Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Saving Lives, Improving Mothers' Care

Lay Summary 2026

Key messages for women and families and recommendations to improve future care

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Introduction

Notes on content and terminology

The following material contains data and discussion regarding maternal death, baby loss, and serious pregnancy complications. It references sensitive themes including maternal suicide, substance use and domestic abuse. Reader discretion is advised.

We use the terms 'mother' and 'women' throughout this report to refer to those who are planning to become pregnant, are pregnant, or who have given birth. We acknowledge that not all people who are pregnant or give birth identify as women or mothers.

MBRRACE-UK reviews

The United Kingdom's MBRRACE-UK Confidential Enquiry into Maternal Deaths and Morbidity is the gold standard around the world for rigorous reviews that drive improvements in maternity care. MBRRACE-UK recognises the importance of learning from every woman's death during pregnancy and in the 12 months after childbirth, pregnancy loss or termination. This is a crucially important period in the life of women, their children and their families, which can have far-reaching effects. While maternal death is a rare event in the UK, maternal complications are not. For every one woman who dies, it is estimated that 100 women will experience a severe morbidity or 'near miss' event. The learning in this report is important, not only for staff and health services, but also for those who will use UK maternity services in the future.

The full 2026 MBRRACE-UK report and summary 'State of the Nation' report are available on the ***MBRRACE-UK website***. This report includes data on all the women who died during or up to one year after pregnancy in the UK and Ireland in 2022, 2023 and 2024. It also includes lessons learned from the review of care of women who died from obstetric haemorrhage and amniotic fluid embolism, infection, neurological conditions (epilepsy and stroke) and other medical or surgical conditions such as diabetes or asthma. Lessons for the care of women who did not die but who required specialist networked maternity medical care are also included.

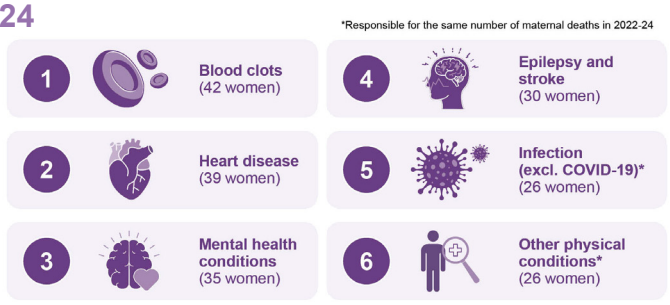
The summary presented here provides an overview of the report's findings and signposts key messages for women and their families. It also includes actions and recommendations for health professionals, the health system and the government to improve future care.

Key findings from this report

Maternity care in the UK has been the focus of several investigations this year. The number of reviews and their findings can be overwhelming, but it is important to recognise that it is still uncommon for women to die during or after pregnancy in the UK.

Headline figures from MBRRACE-UK highlight a 20% increase in the rate of maternal deaths since 2010 when a previous government ambition was set to halve the number of deaths by 2025. While this may seem like a large jump, the absolute number of deaths remains low. In 2022-24, 252 women died during pregnancy or up to six weeks after pregnancy in the UK. This is a maternal death rate of 12.80 per 100,000 women giving birth but represents less than 0.02% of the 1,969,321 women who gave birth in 2022-24. In this same period, there were an additional 322 women who died between six weeks and one year after pregnancy. When these women are included, this represents 0.03% of all women who gave birth. While these numbers are very low, maternal deaths are rising, not falling, in the UK, and continued efforts are needed to prevent future deaths.

Causes of maternal deaths in the UK in 2022-24



During pregnancy or up to six weeks after pregnancy

- **Blood clots** (thrombosis and thromboembolism) remained the leading cause of maternal death (42 women) followed by **heart disease** (39 women) and then **mental health conditions** (including suicide and substance use) (35 women)
- Deaths due to **COVID-19** dropped dramatically in 2022-24; six women died from COVID-19 in 2022-24 compared to 30 in 2021-23

Between six weeks and one year after pregnancy

- **Suicides** remained the leading cause of death between six weeks and one year after the end of pregnancy (61 women)
- Overall, **mental health conditions** (suicide and substance use) accounted for a third of maternal deaths (105 women) in this late postnatal period

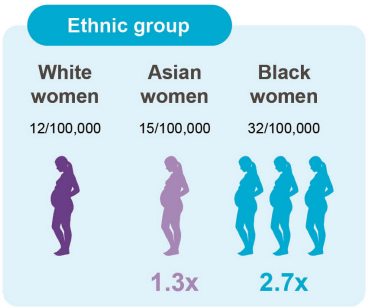
Intersectionality of risk factors – a 'constellation of biases'

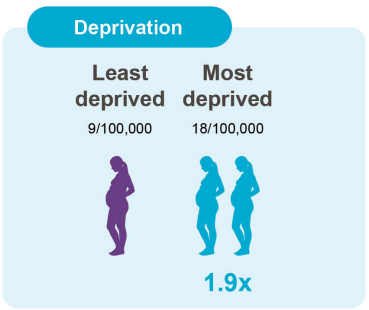
Maternal deaths are rarely caused by a single risk factor. Different circumstances, such as a woman's ethnicity, income, social factors and mental and physical health, can combine to increase the risk for some women.

Inequalities in maternal deaths

This year's report once again highlights the ongoing inequalities in pregnancy outcomes and women's access to, and experiences of, maternity care.

- **Ethnicity:** There was a nearly three-fold increase in maternal mortality rates for Black women compared to White women, and Asian women's risk of maternal death was slightly higher compared to White women
- **Severe disadvantage:**Women living in the most deprived areas continued to die at a rate twice that of women living in the least deprived areas
- **Age:** Compared to women aged 25-29, women aged 35 or older were nearly two times more likely to die





While there are many complex and interconnected reasons for these inequalities[1], there is growing evidence that racism, discrimination and wider structural inequalities persist across UK maternity care[2]. These issues need to be recognised and remain a priority for action.

Social risk factors and mental health

Many women using maternity services face significant and growing social and mental health challenges. Of the 252 women who died during or up to six weeks after pregnancy:

- 47% had known mental health problems or conditions (119 women)
- 21% experienced domestic abuse either prior to or during pregnancy (54 women)
- 20% were known to social services (50 women)
- 18% had known substance use (45 women)
- 16% experienced three or more elements of disadvantage (40 women)

1 Harrison, S., et al. (2026). Chapter 5: The impact of ethnicity on maternal health outcomes. Understanding Race and Health Inequity in the UK. Etti, M. and Botticello, J. London, Routledge.

2 National Maternity and Neonatal Investigation. (2026). "Independent Investigation into Maternity and Neonatal Services in England – Final report and recommendations." ***www.matneoinv.org.uk/final-reports/***

Physical health

Physical health before pregnancy can also impact health during and after pregnancy. Of the 252 women who died during or up to six weeks after pregnancy:

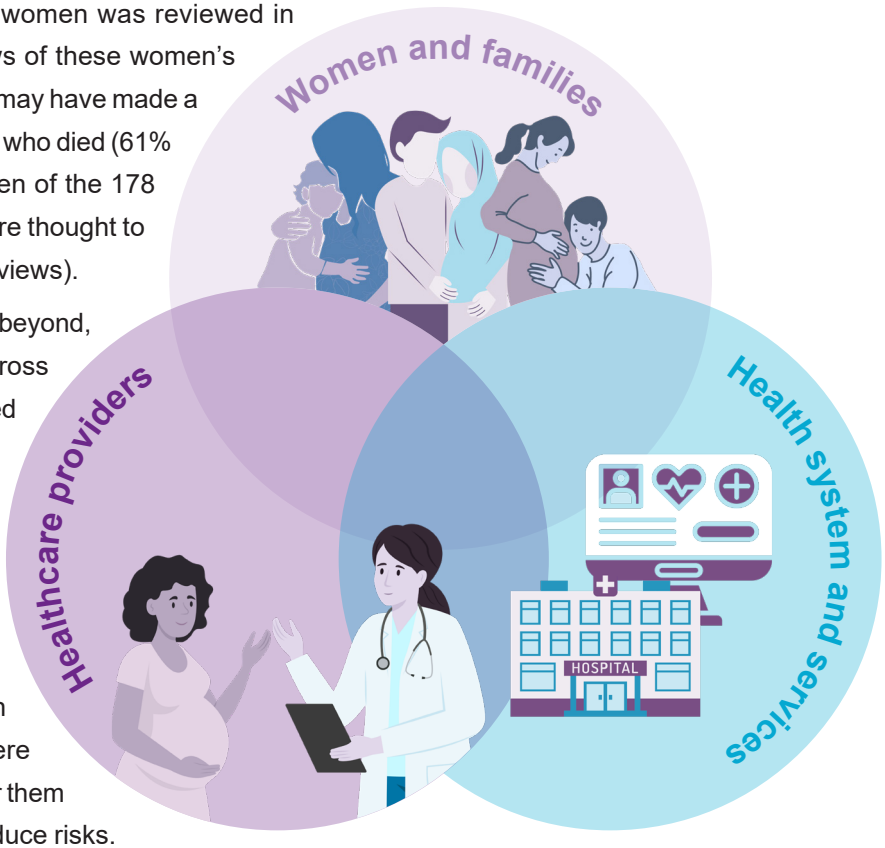
- 61% were considered overweight or obese based on their BMI (153 women)
- 60% had pre-existing medical problems (not including obesity) (151 women)
- 24% smoked during pregnancy (60 women)

Getting advice before becoming pregnant can help women prepare for pregnancy and create a plan to manage physical health conditions once pregnant.

It is important to highlight that, while being in one or more of these groups may mean that your risk is higher, death is still rare. More work needs to be done to fully understand risks and how they relate to each other to develop effective improvements, but there are ways to reduce your individual risk before or during pregnancy. Speaking to a midwife or your doctor before you become pregnant can help you prepare for pregnancy and create a plan to manage your health once pregnant.

Improving care at every level

The **quality of care received** by 178 women was reviewed in depth for this year's report. The reviews of these women's care suggest that improvements to care may have made a difference to the outcome for 108 women who died (61% of the women reviewed). Only 29 women of the 178 of women whose care was reviewed were thought to have received good care (16% of the reviews).



In order to improve care in maternity and beyond, there needs to be coordinated action across the whole system. There is an urgent need for better systems, clearer guidelines and improved policies that support personalised care and respond to women's individual needs. Lasting change happens when women and families, healthcare providers and health services and systems work with each other, not against each other. There are ways women, the people who care for them and the system can work together to reduce risks.

What you can do: Messages for women

The National Maternity and Neonatal Investigation showed how important it is to listen to women and their families[3]. This year's MBRRACE-UK report echoes this point and highlights some key areas women may want to discuss with their doctors, midwives, family members and other supporters to help make their pregnancy as healthy as possible.

3 National Maternity and Neonatal Investigation. (2026). "Independent Investigation into Maternity and Neonatal Services in England – Final report and recommendations." ***www.matneoinv.org.uk/final-reports/***

Key steps for a healthy pregnancy

1

Plan before pregnancy

Have a conversation with a trusted healthcare professional (e.g. GP) before pregnancy

- Discuss your lifestyle and changes you can make to reduce your risk (e.g. losing weight or stopping smoking)
- Make a plan for the care you may need in pregnancy
- Learn more about your personal risk should you become pregnant and discuss birth control options if needed
- Review your health and optimise control of any medical conditions including any changes to medications

2

Medication safety

Most medications are safe to take in pregnancy and can help protect your and your baby's health

- Do not stop or change your medications without medical advice
- Talk to your doctor about the importance of taking your medications and the benefits and risks of each
- Set a reminder or alarm to help you take your medications as prescribed
- Tell your doctor about any side effects or concerns so changes can be made

3

Work in partnership with your team

Regular contact and good communication can help identify and manage risks early

- Speak up if you have any worries about your health or how you are treated
- Bring a trusted person to your appointments for support
- Make notes on any important information as a reminder of your discussions
- Discuss treatment options or birth plans to make informed choices about your care
- Ask questions if you do not understand something

How can you feel safe?

There are many voluntary sector services and community organisations that provide helpful information as well as peer support and practical help for navigating complex services.

The resource below was created by Five X More to help women advocate for themselves during pregnancy and in other healthcare interactions:

If you are pregnant and feel you are not being heard or something isn't right, remember the Six Steps from Five X More (fivexmore.org/6steps):

1. ***Speak up.*** If you feel like something isn't right, make sure you speak to a medical professional and don't stay silent
2. ***Find an advocate for yourself.*** This could be your partner, a family member or a trusted friend that can speak on your behalf if need be.
3. ***Seek a second opinion.*** You are allowed to ask for a second opinion of another medical professional if you feel you need to.
4. ***Trust your gut feeling.*** And speak up. Your gut feelings are almost always right. Don't ignore them. You know your body better than anyone.
5. ***Do your research on pregnancy and birth.*** There are trusted sources such as ***NHS.uk, nice.org.uk*** and ***patient.info*** that can help you feel prepared.
6. ***Document everything.*** Write down any treatment or medication you are given or refused. Include the name of the doctor or midwife and the reason why. You can also go a step further and keep a personal journal of all the information for your own reference.

There are also many resources and supports available to help you think about and advocate for your choices and care:

Where to find trusted information and support for self-advocacy:

Five X More: ***fivexmore.org/***
Black Mothers Matter: ***www.blackmothersmatter.org/***
Maternity Engagement Action: ***maternityengagement.uk/***
The National Childbirth Trust: ***www.nct.org.uk/***

Other organisations provide targeted information and supports for women with specific medical conditions or who experience certain complications during or soon after pregnancy:

The UK Sepsis Trust provides support for survivors of maternal sepsis (***sepsistrust.org/about-sepsis/maternal-sepsis/***) and Group B Strep Support provides information on Group B Strep infection and GBS testing (***gbss.org.uk/***)

The Birth Trauma Association supports women and parents who have experienced or witnessed traumatic births (***www.birthtraumaassociation.org/***)

SUDEP Action provides a free EpSMon app for people with epilepsy as well as specific guidance and a clinical checklist to support maternal safety (***sudep.org/***)

Action on Pre-eclampsia offers advice and education around pre-eclampsia and high blood pressure in pregnancy (***action-on-pre-eclampsia.org.uk/***)

Know your rights

Remember that you have the right to speak up for yourself and challenge any decisions you don't think are correct. Any concerns need to be taken seriously, and staff have a responsibility to listen and act. There are trusted places to find more information about basic birth rights that also provide helpful resources and supports to help you make decisions about the care you want during pregnancy, birth and afterwards.

Where to find help and trusted information to support decision-making in maternity care

AIMS For a better birth: ***www.aims.org.uk/information***
or contact the ***AIMS Helpline***

Birthrights: ***birthrights.org.uk/***

Actions against Medical Accidents: ***www.avma.org.uk/***

Martha's Rule

Martha's Rule[4] is a landmark safety initiative that the government has committed to rolling out in maternity and neonatal wards in England. It gives every woman and family the right to request a rapid review from an independent medical team if they are concerned that the mother's or the baby's condition is deteriorating. A rapid review can also be requested if women and families are concerned they are not being listened to.

There is a lot women and their families can do to help make their voices heard, but the primary burden should not be placed on them. Self-advocacy can be exhausting and may not be possible for everyone. Therefore, this summary also highlights key messages for staff and policy makers that are aimed at reducing risks, generating improvements to safety and preventing poor outcomes.

4 NHS England. (2024). "Martha's Rule." ***https://www.england.nhs.uk/patient-safety/marthas-rule/***

What we are doing: feedback to healthcare providers and the system

The messages and recommendations that MBRRACE-UK produces are primarily aimed at healthcare providers and the places they work. This includes hospitals as well as wider services such as ambulance services, GP surgeries, community midwives and specialist centres. Sometimes MBRRACE-UK messages also target areas for change in the wider healthcare system and government policy.

The key messages from this year's report fall under two main themes related to proactive care: 1. Readiness, or planning ahead for changing needs and 2. Response, or acting early to avoid delays.

Key messages

from the report 2026

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Proactive, not reactive, maternity care

Readiness

Plan ahead for changing needs

Response

Act early to avoid delays in management

Pregnancy counselling and consistent advice

Ensure women with physical and mental health conditions receive pre-pregnancy counselling and that postnatal contraception is available in maternity services for future pregnancy planning

Rapid access to antibiotics and medications

Implement processes to allow for rapid access to antibiotics in hospital-based settings or prescription of urgently needed medications at the point of care

Service provision and clinical demand

Review staffing models and theatre capacity to keep up with changing maternity characteristics, including increased rates of caesarean birth

Maternal observations and escalation of care

Assess and record women's vital signs using maternity early warning scores (MEWS) to recognise deterioration and escalate care if needed

Key messages for healthcare providers

It is the medical team's role to recognise problems, communicate and act. They must listen to women and take their concerns seriously.

Readiness

Understand the full picture and speak to women about their individual risk

The time before pregnancy, between pregnancies, or after a miscarriage, is an important opportunity to improve health. Ask women about their physical and mental health, social circumstances, long-term conditions and medications. Provide advice on healthy weight and stopping smoking, and refer women to mental health, domestic abuse or substance use services where appropriate.

Discussions about the risks of pregnancy should be sensitive, trauma informed, balanced and personalised to each woman's circumstances. Take account of previous experiences and any complex medical conditions, pregnancy histories or social circumstances. Record discussions clearly, provide safety-netting advice and arrange appropriate follow-up and treatment if needed.

Be prepared, not just reactive

Serious emergencies during pregnancy or birth are uncommon, but they do happen. Planning ahead, having clear procedures, and working as a multidisciplinary team can help prevent delays and support safe, effective care.

Provide safe care outside maternity settings

Women who become seriously ill during pregnancy or develop worrying symptoms after birth may receive care outside maternity services. Clear plans are needed to state who is responsible for their care, where they should be treated, and how they should be transferred. Good communication between different specialties and services is essential.

Response

Monitor women's health and act on concerns

Use maternity early warning scores (MEWS) for all pregnant and recently pregnant women, wherever they are receiving care, not only in maternity services. Carry out complete observations regularly to identify changes over time rather than relying on a single normal result.

Look for patterns, recognise deterioration and act promptly

Pregnant women are often young and otherwise healthy, so they may appear stable even when seriously unwell. However, they can get worse quickly. Take any abnormal observations seriously, remain alert to signs of worsening health, and ensure clear processes are in place for escalation, specialist advice and safe transfer to the most appropriate place of care.

Remember the woman's needs

When caring for pregnant women, ensure that attention to the baby or other clinical management does not overshadow the woman's own health and wellbeing. When discussing medications, consider the safety and needs of both the mother and the baby.

Work with others through joined-up care

Women with multiple health conditions or complex care needs benefit from coordinated care. Good communication and collaboration between teams and services are essential to provide safe, consistent care.

Follow-up - incorporate safeguarding into routine care

Safeguarding should be part of all maternity care, particularly for women with complex social factors or multiple disadvantages. Consider how race, ethnicity and bias may affect care and decision-making. If a woman misses appointments or leaves hospital against medical advice, recognise their right to do so and sensitively explore the reasons why. Provide clear safety-netting advice and arrange appropriate follow-up.

It is important to recognise that many clinicians are trying their best to support women and their families so they can have a positive experience. But sometimes they are limited by their workload or are working within a system that does not readily support joined-up, individualised care. It is essential that the system changes to better support clinicians, and the women they care for.

Key messages for the health system and services

The recent National Maternity and Neonatal Investigation showed how austerity measures and funding cutbacks have impacted maternity care in the UK[5]. Similar system-level challenges have been highlighted by MBRRACE-UK and improvements are needed to improve care and safety.

Readiness

System pressures and population health affect care - services must plan for increasingly complex demands

Maternity services should have the staff, facilities and resources needed to provide individualised care for women with increasingly complex health needs. Services must regularly review emergency triage and staffing levels to ensure services remain safe.

The rising rate of caesarean births[6] must also be recognised and appropriately planned for. Operating theatre capacity needs to keep up with the increased demand and services must ensure the availability of appropriately skilled operating theatre teams to manage higher risk operations.

NATIONAL Maternity Voices
Networking maternity & neonatal voices partnerships

Embedding of the voices of women and families in service development and review can help ensure systems work for those using them. **National Maternity Voices** aims to champion this inclusion through Maternity and Neonatal Voices Partnerships (MNVPs) (***nationalmaternityvoices.org.uk/***)

Training

In addition to skills-based training required to manage an increasingly complex maternity population, training is also needed in many areas including anti-racism and discrimination and trauma-informed care. To facilitate this, educational curricula must be updated and systems need to provide staff with the time to participate in training activities.

BABY LIFELINE
The Mother and Baby Charity

In addition to training from the Royal Colleges, **Baby Lifeline** (***www.babylifeline.org.uk/***) provides education to promote safer care, **Antenatal Results and Choices** (***www.arc-uk.org/***) runs training sessions to improve communication when delivering difficult news and SUDEP Action provides support tools and training on SUDEP awareness (***sudep.org/***)

Antenatal Results & Choices

SUDEP Action
Making every epilepsy death count

5 National Maternity and Neonatal Investigation. (2026). "Independent Investigation into Maternity and Neonatal Services in England – Final report and recommendations." ***www.matneoinv.org.uk/final-reports/***

6 Ambia, J., Alderdice, F., et al. (2026). Short Report: International comparison of caesarean birth rates, 2020 – 2025. Oxford, National Perinatal Epidemiology Unit University of Oxford. DOI: ***www.doi.org/10.5287/ora-z6obzn5pq***.

Interoperability of digital systems

Electronic health records can improve care, but differences between systems either within the same organisation or between different organisations or services, can create safety challenges. These include gaps in communication, missed signs of worsening health and lost opportunities for timely intervention. Systems must be upgraded to simplify clinical use and improve interoperability.

Response

Continuity of carer

Continuity of carer is widely recognised to improve outcomes for both the mother and baby. It can be provided by one individual or a small team who are familiar with the woman's circumstances and can advocate on their behalf if needed. Current service models do not always support this model of care, especially for women with complexities who may be seeing multiple teams and professionals. Changes to staffing models may help facilitate such support.

Medication provision

This year's report includes three new recommendations targeted at improving access to contraception, antibiotics and medications where they are needed. This includes having processes in place to enable urgent prescribing and rapid changes to medication in both hospital and community-based settings. Women should also be able to access all forms of contraception in maternity services so they can receive postnatal contraception, if wanted, to support future pregnancy planning before they are discharged from services.

Looking to the future

While listening to women is essential, the burden of ensuring safe maternity care should not rest solely or primarily on the woman or her family. Changes to healthcare culture are also needed at individual provider and system levels.

Maternity services have been under sustained scrutiny this year with reports investigating specific hospitals[7] and national systems[8]. These reports have been described as a 'watershed moment' for maternity care, but the findings of these reports, and the experiences of women and families included within them, will not be surprising. MBRRACE-UK reports have long called for similar change and action from providers and policy makers. It is promising that the government has committed to appointing the first ever commissioner for maternity services and to developing a national action plan to overhaul services and drive long-term change. However, it serves to remember that, while the messages included in all these reports are general, risk is not universal across the maternity population. Women, carers and services must work together to consider individual needs and risks and provide appropriate personalised care pathways.

7 Ockenden, D., Ed. (2026). Findings conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust. London, His Majesty's Stationery Office.

8 National Maternity and Neonatal Investigation. (2026). "Independent Investigation into Maternity and Neonatal Services in England – Final report and recommendations." ***www.matneoinv.org.uk/final-reports/***

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