



New report details long-standing systematic failures in Nottingham's maternity care

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Nottingham

On 24 June, independent senior midwife Donna Ockenden published her long-awaited review of failures in maternity care under Nottingham university hospitals (NUH) NHS trust. The report identified:

long-standing and deeply embedded systemic failures across multiple areas of maternity and neonatal care.

Then-health secretary Sajid Javid first commissioned the review after eight families came forward with accounts of the harm and loss they suffered. However, by the time the review closed in May 2025, almost 2,500 families had taken part. For the most part, their experiences covered just over 3 years, beginning in 2012.

Likewise, over 800 members of NUH staff contacted Ockenden's team to share information.

In an accompanying letter to health secretary James Murray, Ockenden stated that her 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.

Nottingham's Shocking levels of harm

Among the report's many findings, one particularly alarming statistic was the sheer number of avoidable stillbirths, deaths and complications under NUH. These issues were also compounded by the fact that the trust sometimes downgraded evidence of harm and failed to escalate concerns adequately.

Ockenden's team reviewed 462 stillbirths. Shockingly, they identified significant concerns in the patient's care for one in five of the cases. Likewise, the reviewers also identified similar levels of below-standard care in the 27 maternal deaths examined.

The review also found a failure to protect the dignity of the deceased. In particular, the report noted poor mortuary care, inadequate arrangements for pediatric post-mortems, and one early gestation baby disposed as clinical waste.

Meanwhile, even for the babies which did survive, the team identified:

multiple examples where failures in neonatal care may have contributed to long-term brain injury and adverse neurodevelopmental outcomes.

On top of this, patients often experienced high rates of serious and severe complications whilst giving birth. These included 142 fourth-degree perineal tears, 115 massive obstetric haemorrhages, and 76 instances of severe pre-eclampsia.

Unsurprisingly, the report also noted markers of psychological harm amongst both the patients and clinicians themselves. This effect was most pronounced among those who'd been involved in traumatic births. Often, the psychological harm stemmed from:

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.

â??A small minority of powerful leadersâ??

Among the staff who contributed to the review, the most serious and pressing issues raised related to staffing levels. Some 59% of staff reported regularly working longer hours than the optimal level. Meanwhile, just 11% of respondents believed that staffing levels were adequate for the workload they faced.

Further, 40% of staff reported regular bullying from managers or colleagues. In particular, Ockenden noted that:

concerningly, both mothers and staff â??on the groundâ?? 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 â??infectâ?? the unit.

Whilst Nottingham is one of the most demographically diverse cities in England, this fact wasn't reflected in the makeup of the midwifery workforce. Just 8% of the specialist staff were from a global majority background, compared to 26% in the overall NUH workforce, and 34% of the obstetric workforce.

As such, the report noted that:

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.

However, this [lack of recognition](#) of racism among the staff was far removed from the experiences of the [Black and brown](#) families under their care. Of the [27 maternal deaths](#) the team reviewed, the report stated that:

11 of the deaths occurred among women living in the most deprived areas of the city and 14 occurred amongst women who were not white British.

Whilst global-majority patients were also under-represented in the review itself, those who participated frequently reported communication failures, cultural misunderstandings, systematic barriers, mistrust and a lack of belief from staff regarding their issues.

Failures carry consequences measured across lifetimes

At the end of her letter to the health secretary, Ockenden [stated that](#):

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.

Ockenden's findings regarding failures in Nottingham also mirror issues found across the UK. Most recently, [Valerie Amos](#) highlighted causes for alarm in her nationwide February 2026 interim report on NHS maternity and neonatal services.

Like Ockenden, Amos identified [widespread failures](#) in NHS maternity care. Often, these related directly to discriminatory attitudes and staffing issues. And again, these issues were then exacerbated by a lack of accountability for those same failures.

Currently, [legal compensation](#) for clinical negligence is costing the NHS almost as much as maternity care itself. As of 2024/25, £2.5bn of those payouts related directly to maternity care.

That figure accounts for over half (51%) of the Â£4.9bn cost of negligence claims. Worse still, it represents a 2-point increase on the 49% maternity-related makeup of the same figure for 2023/24.

Pregnancy, giving birth, and the first months of life are periods of profound vulnerability. As such, they are often also a time of profound reliance on the safety net provided by our government and health services.

The fact that both are failing these vulnerable people to such an extent is a damning indictment of the state of care in the UK.

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By [Grace](#)

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