Briefing note: The call for a statutory public inquiry on maternity and neonatal care

Who we are

The Maternity Safety Alliance is a group of harmed and bereaved families who are campaigning for a statutory public inquiry on maternity and neonatal care. Our membership extends across the country.

We have written to Secretary of State James Murray - with the support of a wide range of harmed and bereaved families, charities and other organisations, and individuals including midwives - to demand a statutory public inquiry on maternity and neonatal care.

Why we demand a statutory public inquiry

Each year failings in NHS maternity care kills more than 800 babies, hundreds more sustain life changing and often life limiting avoidable brain injuries, a growing number of mothers are dying, and an unknown because unmeasured number of mothers suffer physical and psychological injuries.

A statutory public inquiry is essential to get to the bottom of what has gone so wrong in maternity and neonatal care, and to identify the effective and sustainable changes that will end this crisis. It is not possible to fix the system without understanding the truth of what has happened and why it has continued despite investigations and reviews in other formats, and a statutory public inquiry with all of its powers and focus is the only way to get to this truth.

For many years the experiences, voices and rights of victims have been disregarded and even sacrificed in the pursuit and promise of ‘learning’. Not only has this ‘learning’ not produced the necessary change, but it has compounded and caused further harm to victims by prioritising the system over the truth, and protecting reputations at the cost of safety. A statutory public inquiry is the only way to give the thousands of babies, mothers and families who have been killed and harmed by failings in maternity and neonatal care the voice, recognition and answers that they deserve. Yes, a statutory public inquiry will deliver real learning - but it will deliver a broader sense of justice too.

What has changed recently

On 24th June the Ockenden report on Nottingham maternity and neonatal care was published, exposing horrors that had unfolded there for over a decade. Among the issues Ockenden uncovered were:

- The refusal of ~30 senior staff to contribute to the review, underlining the need for a statutory public inquiry with its powers to compel witnesses and evidence;
- Failures in death care and mortuaries, which laid bare the inhumanity with which babies and their families have been treated by the NHS, and causing many to re-evaluate what they thought they knew about maternity issues and their causes.

On 30th June the report on the national investigation into maternity and neonatal services, chaired by Baroness Amos, was published. This report was greeted by maternity campaigners, charities and other organisations with a mix of incredulity and anger as it became clear that the Amos investigation had:

- Disregarded much of the evidence given to it by harmed families and charities, with it later emerging that in some cases family evidence had been selectively quoted and/or taken out of context to support a point different to the one made by that family;
- Chosen not to mention many of the babies, children and families at the centre of maternity care, for example by glossing over twin and multiple pregnancies and limiting discussion of brain injured children to the section about compensation claims;
- Made a series of observations rather than providing analysis, scrutiny, or answers;
- Provided recommendations not supported by the detail of the report;
- Not even looked at large and important parts of the maternity and neonatal care system; and
- Not added any new information, analysis, or understanding to the system, ultimately failing in its core purpose.

As a result of these two reports many people and organisations with an interest in maternity and neonatal care have rethought their views on a statutory public inquiry and pledged their support for one. They have realised that this rigorous, truly independent format of investigation is essential to create real, lasting change.

Rebutting arguments against a statutory public inquiry

Costs too much

Costs arguments must be considered in the context of the current cost of harm. NHS Resolution says that around £1.3bn is paid out annually in maternity cases - if a public inquiry led to the prevention of even a fraction of this negligence each year it would rapidly recover its costs. There are also further expected savings as a result of a statutory public inquiry, including on spending by the NHS on ineffective solutions and the wider costs to society of avoidable harm.

Furthermore, it would be obscene to deny a statutory public inquiry on the basis of cost. Tens of thousands of babies and mothers have been killed and harmed by failings in NHS maternity and neonatal care: they deserve the truth, broader justice, and accountability that only a statutory public inquiry can provide.

Takes too long

It is essential that time is taken to reach full understanding and find real solutions to the enduring failings in the maternity and neonatal care system. A series of focused local reviews and insufficient national reviews have resulted in either partial (but important) answers or incorrect conclusions.

The government needs to stop wasting time on the wrong national investigation formats, which may be quick but ultimately are misleading and at times dangerous in their ill-informed conclusions, and instead adopt a format which will give solid, reliable answers and solutions - this can only be a statutory public inquiry.

Furthermore, the statutory public inquiry must take a modular approach, delivering interim reports as it goes with learning and recommendations to be immediately implemented. This would be a scaling up of the model that has already worked so well in Nottingham - there Donna Ockenden regularly shared learning with the NUH board and these were actioned as the review was ongoing.

Stalls progress

A statutory public inquiry does not mean work on maternity improvement must stop and wait for its conclusions - work on implementing, for example, Ockenden's Immediate and Essential Actions can and must continue while the inquiry is underway. Stopping this work would be a political decision on the part of the Secretary of State.

However, it is also clear that there is no meaningful prospect of progress based on current structures, measures, and plans.

The maternity and neonatal care system has already shown itself incapable or unwilling to implement the findings from local investigations at Morecambe Bay, Shrewsbury and Telford, and East Kent, and there is no reason to expect that the findings from Nottingham will be treated any differently.

Other measures that have been announced by the Secretary of State will make no real difference to the quality and safety of care received by mums and babies, and will not provide existing victims with the truth and broader justice they deserve.

For example, the application of Martha's Law to maternity is, on the face of it, unworkable as specialist second opinions are not readily available and many harmed and bereaved families report difficulties accessing a first opinion, nevermind a second. The government has also failed to provide any information on how it expects Martha's Law to function in maternity services, despite having been asked. Plans to appoint a maternity commissioner are misguided and risk making things worse by concentrating power and responsibility for maternity improvement in one set of unaccountable hands. Furthermore, pledges to force NHS staff to participate in future reviews relies on a new Hillsborough Law, which is currently subject to dispute and sits outside of DHSC's area of responsibility.

The Secretary of State has said that the maternity and neonatal taskforce will produce a plan in around six months time. This is a serious problem for three key reasons: first, harmed and bereaved families have no confidence that this deadline will be met, given the repeated extension of the Amos investigation despite intentions for it to be 'rapid'; second, the taskforce will be working with only partial information and analysis, and therefore risks drawing incorrect and damaging conclusions; and third, the taskforce and the expert reference groups feeding into it include many of the architects of the current crisis - people and organisations who have repeatedly failed to act to save lives and at times have influenced or made decisions that have caused avoidable harm and death. They cannot be trusted to fix the mess they have made.

"We already know what the problems are"

This is plainly not the case. Failings and problems in maternity and neonatal care continue to be disputed and minimised, and change resisted within the system.

Vast parts of the system, including regulators, education and training, national oversight and investigatory bodies, the third sector and academia, and political decision making, have never been investigated and therefore root causes of the current crisis are not fully understood. Understanding how these parts of the maternity and neonatal care system function and contribute - or not - to safe care is essential to creating real, sustainable change. Interrogating the interaction of all these different elements in order to build a whole system analysis is also critically important to avoid wrong conclusions caused by siloed thinking.

The four local reviews of maternity and neonatal care that have been completed and the two further reviews that are underway do a dramatically different job to a statutory public inquiry - they provide individual families with answers about their care, along with understanding of what happened in specific NHS Trusts, whereas a statutory public inquiry will focus on national structures and themes.

Some people do not want a statutory public inquiry

The main objectors to a statutory public inquiry are people and organisations whose actions/inactions, decisions and failings will be examined by the inquiry. This is not limited to

government bodies but also includes third sector organisations who have influenced policy making and/or been part of various working groups.

Individuals and organisations that will be examined by the statutory public inquiry have a conflict of interest on this matter and should not have input on the decision to order one - this includes many who sit on the maternity and neonatal taskforce and the related expert reference groups.

Some bereaved or harmed families also oppose a statutory public inquiry. It is important to note that many of these have already been part of local reviews/investigations and therefore are in a different position to the majority of harmed and bereaved families around the country.

Regardless of these objections and their reasons for objecting, the case for a statutory public inquiry must be judged on its merits: thousands of babies and mothers have been injured and killed by the state; the truth of how, who and why has been covered up; and deaths and injuries continue despite reviews and investigations in other formats. If more than 800 children were killed each year in schools or supermarkets, or by measles or terrorists, nobody would question the need for a statutory public inquiry. NHS maternity and neonatal services should not be treated any differently - and nor should its victims.