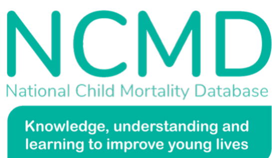
Neonatal Mortality Governance

A BAPM Framework for Practice

February 2026

Developed in partnership with



Endorsed by

Contents

Executive summary ... 3
Recommendations for Neonatal Units ... 3
Recommendations for Neonatal Operational Delivery Networks ... 4
Recommendations for other bodies ... 4
Members of the Working Group ... 5
Abbreviations ... 6
Introduction ... 7
Aims and scope ... 7
Development process ... 7
Language ... 7
Table 1: Timelines for End-of-Life Care and Child Death Review Processes ... 8
Care of baby and family ... 9
Palliative care where death is anticipated ... 9
Family decisions around the time of death ... 9
Lactation choices and breast care ... 10
Family Support and Communication ... 10
Child Death Review ... 12
Immediate decisions ... 12
Child Death Review Meeting ... 18
Reporting, review and dissemination of learning ... 21
Reporting and review ... 21
Dissemination of learning ... 21
Assurance ... 21
Staff considerations ... 24
Staff support and training ... 24
Staffing to support bereavement care ... 24
Dedicated time to support mortality governance processes within neonatology ... 24
References ... 26

Executive summary

High-quality end-of-life care, and an open and transparent child death review process are of vital importance in providing understanding and closure for both families and staff as well as supporting shared system-wide learning. This framework complements existing national and statutory documents while providing more detailed operational guidance in areas where clinical interpretation is challenging.

The term Child Death Review Meeting (CDRM) is used throughout this document to describe the local health professionals review of the care of a baby that has died. Locally, different terminology is often used e.g. Morbidity & Mortality meeting, Perinatal Mortality Review Tool (PMRT) meeting.

Recommendations for Neonatal Units

Care of baby and family

All units should

- give families pragmatic options for where end of life care takes place
- have access to suitable bereavement facilities
- use their country's National Bereavement Care Pathway (NBCP) for pregnancy and baby loss to guide provision of high-quality compassionate care to bereaved families.
- ensure all families have a named consultant and a named family key worker (a bereavement midwife or neonatal nurse) to provide a consistent point of contact regarding key decisions after death and for communication, engagement and support throughout all child death review processes.
- have guidance in place to facilitate rapid release of the baby's body on parental request.
- have guidance regarding neonatal organ and tissue donation and should review whether this was offered as part of the mortality review process.
- ensure postmortem examination is offered to families by a clinician who has received appropriate training (except where a coronial postmortem is mandated).
- provide support for managing lactation and breast care in the event of neonatal death, including discussing and facilitating donation of breastmilk.

Child Death Review

All neonatal units should

- be familiar with national statutory/legal processes and child death review processes in their locality
- adopt best practice recommendations regarding completion of the medical certificate of cause of death. More detailed information with specific case examples can be found in **Appendix 3: Case Examples**.
- use bereavement checklists which are consistent with national and statutory guidance (**Appendix 2**).
- develop good working relationships and processes with the local Medical Examiner (Eng/Wales) and His Majesty's Coroner/Procurator Fiscal (HMC/PF), to enable clear communication channels and information sharing to best support bereaved families. Families should be consulted on how they would like to receive information.
- use the Perinatal Mortality Review Tool (PMRT) to support the child death review meeting (CDRM) for all neonatal deaths in the first 28 days when neonatal care has been received, regardless of the location of death (can also be used for babies who die in neonatal units after 28 days).
- involve all staff who participated in the baby's care in the CDRM (including other specialty multidisciplinary teams).

- use a trauma informed approach to mortality review to enable families and staff to feel safe in raising concerns and identify learning (**Appendix 1: Supporting Families and Staff**).
- ensure the child death review meeting is conducted in accordance with national and statutory guidance, reviewing from pre-conception to bereavement follow-up; appropriate internal and external peer review; and capturing the family's perspective and providing answers to their questions.
- ensure sufficient protected time for leading and participating in mortality governance reviews and for bereavement care (**Staff considerations**).

Recommendations for Neonatal Operational Delivery Networks

Neonatal ODNs or Perinatal Networks (devolved nations) should

- facilitate collation of contact details for clinicians in the network who are willing to undertake external review as well as work with other regions to support units to find external reviewers with similar expertise for complex cases where required e.g. neurosurgical, cardiac cases.
- review neonatal mortality data relevant to the ODN/Perinatal Network (**Fig 1**) and raise any concerns arising with the relevant neonatal/perinatal service, and with regional perinatal and commissioning organisations where appropriate.
- collate learning from individual Child Death Review Meetings (CDRMs) and Child Death Overview Panels (CDOPs)/National Child Mortality Database reports (or equivalent for devolved nations) to look for themes and facilitate shared learning across the ODN/perinatal system and more widely where appropriate.
- provide quality assurance around the CDRM process, including reviewing representation at CDRMs, appropriate family input and response to their questions, PMRT outcome gradings and learning outputs. Neonatal units should provide ODNs/Perinatal Networks with the information required to facilitate this.

Recommendations for other bodies

Department of Health, Northern Ireland

- BAPM strongly supports the establishment of a formal child death review process in Northern Ireland which is an outlier in the UK in this respect.

National Medical Examiner: England and Wales

- To develop training resources to support all Medical Examiners (MEs) with understanding neonatal deaths and to consider initiatives to share insights and learning from the neonatal population as the ME system matures.

His Majesty's Coroner/Procurator Fiscal

- To develop good working relationships and processes with neonatal services to enable clear communication channels and information sharing to provide the best support for bereaved families.

Child Death Overview Panels (England only)

- 'Themed' neonatal CDOP meetings are strongly recommended, to ensure that maximum learning is derived through aggregate review of neonatal deaths. CDOPs are strongly encouraged to share learning with the neonatal ODN/Perinatal Networks.

Child Death Review Programme (Wales only)

- Strengthening of information sharing between neonatal ODNs/Perinatal Networks and Child Death Review Programme (CDRP).

Members of the Working Group

Eleri Adams (Chair)	BAPM President, Consultant Neonatologist, Oxford University Hospitals
Srinivas Annavarapu	Consultant Perinatal Pathologist, representing RCPath
Kate Laura Bannister	Lead Midwife for Quality, Safety and Risk, Singleton Hospital, Swansea
Stephen Brearey	Consultant Paediatrician, Countess of Chester Hospital
Katie Cullum	Lead Nurse, East of England Neonatal Network
Victoria Davies	HMC, Representing the medico legal committee of the Coroner's Society of England and Wales
Lucy Deacon	ST6 Paediatric and Neonatal Medicine Trainee, Singleton Hospital, Swansea
Ngozi Edi-osagie	National Clinical Director for Neonatology, NHS England
Davy Evans	Consultant Clinical Psychologist, Birmingham Women's & Children's Hospital
Vikki Fradd	Consultant Neonatologist, Medical Examiner, Heartlands Hospital
James Fraser	Chair NCMD Professional Advisory Group, representing ACDRP
Janice Gibson	Consultant Obstetrician, Representing BMFMS
Kelly Gill	Yorkshire and Humber Neonatal ODN QI/Governance Lead Nurse
Richard Hearn	Consultant Neonatologist, Royal Victoria Infirmary
Zoe Hemsley	Regional Medical Examiner, England and Wales
Kathryn Johnson	Consultant Neonatologist, Mortality Lead, Leeds Teaching Hospitals
Nigel Kennea	Consultant Neonatologist, Medical Examiner, England and Wales
Adele Krusche	Researcher, National Perinatal Epidemiology Unit, Representing PMRT
Tracy Lawson	Consultant Neonatologist, Clinical Governance Lead, Ashford & St. Peter's Hospitals
Louise Leven	Consultant Neonatologist, Royal Hospital for Children, Glasgow
Renton L'heureux	Consultant Neonatologist, London North West Healthcare NHS Trust
Ben Lobo	Regional Medical Examiner, England and Wales
Karen Luyt	Consultant Neonatologist, Programme Director, NCMD, representing NCMD
Sonia Macleod	Representing Sands Charity
Brad Manktelow	Professor of Medical Statistics, representing MBRRACE-UK
Tamas Marton	Consultant Perinatal Pathologist, representing RCPath
Kate Mulley	Director of Research, Education and Policy, Representing Sands Charity
Nicola Mundy	Lead for Learning from Child Deaths (public health), Surrey Heartlands ICB
Nicola Needham	Child Death Review Manager, Specialist Community Public Health Nurse
David Odd	Consultant Neonatologist, Epidemiologist, NCMD, representing NCMD
Sam Oddie	Consultant Neonatologist, Clinical Lead NNAP, representing NNAP
Hannah Shore	Consultant Neonatologist, Leeds Teaching Hospital, representing MNSI
Susan Smith	Maternity Neonatal Senior Independent Advocate, NHS Devon ICB
Lucy Smith	Professor of Perinatal Health, representing MBRRACE-UK
Timothy Taylor-Smith	Parent representative
Megan Tombling	Post Certificate of Completion of Training, Neonatal Clinical Fellow, Exeter
Alison Verner	Consultant Neonatologist, Craigavon Area Hospital, Northern Ireland

Acknowledgements
With thanks to Jessica Smith for supporting the working group meetings and Laura Fountain for the design.

Abbreviations

There are many abbreviations in use in national mortality governance documents. Please refer to the list below when reading this document.

Abbreviation	Full Name	Abbreviation	Full Name
ACDRP	Association of Child Death Review Professionals	NCMD	National Child Mortality Database (England)
BMFMS	British Maternal & Fetal Medicine Society	NICORE	Neonatal Intensive Care Outcomes Research and Evaluation
CDOP	Child Death Overview Panel (England)	NIMACH	Northern Ireland Maternal and Child Health
CDR	Child Death Review	NICU	Neonatal Intensive Care Unit
CDRM	Child Death Review Meeting	NNA	Neonatal Nursing Association
CDRP	Child Death Review Programme (Wales)	NNAP	National Neonatal Audit Programme
CGA	Corrected Gestational Age	NTG	National Neonatal Transport Group
CHIS	Child Health Information System	ODN	Operational Delivery Network
GP	General Practitioner	ONS	Office for National Statistics
HIE	Hypoxic Ischaemic Encephalopathy	PA	Programmed Activity
HIS	Healthcare Improvement Scotland	PAG	Parent Advisory Group
HMC	His Majesty's Coroner	PF	Procurator Fiscal (Scotland)
HTA	Human Tissue Authority	PM	Postmortem
HV	Health Visitor	PMRT	Perinatal Mortality Review Tool
ICB	Integrated Care Board	PRUDiC	Procedural Response to Unexpected Death in Childhood (Wales)
JAR	Joint Agency Response	PSIRF	Patient Safety Incidence Response Framework (England)
LMNS	Local Maternity and Neonatal System	QI	Quality Improvement
LNU	Local Neonatal Unit	RCPath	Royal College of Pathologists
M&M	Morbidity and Mortality	SAER	Serious Adverse Event Reporting
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries	SAI	Serious Adverse Incident
MCCD	Medical Certificate of Cause of Death	SCU	Special Care Unit
MDT	Multidisciplinary Team	SNOD	Specialist Nurse for Organ Donation
ME	Medical Examiner	SPEN	Submit a Perinatal Event Notification
MNSI	Maternity and Newborn Safety Investigations	SUDI	Sudden Unexpected Death in Infancy
MNVP	Maternity and Neonatal Voices Partnership	SUDIC	Sudden Unexpected Death in Infancy and Childhood
MOSS	Maternity Outcomes Signal System	SUPC	Sudden Unexpected Postnatal Collapse (first week of life)
MW	Midwife	TS	Tissue Services
NBCP	National Bereavement Care Pathway	WTE	Whole Time Equivalent

Introduction

Deaths in the neonatal period (first 28 days of life) make up 54% of all child deaths under 16 years with nearly 2000 neonatal deaths in the UK each year[1,2]. 40% of all child deaths (0-17 years) in England occur in maternity and neonatal units[3]. Each of these events is a tragedy and it is of vital importance that the processes and procedures that occur following the death of a baby are conducted properly and sensitively, and that the subsequent review process is thorough, open and transparent.

The death of a baby is a profoundly painful and life-shattering experience for families, with significant consequences for the mental health of family members as well as impacting staff mental health. The governance processes that follow a neonatal death provide an opportunity to shape understanding and psychological adjustment to loss for all those affected as well as providing opportunities for whole system learning. Throughout this document we aim to adopt a trauma-informed approach to reduce the psychological impact of neonatal death and mortality governance on parent(s), families and staff (**Appendix 1: Supporting Families and Staff**).

Aims and scope

Neonatal mortality governance processes are complex and are subject to variable statutory guidance across the 4 nations in the UK (**Appendix 2: National and Statutory Guidance**). This framework is written in accordance with that guidance and aims to

- collate key aspects pertinent to neonatal practice,
- make recommendations for best practice, and
- provide more detailed operational guidance in areas where clinical interpretation is more challenging (**Appendix 3: Case Examples**)

It is aimed primarily at perinatal healthcare professionals but may also be helpful to His Majesty's Coroners (HMCs), Procurator Fiscals (PFs) and Medical Examiners (MEs). The focus is predominantly on babies who are born with signs of life and die whilst in the care of maternity and neonatal services, with limited information on miscarriages, stillbirths and neonatal deaths occurring outside of perinatal services.

We have provided a full **list of abbreviations** used in this document.

Development process

The scope and content of this document were determined by members of the working group, which contains wide representation across the various bodies involved in neonatal mortality governance. The content is consistent with national and statutory guidance available at the time of publication. Evidence is included from the literature where available. Where there is a lack of evidence/ national guidance, or where there is uncertainty or variation regarding the clinical interpretation of national guidance, an expert consensus from the working group has been developed. The draft document was revised following a consultation process with BAPM members and other organisations.

Language

The British Association of Perinatal Medicine is committed to continuously fostering an inclusive environment and we acknowledge the effect language can have on individuals and populations. This framework uses the terms mother/birthing parent, parent(s) and families. We recognise that different terms may be preferred, and the meaning of these terms may be different to each of us. Please use a person's preferred pronouns and terminology.

Table 1: Timelines for End-of-Life Care and Child Death Review Processes

Timeline	Baby and Family Focused Actions	Staff Actions/Local Investigation	Statutory/National Safety Notifications
Prior to death where anticipated	• Parallel planning/treatment options/ palliative care • Making memories/ Family and Friends • Support from family key worker • Religious rites/cultural beliefs/family traditions • Place of death: hospital/ hospice/ home • Discuss physical changes after death if the family wish • Discuss lactation choices and breast care • Discussion regarding organ donation if applicable • Diagnostic tests for SUPC if appropriate.	• Documentation of Advanced Care Plan/family wishes • Identify named consultant and family key worker (bereavement midwife/neonatal nurse) • Collaborate with local hospice/palliative care team • Contact SNOD/TS re organ/tissue donation if eligible PRIOR to discussion with family • Contact with neonatal transport service if transfer required. • Staff communication and wellbeing • Local safety incident report if applicable	• Early contact with ME (England/ Wales) +/- HMC/PF if uncertainty regarding MCCD <u>and</u> rapid release of the body is likely to be required. • Early contact with ME +/- HMC/PF if solid organ donation is being considered.
Immediately after death	• Making memories/ care for baby's body with dignity • Religious rites/cultural beliefs/family traditions • Post death care: location/use of cold cot/cooling technology • Support from family key worker • If fulfils criteria for SUDI/PRUDiC/ SUPC explain next steps • Discuss lactation choices and breast care • Explain transportation to the mortuary	• Documentation of events leading up to death • Diagnose, confirm and document death in the notes • Documentation of discussions with family • Identify lead consultant and family key worker (bereavement midwife/neonatal nurse) • Staff communication and wellbeing • Digital/EPR flag to notify bereavement on maternal record	• Early contact with ME +/- HMC/PF if uncertainty regarding MCCD <u>and</u> rapid release of the body is required • In event of SUDI/PRUDiC: contact designated individual to discuss arranging JAR or equivalent, and refer to HMC/PF.
1-2 working days	• Discussion regarding death processes, MCCD and/or need for discussion with Coroner • ME discussion with family • Discuss PM (hospital and coronial) • Support from family key worker • Discuss lactation choices and breast care • Referral to bereavement services	• Hot debrief offered • Complete Neonatal Bereavement Checklist • Complete bereavement +/- PM paperwork, and discharge summary (Lead consultant review) • Notify relevant health professionals and NHS information systems (e.g. GP/HV/MW/referring unit, CHIS) • Rapid review re any safety concerns - Local safety incident reporting (PSIRF/SAER/SAI or equivalent) if applicable	• Completion of MCCD and independent scrutiny by ME (England/Wales) • If MCCD cannot be issued, referral to HMC/PF Notifications: • MBRRACE-UK – all UK (<48hrs Eng) & CDOP notification form (Eng) (SPEN/CASCADE system if ≤28 days old), • Child death notification form (Wales) • MNSI if applicable (Eng).
First week	• Ongoing contact with family key worker • Registration of death (and birth if needed) • ME discussion with family if not done day 1-2 (Eng/Wales) • Information regarding review timelines • Discuss lactation choices and breast care if applicable	• Cold debrief (if required) • Statements for investigations (if applicable) • Local safety incident report (PSIRF/SAER/SAI or equivalent) - Immediate Incident review completed/ duty of candour/ actions started (if applicable)	• JAR or equivalent MDT meeting is held (if applicable) • MBRRACE-UK reporting • CDOP reporting form completion (England)/ Child Death Notification Form (Wales)
1 week – 3 months (longer if PM/HMC/PF or MNSI)	• Ongoing contact with family key worker • Input questions to local CDRM • Offer opportunity for bereavement meeting even if investigations are not yet complete • Discuss lactation choices and breast care if applicable	• Formal child death review meeting (CDRM) • CDOP Draft Analysis and supplementary form completion and submission to CDOP office • PSIRF/SAER or equivalent investigation findings/ reports (if applicable)	• HMC/PF process completed – may be >3 months • PMRT completion (pending MNSI/HMC/PF/PM findings) • CDR Core dataset (Scot)/NICORE (NI) completion • MBRRACE-UK surveillance data
>3 months	• Ongoing contact with family key worker • Duty of candour and incident review finding meeting with the family (if applicable) • Bereavement meeting with feedback from CDRM and discussion of post-mortem +/- histology/genetic/biochemistry results	• Regional Neonatal ODN/Perinatal Network Mortality Review • Local/regional review of themes in neonatal mortality	• Coronial inquest findings/ hospital postmortem findings • MNSI report with actions and learning (if applicable) • CDOP review (Eng)- alerts of national relevance to NCMD • CDRP (Wales) escalates alerts as appropriate • PMRT, MBRRACE-UK, NNAP, national reporting • NMCD (England), CDRP (Wales), National Hub (Scot), NIMACH/NICORE (NI), national reporting

©BAPM, 2026

Please refer to **Abbreviations Table**

Care of baby and family

Please refer to Table 1 above for a timeline of actions to support families at the time of death.

Palliative care where death is anticipated

Most babies who die in maternity and neonatal units will have life-limiting or life-threatening conditions where death can be anticipated. Early identification of babies who fall into these categories allows important planning and support to be put in place. The BAPM Integrated Palliative Care framework provides more details on holistic support for families in these circumstances[4].

Family decisions around the time of death

A named consultant and family key worker (bereavement midwife/ neonatal nurse) should be identified to coordinate care and discuss with parent(s) and families the practical arrangements that will be needed around the time of death. The following specific aspects should be considered:

- **Location of end-of-life care/care after death**
  - Where possible, families should be given options for where end of life care takes place, including hospice and home care, or transfer to a hospital nearer their home e.g. local LNU/SCU. In such cases, there should be clarification regarding the named consultant and key worker prior to transfer.
  - All units should have access to suitable bereavement facilities. See building note standards[5]. In smaller units, facilities may be shared with maternity services.
  - All units should have access to a cold cot or alternative cooling facilities, to facilitate parent(s)/ families spending more extended periods of time with their deceased baby[6]. Most cold cots are portable and can also be used at home.
- **Religious rites**
  - Access to appropriate religious support should be provided (**Appendix 1: Supporting Families and Staff: Cultural and Spiritual Sensitivity**)
  - Consideration for whether urgent burial is required (see **Rapid release of body**)
- **Organ Donation[7,8]**

> - Heart valves (tissue donation) can potentially occur from 32 weeks CGA in England and Wales (36 weeks CGA in Scotland). Heart valves cannot be donated in N Ireland.
> - Solid organ donation can occur from 37 weeks CGA
> - Organ/tissue donation should be considered at an early stage when considering end-of-life care
> - Clinicians should aim to contact Specialist Nurse for Organ Donation (SNOD) and/or Tissue Services (TS) for advice BEFORE discussing with parent(s)

  - All units should have clear guidance regarding neonatal organ and tissue donation including how to contact their Regional Organ Donation Team and Tissue Donation Services.
  - Units should record information regarding contact with organ/tissue donation teams and reasons why SNOD teams were not approached for ALL neonatal deaths above the minimum gestation threshold. This information should be reviewed on a case-by-case basis in local CDRM meetings as well as audit of potential missed opportunities for discussion of organ/tissue donation with families.
  - Where a postmortem is also being undertaken, co-ordination between organ retrieval teams and the perinatal pathologist will streamline the process.

©BAPM, 2026

- **Postmortem Examination**
  - All parent(s) should be offered a postmortem examination. In coronial cases there may be a mandated postmortem.
  - Perinatal postmortem services are not available in many hospitals and families should be made aware that this may require their baby to be transferred to a more distant hospital. In Northern Ireland, transfer to Alder Hey hospital in England is currently required[9].
  - Families should have a named consultant throughout the postmortem process from consent until the report is received (Eng and Wales)[10]
  - The clinician or specialist nurse/bereavement midwife leading this discussion should have received approved training in postmortem consent which meets HTA standards[11,12,13]. E-learning is available for everyone with a NHS email address[14]. Training in N. Ireland is run at hospital level.
  - Parent(s) should be made aware of the likely impact of a postmortem on the timing of funeral arrangements and the likely timeframe for the results of postmortem investigations to become available.
  - Examination of the placenta and placental histology can provide important insights into a neonatal death and should be sent to pathology, with detailed clinical information, according to national guidelines. Placental histology and postmortem findings should be considered and interpreted together[15].
  - For families who have experienced sudden unexpected death (SUDIC/SUDI/PRUDiC), a video produced by SUDC-UK explains the process of tissue sample collection and provides advice to parents on the choices available to them once the postmortem has been completed[16].

Lactation choices and breast care

- Mothers/birthing parents should be given support to manage lactation and breast care in the event of neonatal death, including discussing and facilitating donation of breastmilk.
- Breastmilk donation after neonatal death (sometimes called “memory milk gifting”) can provide comfort to some mothers/birthing parents and families. Staff should be aware of the schemes available in their area.
- Details of lactation options available after baby loss are outlined in the BAPM Framework for Lactation and Loss[17] and e-learning is provided on the NHS learning hub[18].
- Practical and emotional support for parents is available through the National Breastfeeding Helpline[19]

Family Support and Communication

The death of a baby is a devastating experience for families, and it is vital that they are fully supported in a trauma informed, psychologically supportive and transparent manner through the mortality governance process. Key aspects of family support and communication are outlined below. More detailed information including support for more vulnerable groups and those requiring specialist support are included in **Appendix 1: Supporting Families and Staff**.

- All units should use their country’s National Bereavement Care Pathway (NBCP) for pregnancy and baby loss to guide provision of high-quality compassionate care to bereaved families[20] (see **Appendix 2** for more details). The NBCP for England is included in NHS England’s medium term planning framework[21].
- Guidelines for effective communication with families at the time of death can be found in the Code of Practice for the diagnosis and confirmation of death[22].
- All families should have a named consultant and a named keyworker (statutory in Eng)[4,23], who can act as a consistent point of contact for families to facilitate support, communication

and engagement in the process. There may be several reviews and families should be informed about the timelines and asked if they wish to contribute

- Families should be consulted on how they would like to receive information, and this should be reviewed throughout the process.
- All families should be offered the opportunity to explain and discuss the causes of death written on the Medical Certificate of Cause of Death (MCCD).
- All families should be given the opportunity to ask questions about their baby's care with the lead consultant and in England and Wales, separately, with the Medical Examiner or Medical Examiner Officer.
- Interpretation services should be used to support good communication if either parent does not speak English fluently. Family members should not be used to interpret[24].
- The family key worker (bereavement midwife/neonatal nurse) should support the family to prepare questions/comments for submission to the CDRM. Families' views should be heard and questions answered at the CDRM.
- Compassionate support and communication from the named consultant and bereavement midwife/neonatal nurse should be maintained throughout His Majesty's Coroner/Procurator Fiscal (HMC/PF) or Maternity and Newborn Safety Investigations (MNSI) processes.
- The named consultant should offer families the opportunity to meet to discuss
    - the results of the postmortem, and any outstanding investigations.
    - the outcome and any actions following the CDRM.
    - the outcome and any actions following any internal or external investigations (if applicable).

  Where another specialist team has been involved in the baby's care e.g. paediatric surgeon, the named surgeon may also wish to be involved in these discussions.
- In some ICBs (England only), Maternity and Neonatal Independent Senior Advocates are available to provide independent support through investigations and complaints processes. Where these are available, they can be accessed through the local NHS ICB.

Child Death Review

- England, Wales, and Scotland have established Child Death Review (CDR) programmes to safeguard children and learn from their deaths[23,25,26].
- A formal child death review programme is not currently in place in Northern Ireland and BAPM strongly supports its establishment.
- Further information on CDR programmes and other key national and statutory documents in use across the four nations are outlined in **Appendix 2: National and Statutory Guidance**.

Table 2: Child Death Review Processes and Reports

Coverage	CDR Process
Local	• Local CDRM • ME (Eng & Wales only) except when referral to HMC
Regional	• CDOP (England) • Regional Neonatal ODN/Perinatal Network Mortality Reviews • LMNS PMRT Review (England)
When Required	• HMC/PF investigation • Safety Investigations PSIRF/SAER/SAI or equivalent • MNSI* (England only) • SUDIC/SUDI/PRUDiC (including JAR or equivalent)
National Reports	• MBRRACE-UK Perinatal Surveillance Reports • MBRRACE-UK PMRT National Reports • NNAP (All except NI) • NCMD (England) • CDRP (Wales) • NICORE/NIMACH (NI) • National Hub (Scotland)

Please refer to Abbreviations Table.
*Investigate term babies (37+ weeks) with no congenital anomalies born following onset of labour with one of following outcomes: a) intrapartum stillbirth, b) early neonatal death (0-6 days) or c) potential severe brain injury (required cooling or diagnosis mod/severe HIE)

- Neonatal CDR review processes shown in Table 2 begin shortly following death with timelines for notifications shown in Table 1.
- All units should be familiar with the child death review processes in place in their locality.
- All units should use bereavement checklists to ensure timely completion of all appropriate tasks, and these should be made available for review during the CDRM. Awaiting results of external reviews should not prevent timely initiation of other CDRM tasks.

Immediate decisions

Diagnosis and confirmation of Life

- For babies who die shortly after birth it is important to establish whether there were signs of life. This, along with the gestational age, determines whether the death is a neonatal death, a miscarriage or a stillbirth. Legal requirements regarding certification of death and referral to HMC/PF differ depending on which country the death occurs in[27,28,29] (see **Appendix 2: National Guidance** and **Appendix 3: Case Examples 1-4**).
- Information and videos for family's and health professionals regarding determination of signs of life following spontaneous birth before 24+0 are available at MBRRACE-UK[30].

Diagnosis and confirmation of Death

- Confirmation of the diagnosis of death will be made using cardiorespiratory criteria in most neonates with only occasional use of neurological criteria. Guidance for both criteria are clearly outlined in national guidance[22].

Death Certification

- Following the death of a child, it is the statutory duty of a doctor who has attended the child during their life to write the MCCD. The MCCD may be issued if a doctor is able to identify a natural cause of death to the best of their 'knowledge and belief'. Absolute certainty is not required[31,32,33].
- Before writing the MCCD, the doctor should consider if the death requires reporting to His Majesty's Coroner (HMC) (Eng, Wales, NI) or the Procurator Fiscal (PF) (Scot) [34,35,36]. A conversation with the Medical Examiner (ME) (Eng/Wales only) as part of this process may aid decision making as to whether the MCCD can be written or not. When to refer to HMC/PF is discussed in more detail below; reporting requirements are shown in **Appendix 2: National and Statutory Guidance**.
- There are two versions of the MCCD for child deaths in England/Wales: a neonatal certificate (for deaths within the first 28 days of life) and the standard certificate for older children. The MCCD for neonatal deaths reflects different aetiologies of death in this period and includes maternal factors. There is one MCCD for all deaths in Scotland/Northern Ireland (NI), and in NI it is electronically completed, with maternal complications leading to death being included in Part 1b if appropriate.
- The duty consultant (preferably the named consultant) should oversee the discussions and writing of the death certificate and the information to be included should be shared with the family.
- The baby's name for registration of birth and death should be checked with the family to ensure the correct information is entered on the MCCD.
- In England and Wales, the proposed MCCD/case will then be scrutinised by a Medical Examiner (ME), with correspondence or verbal discussion between the ME and the attending physician. MEs (or a Medical Examiner Officer) also discuss the contents of the MCCD with the family. Once countersigned by the ME the death can be registered by the informant (usually the family).
- The completed MCCD is then sent directly to the registration office (not given to the family).
- Death Registration cannot occur before an MCCD is completed.
- Funeral arrangements can be started prior to death registration, but the funeral can only take place once the death has been registered or once HMC/PF has given permission – usually after a postmortem examination, but before an inquest has occurred.

The Medical Examiner (England and Wales only)

- Since September 2024, in England and Wales, all deaths (that are not investigated by a Coroner) are scrutinised by Medical Examiners (MEs), and the MCCD agreed and signed off by the ME before it is sent to the Registrars of Births and Deaths[37,38].
- MEs review the clinical records and so rely on good contemporaneous documentation. MEs are independent doctors and provide oversight and safeguards for individuals and the public.
- Different areas of the country will have slightly differing processes in place for interacting with their local ME team. Neonatal teams should forge good relationships with their ME team and ensure all understand their roles.
- Few MEs will have clinical expertise in neonatal care. It is recommended that training resources are developed to support all MEs with understanding neonatal deaths and to consider initiatives to share insights and learning from the neonatal population as the ME system matures.
- An overview of the ME process is shown in **Appendix 2: National and Statutory Guidance**.

Role of the Medical Examiner

- Agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- Discuss the cause of death with bereaved parent(s) (independent of those caring for the deceased) and establish if they have questions or concerns with care
- Act as a medical advice resource for the clinical teams and Coroner and ensure appropriate notification of death to the coroner
- Identify cases for further review under local mortality arrangements and contribute to other clinical governance processes including child death review.

Referral to His Majesty's Coroner (Eng, Wales, NI) or the Procurator Fiscal (Scot)

- The full criteria for referral to HMC/PF differ between England and Wales, Scotland and Northern Ireland[34,35,36] and are outlined in **Appendix 2: National and Statutory Guidance**; clinical teams need to be aware of their legal duties in this respect. General guidance regarding clinical interpretation of issues most pertinent to neonatal deaths are included below.
- If a live birth has been verified by a health professional other than a doctor (or midwife in Scotland) and the baby subsequently dies, a referral to HMC/PF referral is required. Referrals with regards to miscarriages and stillbirths differ across the UK. More details are included in **Appendix 3: Case Examples:** Table 1 and cases 1-4.
- Deaths that are unnatural, and those where the cause of death cannot be identified or explained, require referral to His Majesty's Coroner/Procurator Fiscal (HMC/PF). A death is potentially 'unnatural' and should be referred where there has been an act or omission in care which may have had a more than a minimal contribution to the death. This does not have to be an error in care and could, for example, be a recognised complication of necessary treatment. Referral in these cases should occur regardless of whether the cause of death is known and can be explained.
- Unexpected deaths are not a criterion for referral unless the death is felt to be unnatural, or there is no immediately apparent cause.
- On rare occasions, issues of care contributing to death might be identified sometime later (for example in CDRM or local governance reviews) in deaths initially considered 'natural'; in such cases HMC/PF should be informed although the MCCD may have already been written and the funeral taken place.
- Common clinical scenarios which can cause confusion or where clinical interpretation is variable are outlined in **Appendix 3: Case Examples**. Best practice recommendations are shown below and are based on clinical consensus.

Best practice recommendations for MCCD completion/ Referral HMC/PF

- Sensitively include relevant maternal diseases/conditions affecting the baby (Deaths within first 28-days of life MCCD)
- Be specific about conditions and congenital anomalies
- Where prematurity is a factor, always include the gestation in weeks.
- In babies over 24^{+0} weeks gestation, it is not usually appropriate to write the main cause of death "Extreme prematurity" without justifying it with further diagnoses or information.
- Hypoxic ischaemic encephalopathy should always be justified by its reason on a MCCD. There should be a very low threshold to refer such cases to HMC/PF.
- Where there is reasonable evidence to suggest infection, this can be included along with the source or "sepsis of unknown aetiology".
- Deaths which follow an operation necessitated by a natural illness need not be referred to HMC/PF unless the operation itself had a more than minimal contribution to the death
- Deaths should be referred to HMC/PF if an operative complication occurs and has a more than minimal contribution to death even if this is a recognised complication of the procedure.
- Babies born with signs of life after a medical termination of pregnancy require HMC/PF referral
- Clusters of deaths, or increased mortality rates or unexpected findings in individual case review need investigation. If any such investigations lead to concerns that previously unknown factors which require notification to HMC/PF may have contributed to the death in any individual case, then HMC/PF should be informed.

Communication with HMC/PF

- The named consultant should support the family (alongside the bereavement midwife/neonatal nurse) and liaise with HMC/PF team.
- When making the referral, it is important to inform the family of the reason for referral, that one cannot predetermine the level and timescale of HMC/PF's investigation, and that the investigation may include a post-mortem examination.
- Although the cases that require HMC/PF referral are defined by law, there is variation between Coroners in the mechanisms of referral, and their investigation processes.
- In all cases, referrals need to be timely and should provide accurate, detailed clinical information and contact information for the referrer and next-of-kin to best support HMC/PF in their investigation. It may also be appropriate to include the family's wishes with regards to postmortem whilst ensuring families are aware that the coroner will make a final decision on the need for postmortem examination.
- Neonatal units should develop good working relationships and processes with His Majesty's Coroner/Procurator Fiscal (HMC/PF), to enable clear communication channels and information sharing to best support bereaved families. This should include family consultation regarding how they would like to receive information. In England and Wales, the ME office will also have a close relationship with the coronial team and may be able to assist.

Sudden Unexpected Death

- Deaths meeting the criteria for sudden unexpected death (SUDIC/SUDI/PRUDiC/SUPC) are uncommon in neonatal units and postnatal wards. Where these do occur, investigations and statutory procedures should follow national guidance[39,40,41,] (**Appendix 2: National and Statutory Guidance**). This includes a Joint Agency Response (JAR)/PRUDiC or equivalent) with precise arrangements for multi-agency involvement determined by the circumstances

©BAPM, 2026

and place of the sudden collapse/death.

- Neonatal examples of when a JAR/PRUDiC or equivalent should be considered include:
    - baby born at home without medical professionals present and subsequently dies or was thought to be stillborn.
    - where the death is sudden with no immediate apparent medical cause.
    - where the initial circumstances of death raise any suspicion that the death may not have been natural.
- A JAR/PRUDiC should also be triggered if a baby is successfully resuscitated after any of the above events but is expected to die in the following days. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.
- If the attending neonatal consultant is uncertain about the need for a JAR/PRUDiC referral or equivalent, the case should be discussed with the designated doctor for child death, as part of the immediate decision-making processes.
- The BAPM Framework Sudden unexpected postnatal collapse (SUPC)[42] can also be used in specific circumstances (see below) but should not be used in isolation. The SUPC guidance aims to improve the likelihood of obtaining a diagnosis in babies who collapse soon after birth and there is often an opportunity to carry out investigations during the period of intensive care prior to death.

BAPM Sudden Unexpected Postnatal Collapse (SUPC) Framework Criteria

- Well at birth (Apgar 7+ at 5 minutes) and well enough to have routine postnatal care
- Term or near term (generally >35 weeks but may be applicable to less mature infants, particularly those nursed alongside their mothers whilst receiving postnatal care).
- Collapse within first 7 days following delivery, die or go on to require intensive care or develop encephalopathy.

Registering the death[43,44,45]

- Registration is the legal record of fact of death.
- The Registrar will issue the death certificate (Certificate of Registration of Death in Scot) and a certificate for the burial or cremation of the body (green form {Eng/Wal/Scot}, GR021 in NI), which is normally passed to the funeral director by the person making the arrangements; this document is necessary for the family to obtain the release of the body for funeral.
- If the birth has not been registered before the baby's death, the team should inform the Registrars as both registration of birth and death can be done at the same time.
- The death must be registered within 5 working days of the MCCD being sent to the register office for Eng, Wales, NI (8 days in Scot).
- The registration of death in Eng/Wales/NI should be in the area/borough where the death occurred (telephone registration is available in NI if birth has been registered). Where birth and death are in different areas, registration of birth and death can occur in the area/borough where the death occurred. In Scotland, registration can be at any Scottish registration office.
- The person who registers the death is known as the 'informant'. Either parent can register the death and if they are unable to do this another relative, or someone else present at the death, can register.
- It is important to inform families that death registration will take longer in cases investigated by HMC/PF.

Rapid Release

- Neonatal units should have guidance in place to facilitate rapid release of the baby's body on parental request e.g. urgent burial, taking the baby home or to a hospice.
- For families who wish for rapid release of the body, it is important to help manage expectations and recognise that where HMC/PF referral is necessary this may not be possible, or arrangements may take longer.
- Where deaths are anticipated, discussions regarding organ donation, and with the ME +/- HMC/PF may be helpful in preparation, although ME scrutiny of the record and the formal decision by HMC/PF cannot be made until the death has occurred.
- Neonatal units should ensure they know local arrangements for contacting the ME and HMC/PF out of hours. The chief coroner (England and Wales) has recommended that there should be an out-of-hours scheme in place across all coroner areas, to assist families[46]. However, HMC/PF services are local and out of hours provision varies.

Local Safety Reporting

- Any safety concerns or incidents associated with a neonatal death should be reported and investigated using the appropriate national patient safety incident reporting system (**Appendix 2: National and Statutory Guidance**) [47,48,49,50].
- The outcome of these investigations should be fed back to families by their named consultant.

Other Notifications

- Maternal hospital notes: place a digital/EPR flag to signify the bereavement
- GP, health visitor and community midwife (<24hrs/ next working day).
- NHS child public health and community-based healthcare records e.g. CHIS (Local Child Health Information System in England); Baby Box (Scot); notification to ensure clinic appointments, audiology screening, newborn screening and immunisations are not arranged.
- Other health care professionals involved in the baby's care in your hospital or other hospitals.
- **All Nations**
    - MBRRACE-UK[51] (< 48hrs/2 working days (Eng), no time limit for other UK nations)
        - for all deaths of liveborn babies, 20 weeks gestation or greater, who die up to 28 days after birth).
- **England only**
  A Single Notification Portal SPEN[52] facilitates notification to MBRRACE-UK, CDOP, NCMD (via CASCADE[53]), MNSI and NHS Resolution for babies dying in the first 28 days.
    - Statutory Child Death Overview Panel (CDOP) (<48hrs/ 2 working days)[23]
        - For all deaths of liveborn infants, at any gestation but not including legal terminations of pregnancy, even when liveborn
        - Liveborn babies <20 weeks or babies who die after 28 days – notify using CDOP notification form from local CDOP - CDOP Contacts.
        - Notification should not be delayed where ME or HMC/PF are involved. Notify CDOP with suspected cause of death, or state if unexplained.
        - The NCMD[54] utilises the notification data for real time surveillance and trend analysis, including quarterly ICB and ODN/Perinatal Network reports.
    - Maternity and Neonatal Safety Investigations (MNSI)[55](unspecified timing for notification)
        - for babies born 37+ weeks gestation with no congenital anomalies born following onset of labour who have an early neonatal death (<7 days) or

intrapartum stillbirth.
- Families should be informed about the referral and consent requested for MNSI to contact them.
- An MNSI investigation should not prevent bereaved parent(s) from receiving compassionate care and support from hospitals. Communication with families by the named consultant and family key worker (bereavement midwife/neonatal nurse) should continue.

Child Death Review Meeting

Which babies should be reviewed?

- The review processes for deaths of live births should chiefly focus on babies who are born on or after 22+0 weeks gestation but should also include more immature babies if active resuscitation is undertaken.
- In England and Wales, the death review process (statutory in England)[23,26] includes all **live-born** babies where a death certificate has been issued. In practise, this will include babies born with signs of life below the limits of viability[56]. All these babies will require a CDOP referral, completion of analysis forms and any appropriate supplementary forms (Eng). Unattended stillbirths in the community also require referral to JAR and CDOP referral via obstetric/midwifery teams (Eng).
- In Scotland, the statutory death review process reviews all deaths of live-born children from 22 weeks (babies born with signs of life at <22 weeks are excluded)[25]. If the birth was not attended by a health professional, organisations may carry out initial enquiries to determine if the baby was born alive or not.

Child Death Review Meeting Process

The term Child Death Review Meeting (CDRM) is used to describe the local health professionals review of the care of a baby that has died. Locally, different terminology is often used including local morbidity and mortality (M&M) review, perinatal mortality review (PMR) meeting and perinatal mortality review tool (PMRT) meeting.

Aims of Neonatal CDRM Review

- Identify/confirm the cause of each baby's death by robust and comprehensive review of each case and the quality of care provided.
- Identify contributory factors where issues are identified and assessing whether different care may have made a difference to the outcome (grading of care).
- Recognise good points in care as well as areas for improvement for shared learning
- Develop action plans to address the modifiable contributory factors identified and achieve organisational change and service improvements.
- Recognise a 'just culture' of accountability for individuals and organisations.
- Incorporate the parent(s)' perspective of care and address their questions and concerns.
- Provide parent(s) with a robust explanation of why their baby died (accepting that in some instances, despite full clinical investigations, it is not possible to determine this).
- Improve the care we provide for mother or birthing parent, babies and families in the future.

- A trauma informed approach to mortality review processes should be used to enable families and staff to feel safe in raising concerns and identify learning (**Appendix 1: Supporting Families and Staff**).

- The child death review meeting (CDRM) in neonatal practice is predominantly conducted using the Perinatal Mortality Review Tool (PMRT) and for the purposes of the statutory Child Death Review (CDR) process qualifies as the local CDRM in England.
- Across the UK, the PMRT process should be used for all neonatal deaths in the first 28 days when neonatal care has been received, regardless of where the patient dies. For deaths in other locations in the first 28 days, when neonatal care has not taken place, e.g. Paediatric Critical Care, consider use of PMRT (particularly antenatal, labour and birth care) and if this is not possible, careful consideration of perinatal factors should be incorporated into the CDRM and CDOP (Eng) reviews, and the PMRT should be closed.
- PMRT can also be used for babies who die in neonatal units after 28 days. The PMRT website[57] has a comprehensive list of guidelines, user manuals and training resources and online training.
- Information required to inform the CDRM review should be submitted promptly. Teams should have a process to expedite this to prevent unnecessary delays to the CDRM process.
- Where postnatal care has been more prolonged or complex, it may be helpful to have a CDRM focussed on postnatal events which then feeds into the PMRT.
- The review should proceed in a systematic fashion from pre-conception to bereavement follow-up and be conducted in accordance with national and statutory guidance[23,25,26].
- Where the death is subject to external investigation (e.g. HMC/PF, MNSI, PSIRF/ SAER/SAI or equivalent) the CDRM can be initiated before the results of these investigations are known to prevent delays in implementing any important learning (in N. Ireland the SAI investigator joins the CDRM). However, the CDRM should not be finalised until the results of external investigations have completed and been fed back to ensure comprehensive, joined up learning as timelines for these processes often differ.
- The PMRT should be completed at or shortly after the CDRM. In England, the CDR draft analysis form also needs to be completed and submitted to the Child Death Overview Panel (CDOP) for final independent multi-agency review. In Scotland, the CDR Core dataset should also be completed at or shortly after the CDRM.
- The named consultant should work with the family key worker (bereavement midwife/neonatal nurse) to offer families the opportunity to meet to discuss the outcome and any actions following the CDRM.

Representation at the CDRM

- Representation at CDRM should include all staff who participated in the baby's care and the meeting should be open to all perinatal staff. All staff should feel able to contribute in a supported, non-judgemental environment.
- Where mothers and/or babies have been transferred, it is vital that there is good communication and sharing of information across organisations and all teams involved in the care should be represented including relevant speciality input (e.g. surgery, transport, ambulance services). For surgical cases, the lead surgeon for the baby's care should be actively involved in the mortality review.
- The review should include both internal and external peer review of cases. Selecting the right external reviewer for the CDRM is crucial to ensure a thorough, unbiased examination. Ideally, the external reviewer should be a healthcare professional with significant expertise in perinatal and neonatal care and should be independent of the institution conducting the review.
- Neonatal ODNs/Perinatal Networks should facilitate collation of contact details for clinicians in the network who are willing to undertake external review as well as working with other regions to support units to find external reviewers with similar expertise for complex cases where required e.g. neurosurgical, cardiac.
- Questions should be submitted by families via the family key worker (bereavement

midwife/neonatal nurse) and/or lead consultant. The CDRM should ensure families views are included, and their questions answered. Parent engagement materials are included on the PMRT website[57].

Child Death Overview Panel (England only)

- Full details of roles and responsibilities of CDOP are outlined in statutory guidance[23].
- The CDOP aims to review cases to find modifiable factors within the care or service delivery of a death that could have a wider impact on learning from mortality. They will analyse the findings of the reports from the coroner, PMRT, MNSI and local PSIRF departments. CDOPs add data to national systems (NCMD) to learn from deaths and inform changes in practice.
- CDOPs can raise alerts of national relevance through the NCMD alert system, for escalation to NHS England.
- 'Themed' neonatal CDOP meetings (where all the neonatal deaths for the area are reviewed) are strongly recommended, to ensure that maximum learning is derived through aggregate review of deaths.
- Summaries of learning and modifiable contributory factors from CDOPs should feed into the neonatal ODNs/Perinatal Networks for regional learning and to guide local and regional quality improvement strategies.

Child Death Review Programme (Wales only)

- Full details of the CDRP in Wales are contained in national guidance[26].
- All deaths are reviewed on a case-by-case basis with learning derived through aggregate thematic review of deaths.
- Strengthening of the information sharing between Neonatal ODN's/Perinatal Networks and CDRP is recommended to ensure maximum learning is achieved.

Reporting, review and dissemination of learning

Reporting and review

- An overview of reporting outputs, data review requirements, dissemination of learning and assurance at local, regional and national level are shown in Figure 1 below.
- The core perinatal mortality governance team should consist of a neonatologist, neonatal nurse, midwife, obstetrician and where possible parent voice representation[58] e.g. MNVP (local) or PAG representative (regional)). Staff and parent voice representatives should have access to psychological support when undertaking this work.
- Local and regional perinatal teams should review all relevant reporting outputs looking for recurring themes, developing and monitoring action plans, instigating further QI work and benchmarking. Equality, diversity and inclusion should be a common thread throughout these reviews.
- Thought should be given to the strength of the action plan with systems-based solutions which eliminate human error developed wherever possible.
- Where possible, data collection for regional/national reporting and assurance purposes should be as aligned as possible –ongoing work is required to align the multiple systems currently in use.
- The regional ODN/Perinatal Network footprint provides a better platform for collating themes and shared learning. Regional level review should not repeat the local CDRM processes. Thematic review across CDOP, ODN/Perinatal regional networks, LMNS and other regional processes should be co-ordinated. Sharing of information between these groups is strongly encouraged to ensure a joined-up approach.
- The neonatal ODN/Perinatal Network should also promote a joined-up approach to review and shared learning in specialist areas e.g. surgery, cardiology.

Dissemination of learning

- Disseminating learning and actions from CDRM processes is essential for improving care.
- Barriers to sharing learning must be broken down as this is not in the best interest of babies and families. Systems need to work together to permit shared data outputs between key organisations involved in reviewing data (Fig 1).
- Learning from local CDRMs, patient safety investigations, and other local/regional reporting outputs should be shared across the local perinatal service, with other neonatal units, the neonatal ODN/Perinatal Network and regional maternity/perinatal systems and where appropriate with national organisations for dissemination (Fig 1).
- Keeping families informed (via the family key worker/lead consultant) about dissemination and implementation of actions is an important part of the grieving process and processes should be put in place to keep them informed. Consideration should be given to ensure information is not sent to families at a time when no one will be available to answer their questions.
- Mixed methods of communication should be used to disseminate learning e.g. huddles/handovers/newsletters/posters/message boards/emails/teaching sessions. A yearly audit of the methodology should be conducted to maintain assurance of message dissemination.
- Messages should be in a standardised format which allow staff to see the relevance of the learning to their clinical practice.

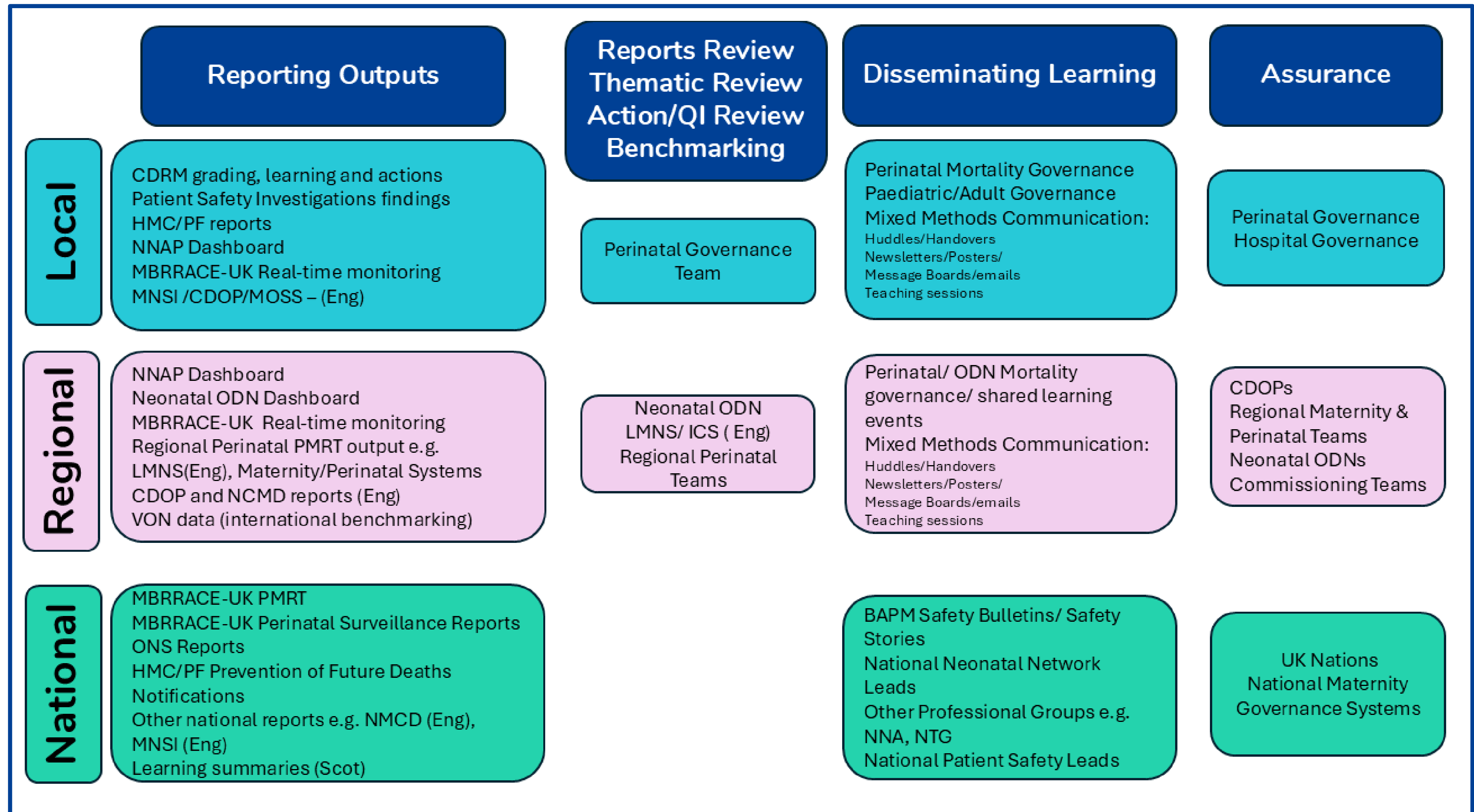
Assurance

- Review of benchmarking and outcome data against similar populations using reporting outputs (Fig 1) should be undertaken at local, regional and national level to ensure equity of

outcomes for populations at high risk.

- Mortality data is complex with many external and potentially unmodifiable factors that impact on outcomes. Time should be spent to triangulate the different reports as they describe different aspects of the neonatal population. No one data source should be taken as "gospel". Early warning signals should trigger further investigation to provide a deeper understanding.
- There should be hospital board-level oversight of key perinatal mortality, morbidity and operational metrics. A national dashboard is being developed to support this in England.
- Neonatal ODNs/Perinatal Networks should have a process in place for notifying neonatal/perinatal services about any concerns and for escalating concerns to regional perinatal and commissioning organisations where appropriate.
- Neonatal ODNs/Perinatal Networks should provide quality assurance around the CDRM process, including reviewing representation at CDRMs, appropriate family input and response to their questions, PMRT outcome gradings and learning outputs, and action plan closure rates. Neonatal units should provide ODNs/Perinatal Networks with the information required to facilitate this.

Fig 1. Overview of Perinatal Mortality Governance Reporting, Review, Dissemination of learning and Assurance



Staff considerations

Staff support and training

- Staff must be trained appropriately to be able to deliver high quality end-of-life care; to provide good bereavement support and to be able to support the family to understand and contribute to mortality review processes. As a minimum, this includes completing SANDS NBCP training[59].
- Staff should also be appropriately trained to manage lactation in the event of neonatal loss[17,18].
- Staff and parent representatives e.g. MNVPs/PAGs must be aware of the psychological impact of this work on themselves and other staff and should receive appropriate training and support to mitigate psychological injury.
- Specific staff support should be considered for services under intensive scrutiny e.g. during an external review.
- A hot debrief[60,61] may be offered to affected staff members soon after the death or collapse of a baby (ideally within 24 hours) to share understanding, address immediate safety concerns, and provide support for staff.
- A cold debrief[62] focused on learning and/or wellbeing may also be offered sometime later.
- All staff likely to need to support hot or cold debriefs should be given specific training.
- Training for staff in understanding compassionate approaches to assurance and governance are strongly encouraged for all those involved in mortality governance review.
- More details on supporting staff, training requirements and resources are included in **Appendix 1: Supporting Families and Staff**.

Staffing to support bereavement care

- Bereavement and palliative care midwives and neonatal nurses are essential to support the bereavement process, provide expert bereavement support to families as well as ensuring the family voice is heard in the CDRM.

- BAPM staffing recommendations for bereavement support are included in full in the BAPM palliative care framework[4]. These include
    - 1xWTE band 7 midwife per 2500 deliveries.
    - 1xWTE band 7 neonatal nurse minimum for NICUs.
    - 0.1-0.2 WTE band 7 neonatal nurse for LNU/SCUs dependent on activity.
    - Consultant lead for palliative and bereavement care: 1-2PAs for NICUs, 0.1WTE per 1000 live births for LNUs/SCUs (minimum 0.2WTE).
- All staff involved in bereavement care should have appropriate time allocated for undertaking NBCP activities and training.

Dedicated time to support mortality governance processes within neonatology

- Each unit should have consultant, and senior nurse leads for mortality governance with dedicated time to lead neonatal Child Death Reviews, thematic review, attendance at CDOP, and for dissemination of learning and assurance processes.
- A recent neonatology consultant workforce survey highlighted insufficient time to lead child death review in job plans[63].
- For leadership of CDRM and thematic review and dissemination of learning, BAPM recommends:

  - In NICUs: Medical Lead 1.5-2.5PAs, Nursing lead 0.15-0.25 WTE (depending on the size of the service).
  - in LNUs/SCUs: Medical Lead 0.5-1PAs, Nursing lead 0.05-0.1 WTE (depending on size of service).
  - Administrative support should also be provided.
- The above are requirements for the neonatal focus on mortality, separate to that required by maternity to support perinatal mortality governance.
- All networks should have allocated time for lead mortality governance roles for both medical (minimum 1PA) and nursing (minimum 0.1WTE) staff to allow review of learning from neonatal network deaths, thematic review, network actions and QI and national benchmarking and assurance.
- All neonatal transport services should have allocated time for both medical and nursing staff to attend transport M&M review, as well as input to network and local CDRMs.
- Job plans for ALL consultants should include appropriate time for
  - preparation of reports for CDRM and HMC/PF.
  - local CDRM meetings.
  - outpatient follow-up for bereaved families.
  - attendance at other hospital CDRM meetings in relation to care provided by your team; regional mortality governance and shared learning events, and CDOP panels.
- Job plans should have separate specific time allocated for external peer review at local and regional CDRM and CDOP panels.
- Where mortality governance activities are not appropriately remunerated, the time taken for these reviews should be recorded for local negotiation of job plans.

References

[1]Office for National Statistics. Child and Infant Mortality in England and Wales. [online]. ONS; 2023. ONS perinatal and child mortality

[2] Gallimore ID, Matthews RJ, Page GL, Smith LK, Fenton AC, Knight M, Smith PW, Redpath S, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance, UK Perinatal Deaths of Babies Born in 2023: State of the Nation Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Population Health Sciences, University of Leicester. 2025 https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/

[3] National Child Mortality Database. Child Death Review Data Release: Year ending 31 March 2024. [online]. NCMD; 2024 Child death data release 2024 | National Child Mortality Database

[4] British Association of Perinatal Medicine. Recognising uncertainty: an integrated framework for palliative care in perinatal medicine. A BAPM Framework for practice. [online]. BAPM; 2024. https://www.bapm.org/resources/palliative-care-in-perinatal-medicine-framework

[5] Department of Health. Health Building Note 09-03:Neonatal units. https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_09-03_Final.pdf

[6] Hackett J, Heavey E, Beresford B. ‘It was like an airbag, it cushioned the blow’: A multi-site qualitative study of bereaved parent(s)’ experiences of using cooling facilities. Palliative medicine. 2022; 36(2):365–74.

[7] NHS Blood and Transplant. Guidance for Neonatal Units when considering Organ and Tissue Donation as part of palliative and End-of-Life-Care. [online]. NHSBT; 2023. Infant Organ and Tissue Donation

[8] Scottish Government, Paediatric and Neonatal Organ and Tissue Donation. [online]. Govscot: document; 2018 Paediatric and Neonatal Organ and Tissue Donation Scotland

[9] Health and Social Care. Perinatal and Paediatric Pathology Services in Northern Ireland. [online] Perinatal Pathology N Ireland

[10] NHS England. Perinatal post-mortem investigation of fetal and neonatal deaths (England and Wales). [online] 2024. NHS England Perinatal Post-mortem investigations of fetal and neonatal deaths

[11] Human Tissue Authority. Codes of Practice and Standards. Code A: Guiding principles and the fundamental principle of consent. [online]. HTA; 2025. https://www.hta.gov.uk/guidance-professionals/codes-practice-standards-and-legislation/codes-practice

[12] Acts of Scottish Parliament. Human Tissue (Scotland) Act 2006. [online]. legislation.gov.uk; https://www.legislation.gov.uk/asp/2006/4/contents

[13] Osborn M, Cox P, Hargitai B, Marton T. G168 Guidelines on autopsy practice: Neonatal death. [online]. Royal College of Pathologists; 2019. G168 Guidelines on autopsy practice - Neonatal death For Publication.docx “.

[14] E-Learning for healthcare. Perinatal postmortem consent. [online]. NHS England. https://www.e-

lfh.org.uk/programmes/perinatal-post-mortem-consent/

[15] Royal College of Pathologists. Tissue Pathway for histopathological examination of the placenta. RCOG; 2022. [online]. G108 Placental histopathology

[16] Sudden Unexpected Death in Childhood. Advice for bereaved parents living in the UK: Tissue samples. SUPC-UK; 2021. [online video]. Advice for bereaved parents living in the UK: Tissue samples on Vimeo

[17] British Association of Perinatal Medicine. Framework for Practice: Lactation and loss. Management of lactation following the death of a baby. [online]. BAPM; 2022. https://www.bapm.org/resources/lactation-and-loss-management-of-lactation-following-the-death-of-a-baby

[18] NHS Learning hub course. Lactation After Loss: Choices for Bereaved Families e-learning Lactation after loss

[19] National Breastfeeding Helpline. [online]. https://www.nationalbreastfeedinghelpline.org.uk/

[20] Sands Charity. National Bereavement Care Pathway for stillbirth and baby loss. [online]. NBCP for stillbirth and baby loss

[21] NHS England. Medium Term Planning Framework. [online]. NHSE; 2025. NHS E Medium Term Planning Framework

[22] Academy of Medical Royal Colleges. A Code of Practice for the diagnosis and confirmation of death 2025 Update. [online]. AoMRC; 2025. AoMRC Diagnosis and Confirmation of Death

[23] HM Government. Child Death Review Statutory and Operational Guidance (England). [online]. Gov.uk; 2018. Child Death Review Guidance England

[24] Sands and Bliss. Audit of bereavement care provision in UK neonatal units 2018. [online]. Audit of bereavement care in neonatal units

[25] Healthcare Improvement Scotland, National Hub for Reviewing and Learning from the Deaths of Children and Young People. [online]. NHS Scotland; 2021. National Guidance when a child or young person dies

[26] Public Health Wales. Child Death Review Programme. [online]. NHS Wales; 2009. Child Death Review - Public Health Wales

[27] Chief Coroner's Guidance No.45. Stillbirth, and Live Birth Following Termination of Pregnancy. [online]. Courts and Tribunals Judiciary; 2023. Chief Coroner's Guidance No.45

[28] Scottish Government. Maternity and neonatal (perinatal) adverse event review process: guidance. [online]. gov.scot; 2023.Scottish Mat Neo adverse event review process guidance

[29] Judiciary NI. In Her Majesty's Court of Appeal in Northern Ireland. Neutral Citation No. NICA 68 [online]. judiciaryni; 2013. NICA 68 2013 Landmark Decision

[30] MBRRACE-UK. Determination of signs of life following spontaneous birth before 24+0 weeks gestation where, following discussion with the parent(s), active survival-focused care is not

appropriate [online]. MBRRACE-UK; 2020. MBRRACE-UK Signs fo LIfe Guidance

[31] Department of Health and Social Care. Guidance for medical practitioners completing medical certificates of cause of death in England and Wales. [online]. Gov.uk; 2025 Guidance for completion of MCCD Eng Wales

[32] NI Department of Health. Guidelines for Death Certification – Issuing MCCD using NIECR. [online]. ni.gov.uk; 2022. https://www.health-ni.gov.uk/publications/guidelines-death-certification-issuing-mccd-using-niecr

[33] Chief Medical Officer. Guidance for Doctors completing Medical Certificates of the cause of death (MCCD) and its quality assurance, [online]. National Records of Scotland; 2018. https://www.publications.scot.nhs.uk/files/cmo-2018-11.pdf

[34] Ministry of Justice. Guidance for registered medical practitioners on the Notification of Deaths Regulations. [online]. Gov.uk; 2024. Notification of Death Regulations

[35] NI Department of Health. Guidelines for Matters Relating to the Coroner. [online]. ni.gov.uk; 2018. https://www.health-ni.gov.uk/publications/guidelines-matters-relating-coroner

[36] Crown Office & Procurator Fiscal Service. Reporting deaths- information for medical practitioners. [online]. Gov.uk; 2019. https://www.copfs.gov.uk/publications/reporting-deaths/

[37] UK Statutory Instruments No 493. Medical Examiners (England) Regulations 2024. [online]. Legislation.gov.uk; 2024. Medical Examiner England Regulations

[38] Fletcher A. National Medical Examiner's Good Practice Series No. 6: Medical Examiners and child deaths [online]. RCPath; 2024. RCPath Good Practice Series ME and child death

[39] Royal College of Pathologists. Sudden and Unexpected death in Infancy and childhood. [online]. RCPath; 2016. RCPath SUDiC

[40] Public Health Wales. PRUDiC (Procedural Response to Unexpected Death in Childhood). [online]. NHS Wales; 2023. PRUDiC Guidelines

[41] Healthcare Improvement Scotland. SUDI Guidance and support documents. [online]. HIS; 2023. HIS SUDI Guidance

[42] British Association of Perinatal Medicine. Sudden and Unexpected Postnatal Collapse. A BAPM Framework for Reducing Risk, Investigation and Management. [online]. BAPM; 2022. BAPM SUPC Framework

[43] HM Government. Register a death. [online]. https://www.gov.uk/register-a-death

[44] NI Direct Government Services. [online]. https://www.nidirect.gov.uk/articles/registering-death-district-registrar

[45] National Records of Scotland. [online]. https://www.nrscotland.gov.uk/registration/registering-a-death/

[46] Chief Coroner. Guidance No. 28. Report of death to the coroner: decision making and expedited

decisions. [online]. Judiciary.uk; 2018. Chief Coroner Guidance 28

[47] NHS England. Patient Safety Incident Response Framework. [online]. https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

[48] NHS Wales. National Policy on Patient Safety Incident Reporting. [online]. nhs.wales; 2023. https://du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

[49] NI Department of Health. NIAIC adverse incident reporting – guidance and forms. [online]. HSCNI; 2023. NIAIC adverse incident reporting

[50] Healthcare Improvement Scotland. A national framework for reviewing and learning from adverse events in NHS Scotland: February 2025. HIS; 2025. HIS Reviewing and Learning from adverse events

[51] MBRRACE-UK. [online]. https://www.npeu.ox.ac.uk/mbrrace-uk

[52] MBRRACE-UK. New process for notifying maternal and perinatal deaths in England – Submit a Perinatal Event Notification (SPEN). [online]. NPEU; 2025. SPEN Notification

[53] MBRRACE-UK. Guidance: New process in England for notifying neonatal deaths to CDOPs. [online]. NPEU; 2025. MBRRACE-UK Cascade

[54] National Child Mortality Database. [online]. https://www.ncmd.info/

[55] Maternity and Neonatal Safety Investigations. [online]. https://www.mnsi.org.uk/

[56] British Association of Perinatal Medicine. Perinatal Management of Extreme Preterm Borth Before 27 weeks of Gestation [online]. BAPM; 2019. BAPM Extreme Preterm Birth Framework

[57] National Perinatal Epidemiology Unit. Perinatal Mortality Review Tool. Implementation Support [online]. PMRT Resources

[58] NHS Resolution. Maternity (and Perinatal) Incentive Scheme [online]. 2024 MIS-Year-6-guidance.pdf

[59] SANDS. Bereavement Care Training [online]. https://training.sands.org.uk/bereavement-care/

[60] Paediatric Innovation Education and Research Network. Debrief tools after a difficult event. [online]. PIERnetwork; 2023. https://www.piernetwork.org/debrief.html

[61] Walker CA, McGregor L, Taylor C, Robinson S. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med. 2020 Dec;7(4):259–66.

[62] Kolbe M, Schmutz S, Seelandt JC, Eppich WJ, Schmutz JB. Team debriefings in healthcare: aligning intention and impact. BMJ. 2021 Sep;374:n2042.

[63] British Association of Perinatal Medicine. Consultant working patterns. A BAPM report. [online]. BAPM; 2023. BAPM consultant working patterns

BAPM

Leading Excellence in Perinatal Care

This document was produced by the British Association of Perinatal Medicine (BAPM).

BAPM is a membership organisation that is here to support all those involved in perinatal care to optimise their skills and knowledge, deliver and share high-quality safe and innovative practice, undertake research, and speak out for babies and their families.

We are a professional association of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers and other health professionals dedicated to shaping the delivery and improving the standard of perinatal care in the UK.

Our vision is for every baby and their family to receive the highest standard of perinatal care. Join us today.

www.bapm.org/join

British Association of Perinatal Medicine (BAPM)
is registered in England & Wales
under charity number 1199712 at
5-11 Theobalds Road, London, WC1X 8SH