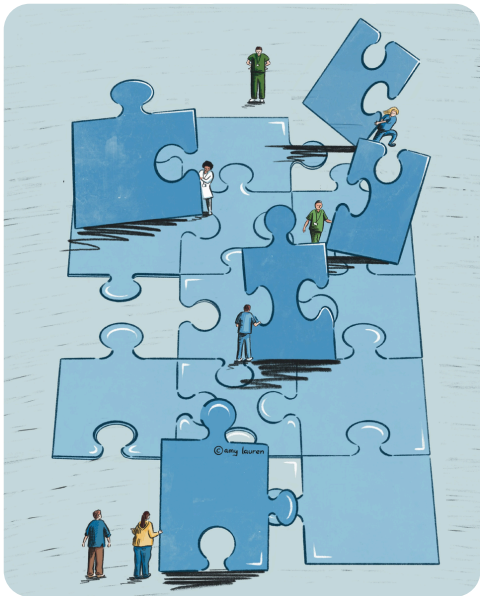
ENDING PREVENTABLE BABY DEATHS

An action plan for Ireland



Perinatal deaths, including stillbirths and early neonatal deaths, remain a major public health issue in Ireland, affecting around 300 families each year. The number of baby deaths (perinatal mortality rate) in Ireland has remained static in recent years. Targeted investment could reduce the number of baby deaths, but unlike other countries, Ireland has no prevention strategy. **This five-pillar action plan sets out how to end preventable baby deaths in Ireland.**

Ending Preventable Baby Deaths: An Action Plan for Ireland

PILLAR 1
Public Awareness & Education

PILLAR 2
Risk Awareness & Communication

PILLAR 3
Best Care, Every Time

PILLAR 4
Ongoing Review of Baby Deaths

PILLAR 5
Driving Research Informed Care

PREVENTING BABY DEATHS must become a national priority

Baby deaths are not rare, they are under discussed

Beyond the primary goal of ending preventable baby deaths, this action plan will also impact on maternity care, experiences and outcomes more broadly.

This action plan is grounded in the recognition that meaningful progress depends on collaboration across sectors, aligned leadership, and shared responsibility.

We can improve pregnancy and perinatal outcomes by combining evidence-informed research and practices, multidisciplinary input and knowledge users' engagement in all units and nationally. Ending Preventable Baby Deaths is our **call to action** to prioritise the prevention of baby deaths in Ireland.

Pregnancy Loss Research Group

NATIONAL PERINATAL EPIDEMIOLOGY CENTRE

Féileacáin
Stillbirth and Neonatal Death Support Ireland

PILLAR 1: Public Awareness & Education

Enhance **knowledge and awareness of risk factors** related to baby deaths within the general population and before and during pregnancy.

1.a Appoint a **clinical public health lead** within the Health Service Executive (HSE) with responsibility for pregnancy and pre-conception health.

1.b Develop **information resources** for both the public and healthcare professionals for use in healthcare settings and beyond, including fact sheets that explain the main risk factors for perinatal deaths and outline practical, supportive actions that women, families, healthcare professionals can take to address these risks.

1.c Design and implement a **public health campaign** to raise awareness about risk factors and prevention strategies.

1.d Develop tailored strategies to engage **groups experiencing health inequalities**, including those facing barriers to care, language, or requiring psychosocial support.

1.e Incorporate education about fertility and pregnancy loss into **school curricula.**

1.f Evaluate the **implementation and effectiveness** of the public health campaign and its related strategies and adapt as needed on an ongoing basis.

PILLAR 2: Risk Awareness & Communication

Ensure risks in pregnancy are **assessed consistently** by healthcare professionals and **communicated clearly** and with sensitivity within healthcare settings.

2.a Develop a **standardised list of risk factors** to guide healthcare conversations.

2.b Reform **medical and midwifery curricula** to include education about prevalence and prevention of baby deaths.

2.c Incorporate guidance into **national antenatal education standards** to support healthcare professionals in promoting health / health behaviours with pregnant women and to discuss risk factors, stillbirth prevention, and options for antenatal care and delivery in antenatal education standards and settings.

2.d Adapt the **'Making Every Contact Count' (MECC)** programme to include education on baby death prevention.

2.e Develop **communication and education materials** for healthcare professionals and update antenatal education standards.

2.f Evaluate healthcare professional education and communication initiatives on an ongoing basis.



Illustrations by Amy Lauren

PILLAR 3: Best Care, Every Time

Deliver **consistent, high-quality, evidence-informed care** for every pregnancy.

3.a Provide targeted supports and structures to enhance national and regional implementation of relevant **national clinical guidelines**, including ongoing monitoring and evaluation across all 19 maternity hospitals/units.

3.b Resource **national coordination and support** for guideline implementation including a dedicated implementation lead.

3.c Develop and implement **clinical decision support tools/clinical algorithms** to support implementation of national clinical guidelines.

3.d Evaluate and audit guideline implementation and examine the effectiveness of the clinical decision support tools and related quality improvement initiatives.

PILLAR 4: Ongoing Review of Baby Deaths

Make maternity services safer through **ongoing review of baby deaths** and learning, to implement recommendations and drive care improvements.

4.a Ensure there are **robust processes in each maternity hospital/unit to review baby deaths**, with regional reporting of findings, and action plans/learning events as appropriate .

4.b Develop the **Perinatal Mortality and Morbidity Review Tool (PMMERT)** for all perinatal death case reviews alongside a new process for stillbirth review that involves parents (via the ACHIEVE project).

4.c Evaluate and refine the use of the new PMMERT process through implementation and ongoing review of the baby death review process in all maternity hospitals/units.

4.d Report findings annually at regional level, including the status of implementation of recommendations, from PMMERT nationally and to the Minister for Health.

4.e Improve **Coronial processes** to reduce delays, improve communication with families and clinicians, and ensure Coronial findings inform care improvements.

Read the full action plan

www.ucc.ie/ending-preventable-baby-deaths/

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PILLAR 5: Driving Research Informed Care

Invest in research for better policy, practice, and outcomes.

5.a Invest in research aligned with priorities outlined within this action plan through national research funders including the Health Research Board, Research Ireland and Enterprise Ireland.

5.b Aligned with 5.a, invest in researchers/clinician researchers and research systems to create the **supportive environments** required to deliver, high-quality, timely research as part of learning health systems, academic health sciences systems, and research ecosystems.

5.c Develop a **theory-based behaviour change intervention** to address the modifiable risk factors for stillbirths and an associated implementation strategy.

5.d Advance **pathological and clinical studies** and invest in research structures to understand the biological causes of baby deaths and preterm births and develop screening, prediction and diagnostic tools.

5.e Investigate how **inequities** lead to adverse outcomes and address barriers to high-quality care.

5.f Maintain and strengthen the **NPEC Maternal and Fetal Classification System**, ensuring compatibility with international frameworks (such as ICD-PM), and aligning with the work of the International Stillbirth Alliance improving global cause-of-death classification and reducing the proportion of unexplained stillbirths.

5.g Better understand and enhance **communication** around pregnancy and baby loss and related risk factors across society, including within political, public and clinical spheres.

We need national commitment to:

- Prioritise preventing baby deaths across maternity, public health, and wider health policy and planning.
- Fund and implement the five elements of this action plan.
- Appoint leadership roles in public health and maternity care focused on pregnancy outcomes.
- Ensure every pregnancy counts and every baby death is reviewed, learned from, and never silenced.

The **Pregnancy Loss Research Group** leads national research to better understand pregnancy loss experiences and impacts.
www.ucc.ie/pregnancyloss

The **National Perinatal Epidemiology Centre (NPEC)** collaborates with each of the 19 Irish maternity services to translate clinical audit data and epidemiological evidence into improved maternity care for families in Ireland.
www.ucc.ie/en/npec

Féileacáin is a not-for-profit organisation dedicated to supporting those affected by the loss of a baby. Their vision is the prevention of avoidable deaths of babies.
www.feileacain.ie