c/o Emily Barley
[redacted]
13th July 2026

Dear Secretary of State,

We write to demand a statutory public inquiry into maternity and neonatal services.

This is now urgently required to build a full, shared understanding of the maternity and neonatal care system, while addressing gaps in knowledge, overturning misconceptions, settling disputed narratives, and giving victims truth, justice, and accountability.

A statutory public inquiry is the only process which can:

- Provide the full truth of what is happening in maternity and neonatal care, and explain why avoidable harm and deaths continue despite various other investigations and reviews over more than a decade;

- Not only observe the racism and inequalities that infest our maternity and neonatal services, but interrogate the causes of these and name them without fear or favour, and identify how to fix these injustices;

- Generate evidenced solutions that will deliver real change across the maternity and neonatal care system, ending the cycle of limited investigations and reviews that result in partial- or mis-diagnosis of failings and their causes, followed by recommendations that are either wrong, right but resisted, or simply unworkable in reality;

- Compel evidence and witnesses, ensuring that in pursuit of the truth no stone is left unturned and no person who has held a position of responsibility is able to hide evidence or dodge questioning;

- Provide a full and thorough analysis of as-yet untouched, uninvestigated parts of the maternity and neonatal system, including: regulators including CQC, GMC and NMC; local and national oversight and investigatory bodies including ICBs, NHS England and MNSI; education and training provision for midwives and doctors; the influence of the third sector and academia on policy and practice; and political decision making;

- Give voice to victims of failures in NHS maternity and neonatal care, including bereaved parents and families; children who have sustained brain and other injuries and the people who advocate for them; mothers who have sustained physical and psychological injuries; and fathers and non-birthing partners who have sustained psychological injuries;

- Give voice to staff who work or have worked in maternity and neonatal services who have been ignored, silenced, and/or bullied, and identify the processes, structures, and leaders who have failed not only patients but staff too;

- Generate a whole system analysis, looking at all factors and contributors to maternity and neonatal safety, or lack thereof, and how these factors interact, instead of the existing siloed approach; and

- Do all of the above through public hearings, providing essential transparency and accountability, and beginning the process of rebuilding trust.

This letter is signed by a range of individuals and organisations deeply concerned with and distressed by continuing failures in maternity and neonatal care. We have all concluded that a statutory public inquiry is essential to truly learn the lessons of the past and ensure that care is safe for every mother and every baby in the future.

Yours sincerely,

Emily Barley, Beatrice's mummy

Ewa and Tom Hender, Mamus and Dad of Aubrey

Alice Topping and Pedro Jacob, Smokey's parents

Katie Fowler and Robert Miller, parents to Abigail

Hannah and Simon Robotham, parents of Austin

Alex and Steve Barr, Marnie's parents

Fiona Winser-Ramm and Daniel Ramm, parents to Aliona

The Revd Charlotte Cheshire, harmed family from Shrewsbury and Telford Hospitals Inquiry (Ordained Priest in the Diocese of Lichfield)

Sarah and Gary Andrews, Wynter's parents

Phoebe and Jim Brooks, Jasper's parents

Lauren Caulfield and Arron Kilburn, Grace's parents

Sarah and Dr Jack Hawkins, Harriet's parents

Leanne and Ben Pether, Leo's Mummy and Daddy

Susan and Donato Cacciacarro, Mum and Dad to Chiara

Chloe Vowels Lovett and Toby Lovett, mother and father to Esme

Hayley Taggart (harmed mum), mum to Olivia

Liz and Ant Charlton, Mum and Dad to Hazel Luna

Yann Trupiano and Kimberley Newark, father and mother to Olivia

Emmie Studenki and Ryan Parker, parents of baby Quinn

Carl Everson and Carly Wesson, parents of baby Ladybird

Lucia Ford-Ferrari, Mum to Freya

Roselle Mclaughlin, Mum to Seth

Stephanie Green, Mother of Alora

Kat Norton, mum to Alissa

Lucinda Watkinson, Mum to Benedict

Ria and Douglas Barr, Evelyn's parents

Eileen McCarthy and Noel German, parents to Walter German

Chelsea Gowar and Oliver Thompson, parents to Bonnie Thompson

Charlene and Tony Collins, Alex's Mummy and Daddy

Marie Hillyard-Adams and Peter Adams, Matilda's parents ♡

Venessa and Jon Oviasu, Imosé's mama and daddy

Mollie and Nicholas Sutton, mum and dad of Rupert

Nick Roper and Katie Morris, Parents of Ava Morris

Hannah Swinburn, Birth trauma and injury survivor

Daniela, Axel's Mum

Becca, Robins mummy

Kate, Mia Boulahlib's mummy

Gemma and Dean, Ronnie-roo's mummy and daddy

Laura and Michael, Henry's mummy and daddy

Melissa and Toby, Jacob's parents

Stephanie and Jack, Ivy's mummy and daddy

Seems and Amo, Abbie's mummy and daddy

Sophie and Josh, Mason's mummy and daddy

Lana and Ryan, Rosemary's mummy and daddy

Ellie and Ryan, Max's mummy and daddy

Lauren, Taylor's mummy

Tracy, Peanut's mummy

Katie and Michael, Ralphie's mummy and daddy

Darren and Amber, Robyn's mum and dad

Natalie Dence, Olive Dench's mum

Eve, Liliana's mum

Marcella, Kade's mum

Carly and Martin, Zephyr's mum and dad.

Sarah Robinson and Ryan Lock, Parents of Ida Lock

Helen and Gareth Hammond, parents who experienced failings in maternity care

Beth Cooper, Mum to Felix

Sharon Luca-Chatha, The Luca Foundation

Rachel Coles, Birth Trauma Survivor

Gabriella Rye

Dr Lucy Spain

Bethany Martindale, bereaved mother to Grace born sleeping

Jemma Hall and Aaron Way, bereaved parents to Willow Wren Way 10.08.25

Sarah and Ryan Shephard, Olivia-Rose's parents

Sophie and Dale Morgan, Mummy and Daddy of Dexter who died avoidably 2018

R Clements and M Procko, Harry's parents

Charlotte and Robert Smith, Finley's parents

Felicity Benyon, harmed mum

Meg Edmonds and Ben Brookes, Magnolia's Parents

Catherine Roy, Harmed mum

Lucy Headland, Luca's Mummy

Amelia and Leigh Crossland, Ophelie's parents

Julie Keegan and Angus McLean, Mason's parents

Jesse Smalley and Nicky Gresswell, parents of Joseph-James

Bianca Chapman and Chris Khalfan, parents to Imiza Affia Khalfan, Neonatal death and harmed mother

Sarah and David, Junior's parents and harmed family

Joanne and Keith Young, parents of Edward, harmed child and harmed mum

Melissa Dale, mother to Clara

Jess and Josh Aldred, bereaved parents to Brooklyn

Katharine Bannister, victim of a traumatic birth (for mum and baby), and inadequate maternity care

Michelle and Christopher Barana, bereaved and harmed family of Ivy June Barana 19.01.26

Fran Heatley, bereaved mother of Beth

Leila Hobart, bereaved parent to Oscar

Lisa Kelly, bereaved mother of Daisy Grace Hughes

Sam and Joey Benstead-Wright, mummy and daddy of Blossom, tragically taken August 2024

Debbie and Richard Horner parents of Abbie Jayne Horner weighing 8lb 3oz, perfect in every way whose life was taken due to the negligence of hospital staff

Emily Stringer and Darryl Gwinnett, Caitlin's parents

Marija Pantelic and Louis Pilard, Sasha's parents

Hannah and Tim Taylor-Smith, Zachary's parents

Jodie and Connor Pattison, parents of Theodore

Alexandra and Jack Penn, parents of Alfred

Kristina and Lee Pepper Mummy and Daddy of Theo Sam Lee Pepper 11.10.23 whose life was stolen

Georgina Albel, Mia and Ollie's harmed mother and birth trauma survivor, still battling after 25 years

Mel and Karl Ibrahim, parents to Amaya Ibrahim who was brain injured at birth in 2016

Pete Arnold, bereaved father to Benjamin

Angela Welsh, bereaved Mummy to Kion

Louise Lyon, bereaved Mummy to Elsa Lyon

Dannielle Lindsay Godfrey, bereaved mummy to Jayden

Lyndsey Shields, bereaved mummy to Jack Allan Shields

Georgia Dionne Wilson, mother and daughter failed by LTHT

Kelly Redhead, bereaved and harmed mummy to Harper Rose

Damon Green, father to Freyja Louise Green

Sana Khan, bereaved sister in law to Almas Khan

Tassie Weaver, bereaved mum to Baxter

Laura Parkinson, bereaved mum to Joseph

Jill Thompson, Beatrice's granny

Helen Wright, bereaved Mum to Betsy Wright

Rachel Baines, harmed Mummy and bereaved Mummy to Callum James

Chloe Emmens, bereaved mummy to Curtis Jax Emmens failed immensely by LGI

Rebecca Tinker and Frankie Tinker both harmed

Amarjit Kaur and Mandip Singh Matharoo, bereaved parents to Asees Kaur Matharoo (06.01.2024)

Rachel Cooper, harmed parent

Claire Emma Butterfield, harmed baby neglected by St James failed by whole NHS

Heidi and Dale Morton, bereaved parents to Lyla Morton

Zoe Ward, bereaved parent to Bleu Ward

Marianne Marlow, Survivor of Birth Trauma and many NHS failures

Lorna Johnstone and Jamie Saye, bereaved parents to Nancy

Caroline Green, bereaved mummy to Freyja

Louisa Hendrickson, bereaved mum of Zion Esau Hendrickson

Tanya Wilkinson

Sammy and Scott Smith, Mummy and Daddy to Owen

Anne-Laure and Dimitry Aubert, parents of Manolo and Cassiopée Aubert

Natalie and Dave Needham, Parents to Kouper Needham

Susan Hargreaves, bereaved Mother

Harriet Layhe and Jason Warren, bereaved parents of Lyra Rose

Kirsty and Jack, bereaved parents of Mia Darling 14/08/2023

Helena Morais, Maila's Present

Louisa Hendrickson, Zion's Lighthouse

Gina Reeves and Rachel Burrell, Founders of Ebony Bonds Bereavement Support

Maternity Safety Alliance

Mumsnet

Zephyr's charity, Nottingham

The Lily Mae Foundation

Love Leo, Registered CIC

Ellie's Gift CIC

Maternity: Right2Recover

Little Wings of Hope, registered charity

The Worst Girl Gang Ever Foundation

Team Caitlin, registered charity

Heidi Eldridge, CEO, MAMA Academy

Natalie Cosgrove, Lawyer and Mum

Steve Yemm MP (Mansfield)

Tim Loughton, Former Minister for Children and MP responsible for the Civil Partnerships, Marriages and Deaths (Registration etc.) Act 2019

Elizabeth Hutton OBE, Chief Executive of Kicks Count

Bobbie Farsides, Emeritus Professor, University of Sussex

Deb Hazeldine, patient safety campaigner

Paula McGowan OBE

Emily Cooper, mum of Alexander and Isabelle

Dr Jenna Johnston, Consultant Paediatrician

Shema Tariq

Laura Buckingham

Bex Gunn

Miss Rebecca Gibbs FRCOG

Heather Heath-Alton, Registered Midwife

Sian Ness (RM), Bereavement Consultant and Midwife

Elizabeth Smith, Retired Midwife Consultant

Hannah Jarvis registered midwife 1994-2012 (specialist midwife clinical governance at university hospitals of Leicester nhs trust 2002-2012)

Dimitrios Siassakos, Professor of Obstetrics, University College London Hospitals NHS Foundation Trust

Kiana Shirvani, final year student midwife

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.