Learning from Standardised Reviews When Babies Die
2025 Annual Report Key Messages

PMRT
Supporting high quality local perinatal reviews

Since the launch of the national Perinatal Mortality Review Tool (PMRT) in early 2018, nearly 29,000 reviews have been started. This report presents the findings for the 4,166 reviews completed from January to December 2024.

RECOMMENDATIONS FROM THE ANNUAL REPORT 2025

REVIEW PARENT ENGAGEMENT

Optimise the engagement of parents in reviews by ensuring they are approached, that staff are trained to support parents and to enable them to provide their perspectives and any questions they have using the PMRT engagement materials.

Action: Trusts and health boards, staff caring for bereaved parents, service commissioners

ADEQUATE RESOURCING

Ensure that PMRT review teams are adequately resourced so that all appropriate staff are able to attend and contribute to PMRT review meetings.

Action: Trusts and health boards, service commissioners

JOB PLANS AND ROLES

Ensure that PMRT review roles are incorporated into consultant job plans and all other relevant role descriptions. Senior leadership is essential and should be designated as part of job plans and role descriptions.

Action: Trusts and health boards, service commissioners

INCLUDE EXTERNAL REVIEWERS

Provide adequate resources and make the arrangements necessary to ensure the participation of independent external clinicals at the multi-disciplinary PMRT review meetings.

Action: Trusts and health boards, service commissioners, regional/network support systems

USE THE REPORTS

Use the findings from local PMRT summary reports and this national report alongside MBRRACE-UK real-time monitoring tool data to prioritise resources for key care quality improvement activities identified as requiring action.

Action: Trusts and health boards, service commissioners, regional/network support systems, governments

DEVELOP STRONG ACTIONS

Enhance the impact of review findings by generating ‘strong’ actions targeted at system level changes, developing and implementing service quality improvement activities based on review findings, and rigorously auditing the implementation and impact

Action: PMRT review teams, governance teams in trusts and health boards, regional/network support systems, service commissioner

Parent engagement in PMRT reviews 2024

98% of parents were invited to provide comments or questions about their care

- **28%** had specific questions about what happened and why
- **22%** had concerns with management plans and care received
- **11%** had general questions, or commented on a lack of information or communication issues
- **12%** had concerns about staff approach and how care was given
- **18%** provided positive comments about care and staff

Parent engagement improves the quality of reviews

Engaging bereaved parents in the review process does not mean having the parents present at the review meeting, it means talking to them, telling them about the review and asking them for their views and any comments or questions so that these can be considered in the review.
It also means providing them with appropriate verbal and written feedback once the review is completed.

"I felt all appointments were methodical. There was no rapport built, no TLC. Felt appointments were very rushed and quick."

"When I was cared for antenatally, I wasn't given the information I required."

"Should I have been told to take it easy? Should I have still been going to work?"

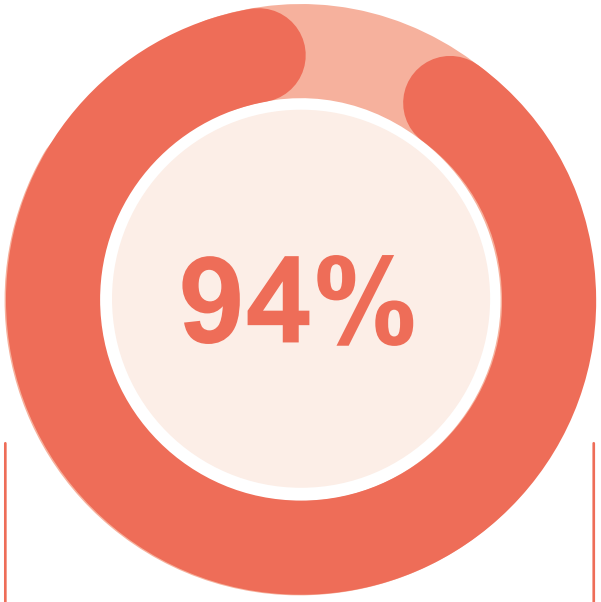
"There is nothing any of you could have done better. You are all heroes and should be blessed for everything you have done for me and my family."

"Failure to listen to my concerns about having no fetal movement, I wasn't offered an ultrasound, and there was an on-call doctor who could have been called as there was no doctor on the ward."

"What happened to my baby?"

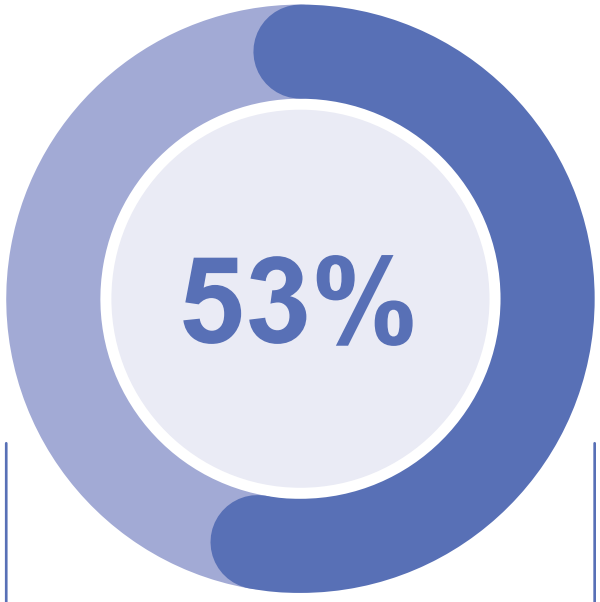
"Why wasn't my pregnancy marked as high risk?"

Care and the review team, PMRT Reviews 2024



of reviews identified at least one issue with care

of reviews identified at least one issue with care which may have been relevant to the outcome



of reviews included an external reviewer

The external reviewer should be a relevant senior clinician who works in a hospital external to the trust/health board undertaking the review. The external reviewer role is to be present at the review panel and actively participate to provide a 'fresh pairs of eyes', independent and robust view of the care provided. They should be from a relevant specialty, and senior enough to provide robust, objective challenge where appropriate.

Multidisciplinary review is essential

7%	of reviews had three or fewer people to carry out the reviews
63%	of reviews of neonatal deaths included a neonatal nurse
87%	of neonatal deaths included a neonatologist
40%	of reviews had administrative support
84%	of reviews had a risk/governance team member present

Actions implemented following PMRT reviews 2024

Examples of Actions Following PMRT Reviews 2024

Weak 47%	Intermediate 45%	Strong 7%
It is not possible to tell if the relevant professionals involved in the ongoing care of the parents were informed about the death of their baby: Learning point highlighted on poster.	Mother had risk factors for a growth restricted baby. Serial scans were not performed at correct times/intervals: Guidance updated and request form amended to prompt USS where required.	Mother and partner were not cared for in either a sound proofed room or away from other mothers and crying babies: Plans in place to get soundproofing to walls and door. Money in place for refurbishment.
The ongoing respiratory management of the baby on the neonatal unit was inappropriate: Medical staff teaching session to be arranged.	Mother presented with reduced fetal movements. There is no evidence that she had written information during antenatal care about fetal movements: Antenatal notes include information about fetal movements. Women are given videos of actions to take if fetal movements reduce.	The medication management for baby during the first 24 hours of arrival on the neonatal unit was inappropriate: Clear labelling of adrenaline in the drug cupboard. Medication now in red resus bags. Emergency trolleys now colour coded.
A reminder of action without controls	**A new support system in place but still without controls**	**Control system designed to eliminate human error**