Hudgell SOLICITORS | Righting Wrongs

Birth Trauma Inquiry Submission

1. Executive Summary

In light of our experience in dealing with families and individuals profoundly affected by birth trauma, we firmly believe that a statutory public inquiry into England's maternity services is crucial. We consider that the safety of maternity services is of paramount importance and whilst we recognise that there is a national strategy to improve them, including independent investigations, an inquiry is more likely to bring about much needed indelible change in this matter, which is clearly an issue of public concern.

2. About Us

At Hudgell Solicitors we represent clients across the UK in a number of practice areas. We act for many women, children and their family members in connection with birth trauma negligence cases as well as providing them with representation at inquests, which is often carried out on a pro bono basis.

We are fiercely committed to representing our clients, who are at their most vulnerable, and giving a voice to those who are seeking access to justice. We often deal with difficult and challenging cases, and the vast majority of our clients seek assistance from us not just for compensation, but importantly to challenge injustice, to hold people or organisations to account for their actions, to find the answers to their questions, to ensure that lessons are learned and so that positive changes are made for the future. We seek to do this within the remit of the legal process, and we work very closely with our clients, who typically feel very strongly that what they have suffered does not happen to others.

3. Our Experience

Over the last five years, the number of birth trauma related enquiries we have received from potential clients, who considered that the maternity care they received was substandard, has continued to rise. In particular, the enquiries we received in 2021 increased dramatically in comparison with the enquiries received during 2020. We note that this shift will also, in part, relate to a decrease in enquiries received at the outset of the Covid pandemic. The rising trend in enquiries has also led to an upturn in birth trauma cases that we have successfully settled during that period. This incremental increase is also reflected in NHS Resolution’s statistics relating to new obstetric (non-cerebral palsy) claims over the same period,

which detail 936 claims during 2020/21, 1055 claims during 2021/22 and 1152 claims during 2022/23.

Through our work, we recognise that pregnancy can be both an exciting and worrying time for expectant parents, and sadly, whilst the vast majority of cases are straightforward resulting with a healthy mother and baby, we have extensive experience in dealing with the devastating effects of simple errors or wider systemic failures resulting in avoidable significant injuries (physical and psychological) or death. We also understand and acknowledge that outcomes are typically worse for individuals with disabilities.

We have supported many parents whose children have sadly been stillborn or died during the neonatal period due to failures of healthcare provision on maternity wards. We are well versed in understanding these complex issues and we are hugely sympathetic to our resilient clients upon whose lives birth trauma has had a profound impact. We frequently assist our clients who wish to engage with the formal NHS complaints procedure, where an internal investigation is being carried out or where the Health Services Safety Investigation Body is involved. In those matters our role is to investigate the events which led to a baby's death, to seek clear answers as to why the life was lost and, if necessary, hold those responsible to account. In doing so, we also seek damages for our clients in enabling them to obtain vital access to therapy, counselling or support. Our involvement in these cases has often led to positive changes being made and extra training being carried out within maternity departments.

In addition to this, we act for individuals and families in connection with other birth injury cases, cerebral palsy being the most common, or cases relating to failures during the immediate neonatal period such as where there has been hypoglycaemia and kernicterus resulting in brain damage. We also deal with birth injury cases, where the following issues have arisen amongst others:

- Cord compression
- Cord prolapse
- Delay in delivery
- Failure to escalate to a senior colleague
- Uterine rupture
- Haemorrhage
- Maternal infection such as Strep B
- Shoulder Dystocia.

We attach to our submission examples of stories shared by our existing clients, which detail the significant impact that negligent birth trauma has had on their lives. Sadly, in dealing with these cases we are able to clearly identify common themes, which have a devastating impact on lives particularly where there are

ongoing issues relating to family relationships, physical injury and/or disability, psychological injury and finances.

As a result of our role in representing families in this area, we are also very proud to support a number of relevant charities whose values and work align with ours. We therefore have established links with Baby Lifeline, Child Brain Injury Trust, Supportability, Stick 'n' Step, Brain Injury Group, House of Light and Sands. We work closely with these organisations whose important work has clearly created a positive impact on the lives of families affected by birth trauma.

4. Our Involvement

Through our work with clients, we firmly believe that the NHS's failure to improve maternity safety is so startling that a public inquiry is imperative in order to ensure that women, babies and their families no longer come to any avoidable harm. As a result of investigations that have been carried out in relation to maternity services, such as those that have been undertaken by Donna Ockenden, it is quite apparent that basic elements of safe care are not in place in several of the maternity units across England.

Maternity incidents remain the highest costs of claims against the NHS in England, and this has been prevalent for a number of years with the Care Quality Commission (CQC) rating around 1 in 4 maternity services as either "inadequate" or "requires improvement". Ultimately, maternity units must be properly resourced with safe staffing levels and access to vital training being provided to those working within them. In order for this to be prioritised, maternity budgets need to increase to support these improvements.

We work closely with families who have suffered devastating effects as a result of avoidable birth trauma. We therefore support the Maternity Safety Alliance's position that individual national initiatives and policies, although useful, are insufficient to tackle systemic issues within maternity services. Upon the basis that the issues affecting maternity services appear to be systemic, a statutory public inquiry can create meaningful change so that families who have suffered can be at the heart of any significant decisions that are subsequently made. It is our hope that an inquiry dealing with maternity services would address widespread issues so that lessons are learned, and recommendations implemented resulting in significant improvements and positive change.

5. Client Statements

We detail below statements obtained from clients of Hudgell Solicitors in relation to their birth trauma experiences.

We have anonymised all of ours clients' statements to avoid any impact on their legal claims, which are ongoing. We support clients with a diverse range of birth injuries across several NHS trusts including:

- University Hospitals Bristol NHS Foundation Trust
- Hywel Dda University Health Board
- Birmingham Women's and Children's NHS Trust
- Northampton General Hospital NHS Trust
- West Suffolk NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- East and North Hertfordshire NHS Trust
- Oxford University

<u>Client Statement 1</u>

I suffered a miscarriage when 19 years of age.

I feel as a 26-year-old women at the time of my first birth I was not seen as someone who should be listened to and that the staff felt they knew my body and my feelings better than me. I felt things were being done to me rather than with me. I felt ashamed of questioning professionals due to my age and inexperience in pregnancy. I do feel as though I was not listened to when I was trying to say things were not right during my labour. I was aware towards the end of the delivery that things were not going to plan yet I was not listened to or communicated with, and this significantly increased my anxiety and stress.

I have experienced severe anxiety, especially when then pregnant with my second son. Over the years I have been incredibly sensitive to any illness my sons have had and this I feel is a direct result of the birth trauma.

I was not offered any mental health support at all following the birth trauma I experienced, in fact I feel I was made very much to feel like I was silly for even questioning or asking for any support. I feel throughout the process I was made to just feel like I should be grateful and not ask for anything.

I would like to see women listened to when they say how their body feels.
I would like people to communicate with women more; before, during and after any intervention that is needed and for people to feel able to ask for support and ask

questions and not be made to feel inadequate or silly for doing so. I would like acknowledgement, understanding and a more human approach.

Client Statement 2

My daughter was born stillborn. There is currently an investigation ongoing. The care I received in hospital wasn't great. When the pain started, I was left from the Friday to the Sunday.

Physically I was cut when giving birth to my daughter to help deliver her and had to have several stitches. It took a while to heal. I had to take another visit to the hospital due to a prolapse caused by delivering my daughter. I still suffer as a result of the prolapse. Whilst at the hospital I suffered panic attacks. Emotionally I struggle everyday - it's the worst I have ever been through. I have some really bad days and get upset over most things. Planning the funeral had a big effect on me and burying my daughter, even thinking of it now, it kills me. I have never ever felt pain like this. I have received counselling and my bereavement midwife calls me every couple of weeks as well.

Financially I was put on maternity pay for my main job but my Saturday job that I do every 2 weeks has been with no pay. If I could stop this happening to someone else and that they could do more tests or just test the blood for everything when they take the test, and not just say something that I didn't even have.

Client Statement 3

My little girl was stillborn. I was worried about my baby, and I wasn't listened to, especially nearer the end. I felt like I was treated as a pest. I had a condition which can be serious, but no one was concerned. We were that close to having my daughter and then we lost her, and it destroyed us. At first, I felt guilty about the loss of my daughter, I felt I had done something wrong.

During my pregnancy disrespectful and inappropriate comments were made by staff. It affected me and my family emotionally. I have tried counselling but felt it didn't work .I took legal action as I wanted justice for my daughter because she really should be here with us, but her life was snatched away. The Trust admitted I should have had a planned labour and said that a breakdown in communication regarding the plan to induce me, and a lack of continuity of care from the medical team, led to loss of our baby. I want midwives, doctors and nurses to listen to the mother when she expresses anxieties and worries, and not be brushed off and made to feel like we are being pests.

There are so many babies dying. When I go to the cemetery and met other families visiting their children's graves, I heard similar stories just like mine. I would say to politicians that maternity services need proper staffing, and those staff need proper training, so more babies don't die.

<u>Client Statement 4</u>

My birth led to a hysterectomy. I think I will always suffer emotionally from what has happened. I received conflicting advice from different consultants in relation to the method of my delivery. One consultant advised I should not be induced with a Propess pessary because of the risk involved due to my previous C-section. At a later date, a different consultant advised the Propess would be 'unlikely' to cause risk as my C-section wound should be well healed.

I was given the choice of the Propess or waiting until a date was free for a C-section, but was advised that the hospital was busy and that I would be waiting at least a week for a C-section, which would also put the baby at risk. I chose the Propess, but was not made aware that the notes that come with the Propess advise that it should not be given to anyone who has previously had a C-section. After having the Propess my waters broke, and the midwives would not check my cervix to see how dilated I was as they did not want to run the risk of infection. My baby's heart rate was monitored, and an abnormal reading was taken.

I have since learned from my birth report that I should have been taken for an emergency C-section at this point because my birth was high risk, but I wasn't. It took over a year for the report to be completed about my birth and I had to contact the hospital repeatedly to get this done.

I laboured on my own in the ward's bathroom, in a lot of pain and was left for a long period of time without being checked on. Eventually I left the bathroom and a midwife agreed to check my cervix. By this point I was 5cm dilated and could be taken to the labour ward so my partner could be with me.

I had a vaginal birth and lost a lot of blood. I was concerned that my previous C-section scar had ruptured, but was assured that the blood loss was from the cut made to deliver my daughter. A speculum was not used to check for internal tears and I was 'packed in' with dressing to stop the bleeding. I began to feel a lot of pain after the birth, which I kept complaining about, but I was told it was normal and that it was my cervix contracting back down to size. After almost two hours of complaining the registrar who delivered my baby came back and removed the

dressing.

As soon as this happened, I lost a lot of blood and was rushed to theatre to operate. The decision was made to remove my uterus to save my life. I was aware of the risks of me haemorrhaging after the birth and I kept raising it with staff, but they insisted that wasn't happening, but my life was in danger. When they did rush me to surgery I was saying 'I don't want to die', I feared for my life.

My cervix had also torn during the birth, and this wasn't noticed until I was in theatre. I was not informed that my cervix had torn until I received the report about my birth over a year later. A speculum was not used to check for internal tears, and I was 'packed in' with dressing to stop the bleeding.

I didn't hold my baby until 48 hours later. I felt that I couldn't straight after the birth due to the pain I was still experiencing and then I spent time in the ICU so was unable to. I could not physically care for my baby independently because of my operation or take care of myself when I did come home. My partner had to help me wash, dress and take on all household chores and lots of care of the baby. I was affected emotionally and spent many days/nights crying. I did eventually receive counselling from the House of Light.

Eventually I took legal advice because I felt someone needed to take responsibility for what happened to me. There needed to be an investigation and there needed to be an understanding as to what went wrong. I would like to see mothers of high-risk pregnancies under consultant care, and to see the same consultant every time. I would like all consultants to follow the same advice and give expectant mothers the same advice. I would like the Propess pessary to not be administered to previous C-section mothers. Recommendations are not enough, because recommendations for change are not evidence of change.

<u>Client Statement 5</u>

I lost my baby at full term despite having been to hospital on many occasions with concerns due to continuing, agonising pains in late pregnancy.

Each and every time I was completely dismissed and often sent home without any tests being conducted. This was my first pregnancy and I was made to feel like I was overreacting to the pain I was in, when I myself knew there must be something wrong. I was in agonising pain for between four or five days before a scan revealed

my baby girl had died. I can remember at one point I had asked a student midwife if I could see somebody more senior as I was so concerned that something was badly wrong and they basically told me they knew what they were doing and nobody more senior was required.

On the occasion that my baby's heartbeat could not be found, I was initially told it was because the machine was old. Had the basics been done, with proper attention and record keeping, I fully believe that I could have had a C-section and that my baby girl would have been delivered safely. As part of a legal claim I have against the Trust, it has admitted errors in the monitoring of my daughter and the care I was provided with. I have received an apology for those failings. It has also admitted that with proper care, my daughter would have survived. However, it has taken a long time to reach the point of that admission. I feel there is generally a culture of denial regarding deaths.

When we found out my daughter had died, I asked for a C-section as I was so distraught and shattered by what happened, but I was made to deliver her normally which took more than three hours and was extremely distressing. I was diagnosed with moderate to severe depression due to losing our baby. My partner has struggled to talk about what happened, and we both struggle today more than three-and-a half-years on.

I think changes need to be made and the first is to stop treating pregnant women like they are over-reacting and being irrational, when they know their own bodies and should be listened to when they feel things are wrong. I think that when mothers come to hospital for a second or third time, matters should be escalated to and tests carried out as standard.
As a mother who lost her first baby I was made to feel like I was at fault for not protecting her. How can that be? We need a complete change of culture, and that is what I hope an Inquiry can bring about.

<u>Client Statement 6</u>

My baby was stillborn. I have a legal claim ongoing. The hospital had to amend the internal investigation report twice because it contained information and events that were untrue/inaccurate. Information regarding the wellbeing of my baby was withheld and not acted upon. The stillbirth of my daughter has left psychological scars as well as post-traumatic stress which severely affected me during my last pregnancy.

I suffered huge financial loss as I had to cancel my wedding reception which was due to take place just a week after the loss of my baby. My husband had to turn down a promotion at work because it involved further travelling for work which I was not comfortable with at the time because of the anxiety induced by my loss. I have suffered with depression in the past, this experience brought those feelings back. I was referred to charities and offered anti-depressant medication, but was not offered mental health support through the NHS.

I would like to see more involvement of consultants with all pregnancies, and safety nets to stop patients falling through the cracks of the system, and a system for parents to be better informed and have their concerns addressed seriously.

There should be an automated alert system when certain criteria is met to re-categorise pregnancies based on quantifiable figures e.g. estimated fetal weight/size going below a certain threshold. This information is stored digitally and thus an alert could be triggered through software changes. All parties involved were courteous before, during and after.

Client Statement 7

I have had to take legal action against the Trust that I work for, as I feel so badly let down over the stillbirth of my baby, which I believe was caused by a toxic environment in the maternity department with regards to inductions. I was admitted to hospital when I was 40+3 weeks pregnant because I was having tightenings and my baby's heartrate was decreasing. I was told that I would be admitted overnight and my understanding was that I would be induced the next day. The next morning, I was seen by a doctor who hadn't seen me before and who sent me home. I think there was a lack of beds, and to me there was an environment where inductions were avoided as much as possible, as the maternity staff want as many natural births as possible.

I was sent home on the Saturday morning, and the next Friday, a day before I was due to see a midwife again, I felt my baby moving quite dramatically, which was out of the ordinary. I called the delivery suite as I had some discharge, but when I was admitted later that day I was told my baby had died.

The Trust has since admitted that had I been induced when in hospital a week earlier my baby would likely be here today. However, they have refused to agree that I should have been induced. I think there needs to be a whole culture change

where women are listened to and not ignored. I knew my body, and I knew what my baby's regular movements were. When I went into hospital, I knew something was not right and that my baby needed to be born. That instinct was ignored, in my view, all to try and make me have a natural birth.

I was told not to talk to anyone about my case at work, either during the working day or out of work, because it is 'too difficult' and 'emotive'. That does not give me confidence that such cases are being looked at with a commitment to learning and being transparent. I also discovered the Trust had not reported my case to the Maternity and Newborn Safety Investigations programme. I see the number of stillbirths at the Trust and it is worrying. Changes need to happen and quick.

Client Statement 8

Due to several failures in my treatment I was unnecessarily placed in a life-threatening situation. I also experienced a significant negative impact to my quality of life in the important first three months of my daughter's life. I underwent surgery under general anaesthetic to remove a significant amount of retained products of conception that had been in my uterus for 3 months since delivery. This could and should have been discovered and removed either during delivery, at my first visit to A&E with PV bleeding. It should not have taken a second visit to A&E with bleeding for this to have been investigated properly and treated.

The negligence resulted in pain, bleeding, and stress on myself and family; all this whilst trying to care for a newborn. I was advised at the time that the length of time that the retained products of conception (RPOC) had been present in my uterus could result in a risk of decreased future fertility. Thankfully further scans have shown that this is probably not the case, but it was very stressful and upsetting to be told this, particularly as it was my first child. I had distressing nightmares, every night for a month. I had intense anxiety about this trauma impacting the bond I have with my 3 month old daughter. I have lost trust in medical professionals and feel extremely betrayed.

I was treated for PTSD, I saw a psychologist privately and the severity of PTSD meant I reviewed and increased the dosage of my prescription of anti-depressant medication. As the anxiety, panic and trauma from the negligence continued to impact my day to day months afterwards.

Six-and-a-half weeks after discharge I experienced a post-partum haemorrhage

where I lost a significant amount of blood and was passing very large clots. I went to A&E where they stabilised the bleeding and a gynaecologist found and removed retained products of conception from the cervix.

She requested bloods and a scan to be conducted within 24-48 hours, and I was sent home with antibiotics as a precaution. I spent the next few days chasing up the hospital as I had not yet received a scan appointment.

I was extremely distressed. I was told I'd have an appointment for a scan within 24-48 hours. I was worried I would haemorrhage again. The team that I got through to (I believe it was radiology) said they could see my request in the system but there were no appointments available. When I said that the scan was urgent, they agreed, could see that it was marked as urgent, but advised that if "it really was urgent I would be an inpatient". I received a call from the hospital a week after my attendance at hospital and was told the sample of what was removed was mislabelled and there would be no official record/so I could not receive results.

I queried the scan appointment again and was advised it's still in the system and I have to wait for an appointment to become available. Part of me trusted that they were medical professionals and knew what they were doing, but I still did not feel right in myself. I felt dizzy, had headaches, cramps, and got out of breath doing the most basic household tasks. After another month of feeling like this and continuously chasing up the hospital for a scan, continual (light) bleeding, and trying to request a referral letter from the hospital/my GP to get a scan privately, I experienced another heavy flow of blood, clots, and RPOC protruding from the vagina.

I called 111 and was advised to go to A&E. The gynaecologist removed a significant amount of RPOC (4cm) from the cervix, which had an offensive odour and I was advised that there was likely an infection. He admitted me as an inpatient and referred me to an internal scan, and likely surgery in the AM. I saw a consultant the following morning and proceeded to have a scan where they located a large amount (4cm) of calcified RPOC in the uterus that would require surgery (not a straightforward D&C) to remove. The comment from the consultant was that this was a very large piece to remove, and not at all commonly seen.

She wrote a letter for us to get a second opinion at another hospital. I was deeply upset and very distressed. I was exhausted at having to fight to be seen, I felt that no one at the hospital was listening to me. It took another visit to A&E for me to be

seen and listened to. It was awful that it had to come to that. Very traumatising.

I made a complaint in February 2023 the hospital responded in August 2023 after much chasing. The delay was upsetting as I did not feel they were taking the complaint seriously but when they did reply they took some ownership and apologised.

I would like to see more training and awareness on RPOC and the risks.
More women need to know about this so they can trust what they feel in their bodies and not second guess themselves. There also needs to be more communication between A&E, hospital departments and GPs, and it made easier to get letters for referral to private healthcare.

<u>Client Statement 9</u>

When I had my baby and my waters broke I was told by hospital that because I was not dilated that I should go home and relax. The pain didn't go away and I started getting contractions so I went back to hospital only to be sent away again as I was told they were too far apart.

An hour later, my partner drove me an hour to another hospital, where I was due to have my baby, as I was in so much pain.

When I was there I was completely ignored and left standing in the corridor crying. I wasn't even offered a seat. Eventually I was given a bed but again I was told that I wasn't dilated and that I should go home. They gave me paracetamol.

I was in such pain I started to push and was told by midwives to stop and that they'd have to deliver my baby by putting me to sleep if I didn't. I was literally howling with pain by the time they decided to send me to the delivery suite, and when I began to bleed they rushed me into theatre.

I had an epidural and both mine and my baby's heartrate went back down.

My baby was born about an hour later, but this was more than 24 hours after my waters had broken, and in that time I'd had no medication for possible infections. In the days after he was born he was continually congested, choking on mucus and appeared to be struggling to breathe. We called hospital on a number of occasions, and they said it was normal given there was no blood, and we were told that it was likely a cold.

A week-and-a-half after he was born he was sick and there was blood in it. We went to A&E at hospital but they didn't do any blood tests, said that he seemed fine and that the vomiting was possibly down to his milk and the blood could be due to

the nasal spray he was using.
Another week or so later we rushed him to A&E as he was projectile vomiting, had blood in his nappy and a high temperature. My mum said he looked like he was dying in her arms, which I will never forget.

He had his bloods taken and a lumbar puncture performed, which confirmed a diagnosis of Strep B Meningitis. It was later discovered that I had Strep B and had passed the infection onto him. This is something which is no longer routinely tested for at birth, but given the pain I had been in, the fact that there was more than 24 hours between my waters breaking and him being born, the fact he had a low temperature after birth, I can't believe a test was not done there and then.

A scan showed abnormalities to the right side of the brain due to lack of oxygen and I then received a letter from the paediatrician which said Jacob had a right sided watershed infarct. We've been told he may have a weaker side and may need physiotherapy. He is almost 3, but cannot communicate and has global developmental delay. His life has been ruined. He is due to have an MRI scan when he is 3 years old which will tell us more about his long term prognosis, but without doubt he has been badly let down.

I can't get over how my excruciating pain was ignored and dismissed, probably because the ward was so busy, and in some ways I believe because I was a first time mum. They only focussed on whether I was dilated or not, and ignored the physical symptoms. Then, given all that had happened during his birth, I cannot understand how tests for infection were not a priority.

Client Statement 10

My baby girl suffered a brain injury at birth, which I believe would have been avoided had I received appropriate treatment. My case is being investigated by lawyers.

There had been no issues during my pregnancy or at any scans. When I was in hospital there were conflicting views between consultants and midwives as to whether I should have a C-section or not, and it was something that I had wanted to avoid as I'd had one some 15 months before with my previous child.

A consultant had said I needed a C-section as he believed my baby was back to back, and so in his notes had put that I shouldn't have a stretch and sweep to try and start a natural labour. However, between him arranging my C-section and the date of the procedure, I had a scan which showed my baby in the right position,

and so a midwife did do a stretch and sweep. After the stretch and sweep I suffered a massive bleed but was then sent home.
A few days later I returned to hospital as I was in immense pain, but I was told it was just labour pains.

A few days after that I had to be admitted again as I was in such bad pain and my stomach was popping. They couldn't find my baby's heartbeat at the time and I was taken to theatre for an emergency C-section. I had a full placental rupture and my uterus ruptured as well. My baby wasn't breathing when she was born. My daughter was taken after birth to a resuscitator and given oxygen. She started getting colour back. They incubated her in neonatal intensive care and because of a lack of oxygen she was in active cooling for three days.

She had an MRI scan when she was 5 days old and the results came back that she had suffered brain damage due to oxygen starvation. I believe this could and should have been avoided with clear planning and communication over the delivery of my baby girl. When I was in hospital I didn't have confidence in what was happening. When my C-section was scheduled I said to the consultant that it needed to be done as soon as possible, as it was causing me significant stress.

Client Statement 11

I would never have another baby. When my waters broke at 35 weeks I felt really poorly and had really bad pains in my abdomen. I went to the hospital and I was shaking, shivering and vomiting, I didn't want to leave.

They kept sending me home and fobbing me off. One doctor even said to me 'your baby's so happy', but we both could have died of sepsis. My son was taken from me as they said he needed to be ventilated due to the infection and he ended up on life support.

I was the only mother on the ward without their baby. I was seen by several different consultants during my pregnancy and they all had different opinions about my symptoms and care.

I didn't know whether I was coming or going and when I did have sepsis no one picked up on it even though I was telling them I didn't feel right. I know my own body; mothers know when things are not right. They just didn't listen.

It was different with the midwives, they were amazing, one even said to me she wanted to deliver it early, but she had to go with what the doctors said. I had more faith in them than the consultants.

Client Statement 12

The consultant we were meant to be seeing every two weeks laughed at us, made us feel we didn't understand, but it turned out he was wrong, resulting in our twin girls being stillborn.

It was due to a lack of professionalism and medical teams not doing their job correctly, otherwise our girls would've survived.

The emotional impact is constant and we've lost faith in people, especially medical teams.

Medical teams need to work together and concentrate on their jobs.

Client Statement 13

It was shocking. I was left in pain for a week and a half.

When they finally agreed to a scan, they found the ectopic pregnancy and I was rushed to surgery but they removed the wrong tube. It wasn't until six weeks later, where I was still going through the same pain and more blood tests and another scan that they realised I still had the ectopic pregnancy but in the other tube.

Now I might never be able to have another child as the remaining fallopian tube is damaged. They've even said I wouldn't be able to have IVF on the NHS because I already have one child and that's just wrong as it was their mess up.

I just wished they had listened to me; I was telling them the pain was on the left side, but they concentrated on the right side. I don't think anyone really cared, no-one rang, there was no aftercare, and I still don't know what really went wrong.

They should listen to mothers; I know they are professionals, but we know our bodies better than anyone else.

I've had miscarriages and this was different, but they were telling me to go to A&E with my pain. I feel that if they had listened to me properly, it would have been called earlier.

It destroyed us as a family; I fell into depression and I'm taking antidepressants; I couldn't work. It's had a massive effect.

I believe one hundred percent that it could happen again, I believe it happens to others all over the country. It's scary.

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We consent to being contacted and named.