All-Party Parliamentary Groups on Baby Loss and Maternity

Meeting notes

- **Date:** 6th July 2026
- **Time:** 15.00-17.00
- **Location:** Committee Room 9, Palace of Westminster

Members and representatives in attendance:

- Alison Bennett MP
- Amanda Hack MP
- Andy MacNae MP (Chair)
- Jess Brown-Fuller MP
- Laura Kyrke-Smith MP
- Michelle Welsh MP (Chair)
- Sean Woodcock MP

Apologies:

- Steve Yemm MP

Attendees:

- Abbie Harris – APEC
- Aisha Balesaria – navigating life without children after recurrent pregnancy loss
- Akila Hanif – bereaved parent
- Amarjit K Matharoo – bereaved mum
- Amelia Harvey – Office of Freddie van Mierlo MP
- Amneet Graham – Willow's Rainbow Box
- Angela Thompson – UHDB Midwife
- Ben Stockdale – Office of Saqib Bhatti MP
- Benedicta Akpede – Sands

- Beth Mallory – University College London
- Bex Gunn – The Worst Girl Gang Ever Foundation
- Bob McGurrell – 4Louis
- Bridget Langford – Willow's Rainbow Box
- Caroline Norledge – NHS Midwife
- Claire Whitehouse – Clinical Director of Research and Development, JPUH
- Colette Murphy – advocate and bereaved mum
- Demelza Murphy-Lucas – bereaved sibling
- Diane Gaston – Royal College of Pathologists
- Elizabeth Duff – NCT
- Emily Butler – Perinatal Institute
- Faye Hill – Abigail's Footsteps
- Geeta Nayar – South Asian Maternal Health Conference/Irwin Mitchell
- Helen Tunnicliffe – Bran's Library
- Jaime Straker – Bereavement Midwife
- Jake Plumb – Group B Strep Support
- Jenna Quinn – bereaved mum
- Jennifer Elworthy – Fertility Matters at Work
- Jo Dickens – University Hospitals of Leicester NHS Trust
- Julia Clarke – Sands
- Kara Davey – Clinical Psychologist
- Karen Burgess – Petals
- Kash Hanif – bereaved parent
- Kate Harding – APEC
- Kate Mulley – Sands
- Laura Welsh – Antenatal Results and Choices
- Lauren Caulfield
- Leanne Turner – Aching Arms
- Leila Hobart – Little Wings of Hope
- Louisa Hendrickson – Zion's Lighthouse
- Lucinda Watkinson – bereaved parent
- Mari-Carmen Sanchez-Morris – Matresa
- Mia Terra St. Hill – Dodds
- Millie Cann – Skye High Foundation
- Miriam Baumgarten – CUH RPL Early Pregnancy Consultant
- Munira Oza – The Ectopic Pregnancy Trust
- Owen Riley – Office of Andy MacNae MP
- Paula Mothersole – Petals
- Peter Reeves
- Racheal Crane – Max's Legacy
- Rachel Burrell – Ebony Bonds
- Rachel Small – EPT/UHB

- Rosie Kendrick – Dignity Care Clinical Lead
- Ruth Oshikanlu – Abule CIC
- Sara Barnett – Chana Charity
- Sarah Kennedy – Sands
- Sharon Darke – Footprints Baby Loss
- Sian Ness – CuddleCot
- Simon Rainer – The Lily Mae Foundation
- Sophie Morgan – bereaved parent
- Tom Hender – Maternity Safety Alliance, No Breath Required (Aubrey's Dad)
- Tracey McGurrell – 4 Louis
- Victoria Morrell – Twins Trust
- Victoria Sowerby – Miscarriage Association
- Zoe Kantorowicz Pike - Sands

1. Welcome & introductions

Andy MacNae MP opened the meeting and welcomed everyone attending.

He asked the parliamentarians in the room to introduce themselves, followed by any members of the National Maternity and Neonatal Taskforce or any of the Expert Reference Group.

He outlined that the meeting would focus on a discussion about the report and recommendations from Baroness Amos, with the feedback shared being taken back to the Taskforce and the Expert Reference Groups by the representatives in attendance.

Andy then shared a brief overview of the findings from the National Maternity and Neonatal Investigation, as well as his initial reflections on the report from Baroness Amos.

He broadly welcomed the report, especially its recognition of racism, avoidable harm and a lack of accountability. Yet he acknowledged that there was much work still do, both in implementing the recommendations and in driving forward change in the areas that Baroness Amos was not able to closely examine.

2. Discussion on the National Maternity and Neonatal Investigation final report and recommendations

Andy then opened the discussion up to the room and asked attendees for their thoughts and reflections on the report.

Bereaved parents shared concerns that the report relied too heavily on staff over family voices, and that they were disappointed with the lack of focus on the experience of bereaved parents and families.

Some felt that the report was not strong enough on inequalities and normal birth ideology, questioning whether these issues supported the need for a public inquiry, and

that the report is not a true representation of what families have experienced given the amount of evidence gathered.

Others in the room felt that an inquiry would only be welcomed alongside immediate and continued action to improve maternity and neonatal care, and that any inquiry could not delay the implementation of existing recommendations.

An attendee then noted their recognition for the work Baroness Amos has undertaken, stating that they felt she had done what she could with the time, scope and terms of reference, but that the report does not go far enough.

They welcomed the clear acknowledgement in the report of the need for systemic change to the fundamental framework of maternity and neonatal care, however questioned how to ensure that maternity remains a continued priority through the Government in a time of political change.

Questions were also raised about the extent to which the intended role of the Taskforce is understood by its current members, and how it could be better fit for purpose.

An attendee then highlighted gaps including early pregnancy loss, gynaecology, birth trauma, birth injuries and neonatal care which must be treated as a priority by the Taskforce and questioned how meaningful change can happen without acknowledgement of the full picture.

Andy agreed that continuity is a crucial factor which has undermined the implementation of recommendations from previous reports and that the Government needs to address this question. The question remains as to ‘how’ these changes are to be implemented.

A bereaved parent in the room raised their surprise to learn about the failures of the regulators, asking how they are going to be reformed and held to account going forwards, and whether that will fall under the remit of a Maternity Commissioner. Parents shared delays in PMRT findings, post-mortem results and investigation outcomes.

There was concern about chief executives of hospitals signing off their own data, and the need to ensure that the data being reported to the Trust board is accurate and being scrutinised correctly. Attendees asked whether a national level role would be able to hold the sufficient local oversight, or whether this should be happening at the ICB level.

Andy outlined that there are many outstanding questions as to the powers of the Maternity Commissioner role and where ultimate accountability will lie, with the need for there to be full reform to the regulatory system alongside such an appointment. He shared concern about the lack of focus on bereaved parents, as well as the lack of focus on mental health and bereavement care.

Returning to the room, an attendee raised concerns with regards to the quality assurance within the Amos report, highlighting that quotes from some families had been included in the wrong individual Trust report.

They also outlined concerns into the lack of scrutiny of the regulators in the report driven by the focus on individual Trusts, which was raised by families with Baroness Amos at the time of developing the terms of reference. They stated that there are currently no

consequences for a hospital not being honest and echoed concerns that a single national level Maternity Commissioner cannot hold the necessary oversight, asking whether the role could dilute rather than strengthen accountability.

They further noted that all parliamentary written questions on the investigation of stillbirths in the last six months have been delayed awaiting the Amos report, which now fails to address coronial oversight.

Andy echoed concern that a Maternity Commissioner role could dilute oversight and questioned whether any of the regulators are fit for purpose, an issue he has raised with the Parliamentary Expert Reference group.

An attendee then outlined that the success of a Maternity Commissioner role must be measured by improved outcomes, rather than their appointment alone representing impact. They also outlined that national level recommendations accepted by the Taskforce to be evaluated and costed, to be rolled out with the funding to support them.

Andy agreed and echoed the need for the renewal of national level targets for reducing stillbirths and neonatal deaths, and for these to be extended to eliminating inequalities in pregnancy and baby loss.

An attendee then raised their concern that the Maternity Commissioner recommendation was included at the last minute as a ‘tick box exercise’ in response to a popular public campaign. They questioned whether accountability should instead sit with existing roles such as the Chief Midwife and the Secretary of State for Health and Social Care.

Two bereaved parents shared their experience of bereavement care and the lack of empathy, compassionate care, dignity and trauma informed support they received following miscarriage. The outlined their concern that the report fails to cover early pregnancy loss in sufficient detail and the need for better mental health care and full implementation of the NBCP to support all bereaved parents.

A midwife raised the issue of lack of funding and support for staff, particularly following their own losses, outlining that it is impossible for them offer the care they need to be providing in the context of cuts to ringfenced funding and specialist bereavement roles. Cuts and restrictive access criteria are also limiting the delivery of trauma informed and mental health care, and there was concern that the training the NBCP is supposed to be embedding is not happening in all Trusts.

Andy agreed that the workforce is fundamental to improving maternity care and acknowledged the importance of compassionate care.

An attendee highlighted that communication repeatedly appears in reports as a problem, but rarely as part of the solution. There are no tangible action points on improving communication in the report and poor communication will continue to undermine reforms if not properly prioritised. They also raised concern that the timeline for the development of the National Action Plan does not seem plausible for tackling these systemic issues.

An attendee then suggested the Hillsborough Law as a potential mechanism for accountability, criticising that many senior executives chose not to participate in the

Ockenden review. They argued that lack of accountability and justice from leadership is a major factor in the crisis in maternity care.

An attendee then outlined their feeling that the rapid nature of the review meant that Baroness Amos was never going to be able to cover everything in the detail required, and that she had done as well as she could within the remit and timescale. They stated that it is now the job of the Taskforce to turn these recommendations into action.

They echoed earlier comments about the importance of the recognition of racism and discrimination as patient safety issues in the Amos report, stating that wholesale systems reform must start with the most vulnerable and then everyone else will benefit.

They suggested that it is better to take our time to get it right, rather than rushing through a National Action Plan in six months and that the Taskforce needs to be more representative of lived experience to build a new system which works for everyone.

Andy then gave a summary of the conversation before introducing **Michelle Welsh MP,** Chair of the APPG on Maternity.

Michelle spoke about her experience as a victim of a toxic culture and the abuse she experienced over the weekend after her views were misrepresented by the press. She emphasised the need for transparent, respectful, open and uncomfortable conversations about the systemic cultural issues in maternity services.

She emphasised that poor culture affects the entire maternity pathway, not any one professional group. She also stated the importance of respecting the findings around racism and discrimination in the Amos report.

With regards to the Maternity Commissioner, she outlined that the appointment of such a role does demonstrate the progress we have made in terms of scrutinising maternity services and would provide a permanent and visible voice for maternity, giving much needed continuity.

She outlined that a Commissioner must have clear powers and statutory authority but needs to be accompanied by wider reform to regulators, funding and systems. The terms of reference and statutory guidance will outline the powers of the Commissioner role and will be discussed with families and the Taskforce ahead of appointment.

From conversations with the Health Secretary, she understands that the National Action Plan delivered in December 2026 will be an initial plan and immediate prioritisation of the actions going forwards, to create a roadmap for longer term transformation.

She then outlined the need to restore ringfenced funding and targets to establish the groundwork for systemic reform in the long term and ensure the future of maternity services in the NHS.

Returning to the room, bereaved parents expanded on their concerns about the Taskforce and Expert Reference Groups being representative of all parents, highlighting that there is currently only one Asian representative in the Health Equity group and no LGBTQ+ member for example.

They also outlined the need for the work of the Taskforce and Expert Reference Groups to be trauma informed for the bereaved parents involved.

Michelle confirmed that there are actions being taken to improve the representation on the Taskforce.

An attendee then shared that accountability to parents must be a core part of the role of a Maternity Commissioner. Bereaved parents should not have to fight for answers and if a commissioner can establish a culture of apology and learning, then they will improve the experience for parents. They must be able to investigate systemic failures, hold organisations accountable, and examine failings across multiple agencies.

An attendee challenged the initial actions taken by the Government in response to the report, asking how the proposed rollout of Martha's Law will be implemented in maternity, as the process of requesting a second opinion won't work unless a second obstetrician is available.

They flagged that there are currently several overdue written parliamentary questions about how the law will work in practice, which **Michelle** offered to raise with the Health Secretary.

An attendee then outlined that the terms of reference must enable a Maternity Commissioner to compel disclosure and data gathering. It was also proposed that the role needs to be established with an Office of the Maternity Commissioner with dedicated staff and resources to be effective.

Another attendee questioned the wait for the development of the Action Plan, arguing that many of the changes identified in the report could begin immediately.

Michelle outlined her understanding that the timeline is not intended to delay immediate actions but provide the time to create a comprehensive plan which provides a clear framework for long term delivery. She stated that a published plan would strengthen accountability.

An attendee raised the need for the Taskforce to consider the whole range of conditions including those affecting pre 24 weeks losses, highlighting that ectopic pregnancy and other early pregnancy conditions are often overlooked. Several attendees also outlined their fears as many of these conditions sit with gynaecology rather than maternity, they receive less recognition and funding.

Concerns were then raised about the experiences of women receiving care across multiple Trusts and the communication failures which can occur between services, calling for better communication pathways, digital records and information sharing.

The need to update the midwifery curriculum to include communication, trauma informed care, cultural competency, and bereavement care was also raised by attendees, to equip students with the reality of delivering maternity care. Attendees agree that reform to the education system is vital to resolving many of the issues discussed.

Finally, an attendee raised the need for midwife staffing ratios to be mandated in law, pointing out that other professions operate with legally defined limits.

3. Meeting close

Andy and Michelle thanked the attendees and closed the meeting, confirming that the feedback shared will be taken to the meeting of the Taskforce and Expert Reference Group members the following day.

Andy also encouraged anyone with further thoughts or feedback to get in touch via his email (andy.macnae.mp@parliament.uk) or via the APPG secretariat (appg.babyloss@sands.org.uk)

The feedback shared will also inform the focus of upcoming APPG meetings.