Donna Ockenden appointed to chair Leeds maternity review

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Secretary of State Wes Streeting appoints Donna Ockenden to lead the independent review into Leeds Teaching Hospitals Trust's maternity and neonatal service

- Secretary of State appoints Ockenden to lead independent review into Leeds Teaching Hospitals Trust's maternity and neonatal services.
- Follows repeated maternity failures in Leeds, one of the largest teaching hospitals in Europe, and the announcement of independent review in October 2025.
- Decision reflects families' own asks, following direct conversations with the Secretary of State.

Families in Leeds are closer to seeing lasting change following the appointment of senior midwife Donna Ockenden to lead an independent review into maternity and neonatal services at Leeds Teaching Hospitals Trust (LTHT).

The Secretary of State spoke this morning with the families, where he set out that this decision has been made with the aim of building the confidence of all the families who have been harmed. It's the third time since September that the Health and Social Care Secretary has met with the families.

Ockenden brings extensive experience as a nurse and midwife, alongside her track record of uncovering systemic failings in maternity care - having examined maternity practices at Shrewsbury and Telford NHS Trust - and is currently chairing the Nottingham maternity review.

From next month, the government will kickstart work with families to further develop the Terms of Reference for the review, with individual clinical case reviews set to begin from August.

The government has taken significant action to overhaul maternity care over the last eighteen months, including a rapid national investigation into maternity and neonatal services in England led by Baroness Amos, who published her interim findings on 26 February.

The Secretary of State will also launch the National Maternity and Neonatal Taskforce taking the national investigation's recommendations and turning them into a concrete plan for real, lasting change.

Wes Streeting, Secretary of State for Health and Social Care said:

> Donna Ockenden is an outstanding advocate for families whose voices haven't always been heard, and I'm delighted to appoint someone so trusted by those who have been repeatedly let down by the NHS.
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> To the families in Leeds, I want to say – thank you for your openness during our detailed discussions in recent weeks, and the courage you continue to show in sharing your experiences and advocating for lasting change, so other families do not experience the unimaginable tragedies you have gone through.
>
> This review must deliver for you and for the sake of all families who rightly expect to receive safe and high-quality maternity care in the NHS. Donna Ockenden's leadership

> will bring us closer to the lasting change so desperately needed in Leeds.

Donna Ockenden said:

> It is an honour to have been asked to chair this review, and I feel a profound sense of responsibility to the parents, babies and healthcare professionals it concerns to ensure that we get this right.
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> This review must remain firmly focused on the families who, in many instances, have waited far too long for answers to questions about their care. My priority will be to listen carefully to families and staff, to understand what has gone wrong, and to ensure that the lessons are learned and the changes required are made, in a timely way, thus ensuring that all mothers, their babies and families receive safe, high-quality perinatal care.

The Leeds family maternity group said:

> It has been a long, drawn-out, and emotionally draining process to get the assurances that this investigation will be handled with the appropriate methodology and care that it needs.
>
> We are grateful that Wes Streeting has listened carefully to all of the evidence we put to him about our concerns and why Donna Ockenden should be appointed as chair. We believe she has the experience, independence and determination required to uncover the truth and deliver meaningful accountability and change.

The independent review into Leeds Teaching Hospitals Trust's maternity units was announced by the Secretary of State in October last year, following repeated maternity failures. Despite being one of the largest teaching hospitals in Europe, Leeds Teaching Hospitals NHS Trust remains an outlier on perinatal mortality according to MBRRACE-UK data.

The review will focus on identifying areas of concern within maternity and neonatal care at the Trust, with recommended actions to help improve the safety, quality and equity of maternity care.

Whilst the Terms of Reference for the review are yet to be agreed, we expect the review to involve case reviews of stillbirths, neonatal deaths and serious incidents, hypoxic injuries and maternal deaths over a 15 years timeframe (1 Jan 2011 – 31 Dec 2025).

Following the successful approach in Nottingham, the inclusion of cases in the review will be based on an opt-out basis, meaning that all families who meet the terms of reference will automatically be included unless they choose otherwise, ensuring that no voices are missed.

It will also look at the governance, accountability and the handling of concerns at the Trust when they are raised by women and/or their families and staff members.

Final decisions will be made following further engagement with Donna Ockenden and families.

Whilst the time reporting timescale for this review will be confirmed in due course, learning and recommendations will be shared on an ongoing basis with the Trust, NHS England and the

Department to allow rapid action at all levels to improve the safety of maternity care.

The vast majority of births on the NHS are safe and women should continue to attend all maternity appointments. Women and families are encouraged to raise any concerns with their midwife or healthcare team without hesitation.

The appointment of the Chair of the Leeds independent review follows a suite of measures this government has taken to improve maternity care. Since July 2024 we have:

- Invested over £131m in 122 infrastructure projects across 49 NHS trusts to improve safety of neonatal care facilities.
- Implemented a new programme to reduce the two leading causes of avoidable brain injury during labour.
- Piloted Martha's Rule in maternity and neonatal units in 14 trusts across 6 regions to give patients and families the right to request a second opinion.
- Launched a package of initiatives and interventions to reduce stillbirths, neonatal brain injury, neonatal death, and preterm birth.
- Introduced a Perinatal Culture and Leadership Programme to develop a culture of safety, learning, and support for leads from all maternity and neonatal units.
- Created targeted schemes to promote midwife retention, and the Graduate Guarantee, so that every qualified nurse and midwife in England can apply to join the health workforce - the latest workforce stats show that as of November 2025, there are 31,024 midwives working in the NHS which equates to 25,530 full time equivalent midwives.
- Expanded maternal mental health services to help women and extended the Baby Loss Certificate scheme to include all historic losses.
- Rolled out guidance across the NHS to tackle the leading causes of maternal death including thrombosis, mental health, epilepsy and haemorrhage.
- Launched an anti-discrimination programme and a system to better identify safety concerns.
- NHS England have published an inequalities dashboard, which will support the identification of areas where specific populations face the greatest disparities, enabling tailored interventions and more equitable support.
- The Secretary of State has ordered a National Maternity Investigation, chaired by Baroness Amos. The aim of this rapid, independent investigation is to develop one set of national recommendations to drive improvements in maternity and neonatal care across England and

reduce inequalities in the delivery of these services.

- The Secretary of State will chair a National Maternity and Neonatal Taskforce shortly. The Taskforce is specifically designed to ensure the Investigations' recommendations translate into action.

https://www.gov.uk/government/news/donna-ockenden-appointed-to-chair-leeds-maternity-review