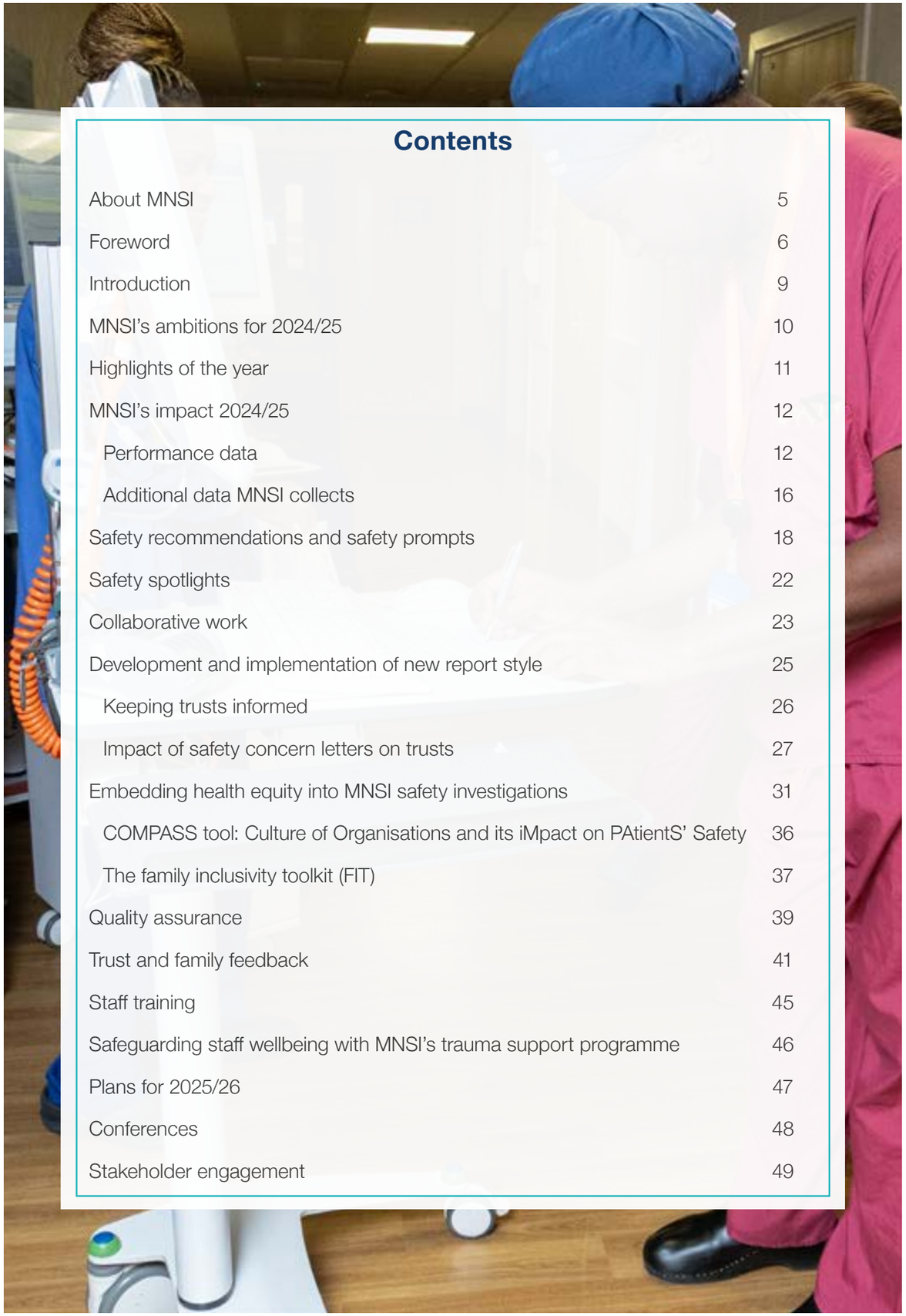
MNSI
Maternity & Newborn Safety Investigations

ANNUAL REPORT

2024 / 2025

www.mnsi.org.uk



Contents

About MNSI

The Maternity and Newborn Safety Investigations (MNSI) programme carries out independent safety investigations related to NHS-funded maternity and newborn care in England that meet the criteria set out on MNSI's website.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Events that meet the criteria are referred to MNSI by the NHS trust where the care was received.

MNSI investigations identify the contributory factors that may have led to harm or had the potential to cause harm to women or babies. The safety recommendations MNSI makes aim to improve healthcare systems and processes, while also reducing risk and improving safety. MNSI works closely with women, their families and the healthcare staff who have been affected by patient safety events. MNSI does not attribute blame or liability.

MNSI shares an investigation report with the family affected and the trust that provided the care. The trust is responsible for implementing any safety recommendations made in the report. In addition, MNSI identifies and examines recurring themes that arise from trust-level investigations so that MNSI can make safety recommendations to local organisations. Thematic learning from safety recommendations inform the national system level improvements in maternity and newborn services.

The Care Quality Commission (CQC) has hosted MNSI since 1 October 2023.

About this report

This report provides an overview of work of the MNSI programme during 2024/25. It highlights activities carried out since 1 April 2024 and outlines MNSI's plans for 2025/26. Its aim is to provide healthcare organisations, policymakers and the public with insights into the work of MNSI.

Throughout this report, MNSI uses the word mother to describe women and people who use maternity and newborn services. MNSI acknowledges that not all pregnant or birthing people identify as women or mothers. This position reflects the Supreme Court ruling in April 2025 that the legal definition of a woman is based on biological sex.

Foreword

Sandy Lewis
Director of the Maternity
and Newborn Safety
Investigations programme

Welcome to the Maternity and Newborn Safety Investigations (MNSI) programme's annual report for 2024/25. The report looks at MNSI's performance between April 2024 and March 2025, provides details of its achievements and steps taken to further improve the quality of MNSI's independent safety investigations.

I would like to begin by extending my thanks to the families and trusts MNSI works with each day, often in challenging circumstances. Without their openness and honesty and a shared ambition to make maternity and newborn care safer, MNSI would not be able to carry out its work.

I also want to express gratitude to MNSI's staff, who strive to manage every investigation with sensitivity and compassion, while ensuring the voices of families and healthcare staff are heard.

Perinatal services, and the systems that support them, remained under significant scrutiny during 2024/25, with almost daily headlines highlighting the often life-changing impact maternity and neonatal events can have on families. When care is not provided as intended and a mother or baby is harmed, the impact is far reaching – not only at that moment in time, but often for many months or years. In some cases, the consequences can span a lifetime.

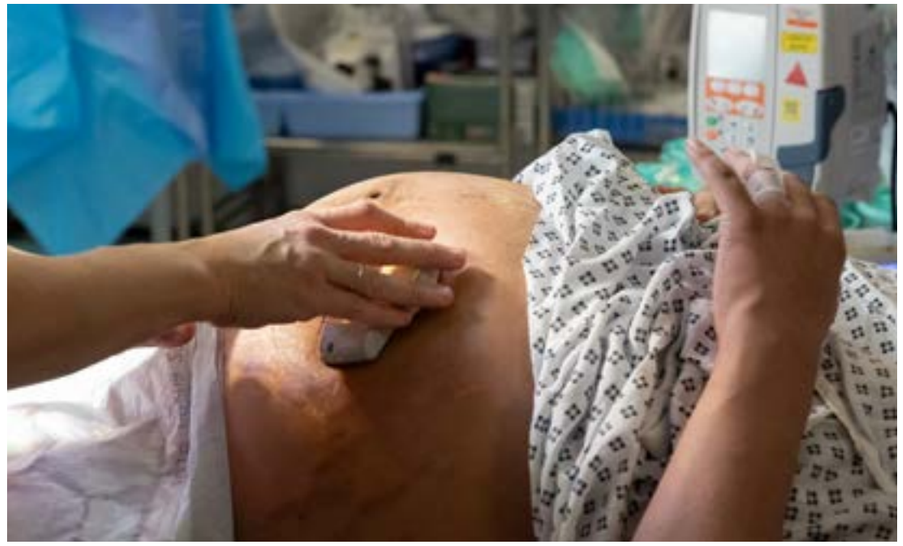
MNSI's work identifies where changes are needed in the system to support safer care. The work aims to explore the reasons why women and babies do not receive the personalised care that optimises outcomes and makes practical and achievable recommendations to address the issues MNSI investigations uncover.

MNSI has completed more than 4,000 investigations to date. This level of data means MNSI understands the complexities of maternity and newborn safety. Despite these insights, sharing meaningful thematic learning from MNSI investigations in a way that impacts how care is provided has remained a challenge. MNSI hopes that steps taken during 2024/25 to present MNSI's work nationally and internationally will rectify this by building momentum and awareness, which will contribute to change.

There is still much work to do to develop the programme and fully understand all the factors that impact on safety. Over the course of 2025/26, MNSI will continue to refine its processes and the way it gathers feedback from the families who agree to share their experiences. MNSI will build on work that began during 2024/25 to understand the considerable influence culture and health equity can have on how care is provided and received.

The 10 Year Health Plan for the NHS has brought scrutiny to the work of the entire NHS. The focus is on creating a truly modern health service and MNSI is committed to supporting the national strategic direction.

Above all, MNSI remains committed to supporting the delivery of the improvements needed to ensure every woman and baby receives safe, equitable and personalised care.



Foreword

Dr Louise M Page
Clinical Director for the
Maternity and Newborn Safety
Investigations programme

For women planning a pregnancy or about to have a baby, the focus on the challenges maternity and newborn services face can add stress to what should be a time of celebration. For staff, frustration arises from working in a system under pressure that may make it difficult for them to always provide care as they would wish to. Staff members can feel unable to influence change or make improvements to ensure women and babies receive safe personalised care at all times.

MNSI regularly sees examples where the skills of individual staff members, working in highly multidisciplinary teams, have ensured exceptional care; MNSI investigations also highlight where the system does not support all women and babies to receive the care they need.

MNSI is one part of the system in England working to make maternity and newborn care safer and cannot work in isolation. Collaboration is essential to support system-wide change. By working in partnership, sharing its unique insights, knowledge and skills, MNSI is at its most impactful. The changes required to improve safety are not always complex and we see how consistent application of a simple change can maximise benefit. Where the challenges are more complex, MNSI recognises trusts cannot find solutions without the support of others, and MNSI acknowledges that one solution cannot be equally implemented in all trusts without adaption.

For those reasons, and others, during 2024/25, there was focus on strengthening opportunities for partnership working. This will continue during 2025/26 and MNSI will look to build new relationships in its ambitions to make maternity and newborn care safer.

Introduction

The Maternity and Newborn Safety Investigations programme is part of the national strategy to improve maternity and newborn safety across the NHS. It began under the Healthcare Safety Investigation Branch (HSIB) in April 2018 and was embedded in all trusts providing maternity and newborn care in England within 12 months. Currently, MNSI teams work with all 120 trusts that provide maternity and newborn care in England.

MNSI investigation teams are made up of individuals with diverse experience. They work closely with clinical advisors who have extensive experience with the NHS and perinatal services. They also consult with relevant advisors from across the UK to help strengthen MNSI's understanding of events.

The programme's key functions are supported by MNSI's business services team, which ensures all reporting requirements are met.

MNSI's values

MNSI's ambitions for 2024/25

Thematic learning	We hold a significant amount of information about maternity and neonatal safety, and we're in a privileged position to access more detailed information to fully understand the 'whys' behind patient safety events.
Equity, diversity and inclusion	We want to build on the intelligence we already hold and understand why Black, Asian and ethnic minority women and babies experience poorer outcomes, exploring what prevents the care women receive from being aligned to their individual needs and those of their families.
Explore opportunities to maximise our impact	Expanding our ability to look at a broader scope of maternity and newborn care will allow us to look more holistically at perinatal care in England while maximising the safety of women, their babies and families.
Investigation excellence	Safety investigators need to reflect a proportionate perspective of events, taking into consideration all the available evidence. The investigations need to explore the systems and processes that demonstrate the holistic picture. MNSI wants to provide investigation reports that are accurate, evidence-based and accessible to all who read them. They need to be of high quality and present clear areas of learning.

HIGHLIGHTS OF 2024/25

618
investigations progressed

1,122 recommendations

Introduction of safety prompts

HEART/HEWS
development, training of the team, implementation within investigations

COMPASS
development work and commencing pilot

TEAM RECRUITMENT AND DEVELOPMENT
Trained 28 investigators, strengthened the clinical advisory team, recruited team members to support investigations and wider programme requirements

New coding system

Collaboration work

Development and strengthening of stakeholder relationships

PRESENTATIONS NATIONALLY AND INTERNATIONALLY
Increased the number of thematic publications presented

Involvement with wider national work

Supported training for coroners' officers about the MNSI programme

DEVELOPMENT OF MNSI'S INVESTIGATORY PROCESSES
New report template / safety prompts

MNSI's Stakeholder Bulletin subscribers increased from 2950 in April 2024 to 3417 in March 2025

MNSI's impact 2024/25

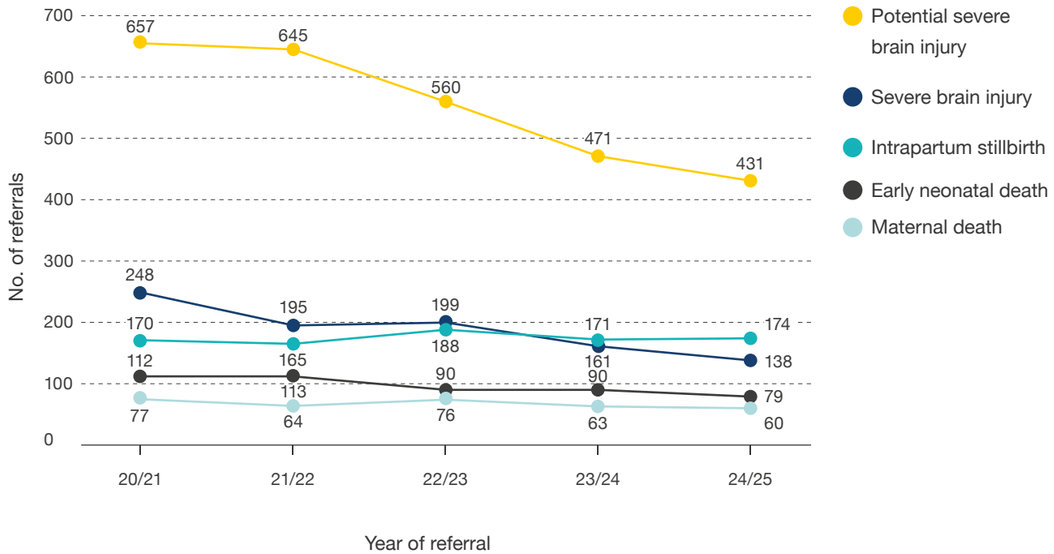
Performance data

MNSI directions require the investigation to be completed 'where reasonably practicable' within six months from the date a safety event is referred to the programme.

During 2024/25, MNSI received a total of 887 referrals, of which 744 met MNSI criteria and 143 did not. Of the 744 that met the criteria, 618 progressed to investigation and 126 did not. Reasons for not progressing to investigation included:

- the referral did not meet the MNSI criteria
- the family did not agree to the sharing of medical records, which is essential for an investigation to proceed
- for potential severe brain injury referrals, there was no severe brain injury and no trust or family concerns.

All referrals to MNSI which met referral criteria

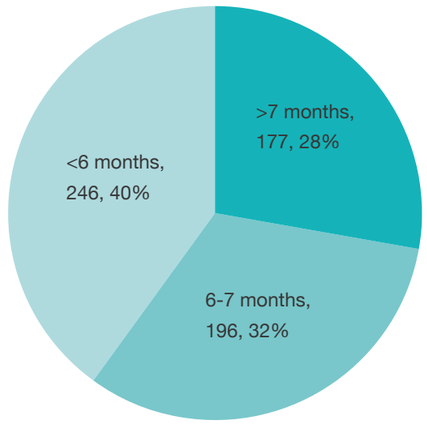


The 'severe brain injury' line is a subset of the 'potential severe brain injury' referrals.

Investigations completed within the six-month timeframe: Rolling 12 months

This dataset looks at investigations referred between 1 October 2023 and 30 September 2024, which would have exceeded their six-month timeframe by 31 March 2025.

- 619 investigations were referred
- 246 (40%) were completed within the six-month timeframe
- 196 (32%) were six - seven months old at 31 March 2025 (172 completed and 24 active)
- 177 (28%) were greater than seven months old at 31 March 2025 (152 completed and 25 active).



In some circumstances, an investigation cannot proceed due to events outside the control of MNSI. In these situations, an investigation may be placed 'on hold'. An investigation being placed on hold, may mean that it is not completed within the six-month time frame.

Reasons for placing an investigation on hold are:

- delay in receiving consent from the family
- when the safety event is being investigated by the police
- when there is a delay in receiving a post-mortem examination report.

During an investigation there may be external delays that do not stop it but will impact the overall time taken to complete it; MNSI records and monitors these as 'exceptions'. These delays can happen during the active phase of an investigation or the time an investigation is shared externally before completion (quality assurance).

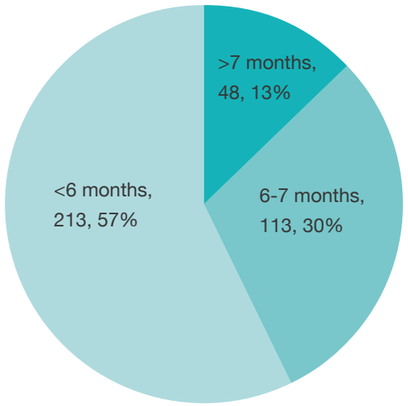
While MNSI works with stakeholders to support timely engagement, there may be delays in:

- arranging meetings with staff or family
- receiving medical records
- the time taken for a family or a trust to respond to MNSI's request for a factual accuracy review.

Excluding investigations affected by external delays, of the 619 investigations that were referred between 1 October 2023 and 30 September 2024, 245 have been excluded (as they contain external 'on hold' or 'exceptions').

The remaining 374 included:

- 213 (57%) were completed within the six-month timeframe
- 113 (30%) were six-seven months old at 31 March 2025 (100 completed and 13 active)
- 48 (13%) were greater than seven months old at 31 March 2025 (40 completed and eight active)



In conclusion, 40% of investigations (57% excluding investigations with external delays) were completed within the six-month timeframe; 72% (87% excluding investigations with external delays) were completed within a seven-month timeframe. Work is ongoing to reduce the delays where possible.

How MNSI's data relates to operational performance

Operational performance data is reviewed monthly by MNSI to monitor and assess organisational performance over time. This includes data on:

- number of open referrals
- the percentage of cases that meet the programme directions timeframe
- number of cases that have exceeded the six-month timeframe.

This review and MNSI's internal key performance indicators (KPIs) enable the programme to identify any issues that impact the progress of investigations so that action can be taken. For example, internal processes were changed to automatically book the first clinical review as soon as consent was received when the KPIs showed that due to some families' circumstances there were delays in obtaining consent to access their medical records. As a result, a working group is now focusing on this area.

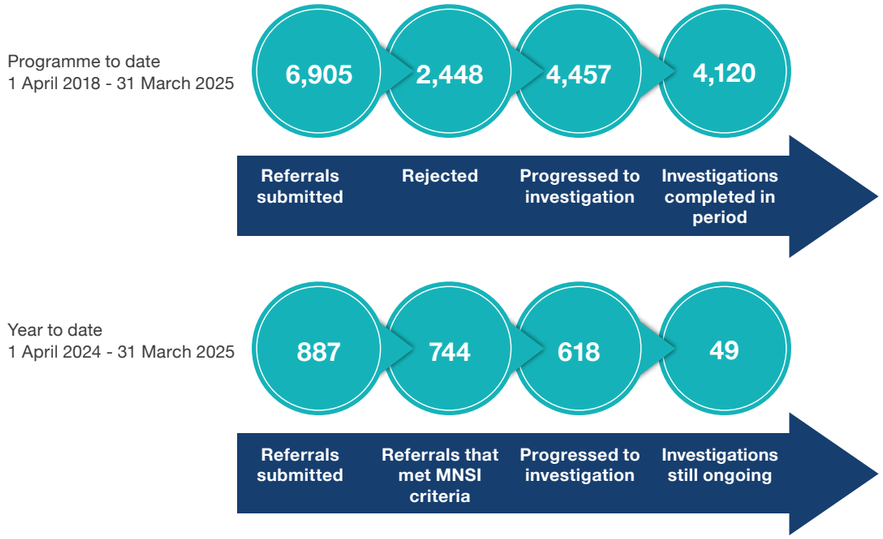
MNSI reviews operational reports from MNSI's four regional quality groups. The reports cover:

- workforce: vacancies and sickness
- workload: the number of investigations/whole time equivalent investigators
- finance
- overview of any escalations of concern
- issues raised at regional meetings.

Additional data MNSI collects

Maternity referrals: summary

01 April 2018 - 31 March 2025



What the data shows

Throughout 1 April 2024 to 31 March 2025, there were a total of 744 referrals that met MNSI criteria, with a median of 64 referrals per month. This reflected a continued downward trend in referrals that met criteria, which have been reducing each year by a total of 25% since 2021/22. This included an eight-percent decrease in referrals for potential severe brain injury investigations compared to the previous year. Conversely, the number of referrals progressed to investigation over this period was 618, which reflected a slight increase (seven-percent) in total investigations compared to the previous year.

At the end of 2024/25 there were a total of 49 investigations that were still ongoing and had exceeded their six-month timeframe; there were no active investigations of more than 12-months duration.

Investigations can exceed the six-month timeframe due to various operational reasons as well as external factors. External factors include the following:

- waiting for postmortem examination results
- ongoing police investigation
- delays in consent being provided by families, or in accessing medical records from providers
- availability of families or staff for interviews
- availability of specialist external clinical advice
- availability / capacity of translation & interpretation services
- factual accuracy process delays with trusts and/or families.

Attempted contact with trusts within two working days of receiving the referral is reviewed on a monthly basis and consistently exceeded the target of 80% over the year.

Attempted contact with families within five working days of receiving confirmation from the referring trust of the contact details and confirmation that families had agreed for MNSI to contact them is reviewed on a monthly basis. This consistently exceeded the target of 80%.

Safety recommendations and safety prompts

During 2024/25, MNSI's investigation reports began to include safety prompts as well as safety recommendations. Introduced in April 2024, safety prompts describe a set of questions or prompts for use at a local level. Safety prompts are used where there is not enough evidence to support a safety recommendation, or because the issue fell outside the direct scope of the investigation. Including them in MNSI's reports enables trusts to find solutions when areas of learning have been identified.

MNSI completed 613 investigations between 1 April 2024 and 31 March 2025 and made 1,122 safety recommendations and 840 safety prompts. All the recommendations are published on the MNSI website on an annual basis. Where recommendations were made, the median number per investigation report was two.

Two codes were assigned to each recommendation identifying broad themes within. The most frequent themes were; clinical assessment, guidance, escalation, clinical oversight and communication.

We are developing a new coding system to increase depth and quality of information that can be extracted from our reports. The system focusses on clinical factors, human factors (based on the System Engineering Initiative for Patient Safety (SEIPS) framework), health, equity, diversity and inclusion, and location (where the event occurred). Each report will be coded following completion. We intend to retrospectively apply this to the investigation reports following testing and finalisation.

MNSI is also exploring the use of artificial intelligence (AI) using large language models to support coding and development of thematic analysis. As part of this work, we have conducted initial analysis of these recommendations using AI and these themes suggest that the 2024/25 recommendations frequently focussed on:

- clinical assessments and risk evaluations
- labour and birth processes, especially around fetal monitoring using cardiotocographs (CTGs)
- the importance of escalation protocols and information sharing
- ensuring systematic processes and support for clinicians
- emphasis on triage and holistic care.

MNSI is looking forward to working with trusts using the new coding system which will enable the programme to share more detailed analysis of individual reports to support ongoing system wide learning, coding and the continued development of thematic analysis.

Thematic publications
MNSI has completed 4,120 individual reports since the programme began. This collection of reports provides a unique dataset of learning from neonatal deaths, intrapartum stillbirths, potential severe brain injury and maternal deaths. It enables MNSI to see repeated themes, which are shared with NHS maternity and newborn care providers and other stakeholders to support maternity and newborn safety improvement.

In 2024/25, MNSI launched a new webinar series and briefing papers to provide additional methods for communicating those themes and any additional learning. MNSI has continued to publish its bi-monthly stakeholder bulletin, which includes a safety spotlight to signal NHS organisations to consider safety prompts that may apply to their trust. In 2024/25, the stakeholder bulletin gained 467 additional subscribers (an increase of 16%).

THE YEAR IN NUMBERS

FIVE WEBINARS

1,080
registrations

490 attendees → **46%** attendance

9%
attendees completed feedback forms

67%
first time ever attending an MNSI event

"The information was presented very clearly and professionally. The speakers were very engaging, knowledgeable. Excellent communication / presentation skills. Very much enjoyed and looking forward to the next one."

72%
said they would recommend the webinars to a colleague

"Fantastic webinar. Very informative will attend future webinars too and recommend to colleagues."

100%
said they would attend other events in the series*
*of the 68 feedback responses

"Really appreciated the Q&A at the end at was really helpful hearing answers and insight from the knowledgeable panel members."

THEMATIC REVIEWS

A number of different topics have been explored in thematic reviews encompassing learning from maternal deaths, neonatal resuscitation and midwifery-led units.

6	17	2	1	1	2
safety spotlights	conference publications	conference workshops	briefing paper	national learning report	thematic blogs

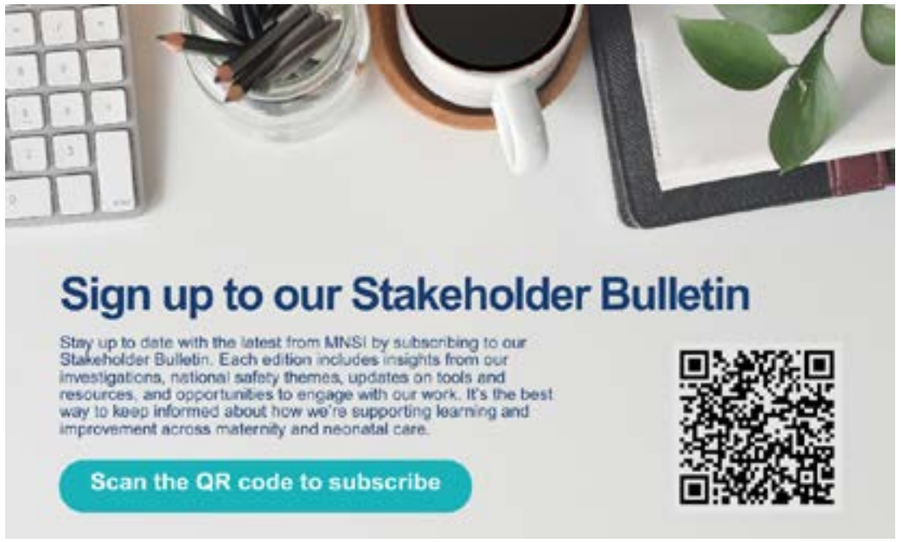
MULTIPLE CONFERENCE ATTENDANCES

MNSI uses a system of horizon scanning that helps identify upcoming conferences and patient safety events that focus on perinatal care and related specialties. MNSI submits abstracts, has presented posters, oral presentations and held workshops at several national and international conferences during 2024/25. MNSI plans to increase its presence at such events during 2025/26, to ensure MNSI's data and associated learning are shared with the widest possible audiences.

MNSI held five webinars focusing on learning from maternal death investigations during 2024/25. The subjects covered by the series were:

- Exploring learnings from MNSI safety investigations: Maternal deaths from pulmonary embolism. (watch the replay here)
- Exploring learnings from MNSI safety investigations: Think beyond sepsis. (watch the replay here)
- Exploring learnings from MNSI safety investigations: Sudden unexplained death in epilepsy (SUDEP). (watch the replay here)
- Exploring learnings from MNSI safety investigations: First trimester deaths in England from venous thromboembolism associated with hyperemesis. (watch the replay here)
- Exploring learnings from MNSI safety investigations: Deaths in England in the first trimester of pregnancy: national patterns and safety recommendations. (watch the replay here)

Subscribe to MNSI's Stakeholder Bulletin to find out about future MNSI events and webinars.

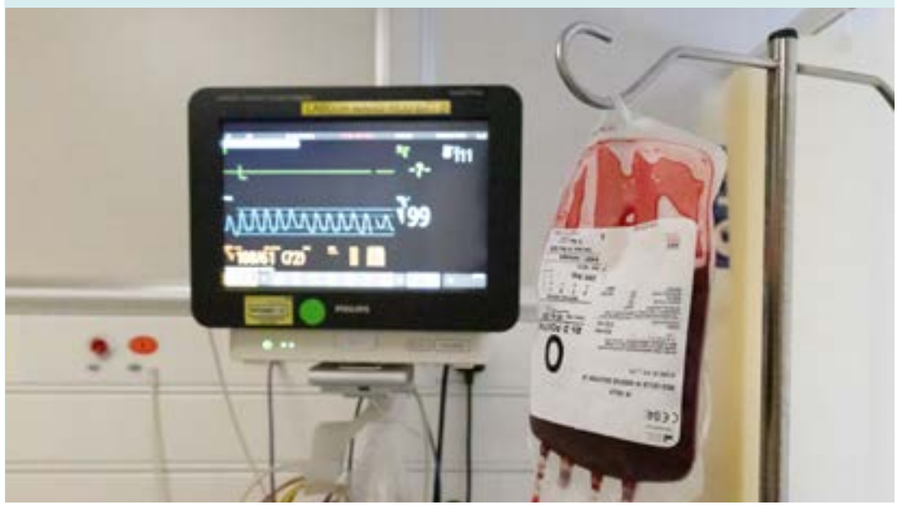


Safety spotlights

Safety spotlights are a new addition to MNSI's stakeholder bulletins. They are a way of sharing system learning from individual investigations. They are written as prompts for trusts to consider a range of issues identified during investigations.

HbA1c testing in women with sickle cell trait

- Laboratory tests for glycosylated haemoglobin (HbA1c) can underestimate past glycaemia in people with haemoglobin variants, such as those with sickle cell trait. This is because there is an increased red cell turnover in those with haemoglobin variants. This means that HbA1c tests, which estimate the glucose level over the preceding few weeks will be unreliable.
- MNSI investigations identified that HbA1c tests were taken in mothers with sickle cell trait, when they were being tested for gestational diabetes. These tests were not processed by the laboratories, as the results of these tests are unreliable. There was no further evaluation of the diabetes risk in these mothers. National Institute for Health and Care Excellence (NICE) does not recommend HbA1c as a test for gestational diabetes in pregnancy, instead recommending a 2-hour oral glucose tolerance test. The HbA1c test may be used to assess women with pre-existing diabetes,
  to assess the level of risk for the pregnancy (NICE, 2015).
- How does your trust ensure that staff are aware that HbA1c testing is not reliable in mothers with haemoglobin variants including sickle cell trait?
- How does local guidance support staff to ensure there is further evaluation of diabetes in mothers with haemoglobin variants when considering HbA1c testing, as the result may underestimate past glycaemia?
- Is there a process in your trust for following up mothers who have samples rejected by the laboratory due to haemoglobin variants, so that an alternative method of testing for measurement of long-term sugar control is offered?



Collaborative work

The volume of completed investigation reports puts MNSI in a unique position to collaborate to improve healthcare systems and processes, reducing risk and improving safety.

During 2024/25, MNSI:

- contributed to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) publications on venous thromboembolism in pregnancy
- began working with the Obstetric Bleeding Study UK (OBSUK) to review maternal deaths from haemorrhage, with a particular focus on problems with blood clotting
- began working with the University of Manchester to review investigations that make recommendations regarding reduced or altered fetal movements.

MNSI has also worked collaboratively with two ambulance trusts to review pre-hospital care in maternal deaths. This has led MNSI to producing an infographic to share learning with hospital trusts and ambulance services. The review made the following safety prompts:

Ambulance services:

- What are the barriers for call handlers in identifying pregnant, suspected pregnant or recently pregnant women to ensure they are correctly triaged?
- Does an ambulance service have a robust system for ensuring pre-alert calls are timely and effective?
- Do dispatch protocols enable early dispatch of appropriate resources to deteriorating pregnant, suspected pregnant or recently pregnant women?
- Does resuscitation training routinely include the importance of early defibrillation, manual uterine displacement and establishment of advanced life support in maternal cardiac arrest?
- How are communication barriers assessed and addressed to ensure timely triage?
- What are the barriers for ambulance clinicians using the pre-hospital maternity decision tool when attending pregnant, suspected pregnant or recently pregnant women?

Maternity and newborn care providers

- Is it clear to staff which telephone number or clinical area a pre-alert call will be made to?
- What are the barriers to using the pre-alert call information in a timely and effective way to mobilise and inform the appropriate multi-disciplinary team?
- Has your trust reviewed potential barriers for an ambulance service's access to the maternity unit?
- Do you have a process to learn from patient safety events that includes the ambulance service?

MNSI welcomes enquiries from partner organisations that are keen to work in collaboration. If you have a project or an idea you would like to discuss, please email enquiries@mnsi.org.uk

All MNSI publications are on the MNSI website at www.mnsi.org.uk/publications

Development and implementation of new report style

In the 2023/24 annual report, MNSI described the planned changes for investigation reports and what this meant for families and trusts.

Since 1 April 2024, MNSI's investigation reports have been streamlined to focus on the system-wide factors that contributed to the outcome for a woman or baby. MNSI carried out training across the programme in February and March 2024 to help staff complete the new reports and has continued to provide training and support throughout the rest of the year. This has included:

- focused training for MNSI's regional teams
- focused reminders in weekly bulletins
- fortnightly investigation report support clinics
- two additional half days of training to reinforce the key elements of the investigation report, which took place in December 2024 and February 2025.

This support has ensured consistency in MNSI's approach to investigations. It has also ensured findings are presented in a meaningful and impactful way that supports ongoing learning for trusts, while enabling families to understand events that may have led to a maternity or newborn safety event.

MNSI has completed more than 280 investigation reports using the new style report template.

In October 2024, MNSI used the Learning Response Review and Improvement Tool, which was designed by NHS Education for Scotland, Health Services Safety Investigations Body (HSSIB)* and NHS England, alongside an MNSI proforma to re-audit MNSI's safety investigation reports. This was to ensure MNSI continues to meet its strategic values, including being systems-focused and not apportioning blame or liability. MNSI also wanted to provide assurance that reports are consistent.

The re-audit highlighted:

- an increased use of everyday language in reports. This has helped to inform MNSI's learning so that it can be understood by a wider audience, thus improving inclusivity
- a reduction in indirectly or directly using language that assigns or implies blame in MNSI's reports
- Using less language that focuses on what people could or should have done, and how this would have changed the outcome, and, instead, describing the systems and processes in place that support staff and how these may be improved
- an increase in meaningful engagement with families
- MNSI's safety recommendations and safety prompts are more measurable and achievable, and focus on the systems that influenced the care of women and their babies.

A quality improvement framework has been used to support the changes to MNSI's investigation report and processes. In October 2024, focus groups within MNSI were used to further refine and provide feedback on the template. This has helped MNSI to make further improvements and other changes to operational processes.

*The Health Services Safety Investigations Body (HSSIB) formally known as Healthcare Safety Investigation Branch (HSIB)

Keeping trusts informed

In November 2024, MNSI published a briefing paper focusing on safety prompts in the external newsletter. This was designed to answer any questions that trusts may have as they started to receive the new-style investigation reports. The briefing is available here: Safety prompts briefing.

The briefing reiterated that a safety prompt will be written when safety concerns that warrant further consideration are identified, and the investigation does not have sufficient understanding or evidence to make a recommendation.

Practically, a safety prompt will always begin with what the investigation has learnt. It will be written to influence the internal environment, tasks, tools and technology, people, or organisation. The prompt will pose several questions for a trust to consider, keeping in mind that the report will be based on what MNSI has learnt during the investigation and may not reflect the entire service.

The briefing also included additional feedback and practical examples of how a safety prompt has been used to improve care at Somerset NHS Trust.

The Trust said:

> "We have received our first report in the new format style and have found the reports less repetitive and easier to read. In particular, we have found the questions in the safety prompts really useful when creating smart actions. The questions have instigated some really meaningful conversations about areas for improvement within our team."

Towards the end of 2025 the programme will look for further ways to improve MNSI's reports where possible. MNSI's plans include:

- re-auditing a sample of reports to provide continuous learning and improvement
- gaining ongoing feedback from trusts and families
- publishing further revisions to the investigation report template, including sharing an example report for families and trusts onto MNSI's website.

Impact of safety concern letters on trusts

During an investigation there are times when safety concerns are raised that lie outside an individual investigation or require action before the completion of the investigation.

Concerns may be identified by any member of the MNSI programme and at any stage during an investigation. MNSI team members raise safety concerns following the MNSI sharing of safety concerns and escalation procedure.

Once a concern has been identified an internal panel reviews the issue/s raised, this may result in a formal letter detailing the concern and response required. This letter is then shared with the relevant trust, healthcare provider and key stakeholders who have a responsibility in relation to patient safety.

Between 1 April 2024 and the 31 March 2025, there were 21 (initial) letters of concern sent, raising a safety concern. A response detailing immediate actions and providing assurance to MNSI is required within five working days. The Care Quality Commission (CQC) is sent a copy of each concern letter.

Leadership and culture are recurring themes. Our letters have triggered support for leadership teams and assisted in supporting plans for the future. Leadership teams have demonstrated how they assure themselves about the safety of their service. We have also been given examples of new posts being appointed to help support leadership teams.

Triage is another area that we discuss regularly at concern panels.

One example related to a trust's telephone triage.

- The Trust's telephone triage system involved circulating unanswered calls to other clinical areas such as the labour ward. This meant that there may be delays in answering calls which are urgent in nature and clinical staff on areas such as the labour ward will be disrupted from ongoing tasks in their clinical area
- The clinical advice given to mothers during triage calls in some investigations were found to be outside of guidance
- Contemporaneous and accurate documentation of telephone triage contacts, including any advice and information given, was not always recorded.

The Trust made a commitment to improve the telephone triage approach within their service. They recognised that the issues raised included cultural approaches to the management of the first stage of labour. They planned and have implemented systems and processes to improve support for staff in providing telephone triage. The Trust and the Local Maternity and Neonatal System (LMNS) identified that the Trust was not isolated in some of the learning shared by MNSI as part of the escalation of concern and the LMNS has taken this issue forward as a regional issue.

As part of this learning the LMNS and local region are working together to develop regional guidance to support families and Trust staff with care in the

latent phase of labour. The LMNS is working with the providers in their area to explore the issues faced and improvement work is ongoing to have a more joined up approach to improving this aspect of care.

MNSI was asked to attend a quality safety meeting with the LMNS and their providers to discuss MNSI learning related to the systems and processes surrounding triage and latent phase of labour care.

Interpretation of guidance
Misinterpretation of local and national guidance is another recurring theme of concern. An interesting example identified confusion between NICE (2017) and NICE (2022) fetal monitoring in labour guidance being used as well as physiology-based interpretation, leading to confusion and ineffective interpretation.

The Trust described their plans to introduce a bespoke fetal monitoring evaluation tool on the labour ward which includes both NICE (2022) guidelines and a physiological based approach to interpretation.

The Trust provided reassurance of:

- how the new guidance will be rolled out and managed
- how the Trust will gain assurance that the local and national updated guidance is being correctly interpreted and adhered to
- how the Trust will gain assurance that all midwifery and obstetric clinicians are suitably trained and supported to effectively interpret and analyse electronic fetal monitoring in line with the local guidance.

A second example in relation to guidelines. MNSI learned that in a Trust both local (Management of hypertensive disease in pregnancy) and national guidelines (NICE, 2023) concerning the management of women with hypertensive diseases of pregnancy, including pre-eclampsia, were not being interpreted and used in clinical practice as expected.

The Trust responded promptly by conducting an urgent review of their local 'Hypertension in pregnancy and postpartum period' guideline. Amendments were made in line with national guidance (NICE, 2023).

At the time of the concern being raised, the guideline for the management of hypertension in pregnancy was being reviewed by the Trust's guideline group. Ahead of the planned review, immediate actions were put in place to enhancing obstetric consultant involvement in decision making and strengthening senior oversight.

With kind permission from two trusts, below are examples of where receiving a safety concern letter has had a positive impact on safety within in trusts.

Trust A

The concern related to handover of care and culture practices. The Trust escalated the concerns promptly through their governance channels and identified planned immediate and long-term action plans. An internal investigation was also undertaken by the Trust to understand the barriers in this instance.

SBAR (situation, background, assessment, recommendation) is a national tool used to handover care. The Trust's expectation is to use the SBAR method of handover, at every point of handover. SBARs were discussed at every staff huddle (twice a day) for one week. It was also shared within the maternity newsletter via the staff social media groups and email, to capture as many staff as possible.

The SBAR audit forms part of the Trust's annual audit plan which has been ratified by the LMNS.

The Trust established a working group to identify barriers for transferring mothers, the learning to be shared and concerns acted upon by the Trust.

To support an improvement with cultural practices, a plan is in place to ensure senior oversight from the labour ward coordinator, in all areas of the maternity unit, to ensure all areas have midwifery cover, especially during break periods.

A leadership and culture workstream is in place under the Maternity Improvement Plan as part of the Maternity Safety Support Programme actions. The service is progressing the implementation of the NHSE Labour Ward coordinator framework which includes actions regarding leadership.

Trust B

Concerns were shared with Trust B in relation to the assessment and management of the Maternity Early Warning Score (MEWS).

MEWS is a numerical assessment used to quickly identify mothers at risk of deterioration.

The Trust was asked to provide assurance in relation to:

- The tools and technology in place to support recording of clinical observations and identification of deterioration in a mother's clinical condition
- The processes that support early escalation to the multidisciplinary team
- The skills and knowledge of all staff undertaking clinical observation to recognise abnormal readings and where to seek advice and support.

In response to the concern the Trust outlined their immediate actions and future planned improvements. MNSI was welcomed at a face-to-face visit, where the Trust shared a detailed action plan for area of improvements.

The concerns letter was shared with the Trusts executive team, women's service quality and safety meeting and local perinatal quality surveillance meeting, which includes representation from the LMNS and integrated care board. It was also included in the maternity and neonatal assurance paper and presented to their July Trust Board.

The Trust explained how their EPR system is used to record all patient observations. Observations produce a graph which enables staff to view trends in recordings and subtle changes, which in the long term will replace the MEWS chart currently in paper form.

The action plan provided reassurance to all the questions asked by MNSI. The Trust continues to give regularly updates at their quarterly review meetings.

Moving forward, the programme plans to develop how it shares the impact of letters of concern with NHS trusts.

Embedding health equity into MNSI safety investigations

Recognising the impact of health and social inequalities on maternity and newborn outcomes, MNSI has developed the Health Equity Warning Score (HEWS) and the Health Equity Assessment and Resource Toolkit (HEART). These tools provide MNSI investigators with a structured, systematic approach to identifying and analysing inequities in maternity and newborn care, while ensuring health equity considerations are integrated into MNSI safety investigations.

- **HEWS** is a standardised assessment tool that enables MNSI investigators to identify potential health equity barriers to care.
- **HEART** is an interactive resource toolkit that supports MNSI investigators with:
  - topic summaries on health and social inequalities
  - prompts and question banks for staff and family discussions
  - an evidence repository linking to national reports, research articles and best practice guidance.

Implementation and early impact
Following a pilot phase and full staff training, HEWS and HEART were embedded into MNSI investigations in December 2024. Since then:

- All new referrals for MNSI investigations have used HEWS, supporting the systematic identification of health inequities during every investigation.
- Health equity leads or equity diversity and inclusion representatives now attend all maternal death investigation panels, ensuring HEWS is applied and health inequities are considered at the outset of the investigation.
- The MNSI team has received training on the use and importance of HEWS and HEART. All staff, including new recruits, will receive ongoing training in the future to ensure their knowledge remains up to date.
- There has been strong engagement and interest from external stakeholders, with the potential for future collaborative work.

Health Equity Warning Score (HEWS) Tool and the Health Equity Assessment and Resource Toolkit (HEART)

Joanna Francis
Louise Wake
Health Equity, Diversity and Inclusion Leads
Maternity and Newborn Safety Investigations (MNSI) programme

BACKGROUND

Health equity ensures that everyone can achieve their best possible health.

MNSI believes, by addressing factors within our safety investigations which are beyond an individual's control, including discrimination, health and social inequalities, we will be able to promote targeted interventions and share insights with trusts and those working to improve health equity across the maternity landscape, especially for women and birthing people from underserved communities.

METHODS

MNSI's health equity, diversity and inclusion leads developed the Health Equity Warning Score (HEWS) to ensure a standard assessment tool is used within all safety investigations to systematically identify, acknowledge, investigate and analyse factors affecting health equity which impact care and perinatal outcomes.

The potential health and social inequities identified using HEWS, are then further explored using the Health Equity Assessment and Resource Toolkit (HEART). HEART is an interactive PDF resource toolkit, that is designed to raise awareness, provide resources and an evidence base from which to explore health and social inequities. HEART includes:

- Topic summaries
- Prompts to identify when health and social inequalities may have impacted care/perinatal outcomes
- A question bank for family meetings
- A question bank for staff discussions
- A glossary of key terms
- A comprehensive evidence repository
- Links to historical reports and safety recommendations

KEY MESSAGES:

In the short term HEWS and HEART will:

- Increase and enhance MNSI safety investigation data on protected characteristic health and social inequities
- Be an auditable resource providing meaningful data for internal training and external insights
- Develop the scope of MNSI safety investigations

In the long term, HEWS and HEART will enable MNSI health and social inequalities data to:

- Position health equity at the forefront of our investigations, to raise awareness of the need for equitable care for all mothers / birthing people and babies.
- Produce thematic learning and reports which highlight health inequities, whilst influencing the wider maternity system to improve the provision of services which increase health equity.
- Collaborate with NHS trusts and those working to improve health equity within maternity, through the development of targeted, user accessible, interventions.

To find out more about MNSI and our investigations or to attend a webinar discussing this topic further please scan the QR code

enquiries@mnsi.org.uk www.mnsi.org.uk

Driving system change
HEART and HEWS aim to:

- embed health equity into MNSI investigations, ensuring inequities are proactively assessed during all investigations
- support thematic learning and influence policy, driving improvements in clinical practice
- foster collaboration with NHS trusts, policymakers and external stakeholders to develop targeted interventions that improve equity across maternity and perinatal services.

Embedding HEART and HEWS ensures health equity is a core component of maternity and newborn safety learning. This will drive long-term improvements in both care and outcomes for women and babies who are facing barriers to their care because of health inequalities.

Commitment to equity, diversity and inclusion
MNSI is committed to becoming an anti-racist programme by embedding equity, diversity and inclusion (EDI) into its core values and vision. To support this ambition, a variety of internal initiatives are taking place to strengthen organisational culture, build inclusive leadership and ensure all investigations reflect a commitment to fairness and justice. This includes:

- attendance at health equity clinics and reflection on the themes and topics that are raised at the clinics
- maternal death panels attended by health equity panel members who share advice and insights with the programme
- percentage of HEWS cases with a score, frequency of each score as well as compliance including all protected characteristics of age, disability, ethnicity, religion, sexuality, and social barriers, deprivation, Language barriers, social barriers, multiple indicators of vulnerability, and factors such as BMI, smoking and so on
- training sessions delivered to the MNSI programme in relation to health equity
- health equity themes arising within investigations
- recommendations and findings made in relation to health equity.

COMPASS tool: Culture of Organisations and its iMpact on PAtientS' Safety

During the year, MNSI worked with the Patient Experience Library (PEL) to develop COMPASS – **C**ulture of **O**rganisations and its i**M**pact on **PA**tient**S**' **S**afety. This innovative tool is designed to gather and evaluate cultural observations gathered during the investigation process and evaluate their impact on patient safety.

COMPASS was developed in response to 'Responding to Challenge,' a literature review of avoidable harm enquiries carried out by the PEL, which repeatedly implicated poor organisational culture in patient safety incidents. It also comes in advance of other future reports, such as the Ockenden maternity review at Nottingham, the Thirlwall inquiry and the Department of Health and Social Care's review of patient safety, where culture is also likely to be referenced.

Organisational culture is challenging to assess, and few patient safety programmes have assessment tools in place to quantify and relay their cultural observations. Through MNSI's investigative processes, staff members have gathered a wealth of cultural observations. Developing the right mechanism to collate, analyse and feedback these observations would give MNSI a unique opportunity to provide valuable insights to help trusts improve patient safety.

COMPASS provides an evidence-based structure to MNSI's repository of cultural observations, which will enhance the quality of feedback MNSI provides to trusts and a scoring methodology that can be used to assess trends and the impact of interventions. It will initially be trialled at 12 trusts by MNSI staff who have recently completed investigations at those trusts, with their observations and scoring then fed back to service leadership.

Following the pilot, the tool will be evaluated using qualitative feedback and further developed and refined.

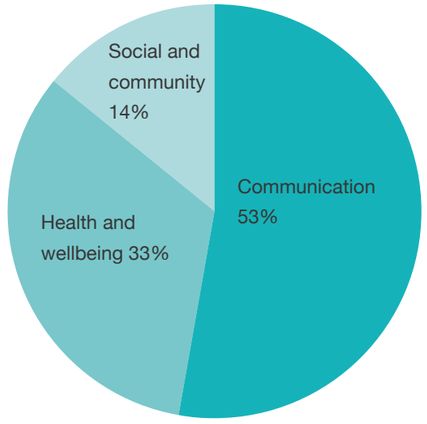
MNSI welcomes external review of COMPASS by research organisations which, if validated, would enable MNSI to share it with other patient safety organisations. Although the tool is based on evidence drawn from across healthcare, it has been carefully designed so that can be adapted for use in different sectors. This would be coupled with other complementary work carried out by the PEL, including its report and 'red flag tracker,' to form a comprehensive package that could be offered to other organisations.

MNSI believes COMPASS will positively impact patient safety by providing external insight into organisational culture. In the context of the multiple maternity inquiries on the horizon that will undoubtedly reference culture, MNSI anticipates COMPASS will position MNSI as a practice leader across care services in addressing the patient safety implications linked with poor organisational culture.

The family inclusivity toolkit (FIT)

MNSI's family inclusivity toolkit (FIT) is a method for gathering information and data that helps MNSI ensure it is inclusive in how it works with families during investigations. Since its introduction three years ago, the toolkit has consistently highlighted communication as a prominent need, which in turn has helped MNSI's investigators to adapt their communication approaches to meet the needs of families.

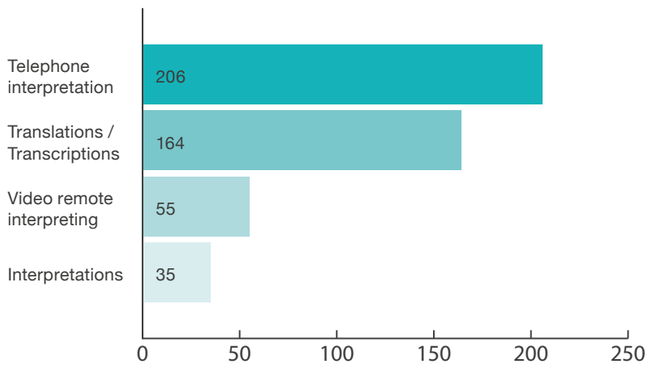
Total needs by category



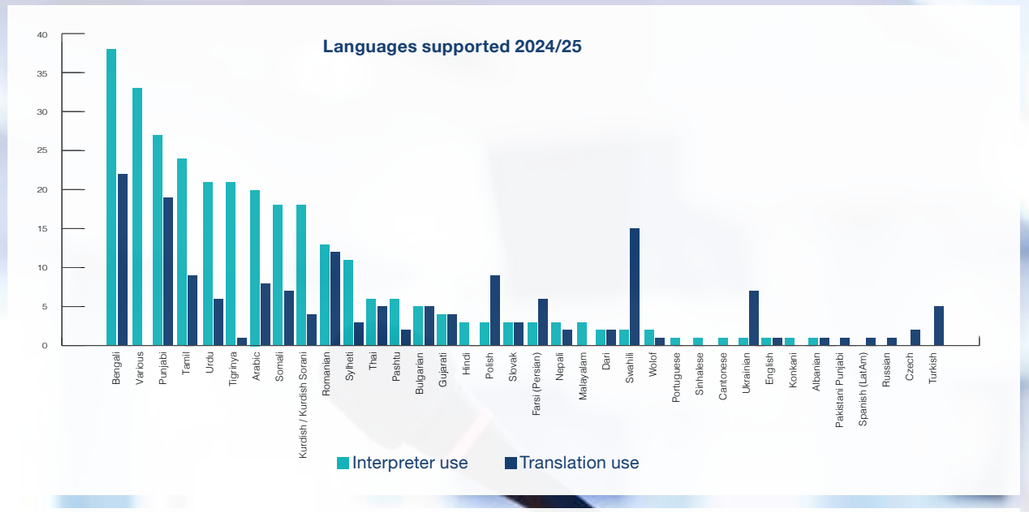
The most frequent need identified through our family needs assessment tool is for investigators to engage with families using language services. Language services may mean the requirement for an interpreter, a translator or a different format such as easy read. MNSI always respects the needs and requests of each family and adapts our approach accordingly. Every situation is discussed on an individual basis as not all families require translation and interpreter services for every contact.

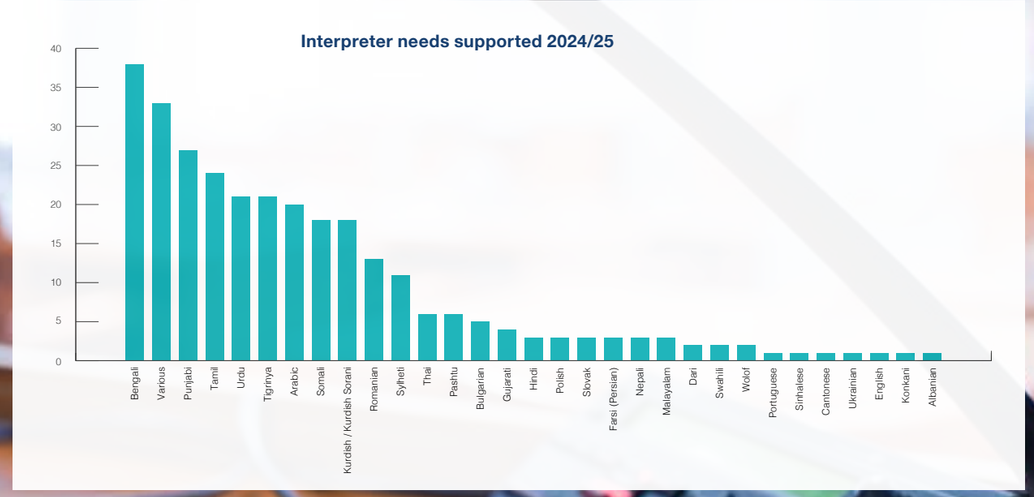
During 2024/25 language services, either in person, remotely or in written form, were used 460 times.

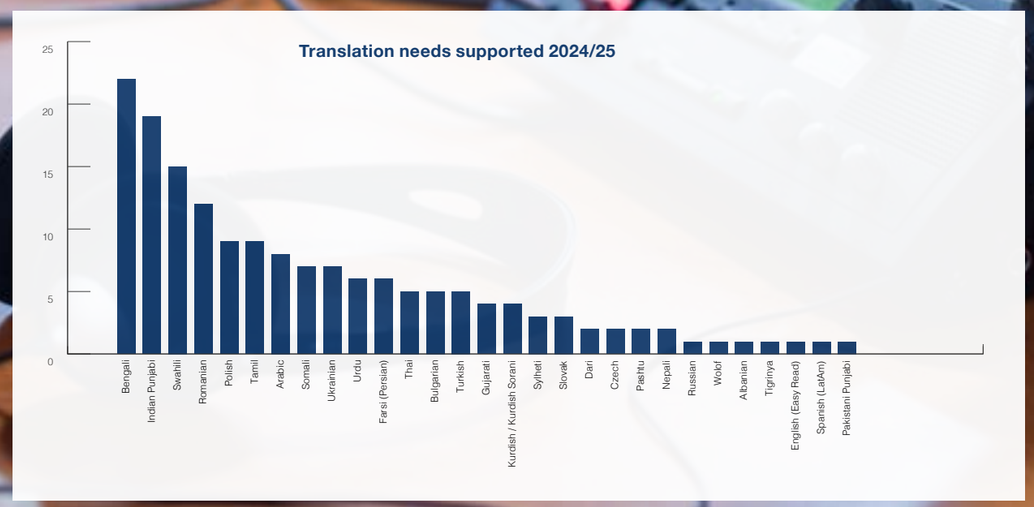
Total language services use 2024/25



Services were provided for 34 languages, with slight variations between languages needed for verbal communications and those provided in written form.







Quality assurance

In 2024/25, MNSI established a quality assurance group to provide and maintain a quality assurance plan for the MNSI programme. The group will oversee quality standards and provide assurance that MNSI processes are consistent and of high quality. This will, in turn, promote excellence throughout MNSI's investigation processes.

The quality assurance group will strengthen existing MNSI and quality assurance processes by meeting agreed strategic objectives. These include:

- Working in partnership with the MNSI's operational delivery group to define and support quality standards and processes across MNSI
- Establishing and maintaining a rolling quality assurance plan
- Using review and audit to identify and prioritise areas for quality improvement across the programme
- Providing assurance and recommendations to MNSI's leadership team via MNSI's agreed leadership and governance structure.

There is a need to carry out an end-to-end review and identify quality assurance workstreams in relation to key milestones within the investigation process. Work has already taken place to define these workstreams, with two already in progress:

- factual accuracy review of investigation reports (FARM)
- quality assurance of investigation reports.

This work will be monitored and supported via the quality assurance group. A new workstream report is also being introduced to assist those leading the work to collate and present data and learning from their workstream so that it can inform next steps for quality improvement.

Additional workstreams will also be established during 2025/26. They include, but are not limited, to:

- review the MNSI triage process (for new referrals)
- review SMART panels
- review the report panel process
- review investigation closure file audits.

The quality assurance group has the ambition to be able to respond to changes in legalisation or policy that may impact on investigation processes. A new prioritising tool will, therefore, be used to help the group determine how quickly a workstream needs to be started and over what timescale.

To support this work, MNSI is developing a quality assurance audit programme to enable a rolling audit process. Audit areas will be identified to help MNSI demonstrate that its day-to-day business meets agreed quality standards, in turn providing assurance to MNSI's leadership team and wider stakeholders.

TRUST AND FAMILY FEEDBACK

We value the feedback we receive from families and NHS trusts and always review it carefully to see whether MNSI's systems can be improved, or other changes made to enhance MNSI's approach. High level analytics from trust feedback reveal the following:

1. CLARITY OF PROCESS

More than nine out of ten (95%) of trust staff responding agreed that the information MNSI provided explaining the investigation process was helpful and assisted their understanding.

95%

2. ONLINE INTERVIEWS

Nearly all (99%) reported that the interview with MNSI was conducted online and around three out of five (58%) were able to complete the interview during their working hours.

99%

58%

3. OPENNESS & FOCUS

Just over nine out of ten (91%) felt comfortable to speak openly with MNSI investigators, stating they considered the interview questions were focussed on learning and not blame.

91%

4. SAFETY & CULTURE

Nearly nine out of ten (86%) considered MNSI investigations are improving safety and culture of maternity and newborn care at their trust and across the NHS.

86%

210 trust staff responded to the MNSI feedback survey between 1 April 2024 to 31 March 2025.

During 2024/2025, 25 families gave permission for their feedback to be used. Of these families, 22 agreed or strongly agreed that “MNSI investigators contact with me enabled me to feel part of the investigation”. The same number agreed or strongly agreed that “I felt that my perspective on what happened was considered by the investigation team”.

Despite this positive feedback, the number of families agreeing to share their views is low. MNSI is redeveloping the feedback process as a result and working with stakeholders to increase opportunities for families and trusts to provide feedback in a variety of different ways. This will give MNSI access to a wide pool of valuable information, which we will use to further develop MNSI’s investigations processes.

Families’ comments about what they found most helpful regarding the investigation process included:

> “Being able to openly recount our perspective helped us feel like we were involved and listened to. But ultimately the most helpful thing, as difficult as the report was to read, was having that information and some answers as to what actually happened.”

> “I am really pleased the Trust made the referral to MNSI. The process enabled us to share what happened fully and I feel as though we got answers that we would not have had, had we not participated. After such a terrible experience with the Trust, it was refreshing to engage with such a professional team.”

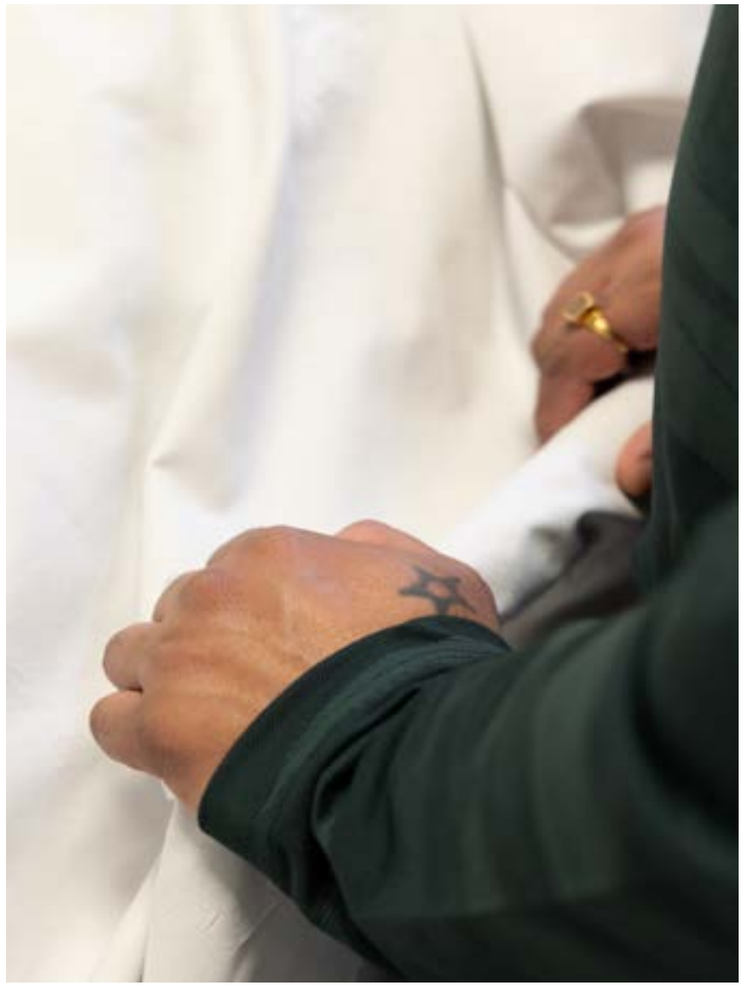
> “I personally felt that my feelings and perception of the experience we had of birth were validated and the investigators at times were able to provide clarity… This helped me during a really challenging time. I fully understood the remit of the investigators and really appreciated their professionalism. The outcome of the report really focused on elements of care that will be helpful to other families. This helped us, (as did) knowing that recommendations will be made and the report used a learning tool by the Trust in the future.”

> “As a family we are very happy with the report and investigation. The investigation found a lot of things we never would have known without the involvement of MNSI. We had a tripartite meeting with our investigator and relevant Trust staff after the report was completed, which was really helpful. The Trust made an action plan, based on the safety recommendations and findings in the report. It was good to have our MNSI investigator present at this meeting to support us and make sure all of our questions were answered. We really feel that the report… will help other families have a better experience and save babies lives. We will forever be grateful of our brilliant and kind investigator, and the MNSI as an organisation.”

How MNSI uses feedback

Wherever possible, MNSI acts on the feedback received to improve ways of working. Two examples of where changes made in 2024/25 are:

- adaption of the triage process for accepting investigations where an magnetic resonance imaging (MRI) result is of concern; this now includes an independent review of the MRI where necessary. This change was made following feedback from a family whose investigation was initially closed following their baby's first MRI. More evidence emerged following a second MRI held later.
- MNSI has continued to develop the reports and improve their structure to align more closely with the timeline of events. Safety prompts are also included where appropriate to help trusts to learn and further develop their maternity and newborn services. A family suggested format changes because members found the structure of the report they received difficult to follow.



Staff training

MNSI increased the range of educational opportunities available to all staff members in 2024/25 so that colleagues were able to enhance their skills and knowledge. Events included:

- a two-day innovation and learning event that gave all MNSI staff the chance to listen to a variety of internal and external speakers on a range of safety subjects
- Coroners' officers continuation training, which MNSI was invited to take part in by the Judicial College. The training was delivered seven times during the year. It highlighted the role of MNSI in child death investigations and how this may touch on the work of a coroner's officer. The training led to better awareness of the role of MNSI and the criteria for investigations, together with a shared understanding of the impact on families.

MNSI offered bespoke induction packages to two new cohorts of maternity investigators. These sessions were organised and facilitated by the MNSI education team, with some sessions delivered by other internal staff.

The induction programme uses case studies, which helps new team members fully understand fully understand MNSI's internal processes. Role play and interview techniques are an integral part of the training, as is revisiting human factors and analysis tools used for investigations.

The induction programme spans three weeks and is largely residential, which creates a supportive and safe learning environment, making new investigators feel their input is valued and respected. Some online learning is also included to ensure the programme accommodates the diverse learning styles of all participants.

Following induction, new investigators complete a competence portfolio and give evidence against 10 separate themes. This equips them with the skills they need for their role. The competences are based on the role profile of a maternity investigator and the Skills for Health National Occupational Standards.

The next steps within MNSI's education work will be to develop an education strategy for 2025/26 with a focus on refresher and Continued Professional Development (CPD) training.

Safeguarding staff wellbeing with MNSI's trauma support programme

During 2024/25, the psychological screening programme established to support MNSI staff entered its second year. The programme enables MNSI to monitor the impact of trauma related to its work, while also providing initiatives to support MNSI's teams. These include education sessions focusing on neurodivergence, wellbeing and line management.

Screening takes place on recruitment and then annually, and can also be accessed by referral at any point. The management information it provides enables MNSI to compare clinical scores, lifestyle and stressor data to previous years and benchmark levels, in turn highlighting any trends and areas for further focus.

Source: Psychological screening | Noreen Tehrani

Two MNSI's staff members have become wellbeing coordinators. Working on a voluntary basis, they champion, signpost and raise awareness of wellbeing and mental health initiatives and the support that is available for colleagues.

Plans for 2025/26

MNSI has begun work to develop a new three-year strategy. The strategy will guide the work of the programme and provide a clear roadmap to develop and continue MNSI's work to improve the safety of maternity and newborn care in England.

MNSI wants to develop an ambitious forward-thinking strategy in partnership with people with first-hand experience of maternity and newborn care in England alongside maternity, newborn and patient safety experts. MNSI is working with mothers, families, NHS staff and key stakeholders from across healthcare, patient safety organisations, government and MNSI staff to develop this new strategy.

The new strategy will reflect recent changes to the healthcare landscape including the absorption of NHS England's responsibilities by the Department of Health and Social Care and the changes to the roles of Integrated Care Boards (ICBs). The strategy will guide MNSI's work until the late 2020s.

MNSI expects to deliver the final strategy in the autumn of 2025.

Conferences

MNSI is planning to attend the following conferences in 2025/26:

- **British Association of Perinatal Medicine Spring Conference 2025** Leicester | 1 to 2 April
- **Ergonomics and Human Factors 2025 (Chartered Institute of Ergonomics and Human Factors)** | Burton-Upon-Trent | 28 to 30 April
- **Obstetric Anaesthetists' Association Annual Scientific Meeting 2025** Belfast | 15 to 16 May
- **Anti-racist Healthcare Conference** | London | 15 May
- **British Maternal & Fetal Medicine Society Conference 2025** | Belfast | 8 to 9 May
- **Emergency Medical Services Congress 2025** | Stockholm | 2 to 4 June
- **NHS Confed Expo** | MANCHESTER | 11 to 12 June
- **Royal College of Obstetricians and Gynaecologists World Congress 2025** | London | 23 to 25 June
- **British Society of Gastroenterology Live '25** | Glasgow | 23 to 26 June
- **HSJ Patient Safety Congress** | Manchester | 15 to 16 September
- **Baby Lifeline National Maternity Safety Conference** | Birmingham | 25 September
- **British Intrapartum Care Society Conference 2025** | Belfast | 13 to 14 November

Members of MNSI staff are scheduled to present or speak at several of the events to share more information about MNSI's work with the wider system while learning from others.

Stakeholder engagement

MNSI's work cannot be delivered or have a positive impact without the engagement and commitment of stakeholders. Throughout 2024/25, MNSI has worked to develop and strengthen stakeholder engagement.

This has included developing relationships and partnerships with third sector and research organisations, enabling the development of MNSI's thematic work. As a result of this work, MNSI has begun a collaborative project with the University of Manchester to analyse safety recommendations related to fetal movements. It is expected that the initial analysis from this project will be shared later in 2025.

MNSI has also begun work to develop and improve its approach to family engagement. This includes bringing together a family reference group that will support MNSI to co-develop approaches to family engagement as well providing insight and feedback on other elements of MNSI's work.

MNSI continues to build relationships with NHS trusts providing maternity and newborn services to ensure they can efficiently implement the recommendations made following MNSI investigations. Work has also begun to improve and develop how MNSI gathers feedback from NHS trusts who participate in MNSI investigations. This information is key to MNSI refining and improving its investigation process and ultimately improving maternity and newborn safety in England.

MNSI is in the early stages of establishing an editorial board to support the co-production of thematic learning and briefing papers. The board will bring together clinical experts and other system partners to contribute to the development of clear, evidence-based outputs. This approach is intended to strengthen the quality and relevance of MNSI's publications and support efforts to improve the safety of women and their babies.

Appendix 1

Maternity and Newborn Safety Investigations programme website. Available at https://www.mnsi.org.uk

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Learning Response Review and Improvement Tool. Health Services Safety Investigations Body (HSSIB). (2025). Resources. [online] Available at: https://www.hssib.org.uk/education/resources/

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Safety prompts within MNSI investigation reports. Sharing learning for maternity safety MNSI BRIEFING. (2024). Available at: https://mnsi-2zor10x7-media.s3.amazonaws.com/production-assets/documents/Safety_Prompts_Briefing.pdf

Skills for Health (2022). National Occupational Standards Overview. [online] Skills for Health. Available at: https://www.skillsforhealth.org.uk/info-hub/national-occupational-standards-overview/

Noreen Tehrani. (2020). Psychological screening | Noreen Tehrani. [online] Available at: https://www.noreentehrani.com/psychological-screening

Webinars

Exploring learnings from MNSI safety investigations: Maternal death from pulmonary embolism https://www.mnsi.org.uk/news/catch-up-webinar-series-exploring-learnings-from-mnsi-safety-investigations/#:~:text=Exploring%20learnings%20from%20MNSI%20safety%20investigations%3A%20Maternal%20death%20from%20pulmonary%20embolism ?

Exploring learnings from MNSI safety investigations: Think beyond sepsis https://www.mnsi.org.uk/news/catch-up-webinar-series-exploring-learnings-from-mnsi-safety-investigations/#:~:text=Exploring%20learnings%20from%20MNSI%20safety%20investigations%3A%20Think%20beyond%20sepsis

Exploring learnings from MNSI safety investigations: Sudden Unexplained Death in Epilepsy (SUDEP) https://www.mnsi.org.uk/news/catch-up-webinar-series-exploring-learnings-from-mnsi-safety-investigations/#:~:text=Exploring%20learnings%20from%20MNSI%20safety%20investigations%3A%20Sudden%20Unexplained%20Death%20in%20Epilepsy%20(SUDEP)

Exploring learnings from MNSI safety investigations: First trimester deaths in England from venous thromboembolism associated with hyperemesis https://www.mnsi.org.uk/news/catch-up-webinar-series-exploring-learnings-from-mnsi-safety-investigations/#:~:text=Exploring%20learnings%20from%20MNSI%20safety%20investigations%3A%20First%20trimester%20deaths%20in%20England%20from%20venous%20thromboembolism%20associated%20with%20hyperemesis

Exploring learnings from MNSI safety investigations: Deaths in England in the first trimester of pregnancy: national patterns and safety recommendations https://www.mnsi.org.uk/news/catch-up-webinar-series-exploring-learnings-from-mnsi-safety-investigations/#:~:text=associated%20with%20hyperemesis-,Exploring,-learnings%20from%20MNSI

MNSI
Maternity & Newborn Safety Investigations

Further information

More information about MNSI including its team, investigations and history is available at www.mnsi.org.uk

If you would like to request an investigation then please read our guidance before contacting us.

To keep in touch you can subscribe to our bi-monthly bulletin or follow us on LinkedIn where we raise awareness of our work and to share our publications, news and events.

Contact us

If you would like a response to a query or concern please contact us via email using enquiries@mnsi.org.uk

We monitor this inbox during normal office hours - Monday to Friday from 09:00 hours to 17:00 hours. We aim to respond to enquiries within five working days.

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