for the specialty of anaesthesia in the UK. (RCoA)
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce.
Royal College of Physicians (RCP)	A professional membership organisation representing around 40,000 physicians worldwide. (RCP)
Royal College of Physician's Acute Care Toolkit for Acute Medical Problems in Pregnancy	A toolkit launched in 2019 which provides practical guidance on the management of mothers with acute medical problems in pregnancy for hospital physician s and others who may be unfamiliar with the normal physiology of pregnancy and / or diseases that present in pregnancy. (RCP)
Safety Culture	A culture in which staff are valued, treated with civility and respect, well supported and engaged in their work leads to safe, high-quality care. (NHS)
Salpingectomy	Removal of a fallopian tube.
Sanctuary Birth Centre	Sanctuary Birth Centres at Queen's Medical Centre (QMC) or City Hospital (which are alongside the Maternity Units).
SANDS	Stillbirth and Neonatal Death Support Charity.

Saving Babies Lives Care Bundle V3 (SBLCB)	A national bundle of 6 safety standards to improve safety and outcomes in maternity care, forming one of the ten Safety Actions within the Maternity Incentive Scheme (MIS). • Reducing smoking in pregnancy. • Risk assessment surveillance and management of fetal growth. Raising awareness of reduced fetal movement (RFM). • Effective fetal monitoring during labour. • Reducing preterm birth. • The management of pre-existing diabetes.
Second Stage of Labour	From when the mother's cervix is fully dilated until the birth of the baby.
Sepsis	Sepsis is an overwhelming and life-threatening inflammatory response to a severe infection, which can lead to tissue damage, organ failure, and death. (NICE)
Serious Incidents	Serious Incidents include acts or omissions in care that result in; unexpected or avoidable injury or death. Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. Previously known as Serious Untoward Incidents (SUI).
Shoulder Dystocia	An emergency situation when a baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. (NHS)
Sickle Cell Anaemia	Sickle cell disease is the name for a group of inherited health conditions that affect the red blood cells. The most serious type is called sickle cell anaemia. Sickle cell disease is a serious and lifelong health condition, although treatment can help manage many of the symptoms. (NHS)
Situational Awareness	Situational awareness is being aware of what is happening around you, what others are doing and what will happen next. A range of factors, in particular high-pressure or stressful situations, can cause a loss of situational awareness.
Small for Gestational Age (SGA)	Refers to a baby identified by ultrasound in pregnancy to have an estimated fetal weight of less than the 10th centile for gestational age OR a baby born with a birth weight less than the 10th centile. (RCOG)
Special Care Units (Neonatal) SCU	(formerly known as Level 1 neonatal unit) These provide special care for their own local population. All SCUs must be able to provide stabilisation and/or resuscitation for newborn babies of all gestations.
Spontaneous Rupture of Membranes (SROM)	When the protective sac of liquor (waters) around the baby breaks naturally. (NHS)
Stillbirth	The death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antepartum stillbirth occurs prior to the onset of labour.
Strategic Executive Information System	

(StEIS)	An intrapartum stillbirth occurs after the onset of labour. (MBRRACE-UK) A system (which holds Serious Incidents, as defined by the revised Serious Incident Framework (2015). Never Events, as defined by the Never Events framework, are also included here. StEIS will eventually be decommissioned and its functions replaced by 'Learn from patient safety events' (LFPSE) (NHSE)
Supervisor of Midwives (SoM)	Midwifery Supervision was established to provide support and advice to midwives and ensure practice was consistent with the regulatory framework of the Nursing and Midwifery Council (NMC). Supervisors were accountable to, and appointed by, the Local Supervisory Authority Midwifery Officer (LSAMO). Statutory midwifery supervision was formally discontinued with the enactment of new legislation which separated supervisory and regulatory functions, retaining supportive mechanisms at Trust level, while the regulatory function reverted to the NMC.
Surfactant	A naturally occurring biological lubricant medicine given directly into the lungs of premature babies. Treatment with surfactant has been shown to reduce the risk of death and bronchopulmonary dysplasia (BPD) in preterm infants. (NHS)
Symphysis Fundal Height (SFH)	A measurement from the Symphysis Pubis to the top of the fundus (womb) that estimates fetal growth when plotted on a growth chart.
Symphysis Fundal Height (SFH) Growth Chart	A chart which is used to plot serial fundal height measurements in pregnancy to estimate fetal growth. 'non-customised' or 'population based charts' or 'customised charts' (which adjust for physiological variables such as maternal height, weight, ethnic origin and parity) are in use in Trusts. (NHS)
Syntocinon	Syntocinon (a synthetic form of Oxytocin) is a drug used to induce or strengthen contractions via intravenous infusion during labour, and prevent, or treat postpartum haemorrhage.
Tachycardia	When the heart beats faster than normal. (NHS)
Tachypnoea	A respiratory (breathing) rate greater than the normal range.
Tachysystole (Uterine)	Uterine Tachysystole is defined as: more than 5 contractions in 10 minutes over a 30-minute period AND The CTG remains 'Normal'. (NHS)
TACO	Transfusion-associated Circulatory Overload.
Therapeutic Hypothermia (Cooling Therapy)	A way to treat newborn babies who have experienced a lack of oxygen to the brain and other organs before or during labour and birth, and include babies with moderate or severe Hypoxic-Ischaemic Encephalopathy (HIE). The baby is cooled from the normal body temperature of 37°C (98.6°F) down to a temperature of 33.5°C (92.3°F), for 72 hours to help protect the brain.
Therapeutic Lactation Suppression	Use of medication to suppress milk production.
Thermoregulate	Whereby the body maintains its core temperature.

Third Stage of Labour	The time between birth of the baby and the birth of the placenta and membranes.
Thrombocytopenia	Low blood platelet count.
Thrombophilia	Blood has an increased tendency to form clots. (NHS)
Thromboprophylaxis	Methods used to prevent blood clots in pregnant women or those who have recently given birth, who are at increased risk. (RCOG)
Thrombosis	Blood clot in a blood vessel, usually in a vein.
Tissue Viability **Tokophobia**	Relates to care of skin to prevent damage from pressure, the positioning of medical devices or restricted mobility. Tissue viability nurses, may offer guidance on how to treat wounds, skin damage and pressure ulcers. A pathological fear of pregnancy and birth.
Tranexamic Acid (TXA)	A medication used to treat or prevent excessive bleeding by helping blood to clot.
Transcutaneous Bilirubinometer	A non-invasive device using light reflection to estimate bilirubin levels in the skin of babies with suspected jaundice. (NICE)
Trauma-informed Care (TIC)	Approach to health and care interventions grounded in understanding that trauma exposure impacts individuals' neurological, biological, psychological and social development. (gov.uk)
Trial of Instrumental Birth	The majority of instrumental vaginal births take place on labour ward, but in some cases of anticipated difficult births a trial of instrumental vaginal birth is conducted in theatre with preparations for proceeding to caesarean section if required.
Twin to Twin Transfusion Syndrome (TTTS)	Identical twins who share a placenta (monochorionic) have blood connections in the placenta. Twin-to-twin transfusion syndrome (TTTS) happens when there are too many blood connections in one direction, causing an unequal flow of blood between twins, and is potentially life threatening to the unborn babies. (NHSE)
Umbilical Artery Dopplers (UA)	Umbilical arterial (UA) Doppler assessment by ultrasound is used to survey fetal well-being in the third trimester of pregnancy. Abnormal umbilical artery Doppler is a marker of placental insufficiency and consequent intrauterine growth restriction (IUGR). (ISUOG)
UNICEF / WHO Baby Friendly Initiative (BFI)	United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO) launched the initiative in 1991 to encourage health facilities worldwide to better support breastfeeding and to promote optimal clinical care for new mothers and their infants. It was introduced to the UK in 1994 to support best practices in infant feeding. (UNICEF)
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment.

Uterine Arteriovenous Fistula (UAVF)	Uterine arteriovenous fistula (UAVF) is a rare acquired cause of life-threatening vaginal bleeding and can occur after traumatic events, (surgery, delivery or miscarriage), or in the setting of a preexisting pathologic uterine process.
Uterine Artery	Main artery supplying blood to the uterus (womb)
Uterine Artery Dopplers (UAD)	Mothers who are high risk for fetal growth restriction (FGR) should undergo uterine artery Doppler ultrasound assessment between 18+0 and 23+6 weeks' gestation. UAD measurements assess the blood flow between mother and baby (SBLV3)
Uterine Artery Embolisation (UAE)	A procedure to stop excessive vaginal haemorrhage. UAE is minimally invasive, with a high success rate and works by blocking the blood supply to the uterus.
Uterine Atony	The failure of the uterus (womb) to contract following delivery, and is the most common cause of postpartum haemorrhage.
Uterine Didelphys	A rare congenital condition where a woman is born with two uteruses
Uterine Rupture	A tear in a mother's uterus (womb) during pregnancy or childbirth. Uterine rupture is a rare event which requires urgent attention. It is associated with significant complications for both a mother and baby.
Uterotonic	A medication used after the birth of the baby for the prevention, or management of post-partum haemorrhage (PPH), by causing the uterus (womb) to contract. (NHS)
Vasa Praevia Vasopressors	A rare condition where blood vessels travelling from the baby to the placenta, If these blood vessels tear, this can be very dangerous for the baby. (RCOG)
VBAC	Vaginal birth after Caesarean
Venous Thromboembolism (VTE)	A condition that occurs when a blood clot forms in a vein. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE). (NHSR)
Venous Thromboembolism (VTE) Risk Assessment	A clinical scoring system or checklist used upon hospital admission (and upon clinical change) to identify patients at risk of developing venous thromboembolism (deep vein thrombosis or pulmonary embolism). (NICE)
Ventouse Birth	A suction cup is applied to the baby's head in order to help deliver the baby. (NHS)
Videolaryngoscopy (VL)	Uses video camera technology to visualise the airway and facilitate intubation.
Wound Dehiscence	A post-surgical complication where the incision, (a cut made during surgery), reopens in the days or weeks after closure. (Wounds-UK)

APPENDIX 3:

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The Care Quality Commission (CQC). Issues this formal notice to NHS Trusts when an inspection identifies a need for 'significant improvement' in the quality of healthcare provided. It sets a strict legal deadline for compliance. If the Trust fails to address the specified concerns within the given timeframe, the CQC can escalate enforcement action, which may include: restricting or suspending services, cancelling the provider's registration, recommending the Trust be placed into Special Measures (now often referred to as 'oversight' under the NHS System Oversight Framework) https://www.cqc.org.uk/guidance-regulation/providers/enforcement/section-29a-warning-notices-nhs-trusts-and-nhs-foundation-trusts

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Designated responsible officer who holds legal accountability for medical revalidation, fitness to practice and liaising with regulatory bodies

https://www.gmc-uk.org/cdn/documents/dc12553--guidance-for-decision-makers-on-the-five-year-rule--external-_pdf-82134517.pdf

Provides an outline of the ongoing work Regulators have undertaken to support the Review, see Appendix.

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Since March 2026, the UK government is actively seeking to change the GMC 'five-year rule' as part of a wider overhaul of medical regulation. https://www.gmc-uk.org/news/news-archive/gmc-welcomes-plans-to-reform-restrictive-legislation#:~:text=And%20end%20to%20the%20'five,a%20requirement%20to%20consult%20stakeholders

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The Home Office Large Major Enquiry System (HOLMES) is a specialised computer system used by UK police forces to manage large-scale investigations, such as murders, complex frauds, and major disasters. It centralises data, enabling real-time collaboration, document management, and cross-referencing of evidence across different police forces.

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