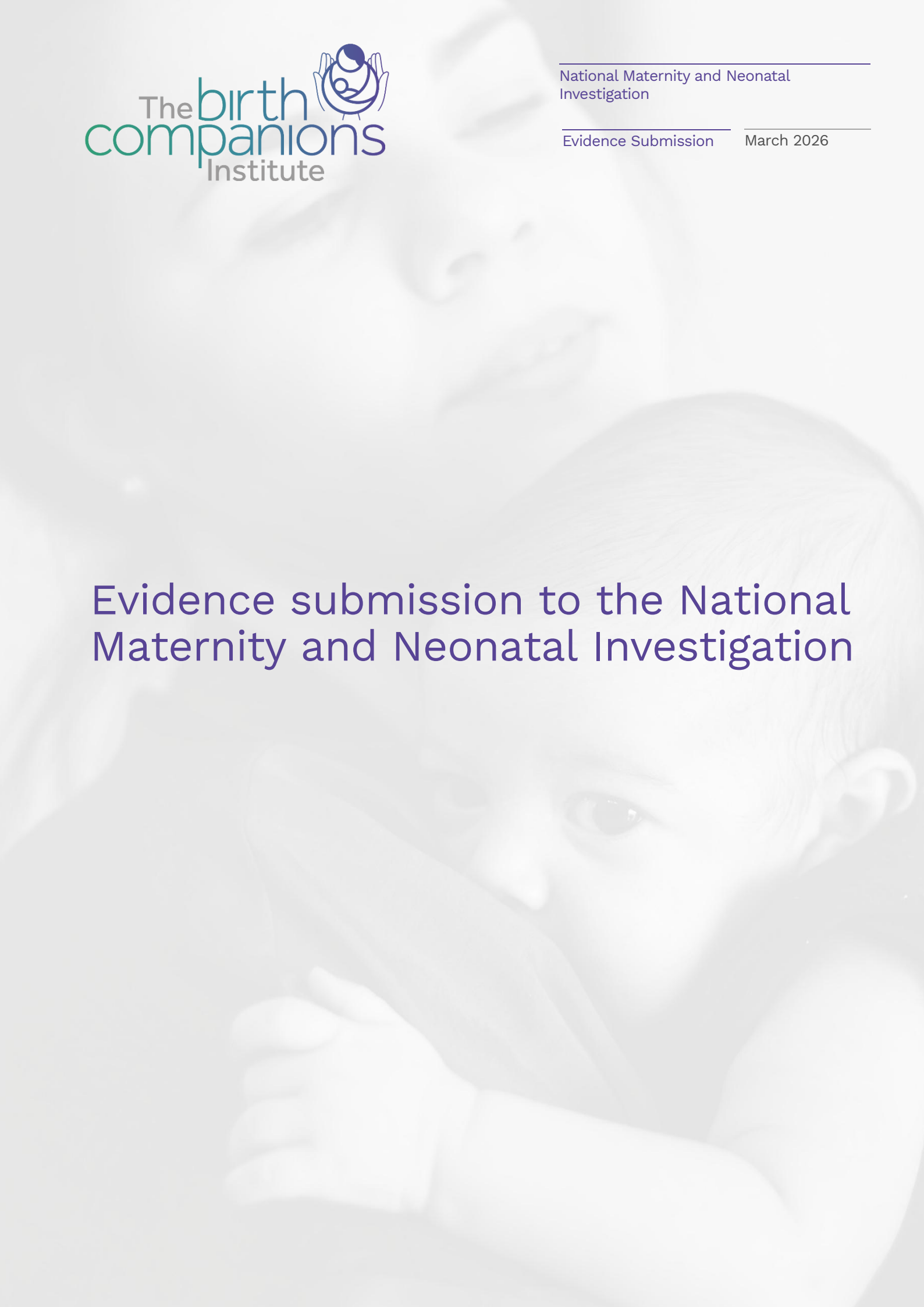
The birth companions Institute

National Maternity and Neonatal Investigation

Evidence Submission | March 2026

Evidence submission to the National Maternity and Neonatal Investigation



1. About Birth Companions

Birth Companions is the leading national charity supporting women facing severe disadvantage and inequity during the first 1001 days - the critical period from conception to a child's second birthday.

The Birth Companions Institute is Birth Companions' centre of expertise, housing all our work to achieve better care, equity and justice for pregnant women, mothers and babies through research, public affairs, policy, campaigns, consultancy, the law and the media.
As an organisation, we have a vast amount of insight and evidence on what is working and what needs to change within the maternity care system.

The women Birth Companions supports include those in contact with some of the most complex, hostile and strained systems. We work with women in contact with the criminal justice, children's social care and immigration systems, and those experiencing challenges such as housing insecurity, domestic abuse, substance use and mental ill health.

The women we work with, and their experiences within these complex systems, must not be treated as peripheral to the aims of the National Maternity and Neonatal Investigation. As MBRRACE data consistently shows, they are among those most likely to experience our maternity system's most serious failures, including preventable deaths.[1] As highlighted in Mary Renfrew's 2024 review of midwifery services and care in Northern Ireland, women experiencing socio-economic vulnerability and complexity are also among those with the most to gain from truly joined-up, midwifery-led, personalised and trauma-informed care.[2]

2. How this submission maps onto the Investigation's priorities

Our submission aligns to the following areas of the Terms of Reference:

- understanding lived experience;
- identifying drivers and impact of inequalities;
- understanding models of care delivery for those with increased risks or additional needs;
- identifying barriers to improvement.

3. Evidence submitted for consideration as part of the Investigation:

1. Birth Companions. (2026). Birth Companions' Mums and Midwives Cafés: Evidence for the National Maternity and Neonatal Investigation.
2. Birth Companions. (2025). Spotlight: Understanding the circumstances, experiences and outcomes of women with children's social care involvement who died during or in the year after pregnancy. https://www.birthcompanions.org.uk/articles/spotlight-csc-involvement-maternal-mortality

[1] MBRRACE-UK. (2025). Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. National Perinatal Epidemiology Unit, University of Oxford. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023.
[2] Renfrew, M. (2024). Enabling Safe Quality Midwifery Services and Care in Northern Ireland. https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-midwifery-renfrew-report-oct-2024_0.pdf

3. De Backer, K., Felker, A.M., Rose, E., Bull, C., Labisi, O., Kitchen, K., et al. (2025). Characteristics, outcomes, and maternity care experiences of women with children's social care involvement who subsequently died: national cohort study and confidential enquiry. *BMJ Medicine*. 4:e001464. https://doi.org/10.1136/bmjmed-2025-001464
4. The Safer Start Collaboration. (2025). A Safer Start: Understanding the policy priorities for pregnant women, mothers and babies seeking sanctuary during the first 1001 days.
5. Birth Companions. (2025). The Izzy Project: Birth Companions Early Insights Webinar 24 02 25. https://www.youtube.com/watch?v=RRJMdn_JcIo
6. Birth Companions. (2023) The Birth Charter for women with involvement from children's social care. https://www.birthcompanions.org.uk/articles/birth-charter-csc.
7. Birth Companions. (2023) Understanding women's lived experience of children's social care proceedings during their pregnancy and in early motherhood: an insight report. https://www.birthcompanions.org.uk/articles/understanding-womens-lived-experience-csc.
8. Birth Companions. (2023). Spotlight on Dual Contact: Understanding the needs and experiences of women in contact with the criminal justice and children's social care systems during pregnancy and early motherhood. https://www.birthcompanions.org.uk/articles/dual-contact.
9. Birth Companions and Clinks. (2021) A Window of Opportunity. https://www.birthcompanions.org.uk/articles/window-of-opportunity.
10. Birth Companions and Birthrights. (2020) Holding it all Together. https://www.birthcompanions.org.uk/articles/holding-it-all-together.
11. Birth Companions. (2016). Birth Charter for women in prisons. https://www.birthcompanions.org.uk/articles/birth-charter-prisons.

4. What Birth Companions' evidence shows

Grounded in our three decades of work supporting women in contact with complex systems during the first 1001 days, Birth Companions evidence consistently shows that women whose lives are shaped by severe and multiple disadvantage encounter a maternity system that is structurally ill-equipped to respond to complexity, and a wider set of systems – criminal justice, children's social care, immigration – that are far too often oblivious to the particular risks and opportunities of pregnancy and early motherhood. The consequences are serious and, in many cases, preventable.

Multiple disadvantage requires holistic responses. Risk assessment tools designed for single or binary risks cannot capture the compounding, intersecting needs of the women Birth Companions works with. Our work with Kings College London and MBRRACE-UK on the

characteristics, outcomes, and maternity care experiences of women with children's social care involvement who subsequently died found that healthcare professionals frequently focused on one dimension of risk to the exclusion of others – the baby's safety to the exclusion of the mother's, or social risk factors to the exclusion of underlying medical conditions. The same pattern routinely appears in our criminal justice and asylum evidence. Maternity care systems must be redesigned to support holistic responses to complexity, not just identification of individual risk factors.

Trauma-informed care is not optional – it is a safety requirement. The majority of women Birth Companions supports have histories of trauma, abuse and damaging prior contact with statutory services. Fear of those services – and in particular, fear of losing their baby – is itself a driver of non-engagement, non-disclosure or minimisation of needs, and delayed presentation. Our evidence shows that where practitioners involved with a woman's care during the first 1001 days are compassionate, non-judgemental and able to build trust, the outcomes are transformative. Midwives in particular have a vital role to play here. We hear time and again how transformative a positive midwifery relationship can be and how crucial midwives can be in connecting the dots between otherwise disparate services. We also hear, routinely, just how detrimental it can be to women and babies when midwifery relationships feel unsupportive, disjointed or judgmental.

Specialist midwifery and voluntary sector navigator roles are critical, and chronically under-supported. Across our evidence base, the most consistently positive outcomes arise where specialist midwives and voluntary sector organisations provide sustained, relationship-based support that bridges systems and services, advocates for women and holds complexity over time. Women we work with often identify their midwife or a voluntary sector provider as the only ones who treated them with genuine compassion – often the one person they trusted. These roles – specialist midwives and voluntary sector coordinators – are absolutely central to equitable maternity care, yet they are funded insecurely, distributed inequitably, and in the case of midwifery support, end too abruptly, typically at or before 28 days postnatally. The evidence base for the value of this relational, woman-centred model of care – including the findings of the Renfrew Review of maternity services in Northern Ireland – must inform this Investigation's recommendations. We address the state of the midwifery profession, and what must change, further below.

Cross-system coordination is failing, and women are dying as a result. Our evidence shows that information is not shared, appointments are not coordinated, and professionals in one system have little understanding of the others. For maternity care to be truly equitable, and to ensure better outcomes for women at the sharpest end of inequity, national, integrated approaches to care, information-sharing and joint working protocols are needed. The Birth Companions Institute is currently leading the co-design of a National Integrated Care Framework to improve the support provided to of women in contact with children's social care during the first 1001 days, and we look forward to working with colleagues across DHSC, DfE, NHSE, and beyond to implement this.3

NICE CG110 is critically outdated and must be revised. Last updated in 2010, the guideline on pregnancy and complex social factors does not reflect the current evidence base, the realities of women facing complex inequity and disadvantage in today's society, or the co-occurrence of multiple risk factors. As noted in our Safer Start spotlight report, this guidance

[3] Birth Companions. (2026). A National Integrated Care Framework: Co-designing a national integrated care framework for women and babies with children's social care involvement in the first 1001 days. https://www.birthcompanions.org.uk/initiatives/national-integrated-care-framework.

is particularly unsuitable for refugee and asylum-seeking women. Its revision must take account of the full range of complex social factors and intersectionality, and should be a priority recommendation to come of this Investigation.

The period following discharge from maternity care is a blind spot that is costing lives. It is well-evidenced that the risks associated with pregnancy and birth do not stop at 28 days nor six weeks postnatal; in fact, they often intensify.4 The 75% of deaths occurring among women with children's social care involvement between six weeks and one year after birth is one of the starkest expressions of this pattern,5 with such involvement acting as an instructive proxy for a wider population of women facing inequity and disadvantage. Across Government policy, the first 1001 days is widely recognised as a critical period, yet support after maternity care ends is too often patchy, disjointed, or non-existent. Joined up working is critical to address these cliff-edges in care, and must span maternity services, health visiting, GP care, perinatal and maternal mental health services, community-based Mother and Baby Units, children's social care, housing services, the criminal justice system and voluntary sector organisations. Reforms that focus solely on maternity services, and on experiences prior to discharge from midwifery care, will not protect the most vulnerable women and babies. The Investigation has a clear opportunity to make a strong case for this work.

5. The midwifery profession: Protect, invest, transform

Women who have experienced trauma, whose trust in statutory services has been repeatedly broken, and who are navigating multiple hostile or indifferent systems at once, often identify their midwife as the single source of kindness, stability and genuine care in their lives during pregnancy, birth and the postnatal period. Not a service, not a pathway, not a system – a person. A midwife who listened without judgement, worked to understand their needs and preferences, and met them with care, compassion and love at a critical point in their lives.

The Renfrew Review of maternity services in Northern Ireland demonstrated clearly that relationship-based, woman-centred midwifery care, delivered within a model that respects midwives' professional autonomy, produces substantially better outcomes and experiences, particularly for women with complex needs. The Review's findings on the value of community midwifery, the role of continuity and the centrality of the midwife-woman relationship to safe, humane care should be read alongside Birth Companions' evidence on what the women we work with actually experience and need.

We note with admiration and strong support the work of midwife, author and Birth Companions Ambassador, Leah Hazard, whose campaigning on working conditions, professional protection and public understanding of midwifery[6,7] speaks to a structural crisis in the profession that this Investigation cannot afford to ignore. Midwives are routinely going above and beyond – holding complexity, advocating for women, bridging systems – while burning out within a workforce that is overstretched, undervalued and poorly protected. The

[4] MBRRACE-UK. (2025). Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. National Perinatal Epidemiology Unit, University of Oxford. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023.
[5] De Backer, K., Felker, A.M., Rose, E., Bull, C., Labisi, O., Kitchen, K., et al. (2025). Characteristics, outcomes, and maternity care experiences of women with children's social care involvement who subsequently died: national cohort study and confidential enquiry. BMJ Medicine. 4:e001464. https://doi.org/10.1136/bmjmed-2025-001464
[6] Hazard, L. (2025). Petition: Establish legal limits on midwives' working hours. https://www.change.org/p/establish-legal-limits-on-midwives-working-hours
[7] Hazard, L. (2025). Midwives' working hours: an unseen national scandal. Maternity and Midwifery Forum. https://maternityandmidwifery.co.uk/midwives-working-hours-an-unseen-national-scandal/

failings that appear in clinical records and inquiry reports are, by and large, not failures of individuals who do not care. They are the failures of a system that does not support midwives to care well: chronic under-resourcing, unsustainable rotas, insufficient supervision, and the absence of the kind of reflective, trauma-informed cultures that allow good practice to flourish.

This Investigation must not allow legitimate scrutiny of poor practice to shade into scapegoating of a profession whose members are among the most committed, underpaid and overburdened in the NHS. The answer to failures in maternity care is not less trust in midwives – it is the conditions, investment and professional infrastructure that allow midwives to practice as they trained to do.

On continuity of carer: Birth Companions strongly supports continuity models where they are achievable, and the evidence for their benefit – particularly for women with complex needs – is robust. But our experience at Birth Companions cautions against framing continuity of carer as the only or primary vehicle for the relational care that disadvantaged women need. Continuity of a particular named midwife is not always possible for the women we work with, whose lives are often in flux, who may be dispersed, detained or in crisis. What can and must be possible for every woman, within whatever model of care is available, is the quality of relationship: the trauma-informed approach; the non-judgemental stance; the willingness to understand a woman's life beyond her clinical risk factors; the commitment to keep showing up. These are not the exclusive property of continuity of carer models. They are professional values that must be embedded across the entire workforce through training, supervision, leadership and organisational culture.

The longer-term ambition must be a maternity system in which trauma-informed, midwifery-led care is properly resourced and respected as the primary model of safe, humane, woman-centred care, with appropriate medical support when needed. Getting there requires honest reckoning with what the profession currently faces. It also requires the kind of bold, evidence-led recommendations that this Investigation is uniquely positioned to make.

6. Response to the Investigation's interim reports

Birth Companions welcomes in Baroness Amos' interim report the strong framing of racism and discrimination as structural and systemic issues, the clear acknowledgement of socioeconomic inequality in outcomes, and the recognition of voluntary and community organisations as vital – if currently under-supported – partners in improving care and support for marginalised communities. These are important foundations.

We also welcome the acknowledgment that information on outcomes for refugee and asylum women, and other marginalised groups, is limited and that "some forms of discrimination remain under-recognised." This is an honest and important admission. Our submission exists, in part, to help address it.

We raise three concerns.

First, women in contact with the criminal justice system are entirely absent from both interim reports. This is a significant gap. Our evidence demonstrates that this group faces acute levels of need during pregnancy and the postnatal period, and that neither the maternity system nor the criminal justice system is currently equipped to meet those needs. This is not just about women who are in prison – it's about women who have contact with

the police, and women who are under probation supervision while serving community sentences, on bail, or after release from custody. We urge the Investigation to remedy this absence in its final analysis.

Second, while the interim report cites national mortality data noting that over a quarter of women who die are known to social services, women with children's social care involvement do not feature as a distinct analytical focus. We hope our evidence submissions, plus the Family Engagement Panel we have recently facilitated with members of our Lived Experience Team, can go some way to supporting increased attention to women in these circumstances.

Third, the Investigation's analytical framework – focused on six systemic factors within NHS service delivery – is necessary but insufficient. Our evidence shows that the most serious failures affecting the most disadvantaged women often occur at the boundaries between systems, and in the period beyond six weeks after birth. Reforms anchored solely in maternity care will not fully surface these failures, and we would encourage the Investigation to acknowledge these systemic intersections.

We recognise Baroness Amos' terms of reference and the rapid timeline within which this Investigation is operating. But we ask the Investigation – and the Maternity and Neonatal Taskforce that will take forward its recommendations – to be explicit that any serious effort to reduce inequalities, improve outcomes, and prevent avoidable deaths will require action across the full first 1001 days, and across the systems that shape women's lives before, during and after that period. Recommendations that address only the formal maternity pathway will not be sufficient to protect the women whose experiences are documented in this submission, or to give their babies the best start in life.

To discuss anything mentioned in this Evidence Submission further, please contact Katherine Miller Brunton, Policy and Influencing Manager at the Birth Companions Institute: katherine@birthcompanions.org.uk