National Maternity and Neonatal Investigation

Barking, Havering and Redbridge University Hospitals Trust

Trust report

Note of acknowledgement

We would like to thank the women, birthing people and families who came forward to share their experiences of maternity and neonatal services at Barking, Havering and Redbridge Hospitals with us. By sharing their experiences, families relived deeply painful and traumatic events in their lives, and we are grateful for them for their preparedness to do so. From the outset we have put the voices of women and families at the heart of this Investigation, and that is why our visits to trusts carried out family evidence panels separate from trust premises.

We would like to thank staff at the Trust for their time and contributions to the National Maternity and Neonatal Investigation (NMNI) including organising our visits, sharing data and evidence, and for their honesty and openness in interviews and panels.

Introduction to Barking, Havering and Redbridge University Hospitals Trust

The National Maternity and Neonatal Investigation Team visited Barking, Havering and Redbridge University Hospitals Trust (from here on referred to as BHRUT or the Trust) on 4 and 5 November 2025. We then revisited the Trust on 3 February 2026 to hold additional family evidence panels. BHRUT maternity services operate across Queen's Hospital and King George Hospital. Queen's Hospital is the Trust's single obstetric led maternity and neonatal unit, whilst King George Hospital provides outpatient and community maternity services.

The aim of our visit to the Trust was to speak to families about their experiences and understand the experience of staff working there. It was also important for us to view the estate itself, as staff and families reported the impact this could have on services. The trust visit contributed to our understanding of what is happening in maternity and neonatal services in England.

Each individual trust report provides a snapshot in time, based on the evidence gathered during our site visit and review. These reports were not intended to replicate the role of the Care Quality Commission (CQC), and they should not be read as equivalent to a formal inspection or rating.

We have used nationally published and validated statistics to help us understand the performance and the context in which services are delivered as part of our site visits to NHS trusts.

Some trusts have told us that there are differences between these national data sets and the information they hold locally, or in how they define certain measures.

We recognise that these differences exist. Where a Trust has raised this with us, we have noted this and, for completeness, included both the nationally published data and the Trust’s own data or explanation.

Maternity services

BHRUT’s maternity services were rated ‘Good’ by the CQC in August 2025.

An explanation of what the CQC is and what their ratings mean can be found in Annex 2: Glossary.

Activity and modes of delivery

Activity:

National published statistics

- In 2024/25, BHRUT supported 7,120 births.

Statistics provided by the Trust

- In 2024/25, BHRUT supported 7,185 births.

Modes of delivery:

National published statistics

- In February 2026, 42.9% of deliveries were by caesarean section, compared with 39.6% three years earlier in February 2023.
- In February 2026, labour was induced for 27.4% of deliveries, compared with 17.7% three years earlier in February 2023.

Statistics provided by the Trust

- In February 2026, combined elective caesarean section and emergency caesarean section were 44.4% (elective caesarean section 17.46% and emergency caesarean 26.94%).
- In February 2026, labour was induced for 41.52% of deliveries, compared with 28.5% three years earlier in February 2023.

Workforce

As of January 2026, the Trust employed:

- 281.4 full-time equivalent midwives.
- 89.6 full-time equivalent doctors working in obstetrics and gynaecology.

There were an estimated 28.2 deliveries per midwife in BHRUT in 2024/25. The number of births per midwife in 2024/25 is higher than the national average (23.1).

Neonatal services

The Trust's neonatal services were rated 'Good' by the CQC in 2017 as part of an Inspection of the 'Children and Young People' services.

Unit and care pathway

Queen's Hospital has a Level 2 Neonatal High Dependency Unit for babies who need a higher level of medical care and for babies born after 27 weeks' gestation. This might include short-term intensive care, ventilation for breathing support, or tube feeding. There are 74 Level 2 Neonatal High Dependency Units across the country.

In 2024, babies were cared for in neonatal units for a total of 8,310 days of care, placing BHRUT in the second-highest 20% of providers of neonatal care nationally.

Workforce

As of January 2026, the neonatal service employed 67.2 full-time equivalent neonatal nurses. In the 12 months ending October 2025, 87.8% of neonatal nursing shifts were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

This means that the neonatal staff-to-patient ratio was followed as suggested by BAPM. A full explanation of neonatal staffing guidelines and service specifications can be found in Annex 2: Glossary.

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences were rated around average for the start of their pregnancy, antenatal check-ups, their labour and birth, care in the ward after birth and feeding their baby.

Women's experiences were rated somewhat worse than average for their care during pregnancy, and at home after birth. Experiences were rated worse than average for staff caring for them, triage: assessment and evaluation, and complaints.

In the 12 months ending October 2025:

National published statistics

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) was 1.0 per 1,000 live births, comparable with similar trusts.
- A stabilised and adjusted stillbirth rate of 3.0 per 1,000 births, comparable with similar trusts.

Between 1 October 2024 and 31 October 2025:

Statistics provided by the Trust

- A neonatal mortality rate of 1.5 per 1,000 live births.
- A stillbirth rate of 2.83 per 1,000 all births.

A full list of evidence sources that were used to inform this report alongside details on what analytical methods we used can be found in the ‘How we gathered and analysed our evidence’ section at the end of this report.

What families told us

The Investigation's engagement strategy has been underpinned by a Families First approach. 'Families First' originated as a key principle of the Hillsborough Independent Panel and has been adopted in several subsequent investigations, including maternity investigations.

When visiting BHRUT, the first thing the team did was to hold family panels in locations separate from the Trust's sites. We invited women and birthing people, fathers and partners[1] who received care from the Trust to share their experiences at the panels.

Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences speak to the lasting impact of harm and bereavement on their lives and the lives of their loved ones. Families told us that they came forward as they did not want other families to go through the experiences that they did and they wanted to see long term change.

This was followed by a panel held with local community organisations and local authority representatives who shared their views on local maternity and neonatal services. The team held two further family evidence panels in February 2026, one with families who had been bereaved or harmed and another where women, birthing people and families shared a range of experiences of their care at the Trust. The team also held four individual interviews with families who had received care at the Trust.

We did not place any restrictions on the time period in which experiences of maternity and neonatal care occurred, allowing women, birthing people and families to share their experiences from different time periods. As a result, some of the issues raised, such as the condition of the estate or ways of working may have changed, got worse or improved since those experiences. However, there is consistency in the issues raised and the themes which have emerged remain important in understanding how families felt and what mattered most to them at the time.

Women and birthing people, and their families, described distressing experiences that left them feeling unsafe and unheard. Early warning signs or complications during pregnancy and labour were not recognised or acted on in time, leading to emergencies and in some cases avoidable harm. We heard that they repeatedly voiced concerns about pain, reduced baby movements, or unusual symptoms only to be dismissed or reassured

[1] This report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services identifies as a woman or mother. Further information on our approach to inclusive language and terminology is provided in the Annex: Glossary.

without clear explanation. They felt their worries were minimised or even blamed on them, which made them lose trust in their care.

> *"...I suffer with anxiety and that was used against me the whole time that I was there. "You're so anxious, you're very anxious". I said, "Yeah, I am anxious because something's wrong, the baby's not moving". This baby was so active before, like there was a change, a complete change. That's all they kept saying to me, "You're anxious. This anxiety needs to stop because this is what's not good for your baby."*

We heard from women and birthing people that their experience felt chaotic and *"factory like"* where the pressure to move people through came at the expense of compassion. Mothers and partners described being left in harmful situations such as being denied a bed and adequate pain relief while in active labour. After giving birth, some mothers said they were "*out of sight, out of mind"* on the postnatal wards when the unit was full. They noticed that regular check-ins or assistance could tail off once their baby was delivered, which made them feel abandoned or unsafe in caring for themselves and their newborn baby.

Many women and birthing people also experienced inequitable treatment. For example, some women and birthing people who were non-UK nationals or from ethnic minorities felt they received less attentive or respectful care than others. Several women and birthing people felt their reports of being in pain were dismissed. They recounted being told that what they were feeling was normal or that because they were young or of a certain ethnicity, they should tolerate it better.

Families described long term emotional trauma long after leaving the hospital. Some parents reported that their other children needed counselling to cope with what had happened. Many women and birthing people still experience flashbacks, sleep difficulties, or anxiety in later pregnancies. Physical injuries from childbirth were also life-altering. This included ongoing pain, incontinence, or mobility problems from birth injuries, sometimes forcing them to give up work or limit family plans.

> *"I was misdiagnosed. It was reported as a 3B tear, but this was not the case. It was a large 3C, possibly a fourth degree tear.... I live in fear and embarrassment of not being able to make it to the toilet in time. I spent the first one and a half years thinking it was normal for professionals, a professional who falsely blamed my ethnicity for tearing. That it was normal for Asians to tear because we have a short perineum. It was made out to be my fault."*

Families experienced what they considered superficial investigations, where they were offered reassurance about learning rather than clear explanations of what had happened or why decisions were made, leaving them uncertain about accountability. When meetings were arranged, they were attended by staff without decision-making authority or knowledge of the case. This made families feel dismissed and that the Trust was avoiding responsibility. Problems receiving complete medical records further delayed understanding, meaning families were left without the openness, clarity and answers they were seeking.

"The senior team are not visible… Not one of them was there… They are the people that need to see what's going on."

When care went well

Families also shared examples of some of the good care they had experienced. Some families were able to recall times they received prompt care and moments when they felt listened to, respected and supported by staff.

"It was only because I had Staff Member B, the bereavement midwife, on my side that I could text her and say, "Look, they're saying they're not going to scan me". I left it with her. She said, "Scan tomorrow at this time", and I just felt so relieved that like I'm being listened to, but it shouldn't be that difficult to be heard."

What we saw and heard in BHRUT

During our visit, we spent two days at BHRUT, including a full walkaround of all areas where maternity and neonatal care is delivered. The Investigation team in attendance included a midwife, a neonatologist and an obstetrician.

The community that BHRUT serves contains more Asian women compared to the national average. The Trust also cares for more women who were overweight in early pregnancy. BHRUT cares for a higher proportion of women from lower socioeconomic backgrounds and a lower proportion of white women, women aged 35 or over, and women aged 19 or under compared with the national average.

This means that the services must plan and deliver care that is suitable for families who may need more medical or social care during pregnancy, birth and after birth. This includes translation services or guidance of how to find public health support.

The executive team described BHRUT as a trust that has faced serious challenges but is working to improve. We heard from the current Chief Executive who told us that his tenure was the longest for the Trust and he felt this was helping to bring more stable leadership after a period of change and poor-quality care, including time in special measures for maternity services. Most of the leadership team had changed during his tenure and leaders are trying to build a more open and supportive culture. We heard that staff feel more able to speak up.

Leaders were clear that pressures remain with reports of staff burnout and discrimination. To improve staff satisfaction, leaders said they are moving away from a *"bums on seats"* approach. This means that rather than focusing on hiring as many staff as possible, they would focus on skills and place staff where they are most needed.

Leaders described high risk and fast paced maternity services. Staff manage risk in real time, which can feel like personal risk on every shift. Maternity can feel separate from the rest of the Trust, but they are working to address this and ensure maternity voices are heard. There has been a move to a *"just culture"* that supports learning. We were told by the executive team they felt it was important to recognise that there have been *"terrible experiences in the past"*, while also showing where care has improved.

The executive team acknowledged that not all families have felt or seen change yet. They receive ongoing reports of women and birthing people feeling communication is brusque or that their concerns are not fully addressed, showing that intentional culture change takes time to embed. We also heard from some bereaved and harmed families still experiencing defensive responses from the Trust and a lack of clear apology or acknowledgement of their experience.

Families also told us about the compassion, support and care they had received from the local Maternity and Neonatal Independent Senior Advocate (MNISA) and praised them for helping to navigate investigations or legal processes following harm or bereavements.

Families described their disappointment that following a national decision the MNISA services trial was concluding at the end of March 2026. MNISA services were introduced to ensure that women and families' voices were listened to and acted on.

Leaders raised concerns about the level of regulation in maternity services. Many different organisations and programmes are involved, with a significant number of clinical midwives taking part in regulatory work. They said systems do not link well and described this as *"feeding the beast"* and taking time away from patient care.

We heard about targeted work to reduce inequalities, including action in areas with higher stillbirth rates. This includes continuity of care focused on some postcodes, bilingual support workers and a focus on reduced fetal movement.

Staff described a service under constant pressure with women, birthing people and babies needing increasingly complex levels of care. This leads to longer stays which impacts capacity across maternity and neonatal services. This in turn results in cramped conditions and lack of space.

We saw a constrained physical site for both maternity and neonatal services. There are two obstetric theatres, and staff said a third is needed to manage demand. Internal reviews note that maternal triage areas frequently face surges of high activity. Improvements have been made by adding staff in triage, with a system in place whereby a consultant is called once three women are waiting for medical review. However, delays in initial assessment remain a recurring problem during busy periods. Some of the women and birthing people we heard from described being in pain or feeling anxious in crowded waiting areas, uncertain when they would be seen, which heightened their fear that something might go wrong while they waited.

The neonatal service is a Level 2 unit and transfers around 80 babies a year to Level 3 units for higher level care. During the walkaround, the unit was described as very tight for space, including limited staff facilities. Staff reported the need for Level 3 neonatal accreditation because of demand and the disruption caused when babies had to be transferred out of the Trust.

Digital systems, Wi-Fi and information flow were raised as repeated issues of concern. Staff reported using multiple electronic record systems alongside paper notes. The Trust informed us that a new trust-wide electronic patient record was being launched shortly after our visit. However, staff reported that this system would not provide a single, integrated pathway for maternity and neonatal care. Instead, the absence of an end-to-end maternity and neonatal digital solution meant that multiple systems would still be required, which was recorded by the Trust as a risk.

Staff also highlighted high demand for translation support in hospital and in the community. They noted some site-specific areas where internet signal is unreliable and therefore makes it challenging to use the online translation support available.

What staff told us

Staff reported that the maternity and neonatal services at BHRUT face demand and capacity challenges. Midwives and doctors described a constant balancing act in triage, the induction suite and theatres. They described trying to prioritise those needing care urgently when too many patients arrive at once or beds are full. Senior managers and the executive team described demand and capacity as fundamental challenges. They noted that the number of births at the hospital has grown and that the care that women and birthing people need is becoming more complex.

Staff across all levels felt that workforce shortages and heavy workloads are daily realities in the maternity and neonatal units. Staff highlighted differences in staffing pressures in various parts of the service. For example, on the postnatal ward, midwives might be responsible for several new mothers and their babies, medication rounds and administrative duties such as discharge paperwork. This means women may wait longer for medication or help with feeding. Staff said this can lead to delays in care.

When there are staff shortages, staff said they may not have time to do everything and tasks like documentation, debriefs, or taking their entitled breaks can be missed. Some staff were worried that working while tired or not having time to do safety checks such as postnatal observations, could lead to mistakes being made or missing signs that a woman or baby is becoming unwell. The Trust told us they have increased staffing numbers and reduced reliance on agency staff. The executive team also acknowledged that the demands on staff remain high and that numerical staffing levels “on paper” do not always translate into the felt experience of staff and patients on the ground.

Hierarchies in teams mean that some junior staff do not always feel comfortable questioning senior colleagues. This can make it harder to speak up about concerns. This can affect women, birthing people and babies, for example if a concern is not raised about their care. However, staff told us that the leadership culture is improving. Many described a move away from blame and towards learning and support. Leaders were seen as more visible and easier to approach There are also more forums and opportunities for staff to raise concerns, learn from incidents and share good practice. Some teams said they now come together to reflect after difficult cases and share good practice.

“I can confidently tell you the leaders that we have within our midwifery now, I can go to anyone's office and open the door to say, ‘I’m concerned about X, Y and Z’, and they will listen to me.”

Staff also told us they trust the governance processes in place across maternity and neonatal services. They said improvement plans are clear and are reviewed regularly.

"We also have a very good governance process. So, everything that we do, all the safety action plans, they are being followed throughout... We present all our changes into a corporate team. Then we go back in three months' time and we present our improvement as well. So we are monitoring the same problems. Making sure that this actually happens."

However, not all feedback was positive. Some staff said they were unsure about the Trust's overall plan or felt the executive team did not always understand how services worked day to day.

IT systems are a major challenge. The current experience of staff includes entering the same information more than once across systems, which creates extra work and frustration. It can also lead to different information recorded on systems if records are updated at different times. This can make it harder to get a clear picture of a woman or baby's care.

"I can see midwives get really frustrated trying to move this information because you're repeating yourself everywhere. And sometimes it does affect the documentation because sometimes you will see that on [System One] to point five and then you got to [System Two], they're documented to point seven. ... we're moving information from one case to the other. So I think EPR [electronic patient record] is a massive challenge"

What this means for families and services in BHRUT

For families, the evidence points to a simple need: people must be listened to, believed and treated with kindness, especially when they are scared, in pain or grieving. When women and birthing people are not listened to, this is a safety issue that increases risk. We found a clear difference between the experience that women, birthing people and families reported to us and the care that the Trust's executive team thought was being consistently delivered by maternity services.

We consider that the executive team do not fully appreciate or understand instances that were reported to us by families where care fell below what would be expected in terms of compassion. There did not seem to be a recognition by some members of the executive team of the value of family feedback in highlighting areas of service provision requiring improvement. We heard of instances where families felt dismissed by the executive team during the complaints process.

For **maternity care**, the pressures we saw create predictable pinch points:

- Limited theatre capacity can lead to delays and difficult choices when emergency and planned care compete for the same space. A split layout, including the Birth Centre being on another floor, can add time and complexity when staff need to move quickly. Cramped triage space can make waits, privacy and communication harder at the front door of the service.

For **neonatal care**, the service model and estate constraints have a direct impact on families:

- When babies need higher level care and must be transferred out, families need to travel and can face separation, which generates fear at an already traumatic time. Staff described this as a key gap. Cramped neonatal space makes it harder to work safely and comfortably. It also reduces the ability to adapt when demand rises.

Across both maternity and neonatal pathways, the digital systems are affecting safety and experience. Multiple record systems and paper notes increase staff workload and raise the risk of missed information, repeated questions to patients and poor handover. The evidence from Queen's Hospital suggests this is not a minor inconvenience but a real contributor to confusion and risk.

The Trust serves a large and diverse community and staff described high demand for translation and communication support. If language support is not reliable, families can struggle to understand what is happening, what choices they have and how to get help. This can widen inequalities, especially for families who already face barriers to care.

Finally, the evidence suggests that improvement work needs to be seen by families, not only recorded through the governance processes. The Trust described a very busy and crowded oversight landscape and families described defensive responses when things go wrong. Families need timely, compassionate engagement, clear explanations and open acknowledgement of harm.

How we gathered and analysed our evidence

How we gathered evidence

The evidence in this report was gathered through multiple sources. These included:

- Trust documents and data reviewed:
  - Quality Committee (or equivalent) minutes
  - Finance Committee minutes
  - All maternity and neonatal performance and service data that goes to the Trust Board
  - Any CQC warning notices or other formal or informal actions related to maternity and neonatal services
  - Complaint documentation relating to maternity and neonatal services
  - Any Freedom of Information requests received by Trusts in relation to maternity and neonatal services
  - Patient Safety Incident Investigations Reports (PSII) related to maternity and neonatal services
  - Patient Safety Incident Response Plan
  - Maternity and Newborn Safety Investigation (MNSI) data
  - Maternity Safety Support Programme (MSSP) documentation reports
  - ICB performance reports
  - NHS Resolution reports and activity
  - Improvement strategies for Maternity and Neonatal Services
  - Maternity and Neonatal risk register
  - Staff disciplinary data
  - Freedom to speak up occurrences
  - Prevention of Future Death Reports
- Three family evidence panels with women, birthing people and families
- One evidence panel with local community organisations
- Interviews with four women, birthing people and families
- Two listening events across different staff groups and grades

- Interviews with 13 members of staff
- Five additional pieces of information were sent to the Investigation email address which were submitted as evidence for Barking, Havering and Redbridge University Hospital NHS Trust.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the Maternity and Neonatal Voices Partnership (MNVP) Leads for Barking, Havering and Redbridge University Hospitals Trust, the Maternity and Neonatal Independent Senior Advocate (MNISA) for North East London and local MPs. To ensure widespread involvement, local third sector organisations were approached to help promote the events and support recruitment, with particular focus on reaching those who may otherwise be under-represented.

Through these listening events, we engaged directly with women and birthing people, fathers and partners, and families from a wide variety of backgrounds, including those from marginalised communities and deprived groups. Our approach was intentionally inclusive, aiming to capture the perspectives of seldom heard voices and ensure their experiences were reflected within our findings. During the panel events, participants shared personal stories and expressed their views about the care they received at the Trust.

These candid discussions provided valuable insights into both positive experiences and areas where improvements are needed, highlighting the diversity of needs and expectations amongst the community.

The listening events with staff were structured so that staff prioritised the issues for discussion based on those they experienced as most important to giving high-quality, safe and compassionate care.

Interviews with senior leaders in maternity and in the Trust were structured around a set of questions developed to gather information about key issues and requirements if care is to be high-quality care. For example:

- How do maternity and neonatal services level governance meetings report to the board to highlight any concerns, issues or good practice?
- What would you say now are the main barriers to giving safe and compassionate care? On the flip side of that, what would you say if you were to speak to another trust who were in the ‘struggling’ or ‘requires improvement’ CQC report landscape now, what would you say to them?
- During the site visit, we heard about the amount of work carried out to meet the needs of the local population, which is often quite complex. Can you tell us about how that impacts your service?

- How are the needs of different groups of women considered? Do you provide any support or training to deliver culturally sensitive care?
- We want to understand how the board supports the Trust to listen to women, families and staff. What processes are in place to hold the Trust to account on this?
- What is your view of where the organisation is at, in terms of maturity, in terms of PSIRF and its aim of involving patients and families and listening to them more as part of investigations?
- How would you describe incident investigations on the maternity and neonatal unit? Are wider system issues considered or is the focus on individuals and blame? How are staff supported during incident investigations?

The interviews were recorded and transcribed. The interview transcripts were sent to interviewees to check for factual accuracy and add any additional elements they may have omitted on the day.

How we analysed the evidence gathered

Trust documents and data received from the Trust were reviewed by the Investigation team to triangulate evidence and review governance structures.

The listening events with women, birthing people and families, and those held with staff, were recorded in order to ensure evidence was accurately captured word by word and not misrepresented. Individual interview and panel interview transcripts were analysed through a mixture of AI use and human analysts. Analysts developed a specific AI programme for the analytical work that focused on qualitative data analysis. The analytical steps taken were:

- Analysts gave the AI tool information about the aims of the Investigation and the analytical approach. Analysts reviewed the tool's contextual understanding of this.
- The AI tool identified clear topics across the evidence and signposted where this was found across the evidence including suggested quotes. This was checked for accuracy by analysts.
- The AI tool coded the full dataset and organised these codes into suggested themes. Analysts reviewed and refined the themes to ensure they were accurate, clear and firmly grounded in the accounts of women and birthing people, families and staff.
- The final analysis was handed over to the Investigation team to feed into this local trust report and inform the themes and recommendations in the national report.

National Maternity and Neonatal Investigation