

FAMILIES FAILED

BY OXFORD UNIVERSITY HOSPITALS

MATERNITY SERVICES

**SYSTEMIC FAILINGS
TOLD THROUGH
FAMILY VOICES**

NOVEMBER 2025

EXECUTIVE SUMMARY

This report presents evidence from the *Families Failed by OUH Maternity Services* campaign – representing over 700 families who have experienced preventable harm, trauma, and loss at Oxford University Hospitals NHS Foundation Trust (OUH). These are not isolated incidents. Together, these testimonies reveal systemic patterns of avoidable clinical harm, denial of informed consent, coercion in childbirth, suppression of complaints, and a culture of institutional defensiveness that has persisted for decades.

Despite its status as a world-leading teaching hospital and centre of research excellence, OUH has fostered a maternity culture that prioritises ‘normal birth’ ideology, research reputation, and institutional self-protection over patient safety, compassion, transparency, and evidence-based practice.

Families describe a service where:

- Requests for pain relief and caesarean births are routinely denied and women are pathologised as mentally unwell for requesting evidence-based care
- Women’s concerns about reduced fetal movement, bleeding, and pain are systematically dismissed – sometimes with fatal consequences
- Informed consent is routinely undermined by coercive practices and biased antenatal information that violates Montgomery standards
- ‘Normal birth’ ideology is prioritised over safety and women’s bodily autonomy
- Complaints are dismissed, records are falsified, whistleblowers silenced, and campaigners subjected to retaliation
- Recent FOI evidence reveals coordinated institutional responses across three NHS bodies.

While OUH’s inclusion in the National Maternity and Neonatal Investigation (NMNI) is welcome, this cannot be treated as a box-ticking exercise. Oxford is not simply another failing maternity service; it is a case study in how systemic harm can flourish even – perhaps especially – within elite institutions led by nationally recognised experts. The same ethical failures that enabled tragedies at Morecambe Bay, Shrewsbury and Telford, East Kent and Nottingham are visible here: a disregard for women’s autonomy, misogynistic practice, the silencing of advocates, and regulatory complacency. Uniquely, OUH demonstrates how institutional prestige can shield harm from scrutiny.

This report draws on first-hand accounts from families harmed by OUH maternity care; documented correspondence and complaints evidencing institutional obstruction; analysis of policy, governance, and ethical breaches within OUH; and cross-referencing to national standards and legal obligations. This report concludes with clear recommendations for the NMNI. Above all, we demand that the NMNI centres those who have lived the consequences of failure – families whose trust was broken by a system that is designed to care for them.

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OUR CAMPAIGN STORY SO FAR

Families Failed by OUH Maternity

Services was co-founded in June 2024 by Rebecca Matthews and Dr. Kim Thomas as a result of years of concerns about the standard of care within OUH maternity services. Just over a year later, over 700 families have come forward reporting physical, psychological, and systemic harm.

The scale of harm is unprecedented:

- Extensive preventable harm including stillbirths, neonatal deaths, and life-changing injuries to babies and mothers
- A culture of “normal birth at all costs”, where caesareans and pain relief are routinely denied or delayed
- Systematic silencing of women, particularly those from marginalised and working-class backgrounds
- Institutional protectionism: patient advocates and whistleblowers have been discredited and subject to retaliation.

OUH is uniquely concerning because of its prestige and influence. The Trust’s leadership has embedded ideological maternity practices that contravene NICE and RCOG guidance while simultaneously claiming national leadership in patient safety and ethics. There appears to be systemic prioritisation of research reputation over safe, compassionate care.

What we are calling for

- **A full & independent inquiry**
- **Accountability & apologies**
- **Compliance with national guidance**
- **An independent feedback channel**
- **Systemic change:** a move away from cover-up culture to a willingness to truly listen and improve

Read more about what we’re calling for on page 36.

700+

FAMILIES HAVE COME FORWARD SO FAR

As of 26 November 2025

To date, the campaign has raised concerns to NHSE, CQC, NMC, GMC, Healthwatch Oxfordshire, Thames Valley Police, and the Parliamentary & Health Service Ombudsman. Regulatory response has been inadequate.

HUMAN IMPACT AT A GLANCE*

Widespread unsafe & traumatic care

76% concerns about labour & birth care

69% concerns about postnatal care

31% concerns about antenatal care

7% experienced stillbirth

5% experienced neonatal death

6% of babies experienced brain injury

Systemic violations of informed consent & human rights

Not listened to

73%

No informed consent

18%

Felt coerced

30%

18% experienced maternal haemorrhage

31% reported mismanagement of complications

Denial of safe birth options

Denied a planned caesarean

7%

Denied caesarean during labour

10%

53% of those refused a planned caesarean required an emergency caesarean

21% were refused pain relief

Inadequate care

Lack of empathy or compassion

75%

Experienced poor postnatal care

74%

Psychological harm

Developed PTSD

70%

Developed depression

45%

Received NO mental health support

33%

Lack of accountability

75% said NO investigation followed adverse events

Outcomes of investigations were minimal: apologies/ staff retraining/ no change

*Data collected from 229 campaign members

Evidence of systemic failures at OUH: BREACHES OF INFORMED CONSENT AND THE MONTGOMERY STANDARD

1 Ban on Maternal Request Caesareans

For many years, OUH enforced a ban on maternal request caesarean section (MRCS), directly contravening NICE (2011) guidance and the Montgomery v Lanarkshire (2015) legal standard on informed consent. Women requesting caesarean birth were subjected to coercive psychiatric gatekeeping, pathologised as mentally unwell, and sent out of county – even as far as Greater Manchester – to access a safe mode of birth that NICE mandates as a woman’s right to choose.

In 2020, Birthrights submitted formal evidence to the OUH Ethics Committee, documenting that the Trust’s MRCS ban breached both NICE guidance and the legal principles of Montgomery v Lanarkshire (2015), relied on paternalistic and discriminatory assumptions about women’s mental health, and amounted to unethical and potentially unlawful gatekeeping of care.

In 2021, following legal and ethical pressure, OUH claimed to have ‘revised’ its MRCS policy. In practice, the new policy continues to impose barriers designed to deter, delay, and deny:

- Prohibits MRCS requests after 34 weeks gestation, a restriction with no clinical or ethical justification and unsupported by NICE or RCOG
- Requires completion of a ‘Fear of Birth Scale’, medicalising rational concerns about birth risk as psychiatric pathology
- Encourages referral to mental health services as a precondition for progressing an MRCS request
- Antenatal information remains systematically biased against caesarean birth, actively promoting ‘normal birth’ while minimising or omitting the risks of vaginal birth, particularly instrumental birth.

Women continue to report being refused caesareans even when clinically indicated, coerced into unwanted inductions, and denied caesareans during labour despite begging OUH staff.

“I requested a caesarean and was told there was no justification...hours later my baby was in distress.”

Evidence of systemic failures at OUH: BREACHES OF INFORMED CONSENT AND THE MONTGOMERY STANDARD

2 Ideological culture of promoting “normal birth”

The persistence of anti-caesarean rhetoric within OUH reflects a deeper ideological commitment to ‘normal birth’ – a culture that prioritises the drive to save money, and increase vaginal birth rates over women’s rights and safety. Despite OUH’s Chair, Sir Jonathan Montgomery’s, role as expert ethics advisor to the Morecambe Bay Inquiry, which explicitly criticised the “normal birth at all costs” ideology, the same ethos has been allowed to flourish at Oxford, perpetuating avoidable harm.

3 Denial of pain relief

Women repeatedly describe being refused or delayed pain relief, most often epidurals during labour – even after repeatedly requesting them. Others were told to “trust their bodies”, or told that they weren’t in enough pain yet. This exposes serious ethical, clinical, and human rights breaches:

- NICE guidance and GMC consent standards require that all reasonable options, including pain relief, are discussed and made available. Refusal to provide, or unjustified delay in offering epidural analgesia removes women’s agency and undermines their ability to make informed choices about their care.
- Denying pain relief constitutes inhumane and degrading treatment, contrary to Article 3 and Article 8 of the Human Rights Act (1998).
- The experience of begging for pain relief and being ignored is one of the strongest predictors of birth trauma and childbirth-related PTSD (Ayers et al., 2016; Simpson & Catling, 2016). These are not isolated incidents but part of a pattern of coercive control within maternity care that damages trust, self-worth and mental health.
- The rhetoric of “trusting your body” and “your body is made for this” reflects not just a persistent ‘normal birth’ ideology, but deep-rooted misogyny in OUH’s maternity services.

“After the birth I needed stitching and I felt every single stitch! It was almost worse than the birth. I was screaming and not once was I offered any pain relief or extra local anaesthetic.”

Evidence of systemic failures at OUH:

PERSISTENT GOVERNANCE FAILURES

Repeated failure to learn from preventable harm

The CQC's inspection of OUH maternity services in 2021 identified serious concerns around governance failures, culture issues, and inadequate risk assessment. Despite these concerns, families have continued to experience catastrophic and preventable harm.

As a campaign, we have been contacted by women reporting ongoing unsafe and coercive practices in 2024-25, including inadequate antenatal care, a lack of due diligence within the MAU, and receiving callous care on the postnatal ward. Women consistently report feeling unsafe in OUH's care, disbelieved when they raise concerns, and retraumatised by defensive responses. Even as we type we have women contacting us with concerns from the John Radcliffe Hospital.

What does it say about OUH's maternity services if current patients are contacting a maternity campaign due to feeling unsafe and not listened to while in OUH's care?

Sadly, OUH continues to prioritise reputation management over accountability. The Trust's repeated emphasis on "positive stories" and its deliberate disabling of public comments on maternity social media pages exemplify a culture that silences families rather than learning from them. This represents not only a failure of individual learning, but a systemic failure of Board-level governance, psychological safety, and Duty of Candour.

This inability – or unwillingness – to learn from harm happening within OUH's maternity services is exacerbated by a wider failure to embed learning from previous maternity reviews. Despite a growing number of critical recommendations from maternity reviews over the past ten years, OUH does not appear to have made effective changes to prevent harm from continuing in its maternity services.

This raises critical questions regarding the governance and ethical accountability of OUH's leadership. **Until leadership accountability is treated as a matter of patient safety rather than reputational management, OUH's maternity services will remain unsafe.**

Evidence of systemic failures at OUH:

CULTURE AND LEADERSHIP

1 Defensive management

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2 Lack of transparency and honesty

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3 Two-tier systems of care

At OUH, low-risk, able-bodied women can give birth in more comfortable settings with en-suites, while high-risk women or those requesting pain relief are confined to the delivery suite – some rooms windowless, with toilets down the corridor. Postnatal care is similarly unequal: women recovering from caesareans or delivery suite births face partner visiting restrictions and limited compassionate care.

Meanwhile, private maternity care at the John Radcliffe Hospital offers “superior” scanning equipment and 24/7 access to epidurals. Even during OUH’s ban on maternal request caesareans, affluent families could pay privately for a caesarean birth in the very same hospital, raising serious ethical concerns about equity in access to care.

Evidence of systemic failures at OUH: INSTITUTIONAL BETRAYAL

1 OUH “Marking its own homework”

OUH’s handling of oversight processes demonstrates a collapse of independent scrutiny. In April 2025, the Trust conducted an “insight visit” as part of its bid to exit the Maternity Safety Support Programme (MSSP). The visit included representatives from the CQC, GMC, NMC, NHS England, and Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP). Despite the scale of family harm known at the time – over 300 families in our campaign had already reported serious concerns – the minutes record no concerns raised. No campaign representatives were invited or contacted, and families were systematically excluded from the process. OUH effectively audited itself.

Given that the CQC rated OUH’s maternity services as Requires Improvement in 2021, how were they able to report ‘no concerns’ three years later without clear evidence of improvement?

2 Leadership conflicts

The current OUH CEO, Professor Meghana Pandit, was seconded to NHS England on 1st April 2025 while serious concerns about OUH’s maternity safety were active and unresolved. Despite being in role as CEO since July 2022, and previously in post as Chief Medical Officer, Professor Pandit did not contact or engage with Families Failed by OUH Maternity Services at any point.

This dual role raised concerns among campaign members about potential blurring of accountability between the Trust under scrutiny and the regulator responsible for scrutiny. **How can we trust that those who are meant to uphold rigorous national standards of patient safety are able to do so if they have overseen their erosion within their own institutions?**

3 Lack of effective regulatory action

For many years, families have repeatedly raised concerns to CQC, GMC, NMC and NHSE, yet responses have been slow, dismissive or absent. Regulators have too often appeared to distrust families’ accounts, placing the burden of proof on those who are already traumatised and grieving. They have relied on families to gather and submit evidence, forcing them to re-live painful experiences simply to be believed. Even when investigations occur, they are frequently narrow in scope, delayed, or limited to procedural details, leaving clear areas of concern unexamined. Regulators seem unwilling to take decisive action, and OUH appears to have learned that managing reputation is more effective than embracing transparency and accountability.

Evidence of systemic failures at OUH:

INSTITUTIONAL BETRAYAL

4 Treatment of patient safety advocates

After campaign co-founder, Rebecca, raised concerns about OUH's ban on MRCS in a professional meeting with senior OUH maternity staff in 2021, and being reassured that her campaigning would not be held against her in her current pregnancy, a few weeks' later a consultant obstetrician wrote to the consultant obstetrician that Rebecca had met with, within her formal patient record: **"Now that you have met her do you want her? I don't!!!"**. This represents a breach of professional ethics and confidentiality and suggests retaliation against a patient safety advocate.

Following Rebecca's appearance on BBC South in March 2021 discussing her own experience of being denied a caesarean, Oxfordshire's Maternity and Neonatal Voices Partnership (OMNVP) – a body meant to amplify service users' voices – made a complaint to her employer. In March 2025, minutes from an OUH OMNVP meeting record that campaign leaders' backgrounds were discussed. Despite repeated requests, OUH has refused to disclose what was discussed or why campaigners were profiled.

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These examples demonstrate retaliatory actions against those who expose failings. Instead of valuing lived experience as essential to safety improvement, campaigners report experiencing attempts to control, discredit, or silence those speaking on behalf of harmed families.

PATTERNS OF HARM

AN OVERVIEW

The following pages document the recurring patterns of harm across hundreds of testimonies bravely submitted to our campaign.

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- 14** Harm to babies
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Please note that the quotes used in this report represent only a small proportion of our families' voices. Full testimonials are available on our website.

PATTERNS OF HARM:

PERINATAL LOSS & PREVENTABLE DEATHS

A large number of families in our group have shared devastating accounts of perinatal loss where delayed action, ignored concerns, and poor risk management have contributed to unforgivable outcomes.

- *“Our son was stillborn at 35+5 weeks in June 2019. I was 35 weeks pregnant when I noticed something wasn’t right, it was Monday afternoon and I felt a jolt of pain through my abdomen. I could hardly walk, I’d never felt anything like it before. I phoned MAU who wanted to see me. A CTG, cervical examination and a urine dip were carried out. I was told I was having contractions due to a UTI and was sent home with a course of oral antibiotics. I questioned how much pain I was in and they said give the antibiotics three days and if no better contact my GP... We now know he died of a concealed placental abruption. In our eyes he could have been saved. I saw three healthcare professionals in the week leading up to our son’s death and they all diagnosed me with conditions I never had.”*
- *“Losing a child never leaves you, you learn to live with it but the pain doesn’t go. However, I have also had the feeling that had they listened to me on my first attendance, had they done the correct checks, there may have been a chance to save my child and prevent her death.”*
- *“My daughter was born 5 weeks early... I went to the JR and waited an hour and a half to be seen... when I was seen I was on the monitor for 30mins and then the surgeon came in and said the baby needs to come out. However they weren’t clearly in much of a rush... they had no one to do the c section so they had to call someone... She was born dead and took 20 mins to bring her back to life but because she was starved of oxygen she was brain damaged... The hospital wasted nearly 3 hours with me... she was struggling to breathe... we was told to just hold her until she died... I was cuddling her and she took her last breath.... The nurses knew the signs of an abruption but I was just shrugged off and put to one side and not taken seriously... I had an investigation done and they have admitted fault but obviously no apology from anyone... If only they had done their job properly, then maybe my daughter would still be alive.”*
- *“I recently lost my baby at 20+4, I believe due to my cervix which was a previous issue and was not monitored early on, even though I kept mentioning it. My daughter died an hour after birth and couldn’t be saved due to infection. I was also left for hours on delivery listening to other babies be born.”*

PATTERNS OF HARM:

HARM TO BABIES

Families have shared experiences of devastating failures that resulted in life-altering disabilities, and near-fatal emergencies for newborns. Babies were starved of oxygen during prolonged labour, left undiagnosed with serious conditions, or denied timely intervention despite clear distress signals. These cases demonstrate a pattern of missed warning signs, delayed emergency responses, and inadequate monitoring that has had permanent consequences for children and their families.

- *“He was my first born and arrived at 33 weeks. I had a very traumatic birth where he was starved of oxygen and not put into his incubator the second he was born. He has spastic diplegia cerebral palsy (is a full time wheelchair user), severe learning disabilities, is non verbal and has autism. I don’t feel I was monitored properly by the midwife team and feel that things could have been very very different if they acted immediately when he was born.”*
- *“My son received substandard care at the John Radcliffe Hospital. An SHO misinterpreted his CTG trace, and despite signs that he was in distress, no action was taken. Two hours later, his heart rate dropped again, and this too was missed by the attending midwife. It was only when a doctor happened to glance into the room roughly half an hour later that the serious nature of the situation was recognised. He was delivered immediately, but at birth his Apgar score was 0. He was resuscitated and, after approximately 17 minutes, took his first breath. As a result, he suffered a severe brain injury. We later received a formal letter of apology, in which the hospital promised that staff would be required to attend a minimum of two CTG training sessions per year “to minimise the risk of misinterpretation in the assessment of complex CTG traces.” We pursued a medical negligence claim, and the hospital admitted liability from the outset...I do however feel very let down by the management of the hospital, who failed to ensure that the Maternity Unit was adequately staffed, that the staff were adequately trained and that the duty of candour was upheld. If it was not for a consultant who inadvertently admitted that things had gone wrong, I am not sure that the hospital would have capitulated as quickly as they did.”*
- *“I asked for a caesarean multiple times as I could tell nothing was progressing. My requests were ignored by the 5 or 6 midwives that checked on me during that time. My son was born with meningitis from the infection I contracted after having waters broken too early. I was rushed down for an emergency caesarean after I passed out and my then husband was left for hours not knowing where I or our baby was. Me and my son ended up staying in hospital for 3 weeks, with my son needing daily medication, lumbar punctures and other procedures. The whole experience has stopped me from ever wanting another child.”*

PATTERNS OF HARM: BIRTH INJURIES

Many mothers describe inadequate care during vaginal births causing avoidable long-term harm. A number of families link high rates of forceps use to an institutional reluctance to perform caesareans. Families report a lack of informed consent around the risks of vaginal birth and instrumental birth.

- *“I have a life long injury thanks to a poorly managed forceps delivery that I was told I needed because my baby was in distress – when I complained I was told she was never in distress. They were short staffed with only one doctor covering delivery. He took the gas and air off of me ‘so I could concentrate on pushing’ then tore me in every direction with an unmedicated forceps delivery. I was begging for pain relief afterwards...I spent years crippled with pain, barely existing. It’s now manageable but I’m still in pain everyday.”*
- *“I asked for an epidural several times and I was told I would get it but I never did. It turned out one of my cervical stitches was still there and baby was suffocating. He had forceps and a few other tools to pull him out. I’ve been left with being incontinent.”*
- *“I was photographed for a medical journal, as they told me it was one of the largest cases of anal prolapse they had seen. My recovery was long and difficult. Over the next few months I developed incontinence both faecal and urinary. I had to have several large operations to fix these injuries which were caused as a direct result of having had the undiagnosed large baby, not being dilated fully and the 4th degree tear.”*
- *“Today, I am still impacted as a direct consequence of the traumatic birth and the several large operations I have had to have. This included a permanent Sacral Nerve Stimulator which is similar to a pacemaker implanted in my right hip which I control remotely, that helps control my bowels. This was last replaced 2 years ago at a cost to me of £18k. I have also had botox in my perineum and bladder to help with symptoms every 1-2 years since I had my boy, the last treatment being September 2023, again at my cost. I have recently (Jan 2025) had another prolapsed bladder repair surgery. To this day my birth trauma still affects me not only mentally, but physically.”*
- *“My son got stuck and had the cord around his neck. I was put in all sorts of positions with tons of people trying to help get him out. It’s a blur at this point but he ended up with a pneumothorax. I am left with a prolapsed bladder.”*

PATTERNS OF HARM:

MISOGYNY, PATERNALISM & MORALISATION

Women's testimonials reveal a culture that prioritises vaginal birth ideology over women's bodily autonomy, where staff shame mothers for feeding choices, dismiss their concerns as anxiety or attention-seeking, and treat them as inconveniences rather than patients deserving dignity and care.

- *“She decided that I had to see a psychiatrist because “(I) wasn’t ready to be a mother.” I was incredibly hurt by that comment...The psychiatrist came to MAU. They documented that I had no acute mental illness or risk factors for post-partum depression or anxiety and that my reasons for wanting a c-section were logical, medically-founded and that I had expressed a clear understanding of the pros and cons of vaginal vs c-section births.”*
- *“During the night my baby woke and I couldn’t feed him, lights were on next to my cubicle so I couldn’t sleep. I rang the buzzer and no one came for hours...In the morning I asked for formula and was made to feel awful by a midwife asking ‘are you sure about that’ with a nasty attitude. I’d had no support with feeding and was left with a starving baby.”*
- *“When I got to the JR after I was seen by a nurse/midwife and explained my concerns and symptoms she did a cervical examination. Afterwards she said ‘what would you like me to tell you?’ I am still furious and aghast at her lack of care and professionalism. She told me I was one centimetre dilated and I should return home and take paracetamol. I couldn’t believe that’s all the progress I had made after all that time spent in such severe pain and having contractions as close together as I had been having, I couldn’t understand how much longer I could/was expected to go before I made any significant progress.”*
- *“He stopped halfway through and said the tear was larger than he thought – it was actually a 4th degree tear... I remember a sea of doctors down at my feet ogling my injury and talking about it. I still don’t remember holding my baby and my mother can confirm that she was left in the delivery room with the baby for 4 hours and no-one came to check on her or the baby.”*
- *“I ended up sat in the dark, in the middle of the night trying to hand express colostrum into a syringe just to feed my baby because she wouldn’t latch, panicking that I wouldn’t be able to feed my baby. Some midwives snarled at me, judged me, and made passing comments that left me feeling like a terrible mother. At the time when I needed compassion most, I was instead humiliated.”*

PATTERNS OF HARM: COERCION & LACK OF INFORMED CONSENT

Families have described having medical procedures performed without explanation, being pressured into unwanted decisions, or denied the care and interventions they requested. Women report feeling dismissed, coerced, and powerless.

Procedures performed without adequate explanation

- *"Someone with less experience attempted the epidural four times until a consultant took over (five attempts total). I was treated like a guinea pig, someone to gain practice on. They never asked me if the multiple attempts were ok. There are risks with each attempt and I wasn't able to advocate for myself because I couldn't speak. Unsurprisingly, I ended up having a failed forceps trial and then an emergency c-section."*

Coerced medical interventions

- *"I was coerced to have an induction by my community midwife."*
- *"I felt I had no choice in having this induction."*

Denying requested intervention

- *"At 41 weeks, I was so swollen from pre-eclampsia I could barely move and I wanted to avoid an induction so I asked for a caesarean (something I had really wanted to avoid). The obstetrician refused my request, despite the fact that I was so swollen, exhausted and could barely move, and told me that it would be better if I 'gave vaginal birth a go'. I was then attached to a drip, and monitors, and spent 19 hours in a windowless room in absolute agony with back-to-back contractions, not allowed to eat and only allowed to drink 75ml of liquid an hour."*
- *"I requested an elective c-section...I was told it was very unlikely they'd agree, and I'd have to discuss it first with the chief midwife and then [male obstetrician name] at the mode of birth clinic....When the nurse measured my blood pressure, it was 200/120. I was rushed to see [male obstetrician name] who said he could see from my notes that "we were pissing each other off" and he agreed that I could have a c-section the next day, telling me that it was now medically necessary."*
- *"I asked for a caesarean and the consultant anaesthetist denied me this and made me feel like I just wasn't coping with a normal birth"*
- *"I begged for a c-section and spoke of my concerns multiple times but it fell upon deaf ears."*

PATTERNS OF HARM:

CATHETER NEGLECT & BLADDER TRAUMA

Bladder injury and catheter mismanagement emerge as a recurring and devastating pattern in families' testimonies. Women describe being left in agony with overfilled bladders, dismissed when reporting pain, and told their symptoms were "in their head". These failures reflect not only clinical negligence but a deep absence of compassion and respect for bodily integrity, leaving lasting physical damage and psychological trauma for mothers already vulnerable after childbirth.

- *"I was transferred to the maternity ward on level 5 and a trial without catheter was performed and I was still unable to pass urine even though I was desperate to. The midwife told me it was "all in my head" and left me for six hours in agony with a hugely full bladder. She did not follow procedure and scan my bladder. When the next midwife came on shift, she saw my pain and distress and put the catheter in at which point over a litre of urine came out which I could not have intentionally held. This stretching of my bladder caused permanent damage to it."*
- *"My baby was finally born on Thursday in the late morning, more than 72 hours after my waters had broken. On top of this, I retained more than 1000ml of urine during the second stage of labour and was sent home with an indwelling catheter. I had this for seven days to prevent further damage to my distended bladder. So far I don't seem to have incontinence issues but I wonder what the long term effects of this and the forceps will have on my pelvic floor health."*
- *"My catheter bag almost overflowed several times during my stay as it was not emptied in good time, causing it to back flow into the tube as it was at full capacity. Following this experience, I buzzed for help every time it started to get full only to find out there was an expectation for me to be emptying my own. Nobody had told me this or shown me how to do it. I was still not very mobile following my c-section."*
- *"I remember ringing for help as needed to change my pad and also had a catheter that needed emptying. The nurse was so rude, basically said you should be able to do this yourself. I'd just had a major operation, my baby had been taken and I was groggy from all the medication and I sat there and cried my eyes out."*
- *"I was left with a full catheter bag and shouted at for requesting help."*
- *"I received a letter apologising from OUH stating that they take bladder stretch cases very seriously and postnatal bladder care is an area that they have identified as one they need to improve on. It made me wonder - how many more mums have gone through this?"*

PATTERNS OF HARM:

CATHETER NEGLECT & BLADDER TRAUMA

CONTINUED

- *“I had trouble going to the toilet, a complication of the epidural, so received a catheter. I complained multiple times that it was painful and scratching. I kept being told they'd come check but never did. I was struggling to care for my daughter or myself. They wouldn't watch the baby or help me out of bed. A lack of visitors, due to lockdown, meant I was completely by myself. They let me go home after the three days were up, even though I was still complaining about the painful catheter. I can't remember all the in between steps that happened but I remember I had a follow up appointment with a bladder specialist nurse or midwife. I couldn't wait until then. I called to get seen earlier but they refused and insisted the pain was just part of healing from birth. So I used a syringe I had from the lab where I worked and drained the catheter myself at home to remove it because I couldn't take the pain anymore. I instantly felt better. Lucky for me, I quickly regained feeling in my bladder and was able to use the toilet without issue. What I did was reckless and could've had consequences had I not been able to feel my bladder again. But I was in so much pain, I couldn't think rationally.”*
- *“As I had a catheter in, I felt no desire to pee and as a result didn't go to the bathroom. So I was shocked when I stood up and blood ran all over my sheets, legs and the floor. I called the midwife and asked for more pads as I hadn't brought enough and she shamed me saying ‘did you not realise you were having a baby’. Probably not the best response to a sleep deprived new mother. She wouldn't give me a clean pair of compression stockings... it was one per person...so I spent the remainder of my time in bloody stockings sleeping on bloody sheets. I also had to learn how to change my catheter bag as it would overflow otherwise...something I never expected to have to do in a hospital setting.”*
- *“As a new mum who had laboured for almost 48 hours and with 2 failed epidurals, the nurse assigned me her duty of emptying my catheter and telling her the amount each time I emptied it.”*
- *“When my catheter was removed, I knew something wasn't right. I repeatedly told staff that my bladder felt full, but I was dismissed and told I was passing enough urine, and that is normal afterbirth to feel uncomfortable. I persisted until a scan was finally done — revealing I had 2 litres of urine retained. A catheter was urgently reinserted, and only then did I feel relief. But again, the trauma continues. That delay caused severe bladder damage. I had to leave hospital with a catheter and keep it in for three weeks after birth. I returned twice for failed TWOC procedures, crying at the humiliation of walking through the ward with a catheter bag. Even now, my bladder is weak, and I've had to work hard to rebuild strength and sensation.”*

PATTERNS OF HARM:

DISCRIMINATION & INEQUALITIES

Many families reported feeling dismissed, ignored or treated differently because of race, language, age, or socioeconomic status. Several families identified a link between being non-privileged or a younger mother and receiving poorer care.

- *“They spoke to me like I was stupid because English isn’t my first language.”*
- *“I was treated horribly by a midwife I saw initially at the maternity assessment unit. Despite explaining to her that I saw a consultant midwife throughout my pregnancy and that she had recommended I have epidural as soon as I get any contractions she refused to listen and left me alone in pain for over an hour. When she realised there was a letter explaining this, she backtracked. She also made a fuss when I said I need gas and air when she examines me internally as I get anxious and find it painful. I believe she was racist and Islamophobic as I’m south Asian and wear a headscarf.”*
- *“I was ignored, while the middle-class women got all the attention.”*
- *“I was treated as a nobody because I was a “young mum” 21 at the time. I had countless emails to and from multiple members of staff as I felt something wasn’t quite right. It was passed off to being a first time nervous mum.”*
- *“The midwives didn’t listen to me and as a 19 year old giving birth, I don’t think they took anything I said seriously.”*
- *“I had to fight hard to be recognised as a father with rights because no one completed the family link on their NHS system...I filed a request to access procedures and protocols especially about the internal auditing and documentation. I was ignored...I am foreign. I felt treated as an outsider even though for so many years I served as a staff nurse for the NHS and served and helped the people in this beautiful country. What should someone do to be taken seriously?”*
- *“Before I gave birth, a black midwife quietly warned me about what I might face on the maternity ward. She told me to speak up if I was in pain and to exaggerate what I was feeling and added that I might not be listened to because of the colour of my skin...After giving birth, I became unwell on the postnatal ward. I told the nurses something wasn’t right, but they didn’t listen. My pain was dismissed, and I was denied pain relief or medical assessment. I felt invisible and powerless in a moment when I should have been supported and believed...Two years later, I still think about that experience and wonder if the colour of my skin influenced the care I received. Racism in maternity care isn’t always obvious or deliberate and unfortunately, this story isn’t unique. Every woman deserves to be heard and cared for equally without discrimination.”*

PATTERNS OF HARM: DISMISSED CONCERNS

Parents describe being ignored or dismissed when they raised fears about their own and their baby's well-being. Red flags went uninvestigated, symptoms were minimised, and pain was downplayed. Time and again, families were made to feel like a burden rather than patients requiring care.

Ignored red flags and symptoms

- *"I lost my 29 week old little girl because no one acted quick enough when there were many signs something was going wrong with my pregnancy."*
- *"There were warning signs throughout my pregnancy that something was wrong. The NT measurement was very high, there was a single artery umbilical cord, and an extra vein going into my baby's heart. I was told there was a 50% chance my daughter had a chromosomal abnormality. And yet, despite these red flags, I was still marked as a low-risk pregnancy. Even when I asked to be induced around my due date, my concerns were dismissed, and I was forced to go two weeks overdue."*
- *"I felt unheard and unsupported throughout this experience, and my partner, who acted as my advocate, was also dismissed. This journey has left me feeling let down by the John Radcliffe Hospital, as my concerns and those of my partner were not taken seriously, impacting both my daughter's and my health."*
- *"Had I been listened to and my concerns taken seriously and not dismissed - again!! - and the bleed and pain been investigated properly, it would have been evident that my cervix was funnelling causing the overwhelming pressure in my vagina which ultimately led to the most devastating thing that has ever happened to me."*

Dismissal during labour

- *"We voiced our concerns and asked if a c section should be considered, but they were adamant it was best to keep going. There was a lot of 'wait for the next check' but an hour feels like a long time when in labour! I was eventually diagnosed with pre-eclampsia and a male registrar came in. When I voiced concerns about my extreme back pain and how I didn't know if I could do the final stage of labour he simply remarked 'It won't hurt when the baby's out'. I was too shocked to respond."*
- *"I continued to request support multiple times, only to be dismissed. At one point, I was even told it might be Braxton Hicks. When a doctor finally examined me, she seemed surprised at how far along I was and immediately called for me to be transferred to the birthing suite. Unfortunately, by then it was deemed too late for any pain relief."*

PATTERNS OF HARM: MISSED SEPSIS

Sepsis – a preventable, life-threatening medical emergency – emerges repeatedly in families’ testimonies, revealing a catastrophic pattern of missed symptoms, delayed escalation, and denial of women’s pain. At OUH, mothers describe being left to deteriorate despite obvious signs of infection, dismissed as anxious, or reassured that their symptoms were “normal.” Others discovered evidence of suspected sepsis only later in their notes – never disclosed to them at the time.

Symptoms of sepsis missed and dismissed

- *“I had second degree rips. It took them a while to get the equipment ready to stitch me up. After I had a shower, they said I could go home... On day 4, my partner rang 111 due to symptoms of Sepsis. I was getting worse every 30 minutes still no phone call back, rang again, no phone call. My partner rang 999 and they rushed to me on blue lights, as soon as one of the paramedics saw me, he knew I had sepsis. Got rushed to JR again but to Resus this time. I managed to go home after 4 days of being in hospital. I found out that when I gave birth, they left some of the placenta and because I was left for a bit before I got stitched up, they were the reason why I got sepsis in the first place.”*
- **“With such a traumatic time I was then left to develop two massive blisters on my stomach & leaking womb from the c section. I ended up having 4 major surgeries & missed 3 months of my daughter’s life because I was so sick with sepsis & left with leaking holes for weeks at a time.”**
- *“After a short while I began to shake uncontrollably, horribly nauseous, heaving, absolutely freezing, and progressively in unimaginable pain. When I told staff that something was wrong, I was ignored - they did not believe me. It went on so long that I developed a very real and frightening feeling that the baby and I were going to die and that no one was going to help us, and I think my husband had similar fears, which was beyond awful to experience first-hand, and observe in his eyes. After a long time, a different anaesthetist finally came in to check on me, and very crossly (on my behalf) confirmed that the epidural had fallen out. I was cranked up to the max of the hormone drip, and rather than turning it down, I had to be held down by staff for them to start a new epidural. I felt like a crazed, caged animal, screaming, pinned to the bed. It was confirmed that I had developed sepsis, and as the baby was now in serious distress, an emergency caesarean section was our only option.”*
- **“The second midwife said that I had a raised temperature and that they were going to put me on antibiotics 'as a precaution'. At no point did anyone mention sepsis to me before, during or after labour. Imagine my surprise when I saw this in my maternity notes months later, as well as on my child's health record ('obs sepsis') on the NHS app years later...”**

PATTERNS OF HARM: SYSTEMIC FAILURES & STAFFING INADEQUACY

Accounts from families reveal a pattern of systemic neglect within OUH maternity services – marked by abandonment, poor communication and inadequate monitoring.

Chronic neglect

- *“There was no midwife available for me while I was in labour”*
- *“One of the SSNAP ladies actually come up with me to get my stuff and had a word with the ward sister to advise there was absolutely no empathy given to any of the women in the ward where all the NICU mums were”*
- *“I was left in labour from then until 1:59am on the 4th of May as I was then taken in for an emergency c-section as they told me my son was in distress...90 hours since my waters had broken”*

Poor communication & lack of handover

- *“MAU failed to provide an adequate handover to the delivery suite”*
- *“Every time a shift changed, it was like starting over. New midwife, new advice, new energy. No one seemed to communicate”*
- *“At this point the epidural stopped working again on both sides, I was waiting to go to theatre distraught and back on gas and air”*
- *“She dumped us on level 5 with no handover of where toilets were or staff. I ended up laying in blood for hours and not one member of staff checking on me for 8 hours.”*

Lack of monitoring & observation

- *“I was left in a room for several hours waiting for an on-call midwife to arrive due to lack of staff...No one checked on us during this time and my contractions were ramping up”*
- *“When labour began, I was admitted — and left in pain for four days with no progress. I was not dilating, but no one acted. Only when my partner shouted at staff saying, “You wouldn’t keep a pet in pain like this,” did a slot suddenly appear.”*
- *“Emergency c-section. Left in ward with no obs being done. My dad thought I was sleepy, I was drifting in and out of consciousness. Lips had turned blue before they actually took my dad seriously. Another 30 mins, I’d have died.”*

PATTERNS OF HARM:

DENIED ACCESS TO HOSPITAL

Many families report being sent home in labour, told to wait, or told that they were “not in labour” sometimes resulting in delayed interventions and devastating outcomes.

- *“I came to the JR in active labour. I was having regular, intense contractions every 2-3 minutes, unable to walk or speak during them, with blood-streaked watery discharge. A midwife offered to check my dilation — she performed a very quick, superficial check and told me I was far from labour. I was sent home, in agony, despite clearly being in established labour.”*
- *“I went in one evening at 39 weeks to be checked for reduced movements and report of pain when touching my bump, I was checked and sent home and told everything was fine. This was the start of placental abruption, I had no idea and the next day when my waters had started to leak I was called in for an induction which went from 0-100 and was told this was totally normal. After 3 hours of back to back contractions and complaining many times that this was in fact not normal, I was ignored until I started haemorrhaging. To then be told, ‘what a way to skip the queue’. I had an emergency c section 10-15 minutes later, where I was told I was lucky, ‘the baby was nearly a goner’.”*
- *“I returned to the hospital only three hours later, this time in even more extreme pain and unable to stand. I rang the bell at the Spires Unit, only to be told coldly through the intercom, “We are busy, go to MAU.” No one came to assess me at the door. I was in visible distress and could barely remain upright.”*
- *“Contractions began around 11am. By 4pm they had become close together and increasingly intense, so I called the maternity unit. I was told I didn’t “sound like I was in enough pain” and advised to take a bath, relax, and wait longer at home. By 7pm, the pain had escalated, but I was told again to stay at home since I could still talk through contractions. I didn’t feel comfortable with this advice, so I made the decision to go to the John Radcliffe assessment unit anyway. On arrival, I was met with eye rolls and told to wait in the corridor. I felt increasingly distressed and ignored. My waters then broke in that corridor, and my contractions intensified even more. I was told to “just go to the toilet and clean [myself] up,” despite barely being able to move due to the pain. Only then was I taken to an assessment room. Our baby was born at around 8:20pm — in the assessment room. It’s worth noting that this was a high-risk pregnancy due to a heart condition.”*

PATTERNS OF HARM: DENIAL OF AUTONOMY

Many families report being refused access to their chosen mode of birth, and experiencing coercion both around vaginal birth and breastfeeding. Policy barriers are repeatedly experienced as gatekeeping rather than shared decision-making.

Refusal of birth mode choices

- *"I repeatedly raised my concerns and fears. I was told that a planned C-section wasn't available because 'the Trust doesn't have the money.' I broke down in almost every meeting. I was terrified. I even made a will, convinced I might not survive the birth."*
- *"Refused option of C-section, despite high risk twin pregnancy (MCDA) one twin breech...I was categorically told I could not elect for a C-section"*
- *"Throughout this ordeal, I repeatedly requested a C-section due to the complications, but my previous natural births were used to deny my request."*
- *"At my due date midwife appointment I requested to explore the option of an elective C-section because my baby was measuring very big on scans and was now at term. I was told it wouldn't be discussed because having a C-section would stop me bonding with my baby. When he was born two weeks late, I had a 3b tear due to his size. I believe this could have been avoided."*

Forced feeding method choices

- *"I told midwives in the hospital I no longer wanted to breastfeed. This was in part because they were saying I was not doing it properly and that this was making my baby unwell. I said I wanted to give him formula instead. They told me I was not allowed to stop and instead I had to pump. I expressed this routine was making me feel miserable but was not listened to. I had no voice."*
- *"Then my baby developed jaundice. And just like that, I was told to stop breastfeeding and move to formula. No real discussion. No proper explanation. Just a decision made for me, without me."*
- *"Again the aftercare was bad. Yet again I had multiple doctors and nurses telling me off for not breastfeeding (it happened with my son a year earlier) despite me being advised not to."*
- *"I couldn't produce any colostrum despite trying repeatedly. I asked the midwife for some milk - she refused to even give donor milk, telling me that I couldn't have any unless I showed I could express! I pushed to be discharged in under 24 hours after a caesarean because my newborn daughter was refused milk."*

PATTERNS OF HARM:

COMPASSION DEFICIT & CRUEL TREATMENT

Testimonies from families reveal a profound compassion deficit from OUH maternity staff. Women and families are not met with empathy, but with cruelty, contempt and punitive treatment. A culture of emotional neglect and cruelty appears to have become normalised at OUH; this treatment is causing lasting psychological harm.

- *“I was told abruptly that it was time to dress my baby, but nobody helped me out of bed...some midwives snarled at me, judged me, and made passing comments that left me feeling like a terrible mother. At the time when I needed compassion most, I was instead humiliated.”*
- *“I went to MAU with bleeding when I was about 28 weeks. It was a significant amount of blood (soaking underwear and through to my trousers) and I was terrified. A midwife laughed when she saw the amount of blood and told me it was nothing. Told me not to bother returning unless it was pouring out.”*
- *“A midwife complained I didn't say 'please' when I was in third stage labour and had asked her to put down the bed because I was falling off of it.”*
- *“Looking back on my experience it is one riddled with inhumane treatment with a severe lack of compassion and empathy. I cannot fathom how the response of a midwife to a brand new mother who actively states they want to end their life is to leave them alone on a delivery suite, suicidal, grappling a mobile phone calling a crisis line to save their life. I was surrounded by medical professionals but have never felt so scared for my life. They made me feel like life was not worth living and I could not see a way out. My husband was terrified of losing me and having to raise our baby alone.”*
- *“I was left to suffer in excruciating pain... I was screaming and telling them all that they were hurting me and I was struggling to cope with the pain and I was continuously begging for the epidural...which was given to me at the very last minute, after suffering for hours, not being heard and the midwives were very dismissive of the distress I was under and one of them asked me, “Have you been sexually abused, is that why you are in so much pain?” What!!! This was so shocking to me that the trauma I was displaying because I was in so much pain, was simply interpreted and assumed that I must have been abused because surely nobody could be in that much pain otherwise.”*
- *“In the morning I asked for formula and was made to feel awful by a midwife asking “are you sure about that” with a nasty attitude. I'd had no support with feeding and was left with a starving baby. We had no help and felt abandoned. There was no care and staff were rude.”*

PATTERNS OF HARM:

INHUMANE & DEGRADING POSTNATAL CARE

Women have described their postnatal experience at OUH as dehumanising. Instead of compassion and support after birth, many were left in pain, ignored, and stripped of dignity. The testimonies reveal a pattern of abandonment, withheld pain relief and a shocking lack of basic care – experiences that no new mother should ever have to endure.

Abandonment & lack of basic care

- *“If I had to describe my experience on the postnatal ward, I would say lack of compassion, lack of dignity, lack of care. My basic needs were not met. I went without food for 24 hours and without pain relief or water for 8 hours. A midwife took away my sanitary protection and underwear and promised to return with new ones. She never returned, leaving me humiliated in a pool of my own blood. I felt I had no dignity left. It was like I was abandoned on the ward and even though I had just had major surgery I was treated as an inconvenience. I just wanted to go home to feel safe.”*
- *“I was rushed downstairs in a wheelchair, in agony. In the birthing room, I was offered gas and air, and a midwife began guiding me through the breathing process. I asked again about an epidural, and while she said she would call an anaesthetist, she added that it was likely too late. Shockingly, she then said she would be going on her lunch break, leaving me feeling utterly abandoned and terrified. I pleaded with her not to leave as I knew the baby was coming and indeed, my son was born within minutes. The delivery was quick, but it left me physically and emotionally traumatised. I passed out afterwards and was left shaking. Even now, recounting the experience sends chills through me.”*
- *“The trauma really began afterwards — and it was preventable. Only two hours after surgery my husband was told to leave. At 10pm, as a first-time mum, still numb, sore, and traumatised, I was left completely alone with my baby. I was taken to the postnatal ward at 3am in a wheelchair, disorientated, in pain, surrounded by crying babies and sobbing mothers, who all clearly felt the same way. This place was hell. The ward was dark, lonely, and frightening. Nobody to help. Just left to figure it out on our own. I have never EVER experienced care like it. It’s so degrading, careless and humiliating.”*
- *“The postnatal ward was hell. Mothers crying, babies screaming, and hardly any support. I cried the whole way home when I was finally discharged, relieved never to return to the hell that is the postpartum ward. The labour itself was traumatic but unavoidable. The postnatal care was traumatising and preventable. I have never felt so alone, humiliated, and depressed in my life. In a time that should be the best time of my life. No mother should ever be made to feel like this after giving birth.”*

PATTERNS OF HARM:

INHUMANE & DEGRADING POSTNATAL CARE

CONTINUED

- *“After a safe delivery of my daughter via c-section with caring, professional and empathetic staff, it was a stark contrast to experience the complete lack of care on Level 5. On arrival, I was wheeled on to a four bed bay, and left for a long period of time without any support. I was, of course, unable to move at this stage following the c-section and I was not provided with the buzzer to call for help. When a nurse came to check on me, I asked for food, water and pain relief. These were not provided. I understand that the NHS is stretched but I believe basic care such as water and pain relief is a non-negotiable.”*
- *“The postnatal ward (I believe L5) was the worst. With the exception of one midwife, they were some of the most callous people I have come across in my life. Heartless, uncaring, condescending and absolutely lacking in empathy. This was the way all other mums on the ward were being treated as well.”*
- *“Later, when I read my postnatal notes, I was stunned. They didn’t reflect how I felt or what I went through. It was like reading about someone else entirely—someone who was coping fine, someone who didn’t ask for help. That wasn’t me. And no one—not once—asked how I was doing emotionally. I was vulnerable, I was overwhelmed, and I was silently falling apart. But I put on the brave face. Like so many of us do. I just needed someone to notice... but no one did.”*
- *“When my partner returned to the postnatal ward the next day no-one even asked who he was, or checked any ID. There was a complete lack of safeguarding for women and new babies. My postnatal experience got worse as I requested milk for my daughter and I was told that they wouldn’t even give her any human donor milk until I could demonstrate that I could hand express colostrum. I had been expressing colostrum for weeks antenatally but after the caesarean my body wasn’t producing any. Due to the ‘Baby Friendly’ policy that OUH follows, milk was withheld from my newborn baby. I dread to think what would have happened to her if I hadn’t pushed to be discharged so quickly.”*
- *“Around 1am, I was transferred alone - via wheelchair, barely dressed and somehow carrying my daughter in my arms - through the deserted hospital corridors by a male porter, and placed on Level 5, a boiling, dark, overcrowded postnatal ward where all I could hear were the cries of other mothers and babies. There was no support available, despite recovering from major abdominal, emergency surgery and sepsis.”*
- *“The wards are hideous. No privacy, no food, no care or support.”*

PATTERNS OF HARM:

INHUMANE & DEGRADING POSTNATAL CARE

Withheld pain relief postnatally

- *“After the birth, they had cut me and I had ripped multiple times. As I was being sewn up, completely covered in blood, I was told my husband would need to leave, I cried and begged that I was in too much pain to be left to look after my newborn without support. They told me, after a 16-hour labour, with no rest between contractions, that my husband was tired too and needed to rest. They took away the gas and air, I begged them not to as I was in a great deal of pain, but they did, and offered me no other pain relief.”*
- *“I was having a lot of trouble walking upright after the c-section but they would not give me any pain killers other than paracetamol that did nothing, I eventually had to get my own pain relief which my husband brought in for me.”*
- *“So instead they gave me nothing, not even verbal information - which is completely negligent. I was discharged without pain relief, after a 20 hour labour, forceps and a c-section. The community midwives that visited me the day after discharge cried when they heard what had happened and organised emergency pain relief because I was in so much pain.”*
- *“When I was finally moved, the care became less and less. I was told by the consultant to take as much pain relief as I needed. From my notes I can see I was prescribed both dihydrocodeine and morphine however I was only given paracetamol and ibuprofen. It again took tears for them to take me seriously and give me some dihydrocodeine which did help.”*

Lack of dignity & privacy

- *“When we returned, I had to wait for almost 3 hours until I was taken to the postnatal ward. All this time, the curtains were open, my breasts were exposed, people were walking by in the corridor and a male cleaner was cleaning the bed next to me. I felt like I had no dignity. No food or water was ever brought to me while I was in the recovery ward. I was absolutely starving as I had not had anything to eat since noon the previous day because I had had an epidural.”*
- *“One morning, the matron marched onto the ward, flung open everyone’s curtains, and told us they had to remain open — stripping away any sense of dignity or privacy. I couldn’t wait to leave. I experienced very low moments afterwards.”*
- *“Aftercare on the ward was non-existent. There were no curtains on the first ward which was busy with families visiting other women. I felt incredibly vulnerable - bleeding, unable to move, exhausted after three days of labour and trying to breastfeed.”*

PATTERNS OF HARM:

FORCED SEPARATION FROM PARTNERS

Being forced to face the hours after birth without a partner is profoundly traumatic. Women describe feeling frightened, powerless and abandoned – left to care for their newborns while still in pain, bleeding, or unable to move. No one should ever be left alone in those conditions.

- *“Women should also never be left without their birth partners in hospital, especially after giving birth when we are at our most vulnerable. I had no one to advocate for me, look after me, reassure me, hold the baby so I could wash myself, or just bring me a glass of water. It was awful. I felt scared, helpless and humiliated.”*
- ***“I cried and begged the nurse but she told me it was “one rule for everyone”. My partner was made to leave and I was left alone, unable to move, soaked in blood, looking after a newborn baby.”***
- *“I was still vomiting, shaking, my temperature had gone through the roof and a midwife was left to look after my newborn. Myself and my husband were both horrified and devastated. I struggled through the next couple of days on the ward with my husband’s 1 hour visit, in pain and very tired.”*
- ***“if birth partners aren’t allowed to stay, then the midwives must step up and fill that gap. No mother should be left alone and unsupported at their most vulnerable.”***
- *“They asked my partner to leave after just 1 hour - I still could not feel my legs or my right arm. I was left alone and helpless with the baby from that point on.”*
- ***“I was also told that my partner would not be allowed to visit me that day. I had asked if he could bring me food, help me wash etc but they said the 1 hour he had stayed with me after birth counted as my visit for the day and I could not have any more visits that day.”***
- *“I finally came out of theatre and was brought round to the observation ward I couldn’t move or do anything my partner was told to leave, my son was left with just a nappy, hat and blanket around him. That night he was sick and I don’t know how I managed it but I sat up and grabbed him because if I hadn’t he would of suffocated on his own sick.”*
- ***“After a major surgery, my partner was not allowed to stay with me overnight. I was left alone and immobile while my baby lay in the cot. He began choking on mucus multiple times.”***
- *“My mum and partner were therefore asked to leave at 9pm. I was left with my newborn, unable to move from the spinal block, multiple cannulas in my hands making it painful to lift him, hold him, feed him.”*

PATTERNS OF HARM:

PSYCHOLOGICAL HARM & BIRTH TRAUMA

Families describe ongoing PTSD symptoms including nightmares, panic, anxiety and depression, alongside problems bonding with babies, and suicidal ideation linked directly to experiences in OUH maternity services – particularly feeling coerced, silenced or retraumatised by complaint processes. The psychological harm caused by OUH is debilitating and long-lasting.

PTSD & birth trauma

- *“I was very depressed and diagnosed with PND quite quickly afterwards by my health visitor. I had help from a psychiatrist who would come to my house once a week and help me bond with my baby. She diagnosed me with PTSD. For the first 18 months of my son’s life I wasn’t ‘there’ - I wasn’t a proper mum to him, I was in and out of hospital and my mother was caring for my children whilst I had long recovery stints in bed.”*
- *“No mental health support arrived. I waited nearly a full day before someone realised they’d been bleeping the wrong number. “Oops.” That single word still echoes in my head. I broke. Hallucinations began — blood running down walls, voices in my head, compulsive washing until I bled. I was admitted to the Warneford for emergency psychiatric care. The diagnosis: birth trauma-induced psychosis and severe PTSD. All of it preventable. A year later, I’m still battling for my health. Daily hallucinations. PTSD.”*

Postnatal depression & suicidality

- *“I have never felt so alone. Flashbacks, tiredness and guilt plagued me. By September that year I was suicidal. Postnatal midwife nurse came to see me. Said I just had anxiety.”*
- *“As a result of the traumatic experience, I do not have any memory of my post birth experience/memories of my child. Even when returning home I struggled to readjust past the typical and adjustment phase and have suffered with postpartum depression ever since and resulted in attempts at taking my own life.”*
- *“I went on to develop severe postnatal depression and how I was treated by OUH during my son’s birth was a huge contributory factor.”*

Long-term mental health impact

- *“Even thinking about having to step back in JR is still a trigger 6 years on.”*
- *“Five years on and I’m still on antidepressants due to this birth... I’m also waiting for counselling for ptsd and help for my fear of hospitals.”*

PATTERNS OF HARM:

LACK OF INSTITUTIONAL ACCOUNTABILITY

Defensive responses to complaints

- *“They took over the 25 days they should have done to respond to our complaint and what followed was lots of back and forth with no answers and just apologies and excuses. At this point our son hadn’t had his post mortem. We now know he died of a concealed placental abruption. In our eyes he could have been saved.”*
- *“I put in a complaint about my experience and received a defensive response, blaming all issues on me.”*
- *“We reached out to PALS to raise a complaint and had a response that essentially said ‘these things happen’ with no apology.”*

Inadequate Birth Reflection service

- *“I experienced very low moments afterwards and returned to the JR seven months later for their Birth Reflections Service. Unfortunately, that session felt defensive, more about placating mothers than genuinely listening.”*
- *“I put in a complaint pretty much straight away and got just a generic we have passed this on to the necessary people reply. Nothing has ever come of it, I also did the Birth Reflections meeting but it honestly did not help at all. I hope telling my story will maybe give me a little bit of closure.”*
- *“After this traumatic experience I used the birth after thoughts service where I was made to feel like I was mental for being diagnosed with PTSD.”*

Falsification & misrepresentation of records

- *“Nine days postpartum, I found myself on a ward surrounded by pregnant women. The next morning, I woke to be told my medical notes were lost. They asked me to retell my story. Again. After all I’d been through, I was forced to relive the moment I lost my son.”*
- *“I was handed some notes, which I looked at a few years later, where all the times for each step and check throughout me arriving and having my daughter were all wrong. They had her down for arriving after 8am, she was born at 6:32am.”*
- *“They actually gave me someone else’s birth notes, and inputted his weight wrong which we had to tell them.”*
- *“Midwives also falsified my notes declaring I never vomited during labour.”*

PATTERNS OF HARM:

BETRAYED BY THE PEOPLE WHO WERE MEANT TO CARE

Breach of Duty of Care

- *“I feel let down by both community midwives during the end of my pregnancy and the midwives during the birth. I was measuring 48cm, baby was obviously big and they waited 2 weeks overdue to induce. I naturally went into labour in the end and was sent home to progress. 2 days later I went back begging them to help me as no further progression. I was exhausted. My son got stuck and had the cord around his neck. I was put in all sorts of positions with tons of people trying to help get him out. Its a blur at this point but he ended up with a pneumothorax. I am left with a prolapsed bladder. I feel very lucky we are both still here. Why not do a C-section?”*
- *“This tragedy should not have happened and could have been prevented, I still feel so angry and let down and deeply saddened for everyone that has suffered. The mental pain is indescribable and it’s living alongside this trauma while trying to live the best way possible for my other children’s sake!”*
- *“Despite the seriousness of my condition, no surgeon came to assess me. Some midwives dismissed the prolapse as haemorrhoids, overlooking the potential for rupture or permanent bowel damage.”*

Failure to protect vulnerable adults & infants

- *“During a follow-up appointment with a midwife at the hospital a few days after giving birth, I told them I was feeling low and was crying a lot. I was visibly distressed and on my own. They showed no emotion and said that it was fine and only if I was feeling suicidal that they would get me to speak to someone.”*
- *“My partner was made to leave and I was left alone, unable to move, soaked in blood, looking after a newborn baby. It was cruel and I will never forgive the staff for their failure to advocate for women, babies and their families.”*
- *“On the second day a doctor visited and I begged him to let me have regular paracetamol, he agreed but I never received any. When he returned the next day to check I told him it had not happened. He said he would look into it. A few minutes later, a nurse came, walking at a pace directly up to me, put her face up to mine and in a hiss asked why I had ‘told on her’ that she ‘was too busy to remember my stupid medication’. I was left scared and no longer asked for any pain medication. Instead I asked my mum to smuggle some in for me and I took my own.”*

THIS HARM MUST END

Despite media attention and national attention, the situation at OUH remains unsafe:

- Women are still being denied timely intervention
- Women's concerns and risk factors are still being ignored
- Psychological trauma continues to be dismissed
- No meaningful accountability has occurred within the Trust Board or clinical leadership

We strongly feel that without external intervention, this harm will continue.

What we ask of the Independent Investigation

- Ensure a Families First approach also concludes with families too: we deserve the right to respond to findings and the Trust's response
- Examine governance, research, conflicts of interest and systemic ethics failures
- Audit OUH's compliance with NICE and Montgomery Standards: examine all iterations of policies, whether women are fully informed of the risks of vaginal birth and birth at midwife-led units, carefully consider pain management protocols in comparison with lived experiences, examine OxGRIP/ Pathway D and other research projects for ethical compliance and clinical practice implications
- Examine leadership accountability and potential conflicts of interest between OUH, NHSE, and the University of Oxford
- Contribute learnings to national legal and policy reform: recommend statutory protection for maternity consent, mode of birth, and pain relief access rights. Mandate that denial of MRCS or pain relief be treated as a rights violation
- Suspend the MNVP system and call for a truly independent, service-user-led organisation
- Call for legal protections for patient advocates and campaigners to prevent legal attempts at silencing
- Ensure OUH provides individual Duty of Candour meetings and apologies for failings for all families harmed
- Call for accountability of leadership: senior leaders within both maternity and at Board-level must be held accountable for allowing harm under their governance.

CONCLUSION: IT'S TIME TO ACT

The experiences of over 700 families reveal a maternity service across Oxfordshire where misogyny, moralisation, and denial of choice have replaced compassion, safety and ethics. Women's suffering has been normalised, psychological trauma minimised, and informed consent treated as optional rather than legal obligation.

Oxford – a city synonymous with privilege and excellence – has become the site of systemic obstetric harm, where institutional reputation has been prioritised above women's rights and babies' safety.

The inclusion of OUH in the National Maternity and Neonatal Investigation is a vital and long-overdue step. But for harmed families, it must mark not the end of an investigation – but the beginning of accountability and change.

If this review is to restore public trust, it must centre those who have been failed – not those who failed them.

Accountability cannot mean polite reflections; it must mean structural reform. Justice cannot mean improved messaging; it must mean recognition, redress, and prevention.

We call on the NMNI to:

- Support our calls for a public inquiry into OUH's maternity services. The scale of harm, governance failures, and leadership conflicts of interest warrant a public inquiry.
- Ensure psychological safety is embedded in maternity care and policy nationwide: psychological safety must be treated as equal to physical safety.
- Ensure the introduction of clear guidance reaffirming Montgomery standards, prohibiting coercive referral practices for MRCS, and ensuring human rights compliance.
- Call for the introduction of an independent oversight mechanism for complaints and Duty of Candour: all complaints must be independently reviewed.
- Call for an investigation into regulatory processes to examine their efficacy and efficiency.

BEYOND THE INVESTIGATION

WHAT WE'RE CALLING FOR

Since the start of our campaign, we've been calling for a full independent inquiry – and we won't stop until it happens. Families deserve answers, accountability, and recognition for the harm caused under OUH's maternity services and the lasting impact we live with every day.

Beyond the NMNI, we will continue to call for:

An independent, judge-led inquiry

Families will only get the truth they deserve through a full, independent inquiry – one that exposes the systemic failings, the culture of cover-up and the scale of avoidable harm across OUH's maternity services. Those who caused and allowed this harm must finally be held accountable.

Accountability and apologies

Acknowledgement from OUH of its failings and apologies to the families who have been harmed by its unethical care of mothers, babies and families.

Compliance with national guidance

A non-negotiable commitment from OUH to deliver its maternity services in line with national guidance to provide the safest care for women and babies.

An independent feedback channel

A platform managed by a truly independent, unbiased body that listens to families' experiences and proposes actions for OUH to take.

Systemic change

An action plan of interim changes to improve the physical and psychological safety of OUH's maternity services immediately. A long-term plan for permanent changes to ensure OUH delivers its services to the highest standards of safety, and creates an environment and staff ethos where women and their families are listened to, respected and cared for.

SUPPORT FOR THE CAMPAIGN FROM MEDICAL NEGLIGENCE LAW FIRMS

Laura Cook, Obstetric Clinical Negligence Partner at CL Medilaw

“Having a birth injury specialist team nationally, and being established in Oxford for over 25 years, we have represented many women, children and families whose lives have been turned upside down by poor standards of maternity care at Oxford University Hospitals, including babies left with life-long disabilities and parents left traumatised. We see many common themes being repeated in the cases we manage – from lack of counselling on risks and failure to obtain informed consent around timing and place of delivery, to a lack of intervention with delays in achieving a safe birth, to poor postnatal care. An independent review with urgent improvement is greatly needed and we are very pleased to offer our support to the campaign.”

Suzanne White, Clinical Negligence Partner at Leigh Day

“At Leigh Day we have worked with so many families that have tragically suffered poor maternity care. We know that families want answers to make sure that the same mistakes are not made again. We can see from the many maternity scandals being reported in the UK today, that maternity services are failing a significant number of mothers and babies. That is why Leigh Day wholeheartedly supports the families who have received poor maternity care at Oxford University Hospitals and their campaign to get to the truth.”

Lucy Crawford, Senior Associate at RWK Goodman

“It is sad to see such a large number of people join a group such as this as it clearly shows something is not working with the services being provided. There are families who have suffered the loss of their baby, families of children with profound disabilities and parents who have suffered significant psychological harm as a result of their experiences. A single theme of lives being devastated is clear. I wholeheartedly support the campaign. It is important that patients harmed in such a way are given a ‘voice’ and are listened to, so that such practices are scrutinised to ensure patient safety is prioritised.”

HOW FAMILIES FELT IN OUH'S MATERNITY SERVICES:



FOR TOO LONG FAMILIES HAVE BEEN MADE TO FEEL ALONE. BUT WE WERE NEVER ALONE.

Women giving birth should be treated like human beings, not like cattle. We deserve to feel respected, safe and heard. Women should also never be left without their birth partners in hospital, especially after giving birth when we are at our most vulnerable.

Women giving birth deserve better. They deserve THE BEST CARE. Thank you for this opportunity to be heard, I really do appreciate it.

There seems to be so much focus on 'if you and your baby are healthy you should be grateful' - we should be aiming for a higher standard than "you've survived". I'm angry - families deserve better.

This experience has stayed with me. Not just because of what happened - but because of how alone it made me feel. I left that hospital thinking I had failed. That I wasn't strong enough. That I hadn't tried hard enough. But now I see that I didn't fail - the system did. If you're reading this and you've felt that way too - please know it wasn't your fault. You deserved better. We all do.

And If someone in a position to make change happens to read this - I hope you hear the pain behind these words. And I hope you realise that better support, real empathy, and honest communication could change someone's entire journey. It would've changed mine.

It has taken me 2.5 years to be able to speak up, and I do it now as well because too many women and families have been failed in the JR, and our babies deserve better beginnings.

FAMILIES HAVE SPOKEN. WILL YOU FINALLY LISTEN?

ACKNOWLEDGEMENTS

Thank you to all of the families within the *Families Failed by OUH Maternity Services* campaign group who shared their experiences with the campaign and contributed to the data collection for this report.

Ours is a group that no-one wants to be a part of and no-one should have to be a part of, but we are all determined to hold those who have harmed us to account, and to ensure that no more families experience what we have been put through.

This report was authored by the *Families Failed by OUH Maternity Services* campaign committee. If you would like to read the testimonies included in this report in full, please contact us on the email address below or visit our '*Families' experiences*' webpage.

Find out more



FamiliesFailedByOUH.co.uk



info@FamiliesFailedByOUH.co.uk

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