KEEP THE HORTON GENERAL

Birth Trauma Dossier

by Beth Hopper and
Keep the Horton General Campaign - 2024

Mothers' accounts of their pregnancy, labour and postnatal care at both the Horton General Hospital and John Radcliffe (JR) hospitals since the downgrading of consultant-led obstetric and gynaecological care at the Horton General Hospital to a midwife-only unit in 2016 and centralisation of obstetrics and Special Care Baby Unit to the JR, Oxford.

These accounts were collected in May 2024 and others being received will appear in a supplementary dossier. A further 20 accounts in past press cuttings appear at the end of this publication

FOREWARD - by Beth Hopper

Following the Care Quality Commission report on the midwife-led maternity service at the Horton General Hospital in March, I was contacted to speak on behalf of Banburyshire mums for a number of media interviews about my own birth trauma. These interviews started with a piece for BBC radio alongside Keep the Horton General campaign group.

I was subsequently inundated with messages of support from friends, family and strangers who often followed it with their own awful maternity care experience.

I felt a mixture of anger and despair that things hadn't changed or improved since my own multiple traumatic experiences - rather they had worsened. I decided to start collecting these stories to create a document highlighting how many women and their families, even in my own circle, had been adversely affected and traumatised as a result of the 2016 downgrading of the Horton General Hospital and the ongoing, poor quality of care at both the Horton and John Radcliffe hospitals.

As these stories have been published in the Banbury Guardian and on social media, more mothers have come forward wanting to share their experiences.

Women are reporting that they are being dissuaded from natural birth in favour of agreeing to inductions as early as their routine 20 week appointment. Interventions are routine. This, in my opinion and that of other mothers (and some staff when they have let it slip), is to control the numbers of women giving birth at any time at the JR because they simply cannot cope with the number of births coming from Banbury.

The strain the staff are under is evidently leading to awful and sometimes unbelievable care which you will read about in this harrowing document. A number of women have been so traumatised by their birth experiences they cannot face pregnancy again.

These mothers' traumas come in addition to the extreme difficulty, financial expense and time taken actually getting to the JR from Banbury and the outlying villages. This means distances of up to 36 miles. Ambulances are only available in emergencies.

We want the outcome of this document, and successive accounts still being received, to result in the return of a fully staffed obstetric department the Horton General Hospital, Banbury, offering full maternity, birth care, a gynaecology service and a special care baby unit such as Banbury previously had, to care for premature and sick babies.

In addition to this we want to see drastic improvements in communication and compassion from all staff to their patients.

We do not want any more mothers, fathers and families to suffer medical negligence leading to baby loss, injury, Post Traumatic Stress Disorder (PTSD), post-partum depression and ongoing mental illness.

Introduction

This dossier is a growing collection of accounts of childbirth in Oxfordshire following the 2016 downgrade of the Horton General Hospital's obstetric (consultant-led) unit. We have 50 cases. The first 39 alone came from contributors known to one mother, Beth Hopper, who had a terrible set of experiences and feels deeply that full maternity must be returned to Banbury.

Each account published in the Banbury Guardian produces more awful descriptions of childbirth - something that should be as natural and peaceful as possible as couples welcome a new child to their family.

Accusations range repeatedly include

- Mothers in labour being sent home - up to 36 miles - because they are not sufficiently far gone, in some cases narrowly avoiding disaster
- Mothers being sent home without pre or post-birth checks, causing serious complications requiring operations
- Systematic neglect at the bedsides
- Midwives being unacceptably over-stretched, resulting in some becoming 'rude', 'surly' and lacking compassion
- Mothers being induced and then delayed - sometimes for days - because of the pressure of emergency workload, and being 'allowed' to deliver only when they are emergencies
- A reliance on induction to manage the throughput of expected births - many of these resulting in complications/forceps births resulting in injuries to babies and emergency Caesareans because the babies have not been ready.
- Medical management of births and subsequent procedures causing serious and ongoing physical damage to mothers
- The psychological impact on mothers in trauma, PTSD and post-partum depression
- The impact on partners, family, siblings and mothers themselves, being so far from home and community with all the issues around distance, cost and parking
- All but impossibility of mothers getting to the JR by public transport (one women did this after her waters had broken)
- All believe their experience would have been a lot better and dangers avoided if they had been able to give birth locally, at the Horton General Hospital.

It would be easy to just accuse the Oxford maternity team. The truth is that the JR is 'managing' births to match the appalling restraints they are under.

It is a production line when, at busy times, they are lining women up in labour and keeping them at the same stage until they become emergencies and are prioritised to the front of the queue

They have far too many births, too few midwives and maternity staff, and not enough space. Women are being 'held' in rooms without windows, daylight or fresh air, and even rooms used to store plumbing paraphernalia.

Far too many deliveries are proving unnecessarily distressing and downright dangerous. It is not how childbirth should be. Mothers who have invested in learning about natural childbirth are being cruelly denied any chance of that with no sympathy whatsoever.

Many of our accounts are borderline compensation cases and we are having the dossier scrutinised by specialist barristers.

Warnings were given at the time (see cuttings attached), not just by the Keep the Horton General Campaign but by doctors and midwives, that the John Radcliffe Hospital was not going to cope with the extra 1700+ births annually (then) as well as their own workload. Since then the Banbury catchment (stretching into south Warwickshire and south Northants) has grown exponentially and the numbers will be far higher. This at the same time as the JR has found it difficult to recruit and retain midwives and special care baby nurses - something the Horton never had a problem with.

The dossier shows that mothers are being taken to the brink of disaster in the JR maternity unit, and the OUH trust is laying itself open to legal proceedings. We do not aim to point blame at any single person, but at a system that has insisted on taking decisions that have resulted in a scandalously deteriorated and unacceptable service. This has to change.

The biggest thing to come out of this is that there are too many births, not enough midwives or facilities and NOT ENOUGH TIME. Labouring expectant mothers are being denied dignity and respect. They are being castigated for wasting people's time. They are not receiving water or food; some are not being offered washing facilities if their waters have broken. Vulnerable mothers are being treated as second class citizens. Women being treated as though they are panicking unnecessarily - and as ignorant because they may be first time Mums.

Many have described feeling humiliated, being left with waters leaking or bleeding in public - there is no privacy in this overcrowded department.

One of the biggest takeaways from this is that mothers are not being allowed into the JR maternity unit unless they are an emergency or about to deliver. They are not allowed or encouraged to have a relaxed labour in a place of safety, with their partners and ongoing midwife attention - because the JR cannot cope with the number of births they are obliged to accept. There is clear evidence of indefensible systematic negligence. Patient choice has been completely abandoned.

These stories prove how the promises of safe, better childbirth at the JR, since 2016 when Banbury's consultant-led service ended, were false. The reality has resulted in some indescribable experiences for mothers who have been terrified, traumatised and in many cases left with PTSD.

The dossier indicates young, newly qualified midwives are still determined to give a good service. But some others appear pressured and jaded, and are presiding over inhumane treatment. The 50 appalling dossier cases are the tip of a huge iceberg.

Keep the Horton General believes a serious discussion must take place with a view to ensuring redevelopment of the Horton General includes, as promised, space for a return of obstetrics and SCBU with gynaecology. Then Banbury can again share the workload with the JR and offer decent, humane childbirth opportunities to the women of our catchments. We are assured that a team of midwives would immediately return to a reopened Banbury obstetric centre.

Glossary:

Silver Star - a JR unit offering care to about 500 pregnant mothers per year who have serious and rare difficulties e.g. repeated miscarriage, pre-eclampsia, placental bleeding/problems. Women with high blood pressure, diabetes, kidney or heart problems are offered Silver Star care.

MAU - Maternity Assessment Unit

Doppler - Hand held ultrasound (battery operated) used to measure blood flow through blood vessels

Symphysis Pubis Disfunction - unevenness or stiffness of pelvic joints causing pain

Braxton Hicks - birth preparation contractions experienced by women in the latter weeks before childbirth

Level 6 - maternity assessment unit, day assessment, private scans etc

Spires - the JR's 'alongside' midwifery unit

D&C - dilatation and curettage, formerly known as a 'scrape', removes tissue such as incomplete miscarriage from inside the uterus

Stretch and Sweep - midwife or doctor sweeps finger around cervix in a bid to start labour

Episiotomy - An incision made to make the vaginal opening larger for childbirth

Meconium - the baby's first poo, a sticky, thick poo made up of cells, protein, fats and intestinal secretions, like bile

Gas and Air (Nitrous Oxide) - an inhaled gas used as pain medication and with other medications for anaesthesia

Hashimoto's (disease) - an autoimmune disorder affecting the thyroid

Contents

After receiving legal advice Keep the Horton General has redacted the identities of the 50 mothers in this dossier.
Some of the women are happy to release their stories for publication on request

Case 1 - [redacted] - **September 2023** Extremely distressing story about single Mum, humiliated, sent home in labour, disbelieved, deceived about treatment, regained feeling during epidural/C-Section and was ignored while in severe pain, then belittled and mistreated during terrible, 10-day after-birth period. Suffered Post Partum Depression.

Case 2 –[redacted] **- 2023 -** Systemic failures resulted in mum feeling unheard and abandoned. Mum's concerns being ignored, she lost her baby. Uncaring treatment throughout. And the post mortem result confirming the outcome may have been different had the baby been delivered earlier.

Case 3 – [redacted] **- 2021 -**Waters broke at 38 weeks but midwife dismissed it as urine. No testing at HGH 'due to Covid'. Staff missed information about meds and mum told that baby would probably be born fitting, causing immense distress. Induced at 41 weeks at JR. Waters had, indeed, broken. Baby badly injured during process of examining mum.

Case 4 - [redacted] - Mass induction of women, not enough staff, chaotic attempts at managing the births. Women left stranded giving birth on the ward. Stoke Mandeville asked to take some births. Had her baby on Level 6 in a bed without pain relief because they were too busy and she was not believed that she was pushing.

Case 5 - [redacted]Taken ill after good birth at Horton and moved to JR - seriously ill, treated for 'sepsis' but left in busy ward. Pain relief not brought - staff too busy to attend. Tried to discharge self but security barricaded her. Rude staff, bloods taken without protection. Male doctor does internal scan without chaperone - no staff.

Case 6 - [redacted] **- 2021 -** Left emotionally scarred, midwife 'cruelty' on ward, had C-Section, then life-threatening haemorrhage at home, checks had not been made causing this; resulted in two painful scans and emergency operation (again delayed). C-Section incision later found to be opening. Neighbouring bed mother was given morphine, though allergic to it. Dangerous negligence.

Case 7 Anon - Treated for sepsis. This bowel cancer patient was left on a trolley with pyjamas around her ankles. Humiliating. Patient was lost among the large numbers of labouring mothers.

Case 8 Anon - JR missed postpartum pre-eclampsia, compared with Horton care

Case 9 [redacted] - litany of mis-treatment and lack of knowledge about her miscarriages and tragic stillbirth, covering several years. Some terrible indictments on the inadequate service at the JR and lack of facilities at the Horton, impacting on this intelligent but vulnerable young mother.

Case 10 - [redacted] - Appalling disregard of birth plan wishes, used for experiments, loss of contact with twin babies, emotional assault. An horrendous description of **everything wrong with the system**.

Case 11 - [redacted] - wheeled on a wheelchair through the hospital with no trousers or knickers on, bleeding, in pain, to a birthing room; entire labour had been ignored by busy staff.

Case 12 - [redacted] - Baby only born safely because a friend (who is a midwife) attended after several calls for help. Staff at JR had no knowledge of setting up pool - no midwives available.

Case 13 - [redacted] - baby stillborn - born into the toilet at home as JR had sent her home to start induced labour. Op to remove placenta and woke in recovery with newborn babies crying around her.

Case 14 - [redacted] - single mother with heart condition, left to find money for public transport to travel alone to JR after waters broke - in labour. Not treated with any care, left in the bath three hours. Disgusting rudeness by staff. Ridiculed. Requested breastfeeding help but bottles of formula given carelessly. Felt dehumanised.

Case 15 - [redacted] - Appalling treatment post birth, bullied, ridiculed, denied visitors and had to see mother near front doors in bloodied theatre gown post Caesarean Section.

Case 16 - [redacted] - Left five days after being told she needed immediate induction for blood pressure, because of staff shortages.

Case 17 - [redacted] - Discharged with baby, without checks to infant. When done at Horton a trainee doctor dropped her baby on its face.

Case 18 - [redacted] - Sent home on morphine and painkillers when 6 - 7cm dilated. Returned in agony, about to deliver but was pushed through the MAU system and suffered indignity of being made to wait with waters

leaking. So badly delayed, midwives had to remove her clothes while getting her through the hospital to delivery suite.

Case 19 - [redacted] **- 2023** - Miscarriage, fell between two stools with no one to take responsibility for her serious bleeding; shuttled around because no gynaecologists at the Horton. Scan and confirmation of loss by sonographer unkind and reluctant in ward full of pregnant mums. Insensitive

Case 20 - [redacted] **- 2022**- taken in for induction but lack of staff and emergencies in a crammed system delayed delivery and she was then too exhausted to give birth naturally - full forceps delivery was totally unnecessary and traumatic for mother and baby.

Case 21 - [redacted] **- April 2024 -** Got Bell's Palsy during labour, sent home but blue-lighted back - was terrified by doctors' stroke fears, baby born very rapidly, tearing Mum internally who lost nearly 2l blood. Once baby born, total neglect by post natal system, checks not done.

Case 22 [redacted] **-** Taken in for caesarean - doctors debated publicly which of four was most high risk to prioritise! Awful issues with post-birth nurses re feeding, helping mother; rudeness and no compassion. Twin babies' jaundice not picked up, nor son's stomach hernia.

Case 23 - [redacted] Wanted Banbury delivery - not possible because overdue. Had to have forceps because of a failed epidural that doctors were too busy to come and fix, after being asked multiple times by midwife. No bed for hours after birth at JR so forced to sleep on floor or soiled delivery bed. Chose the floor.

Case 24 [redacted] **- 2022** Second birth Horton, which left her in blood soaked clothes, sheets all night, had no hot water bottles for cold caused by shock. Staff were offensive, dismissive and rude.

Case 25 - [redacted] **- 2012 - 2023 -** two emergency transfers to Oxford from the Horton, traumatic journey in labour, only just got there in time, third baby started at Horton with another late stage transfer - very scared. Need for iron had been missed - needed intravenous iron in hospital. Gestational diabetes had been discovered but not told to her.

Case 26 [redacted] **-** JR was 'like a prison', no breastfeeding support - was given a bottle. No chance to socialise - food was awful. Had traumatising miscarriage, children traumatised by her haemorrhaging at home; Horton with no miscarriage/gynae service. Nurse went off shift leaving her lying naked on table. Has had trauma therapy, has PTSD.

Case 27 - [redacted] - had bleed early - JR couldn't do anything for her - couldn't diagnose baby's survival - sent home and Horton stenographer couldn't understand why she was upset that her baby had died.

Case 28 - [redacted] - Not believed she was in labour (first baby). Second pregnancy waters broke, had to carry wet knickers every day to hospital, was not believed. 'It was wee'. After a week, went to JR 'for a swab' and was immediately put on antibiotics as it was waters; was induced within the hour.

Case 29 - [redacted] - Mother's traumatic 2-hour transfer in delivery stage of labour, moved from ambulance to ambulance during rush hour on the A34 dual carriageway after ambulance broke down, in delivery stage.

Case 30 - [redacted] - Reduced to tears by Horton midwives who 'couldn't help' even though it was a 'safe space'. Had gallbladder issues. Felt diminished as a 'mental health' case because she was grieving her mother's death.

Case 31 -[redacted] - Lives in Byfield and huge distance (36 miles) from JR who wanted to send her home. Refused, C-section delivery. Felt disbelieved and refused breastfeeding help.

Case 32 –[redacted] **-**Treated at Banbury and Warwick as no obstetrics at HGH. Uncomfortable journeys involving Mum and partner having to take prolonged time off work. Mixed levels of care through two miscarriages. Diagnosis of extreme anaemia missed, resulting in mum feeling unwell for prolonged period, unnecessarily.

Case 33 – [redacted] **-**Twin pregnancy - travelling (to the JR) a huge challenge. HGH unable to perform blood pressure checks - unacceptable. No continuity of care with midwives.

Case 34 – [redacted] **2014, 2018 -**Extremely favourable delivery in 2014 at HGH - the other a midnight dash to the JR in 2018 involving an immediate delivery, a subsequent infection and tear in stitches.

Case 35 – Anonymous 2022 -Successful delivery at HGH but rushed to JR by ambulance due to serious fever. Two ambulances employed as baby could not travel with mum. Five day stay in JR and prolonged separation from family. Concerned about future pregnancies and being forced to go to JR.

Case 36 – [redacted] **2020 -**Pregnant during Covid, partner an essential worker and older children at home. Mum's family not local, so logistical nightmare going to JR for iron treatment. Ditto for planned C section.

Case 37 [redacted] **2018 -** Fourth child with complications at week 20 requiring JR appointments. Challenging journeys, problems parking, additional expenses plus concern about other children made this particularly stressful

Case 38 – [redacted] **-**Delivered three minutes after arriving at JR. Stressful for all concerned. Fast labours are put in danger.

Case 39 – [redacted] - Mum attended JR because of chance of infection. Spires staff reluctant to allow mum to stay; she delivered within ten minutes. Communication poor between Spires and other departments. Mum stressed by travelling to JR for appointments, family disruption etc. Praised HGH midwives who listened to her and discussed options.

Case 40 - [redacted]**-** Stressful journeys throughout pregnancy, poor aftercare of Caesarean section with medical condition.

Case 41 [redacted] **-** wanted to birth at Horton but threshold for painkillers too high, prolonged and painful labour at JR

Case 42 [redacted]- turned away from JR without inspection, long journey home and had to turn around and go straight back in lots of pain, baby born just after arrival.

Case 43 - [redacted] - Distance, expense, baby born with kidney problems, surly staff.

Case 44 - [redacted] - taken to Oxford with third baby just after downgrade - delivery suite at capacity.

Case 45 [redacted] - Good care but JR is tired and outdated. Problems not getting baby checked at Horton.

Case 46 [redacted]- Not believed, not checked for progress; nurses were rude and dismissive. Disorganised and too many women to give decent care to any new mother.

Case 47 - [redacted] - Three weeks of travelling twice a day from Banbury to Neo-natal Intensive Care to see premature infant.

Case 48 [redacted] -Warwick C-Section and Coventry ITU - no comms between Warwick & Banbury. All patient-delivered info.

Case 49 [redacted] - 2015 - 2020

Mother has had flashbacks after awful experience with added complaints about gas and air running out, urine samples being left for 12-hours - all evidence of over-pressured department.

Case 50 [redacted]- 2022 In the JR with pre-eclampsia but also had Covid. Was treated like a leper, given a commode which wasn't emptied. Disbelieved when in labour, given paracetamol.

IN MOTHERS' OWN WORDS

Case 1 - [redacted] - 2023

Throughout my whole pregnancy my care was amazing as I was seen at the Horton. It wasn't until 35+2 when my waters broke and I had to be seen at the JR that it went downhill. It really ruined my pregnancy and birth experience.

My waters broke at home and I called the Horton. They told me because I wasn't full term I had to call the JR. I called them 3 times in the space of 10 minutes - all while sitting on the toilet crying and scared, thinking I was about to birth my son in my bathroom alone. In the end I called my health visitor who called the JR and got an answer. I was told to go in straight away as it was an 'emergency'.

We got there about 45 minutes later, only to then be left outside the MAU for a further 45 minutes, covered in amniotic fluid and sitting on a drenched towel as no one would answer the door. Finally when someone did I was told I should've knocked or buzzed, which I had been doing the whole time. We got sent to the waiting room with 4 other women in, not once offered a gown or something to clean myself up with.

I'd bought my hospital bag with me which saved me from being a tiny bit less humiliated. We sat in that hot waiting room with no fan in September for another 2 hours. Contractions had started slowly which I told them about, only to be met with 'we're really busy you'll just have to wait'.

After being seen and having to ask 3 times for a gown or another towel, I was taken up to the ward, having to walk steps behind the midwife. She seemed in too much of a rush to let me catch up. In wet knickers, my whole bottom was visible to everyone and anyone and still with dripping fluid down my legs and dragging my suitcase behind.

I spent the night on the ward. I had no sleep - no one's fault, but was told off for having a shower at 10pm. A midwife asked where I was going and wagged her finger in my face when I told her I was going to the toilet. She then said if I was contracting I wasn't allowed to do a poo. Contractions were coming in at 1 every 60-70 minutes so neither me or the midwives were too concerned but being a young mum I was petrified alone by myself in that dark ward.

The following morning on the doctors' rounds was where I had the biggest issue. For my whole pregnancy I had planned a natural water birth and when I asked the doctor if that was still possible she said no. I sat there and cried as my heart was set on that. She looked at me and said 'why are you crying? **You're one of many women who can't get the birth they want, it's not a big deal'**. In that moment it felt like the biggest deal and hearing that while feeling so vulnerable broke my heart.

I self-discharged after that. We were given an induction date for 15/09/2023, 12 days after my waters broke. My son was born 13/09/2023.

The day after was a Wednesday. I was contracting all through Tuesday and that night. By Wednesday morning they had picked up and although they felt more like a period cramp than anything, it was still uncomfortable, I called the MAU for advice and was told that because they weren't so many minutes apart there's nothing they can do and to not 'waste their time as someone else needs their help more than I do'.

They stayed relatively the same until Friday when we decided to head up there instead of calling and after another long wait I was called in where they checked my cervix and I was only 1cm dilated but the contractions were brushed off as Braxton Hicks. We went up again Sunday night as they were definitely getting more intense, the same thing happened except I was sent home knowing I was 3cm and still having 'Braxton Hicks'.

I felt so disheartened. I waited until what everyone thought was too late to actually go back up on Tuesday. The contractions were now 3 minutes apart lasting for a minute so we ended up being blue lighted to the JR and the paramedic was getting everything ready thinking I was going to have my son in the back of the ambulance. On arrival at the JR we were seen swiftly, although had a 30-minute wait in a side room before being taken into delivery.

Most midwives on the delivery ward were lovely and I can't fault their dedication to patients and I had quite a nice time until my son had shifted into my back. After a cervical check and being told I was at 5cm I was given

the ultimatum of an epidural or a C-section. I chose the epidural only to have to wait nearly 2 hours for the guy to arrive and being told every few minutes that he'll be there in 5 minutes. I was adamant I wasn't going to have a C-section but looking back on it I'm sure they knew that's how I was going to give birth. I finally got the epidural around 3am and at 6am I was told I had an hour until I could push, 7am rolled around and I was told to wait until 12.

I couldn't feel anything past my bellybutton at this point and had to have people move my legs around for me. When it got to pushing I had 3 tries before being whisked to theatre for forceps. I couldn't feel anything therefore couldn't push.

In theatre I watched them perform the forceps procedure in the lights overhead and whether it's me or not I'm certain they weren't doing anything except making it look as though they were.

After the failed attempts and being told I needed a C-section there was maybe a 20 minute wait between being told and the surgery actually starting. They took my epidural out when I was being taken into theatre and I never had anything else put back in, I told someone in the room I could feel them poking and prodding about when disinfecting the area, she ignored me.

When I started gaining more feeling back was when they started making the incision, I screamed that I could feel it, I screamed and cried over and over again I could feel it, the same woman who ignored me earlier said nothing but 'hold my hand' and from there the pain only got worse.

I'm certain i passed out multiple times during and no one seemed too bothered, the feeling of them digging around still haunts me 8 months on, I felt them rip the muscle which I can only describe felt like tearing cotton wool only a lot more painful, I felt them cut through the layers of skin and fat, fascia and everything else, I felt them pull my son back out through the vaginal canal where now I could feel where he was and that he was almost out and I felt them sew up all the layers again only for that to be happening having people bombarding me with the baby.

It was so bad I'd thrown up a load of stomach acid (as I hadn't eaten in over 24 hours) which even while being taken to observation was still sitting on my cheek and in my hair.

I asked so many people during the few hours I was in observation to talk to someone about what happened as something didn't feel right, I got to see

someone for them to tell me 'it was my brain playing tricks on me' and that I never felt it, it was my body's way of telling me what was happening to my body.

About an hour after delivery my birthing partner had to leave because of other commitments at home and as a now freshly postpartum mother I found suddenly being alone with a newborn really scary and just wanted someone there. There was a young midwife who stayed with me for about 45 minutes where she washed my face and was trying to get my son to latch and helping harvest some colostrum for him and when she left I felt a lot calmer.

They hadn't given me any water so I'd buzzed for that a few times only for no one to come, I realised after trying to stand to get it myself there was no pad for me to bleed on and I was bleeding straight on to the bed, I'd pulled myself up and held onto the foot of the bed where I had loads of blood fall on to the floor and after the failed attempts at the buzzer I decided to shout when someone arrived I was scolded for making too much noise, a mess. There was no asking what I might need. For the rest of the time in observation I sat alone in the dark just waiting for someone to come and help as I was too scared to ask for it myself as I felt like a burden.

While being taken up to the postnatal ward my catheter was snagged against something and torn out, no one came to put it back in at that point the pain medication had worn off and I couldn't move as I was in excruciating pain, from around 12am to 8am I sat in the same position only moving to care for the baby all while in horrible pain and bursting for the toilet still too worried to buzz for help after what had happened earlier that night.

During the doctor's rounds I was taken to the toilet to sort myself out by a lovely midwife who definitely made me feel better and more confident in asking for help. That day my son was taken down to SCBU. It took them 4 hours to tell me where he was, what was wrong and when I could see him. I didn't see my newborn son for 8 hours that day, the SCBU team was lovely and he spent 27 hours in there for jaundice.

I thought he was dying and when crying to a midwife she said nothing to me except 'don't disturb the other mothers and babies' and that she'll move me somewhere with no babies, I declined her offer to move me.

On our third day I was desperate to get home, I spent 23 hours a day alone in that tiny bay with no natural light or fresh air. I asked the doctor at 8am when I could go home and she looked at me, smiled, let out a small laugh

and said ‘not for a while’. I requested not to see her again as that really hurt me. I saw her every day for the next 7 days where everything she said felt rude and full of spite.

This same doctor when I accidentally tore my cannula out and poked it into my leg, laughed and refused to even look at it, it later got infected and we’d noticed it had poked all the way through into my wrist where I still have the stain from my iron infusion.

By day 5 my son had come off the lights once and back on again, we had been moved bays to one with a window which was great.

Between day 5 and 10 I’d completely shut everyone off and I hardly ate during those last 5 days but as well during those days I had a midwife handle me really roughly when I asked for help adjusting myself on the bed as moving was still hard; another asked me where my son’s Dad was as she’d only seen my parents visit. I told her he just couldn’t make it. She scoffed and said ‘that’s what I thought’. Someone who was helping with breastfeeding told me formula was like poison to babies and would damage his stomach.

I finally felt confident enough to go down to the shop on day 7. A midwife took my son to watch while I went. It took over an hour of me stressing for him to come back. They never told me where he was.

On night 8 my son vomited down my chest and on the bed, I called for help only to be told that they’re too busy and I wasn’t going to get help when at home, and she walked off. Another mother on the ward held my son, changed his clothes and wiped his face while I cleaned myself and the bed up. That same night we were told to quiet down and stay in our bays because we were sat talking in mine at around 1am.

The following night that same midwife from the night before berated me for the previous night and leaving my son in the bay to walk a couple feet to the sink to wash the pump parts.

We went home the evening of day 10 and I can’t fault the team that day and besides the long discharge process it was lovely and the midwives I’d got to know and like we’re amazing at making me feel comfortable and confident going home with my baby.

My experience is definitely one I never wish for myself or anyone else to go through. After birth I suffered badly with Post Partum Depression and I think my experience at hospital may have had a part in that. I feel very

discriminated against. As a young, naive single parent, I feel like a lot of the comments and treatment were because of this I met a woman there about 13 years older than me who I’m still in contact with, whose experience was massively different to mine.

Although I can’t fault the care from some there, I believe many are in the wrong job field or simply do not care enough about the women they’re caring for.

Case 2 [redacted] 2023

My Name is [redacted] and I would like to share my story on losing my son, [redacted], His stillbirth on January 19, 2023, at 1430 hours, shattered my world and left me grappling with a grief so profound it felt like it would never end. But [redacted] passing wasn’t just a tragic event, it was the culmination of a series of systemic failures within the healthcare system that left me feeling abandoned and utterly alone in my darkest hour.

My journey began weeks before [redacted] birth, with complications plaguing my pregnancy from the 34th week onward. A kidney infection, Klebsiella Pneumoniae in the vagina, and dangerously low iron levels left me in and out of the Horton and John Radcliffe, seeking help and reassurance from medical professionals who repeatedly dismissed my concerns.

Despite my intuition telling me something was terribly wrong, doctors reassured me with a refrain that would soon become bitterly ironic: “He is safer inside you than outside of you.” Even though the entire time throughout this time I begged them to get him out of me to prevent an unfortunate outcome.

Then, my worst fears were realised: [redacted] stopped moving altogether. Desperate for help, I called the Horton multiple times, but my cries fell on deaf ears. Left waiting for over 5 hours, feeling utterly helpless, the weight of uncertainty suffocated me with fear and anxiety.

The most agonising moment came when I was left alone in the waiting room, grappling with the uncertainty of my baby’s fate, while the midwife took her lunch break. Most of the midwives simply watched me cry in the scan room, with only one offering any comfort. When the woman who had performed all my previous scans saw, her words were delivered bluntly: “Your baby has died,” devoid of any compassion.

The Horton had told me, at this terrible time, that I would have to provide my own transport as they couldn't facilitate it. Arriving at the John Radcliffe only compounded my sense of despair. Forced to walk through the halls with a dressing gown over my head to hide my grief, I felt invisible, like my pain didn't matter. And when I finally reached Level 7 after waiting to speak to a consultant who never arrived, instead of finding comfort and support, I was met with more waiting and indifference.

The hours stretched into days, each moment filled with anguish and uncertainty. I begged for an emergency C-section, but my pleas were ignored. We had arrived that evening at 1705 hrs and weren't seen until 2330 hrs and I wasn't given medication as they "didn't want to wake you up". At 0653 hrs we still had no result on when this would start. Then at 0718 hrs we were told a doctor was waiting on her bloods. A Midwife came in at 0824 hrs and told us "The doctor is new and doesn't know what she is doing, but the day staff do so she is going to pass over to them and they should be in soon."

Finally at 0850 hrs the doctor arrived with a consent form to get the ball rolling. We didn't arrive at the delivery suite until 21/01/2023 at 2149 hrs. [redacted] was then born on 22/01/2023 at 0646 hrs; two and a half days after finding out he had passed away.

In the delivery suite we were made to sit in a room surrounded by other mothers giving birth and hearing the cries of live babies, as well as having no comforts such as TV or radio - and with the expectation of a 22 hour labour. It was just an empty delivery room where my mother-in-law had to improvise with music from her phone to block out the sounds of other women giving birth.

When [redacted] was finally born, his appearance shocked and devastated me. No one had warned me of the grim reality I would face - he was bleeding from every orifice and skin peeled and raw. The lack of compassion from medical staff only added to my pain.

When we finally mustered up the courage to leave him in the cold cot and go home, when we returned he had bled through his clothes; no Midwife had felt the need to change them anticipating our return to see him again before he was taken for a post mortem.

Even in the aftermath of [redacted] birth, the indignities continued. The responsibility to register his passing fell to my partner, as well as funeral arrangements - another painful reminder of the void left by his absence. Yet, amidst the darkness, there was a glimmer of validation. The Consultant in

Obstetrics and Fetomaternal Medicine accepted liability on behalf of the NHS, acknowledging the profound failures in my care. We did have consent to record this.

When they performed the post mortem they advised that, had I been seen sooner, there was a possibility the outcome may have been different.

But while accountability may offer some measure of closure, it can never fill the hole in my heart where [redacted] presence once was. His memory will forever be etched in my soul. Let this be a reminder of the urgent need for change in our healthcare system. May his legacy inspire compassion, empathy, and a commitment to ensuring that no parent ever has to endure the pain and neglect I experienced.

Case 3 - [redacted] - 2021

I was 38 weeks when I got up and there was a wet patch, so I raised my concerns with my midwife who told me 'I probably wet myself'. I thought hmmm maybe I did… Then I had another sort of gush and I rang up and they told me to go to the Horton.

They didn't even test the fluid but told me again it was probably urine. I mentioned this again to my midwife who just shrugged it off. At the Horton, I got told Covid had stopped them using whatever it is they usually do to test for waters.

I also had problems with my midwife there as well. I planned on having a home birth and she was all for it. She knew my medical history - I had told her the medication I was on (beta blockers) right from the start. She came to my house at 36 weeks to see if it was doable and she asked me again, what medication I was on and I told her again and she didn't say anything.

About an hour later I got a phone call saying, your baby will probably be hypoglycemic and will highly likely have fits when it is born... I just cried and cried. No other information. I then had to do my own research and wean myself off these tablets quite quickly. Apparently that midwife was having marriage issues.

JR (Three weeks later):
I went in to get induced three weeks later at the JR, and [redacted] heart rate was 190. They sent me home and told me to come back the next day for them to break my waters. I shouldn't have gone home with her heart rate being that high. When they went to break my waters they tried so many

times before they realised there weren't any (and hadn't been for three weeks), which resulted in [redacted] having a cut on her head, then she was in neo-natal intensive care (NICU), having lumbar punctures - the lot.

No one told me to go to the JR to be checked after waters breaking once. I had to travel to JR after having [redacted] for her antibiotics which we could have done without after having a Caesarean section.

I had such a terrible time both pregnancies. Apparently I 'fell through the net' with [redacted]. I also had low iron weeks before birth and no one told me. No one had referred me to a consultant for a C-section, nothing. I'm one of the lucky ones though, I can't even bear to think what some of these poor women have been through. It made me so paranoid for my second pregnancy.

Case 4 - [redacted]

My story started on March 6th when we had to travel to the JR for a scan, as my 36 week scan showed the baby was a bit small and the blood flow in the umbilical cord was concerning.

At this appointment it was decided that since I was already 36 weeks +2 days it was best to be induced. So we were booked in for 10.30am Friday, March 8th. Since I was under 37 weeks the induction had to be done in the observation area so we had to wait for a bed to become available.

We waited until 9.30pm that night to be moved down. Once there I had the induction gel and around 12.30am I started getting contractions. I called the midwife who gave me some paracetamol and didn't come back until just after 6am to do the observations she had to do anyway.

On the Saturday day we had a fantastic midwife who was with us when my contractions started again. Once I got to 2cm dilated she spent the whole day calling the delivery suite for them to break my waters and get the labour moving. Due to being short staffed, this did not happen. Instead I got moved back up to level 6 at around midnight. Luckily my contractions did stop.

Due to lack of staff the communication was non-existent. I saw an assistant to do my observations every 4 hours and a midwife twice a day to observe the baby. No one could tell me when I would have my waters broken - just that there were **lots of women in labour and not enough midwives to safely deliver my baby**.

The whole ward had all been induced and left at 2cm. Some were higher risk than I and some had been there longer than I had. I had three breakdowns while in the hospital and was sick every day. On Tuesday, March 12th we had my morning observation and was waiting for the midwife to come. By 12.20pm we decided we would not wait anymore after asking repeatedly to be seen as I was so upset and went to go see my first born (at home) for the afternoon.

It took until 4pm for the midwife to ring to see where I was and if I was even coming back. On the way back I started getting slight twinges in my belly. On return at 6pm I was told that Stoke Mandeville Hospital had said they would accept some of the inductions, but this had been hours earlier so they didn't know if they would still take me.

After 5 days of the unknown I said I would go. I didn't get this chance as the baby's heart rate dropped and took a while to come back up. I was then told I was number one priority to go to the delivery suite. By 7.30pm I had gone into labour on my own; by 9.30pm my waters broke. I was still in the room on level 6 with no signs of being moved to delivery anytime soon.

By this point the contractions were coming thick and fast and the midwife was struggling to monitor the baby as I was in so much pain I wouldn't lie on the bed. At around 11pm I was being moved to delivery but baby had other ideas and I was pushing her out in the corridor on the way to the lift. I was told I didn't need to push and just needed to poo. After being told the same when I had my son, I ignored them. We were rushed back to the room where at 23.07pm my baby girl was born - still on level 6, no pain relief offered due to not being able to move to the delivery suite due to **lack of staff**.

The lady in the room next to me **delivered on the ward as well** at some point before I did the same evening. I delivered the placenta in the delivery suite. I was moved up to the maternity ward level 5 at around 4am. I had my observations taken and was left till around 6am. I had baby's head-to-toe check on Wednesday the 13th and realised my daughter's red book was missing. It soon came to light that none of the women in the bay had their red books either.

This ward was also extremely short staffed in the time I was there meaning I only ever saw anyone when I needed observations or the baby needed to be checked. **Every other lady in the bay had had a C-section** so it seemed.

I was left hours at a time still suffering sickness. On a number of occasions I asked for pain killers that never came. It took me 7 hours to be discharged

on Friday, March 15th because **there was only one midwife to 12-14 patients** - she physically couldn't get to my paperwork.

I hadn't had any observations done since the Wednesday. We were just there for the baby to be observed yet she was discharged 5 hours before I was.

All in all, my story doesn't sound as horrendous as the ones in the Banbury Guardian article but to us it was a terrible time. To be told it was safer to induce me at 36+4 then to leave her in and then be left for 5 days worrying if she is okay, to then have her at 37+1, which if we had waited till 37 I could have just been induced on level 6 which may have taken some time off of our week long stay.

To be told there is something wrong with my baby and have no communication, no reassurance and constantly told they are short staffed and haven't got enough midwives to deliver safely made me regret my decision.

I was determined I did not want to go to the JR after what I thought was not a great experience with my son two and a half years earlier. But at the 36 week scan the baby was small so I didn't have a choice. Luckily for me, myself and baby are both home and well other than her being a tiny 4lb 11oz she is healthy. This could have been so much worse. We spoke with other people on the ward and my partner spoke to many dads with the same stories as ours.

Case 5 [redacted] - December 27th, 2018

After labour starting slowly on Christmas day 2018, we finally had our baby girl at the Horton on December 27th at 3am. The birth was great at the Horton. The midwives were professional, caring and supportive. We had a lovely water birth, the midwife was so reassuring we managed another birth with just gas and air. We were discharged later that day after all the checks had been completed and all was well.

Unfortunately, later that evening I began to feel unwell. Fever and excruciating abdominal pain. I self-medicated with paracetamol and Ibuprofen and slept as much as I could between feeds and enjoying my other 2 children.

The following day the midwife visited and advised I needed blood tests and to be seen by the GP. The GP visited within the hour and with a call to the JR they advised me to be seen. Home to pack the baby's and my stuff and say goodbye to the children.

I arrived at the JR within 2 hours of the referral, given it's an hour's drive away. Notes collected, urine sample done, I was placed in a side room. After 2-3 hours of being in that room, a midwife/nurse finally came in to take some bloods.

I had been advised not to take any pain medication beforehand as they may want to give me something different at the hospital. I was in agony. Asked for some pain relief whilst the nurse/midwife was there, she advised she would be back with some.

It got to 8 hours of being in the room and no one came back. Partner went off to find someone, to be told that someone would come when they were free. I was in that much pain and now with an excruciating headache, I sent partner to the car to get me some pain relief I had in the car. Took those but it didn't touch the pain.

Finally, someone came to take me to the ward - still no pain relief, over every single bump, no information on what was happening. They placed me in the middle of a bright noisy ward with lots of screaming babies. I buried my head under the pillow, I felt that bad. Luckily my baby was well behaved and my partner very supportive. 1-2 hrs passed and a midwife came.

She ripped the pillow off my head and just stood there staring at me without a word. I couldn't take much more so I discharged myself. They tried to barricade the doors, tried to get security to keep me in and then tried to guilt trip my partner into keeping me in by telling him that if I went home, he would need to call me an ambulance, so it was his job to talk me into staying. The way I saw it, I would be more comfortable at home as they hadn't given me any medication anyway.

I did need to go back the following day as I wasn't better. I called Warwick hospital first to see if they would see me; I really didn't want to go back to the JR, but I was advised because the JR had my blue notes, I needed to go back there.

On arrival, I was met by a rude midwife. I got placed in that same room again and told to wait whilst they found my notes from the day before. After 1-2 hours a nurse/midwife came to place me on intravenous fluids.

She didn't wear gloves; she didn't prep the skin and failed the first attempt. She did advise that my infection markers were really really high so I needed some fluids and antibiotics. She ran freezing cold fluids through the back of

my hand that fast it hurt, then proceeded to shove stingy antibiotics through.

I was given some morphine and taken to a crazy busy ward. No one really kept me up to date with what was happening. The plan for my treatment changed every time a different doctor came on shift. The midwives were rude, they were short staffed and didn't keep up to date with medications so my antibiotics were late, my pain relief would wear off, my temperature would shoot up and I would be back to feeling so awful I would have to press the buzzer, where I was made to feel I was being a nuisance until they did my observations etc. They would then say "oh gosh that's high, you must feel poorly". This continued for 3 days.

Abdominal scans hadn't revealed anything. The antibiotics had brought down my infection markers slightly but not a huge amount. The late evening of day 3, I was exhausted from no sleep on the ward (my baby still well behaved). I was advised I needed another ultrasound. I got walked round by a male doctor who advised me he needed to insert the probe into my cervix but there wasn't a chaperone available so I would basically have to deal with it. He wasn't overly comforting and he really wasn't gentle with the probe and hurt me. I asked him to stop.

Day 4, a midwife who had been on shift, rushed off her feet 3 days prior, came back on shift and told me I looked awful and moved me to a side room so I could get some sleep. I took advantage of her being nice and tried to get answers as to what they were treating me for as it still was not clear to me and no one could tell me. She advised they were treating me for sepsis because they didn't know what was going on, but this was the first I had heard of it.

Day 5 came, and I'd had enough. I was feeling much better and less painful so I asked to go home. They were vile in their response and said they were that busy they didn't know if they had time to get all my oral medications ready for me to be discharged. Hours and hours later I ended up getting discharged but had to go and collect my own medication to be able to go home.

Overall a hideous stay and to avoid ending back in the JR as an older mum, I chose to have my 4th baby (born November 2023) in Warwick Hospital.

Case 6, [redacted]

After relocating in the summer of 2021 from Surrey already 12 weeks pregnant I was hoping to be able to have my child at the Horton. Due to

complications in the latter stages of my pregnancy I was booked into the JR for planned C-section. The surgery went 'well', however the after care on the ward was terrible and left me emotionally scarred.

The midwife on duty for the 2 evenings I was admitted for was just so cruel. If that couldn't get any worse after being discharged a week later I suffered an almighty (life threatening) haemorrhage at home with my son in my arms and had to be rushed back into the JR. After 5 failed attempts to take my blood and an extremely painful (no pain meds offered) abdominal scan right where my incision was, the doctor could see that my uterus had not retracted.

They explained that this should have been checked before being discharged and meant I'd need more surgery and was readmitted. The next day I was scanned again (ouch) to check that they didn't leave placenta behind (great) and they put me on the list for surgery. Doctor said I was ok to have something to eat as I hadn't eaten for the last 24 hours, then a few hours later another doctor came to see me and said my surgery had to be postponed because I had 1 slice of toast.

I had to wait till 8pm that night where my partner and brand new son came to see me to bring me home as the doctor said I could go home after surgery. By the time I was operated on and came back it was too late and they sent my partner home. I had to stay another night and eventually discharged on Mother's Day.

Throughout this ordeal they didn't even see that my incision had slightly re opened and I had to go into my GP's every other day for the next week for my dressing to be tended to to avoid further infections,

Another point to mention was the lady opposite me in the ward was given morphine even though she was allergic and for the 48 hours we were first admitted after childbirth, was so sick she couldn't keep any food down and was very unwell. My heart went out to her as she was trying to learn to breastfeed in between being so unwell. This meant at times she had 2 nurses attending to her which I understand, but then I was left for hours without pain medication and wasn't mobilised properly until 2am after being on the ward since 5pm.

Case 7 - Anon - September 2017

Pregnant as a first time mum. After having had four stretch-and-sweeps at the Horton - we were advised to go home and wait. We rang for information

and reassurance as not having experienced labour before, I believed what I was going through was 'normal labour'.

We were finally told to come into the Horton which was eerily quiet and dark, where we were taken into a labour bay to be assessed and told because I had signs such as not being able to urinate, shaking and a high temperature, we were being transferred to John Radlciffe straight away as I had suspected infection.

We had to leave the car (and baby seat) at The Horton and climb into the ambulance - blue lights all the way, in the winds of a storm (all the more terrifying for a first time mum in labour) to Oxford late at night.

Anxiety was at an all time high on this journey with fears and thoughts totally overshadowing what should be a memorable experience.

I was then treated for Sepsis during labour and birth and which I was only informed of on discharge, having had to organise a lift home with family members bringing over our car and the forever increasing costs for petrol and parking, not only for ourselves but for family too.

Although I appreciate the care we had with the midwives in labour, I can only say I feel for the staff. Having heard horror stories of mums being left in wheelchairs, mums being left alone after birth and even one mum having to lay on the floor due to the high number of patients in maternity at the John Radcliffe, I was terrified from start to finish.

Unfortunately in my second pregnancy in December 2021 I was diagnosed with bowel cancer. Whilst a plan was completed between colorectal consultants and obstetricians on how best to ensure a safe arrival of my baby girl and safety of myself, every meeting, every baby question, every scan, every hospital admission for pregnancy was straight to the John Radcliffe.

One memory that sticks out for me is, having been examined on an admission for pain, I was left on the bed with my pyjamas around my ankles as the doctor was called off elsewhere - left there alone, terrified, in floods of tears, unaware of what was happening to me and physically unable to pull these pyjamas back up. If I was able to receive support from the Horton through this trauma it may have offered some ease with an already very difficult situation.

It's just not an ideal situation for any mum to have to travel all the time both physically and financially, I can only hope by sharing a snippet of our

experience it can help pave the way for a more positive birth story for future families.

Case 8 - Anon

When I had my youngest back in 2019 the birth was smooth and the midwife I had was wonderful. However, as any new mum with another little one at home, I just wanted to get home and be there for when she woke, so when they let me go a few hours later I thought 'great'.

That being said they failed to do final observations on me such as blood pressure etc and sent me on my way... The following morning I had an unexpected visit from my midwife to check all was OK with baby. It was just on the off chance that she asked to take my blood pressure (she also states they don't usually check mums). It turned out my blood pressure was sky high and I had to travel to the JR immediately for further tests.

After getting to the JR with a newborn, leaving my 4-year-old at home, and moving from room to room taking different dose tablets I was told I had dangerously high blood pressure and was suffering from postpartum preeclampsia.

The JR care wasn't great. I completely missed a meal as they hadn't explained the process of having to tick boxes on a random piece of paper that was left on the table under the water jug. They also didn't really check in. I was also left with dirty sheets and when needing to use the toilet I didn't feel as though I could ask someone to sit with the baby and wouldn't leave her, so ended up holding it in until I had a visitor.

Horton (prior to 2016 downgrade) was completely different. I couldn't fault them, especially being a first time mum.

Amazing midwife, baby born healthy, they checked me out after, I had an erratic heart so they said they would keep an eye and get an opinion from a doctor as to whether I could go home. They advised I stay the night, which I did. I was taken up to the unit upstairs. I had a whole bay to myself as I was the only person that had given birth. They allowed my partner to stay way past visiting time; they had the baby in the office with them so I could sleep and brought her back to me when she needed a feed. They supported me with my breastfeeding. I woke late the following morning so missed breakfast but they then brought it to me. I couldn't fault them at all! Totally different experience!

Case 9 - [redacted] - 2017/18 - 2022
In 2017 I attended the Horton for a 12-week scan which diagnosed a missed miscarriage. I was seen to quickly, the decision on what steps to take were totally in my hands and I was supported with my decision for expectant management in the hope things would happen by themselves.

Approx 4-5 weeks after the baby had died still nothing had happened and so due to weeks of contractions I decided the best option was surgical management. The procedure was carried out 2 days after my decision was made, I was looked after in a comfortable and homely ward where my husband was able to drop me off and pick me up once ready just a few hours later. Knowing I was close to home, friends and family made the experience that bit easier. Something that sounds so simple but was not possible at the JR…

In 2018 I had my second pregnancy, discovering in January I was expecting I was obviously nervous due to my previous experience. A day before my 12 week scan was due and I lost a lot of blood. I went to my GP who checked me over and it was decided between the GP and scan department at the Horton that as my scan was scheduled for the next day and they were full I would wait until then.

Not ideal with not knowing what was happening for 24 hours but obviously there wasn't the space or enough staff there to see me.

The following day I attended and it was confirmed there was a heart beat and I was 12 weeks pregnant. Now it seemed between 12 - 16 weeks there was a grey area over which department was willing to see you. I had light bleeding most days but was told not much would be done in that time as Oxford would see you from 16 weeks - but no one was really interested before then unless the bleeding was excessive so we booked for a private scan for some reassurance.

At 16 weeks I was seen at the MAU in Oxford after calling the midwife unit linked to my doctors – Chipping Norton, which is over half an hour's drive from my house.

So from then on more or less every week, **sometimes twice a week with every fresh bleed I had to be seen at the JR as there's no one at Banbury to do this**. Basically any issue during pregnancy now you have to be seen in Oxford. No one was apparently able to check my blood pressure and bleeding in Banbury…

This meant on one occasion a work colleague having to leave work to drive me all the way to Oxford and drop me off and then for me (still bleeding) to make my way home on public transport which is one bus to Summertown, then wait for another to Adderbury, my nearest stop, which took well over an hour.

Some weeks I was kept in for a night or two - a lot of the time because they were concerned about my distance from the hospital. This meant I saw my husband for around half an hour to an hour each day at around 8pm. Due to his hours, the distance and the traffic it was very difficult for him to visit which was upsetting for him as well as distressing for me, spending that much time alone. Unfortunately, all too often, the men get forgotten about. This is their unborn child too at risk and it makes them feel so helpless being so far away. That could have been eased. as well as being able to see my family, if I was closer to home.

So the weeks went on and when I got to 22 weeks I was staying in again on one of the hottest days of the year (there's not much in the way of air con for those who feel the heat most).

At this point I had missed a lot of work as each visit would require half a day to a day off work, and on around 4 or 5 occasions I had to stay for a couple of nights. We spent a LOT of money on fuel and parking (working out below) and we lost money from my husband's wages when he was needed for transport.

I was feeling pretty low but still hopeful and desperately holding on. One of the consultants I saw said if the bleeding was minimal, as it hadn't stopped the whole pregnancy, I didn't need to return until around 25-26 weeks as 'nothing could be done until then'.

Fast forward a few weeks and I attended my 25 week check on the afternoon of July 2nd which was done by an elderly male locum doctor at my practice. He was insistent on vigorously moving my stomach around to tell me which way the baby was laying despite me telling him I'd had bleeding and pain in pregnancy. I felt very weird afterwards and even mentioned this to my colleagues when I arrived back at work and I believe this to be the initial cause of my large blood clot and placenta abruption that led to the death of my baby.

I awoke and called MAU at the JR at 1am on the morning of Wednesday, July 4th. My waters had broken. The midwife who took my call deliberated for a few moments and said she wondered about sending an ambulance but thought we would probably get there in the same time, as there was no

traffic on the road at that time. She seemed to sense more urgency than the doctor I saw upon my arrival.

As soon as we pulled up I was taken to the delivery suite and was checked over straight away by 4 or 5 people who were discussing how busy they were and who they had left to attend to me. I lost a very large blood clot whilst there and I was scanned which showed there were still some waters around our baby and her heartbeat still present. I was given a first dose of steroids. Once all tests had been done the doctor said she wasn't sure what would happen but was hopeful.

It was at 3.15am that I was put on the observation ward and was told there were no rooms and my husband had to go home. No observations were carried out for the rest of the night and **I was not hooked up to any sort of device to monitor the baby's heart rate – this was a fatal mistake**.

At 7.30 am I woke and ate some breakfast and hadn't felt much kicking which normally followed eating. I hadn't seen any nurses or doctors all through breakfast time so I had to ask the catering staff to go and find a nurse for me. I asked her to listen in and it turns out she was a midwife support worker, she was lovely, but lacking the knowledge on how to handle the situation.

It took a long time to complete this request as there didn't seem to be a simple Doppler available with working batteries- she kept disappearing to try another. Once it was found she listened in and struggled locating the heart beat. My baby was often in the same place so I directed her to it. The midwife came to help and she too struggled to locate it.

Finally a doctor was called and there at my bedside, alone, **next to a woman and her newborn baby in the next bay, I received the news our baby girl had died**.

My world fell apart and I couldn't take in what was being said. I was just silent, surrounded by strangers at the worst moment of my life.

I won't forget the support I received from the caring midwife at that time but I also won't forget having to make that phone call to my husband, 30 miles away and worse, due to it being rush hour, he would be over 2 hours. It still haunts me that my husband had to drive all that way to get to me on just a couple of hours' sleep with that news. I was terrified he'd have an accident.

The most upsetting was him contacting me, distressed and worried, from the queue for the car park. Of all the things you have to think about when visiting a hospital for many reasons. You then have a queue before you can reach your loved ones inside. Why this hasn't been addressed, successfully, infuriates me.

It took 6 hours after the heartbreaking news to be given a bed on a ward, as the one I was in as I mentioned before was next to a lady and her newborn and opposite a heavily pregnant lady. I was then moved up to level 6 in a private room on the antenatal ward as I was **told level 7 (the ward for mothers whose babies died) was closed due to staff shortages**.

I was told my pulse was low and to drink plenty of water whilst downstairs so I asked for a jug of water on arrival (a very hot day) It took 4 calls on my buzzer and an hour and 45 minutes to get that jug of water due to those staff shortages.

My husband was able to stay with me that night as the room had a fold out bed. But the next day, due to the nature of his work (farmer), he had to go and do a few hours in the morning and returned at around 4pm that day.
Again, around 3 hours of the day was spent travelling and parking. My parents were also able to visit that day for the first time out of my hospital stays, as my dad was off work so could drive himself and my mum over.

Our daughter was born peacefully on the Thursday night with an amazing bereavement midwife called [redacted]. Unfortunately, I had a retained placenta after an hour which had to be removed under GA in the operating theatre - again something common, which a large town like Banbury should be able to provide at the Horton rather than requiring a transfer. I couldn't imagine anything worse, during or after giving birth, than having to then travel in an ambulance.

I was told I would be able to complete my daughter [redacted] paperwork there at the JR on the Friday (the following morning) with the head of bereavement care who was working that day, but she didn't come to see me for whatever reason so I never did meet her when that was promised.

I kept asking about the paperwork side of things and the response was mostly a 'we'll see'. So we left with some leaflets and boxes without our baby girl on the Monday morning. I had to call the registry office myself to make an appointment to register our baby's birth and death. When we met with the registrar in Banbury council offices she was quite annoyed and appalled that the hospital hadn't arranged all this for us.

In 2019 I fell pregnant with my now 4-year-old daughter. This pregnancy fortunately had a happy ending but it was not without problems and lots of stress emotionally due to previous loss and ongoing grieving, financially (from having to go part time at work due to appointments) and physically due to having SPD (pelvic girdle pain). I struggled to walk and drive in the third trimester which made getting to Oxford incredibly traumatic due to pain and the distance I had to walk even from the bus stop to the women's centre.

I was also sent away with a baby who quite clearly had jaundice and was made to go into hospital (either Horton or Chipping Norton) for jaundice tests every 3 days for weeks afterwards - they never once treated her with the light therapy just kept pricking her feet and creating extra stress and upheaval which tarnished the first few precious weeks.

In 2022 I fell pregnant again however I knew that because my hyperemesis symptoms (I have this with each pregnancy) had eased slightly, that something was wrong. I mentioned this to my midwife at my surgery and that I wanted an early scan and she brushed it off saying everything would be fine. I then had to pay £90 and travel around 30 miles to a private clinic to have a scan to diagnose what I knew had happened – a miscarriage.

I was then referred to the Horton who did apologise that I'd had to do that but again, too little, too late. I opted again to have a D&C procedure as my miscarriage wasn't passing naturally. I was told on the day of surgery at the Horton that I was first on the list so I didn't have sips of water. I then kept being bumped back and back. Because I'd fasted and had no water since the night before I developed a migraine mid-afternoon. I was in so much pain I had to have fluid through an iv drip and I was finally sent to theatre around 5.30pm, after which I was able to receive some pain relief.

More recently I fell pregnant in my 'last attempt for a sibling for our daughter'. I was quickly given medication to support this pregnancy but at around 6 weeks I started excessively bleeding, losing large clots and feeling very dizzy and this lasted for a week where I couldn't leave the house. I went to Horton A&E as was advised due to the amount of blood loss to attend here. Upon arrival they first asked 'why I was there if I was pregnant' as they don't have a gynae doctor. I replied, 'because I'm losing lots of blood very quickly as well as having racing heartbeat'! They ran a few tests and decided I needed to have a simple speculum exam. But because this needed to be done by a gynaecologist they transferred me via ambulance to the JR – all that expense for an exam!

No one was available at the JR to scan me to confirm if miscarriage had happened as it was Saturday tea time so I was told to go home and come back first thing Monday morning.
I was scanned on Monday morning and the sonographer said there were still clots present but also still a baby with a heartbeat. I had to wait on the gynae ward to meet with what I thought was a doctor but it was a nurse.

She also told me to continue taking aspirin as the amount I was taking 'wouldn't affect the bleeding'. I wasn't convinced by this so I emailed my consultant who disagreed with her and said yes stop taking until bleeding settles. It calmed down a little but not completely and around 10 days later I had excessive bleeding again with very large clots. On February 14th I attended A&E at the JR on advice from my consultant as you have to be triaged there and moved to gynae. I did have to explain to the A&E team why I was there instead of maternity/gynae and of the process - that they needed to triage me first and then transfer into the gynae ward.

I was moved to the gynae ward around 10.45 and by that time I was having labour contractions which I made A&E aware of. All I had was the paracetamol I'd brought with me to take the edge off the pain. I told the gynae ward of my pain, however nothing was available or offered to me. I was then kept waiting for hours in a chair in the triage area before being seen by a doctor around 2pm. I was asking again about a scan to see what was happening and I was told they only have 3 slots available a day and they had no space for me.

So after spending an entire day in what is supposed to be a pioneering, world-class super-hospital – no one could tell me if my baby was alive or dead. At one stage **the doctor was leaning on a portable ultrasound machine while talking to me and despite being the on-ward gynaecologist she wasn't trained to use it!** I asked the doctor what my HCG levels were on the bloods taken and she said they hadn't been requested by A&E but she would request them retrospectively.

Around 3pm I was finally given some medication to help with the contractions – I asked to go and get some food as I hadn't eaten since 6am and wasn't offered anything on the ward. I came back and checked if the HCG test had been done so I didn't need to do another blood test before leaving. 'Yes they had been requested'. Before going home to rest until the scan the next day, I asked for some help with pain – I was given some codeine with no advice. That night I had lots of pain so I took some codeine – this made me extremely sick, as I was still taking anti-sickness medication for hyperemesis (Odansetron). I went to take one of these but thought maybe I should check online first and it transpired these drugs conflict with

one another and can likely cause adverse reactions including vomiting and hallucinations. **Why did no one mention this when they knew what medication I was taking**?!

I attended the Horton the next day as I fortunately had a scan appointment already scheduled. A miscarriage was confirmed and luckily I needed no further treatment. I felt like during this whole pregnancy I had to talk every member of staff through what the routine was and what tests they should run – I even had to say to them about a urine sample as they hadn't asked for one- very basic!

This whole process and every other pregnancy could have been made so much easier and likely cost the NHS less money if all appointments and treatments were available at the Horton General Hospital.

- Why are hundreds of pregnant women forced to travel to the JR when just a few consultants could travel to Banbury?
- Why are services deliberately being sabotaged to make the attendance figures lower? For example someone I know sees a gynaecologist who happily travels from Oxford to Banbury to do a clinic but her appointments are always booked too close together so as not to allow enough travel time. Either those organising are completely oblivious to the travel situation or this is done deliberately. I suspect the latter as I have also been informed that now, Brackley area residents who call 111 are now sent to Daventry even when asking for the Horton. Why is that?
- Why, when the Banbury unit was closed in 2016 due to staff shortages in the JR, did the director of midwifery (at the time) Rosalie Wright make the thoughtless statement that women had 'chosen' to give birth in Oxford. This is not a choice, this is an involuntary route that families with any sort of problems, medical issues, worries or concerns have to take.
- Each visit to John Radcliffe (of which I've had a lot!) has ranged from 45 mins to over 2 hours in total, due to traffic and queuing for parking. It's so distressing and unsettling that we have no consultant-led antenatal care in Banbury and services are continuously being dwindled. For a constantly growing town, why is our healthcare and subsequently our lives being compromised?
- At a time when a woman is at her most anxious anyway, why do you knowingly increase her stress levels, which we know can affect the health and growth of the baby as well as the gestation?

I wonder already how many lives this has cost unknowingly from non-driving or pregnant mothers struggling financially, or anyone else pushing concerns

to the back of their minds as they are not confident enough or able to afford to make that awful journey to Oxford.

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We worked out in 2018 alone, we spent 15 times – approx £260 in fuel and parking as well as wages lost from my husband which is hard to calculate but definitely a great deal more.

I can't work out if this is a twisted attempt at population control, a political move from a party who can't stand that the NHS was originally a Labour policy, civil servants on a power trip with the NHS or just complete incompetence and lack of compassion from both higher management and political leaders.

Case 10 - [redacted] - 2018

I gave birth to my twins on December 3rd 2018 at the JR. I had a terrible experience.

Throughout my pregnancy, apart from one quick scan, all of my appointments were at the Horton General Hospital where I was always given the best care and had no issues whatsoever. I met with numerous people including a specialist from the JR who had nothing but great things to say, including that the twin team at the JR were excellent and she couldn't be prouder. I went to the JR the morning I went into labour full of hope and assurances and was hugely betrayed.

When I first arrived they were helpful over the phone instructing us to go around the traffic and allowed us to park right at the doors and (aside from a panicked drive from Banbury) I was relieved to be there. I was moved to a bleak room between two corridors with no window. There was nothing in there besides the bed, monitors, a kneeling pad, two hard chairs, a radiator propped on its side, hanging off the wall and a shelf with a radio attached to it with a bicycle lock.

I had very bad symphysis pubis dysfunction through the end of my pregnancy so lying on my back was a no go. I wanted to stay active and upright during labour. I was not offered a gown. I opted to have two thigh injections at separate points so ended up vomiting a lot (had to keep asking for a sick bowl and fresh water as the midwives were always in the corner of

the room writing on a pad). [redacted], the midwife was was the best of them but still didn't give the support I needed until the very end when she tried to stop the doctor intervening.

After moving into the new room [redacted] took a break and a new woman called [redacted] took over. All she did was keep moving stuff. She took my kneeling pad which I was using on the floor with my arms on the bed, she then raised the bed up and told me to stand when I was happy and comfortable where I was. As if constant monitors strapped around my stomach wasn't uncomfortable enough, I was then told I needed internal monitoring as Twin 1 kept losing signal.

I had this reattached several times which was very uncomfortable and made it hard to move around. The doctor came in and said Twin 1's monitor hadn't been picking up anything even though it was showing in my room. **When I was fully dilated I was told I had to wait two hours before pushing,** they said 'we will push at 7 o'clock'. I was made to have a catheter inserted as apparently I must pee before pushing. I did pee in a bowl first but they said it didn't look like enough. After they did this I had cystitis like pain on top of everything else.

When it was time to push I was on all fours on the bed leaning over the top. The cannula started coming out of my hand (a good centimetre). A woman tried to push it back in so I cried out and told her to stop. She pulled it out and went to put cotton wool over it but blood was going everywhere and said I had to have another put in. They made my husband hold the cotton wool over my bleeding hand while someone else grabbed my other hand to put a new cannula in. They said it went wrong so then put it in at my inner elbow joint.

While all this was happening the doctor wanted me on my back. I was sitting on one of my legs with neither arm free having full blown contractions. I told them I didn't want to be on my back. At this point I started to cry and my husband cried too. I was forced on my back against my wishes as the doctor said she must examine me. She stuck her hand inside with no care for me at all in the middle of a contraction and I cried out in pain. This is one of the memories that will stay with me for life. I was completely helpless and unable to stop them.

She then decided I needed to continue to labour in theatre just in case. She talked at me very quickly and due to her accent I couldn't understand what she was saying to me. [redacted] argued that I was fine and said pushing had been going well. Twin 1s heart rate had only dipped briefly and she could see her head coming down. They didn't listen to her. My mum and husband had

both been **witness to people saying the monitoring equipment was actually faulty.** Throughout all of this there was no let up between contractions, they had been very intense and constant from not long after arriving at the JR. My husband was distressed too and tried to fight my corner as they were arguing over me instead of looking after me.

I was wheeled across into theatre on the understanding that I would be continuing to push as normal and that my husband would be allowed through in just a moment. The doctor appeared and talked at me again, I don't know what she said but she gave me a form to sign. I remember seeing something written on a white board on the far wall, something like 'trial instrumental delivery' but it was already written on there when I was wheeled in so I didn't pay any notice at the time.

They then told me I needed a spinal which was something I was very scared of and didn't want to have. The anaesthetist came in and was very friendly and tried to reassure me things would be ok. The only way I can describe how I felt after this was that I had given up. By the time they let my husband back in I was numb from the chest down, flat on my back and he was as confused as I was. Loads of people started to come in even though I had asked for no students etc. The **new people all argued with each other across me** just like the previous people had. I begged [redacted] to stay with me as she was the only person that seemed to care by this point and she did. I remember her saying she was so so sorry this had happened to me.

When my baby girl was born (Twin 1) they dumped her on my stomach facing away from me so I couldn't see her. I only remember touching the top of her head covered in hair. Another memory that breaks my heart, why didn't they show me my baby. I was flat on my back, one arm outstretched to the side due to the cannula at my elbow joint. I actually had to grab it a couple of times as it slipped down and was tugging out from my arm. They took [redacted], wrapped her up and gave her to my husband. I couldn't see her as I was too low down.

They all argued about hurrying Twin 2 with more hormones even though his heart rate was fine and there were no issues. Delayed cord clamping was something I felt really strongly about. I heard a young man say 'erm that was about a minute' very shortly after my boy (Twin 2) was born. It didn't seem like they waited at all. I didn't get to see him. They took him and wrapped him up. I didn't even see the umbilical cord or the placenta for either. Even after 8 hours in labour I would have taken the rest of the pain to push my babies out as I wanted to instead of on my back like a vegetable but I was robbed of all of that.

I had to ask afterwards if I had torn at all at which point they told me they had to make a 'small cut' and were going to stitch it up. An episiotomy is one thing I **explicitly did not want and I was not asked before they made that decision**. There was no indication of there being an emergency delivery but **they used forceps and cut me without asking**. So much happened that does not make sense. **I believe they used a slight alleged dip in my daughter's heart rate (if it wasn't down to faulty equipment) to hurry my labour along to suit them and to give their students training**.

I was wheeled off to the ward after laying for ages being stitched up. The ward was noisy and I could hardly move as I was still numb from the waist down. The cannula in my elbow meant I couldn't really bend my right arm and if I did it set off a monitor beeping more than normal. On the same arm I had a finger monitor and my other arm had a blood pressure band round which was timed to keep going off. It was an awful struggle trying to see the babies or do anything really as I was tangled with wires.

The following morning around 10am after no sleep I was told they would move me to a room (at the time I thought that was a great thing) but the room was tiny and boiling hot with windows that didn't stay open. From this point I was pretty much abandoned. They left me to it. I had to keep the cannula in 'just in case' so every time I bent my arm it hurt and the cannula started to come out a little as it was taped so badly. I could hardly sit due to pain from the episiotomy so I was left in this tiny room sweating, frantically trying to express breast milk into syringes whilst keeping the babies settled. I am a first time mum so this would have all been scary and new even without everything else.

When pressing the buzzer it took 20 minutes for someone to come and all they cared about was breastfeeding, they gave me no other help. The lady who had first shown me to the room had said there were loads of staff on that day yet clearly nobody cared.

A lady brought food in on a tray at one point but I couldn't look at it as I had to express what I could and look after the babies. She came back in ages later and asked if I had finished.

I told her I'd not had a chance to even touch it yet - she said ok put it in the kitchen when you're done. Later in the day I managed to get someone to bring me a little bowl of food although they forgot to give me cutlery so I had to wait another 10 minutes and then had to inhale it as one of the babies was crying again by that point. I didn't get the next lot of food as I

didn't realise there had been a form on the first tray to order dinner with. I got given a horrible sandwich eventually later in the day after a lot of hassle. I called a bell again later as I was struggling so much. The first lady said she would get someone, 20 minutes later a lady came in with a knitted boob to lecture me on breastfeeding and was no help at all.

I told the main midwife [redacted] when she eventually showed her face that I was sick of it and wanted to go home. She said she wanted me to stay until I establish breastfeeding. I did not want to stay in this hot room where nobody helped me. My husband finally arrived back and we entered into a constant battle back and forth to get discharged.

The midwives were stalling us intentionally and said we had to wait until staff changed to the night shift as the paperwork would take so long. Around 10pm we started prepping the babies to leave. A lady came in and went through a bunch of leaflets telling us what each was about as if we couldn't read (although nothing to tell me how to care for the episiotomy wound). Then she said she had to go and print something off. We went to reception after another short frustrated wait and saw she was sitting in a room with the door open, the computer on the main screen, no document even opened.She then actually printed the document off so that we could leave. Nobody spoke to me about after-care for me as the mother who had just been through what I had. I was given no pain relief, the only thing they gave me were injections to prevent blood clots.

I finally showered late that night when we got home and almost had a panic attack in the shower, I couldn't breathe.

A few days after I came home my stitches opened up and I was left with a gaping wound. There's no real way to describe day to day life looking after newborn twins with an open episiotomy wound but it was excruciating, walking, sitting, going to the toilet, everything, and after numerous people checking it and a few different courses of antibiotics for infections it healed, sort of over about three months of suffering. I also had intense abdominal pains which I was given Naproxen for and had scans to investigate, these did not go until 7 months postpartum and I'm told may be a result of internal injury. This combined massively took away from enjoying my babies, it made it difficult to get much joy out of anything. Nine months on I am a week post operation to refashion my episiotomy (still has slightly opened up again so I may need another operation).

I would like to look on the day my babies were born with happiness and love but all I can think of is the mistreatment and pain. I can never get those memories back or get rid of the terrible ones I have been left with.

Case 11 -

I had my first daughter in 2021, a low risk pregnancy but under a mental health midwife due to anxiety.

At 41+2 I went to the John Radcliffe with constant pain in my abdomen. I was told it was a urine infection and possibly slow labour; I was also meant to be induced this day. Because of these factors I was admitted to level 6 of the women's centre at 7am and I was given paracetamol which I threw up. I told a midwife I didn't want to be induced today as I didn't want to be in pain in labour with this 'urine infection'. My blood pressure was checked every few hours but other than that I was left in the room for around 12 hours, on my own (Covid restrictions applied).

I had asked to be examined twice whilst I was there but was told no, as I 'didn't look like I was in labour'. I think I knew I was experiencing labour as I was calling the pain 'waves' - these were contractions but they were in my back.

In the evening I started to haemorrhage and pressed the call button for help, no one came, so I had to walk out to alert a midwife and show her my tissues.

She popped me on a monitor and told me she'd watch from the other room. Having to lay still and at this point in a huge amount of pain I called the button again and a different midwife came in and took one look at me and said 'do you know you're bleeding through your trousers' to which I said 'yes I need help'.

It was at this point she had to call other midwives in and take my trousers off so she could have a look. She decided not to look as it could have done 'more damage' and they were so busy it was likely there were no labour rooms.

It escalated very quickly and I was wheeled on a wheelchair through the hospital with no trousers or knickers on, bleeding, in pain, to a birthing room where I was examined and told it was time to push, I could only have gas and air and my birthing plan to give birth on Spires went out the window.

I had to call my partner and tell him to get here as soon as he could. He made it just in time for her to be born.

The OUH maternity statistics that are shared every month showed me that my baby was born on the day in April that they had the most births.

I genuinely believe midwives were reluctant to check me because they knew if they did they would have found I was in active labour and there were no rooms or enough staff for me. Only when it turned into an emergency was I taken seriously.

I'm not sure if this treatment was due to lack of staff but I had laboured on my own, with no support from a midwife or a birthing partner, and wasn't listened to on numerous occasions.

Due to my experience and fear of haemorrhaging again I decided to have my second born at the JR too but my midwife at the Horton really pushed for me to have my baby at the Horton. In hindsight both my labours would have had to be at the JR due to PROM (premature rupture of membranes) with my second and the haemorrhage with my first, but if the Horton was an option to deal with cases like these I would have birthed there as I genuinely believe JR cannot cope supporting Oxfordshire.

Case 12 - [redacted] - 2022

I would like to share my story with you on the way I was treated at the JR and for my midwife to get recognition for the exceptional care she provided

The way I was treated by staff at the JR was not acceptable. They are overworked and understaffed because of local hospitals being downgraded to midwife-led.

I think it really needs reconsidering for the Horton and other local hospitals to be upgraded for the safety of mothers and babies. I will be emailing [redacted]'s managers to make them aware of her exceptional care. I have also nominated her for the Daisy Award of recognition. I will also be making the JR aware of their failed duty of care. I have emailed Victoria Prentis MP and I have also emailed this to you. I want as many people as possible to hear about my story.

On February 14th 2022 I started to get contractions coming regularly so I rang Chipping Norton birth centre at 1.39pm to get some advice as they are local to me and this is where my midwife is based. I was advised to call the JR MAU as this is where I needed to deliver.

When I called the MAU at 2pm they asked for my contact details and that they will get someone to call me back. They failed to ask me what the

reason for calling was or my address.. I feel this is very important for them to know as people could be travelling 5mins or 40+mins - which was the case for me - and waiting for a call back may be too late. It took them till 5pm to return my call, but at this point I was already at the JR.

As I didn't seem to be getting any advice from the JR I decided to call the ambulance for advice around 2.30pm.

The operator was fantastic and stayed on the line, spoke to me and my partner through everything until she could get an ambulance dispatched. It took till 4pm to arrive.

Things started to progress really quickly whilst waiting for an ambulance to arrive and whilst talking to them, my waters broke around 3.30pm. I panicked as I needed someone at home with us in case this baby was about to come. So I decided to get my partner to call the on-call midwife. Again they said they would get someone to call back at this point we were still waiting for an ambulance to be dispatched.

After my waters broke I really needed a professional to be with me in case the baby came. I then decided to ring my midwife, [redacted] on her personal number (as I knew her before being assigned my midwife). She said she wasn't at work and was at home but she said she would leave home straight away.

Within 5 minutes [redacted] arrived shortly following the ambulance crew. [redacted] had brought all the equipment she needed, but unfortunately for her she was in her home clothes.

She didn't hang around - straight away she did an examination to see how far dilated I was and she said that I was 3cm dilated and if we wanted to go to the JR, we needed to leave right away.

At that moment she realised she had left her phone at home rushing to my house. She called Chipping Norton birth centre from my phone to let them know that she was doing a transfer to the JR.

On arrival at the JR a staff member from MAU was at the door. She asked who we were and if we still needed to go to MAU. [redacted] advised we would be going straight to delivery.

On arrival at the pool room on the delivery suite [redacted] asked the staff to help set the room up and they advised that unfortunately they didn't have any midwives available to relieve [redacted].

The staff in the room at the time had absolutely no idea how to set the room up. They didn't know how to work the bed and it had to be changed for another one. They didn't know how to dim the lights or work any of the equipment in the room. They didnt know how to set the temperature for the pool, the lady filling it made it way too cold for a baby to be born in and when my partner questioned it she said that's the temperature we always do it and the lady before had it at that temperature.

When [redacted] checked, she said it was way too cold and asked if they had a thermometer. They said they didn't have one. Eventually the room was set up ready.

[redacted] wasn't once relieved after a number of times asking just to change into some uniform. At one point **they said they were too short staffed and that Trudy didn't need another midwife present until the baby's head was out.**

I am disgusted with the way [redacted] was treated by staff when she wasn't even supposed to be working. She went above and beyond to make sure everything went smoothly and the way I wanted my birth.

If [redacted] wasn't available I could have had my baby at home.

If I had left it any longer I could have delivered her at home and unfortunately whilst in hospital I lost 900 ml of blood after birth. If this had happened at home it could have been fatal.

I could have had the ambulance crew delivering my baby if [redacted] hadn't been there. I probably wouldn't have even had the pool in time and may have not even had a midwife available for when my baby was coming.

Case 13 - [redacted]

On March 4th, I rang the JR to say I was bleeding. They asked me if I had intercourse or anything that could have caused this as it could be normal. I told them no and this isn't normal. I've not bled in my pregnancy previously.

They advised I travel to the JR from Banbury to be checked within 2 hours. I had to call my husband from work and when I got there I sat around in a waiting room for over an hour and then was called in. The midwife said she couldn't find the heartbeat with a Doppler so went and got a scanner.

She couldn't find a heart beat so called a doctor to confirm. The doctor said 'I'm sorry' and explained what happens next. He said 'it's about moving forward now' after telling me my baby's dead.

I took a tablet (to bring on birth) and was expected to come back on Wednesday to give birth to the baby. We drove home. As I was driving home my waters broke and I gave birth on the toilet at home (the hospital didn't check my cervix or anything just took blood and gave me a tablet, I could've already been in labour).

I rang the JR and said my waters have broken. They told me to phone an ambulance and stay on the line. My husband rang an ambulance and they arrived about 10 - 15 mins later. I was bleeding a lot. They had to help me off the toilet as I was shaking and couldn't stand. They put me on a stretcher and into the ambulance. They said they couldn't remove anything so left the baby laying between my legs.

I bled so much I passed out in the ambulance and got blue lighted to the JR. When I arrived everyone looked in shock. I got rushed into theatre shortly after arriving as my placenta hadn't come out and they couldn't remove it whilst I was awake as the doctor couldn't find it and it was hurting too much.

I came round from theatre on the delivery suite to crying babies. **Yet my dead baby was in a cold cot next to me**; it was like it was a dream. They were doing observations every half an hour. They got me up and sat me on a chair and I passed out again a few hours later.

I didn't get taken to the bereavement ward until the next morning, despite pleading to go to a different ward. When I was on the **bereavement ward the room was swarming with flies**, The midwife said "we've reported it but they keep coming back".

The doctor recommended I have an iron infusion but I would have to go back onto the delivery suite so I refused. They tried taking blood twice and in the end said there was no point if I'd refused the infusion. I left with blood thinners and iron tablets.

There was no compassion. The midwife asked to come round the next day but I didn't want anyone round. I received a parking fine, despite the midwife saying they'd reimburse our parking.

When I emailed them not long ago they claimed they hadn't been able to contact me as they were missing a digit off my mobile number, despite my

number being on my NHS record and no one having a problem contacting me before.

I had a blood test the other week and it's still low. I didn't have a blood transfusion despite me losing a lot of blood! And I've just been given more iron tablets and told to come back in 2 weeks for another blood test. Honestly the worst experience of my life!

Case 14 [redacted]

My waters broke around 3am. I rang the JR and informed them I had no way of getting to hospital as I didn't have money at that time or car; my pregnancy was high risk due to my heart condition.

The lady laughed at me and said 'this isn't a taxi service'. I managed to borrow money a couple hours later and travelled by train and bus to the JR at peak hours, standing the entire time because it was so packed. Once I got there I was told I came too early and they attempted to send me home. I explained I had no way of going back at the moment.

They graciously agreed to keep me - with a lot of eye rolling. I was in pain all day. Any attempts to speak to nurses or ask any questions (my first pregnancy and I was all alone too) I was told each time to go back to my room and that they are too busy to talk to me.

I saw a doctor once for around 1 minute during that day. Around 12am the following night I was in so much pain I informed nurses I would go into the bathroom to have a warm bath. I went there and fell asleep in the bath full of water, and woke up 3 hours later. No-one had noticed I was gone this entire time - I could have drowned and they wouldn't have known.

They got me into the delivery room around noon. I was tended to by a middle aged nurse. I've spent my fair share of time in hospitals and when she went to put IV in my left arm I told her my right arm had better veins to which she said: "I know how to do my job - I don't need a child to tell me how to do it". She put the needle in 6 different places in my left arm, failing each time, and blamed me because I was so anxious my veins were 'hiding'.

She stormed off in a huff and a younger nurse arrived. She was absolutely lovely and the only person who showed me any sort of kindness or compassion during the whole ordeal. She listened to me and got IV in my right arm on the first attempt.

I was then left alone in the room for about an hour. I was in horrible pain, my labour was full on. I was still alone, unable to get help. A bunch of people came into the room and told me it was time for an epidural. At the same time my partner joined us. I was exhausted, shaking and when they went in with the needle I started to cry out and was having a panic attack to which a male doctor said "**don't be a cry baby it's not that bad**". And how would he know?

I don't remember the rest that well. My mind blocked out a lot. I remember someone called me a drama queen. Around 4pm my daughter was born. I was taken to a private room and about 2 hrs later, after my partner and I asked repeatedly, someone came with a menu (at that point I hadn't had anything to eat in over 24hrs).

After the birth I spent a few days in hospital as my daughter was slightly jaundiced. I asked for help with breastfeeding several times, to which I had a couple of bottles of ready formula tossed on my bed.

Next day (second day after my daughter was born) a breastfeeding specialist came to me and tried to adjust latching a few times as my daughter still wasn't feeding right. I was told it was my fault again because I was too anxious. My partner had to leave the previous day for his two final shifts before his parental leave kicked in. So again I was on my own.

I ran out of nappies and asked nurses if I could have some because I wouldn't have any until my partner came the next day. They gave me 2 nappies and told me 'this isn't a charity'. I also hadn't been able to shower at all during that time even though I was getting itchy and uncomfortable.

I had no one to leave my baby with for that time and nurses refused to help. I know this probably isn't the worst story, but it was to me, and I have been through some messed up stuff in my life... I never felt so lonely, scared and dehumanised as I did during that time.

I felt like I was not wanted there and like my labour was a big inconvenience to everyone involved. Hearing stories of ladies who give birth at Horton (not high risk pregnancies) makes me feel that I missed out on an amazing experience and gained a lot of trauma.

Just these few days at JR made me decide to never have another child again. I don't want to go through this again and just writing about it and reliving it makes me sick to my stomach and brings tears to my eyes - and it was 7 years ago.

I also attended therapy after that as I developed slight PTSD due to the whole ordeal and had problems bonding with my daughter.

I want Horton to go back to its full glory. I never had a negative experience with Horton, and their care of me throughout pregnancy was top notch. I don't want other mums to feel this way in time that should be precious. I don't want them and their babies put in danger like I was.

Case 15 - [redacted] - 2023

On November 1st 2023 I was booked into the John Radcliffe Maternity Unit for a Caesarean section. I was under Silver Star, and had all my midwife appointments at the Horton General Hospital. Up until this day, I had no complaints about how I was treated, and every single member of staff was so kind, patient, informative and supportive. I'd like to give a special mention to [redacted] here from the Horton midwife team. She helped me through my pregnancy step by step and was just amazing.

I turned up at the JR at 8am (slightly late due to traffic) and got booked in straight away. The entire surgical team for my Caesarean were just spot on, I was quite emotional and scared, and everybody did their best to help me. Another special mention to the anaesthetist who went above and beyond to settle me, that woman deserves an award - she was just amazing at her job. The actual procedure went really well; I was treated with respect and dignity and I was really very pleased. So a big thank you.

I was then moved to the observation unit, where after a short time I sent my partner home. The lady looking after me was spot on, but I do have a complaint. The sun was shining through the window (I was right next to the window) and I was covered in sweat, I had asked for a fan to be told that they had none. I was given tea and toast, which I did vomit back up unfortunately due to being far too hot, and it was at this point a second lady (who was covering the first lady's break) realised that there was a fan behind my head the whole time (I couldn't see this as still unable to move due to anaesthetic). Once the fan was on, I was completely fine. It was both these ladies who told me that it would be ok for a friend to bring more formula to the hospital that evening due to not bringing enough with me.

The trouble really started when a nurse from floor 5 came to collect me to take me upstairs. She told me that I'd be unable to have any further visitors due to Covid regulations coming back in where you were only allowed 2 visitors (and the same 2 visitors) for the entirety of your stay. Now my friend was due to bring her adult daughter with her, so whilst I understand the rules, I was very upset to only have been told them whilst being taken up to

floor 5, when I had asked every team I had met so far. I had phoned the maternity unit the day before to check visiting times and not one person had told me this. My mum was due to visit me the morning of the 2nd - travelling 2.5 hours to do so - and I was being told that neither my friend nor mum were allowed to visit or come onto the unit.

I needed formula, so I stayed in the wheelchair, with a hospital gown on with my back exposed, sat on an Inca sheet, catheter on my lap - quite honestly covered in blood - whilst holding my hours old newborn baby, when I was taken down the the waiting area on level 2 by the main doors to the outside world.

I sat there for half an hour with my friend whilst I cried, because I didn't want to go back upstairs because the nurses were extremely rude and abrupt and I felt scared.

When I went back upstairs I had asked for a quick shower, but I didn't understand what I was supposed to do with my baby, as I was told that they wouldn't keep an eye on him, but the shower room was apparently too small to bring him in in his cot. So I washed myself with wet wipes (no new knickers or maternity pads on at this point still) and I had asked if it was ok to get some food. I was given dinner at 21.40, bearing in mind that I'd arrived at 08.00 that morning and had vomited the tea and toast. I was exhausted, hungry and really upset by this point.

The night team was phenomenal, they did their regular checks, asked if I needed anything, they did as much as they could to make me feel ok after seeing how distressed I was at what had happened with the day shift.

The next morning I had my catheter removed at 6am, but the nurse forgot to remove my cannula at the same time. My baby had a hearing test and we then went for a full check up at 8am. I had still asked for my mum to visit me, as at this point, after everything I had been through with surgery, and then the upset of the night before, I quite frankly just wanted my mum.

Unfortunately for me, the same day team was on duty, and I had heard myself in handover one nurse tell the others that I had had my 2 visitors (despite neither my partner or friend setting foot onto floor 5 unit) and that I was expecting my mum but she was not allowed to set foot onto the unit.

I told my mum to wait by the lifts and I would ask someone to help me in a wheelchair and baby in cot and we would sit downstairs again in the draughty hallway by the front door. A lovely nurse took me down (after watching another nurse point at my mum and say to her: you, out! - when

my mum was let on to the unit by a nurse!). She said I had 2 hours until my next check, and would I like her to come and get me. I said yes please, but she did forget me - or she got caught up with another patient - so my mum took me back upstairs after 3 hours, just to be told that she could wheel me back to my bed but then she had to leave straight away.

Once mum had gone, I had asked the nurse ([redacted]) who came to do some observations, if it was possible to have some pain relief (as I was due) and if I could have my cannula removed. She said yes, and she would have to get what she needed and be right back, but she didn't come back. Over the next 4 hours I rang my call bell for pain relief and had 3 other different nurses come to tell me that they would be right back with it and nobody came back.

[redacted] came back after 4 hours and apologised profusely, she had got stuck with another patient (completely understandable - And [redacted] was very kind and apologetic), but she gave me what I needed and removed the cannula, she even apologised for how the other nurses were treating me and how they treated my mum, she had said that if she had seen my mum first she would've let her in to my bedside as I had had no visitors onto the unit. She promised me she would from that point be in charge of getting my medication and discharge papers, and she did everything she could for me. So to her I say a big thank you.

It would also be worth noting the following points:

- another lady on the unit had 6 visitors at 1 time and was offered to go to a family room.
- the lady in the bed next to me had 3 adult visitors at 1 time and a young child that was screaming whilst playing and rolling around on the floor under the curtain and kept knocking my baby's cot and they wouldn't listen when I had asked them just to keep an eye on him. The midwife/nurse that almost tripped over him didn't speak to the family to ask them to keep an eye on him despite me asking her to.

- During the 4 hours of no pain relief, I was in a lot of pain. My bed didn't go up and down very easily (control at end of bed not near me) and my baby's cot didn't lower, so I was having to stand up to pick him up to sit back down and vice versa to put him back in the cot.
- I was shouted at in front of a large number of people for carrying my baby - when I wasn't told not to, but also please remember that the night before I had been allowed to hold him whilst I was wheeled downstairs to floor 2 for half an hour. I also was told to hold him whilst I went from the observation unit to floor 5.

- the lady in the bed opposite me was a friend I knew from living in the same area. She informed me that when I had gone downstairs with my mum, there was a very loud discussion between the day team, where they were saying: it's not normal these days to have visitors when you have a baby, [redacted] is going to bring Covid onto the unit and bring down the entire workforce amongst other things.

As a vulnerable female with hormones all over the place, just had surgery and left in charge of a newborn baby, imagine how lonely and distressed I felt. I had asked for help with my baby - I had never even held one before let alone changed a nappy! But I wasn't given help, I wasn't reassured and I do not believe that I was treated with respect and dignity during my stay.

Case 16 - [redacted] - 2022

I visited my community midwife on September 13th, 2022 for a stretch and sweep. During this appointment, my blood pressure was found to be extremely high and my legs and feet were swollen to the point I had to wear my husband's size 11 shoes.

I was sent to the JR Maternity Assessment Unit as Banbury couldn't see me due to me already being a high risk pregnancy (having had gestational diabetes with my first child).

My first child was 23 months at this point and had never been away from me. We waited approx 3 hours to be seen at MAU, to then be told I had preeclampsia and I had to be induced within 24 hours due to the risk to my unborn child.

Understandably I was frightened and scared. I was taken to a ward. My husband wasn't allowed to stay with me; he went home to Brackley (quite a distance). That night on the ward a lady opposite me began to give birth; they eventually moved her as she started pushing.

The next day I was told they were short-staffed on delivery suite and I couldn't be induced until a room was free. I was very worried at this point as I had been told I needed to be induced within 24 hours. I was told I wasn't allowed to leave the ward and as a result only my husband could visit. I wasn't allowed to see my 23-month-old son as children weren't allowed on the ward and I wasn't allowed outside the ward - not even to the cafe to see my son for a little while.

I ended up staying on that ward for 5 days waiting to be induced. I was repeatedly told they were short-staffed and there was nowhere for me to be induced. During my time on the ward a lady next to me began to give birth in the ward toilet after being told there was no room for her down on delivery suite. Eventually they took her down as well, but only at the point she was pushing.

I spent 5 days on the ward crying, missing my son, only to not actually be induced. I went into spontaneous labour on the 18th, and had to ring my husband to come in quickly. He made it in time, just as I was being taken to delivery suite.

My son's birth was quick, with no complications to baby. However, once the placenta had come out I looked at it and knew something wasn't right as it looked small and incomplete. I asked the midwife if it was all there and I was told yes it was.

I stayed overnight with baby and on the morning of the 19th I got up to shower, only to feel like I needed to push - like baby was crowning. I went into the bathroom and pushed out what I now know was retained placenta, it was the size of two fists and I was so frightened.

I rang the emergency buzzer and a midwife came and quickly whipped it away and told me to take a seat. This midwife eventually came back and explained that I had retained placenta and that my placenta had been noted as being incomplete after my birth. I hadn't been told this, I'd been told it was complete.

I was then put on antibiotics as the risk of infection was high. I continued to pass pieces of placenta for 4 weeks post partum. There was no after-care by the midwives as to what I needed to do for my retained placenta. I went to my GP 3 times, and eventually was sent for a scan which luckily showed no infection and that I had thankfully passed all the placenta naturally. I was told I should have had a scan while at the JR after passing the retained placenta so that they could see if any more was present.

It was a horrible experience, not being able to see my son for 5 days, and watching women go into active labour to the point they were pushing on a ward of 6 people. There was no dignity or privacy and the staff were openly saying they were tired and short staffed.

Case 17 -[redacted] - 2023

I had my second daughter in September 2023 at the JR and we were required to go to the Horton a day and a half later for her muscle and hearing checks, as for some reason no one was able to visit me at home, despite the fact I'd just given birth.

When we arrived at the Horton we had no idea where to go, no one was in the maternity reception area and we had to find a midwife to guide us to where we needed to go. We got taken in to see the doctor and there was a trainee doctor in there with him. We are all for the training of NHS staff and helping to be a part of that with a couple of our family members being nurses themselves, so we were more than happy to be a part of her training.

However, it turned out she had no idea on how to hold a baby. She picked up our 2 day old newborn baby first without supporting her neck, then turned her over to check her back muscles and dropped her on her face. The doctor awkwardly laughed as I comforted my baby.

Thankfully my daughter was OK despite tears and unnecessary trauma. My partner and I were very shaken up by it and utterly baffled that a person of care for infants who was training with actual newborn babies had absolutely no idea how to handle one.

After this we were then told hearing checks couldn't happen and that we had to wait to see a midwife. We had to wait in the corridor for quite some time then the midwife led us into a bay which had evidently become an office, a desk in one corner with chairs in front of it, and unused beds shoved to the other side of the room with torn posters left on the walls. It was very much like being in an abandoned hospital. I really felt for the lovely midwife we spoke to, having to work in such a sad and tired environment.

It's such a shame because when I had my first daughter there, 8 years ago, it was a wonderful place. My only complaint from my experience with my first is that while I was recovering and having to stay in hospital, no one told me where the food was or when it was ready!

The Horton needs so much support and the JR shouldn't have to support such a vast area on its own. Especially as half of the people I know who have had children in the last few years, have ended up giving birth in cars or ambulances as the journey to the JR is too far and the Horton cannot facilitate them.

Case 18 -[redacted] - 2023

When I had my son in December 2023. My contractions were very painful to the point where I was very uncomfortable and really had to concentrate on my breathing. I got sent to the JR and they didn't check dilation. They gave me morphine, codeine and paracetamol all at once and sent me home!

I could still feel the pain and I told them yet they still sent me home. That was at around 4am. The next morning I woke up to a very painful contraction that broke my waters. I was crying from the pain of my contractions so my partner called the JR and they told me to come in. This was 4 hours after they sent me home. When I got there I was screaming and crying from pain and couldn't walk and they still made me go to the MAU instead of the delivery suite and made me do a wee sample. I came out of the bathroom screaming as I felt like I was pushing and there was a lot of blood.

They then still made me go and wait in an MAU room where I was pouring out with waters and blood and tried to assess me! Before they could try and assess me I started pushing they then rushed me to delivery suite while I was half naked; meanwhile they took my clothes off all the way through the hospital.

When I got there I was already 10cm and started pushing. I had my boy at 12:17pm, so 4 hours after my waters broke and 2-3 hours after I got there. I had a healthy baby, he was okay and I was okay but they told me I got to around 8-9cm at home!! This made me believe I was around 6-7cm 4 hours before my waters broke at the JR, when they gave me morphine and other drugs to go home with.

I was dilated enough to stay in hospital where they could have kept an eye on me and baby. This traumatised me and I wish the doctors checked for dilation when I first went in.

I may be 18 but that doesn't mean I don't know my body and my baby. The ladies who helped me deliver my baby were amazing and very helpful and so kind. I wish I knew their names. But this was my experience with the JR.

Case 19 -[redacted] - July 2023

I found out via private scan I had a missed miscarriage; my baby had died inside me and the Horton wanted me to wait a number of days before they would see me to scan and confirm this. My body felt like a tomb for my now lifeless baby.

I rang the JR in tears explaining the situation and that I really didn't want to wait due to my mental health at the time. They said they would contact the Horton on my behalf. The Horton rang shortly afterwards with an appointment 'because of a cancellation' and I didn't have to wait as long. They confirmed the loss at the Horton, gave me my options and I went with Medical Management.

A week after my medical management, I was suffering a large amount of bleeding as my body was not passing this naturally. I went to the Horton where A&E told me it wasn't an emergency and sent me to their out of hours (despite being told previously if this happened to go straight to A&E) . Out of Hours told me this was an emergency and sent me back to A&E.

I felt so poorly from the blood loss. In A&E they didn't check my bleeding or pads once, pumped me with various meds and said they weren't sure what they had to do as they didn't have a gynecologist on site. They rang the JR for advice and because I 'wasn't pregnant' anymore I couldn't get support from the maternity ward.

They sent me home still feeling so unwell and losing a lot of blood and told me if it didn't stop to go the JR. Despite the meds, the bleeding actually got worse, I went up to the JR leaking through two large pads and five layers of clothing within 20 minutes. Within 5 minutes I was seen by a gynecologist, the baby was stuck in my cervix causing me to haemorrhage. If I hadn't gone to the JR that night I could have died.

I had to go for a scan a few weeks later at the Horton to confirm the remaining pregnancy tissue had passed. However after losing my baby I was waiting in a room full of pregnant women with their bumps and blue notes which was heartbreaking, and because my pregnancy test was 'negative' the sonographer didn't want to scan me.

The midwife/nurse said to the woman the orders to scan have come from the JR, to which **the sonographer said 'I suppose I'm going to have to then'** as if I'm an inconvenience to her; this was in a room full of people.

I had just lost my baby and my mental health was in an awful place, this was so upsetting.. I reported this treatment to the midwives who said they will feed it back to the sonographer.

This whole experience was very traumatic and has taken its toll on me even now. It is so important that the Horton is given the funding and facilities to deal with situations like this. Women's lives should not be put at risk due to

cuts and lack of funding, especially with Banbury being an ever growing area, this is needed more than ever.

Case 20 -[redacted] - 2022

"I was admitted to the JR on Wednesday 30th November 2022, as I was nine days overdue with my first baby (I'd miscarried twice previously). I'd been asked to arrive at 9pm for an induction. Once I'd arrived, I was assessed on a ward and then told later that evening that there was no one on shift that could induce me, and I would have to wait until early the next morning. Thankfully, my husband was allowed to stay, and we were shown to a small private room with a bed for me and a pull-out bed for him.

The following morning, I was induced at around 9am and told to walk around the hospital as much as possible. By 3pm, my contractions were manageable, but regular and quite painful. They had escalated to the point that I needed pain management by late afternoon. At around 6pm, I was told I was ready to go down to delivery to have my waters broken.

We were then given a room in delivery, settled in and talked through the process of having my waters broken. It was only then that I was told someone else had arrived who needed the room more urgently than me and – due to staff shortages – I'd need to go back upstairs. To say I was devastated would be an understatement. I was already 10 days past my due date, in a lot of pain and – as a first-time mum – absolutely terrified. I'd geared myself up to finally have my baby and then told I'd have to wait even longer.

I was wheeled back upstairs (at this stage, my contractions were every few minutes and painful enough that I couldn't walk) and sent straight back to the room that I had just left, which was no larger than around 10 ft by 10 ft.

The next 14 hours passed by in a blur. The only pain management I was given was paracetamol every four hours which did very little to help. I was physically sick with exhaustion, and unable to speak or eat.

By 6am the following morning (2nd December), I could no longer bear the pain and, for the third time, begged to be taken to delivery. Finally, a bed was available, and I was wheeled down once more.

The rest of that day passed in a blur. Our midwife, [redacted], was wonderful. I couldn't have asked for a better support through the rest of our labour experience, and I felt some comfort in the fact that, whilst I couldn't have the water birth I'd hoped for, a natural birth may still be on the cards for me.

I was finally given some pain medication – an injection – and used gas and air to support through the contractions.

By mid-afternoon though, the baby's heart rate had dropped, and my contractions were slowing down – I was no longer feeling the urge to push. Despite several specialists coming into the room to support and advise [redacted] around next steps – and encouraging me to push as much as I could – my body just couldn't handle any more after more than 24 hours of an exhausting and emotionally draining labour.

I was told then that I would need to have an epidural and go to theatre, for a potential forceps delivery and, if that didn't work, a Caesarean section.

The water birth I had wished for during my six months of weekly hypnobirthing classes slipping away from me with every harrowing minute that I had to endure. All I could think was that my body would give up before I gave birth to my baby – as someone who had suffered two miscarriages previously, this in itself was more than any parents-to-be should have to handle. My poor husband, who hadn't been given access to food or a shower for more than 24 hours, struggled to keep it together for us both. Overnight, my waters broke – I was alone in a bathroom at the time.

By 6am the following morning (2nd December), I could no longer bear the pain and, for the third time, begged to be taken to delivery. Finally, a bed was available, and I was wheeled down once more.

I was wheeled to theatre and met by an extraordinary team – in fact, the anaesthesiologist, [redacted], had supported my sister to deliver a baby boy (also called [redacted]) in the same theatre eight days before. Once there, I was given an epidural and prepared for one final push before I would need to undergo a C-section. Thankfully, our little boy was born, and no more medical intervention was needed.

All-in-all, whilst I can't fault the care and support I was given by the people at the John Radcliffe, the delay in my active labour caused by a lack of staff caused an unspeakable level of trauma for myself and my husband.

It is only now, 18 months later, that I can speak about my experience – in hopes that I can help make sure that other first-time mums, especially those who have lost pregnancies, never have to experience what I did.

My husband and I have been so affected by the experience that we're scared to have more children. If I am lucky enough to plan for another labour in the future, I will be looking into Warwick Hospital for my next birthing experience.

Case 21 - [redacted] - April 2024

I was overdue by 11 days and was booked in on April 14th to be induced. We arrived at the hospital around 10am where we sat in the waiting room for around 2 hours. I was then taken to the ward for observations. There was only one midwife on duty so everything was very slow. I was finally checked around 1pm and told that I was 3cm dilated, that it was too late for the gel (induction hormones) but a candidate now for them to break my waters.

We waited on the ward until around 5pm when we got moved to a private room. We were told they may not get to induce me that day and we would have to 'wait and see'. We stayed the night barely getting any sleep and no signs of induction beginning.

The next morning we were told we could go home as we weren't likely to be seen today either. I told them I had a headache and a twitchy eye. The midwife did my observations and my blood pressure was raised. She took bloods to rule out preeclampsia. We had to wait another 2 hrs for results before we could go home. They came back fine.

We were told we would be called if a spot became available or to just come back Wednesday - which would make me 14 days overdue. I can't understand why they couldn't have just sent us home the night before. At least we would have been well rested.

On the drive home to Banbury I noticed my eye wouldn't close. We got home and rang 111 who sent an ambulance which took us straight back up to JR A&E where I had scans and bloods. Specialists and midwives all came to see me; it was very scary as they kept talking about strokes. I was absolutely terrified at this point and burst into tears.

We spent the next 6-8 hours in A&E deciding what was best for me and the baby. Finally at midnight we went to the delivery suite to be induced, finally. I had to go with a patch over my eye and now a very droopy face. The midwife was so good; she got us some water, made us comfortable and offered my partner a place to sleep for a bit, as we felt like we had been up for about 48hrs.

I didn’t feel confident giving birth at this point; the midwife managed to keep me calm, she checked me and decided it was time to break my waters. When my water broke she noticed baby had a poo in the sac but she didn’t appear too concerned.

Within a few hours, I felt the urge to push. The midwife said ‘we are not at that stage yet, it must just be bad contractions’. She checked me and within what felt like seconds, my daughter arrived very quickly and tore me very badly. I then didn’t stop bleeding and lost 1700 ml of blood. I was rushed to theatre and still to this day, I am unsure what had actually happened and what caused it. I was given no information.

I woke up on the ward with my partner and new baby by my side. I could barely stay awake. All I wanted was to hold her but I didn’t have the strength. My partner rested her next me so I could see her.

My daughter was meant to have 12 hr check but had one check just after she was born. I was meant to be observed every 2 hours and had 3 checks.

I had asked for my catheter to be removed and wanted to try and walk. I was told I needed to stay in bed and couldn’t get up. I had also asked for the steroids I was prescribed for my Bell’s Palsy. We were very tired and upset. By 6pm as nobody was bothering to check on us, we decided we could rest and recuperate better at home, so discharged ourselves. We were advised not to but we hadn’t seen anyone for hours.

I only got my steroids on discharge, even though I had been asking for them for 12 hrs. I have a son so we had arranged for my sister to have him overnight - but it turned into 3 nights. That son was born six years previously at the JR and I couldn’t fault them. This experience is one I never wish to go through again.

Case 22 - [redacted] - 2019

I fell pregnant with fraternal twins in early 2019, and although excited about the unexpected surprise, I was apprehensive about a ‘multiple’ birth. Luckily I could have prenatal appointments at the Horton Hospital, which was good as I needed to be seen more frequently due to being a ‘high risk’ pregnancy. I was told early on that I could not give birth at the Horton due to the risks of having twins. My husband and I accepted needing to go to the JR and didn’t think much more of it.

I was given a date for a planned Caesarean section. We arrived at the JR on October 14, 2019 at 7am having no idea where we were going, We were

then left waiting in a narrow hallway for 20-30 minutes. My emotions were already running high due to the nerves. A nurse came out and took us down to a room where there were 4 other women waiting, hooked me up to monitors and left. 20 minutes went by, with no one telling us anything, when a nurse finally returned and said “The doctors are discussing who is the most high risk birth to order deliveries; you’ll probably be first as you have multiples”.

The doctor came in to meet us and explained we would be the first Caesarean that morning, and our scheduled time would be 9-9:30am. We were then taken to a higher floor into a private room to wait, being told someone would be along soon.
We were told at 10:15am that an emergency had come in which meant they were priority and gave me a gown to change into, and scrubs for my husband. My husband didn’t come in for the epidural and they forgot to tell him we were going into theatre.

The babies were born at 10:56am and 10:59am. The surgeons who did my C-section and midwives in the room, were incredible and I couldn’t fault that part of it at all. Then we were moved to the recovery ward, where it all went downhill from there..

My husband and I enjoyed the early moments with our newborn twins, it was lovely. But our precious time was interrupted repeatedly by someone coming to ask if we had chosen names yet.

I asked the next midwife who came round if I could have some formula, as I had noticed my babies were sucking on their fists in hunger. She was openly unimpressed with the fact I had chosen not to breastfeed, making me feel awful.

She returned about 5 minutes later with some formula. I had got the twins to drink around 10ml each, which she said was good. Without any warning she then whipped off my blanket off and pulled my legs apart to assess my post-birth bleeding and change my pads.

I asked if I could have my toast and tea as I hadn’t eaten since 10pm the night before and was told I could have this 1 hour after surgery, it had been 3. It arrived 40 minutes later.

My daughter then decided to have her first ‘poo’ which is like tar. I was still numb from the epidural and couldn’t move, so my husband had to change her. He needed help but the midwife’s response was “what, have you not done this before?”.

We were both in our early twenties, these were our first babies, we had not done this before. She rolled her eyes and then started telling him in a very patronising way, what to do.

These midwives made us feel like idiots and failures as parents from the early moments. I then asked if I could have some more formula for the children, as it had been a couple hours since their last feed, she told me that 10ml was plenty for their first 24 hours. I asked her if she was sure as I was hesitant about this, she snapped back saying "yes, it is more than enough". As mentioned before, these are my first children, so I didn't know or trust what she was saying.

We had been told my husband would need to leave at 9pm and he needed to know which room I would moved to. It got to 8pm we were both very tired. I told him to go home as I was worried about him driving all the way back to Banbury so tired. We said our goodbyes and he left.

At about 9pm someone came down with a wheelchair to take me upstairs to the ward. The receiving midwife asked where my husband was. I said he had left as it was 9pm. She threw her arms up, huffed and said 'why do you think it has taken us so long to get a room up here? We were sorting a private one for you and your husband as you're a multiple birth! Who's going to be helping you through the night?"

I said we didn't know that and no one had told us anything. She said "well it's going to be just you for the night, so it's going to be a long one."

I went into the room, had a cry and tried to call my husband. His phone was out of battery and he didn't get any of my messages until about 11pm, too late to drive all the way back to Oxford. I settled myself in and got the twins cozy in their cot.

The midwife came in just before midnight asking if the twins had had their feed so she could record it, I said they haven't had anything since 3pm, as I was told they were 'fine'.' She gasped and hurried to get my formula, telling me I needed to feed them.

I tried to, but neither would suck. I asked for help and she said to keep trying. I could not get them to feed. So, I put them back into their cot to try again in 10mins as they were both getting wound up with me trying to force it. I had just started to doze when a new midwife came storming in at 2:15am, turned the lights on and started to shout at me 'how would you like it if no one fed you for over 8 hours, you need to feed your children!'.

I started to cry and explained to her that 1) I was told that the 10ml they each had earlier in the day was 'sufficient' enough for the first 24 hours and that 2) once I had been corrected by another midwife, that I was struggling to get them to take the bottle.

She blankly looked at me and said "Well you should know that you need to feed them, regardless of what anyone said". At this point I was too upset to speak or even do anything, so I decided to just keep quiet and 'get on with it' so that I could hopefully get out of this hell hole. The morning came around and I had just started to get some sleep at around 6:30am after an eventful night with my son, who was vomiting quite a lot after birth so I was having to jump out of bed every 20 mins or so to lift him up so he wouldn't choke (not easy when your recovering from a C-section).

There was more pressure to fill in meal cards, the midwife slamming the door behind her, and waking the twins. I could get no sleep.

At 8.30am I was told they would be discharging me. I called my husband and he started to head back to Oxford, due to the traffic and trying to park, he got to me at around midday.

There were further delays because my medications were not ready. It took until 4pm. They knew we were waiting but had not told us we needed to collect them. We finally left at 5.30pm.

It felt like all they were interested in doing was filling in paperwork side of it all, and ticking the boxes but didn't actually have enough time, staff or empathy to help the human being who they were there to support.

Apart from the midwives who delivered our twins, the rest were horrible and rude, making us feel like terrible parents from the outset. It was a horrible experience. We found out at our post-birth 48 hour check at the Horton that the twins were jaundiced so they needed to go under the lamp which luckily they could do at the Horton. We have no idea why this wasn't picked up at the JR, nor did the health visitors who picked it up. We also found out that our son had a stomach hernia that would need to be monitored - again something that was not picked up or informed to us at the JR.

Our experience at the JR, compared to the amazing staff and time at the Horton in pregnancy, has put us off wanting to have anymore children, as we don't want to have to go through that feeling of being belittled and treated so badly again!

Case 23 - [redacted]

Before I start I'm not looking for any sympathy, or really any kind of reaction but just to urge anyone who is expecting a baby and is in a safe position to do so, to have their baby in Banbury.

I was so desperate to have my baby in his home town of Banbury where all his cousins have been born with a brilliant service, but I was unable to do so because there was no induction space appointment before the NHS guideline mark of 42 weeks. I had him at 42+2 . Also the Horton are no longer able to do inductions which is why I had to go to the JR.

The midwives at the JR were amazing. Our issue was the organisation and lack of time, staff and beds at the JR.

I have a long letter I sent to relevant people in an attempt to prevent another baby having the same experience as mine.

A few crucial points. To set the scene:
I'm a first time mum.
My baby was 10lb 4 and back to back.
I had a failed epidural that doctors were too busy to come and fix, after being asked multiple times by my midwife.
He was a forceps delivery because of a low heart rate and mine went very high.
Along with a host of other reasons my partner took a photo 5 hours after my baby had been delivered.

I had to sleep on the floor in my dressing gown because they were too busy to move us to a ward, or even to change the soiled delivery bed so I could get back in that.

Case 24 - [redacted] - 2022

Childbirth is one of the most important and terrifying moments of our lives. We try to prepare ourselves with courses available to us like hypnobirthing, promising essential oils and birthing pools. It isn't any wonder that we are rarely satisfied when our actual birthing experience doesn't quite live up to the ideal.

I have two children, the eldest was born at the JR Oxford. This was the birth plan. I found great comfort in knowing that should there be any complications, highly trained doctors with medical equipment were just a hallway away.

The Horton was our plan B. We were assured, of course, that midwives are equally qualified and specialists in their field, yet should we require a C-section or extra assistance we were to board an ambulance and take a 30 minute (A34 traffic dependant) journey to the JR. I thought I would save myself the drama.

Whilst I didn't have the childbirth of dreams (meconium in the amniotic fluid prevented the birthing pool concept, but I didn't mind the labour ward) and it was a relatively straightforward birth.

It was my first experience with gas and air, nobody had warned me that it has the same effect as alcohol, but the kind of alcohol that brings out the worst in yourself! I found myself incredibly rude, repeatedly asking the midwife if she had lied to me about having any intention of giving me an epidural (I birthed without it in the end) and despite my appalling demeanour, the midwife was professional, calm and composed. She cleaned me after birth, helped me to the bathroom and couldn't be more accommodating. All in all, a positive experience.

My second childbirth was completely different to the first. I could tell that I did not have time to get to the JR. Birthing at the Horton filled me with dread. It was around midnight when we pulled up, 9 November 2022 and the cheery midwives were on hand with a wheelchair to get me to the labour ward. I was the only patient in the labour ward that night, and I didn't see anyone else admitted for the whole duration of our stay.

It wasn't long before I was on the bed and pushing. The pains were sharp, unexpectedly so, and I pulled the gas and air mask so tightly to my face in the desperate hope for relief. It really did work, but with that the terrible side of me came out once more, under the influence of gas and air. It is not a proud memory of mine. I was begging the midwives to take me in an ambulance to the JR, I told them I was too frightened to give birth in The Horton.

They assured me I was too far gone for that, and seemed incredibly offended that I saw the JR to be a more viable option. The midwife told of her wealth of experience and how she considered herself to be more senior than the staff at the JR.

The firm "no" to my ambulance request only increased my rudeness. I recall my husband rolling his eyes and apologising on my behalf. The midwife became irritated that I was not pushing hard enough, and I heard her mutter that "if she actually just pushed really hard the baby will be here". It

was what I needed to hear, and with that I found the strength to push and baby arrived safely and quickly.

It was from this moment that the experience changed dramatically. It was almost as though the midwives had done their job, the baby was here, and that was all the care I would be getting.

We were not offered to cut the cord, or clamp the cord. As the childbirth was so fast, my body had gone into shock. I was shivering and shaking uncontrollably, my clothes covered in fluids which were clinging and damp on my skin. I begged for more blankets, a hot water bottle, anything. They refused. Nothing was available, "sorry". After ten minutes of this, my husband had covered me in coats to help.

There was no encouragement for skin to skin, no assistance with feeding. The midwives left us in the room for around an hour, in blood soaked sheets. Eventually they returned, and I apologised for my rudeness during labour.

I mentioned that my stomach was hurting from contracting and the midwife offered me a heat pack… "So now there are heat packs?" I ask. The midwife turned away with no words. Only after an apology was I worthy of receiving one. The midwife recommended that we stayed the night on the ward. There was a bed in the room that my husband could sleep on. And so we were left.

I stayed in the blood soaked sheets all night. I was not helped to the bathroom, not cleaned in any way. No midwives returned until morning, where we were greeted by a different face. They had left without saying goodbye.

I reflected on my experience and wondered about if I should report this. I decided against it because I am aware that I behaved unfavourably and I was embarrassed. I do feel however, that no matter what the circumstances, it is the duty of care of the healthcare professionals to undertake their duty from the beginning to end of the patient's stay. We all deal with people that we would rather not deal with, it is part of life. Does that excuse you from providing basic care as a healthcare professional?

I would not recommend the Horton Hospital to parents-to-be.

Case 25 - [redacted] - 2023

I had my first son in 2012, my pregnancy and labour was fine, contractions for 4 days in total but he was born through natural vaginal delivery.

My second son was born in 2020 during lockdown, I had everything done through the Horton and when labour started at 5am that is where I went. After several hours of being in labour they decided the baby should have been born hours ago and I still hadn't dilated fully so they rushed me to the JR in case I needed a C-Section.

Being told this during labour is terrifying and the fact your partner needs to drive up too, so you go alone, is even worse. Being strapped to an ambulance bed, in an uncomfortable position in full blown labour all the way to the JR is awful, especially without your support. Luckily he arrived naturally within about 15 minutes of arriving at the JR.

My third baby was born July 2023. As usual my pregnancy seemed fine and I chose the Horton as my place for delivery as it is somewhere I know and feel comfortable, close to home. I went to the hospital after my waters had broken and started to get contractions. They kept me in and the contractions got stronger. Again, my body took a long time to dilate and I was pushing before fully dilated. They decided I needed to go to the JR. Getting onto an ambulance bed, in labour whilst your body is just naturally pushing is so difficult. The ambulance staff were lovely, but it is so painful and a horrific experience trying to swap beds and then being strapped down and wheeled out.

My boyfriend came in his van panicking the whole way. When I got there they transferred me to a room and by then mine and baby's heart rates had risen so they decided to get ready for a C-Section.

My partner wasn't there at the time they told me all this news and when I was signing the forms. I was petrified, alone, no support and high on gas and air singing and shouting over the lady reading me all the things that could possibly go wrong.

Finally my partner arrived mid-signing and off into theatre we went. Then they had to try do the spinal block, mid contractions, as you can imagine I could not stay still so I had several people holding me in position to try to keep me still enough for them to do it.

After baby was born they asked if I had pregnancy diabetes due to her being 10lb4oz. She also needed glucose (which I'm sure is linked with the pregnancy diabetes). I wasn't aware of this, who knows, it may have been missed.

I was so poorly and gone through so much, the emotions and pain I had been through were horrific. I had to have an iron drip in hospital. When I

was finally allowed home I had to pick up some antibiotics for an infection in my wound from the chemist and they had iron tablets there dated from two months prior.

The Horton is so understaffed nobody let me know I needed these and had I have had them, I probably wouldn't have needed the drip at the JR.

There are some lovely midwives at the Horton, but they are so overworked and they just don't have the facilities for when things don't go to plan. With Banbury/every town getting bigger if they carry on offloading everyone to the JR the services there will also be overworked and lack inlacking care.

I don't want other people to have to go through what I've been through, I know there are many worse scenarios but this could easily be prevented if they just bring services back to the Horton.

It is awful being in active labour and having to be transferred to another hospital alone; not knowing if your partner/birthing partner will be there for the birth. It causes a lot more stress and worry than a woman in labour should have to take.

Case 26 - [redacted] - 2016

I was pregnant in 2016. I was one of the pregnant people that was protesting to Keep the Horton General consultant-led. I stood up in the meeting at Saint Mary's Church in front of the (trust) chief executive and head of midwifery and I said that my labours are quick. My first child was only six hours, my second was only 4, my third was 3. I said if I have to go to the JR, I am going to be rattling around in an ambulance in pain which I believe is against my human rights and I think saying that made them realise that actually it wasn't right.

I got a call to say that I could be induced at the JR at 38 weeks to prevent me giving birth on the side of the road, because it was causing anxiety and I have other children to deal with. I can't be freaking out about where I'm going to give birth.

When I gave birth at the JR it was like prison. I can honestly say the my youngest son's birth was the worst. The room was not well positioned at all. The foot of the bed was so close to the wall that when my waters broke they went up the wall. There was no cot in the room, there were no lights, no sense of calm. It was just dull, dreary and depressing.

Once I'd had my son I went up to the ward. The bells just go off and off repeatedly. It doesn't seem like they ever got answered. My son was having issues latching so I called the bell and I waited for a very long time for somebody to come. When they did I said I was having issues breastfeeding - they did not try to help me, they did not offer any support. She went and got a bottle of formula which was not what I wanted. I wanted help breastfeeding.

After my other births at the Horton they were there to support you and your baby, they would sit with you for an hour or 2 hours, however long it took for you to feel comfortable, rather than 'there's a bottle'. It was very deflating at that time.

It felt very lonely at the JR. Obviously family and friends are all in Banbury; my children couldn't come and visit. They couldn't come and see their new brother because nobody could get them there. When you don't drive and you don't have family members that drive, you're stuck - you're on your own.

There was no TV, nothing - no dayroom so you were literally confined to your bed unless you went to the toilet, whereas at the Horton you had that element of being able to socialise even just for a couple of minutes while you got up and got your breakfast or lunch. At the JR your food and drinks were brought to you. It was horrible, the food was awful.

Then a situation happened during lockdown. I was pregnant and I had a miscarriage. However the sac for the baby didn't come loose so I was at the Horton and was told that the baby had gone. I was told that there was no doctor to be able to help me there and there wouldn't be a doctor until midweek next week so I had to leave, hysterically, on my own with the remnants of my dead baby inside of me.

I chose to wait for everything to kind of happen naturally because I was heartbroken. The devastation of a miscarriage is unreal. A week or so after finding out that the baby had gone I started bleeding and it got to the point where I was haemorrhaging all over my bathroom floor.

I had to send my children to their fathers which was heartbreaking. They've never had long periods of time without me. I ended up having to call an ambulance while I lay in the bath sobbing with blood gushing out of me all over my bathroom floor. When I called the day assessment, the old G ward, I was made to feel like I was over-exaggerating when I said about the blood loss.

They said if it was really that bad then call an ambulance, otherwise just ride it out.

It certainly was 'that bad' as I had to have a blood transfusion. The ambulance came and took me to the Horton where I passed out. When I came round I had all these people around me in between my legs at that point they were giving me a blood transfusion I was terrified.

Then I was told that because Banbury doesn't have (gynae) doctors they can't do the surgery I needed there, so I had to be taken in an ambulance, gushing with blood and feeling chunks of my baby coming out of me on the journey to the JR.

The journey in the ambulance was horrible. I wasn't allowed anybody with me because it was COVID. I was literally dying at one point but they would not allow anybody to come in.

I was taken to the JR and I did have a good experience. The A&E nurses were very respectful of the situation and thought of my emotional needs. As soon as I left there and got taken to another ward I was on I was left for hours. I hadn't had a drink or any food because it wasn't allowed because of needing surgery.

I kept being told the doctor was coming - no doctor came and I was left all night. Again I was told a doctor was on their way. I passed out in the night and a doctor had to come to me but only dealt with the fact that I was on the floor.

When the morning came a junior doctor came and said I had to go into a different room to be examined. The doctor said she needed to share with a colleague what was happening and get their take on it.

She never came back. She left me there on a table half naked, bleeding and cold. I had just lost a lot of blood but she just left me. She didn't come back because she was on a shift change so I ended up having to get off of this table back into my wheelchair.

I cried my eyes out. Luckily the night nurse saw me, even though she'd clocked off and she'd done her handovers, she could see how much of a wreck I was and she gave me some dignity back. She gave me a blanket to cover myself because I had just been left no blanket, just half naked on this table.

This nurse went and sorted everything out and had a doctor came. But I'm left with PTSD. I've had to have trauma therapy. There was a long time where I couldn't look at anybody with a baby or bump. I hadn't been to the doctors - I couldn't go into any medical setting. One of my sons needed to go to A&E and I went in to fight or flight and I had to get out. I still have this when it comes to a medical setting.

I'm OK at the doctor's now but I can't go to the hospital. I was supposed to have my smear test a long time ago but I physically cannot do it because I'm traumatised.

I get triggered by every period. All of this could have been prevented if Banbury had a consultant-led unit where I could have been dealt with there and then. My son had to witness the blood all over the floor. All of this could have been prevented. I had to go to A&E in the summer and I was put on a trolley outside resus and I sobbed my heart out because all I could hear was the bleeping machines, the hustle and bustle and I was right back there in that resus room, alone terrified.

Case 27 - [redacted]

I went through a distressing experience at the Horton. I'm type 1 diabetic and had to be under consultants at the JR for my pregnancy.

At 17 weeks I experienced a bleed whilst picking my eldest daughter up from school. I called the maternity ward whilst walking home. I couldn't get any help from them, so I went to A & E. The nurse there told me to wait and to let her know when I could feel something coming away.

We were then sent home and told to call the JR. They told us to come to them. We went to the JR and they told us, because I wasn't that far along they wouldn't be able to scan me or check the heartbeat of my baby.

We were sent home. We had to go through the whole night not knowing what had happened to our baby, I was still bleeding too.

In the morning I called the Horton again and a midwife told us to come down to have a scan.

We got into the scan room, myself and my husband were holding our breath waiting for her to tell us what had happened. Luckily - our baby was perfectly fine.

I broke down and cried and the midwife simply said: 'why are you getting upset?' - she had no idea why we were there. She showed no compassion towards us.

I was then sent to get examined and they couldn't find the source of the bleed. It was the worst experience of my life.

Case 28 - [redacted]

With my first daughter it was height of Covid so I wasn't allowed up till I was 5cm dilated, I was at home in pain and I called and said can I come up to be checked (I had called probably hourly prior to this) and the lady said 'you don't sound like you are in labour' which was ridiculous, I went to the JR straight away and I was in-fact 5cm in active labour -but I let that slip because it was Covid and I know things were so up in the air.

So, when I got pregnant with my second daughter, she was due on November 12th. On Monday the 7th I woke up to wet underwear, not your average pregnancy discharge, and I knew I hadn't wet myself. So I called them, went up with knickers in tow. They did a speculum and told me I had likely wet myself, so I listened to the professionals and left it at that.

The next day, the exact same thing. I called and was told to check the next day, again the next day.. the same thing. So I went back up, speculum again and was told again I'd wet myself. Same story on the Thursday.

I was expressing that I hadn't (mainly because it didn't smell like wee, and I knew I hadn't).

At this point I was getting very worried and frustrated that no one was listening to me.

On the Friday I went back up, this time the nurse put me in a room, didn't even turn the lights on, just sat me there and went away for 30 minutes. I was left in a dark room on a bed feeling like a nuisance and a time waster. Her manner was short and I could tell she was irritated that I had gone up again.

So, baby's due date came on the Saturday - same story but this time my husband said 'I'm coming with you. He was frustrated and felt that maybe me, being on my own and vulnerable, wasn't being taken as seriously (which I feel is sadly the truth, but who am I to argue with medically trained people?!).

So we both went, again I was checked over and told I'd likely wet myself (again). My husband asked 'surely there is another test or check that can be done to check my waters as this situation is getting ridiculous'. She said I can go to the JR for a swab, so we agreed, she said she would call them and sighed as she left.

Once it was all arranged her parting words to me were 'I hope you prove me wrong'. This isn't about proving anyone wrong, it's about the life of my unborn child.

So we went to the JR who confirmed indeed my waters were leaking and had been for a week. I had to go straight on antibiotics and I was put to the top of the list and induced within an hour.

I am one of the lucky ones, my daughter was born healthy and the care I received at the JR was amazing, but I worry what would have happened had my husband not come with me, and the embarrassment I felt carrying my wet underwear up every day, being told that because I'm not filling a pad it's not my waters.

It was my second baby, so not my first rodeo, but I still felt as scared and vulnerable. This experience has made me nervous to ever have a third.

I feel Banbury Midwives push you to give birth at the Horton. When I first said the JR was my choice after my first pregnancy, I was asked why not the Horton etc. and they diminished all my worries and fears by saying that the Horton can do pretty much what the JR can, but when it came to it, I was let down again.

Case 29 - [redacted]

After a complication-free pregnancy, I was looking forward to having as natural a birth as possible. I had accepted that if any intervention was needed, I would end up at the JR, which was my last choice," she said.
I remember the excitement when my waters broke and my husband phoned the Cotswold birthing suite (Chipping Norton) – and hearing that they were closed as staff were required elsewhere.

We went to the Horton that evening to be tested whether it was waters or not. The midwife was very helpful and it was my waters. However without any contractions, we were booked into the JR for the following evening, in case.

We were so excited and went home to ensure our bag was packed and everything sorted ready for when it might start - the nerves set in for the unknown. At 11pm my contractions started; we stayed at home until 4am and then drove 10 minutes to the Horton.

My labour seemed normal and I was trying the birthing pool and using gas and air. When the contractions started making me want to push, it was very quick as I was not dilated very much.
I was told to get out of the pool (which was not helping as it was fairly cold and didn't cover my back where the pain was) as the midwife wanted to check dilation and ensure baby was ok.
I continued on the bed to push and remember the window getting brighter with daylight. I felt shattered.

The midwives were discussing how the baby was not coming out. I remember my husband being told he had to go to the JR in the car as I was going to be blue-lighted there and he could not fit in the ambulance as well as the midwife.

I'm a little blank on the rest as it's just small things that keep flashing back to me.
There was a stent put into my hand for when I got to Oxford; I was briefly catheterised to ensure nothing was in my bladder to prevent baby moving – this was more painful than any contractions.

I heard the ambulance crew come into the room and I was taken into the ambulance along with the midwife and her helper. It was rush hour on a Monday morning.

I remember the journey being stop-start and uncomfortable - it was never going to be comfortable strapped to a bed in established labour anyway. I can recall the smell of burning rubber and assumed we had made it to JR, I had no concept of time.
I then remember the paramedic on the phone and talking to the midwife. They were not sure where on the A34 we were, as they were from Bristol not Banbury. I recall another trying to lighten the mood, saying they had never known this to happen in 28 years of work.

I'm afraid I wanted to stop listening and concentrate on what I was doing as it was so painful. I told the midwife I had to move or change positions as lying on my back strapped down was certainly not helping.

Finally the back door opened and another paramedic came in and it was discussed how I was to be transferred from one ambulance to the other. I

remember I had to change beds as they had to keep the correct one with the correct ambulance. This could not be done in the ambulance.

I was wheeled out of the original ambulance and I recall opening my eyes to see tarmac on the other side of the barrier and hearing the road. They then transferred me to the second bed.

Then I was wheeled into the new ambulance. I remember there was no gas and air available. This was done at the front of a huge traffic jam – the journey took two hours.

The next thing I remember is being in the hospital and a consultant (I think) telling me the baby was too low for a Caesarean and they were going to do an episiotomy and use forceps to help baby out. I have no idea if the baby had moved and come out any further or if it was in distress.

I was very quickly moved to theatre and there were suddenly about 15 people around me with a massive light above me. They were each informing me what they were doing. This was very professional and maybe reassuring to some.. I was completely overwhelmed by this.

Thankfully we had a very healthy baby and I was physically fine but I have suffered with PTSD since. When we found out we were having a second baby a few years later, there was huge anxiety that there would be difficulties both physically and mentally. Thankfully we ended up at home and had a perfectly natural birth."

Case 30 - [redacted] - 2024

First of all my midwife in Banbury ([redacted]) was amazing, above and beyond care from her, and became a friend in the end.

I chose to give birth at Warwick via planned C section on 02/02/24, I chose Warwick as this is where I had my first son 14/05/22 via emergency c section.

Straightforward pregnancy pretty much, I have Hashimotos so thyroid had to be monitored because Warwick and Banbury have different systems. I pretty much had double appointments when it came to blood tests; also Warwick could never see my midwife appointments in Banbury and Banbury couldn't see my Warwick appointments which made it hard, as I was constantly relaying information, especially when Warwick had picked up on a few things. For example they believed my belly was measuring larger on one

appointment so had to have a scan which showed I had extra fluid around baby.

I became consultant-led and had to have more scans and also a diabetes test. Again Banbury did not know any of this until I told them the information. Luckily the fluid around baby became normal and the diabetes test was negative so I went back to normal appointments. Reduced movements beyond a certain date had to go to Warwick due to it being my birth place which was not always easy to get to with having another child at home.

I also did not get to have my 36-week scan as Warwick don't offer this and Banbury won't offer it to you if you give birth in Warwick.

My C section went to plan and was very quick and the surgeon was very happy. My little boy was put on me and I noticed he wasn't right straight away. He was blue and grunting at me.

Cutting a long story short, his oxygen was at 88% and he was put into special care at Warwick for 24 hours. They treated him for infection straight away whilst in communication with Coventry hospital (Banbury had no idea of any of this).

We then got transferred to Coventry intensive care where we spent the week. Again Banbury did not know about this until I contacted [redacted], which is not something you think or want to think about doing when you have a very poorly baby.

[redacted]had pneumonia, respiratory distress syndrome, air escape from lung onto chest which had to be aspirated out via needle and was also treated for sepsis. I'm not saying that his illness is from any fault of either Banbury or Warwick. I believe he was always going to be born poorly and we have further appointments and check ups in Warwick to follow. However my time could have been made easier if the hospitals were allowed to communicate with each other. Also my baby's future appointments will always be in Warwick, so Banbury will not know any of his information.

I understand that giving birth in Warwick was my choice and down to me, but if Banbury had ever been an option for me I would always always have taken/considered it. Double appts for pregnancy with Warwick and Banbury, further travel, more stress if you have any problems with baby as you have to go to Warwick and make Banbury aware, and also different opinions/ information is given to you being two different trusts…

I was also being contacted by Banbury midwives and health visitors about coming to see [redacted] as they had no idea that he was in intensive care and poorly. When I told [redacted] (Banbury midwife) she sorted everything for me but having to keep telling people that I was intensive care just added stress and sadness.s. This meant constant back-and-forth appointments to the JR which I had to my ex-husband not being able to take the amount of time it took to get to Oxford and back off work so often.

It also meant during each hospital stay I was alone and away from my other three children, which caused a huge amount of separation anxiety for them and me, as the distance was too far to arrange around school and work timings.

The huge increase in maternity visits for the JR also meant that their car parks became so overcrowded that on several occasions I was late for my appointments due to not finding a space.

Case 31 - [redacted]

From the outset of my pregnancy I was consultant-led and would need to give birth at the JR. This did not have too much impact on me at the beginning because I either had telephone appointments with midwives and doctors rather than going to the JR, or they came to Banbury occasionally and I met them there. The only issues which arose were when I experienced any problems.

For example, I was worried at one point during my pregnancy that I was leaking and so my husband and I had to call the JR and travel all the way there to be examined because there was no one qualified at the Horton to do this and if there were any issues, the Horton would not be able to accommodate me, so it was safer to travel there to be seen. This took around 40 minutes each way and approximately. 6 hours of waiting to be seen. But we were examined and there were no issues.

I had pregnancy diabetes and I relayed my concerns to my diabetes midwife about arriving at the JR in time if I went into labour as the Horton could not accommodate me with no consultants, especially as I then had developed pregnancy diabetes. She said I should always go to my nearest safe space which is the Horton, even if there were no consultants as there were midwives there.

When I was 38 weeks pregnant I developed chest pain. I waited a couple of hours, took indigestion tablets and paracetamol, had a hot bath and lay down to try and ease the pain. Nothing worked and I was becoming increasingly worried. We called the Oxford midwife line and could not get through so at this point, as the pain had been constant for a couple of hours, myself and my husband went to the maternity unit at the Horton. It was on a weekend approx. after 7pm.

When we arrived, nothing looked open and there were no lights on. We rang the bell and when someone spoke to us I advised that I was 38 weeks pregnant and had chest pain for a couple of hours. I was asked "why had I come to Banbury" and I again explained and also said that this The midwife was very exasperated with us for coming and told me that they could not help me as they had no doctors and asked why I was even here and not at the JR. By this point I had become distressed as I was in pain, worried and also felt like I had done something wrong by going to the Horton.

We were shown to a room (the place was empty and she had to turn on the lights as we moved to an examination room). Another midwife came to take my blood pressure etc and I gave my blue book to the older midwife and she said she was going to call the JR and see if they wanted to see me because, again, they could not help me. I was in tears at this point and felt very silly.

At the time of my pregnancy, I was taking antidepressants, which I had been on for a couple of years, and I was under Talking Spaces because I had low mood due to my mum passing away the year before.

I have never thought of myself as having mental health problems and sought help at the time of my pregnancy because, to be honest, I was offered more support because I was pregnant than I had been at the time my mum died and thought that it couldn't hurt to use the resources when I was pregnant and dealing with my grief. I have never had contact with the crisis team or anything like that and only contacted the doctor for help when my mum died the year previous.

There was obviously something to this extent in my notes as my husband and I heard the midwife on the phone to the JR saying: "I have a lady here who has mental health problems and says she has chest pain. I don't know why she has turned up here because we can't do anything, should I send her to you?". At this point I was sobbing as I felt dismissed and like I was being a problem. I also felt like I was being labelled as being a hypochondriac as I had "mental health problems". My husband was incensed as I was now so upset and he had also heard the midwife.

When the midwife came back my husband asked what was happening and we were told the JR would be coming back to her. She asked if my baby had turned and when I said no, she said "well of course you are in pain the baby's head is digging into you that's why you are in pain". I felt like I had made a fuss over nothing and she again said that I should not have attended the Horton maternity unit.

Eventually a paramedic came as they were called to transfer me to the JR, but it was decided I would go to the Horton A& E first for observation rather than making me make the trip to the JR.

A&E were fantastic and so was the paramedic. I now know that the pain was due to my gallbladder being inflamed as I then had to have this removed after I gave birth; the pain I experienced when I had a flare-up after I gave birth was the same pain. In any event the pain subsided while I was in A&E, and I decided along with A&E and after they spoke to the JR, that I could go home and to come back (to A&E) if I had any further pain.

After my experience with the one midwife at the maternity unit, however, I advised my husband that if we had any further problems I would not be going anywhere. I felt belittled and like I was only making a fuss because I had "mental health issues". This was the first time since I had been on medication for depression that I had encountered anyone labelling me as having "mental health issues" or judging me and I was scared if I presented anywhere for any further issues with my pregnancy I would be labelled as being difficult or just having "mental health issues". I did not feel that I had been taken seriously at all. Thankfully all was well with my baby.

When I saw my community midwife, [redacted] at the Banbury Cross Health Centre, afterwards for an appointment I explained what happened and asked if there was anything in my file which said I had "mental health issues". She confirmed it did not state this specifically and only said I was on anti-depressants and the care of Talking Spaces for low mood and grief. I explained to Holly that one of the reasons it took me so long to get help in the first place was because I was afraid of not being taken seriously in the future and just being labelled as having mental health issues. I also explained that if I was in any further pain during my pregnancy this experience had put me off getting help.

She asked if she could make a complaint on my behalf, and I agreed. I was too upset and dealing with a difficult pregnancy to go through with a complaint myself and I was also worried that my mental health would be taken into consideration again. I was too upset from already being judged on this basis and did not want this to happen again. I do not know, therefore, if anything happened with the complaint.

My experience is by no means the worst, but I hope it shows that by reducing the services at the Horton maternity unit to midwife-led it means that pregnant women cannot attend for any issues or concerns during their pregnancy and cannot obtain any help or reassurance due to the fact that there is no consultancy care.

It is stressful to travel over 30 minutes, sometimes over an hour, in traffic conditions when you are in pain or you have concerns with your baby. There is then the issue that the waiting times at the JR are astronomical due to the number of extra patients they have coming from Banbury and the fact that basically everything has to be dealt with at the JR as there are no consultants at the Horton in Banbury. Time is also of the essence when dealing with issues with babies as 30 minutes can make all the difference.

Case 32 [redacted]

We need to return obstetrics to the Horton, not just because I work there.

My first labour was in JR as Horton could not provide me with the pain relief I needed. We had to travel from Byfield to Oxford (36.4 miles - a long drive).

They treated me as if I was exaggerating (1st time mum). I had been in agony for more than 24hrs, not sleeping, eating or drinking. I was turned away but went back in absolute agony. The long drive back which would have been much easier if it was the Horton. They were busy and short staffed and tried to send me home but I refused. No way was I going to suffer another long drive. Cutting a long story short, my baby was back to back, they wanted me to have a normal birth. I pushed and pushed, to the point I was sore.

I ended up having a C-section, as my baby's heartbeat had dropped. We were lucky. I lost 1.5 pint of blood and had an infection.

Consultants wanted nurses to help me breastfeed as they were concerned but I had no help. However I pushed to breastfeed. But I never felt so ashamed and embarrassed. I was traumatised. The C-section alone was traumatising. I suffered from depression after and I was never able to breastfeed.

My second labour, they were amazing! It was another C-section, but they did not push for me to go natural. I'm not sure whether it was because they knew I worked at the Horton. They were amazing - they were short staffed, but helped me to breastfeed.

However, I feel like the Horton would have been easier, especially with the driving. Being in a Northamptonshire county, Northampton General REFUSED to take patients from this side

Case 33 [redacted] - 2019

Pregnancy 1. I started my care in Banbury but early on decided I would feel safer giving birth in a hospital with a full team of clinicians in case any interventions were needed. My care changed to Warwick, by no means ideal as it was a 30+ minute drive away.

I had issues during my pregnancy with my hips so after 5 months couldn't sustain driving myself that distance. This meant having to arrange lifts with family members so my husband could keep working. Physiotherapy was arranged via Banbury as the original midwife still saw me for the standard checks where everything else was under Warwick.

The physio referral in Bicester that I struggled to drive to. There was no physical check of symptoms, just a class on how to deal with the pain while we sat on very uncomfortable hard plastic chairs. The physio care was simply to be given a sheet of paper with exercises. It felt very substandard. Also, there is a good physio department at the Horton.

As the baby was growing, the hospital (Warwick) were concerned that the baby was large compared to my own size and I had to be seen every 2 weeks for growth scans. It was an added pressure to take nearly a full day off work for myself and arrange lifts.

Thankfully having opted to give birth in Warwick I had the correct care due because of complications during the birth.

Having had to stay in Warwick for several days, I was discharged. However, after a midwife visit scheduled at home that same day, I was advised to go back to hospital.

This is where the outstanding care of the team at the Horton came in. And it was quite upsetting that I couldn't have just had continuity of care in my local hospital throughout.

It's thoroughly disappointing to live in such a large town and know that the most basic of care, at the most appropriate and safe level, has been taken away for women.

Pregnancy 2. Miscarriage May 2021

I miscarried while on holiday in Poole. My notes were not sent from Poole hospital to the Horton to advise of the miscarriage when I was seen at Horton for review.

During a scan I was told there was nothing there... I had to explain that was the reason I was there for review etc. It would have been nice if the scan staff offered sympathy, but they seemed unable to show any emotion.

Clinic following the scan was very matter of fact. I was told that due to Covid I had to wait in the waiting area alone, without my husband. One really nice lady there. It was very much 'it happens, try again in 3 months' and off you go. Impersonal.

Pregnancy 3. Miscarrage October 2021
Missed miscarriage picked up in a scan. The scan nurse was unsympathetic; no tact in telling me there was no heartbeat. It was difficult to pass others in the waiting area because the clinics are mixed. This seriously should be addressed.

I was sent to the next clinic to be informed of options. I was told to wait in the waiting area alone without my husband due to their on going Covid rules. I refused to enter the waiting area without him and instead remained in the corridor where it was very busy, quite humiliating actually.

But that was better than facing another mixed waiting area without any support that I so needed in that moment. Once called through for the appointment it was discussed what route I'd like to take for 'next steps', i.e. surgery/meds/leave.

The medicines option was selected. I was informed it's like a heavy period and I would have to wait a few days for D&C (operation) which mentally I didn't feel I could do.

I did receive care from this point from a nice nurse from my previous loss - she was at least very supportive and sympathetic.

However in hindsight I don't feel I was fully informed of the process and certainly not what I would be enduring that night. Women are being led into making decisions and consenting to treatment only to find out that they have not been fully informed, this neither transparent for patient care, nor ethical.

This bad experience led to a diagnosis of PTSD. During the process of the evening after the medication was administered, I called out-of-hours line for help and advice. I was told I am meant to bleed, and if worried, call an ambulance, but that if I went to hospital they would say the same.

I passed out at one point due to the blood loss. I called the out of hours line again for support and was told the same thing as before. The bleeding eventually started to slow down and to be honest I no longer cared about my physical health as I was so drained from such a scary and mentally exhausting experience that I just went to bed and somewhat hoped for the best. It was a shocking level of "care".

The following evening I was seen at A&E due to labour pains. I was left on a bed waiting in pain. My stats came back normal. Doctor phoned Oxford for advice as there were no gynaecological doctors at the Horton. He also told me 'I'm meant to bleed'...

I had to push for pain relief before leaving. The follow up at Horton for scan and review showed there was tissue left. I was seen in the next clinic. I was abruptly told my options are surgery or meds and not to leave it due to sepsis risk.

I wasn't happy with the response or manner of the nurse and said I wanted to discuss it with a consultant. I was told I'd be waiting, due to no appropriate doctor at the Horton and I'd be better off making a decision, as If i didn't, I could get sepsis.

I made my expectations very clear that I would await the review of a consultant. I received a phone call later in the day from an apologetic nurse as they had advised me incorrectly and the consultant, upon seeing my scan and reading my notes, advised to wait for tissue to move on its own as there was minimal left and I was still bleeding. The nurse said they will 'all learn something from this'.

Follow up review and scan. I was feeling very unwell and asked for a blood test as I felt anaemic.

Results came back no issues. I was advised by Horton that I was just being emotional due to what happened and that's why I felt "tired".

Some weeks later. I became extremely unwell. I called my GP who, upon reading my notes, was horrified that they had not run full bloods and only a simple haemoglobin test. Full bloods actually showed that my iron stores were extremely low and I was indeed very anaemic and unwell.

Case 34 [redacted]

Travelling to the JR a lot during my pregnancy was a cost I didn't need. Lee (partner) then broke his leg and I had so many appointments that I couldn't keep asking my family to book time off. Sometimes I had to travel there just to have my blood pressure taken. Ridiculous!

I don't like driving out of Banbury so I would get the train and bus. Waddling with my blue folder! It was very tiring as it made it so much of a longer journey. I can't fault the care I received at the JR, it was just a shame it couldn't be done up the road. I was high risk so adding in the worry about travelling didn't help.

My only other issue (and I think it was more to do with staff shortages) was that I never saw the same midwife twice. I didn't know (and still don't know) who my consultant was and I was so on top with knowing what appointments I needed that I actually realised they missed one!

Case 35 [redacted] 2014 and 2018

[redacted] had a son at the Horton in 2014 and a daughter at the JR in 2018.

We had a terrible time when I had my daughter and I had to go to the JR after a previous very traumatic birth with my son. When I went into labour- it progressed quickly and we had the most awful journey to Oxford- the slip road off the A34 was shut.

Then my contractions got to about 1 minute apart and my husband had to jump a load of red lights just to get us there on time - and this was at 1am in the morning! Then when we got to JR I was so stressed that everything stopped and they had to get my daughter out as quickly as possible.

Then I got an infection and a tear in my stitches. And yet again- Banbury sent me to the JR.

It was completely different to when I had my son in 2014 and Banbury was amazing. I had a consultant helping with the birth as my son needed assistance and almost a Caesarean section… I then got loads of help with a breastfeeding person at the Horton - this service didn't exist anymore when I had my daughter.

trip in the car for midwife or GP appointments. We were also fortunate that my scans, and any routine tests could be done at the Horton. The only occasional battle there was finding a parking space in enough time to make the appointment.

I started off my labour at home, like most mums. We called up the Horton Maternity unit and I was able to get to them around 9pm for routine checks and then sent home. After several phone calls, we were allowed back into the maternity unit in the early hours of the next morning.

We were very well supported by the midwives and nurses and I safely delivered my son in the birthing pool at the Horton Maternity Unit.

Unfortunately very quickly after birth, I had to be sent to the JR due to raised blood pressure and temperature. It took two paramedic crews to get us there (one ambulance for me, and another one for my son). I then spent 5 days under observation at the JR before being discharged home.

I cannot fault the care we received from both the Horton or the JR. However the extra stress and travelling into Oxford to get the care I needed from the doctors and obstetricians would have been avoided if the Horton had not downgraded the services to midwife led.

I would also not have been split up from my son and husband after birth had the units at the Horton been active. If we were to think about any future children, it would be in the back of our minds that it would be most likely travelling into Oxford for appointments, scans and birth / after birth care when our local hospital is a 15 minute drive away. We really hope that the full maternity department is reinstated to support our local mums.

Case 37 - [redacted] - 2018 - 2020

I had to travel to the JR in 2020 when pregnant with my youngest child. It was the height of the pandemic and most of my family live at the other end of the country. My partner had to work (as he was an 'essential' worker) and I had to go to the JR for iron as the tablets didn't work.

I had to rely on my partner's family to get me there while having two older children (who weren't old enough to stay home alone) to think about. So I had to take them with me and they sat in the car while I went in.

Had the Horton been a fully-functioning unit I could have stayed in Banbury

and used the facilities there as I did in my previous pregnancies.
I had to travel 2/3 times for iron then delivered there due to a planned C-section. My children missed a lot of their home schooling due to the travelling.

I had to stay in just over 30 hours; they only allowed me to have my partner in. He was supposed to leave when I got to recovery but they allowed him to stay a little longer as I was crying. Again I had to find adequate child care for the older two. Luckily it was the summer holidays so they managed to go to my mum. I didn't have any visitors due to the covid guidelines at that time.

In 2018 I had my fourth child. Complications arose around 20 weeks and from then I had to have multiple monitoring/checks and extra scans. I also required a specialist who I met with after a few weeks. This meant constant back-and-forth appointments to the JR which I had to attend alone due to my ex-husband not being able to take the amount of time it took to get to Oxford and back off work so often.

It also meant during each hospital stay I was alone and away from my other three children, which caused a huge amount of separation anxiety for them and me, as the distance was too far to arrange around school and work timings.

The huge increase in maternity visits for the JR also meant that their car parks became so overcrowded that on several occasions I was late for my appointments due to not finding a space.

IF I could have been in my local hospital up the road (where I had my third child) the difference in stress levels, disruption to family life and ability to navigate a difficult pregnancy would have made all the difference. I honestly believe that the difficulties I faced during pregnancy became heightened by the anxiety and stress of travelling/parking/expenses and lack of ability to have family support added to my negative experience of my last pregnancy.

Case 38 [redacted] - 2018

In 2018 I had my fourth child. Complications arose around 20 weeks and from then I had to have multiple monitoring/checks and extra scans. I also required a specialist who I met with after a few weeks. This meant constant back-and-forth appointments to the JR which I had to attend alone due to my ex-husband not being able to take the amount of time it took to get to Oxford and back off work so often.

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Case 39 [redacted]

I only just made it to Oxford with my second pregnancy as my labour was so fast. It would have been far quicker for me to get to Banbury. We got there minutes before I delivered.

Case 40 [redacted]

My waters broke on Sunday morning at 6am but I didn't have any contractions until Monday morning at 7.30am. I phoned the Horton who said unfortunately they would have to refuse me due to the chance of infection so I would have to deliver at the JR.

Knowing I labour quickly we got straight in the car and on our way by 8am. My contractions went backwards and were getting further apart due to the stress of being stuck in rush hour traffic with road works

When we arrived I was sent to the Spires unit, very much in labour. The midwife then said I had to go downstairs to the labour ward as it was advised I had continuous monitoring and antibiotics. I refused these and just asked for a pool and some gas and air. Reluctantly, the midwives agreed to let me stay at the Spires and my baby was born within 10 minutes of arriving. The lack of communication between day assessment/labour ward/Spires was poor as no one knew where I needed to be.

The midwife said it's a good job I stayed as baby would have been born in the lift if they had moved me.

I had to go to the JR for scans as well, as they thought the baby wasn't growing as well as she should be. The stress of travelling there by myself and parking was hell every time. The midwives in Banbury and the Spires were all so lovely but everyone in between didn't seem to know their arse from their elbow.

I even phoned the labour ward at the JR in the car on the way and the lady on the phone said 'why are you phoning here'? I said because I'm in labour and on my way. I was told to go to the day assessment unit - the lady at reception could see it wasn't going to be long. The faff of not knowing where you're meant to be is not helpful with a baby imminent.

I went in on the Sunday and they checked my waters had actually broken. They said if the baby wasn't here within 12 hours I wouldn't be able to deliver at the Horton.

I phoned the Horton Monday morning and they said I'd have to go to the JR and just to ring ahead to let them know I was on my way. My notes stated continuous monitoring during labour was advised, so the Horton weren't sure if they could have me anyway but they knew I didn't want to travel and said at the end of the day we wouldn't turn you away if you were in labour and didn't think you'd make it to the JR.

I can't fault the Horton midwives. They listened to what I wanted and contacted doctors at the JR to discuss options as they knew I laboured quickly. I felt more pressure from the JR to have every intervention going. They wanted to induce me straight after one of my scans for no real reason - they were pushing for induction. It's only because it was my third baby and I was confident in my mind and body that wanted to do everything as naturally as possible.

If it was my first baby I would have panicked and agreed to be induced without even knowing the reason why.

Travelling for pre-planned appointments meant I had to change shifts at work and also get someone to take my kids to school for the early appointments, as you never know what traffic and parking will be like. It's also the added cost of fuel and stress. Anyone that has been to the JR has had the stress of parking wars.

Case 41 [redacted]

I had to travel throughout my entire pregnancy to the JR instead of Banbury with child two and three. My appointments were always at 9am and because of parking I had to allow myself over an hour to get there and then parking used to take at least 40 mins to get a space and I would be late and this was weekly. I was always left waiting hours and hours - it was always over busy.

I had a C-section in Banbury 11 years ago and that was the most pleasant, caring environment, especially having my first child. I felt so looked after - then I had both my other two at the JR and felt I was just a number.

Aftercare with my third most recent baby was awful, (the day I had her.)

I was told I was recovering well and because it was my third C-section they asked if I wanted to go home. I felt poorly and asked if I could stay. I was pushed to a room at the bottom of the ward where I had hardly any check-ups. Dinner didn't come round - I had to buzz and ask where it was. I then had an infection and child three had jaundice so needed light therapy. I just felt if they were rushing me home and I didn't opt to stay, I would have got more poorly and the baby's jaundice would have spiked even more.

I felt as it was my third C-section I should have been high priority and also as I suffer with Ulcerative Colitis and was Silver Star. So overall not the best experience and Banbury was such a better experience.

Case 42 [redacted]

I wanted to give birth at the Horton for the ease more than anything - 5 minutes up the road. I was told throughout my pregnancy I was "low risk" so could give birth there despite having a urinary tract infection every month for which I had antibiotics. Nothing was actually investigated about these UTIs.

When I was in labour and got to the Horton, they advised if I was in this much pain already at only 1-2cm dilated then going to the JR might be a better option.

All I can say is thank GOD I made the decision to go to the JR as I had a very long labour and complications delivering [redacted] which resulted in a forceps delivery.

They wouldn't have been able to manage this at the Horton because of the lack of doctors there and I would have had to be transferred via ambulance to the JR - something I find absolutely absurd considering the size of Banbury and the amount of people that use the Horton General Hospital.

I was also told at the Horton I could only have paracetamol until I was 5cm dilated. After being in slow labour for three days already at this point and active labour for a day, I was so shocked at how little the Horton actually can do birth-wise.

You have to have had the most straightforward birth possible, but even then complications can happen and it doesn't bear thinking about. I don't think anyone knows or appreciates either just how shockingly little they can provide or manage there unless you've had direct experience of it.

It is such a shame as it clearly used to be a fantastic hospital to give birth at, which is why I wanted to in the first place.

I just cried. I was so exhausted. As soon as I got to the JR I had Oramorph. Just couldn't believe how little they actually do there at the Horton considering it used to do C-sections once upon a time there. Madness.

And also I was told they can't even stitch you up after birth there. But thinking about it, you have to have an injection to numb the area before stitches, so If you did give birth there and then tore, would you have to be transferred again to the JR? It's ludicrous.

Case 43 [redacted]

I had been having contractions since the night before and timing them until the recommended time between each, to go to JR. Went to the Spires, saw midwife who said they were Braxton Hicks as I was 10 days early.

No inspection was done and I was told to go home since there were no contractions while I was there. I got home and phoned Horton who advised me to go back to Maternity Assessment Unit at the JR.

I was in full labour in the car during the 45 minute drive to Oxford. Baby's safe arrival came soon after arriving. It was very lucky all went well and the midwife looking after me in MAU was amazing.

Case 44 [redacted] **2021**

Our accounts of both births with the JR Oxford are very poor - down right awful really. With our first I was in labour for 72 hours and my baby had jaundice for three days. I had very high blood pressure. I spent five days at the JR at the end of Covid in September 2021. We had given birth and I was a mess after.

My husband spent all week driving back and forth to Oxford trying to look after me and baby. I don't know how they thought I was going to look after a baby at 1.30am and I was drugged and out of it. I was so tired. At this stage of the end of Covid I was put into a waiting area/bay. But the horrible thing was that the lady in the bed next to me had given birth and had a still born. Which was upsetting for her and me.

We went home and never complained as it was my first birth and I never knew what we were doing. Husband spent £340 that week on parking tickets and petrol getting back and forth to Oxford. [redacted] came 4 weeks early.

My second baby is now 4 months old and has kidney problems.
From the off at nine weeks pregnant I was ill. Sick. My body hurt and I was not right. I had big bruises on my left leg from 12 weeks. It was Deep Vein Thrombosis but they kept saying it was not. By the time I gave birth my left leg was a right old mess.

So from around 20 weeks pregnant they found that my baby had problems with his boy pipe work. Every 6 weeks we kept going to Chipping Norton and Oxford for scans. The weeks all went ok even though I was bleeding from 29 weeks. I had an infection in the water around the bump. I had antibiotics for a long time.

I got to 36 weeks. I had a scan and check on the Tuesday and my back waters had broken. They had not been very nice to me really as they just kept saying I was an old mum and it was to be expected at 41 years old. I was induced on the Friday of that same week as I could not put up with the pain any more.

Driving to Oxford in an hour's journey is not great at all. Traffic, bumpy road. I thought I was giving birth in the car. This birth was 13 hours. But after I had not had pain relief for 10 hours. [redacted] was not seen and the paperwork started until about 12 hours. He had jaundice and spent 5 days in the light box trying to get better.

We had been told we could go home 5 days later but baby was very poorly the next day and we thought he was going to die during the night. The next day we spent 24 hours in Banbury children's ward trying to get [redacted] better. I think all in all giving birth is a right nightmare. We're not going to have any more children. The staff we saw in Oxford were rude. The Banbury staff during our scans were nice and polite.

Case 45 [redacted] - 2017 - 2024

My third pregnancy sadly for me meant I needed consultant supervision and as this was a service Banbury no longer offered I was forced to travel to Oxford. And whilst Silver Star were wonderful (and of course I'm extremely grateful to be able to access such health care), the inconvenience of having two children already, maintaining a job and trying to attend regular appointments was extremely hard and not only became more tiring the closer I got to my due date but also was extremely costly in both fuel and parking.

I spent my last trimester under extreme stress with the worry about whether I would be able to make it to Oxford in time, since this was my third child. Would I be able to access the necessary transport, would my partner be able to stay with me?

I was extremely lucky that as the transition of Banbury patients was in the early stages, my partner and I were given a private room when I gave birth - this was only because my midwife pushed for it. I'm very sure others were not as fortunate.

The day my son was born, the ward was closed due to being at capacity, and my son was delivered by the on-call midwife due to the ward being overrun.

Again, given that I was under a specific unit, I was lucky to be able to have this care provided.

But should we be lucky? Is this safe? Would my care have been more suitable closer to home? I absolutely think had I been able to do this in Banbury, and therefore, closer to home, it would have felt like a calmer and smoother pregnancy and birth.

I would absolutely love to see Banbury Maternity unit (consultant-led obstetrics) being used again. With an ever growing town and in the interest of local people maintaining local jobs it's not only wanted but crucially needed care for all that require it.

Case 46 [redacted] 2023

Thankfully it's not a tragic story unlike others. But it is enough to make me not want to experience hospitals again..

My labour was 30.5 hours long and started on Monday night at 10:45pm from my waters breaking. My partner and I went into the Horton department and saw a midwife, she explained that we'd have roughly 18 hours before I'd need antibiotics and sent to the JR to prevent any issues and sent us on our way but to come back if we were concerned.

My contractions started not long after. I tried to sleep but only managed an hour. Around 9am we went back in to say that things were progressing. I had been tracking the contractions with the Freya App which were saying 8-5 minutes apart. They refused to check how dilated I was, gave me a tens machine to use and said to come back in 6 hours.

I was fairly calm during this but was feeling anxious. I believe because I wasn't sobbing or screaming they didn't take me seriously.

So we left and I went to my mother's house for more familiarity. We were there for seven hours. I was so tired at this point but trying to stay calm, breathing through every contraction and trying to stay as calm as possible. We had phoned the midwives a few times in between the visits but as I wasn't the one calling them I don't know what was said. My partner wasn't happy though.

Eventually I said I really couldn't take it anymore and we went back to the Horton. By this point they had switched midwives over. They didn't keep notes of what was happening so each midwife we saw was clueless and it felt infuriating as I felt that I wasn't being taken seriously and fobbed off at every moment.

When we went in they refused to believe how far along I was into my labour. Again I think due to me not screaming in agony. They refused to check how dilated I was. They were really really adamant about making me go home again until my partner put his foot down and was stern with them.

Finally they gave in and said I would go to the JR. They had given me the illusion that I was giving birth there (at the Horton) from the beginning, yet wanted to send me away even though it had been 18 hours since my waters broke. It seemed their first course of action was to send me off.

They then wanted my partner to drive me to the JR even though I was begging for gas and air. They gave in and I got an ambulance. That first hit of G&A was amazing. I let my emotions out a little more in the ambulance as I felt safe but as soon as we reached the JR I felt hyper vigilant and tense. I hated being wheeled in past loads of people.

I then waited in the hallway on the trolley for what felt like ages without G&A. I have social anxiety and hate feeling on display in tender moments. My mum came with me in the ambulance so was also internally freaking out without my partner.

Finally they gave me a private waiting room - I think this was now around 8pm Tuesday. I was there for an hour without any medical help. A nurse popped in briefly at the start and left, then when she came back 45 minutes later we sternly spoke to her. I was so angry and in a lot of pain at this point.

We explained how I had been refused to have a cervical check, they refused to believe how far along I was and we had to get to the point of showing the nurse the app to justify how close my contractions were. 2 minutes! After the check they were shocked I was 7cm dilated. I didn't get an apology though.

Thankfully this is where things did change for the better. My delivery midwife was incredibly kind and supportive. The only experience of that yet.

My mother wasn't very impressed that she spent more time on note-taking than caring for me but I was too much in the throes of labour to care.

Medically things were sound until I said I was ready to push and she was again shocked and said I couldn't be. My mother had to remind her that I needed to be checked and yes, I was 10cm.

It was long pushing my son out as he had his hand under his chin. There was a doctor present as I said I wanted a vacuum to help but in the end it wasn't needed.

I had wanted the placenta to come out naturally but I do remember him giving me a shot which I didn't consent to. Looking back I know it's because they want to speed things along.

Everything was alright from there until the evening. I stayed overnight in hopes of getting help breastfeeding. I got so much contradictory advice, I was so tired with having no sleep, anxious without my partner there. The nurses were rude and dismissive. It felt like such a long night. The next day we had to keep reminding them to get our dismissal form. It was a terrible experience, disorganised and too many women to give decent care to any new mother.

The aftercare was bad at the Horton too. My son had jaundice, so we had to flush it out with a lot of milk. I had an under supply which we had to top up with donor breast milk but they made me feel so terrible that he was losing weight that they made me cry. I have hated my whole experience with them and I was anxious about being with the Horton team for my second pregnancy. (During my first pregnancy I was with the Chipping Norton midwives who had been amazing)

I understand how things are for the maternity wards, that the NHS is under pressure, how they prefer to induce now as it's more time efficient etc. But the complete neglect I felt, how no one believed me the whole way through was so disheartening that I do not believe I would get any better treatment this time round. Which has made me want to have a home birth and a relaxed birth which I wanted for my first.

I'm grateful that my son was okay and nothing truly bad happened but the trust is gone. If things don't look perfect further down this pregnancy and they want me to have a hospital birth I'll definitely look into private care.I do not trust the Horton or JR.

Case 47 [redacted] December 2023

We had to go to Oxford for an emergency C-section. Driving up there from Banbury was not fun while in labour. We then proceeded to drive to Oxford, from Banbury, twice a day, for 3 weeks because our baby was in the NICU. We're lucky, we had a car. I know a lot of people don't. Even with a car, the stress of having a baby an hour away while we had to go home, was enormous.

They told me there wasn't anyone available to see me at the Horton. Not enough staff apparently; it seemed like they were already full. They told us to go up to (JR) be checked, put me on a monitor - emergency C-section. I had placental abruption, so if I had left it or chanced going to the Horton, we could have both died!

Case 48 [redacted] - 2018

In 2018 I had my fourth child. Complications arose around 20 weeks and from then I had to have multiple monitoring/checks and extra scans. I also required a specialist who I met with after a few weeks. If I could have been in my local hospital up the road (where I had my third child) the difference in stress levels, disruption to family life and ability to navigate a difficult pregnancy would have made all the difference.

I honestly believe that the difficulties I faced during pregnancy became heightened by the anxiety and stress of travelling/parking/expenses and lack of ability to have family support added to my negative experience of my last pregnancy.

Case 49 [redacted] - 2015 - 2020

I had my first baby in 2015. It started off well, lovely midwives who had to go off shift. New midwives came in and were terrible - on their phones, not bothered. I ended up pushing for I think it was 6 hours.

They were pretty poor, gas and air ran out after hours of begging then I was rushed down to theatre where there was a back up. I remember distinctly saying to them if I had a gun I would shoot myself I was in so much agony with no support.

On the ward after, I was told I should request my notes which we did. I was in hospital for 4 days. Simple things like asking for my urine and me telling them it was in a pot in the loo, and still finding it there 12 hours later, was pretty bad. I had to have my placenta scraped out of my womb as it didn't come out led to me being on antibiotics for 6 months afterwards.

The whole experience was horrific and I had flashbacks for years. My husband was also quite traumatised. I had my second in the height of Covid 2020. I was told I couldn't have a home birth due to the risks and the community midwife was brilliant.

The birth was straight forward and I was glad to be home within 6 hours of delivery. I felt listened to when I got there; they got me straight into the pool at my request and he popped out within an hour of arriving.

Very different experiences. I am glad I had the second just to overcome the horror as I felt a huge amount of guilt with the first one.

Case 50 - [redacted] - 2022

On November the sixth, 2022 I was in labour with my son, and no one believed me. I was given paracetamol and was told I didn't have a clue what I was on about although I knew full well, as I've had two children previously.

I was in the JR for 10 days before I gave birth. I had pre-eclampsia and Covid. I was in a room on my own for two days with no food or drink, and I was given a commode go to the toilet on.

I was always ringing the bell, but no one would come. When staff eventually came, they treated me like I was a monster. They wore masks on top of masks, doubled gloves and double aprons. They would talk to me at the door behind the curtain.

They didn't empty my commode for days. It was horrible. They moaned at me for letting the commode get so full yet I wasn't allowed to leave the room and I didn't wash for days. I was allowed to wash once the Covid had gone. At that point I was allowed in a room with other women, which was a lot better.

On November 6th, I was one of two of the last in the room. I was full in labour and no staff were around. I was shouting at someone to come and the person who responded told me I wasn't in labour. She gave me paracetamol.

She put the baby monitor on me to check the baby's heart rate and made me lay in bed for half an hour, on my own in labour, on paracetamol. I was in tears. Once the monitor had stopped, I got out of bed and walked around to try and get comfortable. I was crying to my partner on a video call in the family room area, crying, bending over a chair in so much pain.

No staff were around. It was like a ghost town. The contractions got worse and unbearable. A young male nurse came to me and asked if I was okay. He saw I was in labour. He got me a wheelchair and took me to the labour ward straight away, he was lovely. I got downstairs and I was six. centimetres dilated. The midwives upstairs refused to believe me.

Article from Banbury Guardian.
22 September 2016

THURSDAY, SEPTEMBER 22, 2016 | 95p | TALK TO US | facebook.com/banburyguardian | @banburynews | banburyguardian.co.uk

BANBURY Guardian

‘How I nearly died giving birth at JR’

By Roseanne Edwards
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A mum said she was ‘nearly killed’ during childbirth at Oxford’s John Radcliffe Hospital because facilities were so poor and staff were too busy.

Karen Osenton lost 3.5 litres of blood during a planned Caesarean section when she had baby Annie in February.

A terrifying catalogue of events meant Mrs Osenton, of King’s Sutton, nearly lost her life and was only saved when a midwife realised her body had gone into total organ failure.

“The JR nearly killed me and all because they were too busy. The powers-that-be say it is unsafe to keep the Horton a consultant-led maternity unit but do they not realise how unsafe it is at the JR?” she said. “The staff did try their best but they are much too overworked to care for their patients.”

After her operation, during which she lost a litre of blood, the further loss of 2.5 litres of blood, development of pre-eclampsia and organ failure were missed.

As her agonised body went into shut down and she complained of severe pain, Mrs Osenton was advised to drink peppermint tea and relax.

She says a doctor refused to take blood tests from her newborn baby – thought to be suffering low blood sugar – because he was ‘too busy’.

When a new midwife on shift raised the alarm, consultants were called from home and an emergency operation carried out which saved Mrs Osenton’s life.

“While theatre was being reopened, a midwife concentrated on me, fully leaving one inexperienced midwife to look after all the other patients,” she said.

In the recovery room, Mrs Osenton was given another woman’s medication which she took for two weeks until the mistake was spotted.

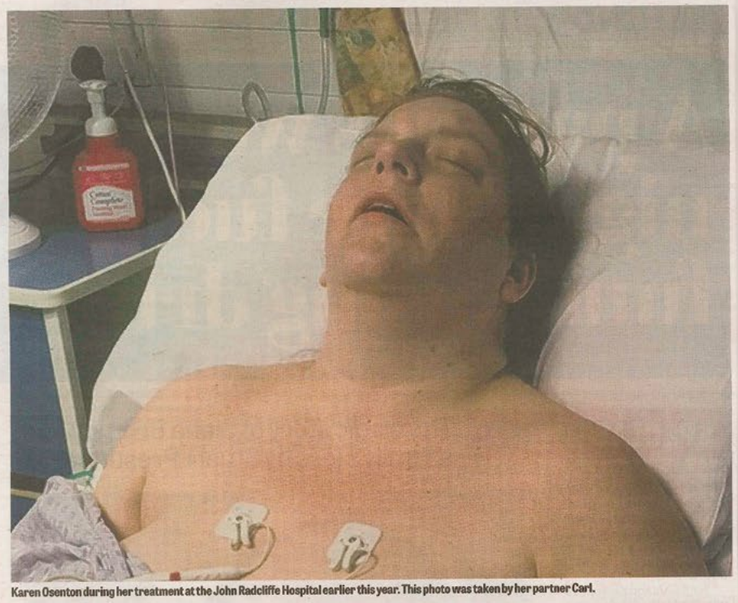
“It was explained after that during that day, they had been too busy to really make sure I was okay and that a serious case review would take place. I have still not heard anything. I was told I was the third person to ‘bleed out’ in as many weeks.”

Mrs Osenton, who described the majority of antenatal care at the Horton as ‘amazing’ said her consultant at Banbury said her Caesarean section should happen immediately because of new complications, but JR doctors made her wait a further two weeks – she believes because they were too busy.

Mrs Osenton says that women’s urine samples built up in the lavatories; women were forced to give birth on trolleys in observation rooms; tests that took an hour at the Horton took four to eight hours at the JR and that her discharge took 11 hours because pharmacy was so stretched, her medication was delayed.

SEE MORE ON PAGE 3 →

Karen Osenton with baby Annie Kay Chappell



Karen Osenton during her treatment at the John Radcliffe Hospital earlier this year. This photo was taken by her partner Carl.

Mum warns of JR overload after ordeal

Mother asks whether Oxford can cope with Horton births

By Roseanne Edwards
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King’s Sutton mum Karen Osenton enjoys life with her partner and daughter Annie but the baby’s birth by Caesarean section resulted in a near-death experience.

Mrs Osenton now questions whether the ‘overwhelmed’ JR Hospital will manage the Horton’s deliveries after the Oxford Radcliffe Hospitals Trust centralises consultant-led maternity from Banbury on October 3.

“The JR staff did try their best but they are much too overworked,” said Mrs Osenton, who suffers a broken back and hip problems.

Annie was born in February, before plans to move Horton maternity were revealed. Mrs Osenton was diagnosed with hypertension so was referred to the JR where she had to go every alternate day for four weeks.

“All women in labour or who need monitoring have to go through the Medical Assessment Unit (MAU). It is dark, cramped and dirty and there are insufficient chairs. Patients were often left standing or in the corridor,” she said.

“Observation rooms had one hard bench in them. I often waited four to eight hours on one. Because of my broken back and being heavily pregnant I could not lie on it for this long but was told due to lack of space in delivery, lots of women had to give birth on these benches.

“Staff requests for proper beds were ignored. Every time I went I had to give a urine sample and was told to leave it on the side. Each time both toilets had at least six to ten samples left. I was told they were too busy.

“Once a lady was having contractions two minutes apart and was ignored. In the end I demanded someone help her and was told they were too busy.

“In the day assessment unit the 30 seats were nearly always full. Waiting times were so long because they had only three beds. A cupboard had been made into a cubicle with a hard observation table in it. There were usually only one or two midwives working so once in a cubicle you still waited four to six hours for tests that should only take an hour. I was told they were too busy and the unit could not cope. You heard women weeping in frustration at the lack of staff and the time taken to do anything,” she said.

‘The JR staff did try their best but they are much too overworked’

“The journey there was horrendous, 45 to 90 minutes. Mum often had to pull over while I was sick. I did my best to persuade my consultant to let me have the tests at the Horton where I had a bed straight away and all tests back within an hour.

“The consultant told me I was very ill and should be delivered that day but he could not enforce this. Back at the JR they made me wait another two weeks and my condition deteriorated.

“For eight hours after my Caesarean I complained of pain and was ignored – again ‘too busy’. I had suffered a mass internal bleed, had developed severe pre-eclampsia and my liver and kidneys had completely stopped working. I was rushed back to theatre and woke up in intensive care. The JR had nearly killed me and all because they were too busy.”

Catherine Stoddart, chief nurse at OUHT said: “We are very sorry to hear about Ms Osenton’s experience in our hospital. We are continually striving for excellence throughout the trust and I therefore hope that Ms Osenton will make arrangements to talk to our team about her experiences so that we can ensure that we learn from any issues raised. It is national practice that women with high risk pregnancies need access to specialist services such as those at the John Radcliffe Hospital for obstetric and neonatal care.”

Article from Banbury Guardian.
6 October 2016

THURSDAY, OCTOBER 6, 2016 | 95p | TALK TO US | facebook.com/banburyguardian | @banburynews | banburyguardian.co.uk

BANBURY Guardian

Premature baby is born in foyer as service ends

Mother gives birth in maternity unit's reception area

By Roseanne Edwards
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Special Care Baby Unit (SCBU) nurses took charge of a tiny premature baby that was born in the foyer of the Horton's maternity unit the day before hospital bosses removed consultant led services.

The nurses were still in the unit on Sunday (October 2) when a mother who had gone in to labour 12 to 13 weeks early delivered her baby in the entrance to the Hightown Road maternity hospital.

The following day, trucks removed beds and other equipment from the delivery rooms in the unit which on Monday became a midwife-only service with one midwife and an assistant in place of the 24-hour teams of obstetric consultants, specialist doctors and midwives, delivering 1,500 babies a year.

Former Horton midwife, Sarah Ayre said: "On Sunday, officially the first trial day of the midwife-led unit and SCBU's last day at the Horton, a young mum-to-be went into labour.

"I hear she rang the JR (where expectant mothers with first babies or who are high risk will be sent) but was put on hold for too long.

"The family took her to the Horton's A&E to be assessed. She was 27 to 28 weeks pregnant," she said.

"She was sent to maternity and gave birth in the foyer. SCBU was there so the baby was able to have respiratory support that avoided intubation, which is unnecessary and painful.

"The baby stabilised and transferred well. If this had happened 24 hours later, the story could be very, very different," said Mrs Ayre, who resigned from the Horton Maternity Hospital last year.

Oxford University Hospitals Trust said it was unable to comment on this particular case owing to patient confidentiality but stressed the situation would be no different now the changes have come into effect.

Chief nurse Catherine Stoddart said remaining staff at the Horton – midwives, paediatricians from the children's ward and anaesthetists – would be able to manage such an emergency.

"The Newborn Intensive Care Unit at the John Radcliffe Hospital provides three levels of care: intensive care, high dependency care and special care, which is the lowest level of newborn care. The Horton Special Care Baby Unit looked after babies born after 34 weeks or younger babies who no longer require intensive or high dependency care," she said.

"From October 3 any woman who goes into labour early and/or who is not booked in to deliver at the midwifery led unit would be directed to an obstetric unit at either the John Radcliffe Hospital or in Northamptonshire or Warwickshire if nearer.

"In the very unusual situation where a woman arrives in premature labour and delivers at the Horton, there is medical expertise available on site to stabilise the baby prior to transfer to the John

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Premature baby born in foyer

FROM PAGE 1

Radcliffe Hospital. Any woman who calls the maternity unit before arrival, which is the normal process, would be advised to go straight to an obstetric unit – by ambulance if necessary.

"The situation has not changed since the Horton became a midwifery-led unit. There are midwives, paediatricians, anaesthetists and other doctors on site all of whom would – and could – respond in an emergency."

Keep the Horton General chairman Keith Strangwood said: "Even at this early stage it appears our worst fears may be recognised.

"We'll obviously be increasing in pressure on the trust to return the service as soon as possible before there is an avoidable event."

KTHG campaign member Val Ingram said: "There was no time for this lady to get to the JR. This is exactly what we have been warning about and it happened during the hours before our consultant led unit was downgraded."

The obstetric unit has been closed at the Horton on safety grounds as the trust said it had been unable to recruit the necessary number of doctors to cover rotas. See page 3 opposite.

Article from Banbury Guardian.
16 March 2017

The John Radcliffe Hospital, Oxford, where most mothers from Banburyshire are now having their babies

Chaos on the wards – 'The JR cannot cope'

New mums report lack of beds and cots at Oxford unit

By Roseanne Edwards
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Mothers in Banburyshire have described a chaotic situation at the JR birthing centre since consultant-led obstetrics was removed from the Horton General last October.

Although Oxford University Hospitals Trust bosses assured councillors there was capacity for up to 1,200 extra births – in addition to the 5,800 already delivered each year at the JR – the new mums describe a worrying picture of stress and overload.

Mothers close to delivery have been sent home because there are too few beds. Others were moved to delivery suites only minutes before their infants were born. Some claim there were no cots.

More than one mum described on social media how husbands were told to drive them to Oxford and, if she began to push, to call an ambulance.

Keep the Horton General chairman Keith Strangwood said: "We have always known this was the likely outcome of the insane decision to remove consultant-led maternity from this rapidly growing area.

"There was never any indication the JR would be able to manage our 1,500 a year births. These accounts shows something has to be done to bring obstetrics back to Banbury."

One mum said: "It was only when I threatened to transfer to Northampton at midnight they called in an extra midwife and showed me to an empty room.

"We had been waiting around all day being told I was high risk and needed my waters breaking. But we were continually told the delivery suite had no room or midwife for us.

"After discharging myself at 10pm, exhausted, we arrived back in Brackley for me to go into labour. We rushed back to the JR to be told there's still no room. I was ready to go to Northampton as I felt so let down by the hospital and so panicked.

"Suddenly I was magically shown to a room on the delivery suite and a midwife was called.

"In the same situation again, I would not go near the JR. It is clearly not coping. If I hadn't insisted on looking into going to Northampton I wonder if my little one would've ended up being delivered in the assessment room too. There was a baby being delivered there on the previous Wednesday when we waited for hours and left without being seen," she said.

'We have always known this was the likely outcome'

Keith Strangwood

Another mum said staff were saying how they cannot accept any more people as they had no beds and would have to turn patients away. "This is the main hospital in Oxfordshire and they are saying this."

Sharon Hills said: "I was left in reception and a waiting room without any drugs. I finally got in a delivery room and my little boy was born 75 minutes later."

Another woman said her sister in law delivered her son at the JR on Tuesday. "She went to the Horton but was told she'd have to go to the JR due to her waters breaking hours before. The midwife said they hadn't had anyone else in.

"Her husband was told that 'if she starts to push, pull over and call an ambulance'. They made it to the JR only to be told there were no beds available.

"She had to stay in the waiting room, full of people. They finally got her into an assessment room as the delivery suite was still full. Then she realised the baby was coming. They found her a room with only 15 minutes to spare. She then had to stay in the delivery room as there were no beds on the ward. There was no cot available until 6.30am. The staff were overwhelmed. All the extra staff had been called in and of course our amazing Horton midwives were there. The JR cannot cope! It's insane that our maternity unit is sat there empty," she said.

Article from Banbury Guardian.
3 August 2017

First-time mum sent to Wallingford – and backs Horton

A mum who wanted to have her baby at the Horton found herself being sent to a midwife-led unit in Wallingford because the John Radcliffe birth centre was full.

Laura Davies, who lived in Valley Road, Banbury before moving to Thame, said she feels the JR cannot cope with all Banbury's births after her experience in June.

Baby Leighton was Ms Davies' first baby and as such would not have been allowed to deliver at the midwife-led unit that has replaced the Horton's consultant-led ward.

"The day my contractions started I rang the assessment unit at the JR," she said.

"I had no idea what to expect as it was my first baby. On the third phone call about 4pm a member of staff said they were really busy and under-staffed – and their Spires midwife unit was closed.

"They told me they would 'do their best' if I came in which doesn't put you at ease when you're having your first baby.

"They gave us two options, we could either go to Wallingford which is midwife-led or Wantage which was over an hour away.

"So my partner and I decided to ring Wallingford. As soon as we rang and spoke to them we felt so reassured. They sounded so nice and helpful."

The Horton General Hospital

During her labour Ms Davies was told the unit in Wallingford was being sent two more mums by the JR because the general maternity ward had by now been closed.

"They were only taking emergency cases at the JR but if they couldn't handle the cases they had there already how would they cope with the extra emergency cases?" she said.

"I know the staff can't help it and they all try their best but it's not fair on them. What I'm trying to say is we desperately need the Horton services back."

The Banbury Guardian has approached OUHT for a comment.

Article from Banbury Guardian.
5 October 2017

A34 blocked as birth transfer is held up

Campaign says emergency transfers are 'Russian roulette'

By Roseanne Edwards
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Campaigners have accused health chiefs of subjecting Banburyshire patients to 'Russian roulette' with risky transfers to Oxford.

The Keep the Horton General Campaign (KTHG) made the accusation after a woman in labour, being transferred from the Horton to Oxford, was held up when an ambulance tyre burst on the A34.

The rush hour traffic was halted while a relief ambulance was summoned and the woman was moved from one vehicle to the other.

"It's a classic case of Russian roulette in transferring women with so-called 'low risk' births at the Horton midwife unit to Oxford when things go wrong, as they inevitably do sometimes," said KTHG chairman Keith Strangwood.

"It is a perfect example of what we have predicted all along – that births go wrong without warning; that they can happen during rush hour and when traffic cannot get to the JR quickly and then something else happens on top to hold the whole process up still further.

"What happens in the snow, thick fog or if an accident has blocked the road? The blunt fact is that the Oxfordshire Clinical Commissioning Group (OCCG) and Oxford University Hospitals Trust (OUHT) are turning their backs on the people of Banburyshire.

"They're doing it because of financial cuts and the OCCG should be telling NHS England that it is not safe to be transferring mothers so far."

'It is what we have predicted would happen all along' Keith Strangwood

The temporary closure of the Horton's consultant led unit took place, with closure of 45 medical beds, last October.

A dedicated ambulance for emergency transfers, hired privately at a reported cost of £1m a year, has been kept outside the midwife-only unit that replaced the obstetric service.

South Central Ambulance Service (SCAS) gave the following timeline for the incident:

- 8.17am – emergency call received from Horton Maternity Unit.
- 8.18am – dedicated transfer ambulance (a private ambulance contracted for OUHT via SCAS) is dispatched.
- 9.02am – ambulance reports a tyre blow out in lane two of the A34 and requests replacement to complete transfer.
- 9.03am – replacement ambulance dispatched by SCAS.
- 9.17am – replacement ambulance and Thames Valley Police arrive at scene.
- 9.40am – patient arrives at John Radcliffe Hospital.

One unconfirmed report said the maternity department chiefs were so concerned about the outcome, the top consultant met the ambulance at the door.

Richard McDonald, head of operations (Oxfordshire) at SCAS, said: "On September 25, our ambulance based at the Horton General Hospital suffered a tyre blow out on the A34 whilst transferring a maternity patient to the John Radcliffe Hospital, Oxford.

"The crew promptly notified our control room and a second ambulance was immediately dispatched to the scene.

"With the aid of Thames Valley Police, the patient was safely transferred from the first ambulance in lane two of the A34 to the second ambulance, which then completed the patient transfer.

"The delivery at the JR was completed without issue and the mother reported as fine.

"I would like to congratulate the family on their new arrival and thank staff in our control room, as well as our staff and police officers at the scene for acting so promptly and professionally to the unexpected interruption during the transfer and helping ensure it was completed safely."

OUHT declined to make a comment on the incident.

Article from Banbury Guardian.
11 January 2018

We'd never have got to Oxford!

By Roseanne Edwards
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A mum who gave birth to the Horton's first baby of 2018 says she would have given birth in Deddington if she had been directed to Oxford.

Sarah Allen went into labour just after the New Year fireworks ended.

She and her husband Adrian made the 12-minute journey from home in Banbury up to the Horton midwife-led unit and baby Joshua was born just 12 minutes later.

"When I went for my booking in appointment I was told they weren't allowed to let women over 40 deliver at the Horton and I am 41, so I should have gone to Oxford to deliver or had a home birth," she said.

"Luckily a consultant I saw said it would be okay to have the baby at the Horton, where my son Ben, five, and daughter Rebecca, two, were also born.

"Joshua was born only 12 minutes after we got there so I calculated that I would have given birth in the car in Deddington if I hadn't been accepted at the Horton.

"The worrying thing is that he was born in his bag – the waters had not broken.

"I don't think my husband would have known what to do and I was giving birth and just being carried along by events, so I wouldn't have known either. Joshua could have suffocated.

"Since then, I keep thinking how many ways this could have gone wrong and how we really do need a fully-functioning, consultant led maternity hospital in Banbury – especially with the increasing population."


Sarah Allen with baby Joshua

Article from Banbury Guardian.
4 August 2018

HORTON CAMPAIGN

Horton proximity helps families visit sick babies

Ginny Mullins' son Ethan, born at 35 weeks, contracted the Strep B infection during delivery and spent the next two weeks in special care at the Horton.
Discharged herself, Mrs Mullins and family were able to visit the baby easily in Banbury. That journey to Oxford every day would have been intolerable, she said.
"Ethan stopped breathing at three days and needed oxygen to stimulate his breathing. He was then under the hospital for about two years, in and out of the children's ward nearly every month requiring overnight stays," she said.
"My second son Oscar was a very quick labour of one hour 23 minutes from me waking at home to delivery. We wouldn't have had time to to reach Oxford after making provision for Ethan. We would have ended up delivering in the car, which could have been fatal as the cord was wound round his neck. In addition I needed to have an intravenous line set up for antibiotics as a precaution in delivery due to the risk of the strep B infection," said Mrs Mullins of Banbury.
"I was born in the Horton with my twin in 1977. Mum was admitted for a eight weeks prior to delivery for observations. I was looked after in the nursery as I had been a breach delivery and was small. It seems ridiculous to be making cuts when the service is needed as much as 40 years ago."

Mums use net page to recall birth horrors

Countless tales told of problems with transfer to Oxford

By Roseanne Edwards
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Dramatic stories of infants at risk in childbirth have poured onto the Save Our Horton social media page since the campaign to save Banbury's maternity unit was launched.

Hundreds of mothers have recounted frightening tales in which they insist there would have been no time to transfer them to the John Radcliffe, Oxford as hospital bosses plan from next month.

The Oxford University Hospitals Trust says it cannot staff the Hightown Road unit safely after the resignation of three senior doctors. It says it is advertising for replacements.

One mum, Charlotte Nealey, wrote: "As my daughter Mia was delivered the midwife quickly realised she was in danger and within seconds a consultant team rushed in.

"Mia was born completely grey and not breathing because of two lots of meconium inhaled into her lungs.

"She was very very poorly - treated for congestive meningitis and brain damage. The fantastic paediatric consultant team saved her life. They also saved her from any damage to her brain and she's now a completely healthy 11-month-old.

"I feel sick to think she would've died within minutes if there weren't any experts on hand to treat her.

'I feel sick to think she would have died within minutes without experts'

"She wouldn't have had a chance if she needed blue lighting to the JR before being treated and stabilised in SCBU first.

"How dare these people threaten to reduce the services? We need more midwives and facilities for this hospital."

Kirsteen MacColl-Bowman suffered a pain condition during pregnancy that necessitated stron g pain killers.

"Without consultant care I would have had to travel to the JR. It was difficult and painful enough attending the Horton, never mind Oxford.

"When I had our son Iain by C-section it was at the HGH and staff went above and beyond what we expected. The SCBU nurses and paediatricians were in the theatre with us as there was an expectation that our son may have breathing difficulties due to the analgesia."

"Banbury is a growing town but has maintained the personal touch to its patients. Unfortunately, the same cannot be said for the JR. I have seen first-hand at both hospitals as a patient and a member of the nursing staff," she said.

Gemma Payne, of Banbury, said she could not have wished for better treatment than that she received at the Horton Maternity Hospital.

"It was a very long, traumatic labour. After about 16 hours and after a failed epidural it was time for Fearne to be born.

"Her heart rate did not recover after several pushes so I was told I needed to go into theatre for a forceps assisted delivery -but in case that didn't work I was prepared for a caesarian section. Luckily it worked and Fearne was born.

"However I had to have another procedure as I had a retained placenta which I was able to have there and then.

"If it wasn't for the fast response of the midwives and the consultants and surgeon Fearne and myself may not be here today. I owe them my life and my daughter's life."

Collette Willoughby Haywood's son Alfie was born by emergency C-section at the Horton eight weeks prematurely. He was tube fed and cared for by SCBU.

"Anne and the team were amazing, reassuring us every day that Alfie would be fine," she said. "Had we been at the JR I wouldn't have been able to spend as much time with my new baby - not being able to drive after my C Section. It would have been a much more stressful and tiring time had it not been for the Horton!"

Article from Banbury Guardian.
30 August 2018

Horton gets national TV exposure in births row

By Roseanne Edwards
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A Banburyshire mum has described her birth ordeal and battle with sepsis miles from home because of the Horton's downgrading.

Alice Watkins of Wroxton told BBC TV's Victoria Derbyshire Show this week how she was taken to Warwick for an emergency caesarean and blue-lighted back a week later when she contracted sepsis.

Mrs Watkins appeared on Tuesday's show with Keith Strangwood, chair of the Keep the Horton General, in a programme examining changes in maternity services.

The programme looked at the effect of temporary closures of maternity units due to staff shortages, while Mrs Watkins outlined how the recent downgrade at the Horton saw her go to Warwick – twice – as a result.

"Our local hospital, the Horton, has been downgraded to a midwife-only unit. It's my first baby so my husband and I were concerned about being at a unit where there are no doctors so we had to choose between two hospitals that were nowhere near our home.

"It's a good job we did as my son had to be delivered by emergency caesarean. We had to choose betweeen Oxford, which is very difficult to get to, or Warwick which is in a different county," she said.

"After I got home I became very unwell and the Horton diagnosed sepsis. But because the maternity unit had been downgraded I couldn't get the treatment I needed there. So I had to be transferred in an ambulance to (Warwick) to receive the treatment I needed to save my life – with a six-day-old baby in tow. It was very scary."

Mr Strangwood said: "We have documented cases of women giving birth in a car, a grandmother delivering her grandchild on the side of the road and a woman giving birth in a supermarket car park.

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Alice and Nick Watkins from Wroxton with baby William

www.banburyguardian.co.uk Thursday, August 30, 2018

Horton featured on national TV in births debate

From front page

"I have personal involvement in a case where a baby now has life-changing disabilities which is going to cost the NHS millions and this whole (downgrade) was about £2.2million the Clinical Commissioning Group wanted to save."

On the show Shadow Health Secretary Jon Ashworth said the statistics – 46 per cent of maternity units temporarily closed to patients, on 282 occasions – were 'atrocious'.

"This is the result of years of cuts and financial squeezing in the NHS. We haven't got enough midwives; we've seen cuts to the numbers of beds in the NHS," he said.

Mr Ashworth said if Labour won the next election they would reinstate the student bursary to encourage more midwife training and address a shortage of 40,000 more nurses, give the NHS more funding, end privatisation and bring the NHS back together from its current fragmented state.

Retired midwife Peggy Woodward told the programme she thought the figures were only 'the tip of the iceberg'.

Ms Derbyshire read out a government statement saying: "The government have announced a 25 per cent increase in midwife training. Temporary closures of NHS maternity units are well-rehearsed safety measures trusts use to safely manage peaks in admissions because they are unable to plan the exact time and place of birth and there are occasions when they cannot accept more women into their care."

Oxford University Hospitals said they had not issued a comment as they were not asked for one until the end of the programme.

■ Did you see the programme? What do you think? Write to the editor at the address on this week's page 28.

Article from Banbury Guardian.
6 December 2028

Births dossier details 'horrendous' traumas

Horton campaign group fears mums are suffering from PTSD

By Roseanne Edwards
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Hospital campaign group Keep the Horton General says women are suffering post traumatic stress disorder due to Horton downgrading.

The group has compiled a dossier of womens' experiences that include accounts of distress, fear, frustration and inconvenience as women have given birth at the JR Hospital in Oxford.

The trust ended the consultant-led maternity service at the Horton in October 2016 saying they could not recruit enough doctors to keep it safe.

The midwife unit left at the Horton was predicted to deal with up to 500 births a year but only a fraction materialised with well over 1,000 Banburyshire women who would have given birth at the Horton being directed to Oxford in a pressurised department delivering 7,000 to 8,000 babies a year.

"The accounts we have been sent depict an catalogue of horror stories," said KTHG press officer Charlotte Bird.

"They include harrowing descriptions of women being left in labour or awaiting treatment post-birth without access to pain relief or support.

"Women witnessed mothers giving birth in the lavatory and others labouring in examination wards.

"In some cases breast feeding advice and help was simply not forthcoming. Mums complained that they were left with flashbacks and that long delays had affected bonding with their babies."

'The accounts are a catalogue of horror stories' Charlotte Bird

The dossier was prepared for the Horton Health Overview and Scrutiny Committee (Horton HOSC).

The contributions were referred to at last Monday's meeting when the Oxford University Hospitals NHS Trust representatives said each mother had one to one care from a midwife.

However most mums who gave their stories said the JR birth unit was too busy and extremely short staffed. There were stories of delay in administering anti-biotics leading to dangerous consequences for mothers and babies.

Among numerous distressing stories was one whose baby contracted life-threatening sepsis through such a delay.

Because of the pressure on staffing the mother - incapacitated by birth complications - was only able to see her sick baby once a day, by wheelchair, when her husband visited.

One said: "My experience completely ruined our journey into parenthood. I don't know if we'll ever get over it."

Women described emergency transfers from the Horton as 'a nightmare'.

One mother said the labour ward at the JR was full the entire time and she was upset hearing a woman screaming for pain relief in the next room.

"I arrived on labour ward completely exhausted as I was too terrified to sleep overnight. The care on labour ward was second to none but the wait was damaging psychologically," she said.

Another mum had to be transferred at the last minute but there were no ambulances available and, needing an emergency caesarean, she had to be driven in her husband's car. There was no parking available and no-one to meet them.

Many women's planned inductions were delayed for long periods because of labour ward pressure. Travel, traffic, parking and worry about children at home were constant complaints.

One woman who suffered a haemorrhage giving birth at the Horton was rushed to the JR leaving her husband to manage the newborn baby in a car seat in the middle of the night.

The frightened mum suffered many hours' distressing misunderstandings that delayed her surgery. She suffers frequent flashbacks.

Article from Banbury Guardian.
27 December 2018

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BANBURY Guardian

Public hears brave mums' harrowing birth stories

By Roseanne Edwards
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Brave women whose babies' births were marred because of the loss of full maternity services at the Horton described some traumatic experiences in public.

A number of Banburyshire women brought their infants along to Banbury Town Hall last Wednesday to tell councillors re-examining the downgrade of the Horton obstetric unit what it had meant to them.

And the traumas some of the mums endured reduced women and men in the audience to tears.

One woman wept as she recounted how she had endured a transfer from Banbury to the JR, Oxford, on her hands and knees in an ambulance, with a midwife physically holding her baby back so it was not strangled by its own umbilical cord.

Another woman described how she had been forced to tell her husband that their unborn child had died, while stuck in a ward in a bed next to a mother who was cradling her newborn infant – because of lack of space at the JR.

Chairman of the Horton Health Overview and Scrutiny Committee, Cllr Arash Fatemian – who called the meeting – said: "Some of the accounts were quite harrowing.

"I can imagine it's harrowing enough to go through it without having to re-live it in a public and daunting setting so I am really grateful to everyone who found the courage to come and speak."

The committee heard from ambulance chiefs, representatives of the Royal College of Midwives and NHS England – the organisation that sets rules for reconfigurations such as moving major services and keeps tabs on whether NHS bosses are following their guidelines.

Ambulance chiefs were quizzed on whether the transfer times and risks would be greater if the downgrade of the Horton maternity unit were confirmed and the privately-sourced dedicated ambulance (said to cost £1m a year) were discontinued.

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'Harrowing accounts' heard

FROM PAGE 1

They said the current arrival time of the dedicated ambulance was two-and-a-half minutes while calling an ambulance could take up to seven-and-a-half minutes. The patient would then have to be 'packaged' and taken to the JR birth unit.

The Royal College of Midwives was pressed by Cllr Fatemian to say whether – if enough doctors could be recruited – they would recommend having an obstetric unit (consultant-led) at the Horton. They agreed they would. Their regional representative, Gabby Dowds-Quinn, said that in September, out of 17 births at the Horton unit, 13 had needed to be transferred to the JR.

The day ended with a sobering description of a near-death scenario for an Adderbury mum, Keep the Horton General campaign member Sophie Hammond, who had suffered a major haemorrhage and was only saved because of obstetricians on hand in Banbury.

She also presented results of a survey run by the group last month that showed 95 per cent of women would want to give birth at the Horton if consultant-led maternity were returned.

Article from Banbury Guardian.
27 December 2018

'I'd have bled out had I given birth a year later'

Sophie's experience led to treatment for post-traumatic stress

An Adderbury mum has given an account of her traumatic experience giving birth.

Melissa Wyatt and Mary Treadwell O'Connor tell their stories of giving birth. Inset: Sophie Hammond

Sophie Hammond, who is also a Keep The Horton General campaigner, spoke at the HOSC meeting in Banbury Town Hall last Wednesday and was among several brave mothers to tell of their experiences.

She said: "The awful thing for me was that having delivered my baby calmly and without intervention in the birthing pool, in the space of moments, my hitherto tranquil, straightforward labour became the stuff of nightmares, the trauma of which my family and I have had to come to terms with.

"As soon as I got out of the birthing pool, I remember being helped onto a delivery couch by two midwives, who checked me and said I'd had an internal tear, which would need stitching, but first they were going to induce the delivery of the placenta, and was that OK? I consented.

"I was given a local anaesthetic, and I don't think the doctor could wait for it to take effect because she attempted to stitch me immediately, and I remember exclaiming with pain.

"At this point I was told this wasn't working and I would need surgery. I was asked if I would prefer an epidural over general anaesthetic, and knowing the recovery to be worse with a general, I chose an epidural and was whisked to theatre. My amazing midwife had been stemming the flow of blood with her hand virtually the whole time.

"While I was in theatre, my husband was left holding our baby, terrified at the amount of blood he'd seen me lose.

"I don't recall feeling any fear at the time, because I felt strangely at a remove from what was going on. But when I came around, I felt like I'd been literally hit by a bus.

"Bruised and exhausted as I was, I felt guilty that I hadn't been there for my daughter when she needed me.

"My poor exhausted husband attempted to sleep in a chair each night because I couldn't bear for him to go.

"For weeks after the birth I felt pretty overwhelmed, the journey home which was familiar seemed strange to me, and I felt guilty that my little girl had lost weight in her first fortnight.

"The support of my family helped me recover but in the months after my daughter's birth I started to experience flashbacks and insomnia.

"I know now these were manifestations of post traumatic stress, something I have had help to deal with.

"I live with the uncertainty it may or may not happen again, and though I would like to have another child, I am frightened at the prospect of giving birth in a hospital far from home which is over-stretched and where the same thing might well happen again. There's no doubt that had I given birth little over a year later at the Horton, I would have bled to death. It is only because of having access to doctors, clean operating theatres and blood transfusions that women like me don't die in childbirth."

CCG and hospital trust thank women for sharing stories

Health bosses thanked the women for sharing their traumatic stories of childbirth at the Horton Health and Overview Scrutiny Committee (HOSC).

Representatives from Oxfordshire Clinical Commissioning Group (CCG), the body responsible for planning health services in the county, and Oxford University Hospitals NHS Foundation Trust, the organisation in charge of the Horton General and John Radcliffe hospitals, were at the meeting on December 19.

The CCG came under criticism for permanently downgrading the Horton's maternity ward to a midwife-led unit last year, with many urging it to reverse the decision.

A lack of doctors and money-saving was blamed for the taking away the consultants from the Banbury hospital, but campaigners and councils have fought, and continue to fight for, their return.

In a joint statement after the meeting, the two health organisations said: "Oxfordshire CCG and Oxford University Hospitals NHS Foundation Trust were invited to attend the Horton HOSC evidence gathering meeting on December 19.

"This was an opportunity for us to hear directly from mothers and families using the Horton General and John Radcliffe maternity services, as well as from other local stakeholders.

"We welcomed this opportunity to listen to the direct experiences of mothers affected by the changes at the Horton, in addition to our ongoing engagement with and feedback from patients.

"We intend to use their testimony to inform our work to keep improving both the service we offer to mothers, babies and their families and our engagement with the HOSC process.

"We would like to thank everyone who shared their emotional and moving stories with the committee.

"We look forward to continuing to engage with the HOSC process in the new year."

Brave mums share harrowing experiences of giving birth

Banbury mothers held back tears as they recounted some of the harrowing experiences they have been through since the Horton maternity ward was downgraded.

Emma Barlow bravely told the committee: "I spent 30 minutes on my hands and knees in the back of an ambulance with a midwife holding my child's head from the cervix knowing that every push was pushing your baby closer to death."

"Women should not fear for their lives or the safety of their children."

Kayleigh Jayne Carter fought back tears as she detailed the trauma of being shipped back and forth between Banbury and Oxford.

She went from the placid Horton ward to the manic JR, then back to Banbury in defiance before being blue-lighted back to Oxford where she suffered bed sores and a delivery by forceps.

"In 2018, women should not fear for their lives or the safety of their children," she said.

Other mums were told their child had died while alone in Oxford as their family could not visit and surrounded by newborn babies.

Many were forced to think about logistics in the moments after their waters broke to decide whether to go to Oxford or Warwick to give birth.

Each one received rapturous applause for being so incredibly brave to share such personal stories with strangers,

Kayleigh Jayne Carter with her son Devan

Article from Banbury Guardian.
17 January 2019

Parents left devastated after baby Adriel dies

By Roseanne Edwards
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Hundreds of Banburyshire people have flocked to sign a petition calling for women in labour to be able to have hospital care all the way through.

The petition was launched after a Banbury couple's first baby died in the womb after the mother was sent home from the John Racliffe Hospital to wait for things to progress.

The grief-stricken mum had to bear labour and then endure a wait of four more hours for an operating theatre to become free for a repair.

Jeeva Philip had a trouble free pregnancy and went into labour on December 27. She and husband Arul knew their baby was a boy.

He was named Adriel and they bought a blue layette to take into the Oxford hospital for his birth.

"We headed to the hospital at noon and after a long wait of two hours they monitored Jeeva's vitals and our little one's too. They informed us that she was 2cms dilated. The midwife said admission is only possible if she was 4cms dilated," said Mr Philip, a clinical perfusionist.

Mrs Philip – a radiographer at the Horton – was given painkillers and told to go home until the labour progressed.

He said: "If only we had insisted on an admission and continuous monitoring of the baby we would have had him in our arms now. He normally isn't so active in the night so my wife presumed he was fast asleep since he had been active since morning.

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Sympathy to family after 'terrible loss'

FROM PAGE 1

"Her waters had broken early on December 29 and we were at the hospital by 7.30am. The midwife made checks and everything was within the normal ranges.

"At last she performed a Doppler test to listen to his heart beat since we informed her about his immobility. We never knew that moment would turn our lives upside down."

A scan confirmed there was no heartbeat.

Mrs Philip then had to undergo a seven-hour labour – knowing her son had not survived – and after that trauma, faced a wait of four hours for theatre space to become available to repair a tear.

Mr Philip has demanded to know why women in labour are not admitted to hospital for continuous monitoring, why delivery could not be led by a doctor rather than a midwife once loss of the baby was known about and why his wife had been 'starved' for 28 hours.

He also questioned whether the JR's level of quality treatment was compromised by the closure of the Horton obstetric unit and consequent increase in deliveries in Oxford.

The grief-stricken father said he felt such helplessness during the intense situation he did not have the wherewithall to question professionals in the JR department at the time.

Dr Veronica Miller, clinical director of women's services at Oxford University Hospitals NHS Foundation Trust, said: "This is an incredibly sad case and we offer our sincere sympathies to the family for their terrible loss.

"We have referred this case to the Healthcare Safety Information Branch for an independent external investigation, in accordance with Department of Health and Social Care guidance. We will co-operate fully with this investigation."

● The Change.org petition was drawn up by Antony Cithera, a family friend. It can be found at https://www.change.org/p/uk-parliament-nhs-should-admit-monitor-pregnant-mothers-from-starting-of-delivery-pain

The editor welcomes letters on any subject, but reserves the right to amend and edit them. Letters more than 250 words may be cut or not appear at all. Letters must carry the name and full address of the writer, even if it is not for publication. Letters containing a name and address for publication will be given priority.

Guardian Opinion

It is time for the pressure to be taken off JR maternity dept

By Roseanne Edwards
Reporter

The heart-breaking story of Jeeva and Arul Philip's loss of their baby Adriel during labour (page one) is a sobering account for a newspaper to have to report.

However it does not come as a complete surprise. Campaigners for a return of an obstetric department to the Horton in Banbury have long warned that disaster was only a matter of time with only one, full, county maternity service 25 miles away from Banbury in Oxford.

An investigation is taking place into the reasons for the loss of this couple's first baby and the reasons for his loss will not be known until then.

However it is understood that rules for midwives say that once labour is 'established' a baby's heartbeat should be monitored every 15 minutes. In this case the mother was in the early stages and sent home, away from any midwifery care. By the time the labour had progressed to the next stage, it was too late.

This distressing episode gives extra force to the argument for an obstetric unit to be returned to the Horton where the couple might have returned sooner, and more easily for checks.

There are always solutions to staffing and funding problems; it takes integrity, creative thinking and determination as well as acceptance that the cost is both affordable and necessary.

Our deep sympathies are with Mr and Mrs Philip.

Article from Banbury Guardian.
18 April 2019

Baby born at side of the road

Call for Horton maternity service to be restored 'before a child dies'

By Roseanne Edwards
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A baby girl is lucky to have survived after being born in the front seat of a car while her parents tried to reach Warwick hospital.

Tiny Freya Darby was delivered by her mother in a terrifying birth in a car on the M40 motorway.

With the umbilical cord wound twice around her neck Freya was saved by her mother Hayley Ward's quick reaction to allow her to breathe.

"We pulled off the motorway at Gaydon and dialled 999 as I was pulling her out of my trousers – not an easy job in the front seat of car. I managed to unwrap the cord and thankfully she cried almost instantly," said Ms Ward.

This week Keep the Horton General chairman said a return of a full maternity service to the Horton Hospital was essential before a baby dies in similar circumstances.

"We keep hearing about mums booked for specialist care in Oxford or Warwick who are told categorically not to go to the Horton when in labour, no matter how advanced it is," said Keith Strangwood.

"This is not the first 'near death' and it will not be the last. Sooner or later a baby is not going to be as lucky as Freya. We must get our obstetric unit back."

Ms Ward was booked in at Warwick because of a haemorrhage after her son's birth.

"When I went into labour, Warwick said my contractions weren't close enough together. They said I should take paracetamol and go to bed. I did question this as Riley had been born quite quickly.

"Four hours later my contractions went from every six minutes to two. Suddenly things suddenly started to speed up," she said. "We got on the motorway and just before Gaydon my waters broke and I could feel

CONTINUED ON PAGE 9 →

BANBURY GUARDIAN 9

Baby born in car at the side of road

Hayley Ward and partner Andy Darby with baby Freya and son Riley

→ CONTINUED FROM PAGE 1

the head really low. I called Warwick and the midwife said, 'If you don't think you will make it pull over and call 999' but as I was still on the phone, with the next contraction, the head came out followed by the body with the next contraction after that."

Thankful that baby Freya had not been strangled, the shocked couple pulled over and waited for an ambulance.

"I must say the paramedics who picked us up were amazing. It probably only took them 15 minutes to get to us but it felt like ages as we sat in a car at 4.40am in the cold and dark with a newborn baby.

"I was hoping I would not start haemorrhaging in the car with no medical assistance," said Ms Ward.

"Two ambulances arrived and blue-lighted us into Warwick hospital. Luckily the placenta didn't come out until I was in hospital so I didn't start bleeding heavily until I was there and my daughter was absolutely fine."

Ms Ward said both she and partner Andy Darby were 'very frightened'.

"Andy said he actually didn't think he would be coming home with both of us," said Ms Ward.

"It was an experience I wouldn't want anyone else to have to go through.

"If the Horton had been an option for me I would have got there in time and not had this problem. Thank God my daughter is fine but things could quite easily have turned out very differently. The next person this happens to may not be so lucky."

A health and scrutiny committee for the Horton has been set up to review the maternity downgrade.

Article from Banbury Guardian.
25 April 2019

Thursday, April 25, 2019 www.banburyguardian.co.uk

New parents call for Horton unit's return

By Roseanne Edwards
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First time parents Kerry-Ann Harris and Frankie Lester with their new baby, also called Frankie

A mum who suffered a serious internal tear while giving birth at the Horton's downgraded maternity unit has called for a return of the full service.

Kerry-Ann Harris, who lives in Banbury, gave birth to baby Frankie at the Horton soon after midnight on March 28.

But because the Horton unit is now unable to deal with complications she had to be taken to the JR, Oxford for surgery – along with partner Frankie Lester and the infant.

"It was a third degree tear which the Horton can no longer deal with," said Ms Harris.

"My partner had to spend the night uncomfortably in the visitors' room while I was taken to theatre, given an epidural and the tear repaired.

"We had to get my parents to collect us the next evening as Frankie does not drive.

"Things would have been very manageable if we'd had the full service here in Banbury.

"We are in full support of the work of Keep the Horton General (KTHG) as we need to get the service back to Banbury."

Keith Strangwood, chairman of KTHG said: "We are constantly getting reports like this where new, young parents are being put through the disruption of being transferred from the Horton midwife unit to Oxford. It must be really frustrating for the midwives who have all worked in a full obstetric service, having to pack up these families, who have just gone through exhausting childbirth and send them down to the JR.

"It is not what anyone would choose and it is certainly not the kind of calm, relaxing start that families should be able to enjoy when they have their babies."

Keep the Horton General campaign group would like to thank all those women who have shared their traumatic experiences publicly in order to help future mothers to enjoy the childbirth they and their babies deserve.

Published by Keith Strangwood, Keep the Horton General Campaign

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