PRACTICAL RESOURCES

Maternity Care Harm: When something went wrong

A practical guide for parents with questions, concerns or unanswered questions about their care



FELIX'S FLAME CIC

A NOTE BEFORE WE BEGIN

You do not have to know that something went wrong before you are allowed to ask what happened.

After baby loss, you may be left with questions about your care, things you were told, things that were not explained, or moments that never quite made sense.

This guide explains the different routes available to you: from simply asking for an explanation, to getting your records, contributing to a review, making a complaint or seeking independent advice.

You can take things one step at a time.

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You are allowed to ask why

Sometimes you know immediately that something felt wrong. Sometimes it takes months or years before you realise that you have questions.

You do not need to have a medical opinion, a legal opinion or proof of negligence before asking for an explanation.

You might be thinking:

- Why wasn't my concern taken seriously?
- Why was a decision made?
- Why did nobody explain this to me?
- Why does the medical record say something different from what I remember?
- Why was this test not offered?
- Why did nobody tell me about this?
- Could something have been done differently?

Asking questions is not the same as making an accusation. You are allowed to want to understand what happened to your baby and your care.

Start with your questions

You do not have to begin with a formal complaint. If you are unsure what happened, you can first ask the relevant maternity team for an explanation or request a meeting. Write down your questions before the meeting.

If possible, take someone with you to listen, make notes and help you remember what was said.
If the explanation raises more questions, you can ask for another conversation.

If you are told 'that's just what happened'.
You can ask: 'Can you explain why?' You can also ask what guidance, policy, evidence or clinical reasoning informed the decision.

Getting your maternity records

Your medical records can help you build a clearer picture of what happened. You may want them before a complaint or review, or simply because you want to understand your own care.

You can make a Subject Access Request (SAR) for your personal data. Health records are personal data, and the organisation holding them can explain its process for requesting access.
You may want copies of:

- Your maternity notes
- Electronic maternity records
- Scan and ultrasound reports
- CTG traces, where applicable
- Blood test results
- Medication records
- Observation charts
- Referral letters
- Discharge summaries
- Consultant and midwifery notes
- Investigation or review reports
- Relevant correspondence

Keep your own copy.
Save documents somewhere secure and, if possible, keep a simple folder with dates. It can become difficult to remember what you were told when you are grieving.

Keeping your own timeline

A timeline can be one of the most useful things you create. It does not need to be perfect.

Record what you remember, including:

- Date and approximate time
- What you were experiencing
- Who you contacted
- What you were told
- What you asked
- What action was taken
- Who was present
- When you returned or contacted the service again
- What happened next
- Anything you feel was not explained

Keep your own memories separate from what you later learn from the records. Both can be important, and differences between them may be something you want explained.

PMRT: the Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) is used to review eligible stillbirths and neonatal deaths. It is designed to look at the care provided, identify factors that may have contributed to the death and identify learning. Parents should be told about the review process and given an opportunity to provide questions or information. Your questions can be important because you experienced the pregnancy and care from a perspective that may not appear in the clinical notes.

Ask your maternity team:

- Is my baby's death eligible for PMRT?
- When will the review take place?
- How can I submit my questions?
- When will I receive the outcome?
- Who will explain the outcome to me?
- Can I have a copy of the report or relevant findings?

If you don't have questions yet.
You may still be asked again later. You do not have to understand everything immediately after your baby's death.

MNSI: Maternity and Newborn Safety Investigations

MNSI is an independent national maternity and newborn safety investigation programme in England. NHS trusts must refer certain maternity and newborn patient-safety events to MNSI.

MNSI currently investigates certain events involving babies born following labour at term (37 completed weeks or more), including:

- Intrapartum stillbirth — where a baby is thought to have been alive at the start of labour and is born with no signs of life.
- Early neonatal death — where a baby is born alive and dies within the first 6 days.
- Potential severe brain injury diagnosed within the first 7 days.

There are specific criteria and exclusions, so not every baby loss will be investigated by MNSI.

MNSI: Maternity and Newborn Safety Investigations

If your case is referred and you agree to participate, MNSI says you will have a named investigator, can discuss how you want to be involved, can communicate in different ways where needed, and will receive a final report.

A draft report is shared with the family so inaccuracies can be raised before it is finalised.

MNSI is a safety investigation. It does not investigate individual staff members for blame and does not investigate from a legal or litigation perspective.

Questions to ask:
“Has my baby's death been referred to MNSI?”
“Does it meet the MNSI criteria?”
“Who is my named investigator?”
“How can I submit my questions and concerns?”
“Can I have the draft report?”
“Who will explain the final findings to me?”

What if MNSI does not investigate?

If an event falls outside MNSI's remit, that does not mean nobody should look at what happened. The responsibility for investigating the event remains with the relevant NHS trust.

Ask the trust:

- If MNSI is not investigating, what investigation or review will take place?
- Who is responsible for it?
- What are its terms of reference?
- How can I contribute questions or information?
- When will I receive the findings?
- Who will discuss the findings with me?
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No MNSI investigation does not mean no investigation.

The national programme has specific criteria. A case being outside those criteria does not decide whether the care was appropriate.

What is Duty of Candour?

The statutory Duty of Candour requires NHS organisations to be open and honest with patients, or their families where appropriate, when things go wrong and the threshold for the duty is met.

Depending on the circumstances, this can include explaining what happened, apologising, offering a suitable remedy where appropriate and explaining what will be done to prevent the same thing happening again.

If you hear the phrase 'Duty of Candour', ask the trust to explain what it means in your specific case and what information you will receive

Making a formal NHS complaint

If you want the NHS organisation to formally investigate and respond to your concerns, you can make a complaint.

You can usually complain to the organisation that provided the care. NHS England explains that every NHS service provider in England must have its own complaints procedure.

You do not have to write the perfect complaint. You can explain what happened, what concerns you have and what you want answered.

You may want to ask for:

- An explanation of what happened
- Answers to specific questions
- Clarification of conflicting information
- An explanation of whether policies or guidance were followed
- An explanation of what was learned
- Information about actions taken as a result
- A meeting to discuss the response

PALS and complaints advocacy

PALS (Patient Advice and Liaison Service) is available in most hospitals and can help people resolve concerns informally. PALS can be particularly useful when you need help navigating a service or need an issue addressed without immediately making a formal complaint.

If you are making or considering a complaint, NHS England also explains that free NHS complaints advocacy may be available. An advocate can help you write a complaint and attend meetings with you, although they cannot make the complaint for you or provide medical or legal advice.

You do not have to do this alone.

If writing everything down feels impossible, ask someone you trust or an advocate to help you organise your concerns.

What to put in a complaint

A useful complaint does not need to be long. It needs to be clear about what you want the organisation to understand and answer.

You can structure it like this:

- Who you are and what care the complaint concerns
- What happened, in chronological order
- What you were told
- What you believe was missing or concerning
- How the events affected you and your family
- The questions you want answered
- What outcome you are asking for

Be specific about what you want answered.

Instead of only saying 'my care was poor', explain what happened and ask the organisation to address the specific decision, communication, delay or omission that concerns you.

What happens after you complain?

The organisation should acknowledge and investigate your complaint according to its complaints process. The exact process and timescale can vary depending on the circumstances.

You may be offered a meeting, asked questions or contacted while the investigation is taking place. Keep copies of everything you send and receive. If you speak to someone by phone, make a note of the date, their name and what was discussed.

You can ask for the response in a format you can understand and ask questions about anything that remains unclear.

If the response does not answer your questions

Sometimes a response can feel like it has answered the organisation's version of events without answering the questions you actually asked.

You can identify the unanswered points and ask for clarification.

If you remain dissatisfied after the NHS complaints process, the next route may depend on the service involved and where in the UK you live.

In England, the Parliamentary and Health Service Ombudsman can investigate some unresolved complaints about NHS services after you have complained to the organisation.

You can say:
“Thank you for your response. I do not feel that questions 2, 4 and 7 have been answered. Please can you clarify these points?”

When legal advice may be appropriate

A complaint and a legal claim are not the same thing. An NHS investigation may identify learning without establishing legal liability, and a complaint response is not a legal judgment.

If you believe your care may have caused avoidable harm and you want to understand whether there could be a legal claim, you may wish to seek independent legal advice from a solicitor experienced in clinical negligence.

You do not need to decide this immediately. If you are considering legal advice, keep your records, correspondence and timeline safely.

Important:
Felix's Flame provides information and support, not legal advice. If you are considering a legal claim, speak to an appropriately qualified solicitor about your individual circumstances and any time limits that may apply.

Protecting yourself emotionally

Seeking answers can be exhausting. Reading your records can be painful. Meetings can bring back memories you have spent months trying to survive. You are allowed to take breaks. You can ask someone to attend with you. You can ask for written information instead of a phone call where possible.

You can decide not to read every document immediately.

- Take someone with you to meetings.
- Write down your questions beforehand.
- Ask for a break if a meeting becomes overwhelming.
- Ask someone else to read documents first if you cannot face them.
- Keep copies rather than repeatedly requesting the same information.
- Give yourself time after difficult meetings.
- Remember that seeking answers does not mean you are 'stuck' in your grief.

Questions to take to a review or meeting

- What happened, in plain language?
- What decisions were made and why?
- What information was available to the team at the time?
- What guidance or policy applied?
- Was that guidance followed?
- If not, why not?
- Was there anything that should have happened differently?
- Was there a delay in recognising or responding to my concerns?
- Did the review identify any missed opportunities?
- What has the organisation learned?
- What actions are being taken?
- Who is responsible for those actions?
- How will I know whether the changes have been made?
- Are there questions you cannot answer, and why?

Things you are allowed to ask for:

- An explanation.
- More time to understand what happened.
- Your maternity records.
- Copies of reports.
- A meeting.
- Someone to accompany you.
- Your questions to be included in a review.
- Clarification when records conflict with your memory.
- An explanation of what guidance was followed.
- An explanation of what happens when guidance was not followed.
- Information about what has been learned.
- Information about what will change.
- Help navigating the complaints process.
- Independent complaints advocacy.
- Time before responding to a difficult letter.
- Your baby's name to be used.

You are not being difficult.
You lost your baby. Wanting clear answers about what happened is a completely reasonable thing to ask for.

When you need support

You may find that seeking answers brings up intense grief, anger, anxiety or trauma. You do not have to manage this alone.

Speak to your GP, maternity team or a mental health professional if you need support. If you feel unable to keep yourself safe or are in immediate danger, seek urgent help through 999 or A&E, or contact NHS 111 for urgent advice.

Felix's Flame can also provide signposting to specialist baby loss support.

A reminder from Felix's Flame

You are allowed to ask why.
You are allowed to remember things differently.

You are allowed to ask for your records.

You are allowed to say, "That doesn't answer my question."

You are allowed to ask what happened next.

You are allowed to want accountability.

You are allowed to want learning and change without wanting anyone to be blamed.

And you are allowed to keep asking until you understand what happened.