National Maternity and Neonatal Investigation

University Hospitals of Morecambe Bay NHS Foundation 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 University Hospitals of Morecambe Bay 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 University Hospitals of Morecambe Bay NHS Foundation Trust

We visited University Hospitals of Morecambe Bay NHS Foundation Trust (from here on referred to as Morecambe Bay or the Trust) on the 27 and 28 January 2026. The Trust has three sites that deliver maternity and neonatal services: Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital.

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.

In selecting trusts to investigate, the Investigation aimed to capture learning from a wide range of provision and experiences, to ensure that findings would be relevant across the system. Trusts were therefore chosen to reflect a variation in case mix, trust type and geographic and demographic coverage. The Investigation also wanted to visit trusts to follow up on the implementation and the sustainability of implementation of recommendations including those published in *'The Report of the Morecambe Bay Investigation'*, which was published following an independent investigation into maternity and neonatal services at Morecambe Bay.

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

Morecambe Bay's maternity services were rated 'Good' by the CQC across all three sites in January 2026.

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:

In 2024/25, the Trust supported 2,700 births.

Modes of labour and delivery:

- In February 2026, 50.0% of deliveries were by caesarean section, compared with 38.9% in February 2023.
- In February 2026, labour was induced for 27.8% of deliveries, compared with 31.6% in February 2023.

Workforce

National published statistics

As of January 2026, the Trust employed:

- 160.4 full-time equivalent midwives.
- 45.3 full-time equivalent doctors working in the obstetrics and gynaecology speciality.

In 2024/25, the number of deliveries per midwife was 17.5, which is much lower than the national average of 23.0. Morecambe Bay is in quintile 1 i.e. the bottom 20% of NHS trusts.

Statistics provide by the Trust

- The number of deliveries per midwife in 2024/25 was 24.9 (financial year).
- The number of deliveries per midwife in 2024/25 was 24.9 (financial year).

Neonatal services

The Trust's neonatal services were rated 'Good' by the CQC in January 2026.

Unit and care pathway

Royal Lancaster Infirmary has a Level 2 Local Neonatal Unit (LNU) that includes a High Dependency Unit (HDU). Furness General Hospital has a Level 1 Neonatal Special Care Unit (SCU).

A Level 2 Neonatal HDU is 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 HDUs across the country.

A Level 1 Neonatal SCU is for babies who do not need a high level of medical care. This could include giving babies additional oxygen, treating their low temperatures or supporting them with feeding. There are 39 Level 1 Neonatal SCUs across the country.

In 2024, babies were cared for in neonatal units for a total of 2,301 days of care, placing Morecambe Bay in the bottom 20% of providers of neonatal care nationally.

Workforce

In the 12 months ending December 2025, 96.3% of neonatal nursing shifts at Furness General Hospital and 86.0% at Royal Lancaster Infirmary were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

An 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 most areas of maternity care including antenatal care, pregnancy, staff caring for them, postnatal wards, feeding their baby, care at home after birth, triage and complaints.

In the 12 months ending October 2024:

- 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 1.1 per 1,000 live births, within 5% of comparable trusts.
- A stabilised and adjusted stillbirth rate was 2.9 per 1,000 births, also within 5% of comparable trusts.

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 Morecambe Bay, the first thing the Investigation team did was to hold family panels in locations separate from the Trust's sites. We held panels in Lancaster and Furness to hear experiences from across the region. We invited women, birthing people, families 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 are situated in the context of 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 because they wanted to see long term change.

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.

The Investigation team heard from families that women, birthing people and partners are not consistently being listened to, believed, or taken seriously, particularly when raising concerns about symptoms, pain, mental health, or past trauma. They said they were dismissed and felt their lived experience or instincts were ignored and repeatedly had to ask for help before they were taken seriously.

> *"Oh, you're a first time mum you just need to relax. I wasn't reassured, I was just given this negative attitude of you'll be ok and then five hours later I deteriorated."*

We were told by families whose babies had disabilities that were diagnosed during pregnancy that they were treated as if their babies were problems to be managed or

[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 at Annex: Glossary

discouraged, rather than being offered support. They were judged and pressured into making certain decisions rather than being listened to.

Women, birthing people and partners also experienced long delays when first engaging with triage services and uncertainty about where there was space for them at the service. For women, birthing people and partners waiting to be induced, they experienced delays and were made to feel like a burden on the service.

"On the way out, they stopped me again at reception and was like, "Actually, you need to come back at 6 o'clock tonight, because we've got loads of inductions booked in tomorrow, so we won't fit you in""

Capacity constraints also meant families were redirected to other sites within the Trust, creating fear about time, distance and what would happen if labour progressed quickly.

"...in our third trimester, we needed to go to triage, so we called Hospital A, and they were full, which meant we had to go to Hospital B, which kind of sent me in a bit of a panic, going -- I've got an hour and 15-minute drive to get to Hospital B."

For families needing to use neonatal services, they spoke about their local services not being equipped to provide the level of care their baby would need. While decisions were made with the babies' care and safety in mind, families' experiences were of services that did not speak to each other and receiving mixed messages from different hospitals.

These experiences leave women, birthing people and partners feeling frightened and uncertain at times when they needed timely care, clear information and reassurance. Prolonged waits without rest can make labour and birth feel overwhelming, add to anxiety and removes a sense of individual control or choice in a given situation.

Pressures on the service also affected the care families received from staff. Families recognised that care had to be prioritised, but they often felt rushed and as if they were just a number in the system. Families described how their basic needs, such as pain relief, were delayed when the services were under pressure.

"I had a caesarean, my pain meds weren't sort of given at a regular time... it didn't need to be immediate, because other people needed these midwives, but it was like there was no-one else being able to give that extra care."

There is a lack of continuity of care. Families told us about never seeing the same midwife or consultant more than once. They understood that this was due to staffing patterns but, due to the lack of continuity, they received mixed or conflicting messaging and felt their care was unsettled. Where possible, seeing the same staff members helps families feel listened to, safer and more involved in decisions about their care.

"There was just never anything uniform in whatever they were saying. So where you felt you were empowered by your midwife, when you then spoke to an obstetrician, you became disempowered by it because you were like -- you felt like you basically had to do what they said."

Despite these concerns, families consistently spoke with warmth and gratitude about staff members who showed kindness and compassion, often in very high-pressure circumstances. Many highlighted the dedication of midwives, student midwives, support staff, cleaners and catering staff.

"All of the midwife support staff were absolutely fantastic in there. I've really got to say a big thing as well to the catering staff, the cleaning staff: they were all absolutely fantastic; they couldn't do more for us."

For some families who went through formal processes and investigations, we heard that the Trust was defensive in its responses, focusing on protecting the Trust rather than being open and learning from what happened. Investigations were often long and distressing for families and meant they could not grieve the way they wanted, leaving a lasting impact on them.

"We didn't grieve, we were fighting straight away…We accept, we always accepted that mistake[s] happen[…]. Mistakes happen in the NHS but what is but be open and be honest."

Families experienced investigations that were complex and lengthy, and found that explanations were incomplete or inconsistent. Accounts were changed over time and information was missing. These experiences have led to a break down in trust between families and the Trust.

Individual staff were praised for providing compassionate and supportive care during some of the most difficult times in a family's life; however, this was not experienced

consistently. Families told us that they wanted honesty and openness from the Trust when things had gone wrong about what had happened and why.

> *"At the end of the day we all make mistakes we got to learn from them. You know, you be honest about it and say I'm really sorry I've done this, I've done it wrong, I will do better next time."*

Bereavement support across the Trust is inconsistent and often relies on the availability of specialist midwives. While Morecambe Bay has a bereavement midwife, they are responsible for a large geographic area, meaning their capacity is limited.

Families told us about missing appointments with the bereavement team because there was only one bereavement midwife between the three hospitals and the time needed to get there would mean they would have to miss work. When the team visited Royal Lancaster Infirmary, there was no bereavement suite: it was under construction in January 2026 and has since opened.

Patients' experiences varied by site. At Furness General Hospital, families valued the spacious private rooms in the bereavement suite, which offered them a peaceful space to make their own. At Royal Lancaster Infirmary however, the wards were cramped and dated and, for families who had to spend longer at hospital, provisions such as family kitchens were limited and cluttered. The lack of space also impacted where families were given bad news, with this happening in areas with little privacy or space for processing information.

What we saw and heard in Morecambe Bay

The Investigation team spent two days at Morecambe Bay. We visited all three sites and did a full walkaround of all areas where maternity and neonatal care are delivered. The Investigation team members in attendance included two neonatologists, a midwife and an obstetrician.

The community that Morecambe Bay serves is split over a large geographic area with some families living in very remote areas and needing to travel over an hour to reach their nearest hospital.

Compared to national averages, there are more white mothers using the services and more women and birthing people aged under 20. This means that some younger service users may need more social support and parenting advice.

Families told us they were not listened to or taken seriously, and their concerns were brushed off as stemming from anxiety or from being a first-time mum. We heard about a defensive culture at Morecambe Bay with conflicting explanations given to families about why things happened. We heard that families struggled to understand the full picture following incidents or complaints.

We found staff morale to be generally low with a feeling that Morecambe Bay was once more under scrutiny. Maternity and neonatal services had improved very significantly following a major investigation in 2015. This is confirmed by staff surveys and CQC reports, with maternity and neonatal staff reporting being proud to work in the Trust and CQC commending the approach to public engagement.

However, following changes in the executive team in the Trust in 2018/19, it appears that this improvement was not sustained. Staff began to feel under scrutiny again, particularly over a high-profile inquest in 2025.

> *"...the past never leaves us, but the future never arrives."*

Midwives told us about public attention causing them to remove their work badges in public and being made to feel ashamed of their jobs despite being inherently proud of the work they do.

The Trust's leadership sought to demonstrate a contrast in the culture between the past and the present, telling us that they had worked hard to implement the recommendations following the 2015 investigation. They spoke about a new learning journey that started in 2022 following a CQC report and how this was being embedded across the Trust.

The geography of the estate had a significant impact on the Trust. Furness General Hospital is in an isolated part of the country which we heard affects staff recruitment and patient numbers. When we visited the Neonatal SCU, there were no babies being cared

for. In the two weeks prior to the visit there had been two intensive care admissions for stabilisation and transfer out, and two special care admissions. This shows the challenge of maintaining staff skills and training at a quiet site and keeping a site open in a geographically remote area.

At Westmorland General Hospital, we saw a freestanding midwife led unit that was a community hub for midwifery support. Staff showed us new home birth kits which were organised and which considered family and staff needs. It was clear that safety and governance was given high priority in this small geographically isolated unit. This showed resilience and planning to support the rural communities they served.

The Trust spoke about ensuring care was 'cross-Bay' and organised regular collaborative safety meetings to ensure learnings were consistent throughout sites.

The hospital estate varied across the sites. At Royal Lancaster Infirmary, the site was old and services felt cramped; it was the only site that we visited that did not have a dedicated bereavement suite (although one has since been opened). Furness General Hospital however, had a new site with 14 private Labour, Delivery, Recovery and Postnatal (LDRP) rooms that women, birthing people and partners can stay in throughout all parts of their maternity stay. While these were widely complimented by staff and families, they were flagged as potential safeguarding risks for more vulnerable women, birthing people and partners as staff did not always have visibility of their patients.

What staff told us

Staff spoke about the emotional toll of working in an service with high demands, staffing risks and about operating under constant scrutiny. Staff were frustrated at not being able to provide the level of care they wanted and emphasised that delays were not a reflection of indifference, but of ongoing pressures.

Large workloads at Royal Lancaster Infirmary often left teams with very little flexibility. This affected the whole service and reduced the time they could spend supporting women, birthing people, partners and families. These pressures sometimes led to visible delays, particularly on postnatal wards, where women, birthing people and partners would wait longer for help with basic care needs such as washing or pain relief while staff responded to more urgent clinical priorities.

Staff pressures linked to vacancies and recruitment difficulties meant that staff often needed to work extra shifts or across different sites, which could create anxiety when working in unfamiliar services. The geography and location of the Trust also made recruitment to some specialist roles more difficult.

> *"We are not like in Manchester, it's not in the central, so it is quite actually hard to recruit."*

Staff also spoke about the importance of developing and keeping an experienced workforce. In neonatology, specialist staff are needed to provide care for very premature babies. The reputation of the Trust is also impacting current and potential future staff.

> *"When you go anywhere and you say, I'm from Trust A, people roll their eyes... and it's like we're never allowed to come out of the shadow of Kirkup."*

Senior clinical staff described how staff are working in the context of accumulated trauma. Combined with staffing pressures, this affects the care they feel able to give, leading to a workforce that is at risk of being worn down and burnt out.

Despite these challenges, staff often spoke positively about their teams and described strong peer support. There were examples of improved team working, pride in the care being delivered and a more open culture under current leadership. Newer members of staff at Westmorland General Hospital described how welcomed they were by the team and the site's positive working culture.

Efforts were being made to create a fair culture focused on learning rather than blame. Staff spoke positively about regular opportunities to share learning, discuss concerns and

celebrate good practice, including daily triage discussions, weekly sign-off groups and skills drills.

This was also reflected in the documentation we reviewed. The Investigation team requested a set of documents from each trust we visited, including Freedom to Speak Up (FTSU) reports. At Morecambe Bay, there were 15 cases of FTSU reports across maternity and neonatal services between 2023 and 2025.

There is a clear contrast between the previous senior midwifery leadership culture and the current team. Staff described the previous culture as one that did not listen to staff, lacked compassion, and did not provide support during periods of stress.

> *"And living through the last regime, I'll call it the regime, because that's how it felt. It was awful."*

In contrast, current leadership was described as "*really approachable*," and "*always visible*." The Director of Midwifery was widely praised and recognised for their leadership and the effect this was having on staff.

> *"She brings kindness… that's something for a long time we lacked."*

Wider involvement in reviews following incidents or complaints has increased. Staff previously felt debriefs were "*really, really missing"* but now there is an improved cross-team approach. Formal processes for investigations and complaints are structured, and improvement and safety plans following incidents are regularly discussed at Board level and followed up on to ensure the effects are long-lasting. However, staff acknowledged there is still further work to do.

Morecambe Bay serves a mixed community, including affluent communities as well as families who face language barriers, have complex social needs or are struggling financially. These factors require more time, advocacy and planning from staff, which adds time pressures to an already busy workload.

> *"It can be difficult… we do spend the time if we need to but that might make clinics run late but we do absolutely."*

Many staff described how language and digital barriers made it harder to deliver fair care. Although interpreting services were available, staff reported that these were not always reliable, particularly in urgent situations, and that interpreters did not always have sufficient medical knowledge. This caused concern about whether families could fully understand information or give informed consent. The move to more online services is

also impacting families who face barriers connecting to the internet, often due to poor equipment, lack of skills or high costs.

Staff spoke about enhanced support teams and specialist roles that had been established. These roles helped protect families by sharing risk, supporting decision making and ensuring vulnerable families were given help using a system that might be daunting to them.

> *"We've got two specialists... that work within mental health and the others work within, they're just enhanced support so they encompass any like teenagers, any social care, any you know safeguarding thing."*

The geography and estates in which staff work at Morecambe Bay affect how they must plan and deliver care. Ensuring that processes and interventions were applied 'cross-Bay' was a priority for the executive team, including ensuring that leadership was visible across all three hospital sites.

The estates and geographies across the sites varied and created different challenges for staff. The estate at Royal Lancaster Infirmary affects how staff can deliver care due to the limited space, poor layout and structural issues. Staff described adjusting their practice to work around physical limitations rather than being supported by a ward that is designed for modern, safe and efficient care.

> *"The nurses were so used to having a leak that when they enter the neonatal unit they look up to the ceiling to check it was okay."*

However, at Furness General Hospital, staff enjoyed the benefits of modern facilities, larger rooms and more control of the temperature and 'feel' of the space. While staff enjoyed the space, they found that the private rooms reduced the visibility of patients which could be a concern for more vulnerable patients.

Staff are also using digital systems that make care harder to deliver. Maternity and neonatal teams used different systems which do not automatically share information. This creates a situation where staff manually enter the same data into multiple systems which is time-consuming, frustrating and poses a risk to safe, joined-up care.

> *"...it's on a totally different electronic system called [name]. [Interviewer asked- And do they talk to each other?] Of course they don't which comes with huge risk."*

This also takes staff away from delivering patient-facing care. Clinicians are spending already limited appointment time working with complicated records and trying to find key details quickly, reducing the time they have for patient discussion and treatment.

What this means for families and services in Morecambe Bay

The geography that Morecambe Bay covers means that the three sites are caring for differing groups of people and are dealing with unique challenges and contexts. Despite pressures and patient volumes varying quite considerably across the Trust, sites cannot be consolidated as it would leave patients isolated with long journeys to use care.

The failure to sustain the improvements following the 2015 investigation has had a negative effect on the Trust. Following demonstrable improvement over the initial three years, the Trust acknowledged that it did not sustain these after changes in the executive team. The Trust told us that it has made efforts since 2023 to reverse the decline and to become more learning-based and open again. Staff spoke of how this has improved the way that they feel at work. These changes are happening too late for some families and cannot change the traumatic experiences they went through or the burden they carried while seeking answers and clarity.

The age and capacity constraints of the site at Royal Lancaster Infirmary are likely to continue to place a burden on the system. Refurbishments, such as the new bereavement suite and maternity assessment centre that we saw being built, show that the Trust is attempting to make the best use of its footprint. However, as the care required by women and birthing people has become more complex and the rate of caesarean rates and inductions rise, the estate might struggle to keep pace with the changes needed.

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
- 3 family evidence panels with women, birthing people and families
- 6 listening events across different staff groups and grades
- Interviews with 15 members of staff

- Additional pieces of information were sent to the Investigation email address which were submitted as evidence for Morecambe Bay.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the Bay-Wide Maternity and Neonatal Voices Partnership (MNVP) leads and by engagement with local campaign groups.

Through these evidence panels, we engaged directly with women, birthing people, 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 evidence panels, 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.

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