



Ein cyf/Our ref: WQ98824 WQ98825

Vikki Howells MS
Pontypridd Cynon Merthyr

12 June 2026

Dear Vikki

I am replying to your written questions:

What steps is the Welsh Government taking to reduce stillbirth and neonatal death rates in Wales? (WQ98824)

The Welsh Government recognises the deeply distressing impact of losing a baby at any stage of pregnancy. Improving outcomes for babies and reducing stillbirths and neonatal deaths remain key priorities. We are committed to driving continuous improvement in the safety and quality of maternity and neonatal services across Wales. This commitment is underpinned by the [Quality Statement for Maternity and Neonatal services](#) which sets out our national vision for safe, equitable, and high-quality care. It supports the delivery of consistent standards across Wales, with a strong focus on reducing avoidable harm, including stillbirth and neonatal deaths, by promoting evidence-based practice and continuous improvement within every health board.

Wales does not currently have specific numerical targets for reducing stillbirth and neonatal death rates. Alongside the quality statement, the Path to Safer Beginnings report, published in February 2026, provides an objective and comprehensive assessment of maternity and neonatal services. The recommendations from the report are being taken forward through a structured improvement programme over the next three years, providing a clear and disciplined framework to support safe, sustainable and long-term change. This phased approach will support services to embed meaningful improvements while maintaining a strong focus on quality and safety. This will include strengthening data gathering, incident reporting and shared learning

This new Welsh Government is also committed to developing and strengthening bereavement care, and to promote best practice on supporting parents and families affected by baby loss. We will shortly be publishing the new National Bereavement Care Pathways which have been developed with third sector partners and bereaved families.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn yr iaith honno ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

What action is the Welsh Government taking, in partnership with Public Health Wales, to reduce childhood mortality and ensure that learning from child deaths leads to improvements in services and outcomes? (WQ98825)

The Child Death Review Programme collects information on all deaths of children in Wales, as well as Welsh-resident children who die elsewhere. The programme is managed by Public Health Wales and analyses national and regional patterns and trends to identify factors contributing to these deaths, with the aim of informing interventions that may help prevent future child deaths.

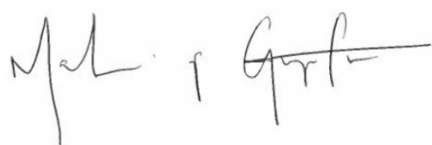
The programme covers deaths of children who are live born, where the death occurred after 1 October 2009 and before the child's 18th birthday and where the child is either normally resident in Wales or dies within Wales. This includes children who are under local authority care and placed outside of Wales, or those who may temporarily reside outside of Wales for healthcare or education purposes.

The Procedural Response to Unexpected Deaths in Childhood (PRUDiC) sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, multidisciplinary collaboration and information sharing following the unexpected death of a child. The PRUDiC applies to all deaths in children from birth until their 18th birthday whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community. The aim of the PRUDiC is to ensure that the response to unexpected deaths is safe, consistent and sensitive to those concerned.

Data generated through the PRUDiC is used by the Child Death Review Programme to determine patterns and trends pertaining to child deaths in Wales, and to inform thematic reviews to identify opportunities for future prevention.

Findings from the Child Death Review Programme are published regularly and shared with the Welsh Government through routine reporting and engagement meetings, enabling ongoing oversight of emerging trends. Where areas of concern are identified, targeted or rapid reviews may be commissioned to inform timely action. In addition, PRUDiC reviews are managed through safeguarding structures, with relevant issues escalated via the National Safeguarding Service into safeguarding case review processes, ensuring that learning is systematically captured to support ongoing service improvement.

Yours sincerely,



Mabon ap Gwynfor AS/MS

Gweinidog Cabinet dros Iechyd a Gofal
Cabinet Minister for Health and Care