



RACE & HEALTH INSIGHTS

Have independent maternity service investigations taken an anti-racism intersectional approach?

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Independent investigations into failings in British maternity services have repeatedly exposed serious shortcomings in safety, quality, and organisational culture. Over the past 15 years, three major inquiries; Morecambe Bay; Shrewsbury & Telford (Ockenden) and East Kent^{1,2}, have examined avoidable harm in maternity and neonatal care. These reviews were intended to generate learning and drive improvements across the NHS but, despite longstanding evidence of racial and socioeconomic inequities in maternal and neonatal outcomes, none of these investigations consistently applied an antiracist or intersectional lens. This omission limits their ability to address structural inequities and risks perpetuating avoidable harm.





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BACKGROUND

Racial disparities in maternal outcomes are well documented. Black women in the UK face around three times the risk of maternal mortality compared with White women³, and Asian women nearly double the risk. Women living in the most deprived areas also experience significantly higher rates of stillbirth and neonatal death. These inequities cannot be explained solely by comorbidities or deprivation; they reflect systemic racism, discrimination, and inequitable treatment within maternity services^{4,5,6}. The absence of intersectional analysis in previous investigations has therefore constrained their capacity to address the structural drivers of poor outcomes.

The NHS Race and Health Observatory's 2022 [policy briefing](#) on the Ockenden Review highlighted the need for equality impacts to be embedded throughout the lifecycle of such inquiries—from design and evidence gathering to recommendations. Baroness Amos' [interim report](#) on maternity and neonatal services (December 2025) explicitly acknowledged the intersectional drivers and prejudices experienced by service users, signalling a shift in national expectations.

Against this backdrop, our analysis examines whether previous independent investigations confronted systemic inequities and whether they considered the intersection of race and deprivation as drivers of maternal outcomes. These questions are particularly timely given the [rapid national investigation](#) into NHS maternity and neonatal services announced in June 2025.



A document analysis of the three major independent investigations published over the past 15 years:



Morecambe Bay



East Kent



Shrewsbury & Telford

WHAT WE DID

We conducted a document analysis of the three major independent investigations published over the past 15 years: Morecambe Bay, Shrewsbury & Telford, and East Kent. These high-profile, government commissioned reports were examined through an intersectional, antiracist lens to assess whether ethnicity, racism, and deprivation were meaningfully considered as drivers of maternal outcomes.

Document analysis involves systematically reviewing and interpreting documents to identify themes, gaps, and omissions⁷. We developed a structured coding frame assessing both the presence or absence of references to ethnicity, racism, and deprivation, and exploring qualitatively why these issues may not have been addressed. The coding frame combined quantitative indicators with open-ended prompts to capture nuance. Input from a Patient and Public Involvement (PPI) co author ensured that lived experience perspectives were embedded throughout.



FINDINGS

Patients' ethnicity



Across all three investigations, ethnicity was inconsistently addressed and often minimised. The Shrewsbury & Telford report acknowledged national disparities but failed to analyse local data, with nearly 9,300 missing ethnicity records. The East Kent and Morecambe Bay reports briefly noted poor treatment of ethnic minority women and to those born overseas but did not investigate systemic discrimination. In Morecambe Bay, concerns raised by families of ethnic minority patients were dismissed without comparative analysis. The limited attention to ethnicity undermines the relevance of recommendations for ethnic minority women.

Workplace racism and staff experiences



Workplace culture was a recurring theme, yet only the East Kent report explicitly identified racism among staff as a contributing factor to poor care. Allegations of racial abuse were often dismissed without resolution. In contrast, the Shrewsbury & Telford and Morecambe Bay reports described negative cultures but did not consider ethnicity as a source of conflict or harm. This reflects a broader failure to recognise racism within NHS workplaces and its impact on patient safety.

Deprivation and maternal outcomes



The Morecambe Bay and Shrewsbury & Telford reports acknowledged deprivation using national data but did not analyse its local impact. The East Kent report overlooked deprivation entirely. None of the investigations examined how deprivation intersects with ethnicity to worsen outcomes, despite evidence that economically disadvantaged ethnic minority women face compounded risks.

Leadership failures



Leadership failures—including poor oversight, defensive cultures, and high turnover—were common across all three reports. However, none explored whether racial discrimination contributed to leadership breakdowns or staff tensions. This omission reflects a reluctance to confront structural racism within NHS governance.



RECOMMENDATIONS FOR FUTURE INVESTIGATIONS

If we're to avoid these omissions in the future and end the cycle of race inequity in our healthcare system, future maternity investigations must embed antiracism and intersectionality at the core of their methodology, governance, and engagement processes. The absence of such an approach in previous inquiries represents systemic racism by neglect and has limited the potential for structural change. Had an intersectional lens been applied, findings and recommendations may have been more effective in addressing inequities and moved us meaningfully toward a genuinely anti-racism system. A comprehensive set of reforms is required.

1. Embedding intersectional and anti-racism frameworks



Future reviews should explicitly integrate intersectional frameworks that consider race, class, gender, disability, and migration status at every stage—from terms of reference to recommendations. The [NHS Race and Health Observatory's Seven Principles](#) should guide this work. Leadership teams must be diverse and culturally safe, with mandatory training in antiracism, cultural safety, and structural competency.

2. Strengthening data quality, transparency, and insight



Accurate and transparent data collection is essential. Ethnicity must be reliably recorded in all patient interactions, and national datasets should be routinely disaggregated by ethnicity, age, gender, and deprivation. Linkable datasets would enable more sophisticated monitoring of outcomes for ethnic minority populations. Where quantitative data is incomplete, targeted qualitative research should fill gaps and capture lived experience. Comparative analyses by ethnicity and deprivation should be standard.

3. Meaningful engagement and co-production



Engagement with local communities—particularly ethnic minority and socioeconomically deprived groups—must be central to any inquiry. Engagement should be sustained, targeted, and not tokenistic, involving coproduction, user validation, and shared ownership of recommendations. Reviews should draw on statutory guidance on working with people and communities and the Maternity and Neonatal Programme. Attention should be paid to ensuring that engagement processes themselves are culturally safe and representative. Inquiry teams should create spaces where diverse experiences, identities, and voices can meaningfully shape the findings and recommendations.



4. **Addressing workforce inequality and organisational culture**



Workplace culture directly affects patient safety. Future reviews must examine how racism, bullying, and lack of diversity in leadership contribute to unsafe care. Investigations should analyse Workforce Race Equality Standard (WRES) data, Freedom to Speak Up trends, and staff experience metrics. Equality Impact Assessments (EIAs) should be meaningfully conducted at the outset and revisited throughout.

5. **Building inclusive leadership and governance**



Leadership structures within review teams and NHS trusts must reflect the diversity of the populations they serve. Leaders should be trained in cultural safety and intersectional analysis and held accountable for embedding anti-racism practice.

6. **Monitoring, evaluation, and accountability**



Reviews should establish mechanisms to monitor the impact of anti-racism and intersectionality initiatives, with measurable indicators and transparent progress updates. Accountability structures must ensure that recommendations lead to tangible improvements.

7. **Policy reform and system level change**



National reviews must advocate for policy reforms addressing the structural drivers of racial and socioeconomic inequities, including poverty, access to culturally safe care, workforce inequalities, and resourcing. Reviews should move beyond identifying failings to actively dismantling systemic racism and classism that underpin disproportionate maternal and neonatal mortality among Black, Asian and minority ethnic women and birthing people, and their babies.

FOOTNOTES

- ¹ Kirkup B. Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation. London; 2022 Oct. Available from: <https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report>
- ² Ockenden D. Ockenden Report Final. Crown Copyright. 2022. Available from: <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review>
- ³ Perinatal Mortality Surveillance: UK perinatal deaths of babies born in 2022 | MBRRACE-UK | NPEU [Internet]. [cited 2025 Jun 4]. Available from: <https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance/perinatal-surveillance-2022>
- ⁴ MacLellan J, Collins S, Myatt M, Pope C, Knighton W, Rai T. Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. J Adv Nurs [Internet]. 2022 Jul 1 [cited 2025 Jun 4];78(7):2175–90. Available from: /doi/pdf/10.1111/jan.15233
- ⁵ Inquiry into racial injustice in maternity care - Birthrights [Internet]. [cited 2025 Jun 4]. Available from: <https://birthrights.org.uk/campaigns-research/racial-injustice/>
- ⁶ Black maternal experiences report — FIVEXMORE [Internet]. [cited 2025 Jun 4]. Available from: <https://fivexmore.org/blackmereport>
- ⁷ Gross JMS. Document Analysis. The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation. 2018 Feb 22;545–8.



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