Technical guidance

Standard		Guidance
1. Notify all eligible perinatal deaths		
1a	Notify all eligible perinatal deaths	• Details of which perinatal deaths must be notified to **MBRRACE-UK** are available at the MBRRACE-UK website. • Deaths should be notified **within seven working days** of the death. • Complete the MBRRACE-UK surveillance information **within 30 working days** of the death. • For deaths in a hospital setting, the trust/health board **where the baby died** is responsible for notifying the death. • Where the baby died outside a hospital setting (for example, in a hospice or at home), the trust/health board who **last provided care** for the baby is responsible for notifying the death. • Notification and surveillance information must be provided for babies who die after a home birth where care was provided by your trust/health board.

1b	The process of death notification and use of the data	• Notification of the eligible perinatal deaths to MBRRACE-UK in **Wales, Scotland and Northern Ireland** are made directly through the MBRRACE-UK system.
		• **In England:**
		  ○ Notification of eligible perinatal deaths to MBRRACE-UK is made through the NHS England Submit a Perinatal Event Notification **(SPEN) portal**, which automatically transfers information about the death to MBRRACE-UK.
		  ○ Neonatal deaths notified via SPEN to MBRRACE-UK are automatically and immediately transferred to the appropriate local Child Death Overview Panel (CDOP) via the Cascade system. See 1(c) below for the timings for notifying neonatal deaths.
		  ○ If a neonatal death is notified directly to CDOP it should still be notified to MBRRACE-UK via SPEN (the Cascade system will manage the duplicate notification)
		• Once an eligible perinatal death has been notified to MBRRACE-UK, MBRRACE-UK users should log on to the MBRRACE-UK system to complete the surveillance information; PMRT users should log on to start the PMRT review.

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1c	The statutory obligation to notify neonatal deaths to local CDOPs (England only)	• The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels (CDOPs) • Neonatal deaths must be notified to CDOPs **within two working days** of the death. Working days are defined as Monday to Friday.
1d	Checking notifications to MBRRACE-UK	• MBRRACE-UK system users should log on to the MBRRACE-UK/PMRT system to check that the information they have provided for each death is complete and correct. • MBRRACE-UK system users must log on to MBRRACE-UK to complete the surveillance information and to start a PMRT review.
2. Seek parents' views of their care		
2a	Seek parents' views of their care	• Following the death of their baby, parents must be informed that a local review of all elements of their care and that of their baby will take place. They should be informed in person before they leave the hospital, wherever possible. • In the case of a neonatal death, parents should be informed that a local CDOP review will also be undertaken. • Verbal information should be supplemented with written information using plain language and translated formats where necessary. • Parents' experience of all elements of their care must be treated as essential information required to complete the clinical picture for a meaningful review. The review process is primarily for parents, and only by incorporating parents' experiences, perspectives and questions can the trust/health board understand how care was offered, given and received by parents. This information must be entered into the PMRT to enable it to form part of the review; the questions about the parents' experience appear first in the PMRT to reflect their central importance. • Parents should be offered several non-intrusive opportunities to share meaningful feedback about their care experience, describe the impact of that care, and raise any questions or comments they may have. • The process of gathering parents' experiences should start at least two weeks before the first panel meeting. A trauma-informed approach should be considered.

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		• It is important to recognise that gathering parent experiences across antenatal, intrapartum, postnatal, bereavement, and neonatal care may require more than one conversation or meeting, including in-person discussions where appropriate. Templates for gathering this as written information can also be used where appropriate and examples are provided on the PMRT website. Other materials to support the parent engagement process are also provided. • If information about parents' experiences is held in another data system, it should be brought to the review meeting, entered into the PMRT and considered as part of the review discussion. • When communicating with parents, staff should apply principles of equity to ensure that socially disadvantaged, disabled, those for whom English is not their first language, and ethnic minority parents are actively and positively included. Parent engagement should be shaped by the parents themselves, with processes flexible to their needs and preferences. Providing a single, consistent key professional contact can also support parents in navigating what can be a challenging and complex experience. • Parents should be given the opportunity to review, amend or add to their reflections before the review begins, if they wish.
2b	Ensure all parents are given the opportunity to be involved in the review process, including where they choose not to engage or do not respond.	• Trusts/health board must ensure that all parents are informed that a review will take place and should ensure that the different ways for them to participate are accessible to all parents, including through plain language and translated or interpreted materials where required (see Note 2a above). • Parents' decisions not to engage must be respected. However, because some may later change their mind, trusts/health boards must provide more than one opportunity for them to contribute, without being intrusive. • Where parents do not respond to the invitation to provide questions or comments, trusts/health boards should consider the steps set out in the PMRT parent engagement guidance, including use of the flow chart and translated parent-facing materials, where appropriate.

Standard		Guidance
3. Review the death and publish the report		

3a	Review the death and complete the multi-disciplinary review for deaths of babies who were born and died in your trust/health board	• The following deaths must be reviewed to meet this standard:
		  ○ Late miscarriages/late fetal losses (22+0 to 23+6 weeks' gestation)
		  ○ Stillbirths (from 24+0 weeks' gestation)
		  ○ Neonatal deaths (from 22+0 weeks' gestation or 500g if gestation is unknown) up to 28 days after birth
		• While it is possible to use the PMRT to review post-neonatal deaths (from 29 days after birth onwards), the PMRT was not specifically designed to review these deaths. These deaths are not included in the best practice standards.

3b	For all the deaths of babies where care was provided in more than one trust/health board the deaths should be 'assigned' to the other trust(s)/health board(s) involved	• Where care was provided to the mother and/or baby by more than one trust/health board, it is essential that all information about the care in the other trust/health board is available before the review starts. To avoid holding up the review process, the review and surveillance form should be assigned **within one month** of the death using the assignment facility. • **Note**: both the review and the surveillance form have to be started **before** they can be assigned.
3c	For perinatal deaths where care was provided in your trust/health board but the perinatal death occurred elsewhere, you will be 'assigned' the case by the trust/health board where the baby died. You should complete the required information, 'return' the death via the assignment process **within two month of receipt**.	• The surveillance form and review will be 'assigned' to you by the trust/health board where the baby died. • To avoid holding up the review process, you should complete the required surveillance information and review the care provided by your trust/health board, and return both forms via the assignment facility **within two months** of receipt. • Ensure a relevant senior clinical member is available to attend the multi-disciplinary review panel meeting led by the organisation where the baby died. • Whilst it may not be possible to achieve this in person, many trusts/health boards now use remote platforms (Teams, Zoom etc.) to enable this to happen.

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3d	95% of reviews should be started within two months of the death	• Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session; this may be the first of several sessions for that death. • As a minimum, there should be a review session where all the 'factual' questions are completed for the review to be considered 'started'; it is not sufficient to just open the first review session. The factual questions are highlighted with the letters **FQ**. • Most of the factual questions can be imported into the PMRT from the surveillance form. To avoid duplicate data entry, you should therefore complete the surveillance form first and then import the answers into the PMRT. • A very small number of additional factual questions are only in the PMRT.
3e	A minimum of 75% of multi-disciplinary reviews should be completed and published	• For babies who were born and died in your same trust/health board, the review should be completed and the report **published within 6 months** of the death • Where the mother and/or baby received care from more than one trust/health board, the review should be completed and published **within 8 months** of the death; this additional time is to allow the other trust/health board to complete their part of the review.
3f	Ensure the PMRT review panel is multi-disciplinary	• To be considered multi-disciplinary, the team conducting the review should optimally include at least one, and preferably two, of each of the professionals involved in the care of pregnant women and their babies. The team should also include an external reviewer (see Note 4a). • At least one neonatologist/paediatrician and at least one neonatal nurse should be present for the review of all neonatal deaths. • At least one neonatologist/paediatrician should be present for the review of all intrapartum stillbirths where resuscitation was attempted. • A list of the members needed to conduct a multi-disciplinary review is available here.
3g	The multi-disciplinary team: the involvement of bereavement care staff in PMRT review panels	• Bereavement care staff (midwives and neonatal nurses) must form part of the review team to provide expertise in reviewing bereavement and follow-up care, and to advocate for parents. • Bereavement care staff **should not** be expected to chair reviews, run review panels, or provide administrative support for the PMRT process.

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3h	The multi-disciplinary team: the involvement of strategic service user voices (Maternity and Neonatal Voices Partnership (MNVP) Leads in England) in PMRT review panels	**In England**:
		• Trusts should enable MNVP Lead attendance at PMRT reviews where readiness criteria are met.
		• Where MNVP Lead attendance at PMRT reviews is not yet in place, trusts must develop a SMART action to address the barriers.
		• For an MNVP Lead to attend safely,:
		  ○ the MNVP Lead should be recruited to and working in line with NHS England MNVP guidance and supplementary materials;
		  ○ the MNVP Lead should have completed relevant training, including the PMRT online training, Sands bereavement training, and Safety II training;
		  ○ the MNVP Lead should have sufficient resourced capacity within their agreed workplan to attend reviews safely and meaningfully;
		  ○ and the MNVP Lead should have access to appropriate clinical or professional supervision to support participation in reviews involving traumatic content.
		• The role of the MNVP Lead in PMRT reviews is to provide strategic oversight of parent experience and learning across deaths, and should not replace direct family input. Nor should it position the MNVP Lead as an individual family advocate; this is the role of the bereavement midwife.
		
		In Scotland, Wales and Northern Ireland:
		• The principles set out above apply elsewhere, but are not required to meet the Best Practice Standards.

3i	**England only:** Deaths where a Maternity and Newborn Safety Investigations (MNSI) investigation will be carried out	• For a small proportion of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term), investigations will be carried out by MNSI. The PMRT review should be started in order to identify any early and immediate learning which requires prompt action. However, the review should not be completed until the MNSI report is complete. • The MNSI reviewer should be invited to attend the final PMRT multi-disciplinary team review meeting to enable the learning from the MNSI review to be incorporated into the PMRT review.

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		• The role of the MNSI reviewer is to present the findings of the safety investigation and the evidence underpinning the resulting recommendations. As the scope of the PMRT and MNSI investigation may differ, these differences should be clearly explained at the start of the multi-disciplinary team meeting. • The multi-disciplinary team should be aware that MNSI investigatory team members come from both clinical and non-clinical backgrounds. A non-clinical MNSI team member with a non-clinical background will participate in the PMRT multi-disciplinary team solely in their capacity as an investigator. If clinical question arises about the MNSI report and no clinical MNSI representative is present, the non-clinical representative should refer the question back to the clinical team who supported the investigation. • Depending upon when the MNSI report is completed, the timeframe for publishing the PMRT report may be affected by factors outside the Trust's control. The PMRT case management screen can be used to record that an MNSI investigation is in progress, and this will be taken into account when calculating the relevant metrics. • If a post-mortem examination result is still outstanding, the MNSI investigation will, in most of cases, remain on hold until the post-mortem report has been received.
3j	The impact of post-mortem delays on achieving the report publication standard	• If a post-mortem (PM) examination has been requested (hospital or coronial) and the results are expected to take more than six (or eight) months for the results to be available, the review of the death should still take place. The report should be completed and published using the information available at the timer. When the PM results are received, the PMRT team at MBRRACE-UK can be contacted to re-open the review so that the new information can be incorporated. • If the PM findings have implications for the original conclusions, an additional review session should be held to consider this new information. • Waiting for the PM results before starting a review may delay important learning, particularly if the PM timeframe extends beyond six (or eight) months. • When PM results are available sooner, they should be included in the initial review. • Families should be kept informed of the review’s progress throughout the process.

Standard		Guidance
4. Include an external panel member in your review panel		
4	Include an external member in your review panel	• For at least 60% of reviewed deaths, the multi-disciplinary review panel should include an external member with relevant speciality expertise. This must be properly documented in the PMRT. • **Note**: this is a **minimum** expected standard. Better performing trusts/health boards will involve an external member in a higher proportion of reviews. • External panel member(s) must be relevant senior clinician(s) who are currently practicing clinically and work in a hospital which is not part of the trust/health board undertaking the review and external to any trust/health board involved in the care at any stage. The external reviewer(s) should be the specialist(s) relevant to the care provided; for instance, an obstetrician for all deaths, and a neonatologist for neonatal deaths. • A 'gold standard' review of a neonatal death would involve both an external obstetrician and an external neonatologist. • An external reviewer may also be someone such as a member of another trust/health board's governance team, provided they currently practice clinically. They must possess relevant clinical expertise, remain up-to-date with required training and continuing professional development (CPD), and either be undertaking clinical shifts or able to do so if required. This is essential because effective externality relies on clinical credibility; reviewers need current experience and knowledge to reflect on the care provided and to offer authoritative, robust, and objective challenge when appropriate. • If a baby died at your trust/health board and more than one trust/health board was involved in the care of the mother and/or baby, staff from those organisations are not considered 'external' panel members. They cannot provide an independent view of the care and therefore should not be listed as 'external' reviewers in the PMRT participant list. • If the baby died at another trust/health board but the majority of care was provided by your trust/health board, you should consider including an external reviewer as part of your own review panel, particularly if a joint review meeting is not possible.

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		• Although the MNVP (and other strategic services user voices) member may not be employed directly by the Trust, they **should not** be regarded or recorded as an 'external' member. Their role is to represent the wider parent voice. • Parents place great value on the independence brought by involving external reviewers, as without this trusts and health boards may be perceived as 'marking their own homework'.
5. Offer parents a feedback meeting with relevant specialist		
5	Offer parents a feedback meeting with relevant specialists	• For all deaths reviewed, offer bereaved parents a meeting with an appropriate senior specialist(s) to share the review findings, discuss any implications for future care, and address any remaining questions. These meetings should be centred on the needs of parents. • For meetings that involve discussing the care of a baby who received neonatal care, the meeting should be held jointly, with both maternity and neonatal staff present. • The purpose of this meeting is to discuss with parents what has been reviewed, what has been found, and what learning or actions have been identified, using plain, accessible language and avoiding technical or defensive terminology. The discussion should cover any questions they have and should also cover any implications for their future care. Some parents may not wish to talk about future pregnancies or care plans; staff should sensitively gauge their readiness for this during the meeting. • The discussion should be at a pace and in a format guided by the parents. This may require more than one meeting and must allow families time to process information and ask questions. • Families should be supported to understand how their experiences, perspectives, and questions were considered within the PMRT and other review processes, and how these influenced findings and actions. • Where review findings are shared in writing, these must be accompanied by a verbal explanation and opportunities for clarification. Written materials must use plain language and be provided in translated or alternative formats where required. The letter should describe what was discussed in the meeting and provide a summary of the PMRT report in understandable non-technical language. • The technical clinical report generated by the PMRT should not be provided to parents without a prior verbal and/or written explanation of its contents and what it means.

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		• Trusts/health boards should avoid one-off or transactional communication. Follow-up contact must be offered so families have the opportunity to raise further questions after receiving or reflecting on the information shared with them to date.
		• Where families do not wish to engage directly, or find direct engagement too distressing, they should be offered alternative options to receive information about the PMRT review and their future care. For example:
		  ○ Offer an online appointment for parents who do not wish to attend the hospital where their baby died.
		  ○ Provide the letter summarising the review findings in a sealed envelope, accompanied by an explanatory cover letter. The parents can open the sealed envelope if and when they are ready to look at the review findings.
		  ○ Offer a follow-up appointment for a later date when the parents feel ready to receive the information.
		  ○ Offer an open appointment which they can take up in the future, if and when they feel ready to receive the information.
		• Trusts/health boards should ensure that learning and actions shared with families are consistent with what is reported through governance structures, to avoid conflicting messages which can lead to a loss of trust.

6. Ensure that PMRT review staff undertake the PMRT online training course		

6	Members of staff regularly involved in the PMRT review panel in your trust/health board should complete the PMRT online training.	• It is essential that individuals undertaking the following roles as part of the trust PMRT panel complete the PMRT online training at least once:
		  ○ The panel chair and vice-chair and anyone who undertakes these roles regularly
		  ○ The designated PMRT midwife or the staff member(s) undertaking this role
		  ○ The PMRT administrator
		• All clinical panel members should undertake the training
		• It is recommended that anyone in a strategic services user voices role (e.g. MNVPs in England), parent advocates and anyone else in a non-clinical role undertake the training
		• This free training is available at: PMRT online training course registration

Version history

Version number	Description of change	Date
1.0.	First published	1 June 2026