



Campaigners react to damning report on Nottingham maternity care failures

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Maternity war, UK

Charities and campaigning organisations have reacted with sadness and a damning lack of surprise to the findings of the [Ockenden Report](#), which detailed [extensive failings](#) in maternity and neonatal care under Nottingham University Hospitals (NUH) NHS Trust.

The review's leader, independent senior midwife Donna Ockenden, included a [detailed 18-point framework](#) of "Immediate and Essential Actions" for improvement, both nationally and in Nottingham.

A single overarching principle "Martha's Rule" underpinned every recommendation. NHS England [explained that](#)

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration. Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient's condition is getting worse and their concerns are not being responded to.

Maternity services "urgent need for change" warning

The government [has already accepted](#) the recommendation to roll-out Martha's Rule across the UK. However, it will only issue its [full response](#) to Ockenden's review in September.

In the meantime, the NUH has announced that Michelle Welsh, the Labour MP for Sherwood Forest, will chair its new [Learning and Improvement Board](#). The board will oversee the progress of improvements at the NUH trust.

The government previously appointed Welsh as its [first official maternity adviser](#) back on 19 May. At the time, she described the role as “deeply personal to me” due to [her own experiences](#) of medical neglect during childbirth.

Regarding the Ockenden Report, Welsh stated that:

I acknowledge the suffering experienced by the families at the heart of this review, whose courage in speaking out has brought to light the desperate need for change.

Having campaigned for improvements in maternity services for the past five and a half years, I am committed to working collectively with families, staff and partners to ensure lasting improvements are made.

Meanwhile, relevant campaigners are quick to put out statements emphasising the urgent need for change.

National Childbirth Trust: “deeply distressing”

The National Childbirth Trust (NCT) is a [UK charity and campaign group](#) focusing on pregnancy, birth and early parenthood. In response to the Ockenden Report, chief executive [Angela McConville](#) said:

At NCT, we hear from women and parents every day who describe feeling unheard, dismissed or unsupported during pregnancy, birth and the postnatal period. The experiences described in this report are deeply distressing and underline a longstanding issue of women and parents not being listened to, something families have raised for many years. Our research, “From expectation to reality”, found that six in ten parents are worried about the safety of maternity care.

The NCT executive stressed that staffing is a serious issue “though it’s far from a silver bullet:

Workforce shortages and sustained pressure cannot be ignored if we are serious about improving outcomes and experiences for women, parents and babies.

This report makes clear that improving maternity care is not only about more funding or more staffing, important though they are. It is also about culture, leadership, accountability and how women and parents are treated.

Birthrights: ‘sadly of no surprise’

[Birthrights](#) provides information on the human rights of women and birthing people during pregnancy and birth in the UK. It stated:

The findings from the review into the maternity provision at Nottingham, are absolutely shocking – but sadly of no surprise.

They echo what we have been hearing from women and birthing people and health care professionals about the current state of maternity care, in which people and families are repeatedly not listened to or believed – with devastating impact.

Birthrights’s language choice, ‘women and birthing people,’ is important here. Back in February, Valerie Amos’s [interim report](#) on the state of national maternity care highlighted many similar issues to the NUH review.

However, Amos also noted that people are alienated by hospitals failing to recognise the diversity of family structures. Ockenden, [throughout her report](#), reiterated that [same harm](#) by referring to people who give birth solely as ‘women’ and ‘mothers’.

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The Patients Association: ‘profoundly concerning’

The [Patients Association](#) is a charity which campaigns to improve health and social care for patients. Its [press release](#) highlighted the cover-up the review unveiled:

The scale of the failings is profoundly concerning. What the review describes goes beyond mistakes, Donna Ockenden found ‘suppression of information’, a refusal by senior figures to cooperate, and repeated failures to investigate and learn.

[Rachel Power](#), the charity’s chief executive, added that:

The experiences of racism in this review are among its most disturbing findings. No patient should feel their concerns carry less weight because of their ethnicity, language or background. A culture that dismissed women’s pain and denied interpretation support did not emerge overnight and it will not be changed by recommendations alone.

Maternity failures ‘ongoing and persistent’

[Healthwatch](#), a committee of the Care Quality Commission (CQC), aims to give the public a voice regarding their healthcare systems. Chief executive [Chris McCann](#) welcomed the adoption of Martha’s Rule, adding that:

Today's findings reinforce concerns that have been repeatedly highlighted over the past decade through at least six national maternity investigations and reviews. Despite numerous recommendations, the same failings continue to emerge: women are not listened to, their concerns are dismissed or downplayed, and racism and bias within some teams and organisations contribute to significant inequalities in care and outcomes for Black and ethnic minority women.

These ongoing and persistent failures raise serious questions about the NHS's ability to learn from mistakes, respond effectively to patient complaints, and act on concerns raised by whistleblowers. Time and again, opportunities to improve safety and prevent harm have been missed.

A common theme ran throughout the organisations' reactions to the litany of maternity care failures. These issues are well-known; they've happened again and again, often stretching back decades.

Ockenden's report, along with Amos's future national counterpart, must mark a turning point, backed both by government and practitioners' willingness to listen to their patients.

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