Letter from JHOSC Chair to Chief Executive and Chair of Oxford University Hospitals NHS Foundation Trust:

I am writing following correspondence we have recently received from families who have recently used the Trust's maternity services, including from the organisation called families failed by OUH.

The Committee has now received and noted the points raised in their correspondence. In order to ensure accuracy and fairness in how this matter is understood and considered, the Committee would be grateful if the Trust could confirm and, where necessary, clarify some of the points raised in their correspondence with us.

In particular, we would welcome confirmation of the Trust's position on the following matters:

- *Whether the Trust accepts that there are data inaccuracies in the report it has submitted to the Committee for its maternity item at its meeting on 29 January 2026 (and if clarity could be provided on those data inaccuracies and assurance that all data inaccuracies in the paper have now been brought to the attention of the Committee).*
- *That the Trust understands the impact on families of data inaccuracies and on the JHOSC ("This not only underestimates the immense patient safety issues present in OUH maternity services, but erases my daughter's death as well as the other babies who died during 2023").*
- *Whether the Trust can expand on it's narrative of the mortality statistics for the death of babies in 2023 (combined perinatal, neonatal and stillbirth) and provide that in writing. The concern of families is that they show higher than average deaths for OUH compared with other tertiary units and that this is a trend since 2017. Specifically it is stated that the stillbirth rate is over 5% in 2023 and therefore the highest of any tertiary unit in the UK whereas the OUH analysis shared with the committee is that it is 'slightly above the peer average (by 0.18%)'. Please clarify what hospitals are included in determining peer average and why as there is a concern that the comparison ought only to be with other tertiary units.*
- *The Trust's understanding of the engagement that has taken place to date with affected families and campaign representatives, including the nature and timing of that engagement.*
- *Any relevant actions, reviews, or remedial steps that the Trust considers directly relevant to the matters raised by affected families.*
- *Whether there are any additional contextual points the Trust believes the Committee should be aware of when considering the issues raised.*

The purpose of this request is simply to ensure that the Committee has a clear and accurate understanding of the Trust's position in relation to the matters raised.

As I am sure you understand the impact of data inaccuracy for families. I am attaching an account we received from one bereaved family whose baby death was omitted from the OUH report because it was part of the 2023 statistics. This also provides a lived experience account of the process in the aftermath of their bereavement and identifies quality concerns. Whilst it is clearly beyond JHOSC jurisdiction to investigate individual accounts, we have secured the permission of this family to share this account with you confidentially at the highest level of the trust and ask what assurance you are able to give the Committee that all actions are being taken to ensure good practice in the investigation and resolution of complaints and that there will be consideration and action to sensitively reach out to this family. I am also attaching our recommendations from the January Scrutiny as our recommendation to complaints is pertinent to this.

We would be grateful if your response could be provided in writing so that it may be shared with Committee members for consideration. Thank you for your cooperation with us on this matter, and we look forward to your response.

Please see below some further extracts from Alice and Pedro Topping's correspondences with the Committee since the January public meeting:

- *OUH said in their internal PMRT report that there were no issues in my care, yet the external investigation showed a catalogue of failures and made 5 safety recommendations all that are considered contributory to the "outcome".*
- *OUH still refuse to update the PMRT, so our daughter isn't even officially down as a preventable death, despite staff knowing my care was a "disaster" and that they "totally failed" me (their words, not mine). We were told the OUH legal team were blocking it being changed. Reputation should not be put ahead of honesty. We have also been left nearly 2 and a half years without a response to our PMRT questions and feedback.*
- *The Trust changed local guidance in response to our daughter's preventable death, the external investigation and the formal complaint we made, but did not inform us of those changes. We have been left to find out ourselves through research, the external investigation and other people*

Best wishes

Cllr Jane Hanna (Chair, Oxfordshire Joint Health Overview Scrutiny Committee)