# Concerns grow over systemic failings and racial disparities in England’s maternity care



The deaths of women and babies during childbirth in England have been described as "normalised," a situation that would be unacceptable in other countries, according to Health Secretary Wes Streeting. Speaking during a House of Commons debate on baby loss, Streeting expressed deep concern about the ongoing culture of silence and cover-up within maternity services. The debate coincides with a significant national investigation into maternity care in England, headed by Baroness Valerie Amos, who is expected to provide interim findings by December.

Streeting highlighted the emotional impact of repeated tragedies, noting his personal dread of meeting families affected by maternity failings, particularly referencing ongoing issues in trusts such as Nottingham. The Health Secretary did not shy away from addressing the systemic racism faced by mothers in hospitals, reporting firsthand accounts of Black women being stereotyped as "strong" and thus denied adequate pain relief, and Asian women being unfairly labelled as divas. This sentiment is reinforced by research from Oxford University, which found maternal mortality rates among Black women nearly three times higher than among white women, with Asian women twice as likely to die during childbirth. Data also reveals a concerning 27% rise in maternal mortality among white women between 2009 and 2022.

The national investigation led by Baroness Amos is structured in two phases: the first focuses on 14 hospital trusts identified as having the most concerning maternity and neonatal services, while the second phase will undertake a broader system-wide review, assimilating lessons from previous inquiries. The aim is to establish a unified, actionable plan to improve the safety and quality of maternity care across the country. The Department of Health and Social Care announced the terms of reference for the investigation in June, emphasising the need for compassionate care for all women and babies.

Baroness Amos's appointment was met with cautious optimism by the Royal College of Midwives (RCM), which welcomed the leadership but urged for an acceleration of the review process. The RCM stressed the urgency of addressing systemic failings such as unsafe staffing levels, entrenched poor workplace cultures, and the failure to listen adequately to women in maternity care. They called on Health Secretary Streeting to ensure the review delivers timely and meaningful change.

This heightened scrutiny of maternity services follows parliamentary reports revealing that Black women’s concerns are frequently ignored or not taken seriously in maternity care, contributing to their disproportionately adverse outcomes. The systemic issues are linked to deficiencies in leadership, training, data collection, and accountability across the NHS. Streeting acknowledged this crisis candidly, committing to making the reduction of racial disparities a core focus of the national maternity and neonatal investigation.

MPs such as Olivia Blake of Sheffield Hallam underscored the recurring problems identified in past inquiries, including poor communication, missed warning signs, and families left to seek answers alone. Blake emphasised the critical importance of the upcoming national inquiry in driving sustained reform, ensuring that repeated failures no longer define maternity care in England.

The investigation’s emphasis on bereaved and harmed families reflects a patient-centred approach, seeking to learn from past tragedies and implement lasting improvements. The hope among healthcare professionals, MPs, and campaigners alike is that this comprehensive review will finally end the culture of acceptance around preventable deaths and systemic neglect in maternity services, marking a turning point for safer, equitable care for all women and babies.

### 📌 Reference Map:

* Paragraph 1 – [[1]](https://www.belfasttelegraph.co.uk/news/uk/death-of-women-and-children-in-childbirth-normalised-streeting-says/a32441957.html), [[3]](https://www.gov.uk/government/news/baroness-amos-to-spearhead-maternity-and-neonatal-investigation), [[2]](https://www.gov.uk/government/publications/independent-maternity-and-neonatal-investigation-terms-of-reference)
* Paragraph 2 – [[1]](https://www.belfasttelegraph.co.uk/news/uk/death-of-women-and-children-in-childbirth-normalised-streeting-says/a32441957.html), [[6]](https://www.itv.com/news/2025-09-17/black-women-ignored-and-not-taken-seriously-in-maternity-care-mps-say)
* Paragraph 3 – [[2]](https://www.gov.uk/government/publications/independent-maternity-and-neonatal-investigation-terms-of-reference), [[5]](https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation), [[7]](https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation)
* Paragraph 4 – [[4]](https://rcm.org.uk/media-releases/2025/08/royal-college-of-midwives-welcomes-appointment-of-baroness-amos-as-chair-of-maternity-and-neonatal-rapid-review-but-urges-health-secretary-to-pick-up-the-pace/)
* Paragraph 5 – [[6]](https://www.itv.com/news/2025-09-17/black-women-ignored-and-not-taken-seriously-in-maternity-care-mps-say), [[1]](https://www.belfasttelegraph.co.uk/news/uk/death-of-women-and-children-in-childbirth-normalised-streeting-says/a32441957.html)
* Paragraph 6 – [[1]](https://www.belfasttelegraph.co.uk/news/uk/death-of-women-and-children-in-childbirth-normalised-streeting-says/a32441957.html)

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## Bibliography

1. <https://www.belfasttelegraph.co.uk/news/uk/death-of-women-and-children-in-childbirth-normalised-streeting-says/a32441957.html> - Please view link - unable to able to access data
2. <https://www.gov.uk/government/publications/independent-maternity-and-neonatal-investigation-terms-of-reference> - The UK Department of Health and Social Care published the terms of reference for an independent investigation into maternity and neonatal care in England. Announced on 23 June 2025, the investigation aims to review individual services and the overall system, bringing together findings from past reviews to develop a unified set of actions ensuring safe, high-quality, and compassionate care for every woman and baby. Baroness Valerie Amos was appointed as Chair on 14 August 2025, with interim recommendations expected in December 2025.
3. <https://www.gov.uk/government/news/baroness-amos-to-spearhead-maternity-and-neonatal-investigation> - Baroness Valerie Amos has been appointed by Health and Social Care Secretary Wes Streeting to lead the independent investigation into NHS maternity and neonatal services. The review aims to identify ways to urgently improve care and safety, with bereaved and harmed families at its core. The investigation will also review the maternity and neonatal system, consolidating past findings into a clear national set of actions to ensure every woman and baby receives safe, high-quality, and compassionate care.
4. <https://rcm.org.uk/media-releases/2025/08/royal-college-of-midwives-welcomes-appointment-of-baroness-amos-as-chair-of-maternity-and-neonatal-rapid-review-but-urges-health-secretary-to-pick-up-the-pace/> - The Royal College of Midwives (RCM) welcomed the appointment of Baroness Valerie Amos as Chair of the rapid review into maternity and neonatal safety. However, the RCM expressed frustration over the pace of the review, highlighting the need for swift action to address systemic failings in maternity and neonatal care, including unsafe staffing, poor workplace cultures, and not listening to women. The RCM urges the Health Secretary to expedite the review to deliver meaningful change.
5. <https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation> - The UK government announced that 14 hospital trusts will be the focus of a rapid, independent, national investigation into maternity and neonatal services. The investigation aims to urgently improve care and safety, with Baroness Valerie Amos leading the work. Bereaved and harmed families will be central to the investigation, which will review individual services and the overall system, bringing together findings from past reviews to develop a unified set of actions ensuring safe, high-quality, and compassionate care for every woman and baby.
6. <https://www.itv.com/news/2025-09-17/black-women-ignored-and-not-taken-seriously-in-maternity-care-mps-say> - A report from Parliament's health committee found that black women in England are being ignored in maternity care, with their concerns 'not taken seriously'. The investigation revealed that black women face disproportionately poor outcomes due to systemic failings in leadership, training, data collection, and accountability. Health Secretary Wes Streeting acknowledged the crisis in care for black women and committed to addressing racial disparities in maternal outcomes as a core aim of the national investigation into maternity and neonatal services.
7. <https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation> - The UK government announced that 14 hospital trusts will be the focus of a rapid, independent, national investigation into maternity and neonatal services. The investigation aims to urgently improve care and safety, with Baroness Valerie Amos leading the work. Bereaved and harmed families will be central to the investigation, which will review individual services and the overall system, bringing together findings from past reviews to develop a unified set of actions ensuring safe, high-quality, and compassionate care for every woman and baby.