Dear Sir/Madam, **(DELETE AS APPROPRIATE)**

We are a group bereaved families who have been affected by failures in maternity and neonatal care and we are writing today to repeat our call for a statutory public inquiry on maternity safety. We hope that as a new Secretary of State in a new government you will be prepared to take the decisions which are difficult but necessary to save the lives and health of Mothers and babies – including by ordering a statutory public inquiry.

Under fourteen years of Conservative government, thousands of babies were killed by negligent and neglectful NHS care. Successive Secretaries of State for Health made the critical and deadly errors of believing that commissioning reports and reviews, making a few policy changes, and pouring more money into maternity care would fix the system-wide problems that cause avoidable harm and death on a massive scale. They trusted that NHS leaders valued the lives of babies as much as you or to each of us, but the reality is that too many are content to merely tick boxes while placing their reputations above quality and safe care. As a result, not only did national and local reviews and schemes fail to improve maternity care, but in the last few years things have gotten worse.

* 800 babies die each year because of failings in care. According to a report from the Sands and Tommys Joint Policy Unit, reviews of individual deaths show that around 800 babies each year die when care following national guidelines could or would have saved their lives. This is likely to be an underestimate given that these reviews are conducted by the hospital responsible for the baby’s care.
* Medway Maritime Hospital explained to Theo Pepper’s parents that they deal with at least 120 families per year – one preventable death is too many.
* More mothers are dying during or soon after pregnancy than at any time in the last 20 years. Data from MBRRACE shows that the maternal death rate increased to 13.41 per 100,000 in 2020-22, a higher rate than at any time since 2003-05.
* The figures also show that proportionally three times as many Black women and twice as many Asian women die than White women. Even when the effect of Covid-19 is stripped out, maternal deaths have increased at an alarming rate.
* More than 500 babies per year sustain a brain injury at birth. Data from MNSI shows that over 500 babies per year sustain brain injuries at birth, but this data excludes babies born below 37 weeks gestation and does not measure how many of these injuries were avoidable.
* Mums are suffering life-changing physical and psychological birth trauma. Despite a parliamentary inquiry on the subject, it is still unclear how many women suffer birth trauma and how much birth trauma is avoidable – again, because the NHS does not measure it. As an indication of the scale of the problem a survey by Mumsnet found that 53% of women suffer physical trauma and 71% of women suffer psychological or emotional trauma at birth.
* Two thirds of maternity units do not meet basic standards for safety. The Care Quality Commission (CQC) has rated two-thirds of maternity units ‘Inadequate’ or ‘Requires Improvement’ for safety, and half ‘Inadequate’ or ‘Requires Improvement’ overall. These ratings show that failings in maternity care are truly system wide. The even more alarming reality is that the CQC is itself failing and continues to rate units where multiple babies have been killed by negligence as ‘Outstanding’.
* The cost of harm in maternity care rose to £4.2 billion in 2022/23. Figures from NHS Resolution show the projected cost of harm in maternity care for 2022/23 is £4.2 billion, 63% of the total NHS compensation bill. This money is awarded to families after many years of desperate struggle to pay for care needs and lost earnings, and just as the harm they experienced is entirely avoidable with safe care, this financial cost is too.

Behind these horrific and tragic headlines and statistics sits a system that is rotten and broken from top to bottom. Regulators, NHS England, hospital boards, clinical leaders, and in many cases the staff delivering care are failing to uphold their responsibilities; maternity units are dominated by cultures where clinicians clash with each other and dangerous care is accepted as normal; precious babies killed by basic failures in care are minimised and dismissed as ‘within the normal range’, or covered up leaving traumatised and grieving parents to fight for the truth; investigations intended to help improve care are fundamentally flawed and frequently compound harm; the entire system deliberately closes its eyes to the breadth and scale of harm by refusing to measure and investigate almost all avoidable injuries; whistleblowers are dismissed from their jobs as maternity leaders double down on their commitment to ideological views of birth over safe care; and there is zero accountability at any level for failing services and the totally preventable injuries and deaths of babies and Mothers.

We are asking you to draw a line in the sand, stop repeating the failures and misapprehensions of the past Government, and order a statutory public inquiry on maternity safety. This whole system analysis is the only way to truly get to the bottom of why so many babies are killed by NHS failings, why it is getting worse despite efforts to change and improve, and finally come up with solutions that will make a real difference and save lives. This is part of what our alliance stands for – campaigning for change, for safer care, and for justice for families when serious injury or death could have been prevented. Families that are going through this devastating time should not have to face such battles for justice for their children, they should not have to fight battles for years causing even more irreparable harm. When a life is taken and that could have been prevented it should have the same consequences of taking a life. However, because they are babies, foetuses or young children this is not the case, and families can only seek a negligence case. This should be investigated also. When a life is taken there should always be action that is taken, and justice given to the bereaved families.

We understand that you have reservations about ordering a public inquiry and are confident that given a fair hearing we can assuage them.

The Safer Births Alliance was co-founded by Theo’s Foundation and Isabella-Grace’s Angels both of which are proud members of The Baby Loss Awareness Alliance. We want to create change to protect little lives, to protect families and these changes to our healthcare system would not only help to ease the compensation budget but protect healthcare workers too. Changes need to be made to do this; the system needs overhauling this can only be done with an inquiry into the current mass failings from various NHS Trusts.

Yours sincerely,

(YOUR NAME and Contact Details)

Your reason for signing