MBRRACE-UK Perinatal Conference 9th October 2025
Questions from Delegates with Responses

Question text	Response
Good morning. Sad to see a lack of diversity in the listed presenters. No seat at the table, small voice.	Thank you for raising an important point regarding the lack of ethnic diversity among the presenters. We acknowledge the disconnect between the findings of MBRRACE-UK, especially the persistent ethnic disparities in perinatal mortality, and the composition of the panels. This is a concern we take seriously. For this year's conference, the speakers in the morning were nominated by their respective organisations rather than invited as individuals. Regrettably, the nominations we received did not result in a diverse speaker group adequately reflecting the communities most affected by the issues discussed nor the diversity within the maternity and neonatal workforce. Although we did not directly select the individuals on the morning panel, we recognise the need for greater intentionality in ensuring inclusive representation. We also note that the afternoon session did not include any speakers of Black ethnicity. In this case, speakers were selected based on the specific topics and areas of expertise required for the programme. However, we recognise that topic-driven selection still requires attention to representation, and we will be more mindful of this in future planning. We will be reviewing our speaker nomination process and taking steps to ensure future panels include clinicians, researchers, and individuals with lived experience who better reflect both patient and staff groups.
Do the research team feel that neonatal care of 22 and 23 week babies in level 3 NICUs can/are distracting care away from 24-31 weekers? Hence explaining the lack of improvement in these groups	There is currently no evidence to suggest that the increased provision of survival-focused care for babies born at 22 to 23 weeks is directly impacting the care of those born between 24 and 31 weeks. However, we did note the potential for such effects in our report on births in 2022. At that time, we recommended that commissioners ensure neonatal intensive care capacity and resources are aligned with the growing number of babies born before 24 completed weeks who are receiving survival-focused care. We recognise that concerns about resource allocation are valid, and we continue to monitor this area closely.

As there are no greens for stillbirths does that mean that we are approaching a standard of care within the UK? To further improve, and reduce the rate, it would seem that adopting best practice from other hospitals is not possible but there would need to be a shift from all of us.	The fact that all organisations received an amber rating for stillbirths—with no greens or reds—suggests that care is broadly consistent across the UK. Most services are providing a similar standard of care, but there is always room for progress to reach best practice. It's also important to remember that the colour ratings are relative to the group average and not indicators of mortality rates themselves. For example, if all trusts in a group had a stillbirth rate of 1 per 1,000 births, their RAG ratings would all be amber; the same would apply if they all had a rate of 10 per 1,000. This means the ratings help identify variation within the group, rather than absolute performance. While this means there are no clear outliers in terms of either exceptionally high or low mortality rates, valuable learning can still be gained from within and across organisations. Each service may have areas of relative strength—such as communication, risk assessment, or bereavement support—that can inform collective improvement. Sharing these practices across the system remains key to further reducing stillbirth rates.
Can we analyze the acuity of Trusts beyond just the level of the neonatal unit? Our regional maternal, fetal, and neonatal unit has a higher extended perinatal mortality rate, with many cases being referrals or in-utero transfers.	This is an ongoing discussion within the MBRRACE-UK team. Currently, we report mortality rates at the level of Trusts and Health Boards, grouping them with similar organisations. We recognise that this approach isn't always ideal—especially when mergers result in large organisations with units providing very different types of care. At present, there's no reliable way to report by individual unit. The denominator data isn't accurate enough to confidently attribute each birth and death to a specific unit. Even if that were possible, we'd still need a robust method to group individual units into meaningful comparator groups. It's also unclear whether such grouping would effectively address the underlying concerns. We're continuing to explore this challenge and remain committed to improving the granularity and usefulness of our reporting.
Is it possible to produce stillbirth and neonatal death rates *excluding* lethal congenital abnormalities because if these are remaining constant (as one might expect) then that would give us an idea of losses which we might be able to prevent?	We already produce mortality rates with and without deaths due to congenital anomalies for Trusts and Health Boards, which are available in our Data Viewer.

Do we know the ethnicity and socio economic demographic breakdown of women/ birthing people delivering via elective section at term?	Although we have ethnicity, socioeconomic status and mode of delivery for babies who died, the routine births data we use does not include mode of birth information for all births. As a result, we're unable to provide a comprehensive breakdown for elective caesarean sections at term across the full population. However, the National Maternity and Perinatal Audit (NMPA) is likely to contain relevant data, as caesarean section type and demographic information are part of their dataset. We would recommend consulting their reports and data tools, or contacting them directly for further insight.
External input needs to be resourced to be successful	We agree. Both MBRRACE-UK and PMRT reports have made recommendations to ensure PMRT review teams are adequately resourced. This includes incorporating PMRT review roles into clinicians' job plans and providing the necessary resources and arrangements to support the participation of independent external reviewers in PMRT meetings. We recognise that securing these resources can be challenging, but they are essential for ensuring high-quality, meaningful reviews.
Is one of the the issues separating the lethal anomalies from the non-lethal from the information provided?	Our role is to report on perinatal mortality, so we only collect information on congenital anomalies that contributed to the death. We do not routinely collect data on anomalies that were present but did not impact the outcome. If a death is excluded from a particular mortality rate due to the presence of a congenital anomaly, it's because that anomaly was reported as a cause of death—either as the primary cause or as an associated condition.

Can you talk more about your vision of MBRRACEs role in making recommendations which are wider than maternity care? e.g. funding pre-pregnancy counselling, access to contraception, education for vulnerable groups, management of pre-existing conditions, role primary prevention e.g. obesity / smoking	This is an important issue, and we work closely with our Oversight Group to ensure that recommendations are appropriately broad in scope when necessary for their effectiveness. For example, our most recent confidential enquiry into the care of recent migrant women included a recommendation for services to provide advocacy support for women who have been in the UK for less than a year or who do not speak or understand English, to help them navigate care. This recommendation was directed not only at healthcare commissioners but also at the Home Office. We recognise that improving perinatal outcomes often requires action beyond maternity care—including areas such as pre-pregnancy counselling, access to contraception, education for vulnerable groups, and primary prevention efforts like smoking cessation and obesity management. Where relevant, our recommendations reflect this wider perspective.
What might the timeline be for useful re-enquiry into previous topics, to review if suggested interventions have had material effect? Not just in an auditing way, but with the depth of a CE	The timing of a re-enquiry into a previously reviewed topic depends on several factors, particularly the uptake and implementation of recommendations. It takes time for learning to be translated into practice, and for any resulting changes in care to become measurable. A meaningful re-enquiry—not just an audit, but a full confidential enquiry—would need to be timed to allow for both implementation and impact assessment. In some cases, a re-enquiry might be prompted by evidence that outcomes haven't improved—for example, if mortality rates for a particular group remain unchanged. But even then, the topic would need to be weighed against other priorities for review, as the confidential enquiry programme also has to consider a topic's relevance to current concerns.

Have MBRRACE considered recommending ambient audio recording of appointments and in birth rooms so that the notes can be double checked. Parents may not recognise what is written in the notes. It is a huge invasion of privacy, but it was a suggestion made to me yesterday. What are your views? What about using AI like HEIDI ?	This is an interesting suggestion, and we recognise the significant privacy concerns it raises—particularly in situations involving safeguarding. There are also serious data protection and logistical challenges. The hardware, storage, and associated costs required to implement such a system at scale would likely be prohibitive. Audio recording introduces its own limitations. Just as not everything said during care is documented, not everything documented is necessarily spoken aloud. Exported recordings—especially without transcription or indexing—can be difficult to navigate and interpret, and may add complexity without necessarily improving clarity. If clinical notes were routinely checked against audio recordings and then updated, this could also introduce a degree of distrust in the records. Multiple alterations—even if well-intentioned—might appear suspicious or undermine confidence in the documentation process. Our view is that the challenges of ensuring accurate documentation are best addressed by supporting healthcare professionals with the time, training, and tools needed to record events and information thoroughly and accurately. Improving transparency and trust in clinical records is important, and we continue to support that goal.
Is part of the CE to assess if national guidance is clinically sound and achievable? We are told to follow it but sometimes there are flaws in the guidance and it cannot be applied in practice	It is not the role of the confidential enquiries to evaluate the clinical evidence behind national guidance or to assess its practical implementation. However, if a recurrent issue is identified during the enquiry that could potentially be addressed through revisions to existing guidance—or the development of new guidance—we will make recommendations to the relevant organisations. We recognise that concerns about the applicability of national guidance in real-world settings are important, and we aim to highlight such issues when they emerge consistently in the cases reviewed.

Is there any overlap between the cases you review, and those which are being reviewed by MNSI with what practical impact if both organisations are reviewing the case?	Some deaths reviewed by the confidential enquiry may also be reviewed by MNSI. However, it's important to understand that the two processes serve very different purposes. The outcome of an MNSI investigation is shared with the trust to support learning from individual events and is also communicated to the family to help provide answers. While MNSI does report on common themes, its primary focus is case-specific learning. In contrast, the confidential enquiry aims to identify and summarise care issues at a national level to inform policy and guidance. Findings from individual case reviews are not shared with families, and are only communicated to trusts in rare cases where the case meets HQIP's "Cause for Concern" criteria. While overlap is infrequent—in part due to MNSI's defined remit and the changing focus of the confidential enquiries—having both perspectives can contribute to a more comprehensive understanding of care quality and support system-level improvements.
How do you collect the data from trusts that have all their records digital, or how do you obtain the data that is only recovered in their digital system, as some trusts have a mixed method of recording their data with both handheld and digital formats?	We receive copies of all types of patient records, including both paper and electronic formats. Electronic records may be provided as exports on disc or data stick, or as printed copies where the system allows. We have a very thorough process to check the completeness of notes, and we are confident that we receive all relevant documentation for each case. However, electronic notes often lose their navigational functionality when exported, and the resulting files can be poorly formatted or organised, making them harder to interpret. In addition, the fragmentation of the narrative caused by multiple, siloed digital systems does present challenges for reviewers. This fragmentation can also affect clinicians, especially when access to certain systems is not universal and healthcare professionals may be unaware of the various platforms in use—particularly for specialist care related to non-pregnancy-related co-morbidities.

How can we volunteer to join the CE Panel? Re: volunteering on CE Panel. You mentioned a call-out? Where to? I would love to take part as an experienced midwife.	Once the next confidential enquiry topic has been chosen, we will open applications for panel membership. We advertise this through multiple channels: - The MBRRACE-UK website - Emails to registered MBRRACE-UK reporters and PMRT users - Notifications via the MBRRACE-UK reporting system - Direct contact with previous panel members We welcome applications from experienced professionals, including midwives, and are always keen to involve people with relevant clinical expertise and insight.
Do you think the lack of women's voices means you are missing some issues? For example clinical notes do not capture anything around birth trauma.	We almost certainly don't capture the full range of issues, because the confidential enquiry process relies on a review of medical notes. It cannot identify important differences in care that may have occurred but were undocumented or insufficiently detailed. These may include staff attitudes, non-verbal communication, or other behaviours that influence a woman's experience—elements that can only be identified through direct feedback from mothers and families. The method does not allow for individual parent feedback due to the confidential nature of the enquiries. Because the woman's voice is rarely captured in the notes themselves, we aim to involve stakeholder representatives from the outset of the enquiry process. This helps ensure that women's perspectives inform both the framing of the enquiry and how findings are reported.
Language barrier is one of the key findings at report. However, the PMRT tool has limited options for the report as many trust using recognised and approved tools like language on wheel or online tools as not recognised by PMRt. Is there any chance that those method can be impeded to the tool.	We are currently reviewing the PMRT questions and will add your request to ensure this is included in the review.

It is also important parents are not being given conflicting or even incorrect information by different people at different times	We agree that this is one of the worst things that can happen to already vulnerable bereaved parents. For this reason that we suggest that any discussions prior to the PMRT review being completed are kept very general and conclusive statements are not made. Note also that if there are other reviews being conducted as well as PMRT (eg MNSI, local governance PSIRF / SIRI / RCA etc) the teams should work together to minimise duplication of work and avoid different investigations coming to different conclusions. This is why PMRT should not be finalised without the MNSI team being present at the final meeting
Could the costs of reviews be better used to improve the services, especially given the reoccurring themes within existing reviews?	The annual report provides the nationally recurring themes the top 5-6 of which have been the same for several years. We advise that all trusts/health board review how what actions they need to take if these are issues in their service e.g., management of reduced fetal movements. It is only possible to know that these are an issues in a particular trust/health board by undertaking a local review. Furthermore, even having accounted for the top 5 issues with antenatal care over 2,000 additional issues with antenatal care were identified nationally in 2024.The important point about local reviews is that the review team identify the issues with the care that they provide and generate local solutions to improve future safer care primarily based on national guidance.
How can we ensure that multiple reviews lead to meaningful change for families and staff, rather than just increasing the burden on services with unproven recommendations? We need to focus on evidence-based care tailored to our local populations, especially for our most deprived women and families	We are agreed that unproven recommendations should not be implemented. Our advice is that you follow national standards and guidelines which are generated from the existing evidence base. Many of the issues with care that arise and are identified in PMRT reviews relate to such guidance not being followed. The important point about local reviews is that the review team identify the issues with the care that they provide and generate local solutions to improve future safe care primarily based on national guidance.

Lack of transparency and perceived 'cover up' also caused anxiety. Currently pregnant parents needs to know that there has been transparency re past harm, and that learning has already / is in progress.	We agree that for parents who think that the review of their care that has been carried out is poor and has not identified the issues which concern them leads to anxiety and loss of trust. We hear from parents in these situation. The key approach to preventing this is to engage with parents very early, to talk to them about the fact that a review will take place, and ask them to contribute to the review process by providing their experiences of care, and any questions and comments they have. It is important that they have plenty of time to reflect on their experiences of care and for them to be given multiple opportunities to provide their input. Then, when parents have provided their reflections, comments and questions for these to be fully incorporated into the review process and meaningfully addressed. The feedback meeting with parents to discuss the review findings is another opportunity to be fully transparent about the review process, the findings, how any conclusions were reached and what plans to improve future care for all mothers, babies and families are in place/already in progress. Realistically the 'in progress' may not be achievable for all actions during the time from the death to the post-review follow-up meeting with parents.
Language barrier is one of the key findings at report. However, the PMRT tool has limited options for the report as many trust using recognised and approved tools like language on wheel or online tools as not recognised by PMRt. Is there any chance that those method can be impeded to the tool.	We are in the process of reviewing the questions in the tool and will look at the response options available for interpretation services.

Severe fetal anomalies are required by PMRT to complete the EFW on the GAP 2 chart. However, some fetal medicine clinicians disagree, as they state that recording on the scan report chart is sufficient. What are your thoughts on this area?	In the case of fetal abnormalities it is a purely clinical decision as to what growth is plotted on what chart. The importance of plotting growth relates to identifying abnormal fetal growth and the clinical decisions that will be made if the baby is found to be growth restricted or falling off the centiles. In the case of a fetal anomaly, depending upon the anomaly, the growth may not follow the normal population trajectories. Therefore it is a clinical decision as to where growth should be plotted and why. If this is an issue with clinical colleagues then it needs a consultant discussion with them about the appropriate procedure. This is not a PMRT issue as such. If, depending upon the clinical decision for any particular baby, the PMRT generates an issue you can deal with this in the process of reviewing the issues. For many babies with fetal anomalies, not having their growth followed will be appropriate clinical course – for others it will not. Of note when it is appropriate to plot the estimated fetal weight, the PMRT does NOT specify which particular growth charts should be used, this again is a decision for Trusts and Health Boards.
Is there any overlap between the cases you review, and those which are being reviewed by MNSI with what practical impact if both organisations are reviewing the case?	MNSI review a very specific groups of baby deaths that occur following a term pregnancy: term intrapartum stillbirth and early neonatal deaths (first 7 days after birth) of babies born at term. These account for about 8% of all perinatal deaths. In contrast ALL perinatal deaths (excluding TOPs) are eligible for a PMRT review. The overlap is therefore relatively small. However, the value in a local PMRT review also being undertaken while the MNSI investigation is underway is that local learning and service improvements can be implemented from the findings of a local review before the MNSI investigation report is available. Furthermore the focus of MNSI investigations is about system learning and will not address all the local clinical issues that the PMRT has the potential to address. The key issue is that the PMRT report should not be shared with families until the MNSI report is available. This is to avoid parents being given potentially conflicting findings thus causing confusion and further distress.

Could we add another grading of care category to the PMRT tool? This would focus on the mother's care from birth until the baby has died, specifically for cases of neonatal deaths.	We are in the process of reviewing the questions in the tool and will look at potential options for doing this.
There needs to be more N/A drop down boxes, as sometimes you have to add in something that it is not accurate in order to move onto the next PMRT question.	We are in the process of reviewing the questions in the tool and will look at potential options for doing this. If you have specific questions that you have in mind please notify us about them using the contact button within the PMRT.
I like the PMRT letter templates, they are really helpful to inform parents about the process and what to expect.	Thank you. We are glad that these are helpful
When writing PMRT reports, should these be written for parents or as a medical summary of the review/care	The PMRT report itself is a medical summary of the care which arises from the primarily medical review that has taken place. We advise that at the follow-up meeting with parents that the consultant discusses with the parents how the review is carried out and the findings in language that they can understand. Following this a plain language letter should be written to the parents directly (and copied to their GP) that explains the review findings, what was discussed in the meeting, answers the questions or concerns that the parents have and makes any relevant recommendations about future pregnancy care. We advise only providing the report generated from the PMRT to parents who request it and ONLY after they have received this verbal explanation and the plain English letter.
It is so hard to make changes to things, like sound-proofing and availability of quiet rooms or spaces away from routine ANC, when we are limited by the physical infrastructure of dilapidated estates	We are sorry to hear that your maternity services suffer from being delivered in a dilapidated estate. This must be an issue which arises in nearly every death that you review. We recommend that you include this evidence in your quarterly reports to your hospital executive board so they are sighted on this issue. If you have received complaints you can also triangulate this evidence. Other hospitals have used this evidence to generate a business case for resources to undertake the capital works required to improve their bereavement spaces/rooms. We presented an example of how Birmingham's Womens Hospital did this in our annual 2022 annual report. See page 15: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/PMRT_Report_2022_-_Main_Report_FINAL_PUBLISHED.pdf

How do these findings avoid a response that furthers the risk of over-medicalisation such as more scans, earlier induction, more un-evidenced CTG, and so on?	Many of the issues identified following a PMRT review concern care where existing national guidance and standards have not been followed. We recommend that these findings are used to improve care which follows existing national guidance and standards, and best practice where such evidence does not exists.
We often find differences in opinion when grading PMRT, around physical care issues identified compared with grading the families experience. I also feel there needs to be some more guidance on the grading as i have attended a few different trust PMRT meetings and grading varies.	We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to.
Grading can sometimes be difficult due to the differing opinions. I feel that when we have questions from parents irrespective of following guidance. we would grade it a B, to enable an action to be developed to provide answers to the parents	We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to. However, if care was appropriate then the grading should be A even if the parents have questions, unless there was a failure to explain things in advance i.e. the care was correct but failure to ensure the parents understood the care, would make it a B. Many parents will accept the explanation / answer to their question if care was appropriate and it doesn't mean there was a 'failure in care' . If the MDT cannot reach a consensus re grading you may need to seek another opinion. Note that the parents questions can be answered fully in the summary box at the end of the PMRT without needing an action to provide an answer to them by using a B grading.
Should external reviewers have full access to notes prior to the meeting or attend with a clear slate to listen to the case at the meeting and make decisions regarding the care?	The gold standard would be to provide the notes (preferably via accessing the EPR) and for the external to have reviewed them prior to the MDT. However, we accept that this may be unrealistic especially if the hospital(s) involved do not have a fully functioning EPR from which notes can easily be extracted and there are IG issues. It also relies on the external having time to fully review the notes which again may not be possible. However, the important point here is that before the review gets to the MDT stage there needs to have been a robust objective review by the 'local' team to ensure nothing has been missed.

There is often a challenge at PMRT meetings agreeing the grading of care and interpretation of this and impact on the outcome. Sometimes it seems like we are being unnecessarily harsh on individual staff and teams. Maybe some examples of gradings in certain circumstances may be helpful.	We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to. However, it is important to recognise that the point of the review is not to assign blame and point fingers at individuals but to identify where care can be improved in the future particularly with system level improvements in care delivery. Part of this process involves the grading of care.
It is even more challenging when mothers may have chosen care outside of guidance and this has directly impacted on the outcome. Any advice how this can be managed sensitively and effectively?	Without the context of the conference it is difficult to be clear which presentation this question refers to. In order to provide a response we are assuming that this relates to the follow-up meeting with parents once the review has been completed. In this situation it is important to be honest with parents about how their actions may have impacted the outcome. We say this appreciating that such conversations can be difficult and may involve conveying information which parents find difficult to accept.
I find it difficult grading when taking into account psychological impact to parents, loss of a baby is psychologically traumatising regardless of quality of care. We tend to grade as higher because of perceived phycological trauma. Was wondering how other people incorporate this into the grading?	We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to. Psychological elements and the care of the mother, both physically and psychologically should certainly be considered in the holistic grading of care. In doing so it is important to acknowledge that at the time of completing the review there will not have been a formal assessment of psychological impact etc and as the questioner notes the death of a baby is psychologically traumatic and this is normal. What the tool is trying to assess is whether the family were supported in the way they should have been, and if there were any failures in care if these added to the psychological trauma. We would not advise downgrading good care just because the family are upset as this is a normal and expected response.

The elephant in the room is the tool is not fit for purpose, it does not support meaningful family engagement and learning. When Trusts struggle with time to do this work, surely we should be creating a tool which can be easily shared with families and also utilised within Trust processes	The PMRT is a clinical tool to support the review process. It is not and was never intended to provide the meaningful support of family engagement. It encourages meaningful engagement with families with the questions in the tool to ensure that any questions they have are considered and also with the parent engagement materials that we provide to support this process. However, family engagement is a process that is and will always be outside the process covered by a clinical tool such as the PMRT. If in your organisation you do not have enough time allocated for this it needs to be highlighted in your quarterly reports to your hospital Board and to be entered into your risk register. If you are in England this should be discussed with your perinatal safety champion
What % of trusts have a PMRT lead midwife? I agree the quality of the reports and patient engagement could be better but its very challenging to give it the time it deserves when it is one part of a bigger role.	We do not have the figures about the number and percentage of Trusts and Health Boards which have a lLad PMRT midwife.
Sorry cant find the original questions...There are specialist/dedicated PMRT midwife roles (they are not all done by risk or bereavement midwives). Dorset has one 15 hours a week but regularly works 22+hours.	This appears to be a response to the question concerning the number of trusts/health boards which have a Lead PMRT midwife.
Is there an expected timeline for the update of the PMRT Guidance, which is currently under review according to the MBRRACE-UK website?	The review of the guidance is underway and we hope to publish it in the early new year.
This is another area in which the MNISA pilot role has been successful. MNISAs have advocated for the personal needs and priorities for individual families through the PMRT process. It has been a learning journey all round in pilot areas, but has worked well.	Our recommendation is that the bereavement midwife(midwives) who is in touch with the parents is the person best placed in the majority of trusts and health boards to engage with the parents, seek their views about their experiences of care and any questions they have. They are then in a position, as a member of the PMRT review panel, to advocate for parents/families and present the personal views and priorities of the parents. This is particularly important for the majority of trusts and all health boards that have not been part of the MNISA pilot which has run in a small number of trusts in England.
Regarding PMRT being able to be accessed by multiple trusts at the same time, has been asked yearly with the same response. Please can we have an official response and update of this as it does add time to the reports	All hospitals involved in a particular review can always access a PMRT review in 'read-only' mode, however, it is only possible for one hospital at a time to edit the review. It is technically NOT possible to allow multiple hospitals to edit the same review at the same time.

Would it be possible to have further guidance around PMRT grading ? It would be helpful to improve objectivity and decrease subjectivity. e.g. Grade C - may - could vary from a very slight chance (more than minimal) to discussions around meeting legal thresholds around probability.	We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to. Of note Grade D covers the legal threshold around probability i.e. would likely have made a difference. Legal threshold for probability is more likely than not i.e. more than 50%. However, the important thing here is that the PMRT is a clinical tool and is not based on legal argument; PMRT panels should be looking at the clinical likelihood of the outcome being different if care had been delivered as it should have been.
What do you advise where a grade has been agreed at a meeting and then you go away and think further on the issues and change your opinion making your grade a D? Do you go with the greatest number or should there be another /updated review?	Grading of care should be a consensus decision. There should always be the possibility of re-discussion even after the review is closed and published. If someone after the meeting feels the grade should be changed then the review should be re-opened and this should be discussed with the whole panel and consensus reached, then if necessary the grading can be changed. If consensus cannot be reached seeking another opinion is an option to resolve the issue. We are in the process of updating our guidance and grading of care is one of the sections that we will pay particular attention to.
Agreed the tool is for us... but parents can and do put FOIs into MBRRACE and these are shared with the families, even partially completed before meetings, and they request the report and decline meeting and talking until they have seen it, very difficult and traumatic	Parents can and do make data subject access requests to us. We are legally obliged to respond to these by providing all the information that we hold about them. We explain the process of collection of MBRRACE-UK data and the conduct of PMRT reviews and the stage at which the review is when we provide them with the information. We also explain the process that should be followed in the trust/health board. The requests we receive are often at the point when the trust/health board process of review and feedback is completed and parents are not happy with the outcome. Or that they have requested changes to the review and are checking whether and when these have been made. Clearly in the ideal situation all the interactions with parents would be via the hospital where they have received care and the follow-up meeting after the review is completed. However, if they approach us we have a legal obligation to provide the information we hold about them to them. Please note this is not a Freedom of Information request where there is some latitude to decline to provide the information.

How can a single service user represent all other service users when the population is so diverse and everyone has individual personalised needs?	The single service user is intended to represent the generic service user voice by raising wider questions about service delivery and how care might affect parents. The bereavement midwife/kay contact with the bereaved parents should be present at the PMRT panel to ask the personalised questions and indeed the specific questions and/or comments that parents have raised.
MNVP specific questions	**Responses from NHS England (17th Oct 2025)**
It's the quoracy requirement which is problematic, happy for MNVP participation just don't want it to be we can't proceed if MNVP are not available	Your MNVP Lead should have enough time to be able to attend and contribute to PMRT meetings at the Trust. However, if this is not the case the MNVP Lead should not attend PMRT meetings until the MNVP's infrastructure is in place – this should be escalated as a risk via PQOM. More information here: MIS SA7 - Maternity and Neonatal Hub - Futures
Once a service user has been trained to become a 'professional strategic service user' , are they not then part of the system in the same way that health professionals are (many of who are also service users or have been at some stage in their lives)?	The MNVP Guidance is clear that 'MNVPs will need a lead with the right leadership skills to influence and lead a complex programme of work and contribute to the quality and safety surveillance framework. It is also important that this role is fulfilled by a person with lived experience of maternity and/or neonatal services, who is not already employed in the local trust or system, for example as a clinician.' More information here: NHS England » Maternity and neonatal voices partnership guidance
What if our MNVP lead (employed role) does not want to be part of PMRT? We clearly can't force this or sack them (and we wouldn't want too as they are awesome but this wasn't part of the original job ask)	The MNVP Lead role has evolved over time and is now a strategic, professional role representing the voice of service users, working alongside volunteer service user voice representatives who form the MNVP membership. If your MNVP Lead does not attend and contribute to PMRT meetings, this should be escalated using PQOM.
Are parents aware that MNVP leads will be reviewing their bereavement journey, this information is not anonymised?	The MNVP Lead is attending and contributing to PMRT meetings to represent the service user voice lens, in the same way the midwifery, obstetric and neonatal perspectives will be represented.
Is there any training required for the MNVPs? and is this available?	This is for local determination and MNVP leads are welcome on the standard PMRT training* PMRT online training course registration
What is meant by the term 'Strategic service user'. Is this something different from an MNVP service user representative?	The strategic service user voice is the same as the MNVP Lead for the trust.

Our ICB has informed our MNVP that she cannot attend PMRTs as there is no additional remuneration and at the meetings she would require clinical supervision. I am hoping this will not become measurable (as external representation has) otherwise we would not be quorate at any PMRT meetings.	The MNVP Guidance is clear that [MNVP] 'Leadership roles and operational support are not suitable to be provided by volunteers and ICBs will need to consider this as part of their budget setting for MNVPs'. Therefore, until an MNVP has the infrastructure in place as detailed in the guidance where the MNVP Lead is appropriately remunerated for their time, they should not be attending PMRT meetings, and the MNVP funding issue should be escalated using PQOM.

*Note from the PMRT team: The standard PMRT training is designed for clinical professionals who are already working in maternity and neonatal services. It therefore does not specifically cater for professionals who have not worked clinically in this area who may require additional training and support.