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NHS investigator says maternity unit care 'appalling'



Image caption,

Former NHS inspector Amanda Ford described the care at Yeovil District Hospital as appalling

By **Dickon Hooper**, West of England, Reporting from Yeovil and **Matthew Hill**, West of England health correspondent

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A former NHS inspector said a hospital's maternity services may not have had to close if she had been listened to.

Maternity services at Yeovil District Hospital **shut in May 2025 due to safety concerns** and are set to reopen in April.

Amanda Ford, a registered nurse and midwife, said her concerns were not listened to after she witnessed "appalling care" and a baby death that should not have occurred while working for the Healthcare Safety Investigation Branch (HSIB).

Yeovil District Hospital said it strived to have an open, safe culture and acknowledged it did not always get this right. The HSIB no longer exists and its successor organisations declined to comment.

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HSIB was announced in July 2015 by then Health Secretary Jeremy Hunt as an independent patient safety investigations service.

Hunt said it was "based on the success of the 'no-blame approach' used by the air accident investigations branch in the airline industry".

It was set up so investigators, with patients' consent, would work to help deliver safer care and prevent harm.

They would investigate adverse incidents and pass on any lessons to the NHS.

'I was appalled'

Ford, 56, worked for the HSIB in the South West from 2019 to 2020.

"Yeovil was one of my first units I was asked to go and investigate some incidents," said Ford.

"Within a month... I just was appalled. One was a baby death. That's a death that shouldn't have occurred - of a very healthy baby.

"One was a lady who was put through labour, who basically shouldn't have been labouring, and she was lucky to have survived that and her baby survived. It was just appalling care."

Ford has not provided the BBC with identifying details of either case.



Image caption,

Ford said Yeovil District Hospital seemed unprepared for emergencies

At Yeovil, she said there was not enough consultant oversight, along with the use of locum staff that "didn't seem to be orientated or supervised adequately".

"They didn't seem to be prepared for emergencies when things go wrong, and in obstetrics or maternity things go rapidly wrong," she added.

Ford said she got a feeling of "defensiveness" from the hospital when she raised concerns during her time at Yeovil.

She said she tried to feed back what she was seeing, but felt managers at Yeovil were too close to her own organisation, which itself was not challenging enough.

She said: "I don't think they got it. And if that was happening in Yeovil, where else was it happening in the country?"

'Bullying' culture

Ford left HSIB and took them to an employment tribunal. She lost her case for constructive dismissal but won most of her grievances at HSIB's internal process.

An independent report concluded she should have been treated as a whistleblower, and that there was a bullying culture at HSIB.

"When I heard about Yeovil closing, it was another validation for my case," she said.

"You would have hoped there'd have been a process where CQC (the Care Quality Commission) would have gone in sooner and HSIB would have escalated sooner.

"I ended up very unwell because of what I've been put through."

Ford said she suffered a "moral injury", adding: "As many NHS whistleblowers will realise, you hit a brick wall... for doing my job and being honest."

Yeovil District Hospital said it strived to have an open culture in which staff and patients felt safe, supported, and heard.

"We recognise we have not always got that right," a spokesperson added.

The HSIB became the HSSIB during a transition period from April 2022 and October 2023.

Its maternity investigations moved to The Maternity and Newborn Safety Investigations, which is overseen by the CQC. Both organisations declined to comment.

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Yeovil District is one of 12 NHS Trusts whose maternity and neonatal care is under investigation by Baroness Valerie Amos.

In an interim report published earlier, **Baroness Amos identified problems** with the mix, seniority and continuity of staffing.

The report also said black and Asian women and women from low-income backgrounds experienced poorer care than others.

It noted that families had faced defensive and inadequate responses from the NHS after traumatic events, which were not properly investigated, and added that families struggled to get independent answers after babies die.

"It is clear from the meetings and conversations I have had with hundreds of women, families and staff members across the country, that maternity and neonatal services in England are failing too many women, babies, families and staff," Baroness Amos said.

She will make national recommendations in the spring.