

Ockenden report reveals a massive regression in UK maternity care linked to staff shortages

Margot Miller
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A review into maternity services at Nottingham University Hospitals NHS Trust (NUH), published June 24, exposed serious failures in UK maternity care that also impact nationally.

Commissioned in 2022 following campaigning by bereaved families, and chaired by former senior midwife Dame Donna Ockenden, the 400-page report examined 2,505 cases of death or serious harm between 2012 and 2025, drawing on testimony from 2,430 families and 822 staff members. It stands as the largest study of its kind.

While most care at the trust was rated good or excellent, the review found that breakdowns in care had catastrophic consequences. A recurring theme was the link between funding shortfalls, staff shortages, and poor outcomes. The report describes dangerously low staffing levels and inconsistent senior oversight, concluding that chronic understaffing was among the most pervasive issues identified.

Maternity services, like the rest of the National Health Service (NHS), have faced sustained funding pressure as the result of savage austerity imposed by successive Labour and Conservative governments since the 2008-09 global financial crisis. The review found that six maternal deaths--over a fifth of total mortality in the period studied--were potentially avoidable, with women dying from complications including haemorrhage, pre-eclampsia, and stroke. It also noted a 21 percent rise in maternal mortality since 2009-11.

Among stillbirths reviewed, roughly a quarter were classified as involving significant or major concerns about care that could have changed the outcome. In total, 94 babies who might have survived died, alongside 62 neonatal deaths in the same category--together, 156 avoidable infant deaths. A further 105 babies suffered severe, avoidable brain injury from oxygen deprivation or brain bleeds, leading to lifelong conditions such as cerebral palsy. The neonatal unit was described as having operated for years under severe capacity strain across two sites, with overcrowding, frequent transfers of critically ill infants, and gaps in consultant cover outside normal hours.

The report gives voice to the families, with comments from expectant mothers for example:

'There was one midwife to cover the whole ward.' (2017)

'Buzzers weren't answered for hours...we heard staff saying

they were dangerously understaffed.' (2021)

'My midwife said she didn't come into the profession to care for three women (in labour) at once.' (2021)

Concerns had been raised by parents and staff for years, echoing findings from earlier NHS trust investigations at Morecambe Bay, Shrewsbury and Telford, and East Kent. The Royal College of Midwives has logged 748 maternity safety recommendations over the past decade, inconsistently acted upon, while maternal deaths nationally are now a fifth higher than a decade ago. In correspondence with the health secretary, Ockenden noted that problems at NUH had been documented since at least 2010, including inadequate staffing and funding, barriers to basic training, and a persistent failure to listen to parents or properly investigate mistakes.

The report's central case study is that of Harriet Hawkins, stillborn after her mother's obstructed labour was misdiagnosed as an earlier, non-emergency stage of labour. Her parents' grief was compounded by what the review calls a cover-up and serious breakdown in hospital governance.

Failures extended beyond the point of death. The review criticizes NUH's mortuary practices, citing an early-gestation baby mistakenly discarded as clinical waste, dehumanizing language used by clinicians, and breaches of legal requirements around mortuary care. In one 2016 incident, a deceased baby was placed in a mortuary space already holding an unrelated adult body without informing the parents; in another case, a baby's body was released to the wrong funeral director.

The review found that women from black, Asian, and other minority backgrounds, along with those living in deprivation, faced elevated risk of poor birth outcomes--made more relevant given Nottingham's standing as one of England's most deprived local authorities. Nationally, black women face nearly triple the risk of dying during or shortly after pregnancy compared to white women, with Asian women facing roughly double the risk.

Staff surveys paint a picture of severe strain: only 11 percent reported adequate staffing levels, 59 percent said they regularly worked hours longer than optimal for care quality, and 73 percent said they often operated in crisis mode in the belief this was the only way to protect patient safety. By 2026, consultant vacancy rates at NUH stood at nearly 21 percent, with

midwifery vacancies at 13 percent, and 82 percent of staff considered staffing unsafe. Burnout was reported by all surveyed neonatal junior doctors, along with 94 percent of nurses and 88 percent of consultants. The Royal College of Nursing estimated a national shortfall of roughly 2,000 midwives in 2022, growing to about 2,500 by 2024.

Staff accounts describe working 12-hour shifts without breaks, managing multiple women in labour simultaneously without adequate support, and being assigned unsafe numbers of infants per nurse despite raising formal concerns. In 2018, 50 maternity staff at the Queen's Medical Centre wrote directly to the trust board over safety concerns, and some reported facing bullying when attempting to escalate issues.

Some families described a lack of compassion from staff, including delayed pain relief and instances of racism--which has received disproportionate attention in much of the media, compared to the underlying systemic underfunding. The aim consistently is to support arguments for further privatisation of NHS services.

The report in fact links diminished empathy and 'compassion fatigue' among staff to heavy workloads, fear of making errors, and insufficient support after traumatic births or losses.

According to reporting from the *Guardian*, dozens of midwives and nurses at the trust remain under misconduct investigation, alongside a police inquiry into potential corporate manslaughter and ongoing litigation from affected families. NHS Resolution figures show maternity-related claims account for £2.5 billion--around half of all NHS clinical negligence costs.

This, however, is the responsibility of governments which have brought the NHS to its knees with austerity cuts and creeping privatisation.

NUH's own financial records trace a long-running budget squeeze: a £47.2 million overspend in 2015/16 despite tens of millions in savings, a near-£32 million deficit by 2018/19 after years of comparable 'efficiency' targets, and a £71 million deficit in 2024/25 alongside demands for nearly £98 million in further savings. NHS funding overall is estimated to fall short by £54 billion a year relative to 2010/11 real-terms levels, with staff shortages nationally linked to nearly 16,000 deaths among patients awaiting treatment last year.

NUH and the then health secretary, James Murray, have both apologised to affected families. A separate rapid national investigation into maternity and neonatal services, ordered by the previous health secretary, Wes Streeting, and chaired by Baroness Valerie Amos, published its findings June 30 after reviewing 12 trusts and over 450 families.

Valerie Amos was a Blair government minister and leader of the House of Lords, later UN Under-Secretary-General for Humanitarian Affairs and now Master of University College, Oxford. Her report concluded that the problems identified at Nottingham are mirrored across the country, with Amos stating maternity services are not equipped for present or future needs.

Amos' recommendations include creating a Maternity and Neonatal Commissioner answerable to parliament, national care standards, improved engagement with families, stronger regulation, and modernized digital systems--though she stopped short of backing the full statutory public inquiry that bereaved families have called for, citing the lengthy timescales such inquiries typically involve. The report was described by health secretary Murray as a 'watershed moment,' with a government action plan promised by year's end.

Ockenden's review calls for neonatal units to have properly funded staffing and equipment sufficient to handle peak demand while running at no more than 80 percent average occupancy and insists that neonatal consultants should never be responsible for emergency cover across more than one hospital simultaneously.

Both reviews ultimately call on government to address the underlying causes--though hundreds of prior recommendations from earlier inquiries remain unimplemented.

No further inquiry, petition or programme of token reform will restore maternity care. The NHS is being systematically gutted. Labour's 10 Year Health Plan for England will deepen the market reforms and expand the private provision that produced the crisis. Resources to fund safe staffing are instead poured into rearmament—a commitment to 3.5 percent of GDP on core military spending, some £25 billion a year in today's terms.

A change in Labour Prime Minister from Keir Starmer to Andy Burnham will change nothing. He has already reassured the bond markets he is not "squeamish" about welfare cuts to pay for defence.

Fully funded maternity care requires the organisation of a political and industrial struggle by health workers, reaching out for support among all workers based on the demand to save the NHS by confiscating the phenomenal wealth of the oligarchy and putting it to the meeting of fundamental social needs. To end the social murder of mothers and babies, as part of the struggle for an NHS providing high quality health care available to all, contact NHS FightBack today.



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