PMRT

Supporting high quality
local perinatal reviews

National Perinatal Mortality Review Tool

Learning from Standardised Reviews When Babies Die

Seventh Annual Report 2025

The Royal College of Midwives
University of Bristol
NHS The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
PARENTS Parents' active role and engagement in their stillbirth & neonatal death review
sands Saving babies' lives. Supporting bereaved families.
Manchester 1824 The University of Manchester
UCL
NHS Sheffield Children's NHS Foundation Trust
University of Birmingham
University of Leicester
NHS East Suffolk and North Essex NHS Foundation Trust
Oxford Population Health NPEU

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Acknowledgements

The development of the national PMRT is a result of a collaborative effort by a substantial number of individuals. We also owe a debt of gratitude to the many users of the PMRT and parents who have made suggestions as to how we might improve the PMRT.

Use of the terms women and mothers

We use the terms ‘women’ and ‘mothers’ throughout this report to refer to those who are pregnant and give birth. We acknowledge that not all people who are pregnant or give birth identify as women, and it is important that evidence-based care for maternity, perinatal and postnatal health is inclusive.

Glossary

CDOP	Child Death Overview Panel (England)
Cool/cold cot	A cot which is kept cool/cold to preserve the baby’s body after death
CTG	Cardiotocograph
NCMD	National Child Mortality Database
MBRRACE-UK	The collaboration established to deliver the MNI-CORP
MNI-CORP	Maternal, Newborn and Infant Clinical Outcome Review Programme
PMRT	Perinatal Mortality Review Tool
Sands	Stillbirth and neonatal death charity

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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?

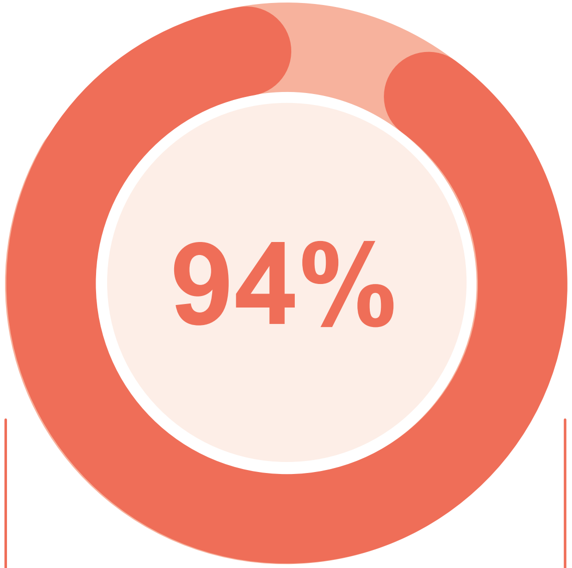
> There is nothing any of you could have done better. You are all heroes and should be blessed for everything you have done for me and my family.

> 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?

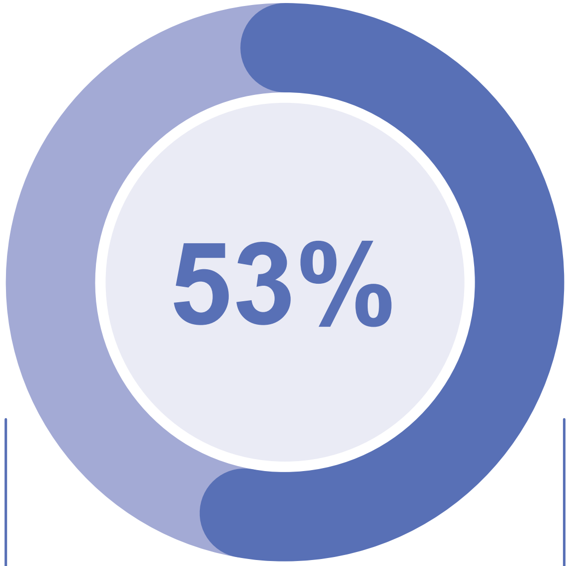
> Why wasn't my pregnancy marked as high risk?

Care and the review team, PMRT Reviews 2024



of reviews identified at least one issue with care

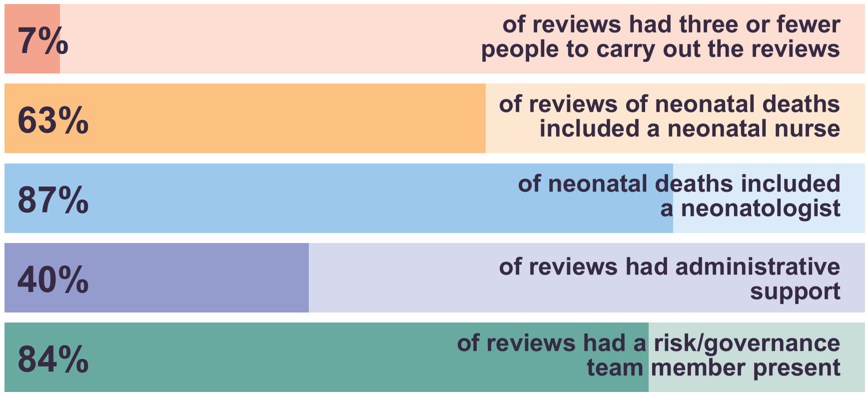
of reviews identified at least one issue with care which may have been relevant to the outcome



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



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**

Contents

Executive Summary

The primary purpose of a review when a baby has died is to provide answers for bereaved parents and families about why their baby died and their care, and explore whether different care may have resulted in a different outcome; the review is carried out primarily for them. A secondary purpose comes from the wider learning from the review findings to identify where quality improvements are needed to improve care for all mothers and babies, to prevent future deaths, and to improve care when a death has occurred.

Audit and review are part of routine maternity and neonatal care; these are not optional extras. It is therefore reassuring that in 2024, the vast majority of baby deaths saw a PMRT review started, completed, and its final report generated. This represents a major improvement since the PMRT was launched in 2018.

Providing information for bereaved parents about their baby's death and answers to any questions they may have about their care is essential. Supporting parents through bereavement and the review process is critical. Meaningful engagement with parents in the review process has the potential to improve the quality of the review and parents' confidence in the process and findings. For parents to understand the process and how they can contribute their perspective of their care, they need a straightforward trauma-informed, verbal explanation of the review in a language they can understand, supported by 'plain language' parent-facing written information. Communication with parents should remain open so they can ask further questions as they arise and know what is happening with their review. PMRT data suggests that nearly all parents were told a review would take place and were invited to provide questions and comments about their care. Whether all parents actually understood what this meant is not clear and research evidence suggests they may need multiple discussion opportunities and to be able to ask questions and provide comments about their care on more than one occasion. Good engagement with parents and families is essential for their wellbeing and it also improves the quality of their review from which they will benefit directly.

Overall, in 19 out of every 20 reviews, PMRT panels identified at least one issue with care. In seven out of every 20 reviews, at least one issue was identified and judged by the review teams to have been relevant to the outcome. The latter represents an increase from six out of every 20 reviews in 2023. From the information available in the PMRT we cannot determine whether this reflects a decline in care, an increase in robust, objective reflections during the review process, or a combination of the two. Hopefully, this largely reflects more robust reviews being carried out.

With a small number of notable improvements, including screening and provision of antenatal aspirin and carbon monoxide screening, the issues with care identified in this report remain largely the same as those identified in previous years. These include issues with mothers booking late or arriving in labour unbooked; inadequate surveillance of fetal growth; management of reduced fetal movements; and diagnosis and management of maternal medical, surgical and social issues; assessment of maternal risk status and staffing issues during labour and birth; thermal and respiratory management once the baby has been born; and the quality of neonatal documentation. The inadequate location and quality of bereavement suites affected 1 in 20 parents which was a marginal improvement from 2023, however, notably this issue was identified in at least one review in half of all trusts/health boards. All these issues must remain a focus of quality improvement activities along with specific recurring issues identified by trusts/health boards from their own PMRT summary reports.

The trend of a shift in the overall grading of care to fewer reviews with care graded as ‘A’ (‘no issues with care identified’) with an increase in other grades continued in 2024. Since the launch of the tool there has been a doubling in the proportion of reviews graded as C (‘issues which may have made a difference to the outcome’) or D (‘issues which were likely to have made a difference to the outcome’). We expect that with an increasingly robust, objective approach to the review of the care provided, more reviews having an external member present, as well as organisations seeking to improve future care, this trend to a more stringent approach to grading will continue.

The membership of the PMRT review panel is critical to good quality reviews being conducted. There has been a steady improvement in the proportion of reviews having an appropriate number of healthcare professionals in the review teams across all professional groups. However, some groups continue to be underrepresented, which may be an impact of limited resourcing. The presence of a professional external to the trust/health board has continued the trend of more stringent grading of care, demonstrating the added value external members contribute, alongside the reassurance that their independence provides for parents. Importantly, unless specifically employed for this purpose, we strongly advise that bereavement midwives should not bear the burden of managing/leading the PMRT process. The role of the bereavement team member(s) is one of parent advocacy and support; allocating responsibility for the PMRT review process to a member of the bereavement team may give rise to potential conflicts of interest.

The final critical step of any review is to identify the issues that require action to improve future care for all mothers and babies, irrespective of the impact of that issue on the specific death being reviewed. Parents, in particular, want to know that care has been improved as a consequence of their experiences and the subsequent review. Not all issues require ‘strong’, system level actions and the current trend of two fifths of actions remaining strong/intermediate is encouraging.

These national findings underline that multiple, stepwise improvements across all stages of the pregnancy, labour, birth and postnatal pathway are required to reduce local and national perinatal mortality rates and improve care for all mothers and babies. The findings from this national report as well as from local reviews should inform the prioritisation and funding of quality improvement activities in trusts and health board to reduce the risk of inadequate care being provided in the future.

Recommendations

1. Optimise the engagement of parents in reviews by ensuring all parents 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

2. 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

3. 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

4. Provide adequate resources and make the support arrangements necessary to ensure the participation of independent external clinicians at the multi-disciplinary PMRT review meeting.
Action: Trusts and health boards, service commissioners, regional/network support systems

5. 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

6. 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 their implementation and impact.
Action: PMRT review teams, governance teams in trusts and health boards, regional/network support systems, service commissioners

Background

In 2016, the Perinatal Mortality Review Tool (PMRT) was commissioned to address the recognised need to review the care of a greater number of deaths to a higher standard when a baby has died in pregnancy or soon after birth. The PMRT was developed in collaboration with clinicians and parents with the primary goal of providing parents with clear answers about their baby's death and their care, and secondly, to promote local and national learning to improve care and prevent future deaths. This complements the primary goal of Maternity and Newborn Safety Investigations (MNSI) which focus on specific deaths of term babies (and brain injury) with the goal of system level learning.

The PMRT was launched in early 2018. Before its introduction, there was no national standard tool for the review of baby deaths across the UK, reviews were not always conducted and parents were not routinely invited to contribute to their review when one was carried out. In many cases, parents were not informed a review would take place, and the findings were not discussed with them. The PMRT was designed to support objective, robust and standardised local reviews of all stages of care when babies have died. The tool supports the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. For the majority of parents, the PMRT review process is likely to be the only hospital review of their baby's death. The PMRT therefore actively prompts the review panel to include parents' perspectives in the review, ensuring that any questions they have can be addressed as the review progresses. The PMRT is continually refined and updated with the support of clinicians and collaborators. This is to ensure the tool remains comprehensive, capturing all pertinent information for review.

This is the seventh annual report, which presents an analysis of reviews completed from January 2024 to December 2024. It is important to note that, as of last year, we now report on a full calendar year basis. There is a large amount of information presented here, we also provide a separate Tables Report document, which includes data from this year and previous reports for comparison. The infographic summarising the main findings in pictorial format, a short report version of the main findings, and a technical report (published in 2024) with details of the development, content, and use of the tool are also available. You can download all these from the *PMRT webpages*.

Findings

1. Reviews started

The PMRT was launched in 2018. Trusts and health boards across England, Wales, Scotland and Northern Ireland continue to use the tool to review care for late miscarriages, stillbirths and neonatal deaths. By December 2024 nearly 29,000 reviews had been started using the tool since its inception.

During 2024, across the UK a review of care was started for 99% of stillborn babies and those who died in the late second trimester (late miscarriages), and 95% of babies who died in the neonatal period (first four weeks after birth). These figures vary by country as illustrated in Figure 1 (see also Tables 1.1 to 1.4 in the Tables Report). For 90% of stillbirths and late miscarriages, and 77% of neonatal deaths the reviews were completed and the report printed; thus overall, 84% of reviews were completed.

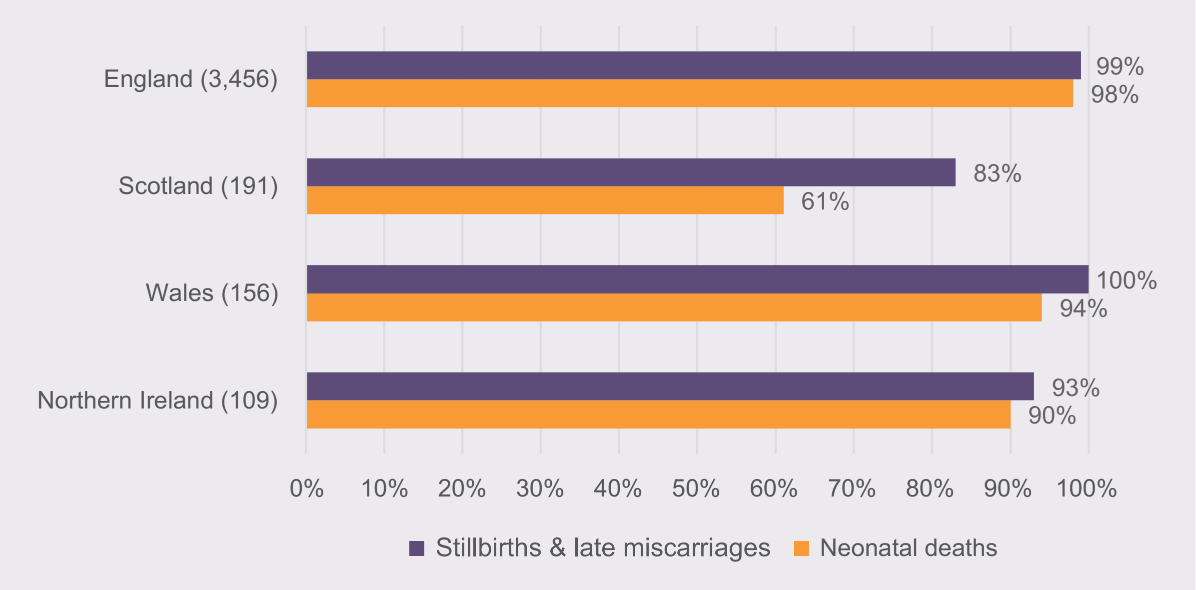


Figure 1: Proportion of deaths where a review was started by country and type of death, Jan to Dec 2024

2. Reviews completed

The findings reported here come from the information entered into the PMRT when reviews are carried out. The rest of this report presents PMRT data relating to the 4,166 reviews that were completed and the final review report printed in the period January 2024 to December 2024 inclusive; note that these figures do not directly align with the deaths in 2024 as reviews take several months to complete so the review of a death in late 2023 may be completed in early 2024 and the review of a death in late 2024 may not be completed until early 2025.

Findings from reviews which were started, but not completed during this period, are not included here. The distribution of reviews completed by country and type of death have remained essentially unchanged over time and reflect in part the distribution of deaths across the four nations and by type of death. See Table 1 below and Table 1.5 in the Tables Report.

Table 1: Characteristics of the reviews completed by country and type of death, Mar 2022 to Dec 2024

		Reviews Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023*		Reviews Jan 2024 to Dec 2024	
		Number of reviews N = 4,111	Percentage of reviews	Number of reviews N = 4,311	Percentage of reviews	Number of reviews N = 4,166	Percentage of reviews
Country	England	3,583	87%	3,806	88%	3,768	90%
	Wales	186	5%	154	4%	165	4%
	Scotland	190	5%	176	4%	143	3%
	Northern Ireland	152	4%	175	4%	90	2%
Type of death	Late miscarriages	383	9%	395	9%	361	9%
	Stillbirths	2,248	55%	2,327	54%	2,214	53%
	Neonatal deaths	1,480	36%	1,589	37%	1,591	38%

*There is an overlap of reviews included with the previous year for Jan & Feb 2023; this is a consequence of changing to calendar year reporting

3. Parent engagement

The voice of parents is critical to the review process. Reviews are primarily conducted to provide parents with clear answers about their baby's death and whether different care may have led to a different outcome. Any questions parents have and their views of their experience of care cannot be addressed if these are not sought. Furthermore, feedback from parents also provides a fuller picture of the care received and can be instrumental in learning and improving for all mothers and babies care in the future.

Engaging parents in PMRT reviews means:

1. **Communicating sympathetically and transparently:** Inform parents clearly and sensitively that a review of their care and that of their baby will take place. This includes using appropriate language (avoiding medical jargon), taking a trauma-informed approach, offering interpreters if needed and choosing a mode of communications which respects their needs.
2. **Facilitating parent input:** Provide parents with ample opportunities to share their questions, comments, and feedback about their experience of care. This should be done using plain, considerate language and their preferred method of communication. Allow them sufficient time to respond and acknowledge that they may need more time or many not wish to engage.
3. **Delivering review outcomes:** Offer to meet the parents to discuss the review findings and any implications for future pregnancy plans. Follow up the meeting with a clear, accessible letter explaining the review findings and what was discussed in the meeting. Provide the full PMRT clinical report if they request it, but only after a prior verbal and written explanation of its contents and what it means.

In their immediate grief, and often shock, parents may not feel able to express any questions or concerns and will need time and often more than one opportunity to do so. People process grief and traumatic events differently and at their own pace. Some parents may never wish to engage with the review process. However, by being transparent and receptive, the key contact with parents can provide the space for parents to come back with questions and any feedback which may be valuable not only to their mental health and processing their grief, but to the review of their care. The PMRT team have developed a set of materials available on the PMRT website to support staff with *parent engagement*.

Engaging parents in reviews

Engaging parents with reviews is a very sensitive process. For it to work effectively, it relies on building and maintaining strong, empathic, trusting relationships with the parents, rather than just following a set of impersonal steps. For information about how the review process is seen directly from a parent perspective, Sands carried out a survey of their members' experience of the review into their baby's death, the results of which, alongside the 'Listening Project' documenting the experiences of marginalised groups, are available on the *Sands website*. The as yet to be published NIHR funded MATREP evaluation of the process of PMRT reviews and MNSI investigations explored how parent engagement was experienced by those parents whose care was reviewed and/or investigated respectively (*https://sites.manchester.ac.uk/matrep/*).

In 2019 the PMRT team developed parent engagement templates for clinical staff to use in their interactions with parents, these were updated in 2024 after conducting interviews with bereaved parents and clinicians. The materials are available on the [PMRT website](). They comprise a leaflet for pre-discharge information about the PMRT review process, a post-discharge contact template for an email or a letter, a feedback form for parents' comments or questions, a follow-up template for use if no contact has been made and a flowchart outlining the PMRT process for parents. The intention is that templates are modified by trusts/health boards to align with their review processes and the specific needs of local parents. To improve accessibility, all of the documents have also been translated into Arabic, Bengali, Simplified Chinese, Hindi, Polish, Portuguese, Punjabi, Romanian, Spanish, Ukrainian, Urdu and Welsh. It may be possible to provide translated materials in other languages if there is sufficient demand.

Were parents told that a review would take place?

Clinician's report that 99% of UK parents were informed that a review of their care would take place. This varied from 99% in England, 95% in Scotland, 95% in Wales and 99% in Northern Ireland (Figure 2), representing a small overall increase from the previous report and a substantial increase in Wales where in the previous year only 86% of parents were informed. The proportion of parents informed about the PMRT review has increased from 84% in 2018 when the PMRT was launched representing a substantial improvement in parental engagement in the review of their care.

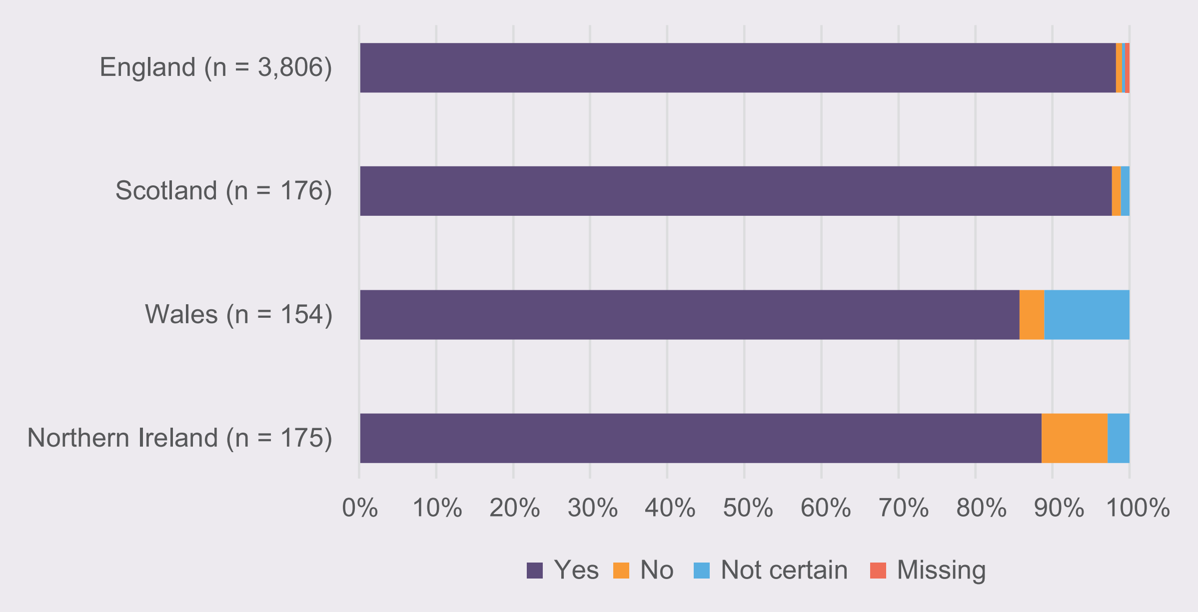


Figure 2: **Proportion of parents who were told a review would take place, reviews completed Jan 2024 to Dec 2024**

Were parents' perspective of their care sought?

Of the parents who were told that a review would take place, clinicians report that the parents' perspectives of their care was sought from 98%, the highest percentage since the inception of the PMRT. This ranged from 99% in England, 90% in Scotland, 88% in Wales and 99% in Northern Ireland. This has increased each year since the launch of the PMRT (Figure 3).

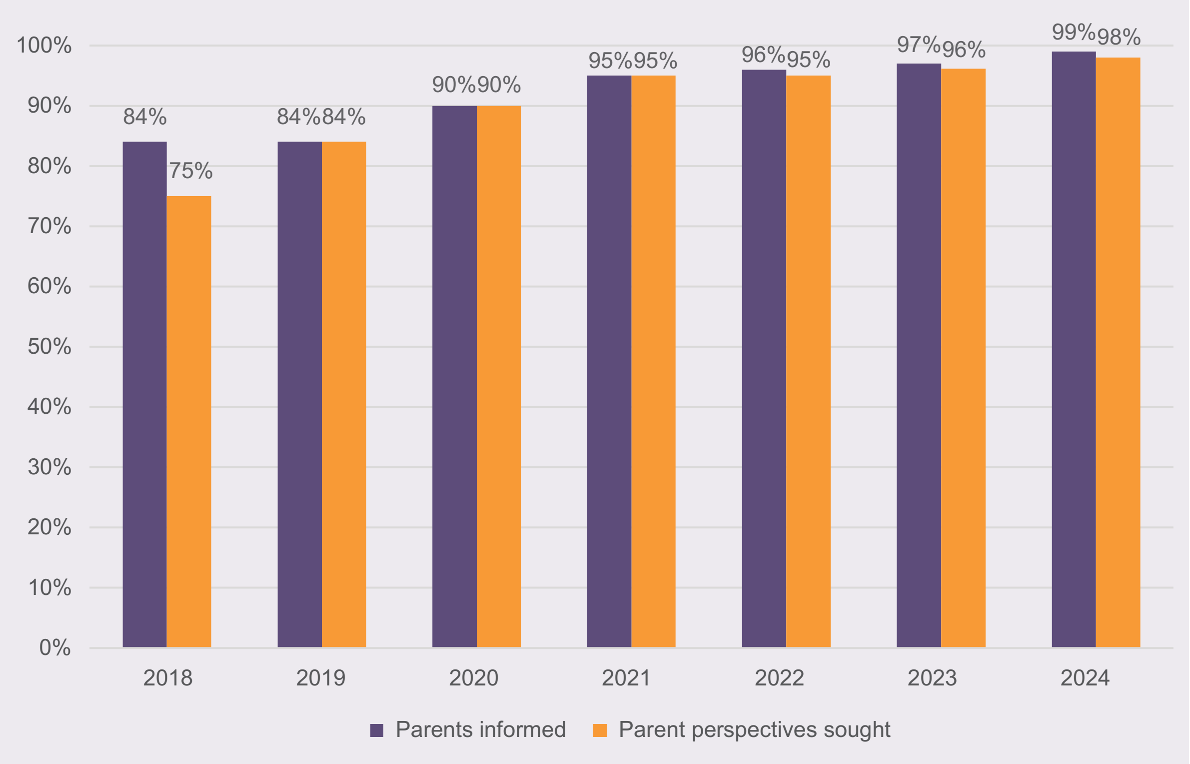


Figure 3: **Proportion of UK parents informed about the PMRT and their views sought over time, reviews completed 2018 to 2024**

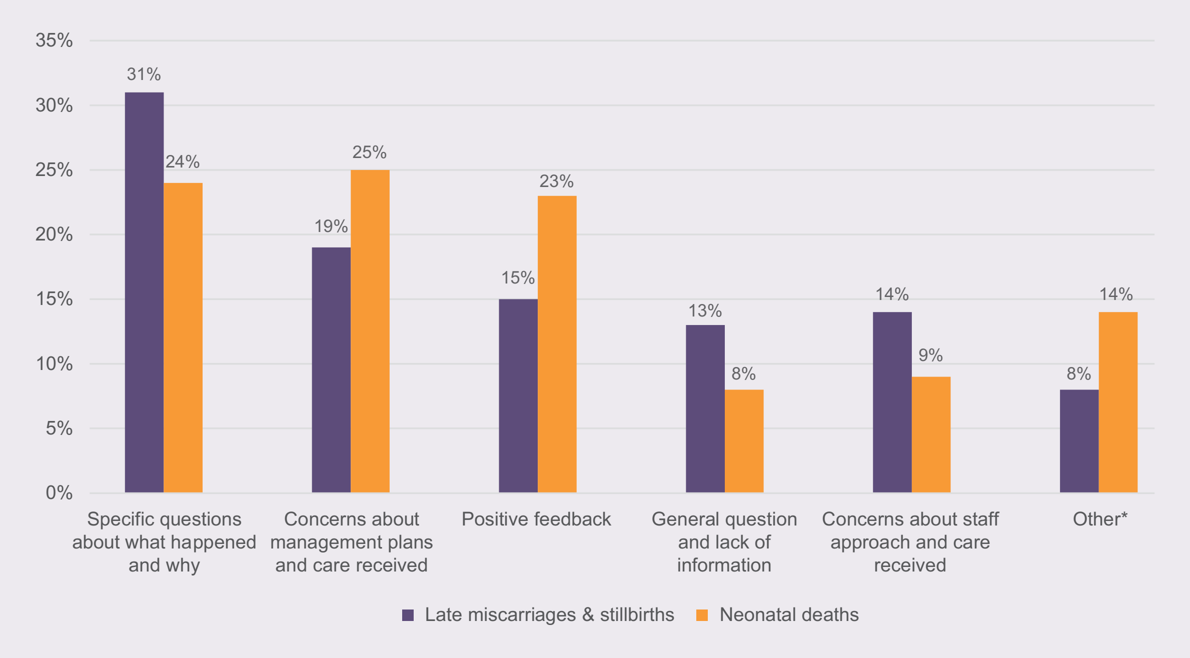
Did parents express their views?

From the information in the PMRT it is not possible to distinguish between different types of parent responses: from the notes included it is not always clear which parents had indicated they had no comments or questions; or that they believed there were no issues with the care they received but had been approached for comment; or that they never replied to requests for feedback, where the note recorded was, for example, 'no concerns' or 'no issues.' After cleaning the data by removing the comments which were unclear, the 'response' reduced from 97% to 56% in which 1,314 (32%) reviews had multiple parent comments. It is unclear why the percentage of parents providing feedback is relatively low, given that 98% were recorded as having been approached for feedback, although this may in part be as a result of the lack of clarity of the comments included in the PMRT.

As a consequence of this lack of clarity, and to improve reporting of parent engagement for 2026, the parent feedback sections of the PMRT are being modified.

Parental comments, feedback and concerns expressed

We analysed a random sample of 200 parent comments (Figure 4). It should be noted that the information about parents' questions and concerns comes from reporting in the PMRT by staff in trusts and health boards and not directly by the parents. See Table 2.2 in the Tables Report.



**Other – comments about procedures, administrative feedback and self-blame, guilt*

Figure 4: Comments, questions and concerns about care expressed by parents by type of death, reviews completed Jan 2024 to Dec 2024

The majority of questions from parents were about specific aspects of their care and why their baby had died (28%), for example, *“Should the baby have been delivered earlier?”*, *“Why did the hospital let me leave if my blood pressure was high?”* and *“Why wasn’t my pregnancy marked as high risk?”* Of note, these questions were reported more frequently for stillbirths or late miscarriages (31%) compared with neonatal deaths (24%).

Concerns about management plans and the care received were contributed by nearly a quarter of parents (22%), for example, *“Felt that there was a missed or late scan”, “Parents raised issues with fragmented antenatal care”* and *“Failure to listen to my concerns about having no fetal movement. I wasn’t offered and ultrasound, and there was an on-call doctor who could have been called as there was no doctor on the ward.”* This was the same proportion as in 2023.

Positive comments about treatment and support received were contributed by 18% of parents, for example, *“Doctors were not what I expected. They were so much better”, “We both really appreciate everything you’ve done for us and are so grateful”* and *“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.”* This is slightly lower than last year where 25% of comments sampled were positive.

Some parents asked very general questions about their care and had issues with communication, questioning why they were not given particular information that would have been relevant to their care (11%). For example, *“Why did this happen?”, “What happened to my baby”* and *“When I was cared for antenatally, I wasn’t given the information I required”*. These were reported more frequently when a late miscarriage or stillbirth had occurred (13%) compared with neonatal deaths (8%).

Overall, there were 12% of reports with concerns by parents about how staff approached them and how care was given. Specifically, there was an increase in reports of a lack of compassion from staff (6% compared with 3% last year) alongside a loss of control through not being listened to and feeling ignored

(6% compared with 2% last year). Some examples of these comments include *“We went with reduced fetal movement and we were worried but it felt like they were trying to dismiss it as nothing”, “I felt all the appointments were methodical. There was no rapport built, no TLC. Felt appointments were very rushed and very quick”* and *“on occasion our baby was referred to as ‘fetus’.”*

A range of other comments and questions (10% in total) related to procedural and administrative issues, such as parents having to wait for results. This year, only 1% of comments reflected questions about whether or not parents own behaviour was responsible for the outcome, for instance, *“Should I have still been going to work, lifting things, etc?”* and *“Should I have been told to take it easy? Should I have still been going to work?”*

4. Issues with care identified

Overall, in 94% of reviews at least one issue with care was identified (Table 3.1 Tables Report). In 36% of reviews at least one issue with care was identified relevant to the outcome for the baby; this is an increase from 30% in 2023.

In previous PMRT annual reports issues with care that were identified in reviews were presented solely as a proportion of the total number of reviews completed. This does, however, not give any indication of how often these issues occur in different trusts/health boards. For additional context this report also includes information about the prevalence of specific issues occurring at least once across trusts and health boards.

Preconception and antenatal care

Overall, in the 4,166 reviews a total of 5,902 issues with pre-conception and antenatal care were identified of which 1,464 (31%) of the issues were identified by the review panel as relevant to the outcome (see Table 3.2 in the Tables Report). The most common issues remain the same compared with the previous report and largely reflect the findings from earlier reports. These issues were also reported by the highest proportion of trusts/health boards compared with other issues. The five most common issues with pre-conception and antenatal care are shown in Figure 5.

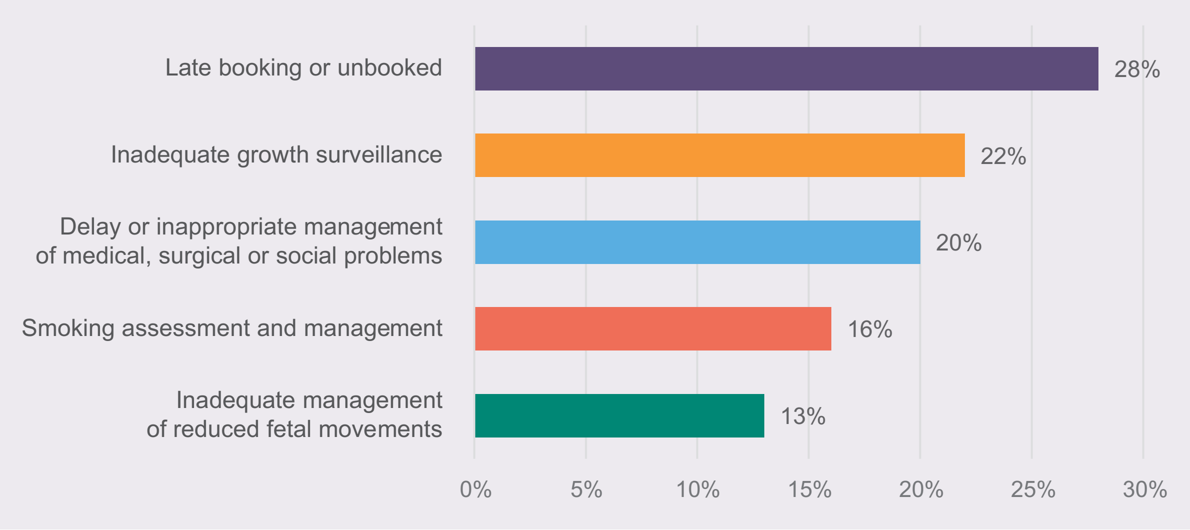


Figure 5: The five most common issues identified during pre-conception and antenatal care, reviews completed Jan 2024 to Dec 2024

The frequency with which the majority of these issues were identified was similar compared with the previous year.

Late booking or not having booked at all (28% of reviews) remains the most common issue identified at this stage of care (31% in 2023 and 27% in 2022) and the proportion of pregnancy outcomes for which this issue was relevant was similar at 13%, compared with 10% the previous year. Notably the proportion of reviews in which this issue was identified has increased from 15% in 2018-2019. Overall, 121 (80%) trusts/health boards identified this as an issue in at least one review.

Inadequate growth surveillance is the second most common issue of concern with antenatal care (22%). The proportion of reviews identifying this as an issue has been between a fifth and a quarter of all reviews since 2018. Overall, 126 (83%) trusts/health boards reported this as an issue in at least one review, placing this as the leading issue in terms of the number of trusts/health boards in which it was identified.

Delay in diagnosis or inadequate management of maternal medical, surgical or social problems is still one of the most frequently reported issues in this care period at 20% compared with 23% last year; this represents an increase since 2018 (10%). This issue was identified in at least one review by 119 (78%) trusts/health boards.

Smoking assessment and management issues have reduced substantially from 24% of reviews in 2023 to 16% in 2024. Furthermore, the proportion of reviews in which this was identified as an issue relevant to the pregnancy outcome has declined steadily since 2018 (13%) and was only reported to be the case in 3% of reviews in 2024. Nevertheless, in 117 (77%) of trusts/health board smoking assessment and management was identified as an issue in at least one review.

Inadequate investigation and management of reduced fetal movements was identified in 13% of reviews and as an issue in at least one review by 101 (66%) trusts/health boards; the proportion of reviews in which this was identified as an issue has remained effectively unchanged since 2018.

Of note the **assessment and management of the need for antenatal aspirin** has continued with a steady decrease affecting only 4% of reviews compared with 23% in 2018, although this was reported as an issue in at least one review by 72 (47%) of trusts/health boards.

Labour and birth

Overall, in the 4,166 reviews a total of 3,159 issues with labour and birth were identified, of which 1,059 (34%) of the issues were identified by the review panel as relevant to the outcome (see Table 3.3 in the Tables Report).

The five most common issues with care identified during labour and birth reflect the findings from earlier reports with the proportions affected essentially unchanged since 2020. See Figure 6 for data from 2022 to 2024.

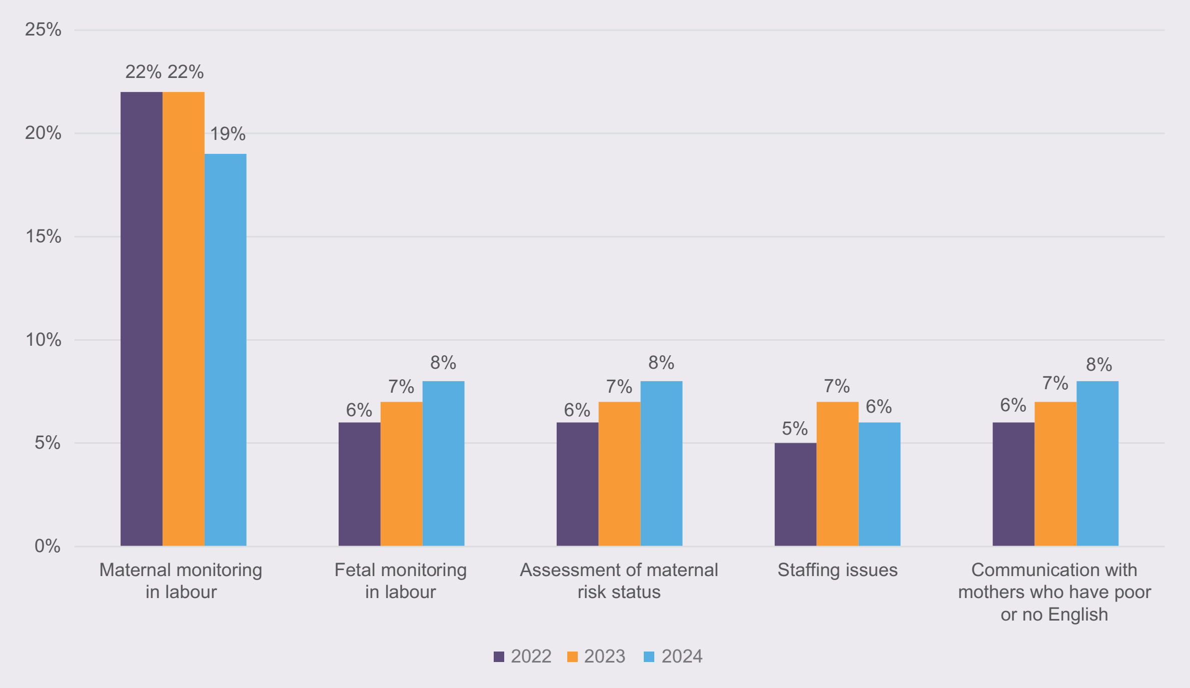


Figure 6: **The five most common issues with care identified during labour and birth care, reviews completed Mar 2022 to Dec 2024**

Maternal monitoring in labour remains the most common issues with care during labour and birth (19%). Issues with maternal monitoring in labour were identified by 126 (83%) of trusts/health boards in at least one review.

The remaining four most common issues were reported in largely the same proportion of reviews with no evidence of improvement over time. These were the assessment of maternal risk status (8%), fetal monitoring in labour (8%), staffing issues (6%) and maternal communication (8%).

Neonatal care

Overall, for the 4,166 reviews there were in total 2,863 issues with care of the newborn baby, of which 660 (23%) were identified as relevant to the outcome of the baby (see Table 3.4 in the Tables Report). The five most common issues found during the neonatal period of care are shown in Figure 7.

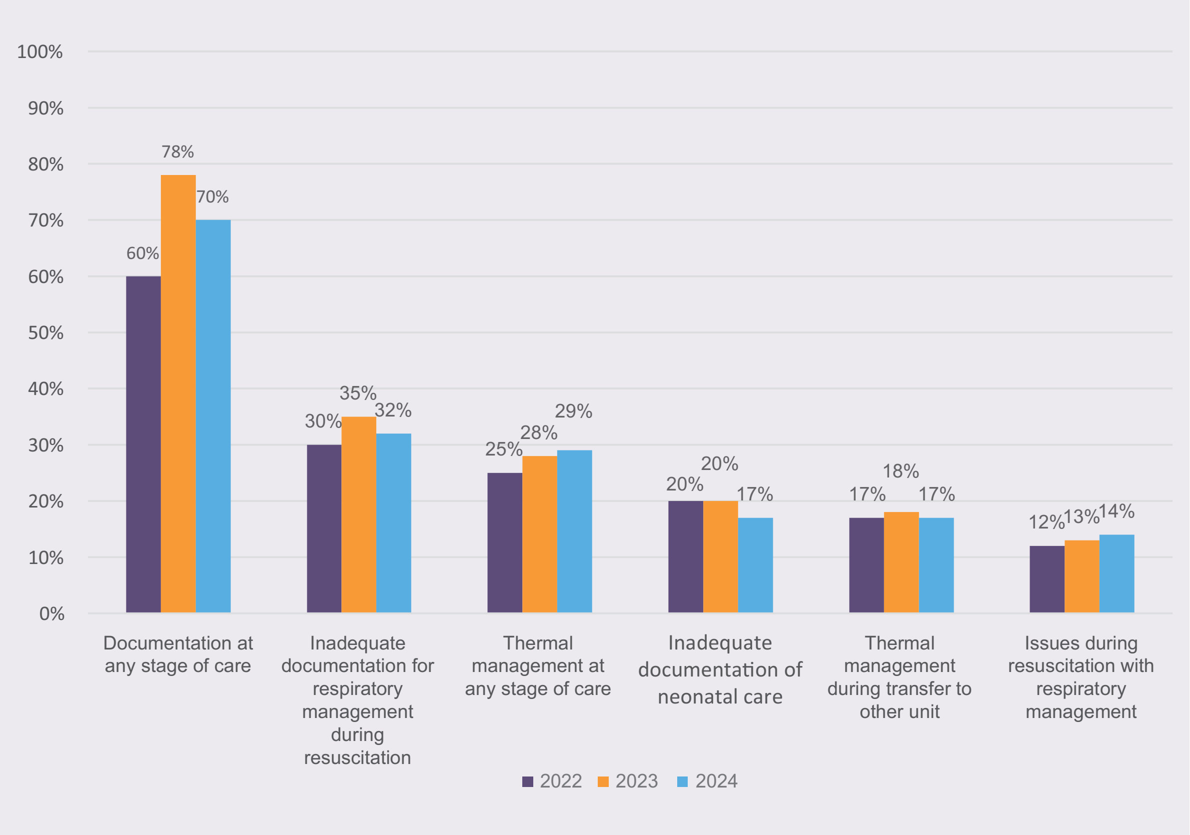


Figure 7: The six most common issues with care (excluding end of life care) identified during neonatal care, reviews completed Mar 2022 to Dec 2024

Issues found during the neonatal care period again reflect those found in recent PMRT reports, with a small reduction in problems with documentation at any stage of care; and 17% of issues with documentation overall were recorded as relevant to the outcome. Inadequate documentation of respiratory management during resuscitation and during neonatal care also remain essentially unchanged over recent years.

Thermal management at any stage of care was again identified as one of the six most common issues with a general upward trend over time. There has been a notable increasing frequency in issues with thermal management at any stage during neonatal care, with this identified more commonly from 2018 (18%) to 2024 (29%), and often being relevant to the outcome (17% in 2018 and 23% in 2024) (see Table 3.4 Tables Report). Issues with thermal management were reported by 38 (21%) trusts/health boards.

Issues with end-of-life care, postnatal investigations and bereavement care

The most common issue found during end-of-life care was the lack of discussion about a post-mortem before the baby's death (14%) although this percentage has remained effectively unchanged since 2018 (see Table 3.5 Tables Report). Not discussing organ donation before the baby's death has reduced marginally in recent years, and inadequate documentation has nearly halved in frequency in recent years (Figure 8). Issues with poor documentation regarding end-of-life care were found in at least one review by 40 (26%) trusts/health boards.

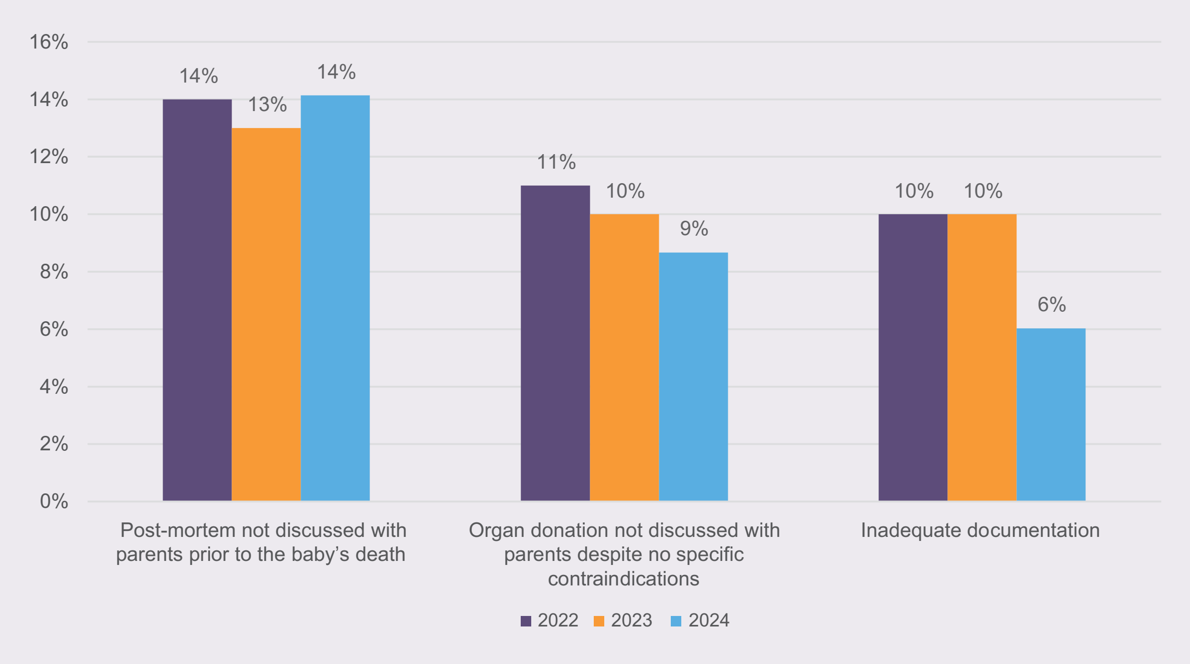


Figure 8: **The three most common issues with care identified during end of life care, reviews completed Mar 2022 to Dec 2024**

The need to transfer the baby for post-mortem remains the most common issue recorded during postnatal investigations being reported in 22% of reviews and by 125 trusts/health boards (82%) (Figure 9) (Table 3.6 Tables Report). Other issues recorded have also remained effectively unchanged with placental histology being carried out by someone other than a perinatal/paediatric pathologist identified in 6% of reviews, see Table 3.6 in the Tables Report.

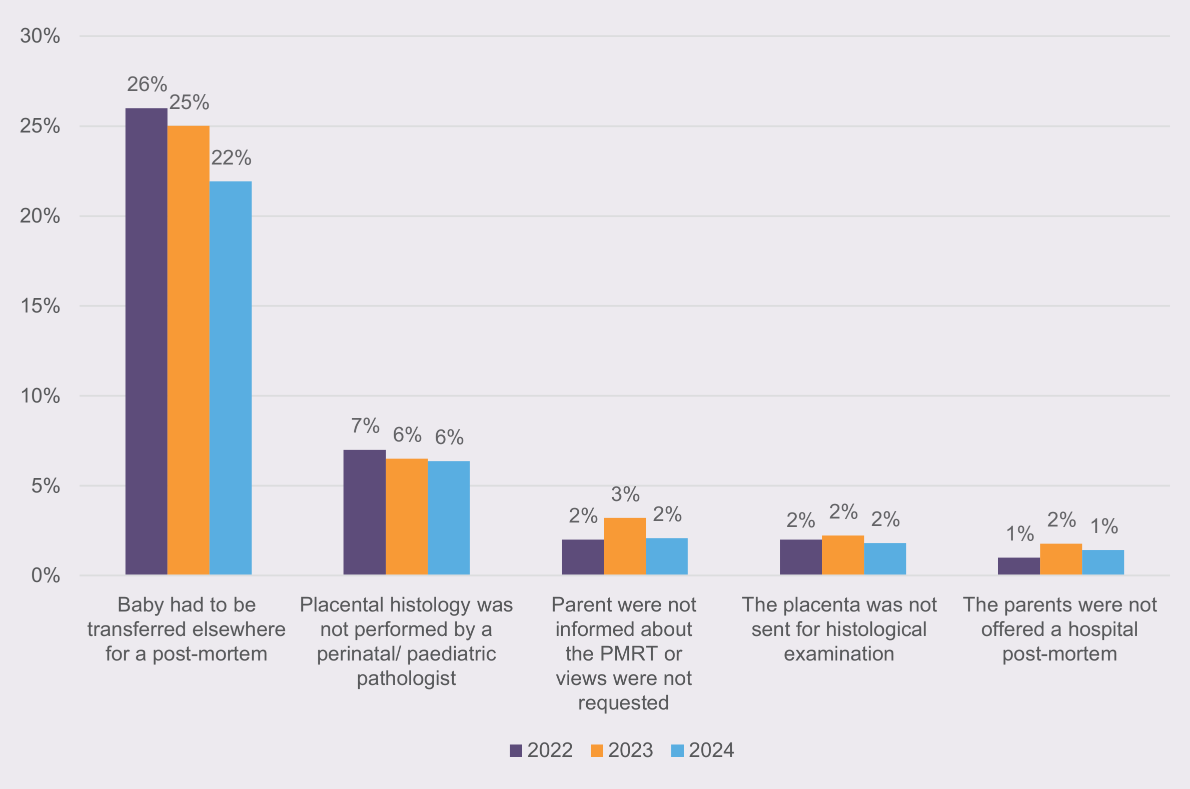


Figure 9: **The five most common issues identified with postnatal care and investigations, reviews completed Mar 2022 to Dec 2024**

The most common issues identified during bereavement care also reflect those found in previous years. However, inadequate documentation regarding transfer to mortuary care or regarding access to a cold cot have both reduced from 5% in 2022, to 4% in 2023 to 3% in 2024 and are no longer in the list of the most commonly reported issues (see Table 3.7 Tables Report). Poor quality of bereavement care and the absence of a bereavement checklist in the notes continue to affect a small proportion of reviews: 4% of reviews in 2024 compared with 3% in 2022 (Figure 10).

The absence of a policy, support or practical help to take the baby home and inadequate documentation regarding this have both decreased in frequency over time from 2018 (24%) to 2024 (16%) for the former and from 18% (2018) to 8% (2024) for the latter; although they are still the most commonly reported issues with bereavement care. Absence of a policy was reported to be an issue in at least one review in 79 (52%) trusts/health boards and inadequate documentation was evident in 85 (56%).

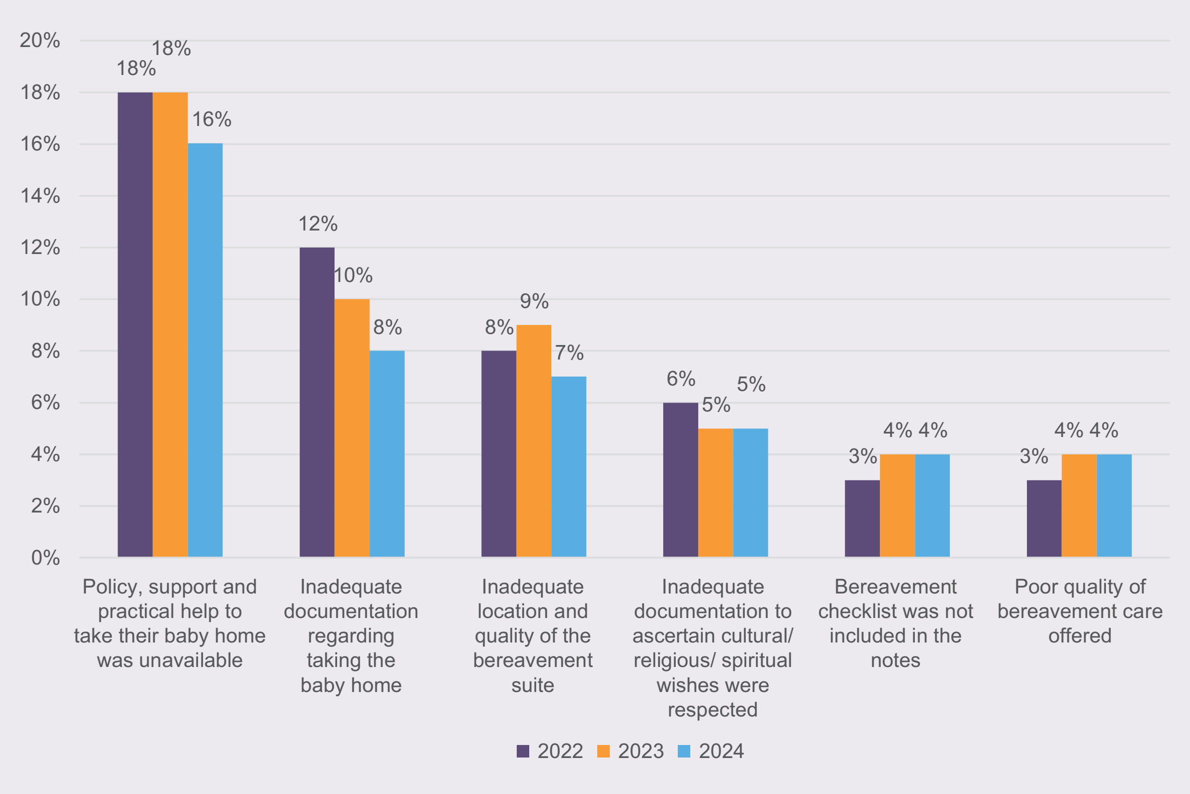


Figure 10: The six most common issues identified with bereavement care, reviews completed Mar 2022 to Dec 2024

Inadequate location and quality of the bereavement suite has reduced marginally from 9% of reviews in 2018 to 7% of reviews in 2024 respectively. However, this is difficult to assess fully due to inadequate documentation being available, particularly regarding the location and quality of the bereavement suite and whether cultural, religious or spiritual wishes have been respected. Overall, 73 (48%) of trusts/health boards had at least one review in which the location and quality of the bereavement suite was identified as inadequate.

The National Bereavement Care Pathway (NBCP) identifies nine standards for good bereavement care (Figure 11). These provide the basis for establishing high quality bereavement care services and can be used to audit local services. More information is available on the *NBCP website*.

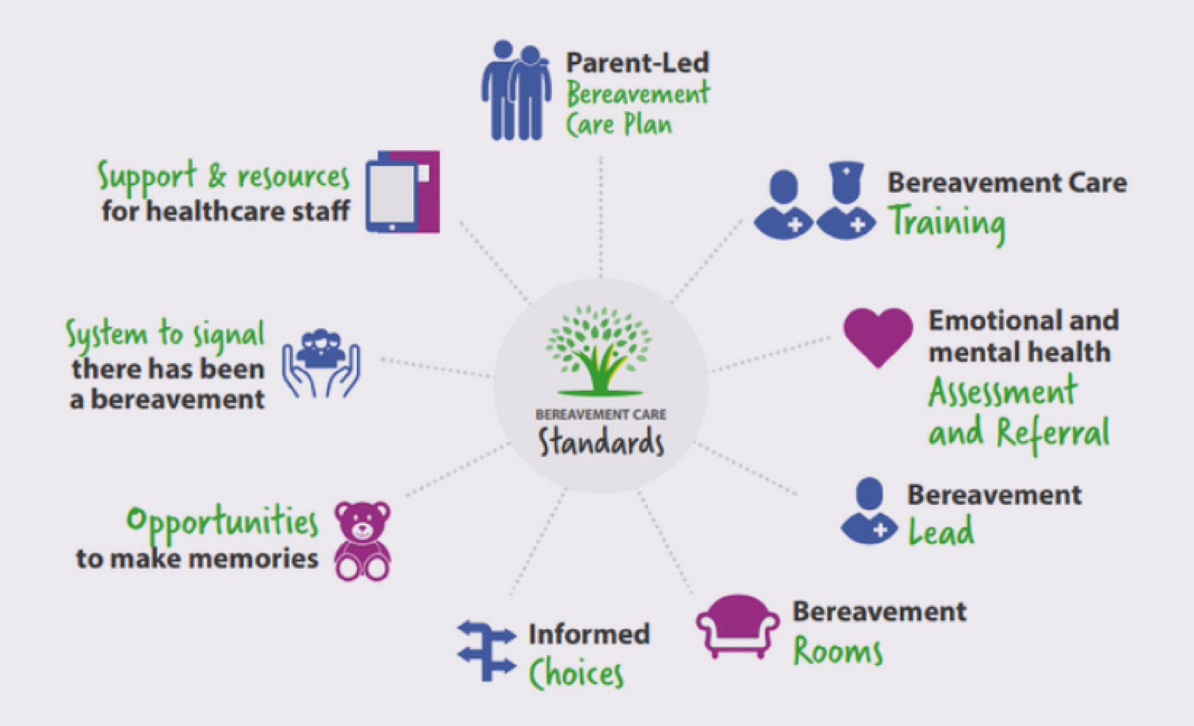


Figure 11: National Bereavement Care Pathway: Standards for good bereavement care

5. Grading of Care

Every review concludes with the team grading the overall care at each stage of the care pathway, including bereavement care. This grade offers a complete, holistic picture, indicating how significant an impact potential care improvements could have had on the outcome (Figure 12) (Tables 4.1 to 4.6 Tables Report). The 'outcome' here refers to the death of the baby and to the psychosocial outcomes for parents.

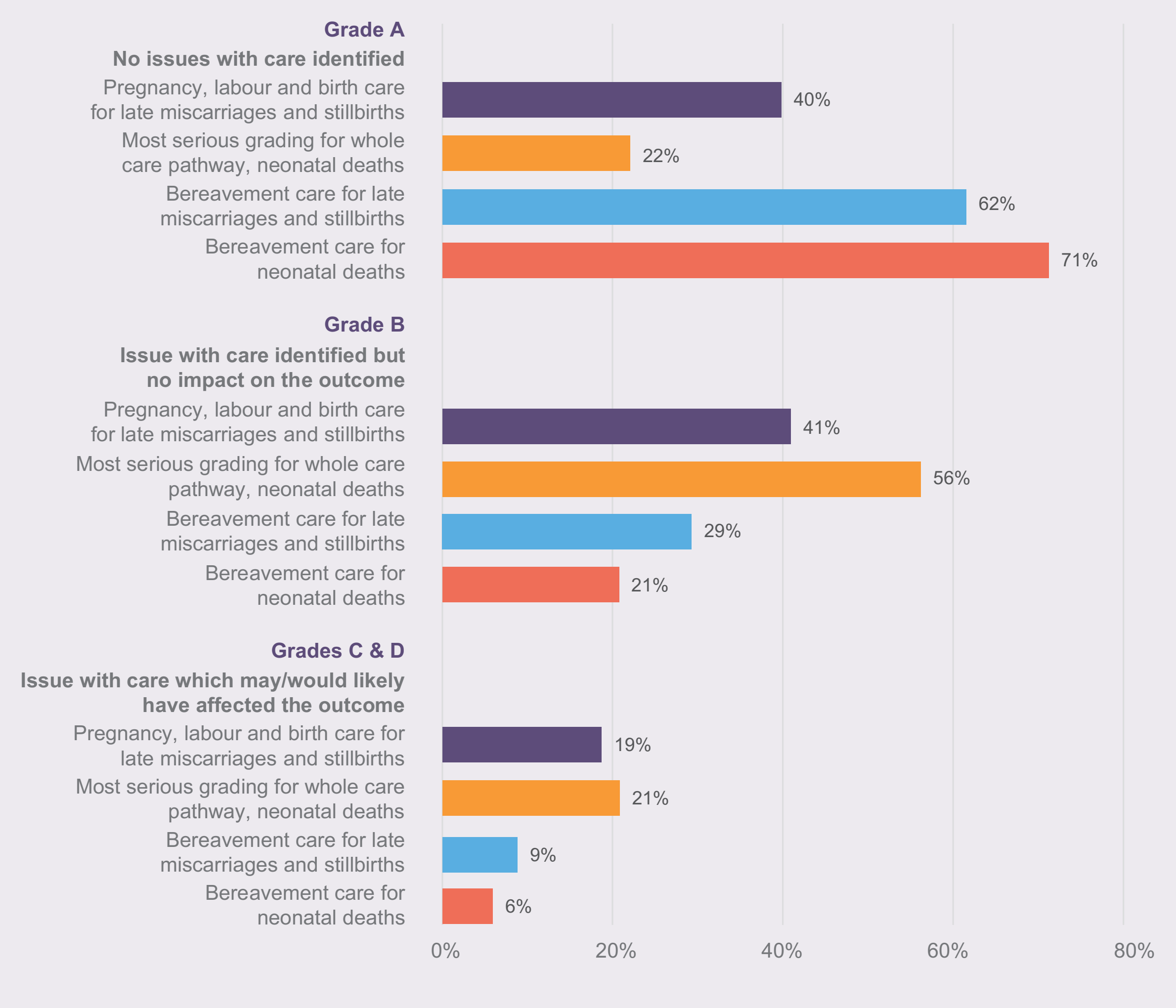


Figure 12: Grading of care by stage of care, reviews completed Jan 2024 to Dec 2024

There had been a steady decrease in the proportion of reviews of pregnancy and labour care for late miscarriages and stillbirths where the care has been graded as A (no issues with care identified) (Table 4.1 Tables Report). This has now remained around 40% since 2022 having been 50% in the 2021-22 annual report and 62% in the first annual report. This change is largely accounted for by a commensurate increase in reviews with care graded as B (issues with care that would have made no difference to the outcome for the baby). The proportion of reviews graded as C (issues with care which may have made a difference to the outcome for the baby) or D (issues which care with were likely to have made a difference to the outcome for the baby) have remained around 18% to 20% since 2021.

The number of reviews graded as A for the whole pathway of care for babies who died in the neonatal period has decreased in 2024, now reported for 22% of reviews compared with 30% in 2023 and 46% in 2018 (Table 4.4 Tables Report). This coincides with the increase of cases graded as B, now 56% compared with 50% in 2023 and 42% in 2018, and those graded as C & D, now 21% compared with 19% in 2023 and 9% in 2018.

The grading of bereavement care for all babies has remained stable since 2022 (Tables 4.5 and 4.6 Tables Report). The grading percentages for bereavement care of miscarriages and stillbirths in 2024 were essentially the same as in 2023 (A 62%; B 29%; C&D 9%) and with the percentages for bereavement care for neonatal deaths again essentially the same as in 2023 (A: 71%, B: 21% and C&D: 6%).

Impact of external members of review panels on the grading of care

The proportion of reviews panels with at least one external member present has continued to increase. In 2024, 53% of all reviews had an external member as part of the MDT panel, compared with 51% in 2023 and 45% in 2022. The presence of an external reviewer has been consistently associated with a slight redistribution of care grades. Specifically, a greater proportion of reviews receive C or D gradings, while fewer are graded A (Figure 13). Notably, when an external reviewer was present, the proportion of late miscarriages and stillbirths graded as A for care during pregnancy, labour and birth was 5% lower: 35% with vs 40% without an external reviewer.

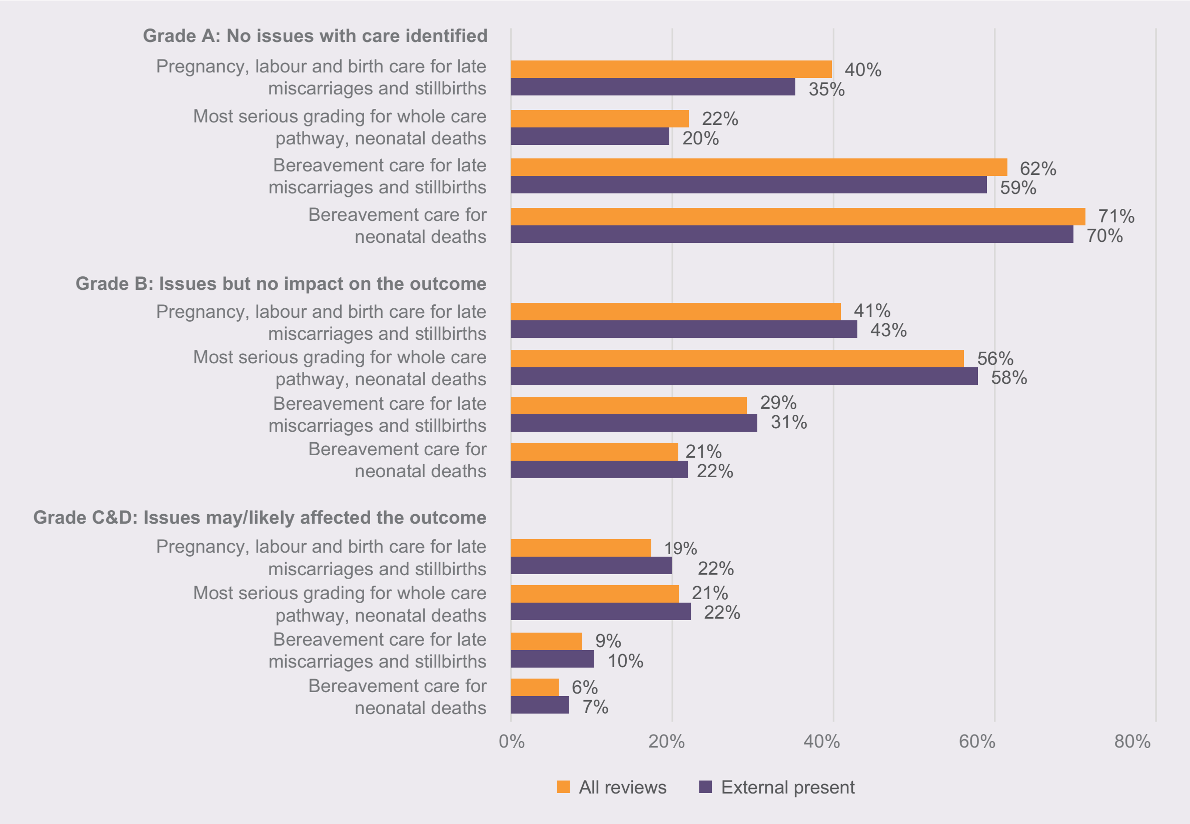


Figure 13: **Grading by stage of care all reviews or with an external member present, reviews completed Jan 2024 to Dec 2024**

6. The review teams

Multidisciplinary review panels

Conducting a high-quality review is a multidisciplinary activity. It is essential that the teams of professionals undertaking PMRT reviews reflect the breadth of multidisciplinary teams who provide maternity and neonatal care, and that these teams comprise appropriate professionals for the care being reviewed. A panel with only a few members of staff is highly unlikely to be able to appropriately and objectively assess all aspects of the care provided and therefore develop recommendations for improvements in care. See Appendix A - Recommended composition of review teams and roles, for details about the professional roles of PMRT panels.

There has been a steady improvement over time in the composition of the review teams, which are now more multidisciplinary than in previous years (Table 5.1 Tables Report). This is reflected in the median number of staff present for reviews, which has increased from five in 2018 to 10 in 2024 for deaths overall, and the number of reviews with a larger number of individuals present. In 2024, 67% of reviews had eight or more members at the MDT meeting compared with only 13% in 2018.

In 2024, 7% of reviews comprised three or fewer individuals, a reduction from previous years where this was 11% in 2023 and which began as 35% when the PMRT was launched in 2018.

Improvements in the multidisciplinary nature of review teams is further illustrated by PMRT reviews having a wider range of staff from various roles present (Figure 14) (Table 5.2 Tables Report). For example, the proportion of reviews with a neonatal nurse present for a neonatal death review has increased from 24% in 2018, to 55% in 2023, and to 63% in 2024. This trend is evident for all staff roles.

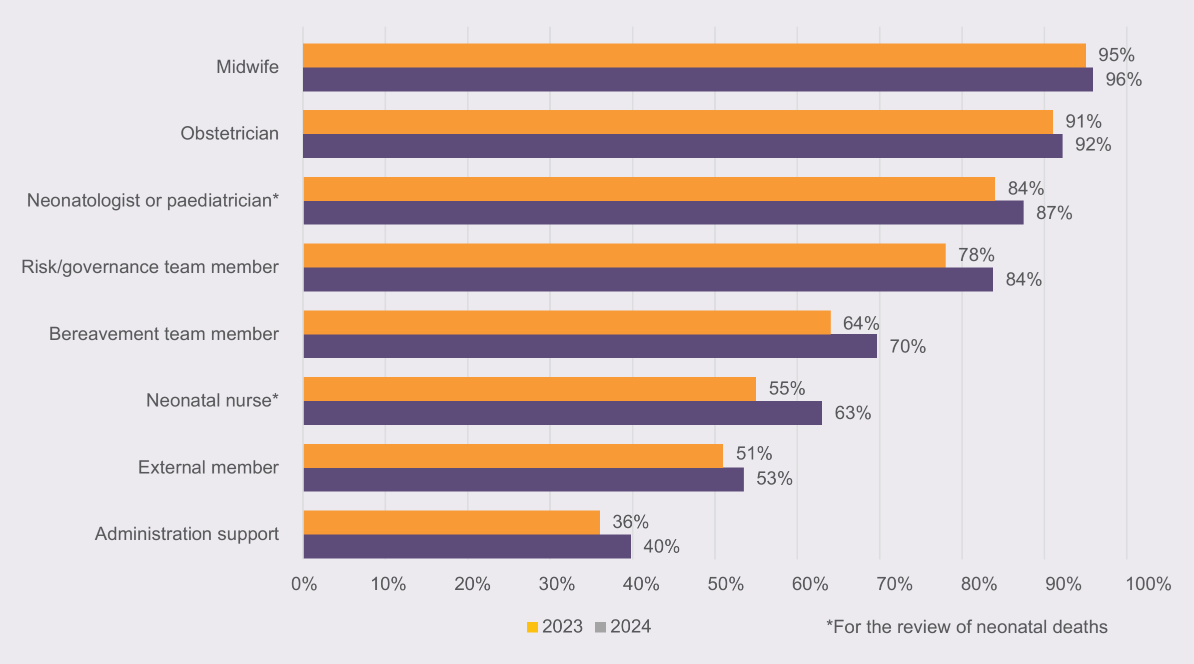


Figure 14: Proportion of reviews with specific professionals present for the review, reviews completed Jan 2023 to Dec 2024

Having a neonatologist or paediatrician present for reviews of neonatal deaths has increased from 84% in 2023 to 87% in 2024 representing a significant increase from 59% in 2018.

Having administrative support ensures that all of the relevant information is available for the review team at the review meeting, essential for conducting high quality reviews in a timely and efficient way. The proportion of reviews undertaken with administrative support increased to 40% compared with 36% in 2023.

The presence of members of the risk and governance team is important to ensure that learning from reviews is translated into actions, which are implemented and subsequently audited. These team members were present for of the majority of reviews, increasing from 78% in 2023 to 84% in 2024.

Proportion of reviews including external reviewers

Ideally, all reviews should involve an external panel member who is there to provide a ‘fresh pair of eyes’ and independent challenge to ensure the review is as objective as possible. In England as part of Safety Action 1 of the Maternity Incentive Scheme for 2025 there is a requirement for at least 50% of reviews to include an external member. Guidance about the inclusion of an external panel member is given in Appendix A.

External panel member(s) should be relevant senior clinician(s) who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage. Ideally, the external reviewer(s) should be the specialist(s) relevant to the care provided, for instance an obstetrician, or a neonatal nurse or neonatologist for neonatal deaths. The external reviewer could be, for example, a member of another trust/health board governance team. However, they must possess relevant clinical knowledge, be up-to-date with training and continuing professional development (CPD), and either currently undertake clinical shifts or be in a position to do so if required. This is crucial because externality demands clinical credibility, requiring the experience and current knowledge necessary to reflect on care provision and offer authoritative, robust, objective challenge.

The proportion of reviews benefiting from the presence of an external member of the review team has increased steadily since the PMRT was launched in 2018 (9%), to 51% in 2023 and 53% in 2024 (see Figure 15).

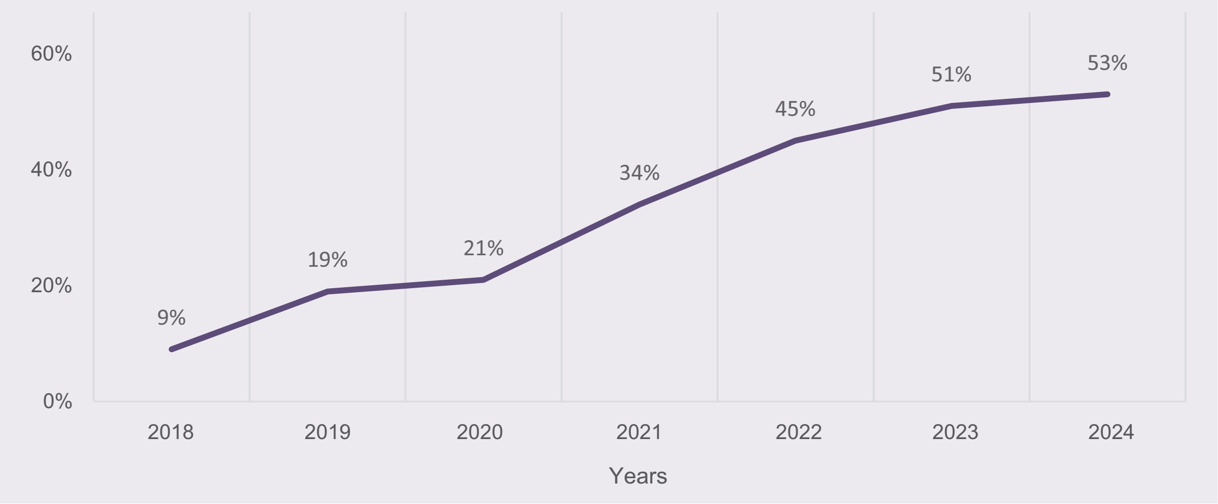


Figure 15: **Proportion of reviews with external reviewers present for the review, reviews completed Jan 2018 to Dec 2024**

There is anecdotal evidence that PMRT users have not always recorded the details of external reviewers correctly. Therefore, it is possible that a higher proportion of MDT review panel meetings include an external member than reported here. To ensure that external members of the review panel are identified as such the ‘participant’ feature in the PMRT system was modified in November 2024 so that the presence of an external member can now be more clearly identified and information about their professional role can also be clearly recorded.

7. Action plans

At the end of each review, where any issues with care have been identified, each issue should be examined in turn to enable the review team to agree if:

1. The issue was likely to have been relevant or not to the outcome for the mother and baby.
2. Whether the issue requires action to improve future care for all mothers and babies, regardless of the relevance for the particular mother and baby.

For example, screening for gestational diabetes may have been indicated but not carried out and the baby died from an unrelated cause. Whilst this omission in care was not relevant to the particular baby’s death, the reasons for the omission nevertheless need to be investigated and systems put in place to ensure that all eligible women are screened in future.

Over the course of the 4,166 reviews completed, 9,764 separate actions were recorded. This represents an average of just over two actions per review, although not all reviews resulted in an action plan and some had more than two actions identified.

The strength of actions

Action plans can be categorised as “weak”, “intermediate” or “strong”. Where possible, action plans should be “strong”. This means that the reliance on individuals to carry out the correct action is removed,[1] for example, by implementing a system-level, automated process that no longer requires individuals to remember the correct action in the particular circumstances. Strong actions use standardisation and permanent physical or digital designs to eliminate human error and are sometimes referred to as ‘forcing actions’ (see Appendix C - Action plan strength for further information). Action strength is illustrated with examples in Figure 16.

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[1] US Department of Veterans Affairs. Root Cause Analysis Tools. VA National Center for Patient Safety.REV.02.26.2015.(Pgs26-29) RCA Step by Step Guide REV 07.01.2016 (va.gov)

	Issues	Actions
Strong actions	This mother and her partner could not be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available.	Redevelopment of a designated bereavement room is currently in development and has been added to the risk register.
Intermediate actions	This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed.	The aspirin guidance has been updated and the ambiguity removed. This is both within Badgernet and the guideline.
Weak actions	There were concerns about the baby's growth rate but these were not investigated and acted upon appropriately.	Email sent to all staff and update via risk update email.

Figure 16: The strength of actions associated with illustrative examples from reviews completed Jan 2024 to Dec 2024

A random sample of 100 action plans were coded by action strength (Figure 17).

Figure 17: Strength of actions in random samples of 100 action plans per year, reviews completed Mar 2022 to Dec 2024

Figure 17 illustrates that based on a random sample of 100 actions plans the proportion of strong or intermediate actions has remained essentially unchanged since 2022.

8. PMRT developments

Training

We have been providing free online training courses since the beginning of 2024 and provided four live, online courses for staff in units to support all aspects of the use of the PMRT to carry out reviews. In 2024 we provided this training to 146 PMRT users.

To address the high demand for our PMRT training course and the challenges busy clinical staff face in attending live sessions, in April 2025, we launched an online, on-demand, training course. It offers the same content as our live online course. Experts in each field deliver recorded presentations. Course participants are *able to register* and complete this free on demand online course at their own pace, at a time most suitable to them and are able to re-review materials whenever they choose. The course covers:

- the background to PMRT development;
- the PMRT in the current landscape of perinatal reviews;
- the importance of parental engagement and putting parents at the centre of the review process;
- optimising the use of the PMRT software;
- multi-disciplinary review panels;
- the role of the panel members and being open to constructive self-reflection;
- feeding back to parents;
- generating action plans;
- using review outputs to leverage service quality improvements.

Experts in each field deliver the recorded presentations. As part of the course, we convene quarterly question and answer sessions with presenters to discuss the presentations, any areas of concern and provide advice to attendees. These also act as a forum for discussions between PMRT users who have completed the training to share advice on all matters PMRT-related.

At the time of writing this report (September, 2025), nearly 300 people have registered for the new online course.

Reducing the duplication of notifications of perinatal deaths (England)

For some time, we have been working to integrate the separate neonatal deaths notifications for Child Death Overview Panels (CDOPs) and the National Child Mortality Database (NCMD) in England into the MBRRACE-UK/PMRT platform’s death notification process. Originally, we had planned that along with the notification of the death the information from the completed PMRT review would also be forwarded. This would meet the information requirements of both the CDOP and NCMD. However, following the phase 1 roll out to a small number of volunteer trusts and CDOPs we identified a substantial number of development requirements, which are needed before the full integration can proceed for all trusts and CDOPs. In the meantime, we launched the Cascade system in January 2025. When a neonatal death is notified to MBRRACE-UK the information is automatically forwarded through Cascade to the appropriate CDOP and then to the NCMD. Thus, the duplicated activity of notifying all neonatal deaths to MBRRACE-UK and separately notifying the same deaths to the local CDOP has now stopped; the information in a single notification made to MBRRACE-UK now flows directly to the relevant CDOP and then to the NCMD.

We have also been working on the integration with the Submit Perinatal Event Notification (SPEN) portal being developed by NHS England. When fully launched this will enable a single notification of a perinatal or maternal death to be sent to relevant national organisations including MBRRACE-UK/ PMRT (from where Cascade will continue to forward the data to CDOPs and the NCMD), NHS Resolution Early Notifications, and the Maternity and Newborn Safety Investigation programme (MNSI formerly known as HSIB). A phased launch of SPEN was initiated at the beginning of September 2025 and is planned for completion in November. SPEN is operational only in England.

9. Conclusions and recommendations

When a baby has died a high-quality review of care is essential to enable parents to understand why their baby died, what happened with their care and, whether with different care, the outcome for them and their baby may have been different. Critically, high-quality reviews need to be conducted to identify where service improvements are required to improve care for all mothers and babies, to prevent future deaths and to improve care when a death has occurred.

Audit and review are part of routine maternity and neonatal care; these are not optional extras. It is therefore reassuring to see that for the vast majority of baby deaths in 2024 a review using the PMRT was started (97%) and for 84% the review was completed and the final report generated. Although there is variation by country, this represents a major improvement since the launch of the PMRT in 2018, particularly in England, where the Maternity Incentive Scheme (MIS) has doubtless provided an impetus to the PMRT activities in trusts.

Parent engagements with reviews

Providing understanding for bereaved parents about their baby's death and answers to any questions they may have about their care is the primary purpose of conducting a review. This can only be achieved by engaging with parents, so they are aware that a review will take place, what this means, what the review is intended to achieve, and to ask if they have any questions or concerns, they wish to be addressed during the review. The latter is so that at the feedback stage, once the review is complete, the parents' questions will have been answered. This requires a straightforward, trauma-informed, verbal explanation of the review process, in a language parents can understand, supported by 'plain language' parent-facing written information. Communication with parents should remain open so they can ask further questions as they arise and so that parents know what is happening with their review. 'Parent Engagement' materials developed by the PMRT collaboration were recently updated with the involvement of bereaved parents and clinical staff, and are available on the *PMRT website*. The intention is that these materials can be modified by trusts/health boards to suit their specific processes. It is vital that parent engagement is done well to avoid additional trauma and adding to the distress of bereaved parents.

PMRT data indicates that 99% of parents were told that a review would take place and 98% of parents were reported as having been invited to provide questions and comments about their care. These figures contrast with the findings from a *Sands online survey* of parents who were bereaved in 2021-2023 where only 78% of parents who responded indicated that they were aware that a review would be carried out and only 64% were given the opportunity to share their concerns and questions. The findings suggest that when parents are provided with information about the PMRT review process they don't always understand what this means. Some did not recall having been given information and only reallising that a review had taken place once they were presented with the findings. Bereaved parents reported needing multiple opportunities to understand what having a review means and to be able to ask questions and provide comments on more than one occasion, whether this is before the review process starts or when the process is underway.

Good engagement with parents and families is essential for their wellbeing and it also improves the quality of their review from which they will benefit directly. What effective parent engagement looks like is highlighted in several sessions in the *PMRT on-line training programme* which is freely available to all staff involved in reviews. Sands provide training and resources to *support clinical staff* having discussions with parents about reviews. They also provide *guidance for parents* to support them in raising concerns and to help them understand the various review processes, including the PMRT review, which may occur when their baby has died.

When parents have provided feedback, some continue to report communication issues, lack of compassion and not being listened to. These concerning points reflect findings in major national investigations including in *Swansea*. The majority of parents who have questions asked either specific or general questions about their care or the reason for the death of their baby. Just less than a fifth provided positive comments about their care and the staff caring for them; whilst this is encouraging it is a slightly lower proportion than the quarter in 2023. Communication with parents needs to be an ongoing process, it is not an event, and continuing communication is important for many parents.

The issues with care identified

At least one care issue was identified in 94% of reviews. In 36% of reviews, at least one issue was identified and judged by the review teams to have been relevant to the outcome, an increase from 30% in the 2023 report. It cannot be determined from the available information whether this reflects a decline in the quality of care, an increase in robust, objective reflections during the review process, or a combination of the two. Hopefully, this largely represents more robust, objective reviews being conducted.

In this years' report, alongside presenting the issues identified by completed reviews, information about the proportion of trust/health board level identifying specific issues is also provided for particular issues with care found in at least one review. This helps to identify whether issues are widespread or affect a small number of organisations. In the future we will be able to assess over time whether particular issues are being dealt with at an organisational level.

The issues with care identified in this report are largely focused around the same areas as in previous reports. For antenatal care these include mothers booking late or arriving in labour unbooked; delayed or inappropriate management of maternal medical, surgical or social problems, inadequate surveillance of fetal growth; and inadequate assessment and management of reduced fetal movements. During labour and birth maternal monitoring in labour was the most common issue identified; with fetal monitoring, assessment of maternal risk status, and staffing issues also identified in a smaller but important proportion of reviews. Once the baby had been born the main issues with care identified were thermal and respiratory management; and the quality of documentation. In particular the issues with neonatal care mirror those identified in national investigations and reviews, for example, the former *Cwm Taf University Health Board*.

With the notable exceptions of the assessment and management of antenatal smoking, assessment and management of the need for antenatal aspirin and thermal management of the baby, these issues have continued to affect roughly the same proportion of reviews over recent years. There has been a welcome improvement in the assessment and management of smoking and need for aspirin, but there has been a small but sustained increase in the identification of thermal management of the baby as an issue. In the quality improvement survey conducted in 2024 several innovative approaches to smoking and aspirin assessment and management were described. Such approaches may have contributed to the decrease in the identification of this as an issue. Whereas the QI approaches to neonatal thermal management described in the survey do not seem to have had the same sustained effect.

The issues identified in this national report should therefore remain a focus of service improvement activities helping to prioritise them. In England, for example this will include the full implementation of the Saving Babies Lives Care Bundle (SBLCB) version 3.

Although the PMRT data available does not allow us to determine the reason for the almost doubling in frequency of late booking or arriving in labour unbooked compared with 2018, anecdotal evidence suggests that for a proportion of mothers, late booking is attributable to relocating during pregnancy and having to re-book at a new hospital. The dispersal of asylum seekers may have been a contributing factor, although it would be speculative to conclude that it accounts for most of the change over time.

The proportion of reviews identifying assessment and management of the need for antenatal aspirin as an issue has continued the welcome downward trajectory. Whilst there is not incontrovertible evidence, the impact of the Saving Babies Live Care Bundle and *QI activities reported* as a consequence of PMRT findings are likely to have contributed to this decrease in England.

The single most common issue with investigations carried out after the baby has died continues to be the need for babies to be transferred to another hospital for a post-mortem examination when one was requested. The proportion of reviews where this was mentioned has remained unchanged at around 25% since 2020; this proportion would be greater if only those deaths where a post-mortem was requested were used as the denominator. This issue was identified in at least one review in over four fifths of trusts and health boards confirming the widespread nature of this problem. The need for transfer relates to access to specialist perinatal pathology services, which are largely centralised due to the small number of pathologists with these skills now available. Transfer may be distressing for parents and, whilst this should not necessarily be the case, anecdotal reports suggest that the need for transfer can lengthen their wait for their review findings. Remaining in contact with parents to keep them updated as they wait may alleviate some of this distress.

The inadequate location and quality of the bereavement suite continues to be highlighted in a slightly smaller proportion of reviews in 2024. However, whilst we cannot compare this across previous PMRT annual reports, it was disappointing to see that this issue was identified in half of trusts/health boards. Whilst appreciating that the improvements will require physical changes to buildings, inadequate bereavement facilities can have a profound effect on parents' bereavement experience.

Some parents may wish to take their baby home prior to the funeral, and others may not. Whatever decisions parents ultimately make, they have the right to make an informed choice and may need help in deciding what to do. Support and practical help were not available for 16% of parents and this was an issue identified in at least one review in 63% of trusts/health boards. Importantly, the ability of PMRT review teams to review the quality of bereavement care was adversely affected by not being able to access bereavement care notes which anecdotally appear to be located separately from the general maternity notes in many places.

Grading of care

Over time there has been a small but steady decline in the proportion of reviews where the care was graded as A, (‘no issues with care identified’) with a commensurate increase in the proportion assigned grade B (‘issues that would have made no difference to the outcome). Given the extent of care assessed in the majority of deaths and that at least one issue with care was identified in 94% of reviews it is somewhat surprising that care was graded as A in so many reviews. With an increasingly self-critical approach in the review of the care provided, more reviews having an external member present, as well as organisations seeking to improve future care a more stringent approach to grading would be expected.

The care in about 20% of reviews was graded C (‘issues which may have made a difference to the outcome’) or D (‘issues which were likely to have made a differ¬ence to the outcome’). This has doubled from 2018 when only about 10% of reviews were assigned these grades. However, there still remains a discrepancy between the holistic overall grading and the finding that review teams judged at least one issue to be relevant to the outcome in 36% of all reviews.

In previous years, the presence of an external professional as a member of the MDT panel was associated with a change in the distribution of grades with a greater proportion of B, C, and D grades. The continuation of this trend demonstrates the added value external member contribute, alongside the reassurance that their independence offers parents.

Review teams

The ability to conduct a thorough, robust and systematic review of all stages of the pregnancy and neonatal care journey requires the involvement of the many health professionals who deliver care in this complex clinical setting. Conducting a high-quality review is therefore a multidisciplinary activity, ideally also involving someone external to the organisation. The external member can provide the ‘fresh pair of eyes’ of an independent senior professional with the clinical authority to provide challenge when the care is discussed. Parents in particular welcome the involvement of external panel members who provide independent scrutiny in a situation that might be regarded as the trust/health board ‘marking their own homework’. Importantly clinical leadership is needed to drive the local PMRT process which requires resourcing by the inclusion of this activity in job plans for medical staff and in role descriptions for other staff. This task is too important for staff to be expected to do it as an extra un-resourced activity, sometimes in their spare time (Pers Comm J Dickens. The Umpire Study).

There has been a steady improvement in the number of healthcare professionals involved in review teams across all professional groups. Notably, 87% of reviews of neonatal deaths now involve a neonatologist or paediatrician and 63% involve a neonatal nurse. The proportion of MDT reviews that involve a healthcare professional external to the trust/health board has increased steadily over time. Ideally, all reviews would benefit from the presence of an independent, appropriately qualified, external clinician, which will require additional resources and creative organisation. The PMRT system has been updated to enable the local PMRT teams to more accurately record whether an external reviewer was present for the MDT review meeting. Additional guidance based on real life examples of how to coordinate external reviewers between organisations has also *been provided*.

Forty percent of reviews benefited from administrative support. This is a slight improvement from the previous year but is certainly far from ideal. Administrative support can help ensure reviews are timely and the panels have all the relevant information available at the meeting. Without such support, this task will fall to a clinical member of the team which is an inappropriate use of this expensive staff resource.

The presence of members of risk management and governance teams is also essential to ensure that learning from reviews is translated into actionable plans, which are implemented and subsequently audited. These team members were present for about 84% of reviews representing an increase from the previous year. Similarly, the proportion of reviews with a member of the bereavement team present, at about 70% of reviews has increased slightly from the previous report. This is still not ideal given the potential impact that poor bereavement care can have on a family's future psychosocial wellbeing. The expectation is that during the review process the bereavement midwife will also advocate on behalf of the parents ensuring that their questions, concerns and comments are addressed. However, it appears that when the bereavement team are involved, in some organisations they are also expected to manage the PMRT process. We strongly advise against this since the role of the bereavement team member(s) is one of advocacy and support, allocating responsibility for the PMRT review process to a member of the bereavement team may give rise to potential conflicts of interest (see Appendix A). Appendix B provides details of the role of user-led Maternity and Neonatal Voices Partnership (MNVPs) in England.

Action plans

The final essential step in any review is to identify which issues require action to improve future care for all mothers and babies. This is irrespective of the impact of the issues identified on the outcome for the specific death being reviewed. For example, screening for gestational diabetes may have been indicated but not offered to the mother. Where or not this was relevant to that specific baby's death, the screening pathway for gestational diabetes should be reviewed to ensure that all pregnant mothers are offered appropriate screening in the future.

Parents, in particular, want to know that care has been improved as a consequence of their experiences and the subsequent review. While a random sample of 100 reviews shows no overall increase in action "strength" compared with 2022 and 2023, it is important to note that not all issues require strong or even intermediate actions. Often stronger actions will also need to be accompanied by weaker ones. For example, changing equipment (a strong action) requires training (intermediate) and staff need to be informed of changes (weak). Therefore, we would not anticipate 100% of actions will be strong and with over 50% of actions being strong/of intermediate strength the current trend is encouraging.

Recommendations

1. Optimise the engagement of parents in reviews by ensuring all parents 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

2. 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

3. 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

4. Provide adequate resources and make the support arrangements necessary to ensure the participation of independent external clinicians at the multi-disciplinary PMRT review meeting.

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

5. 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

6. 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 their implementation and impact.

   Action: PMRT review teams, governance teams in Trusts and Health Boards, regional/network support systems, service commissioners

Appendices

Appendix A - Recommended composition of review teams and roles

The staff conducting PMRT reviews should fundamentally represent the diverse teams involved in providing maternity and neonatal care, ensuring that the roles represented in these teams are appropriate to review the specific care under evaluation. For example, a neonatatologist/paediatrician and neonatal nurse should be present for the review of neonatal deaths.

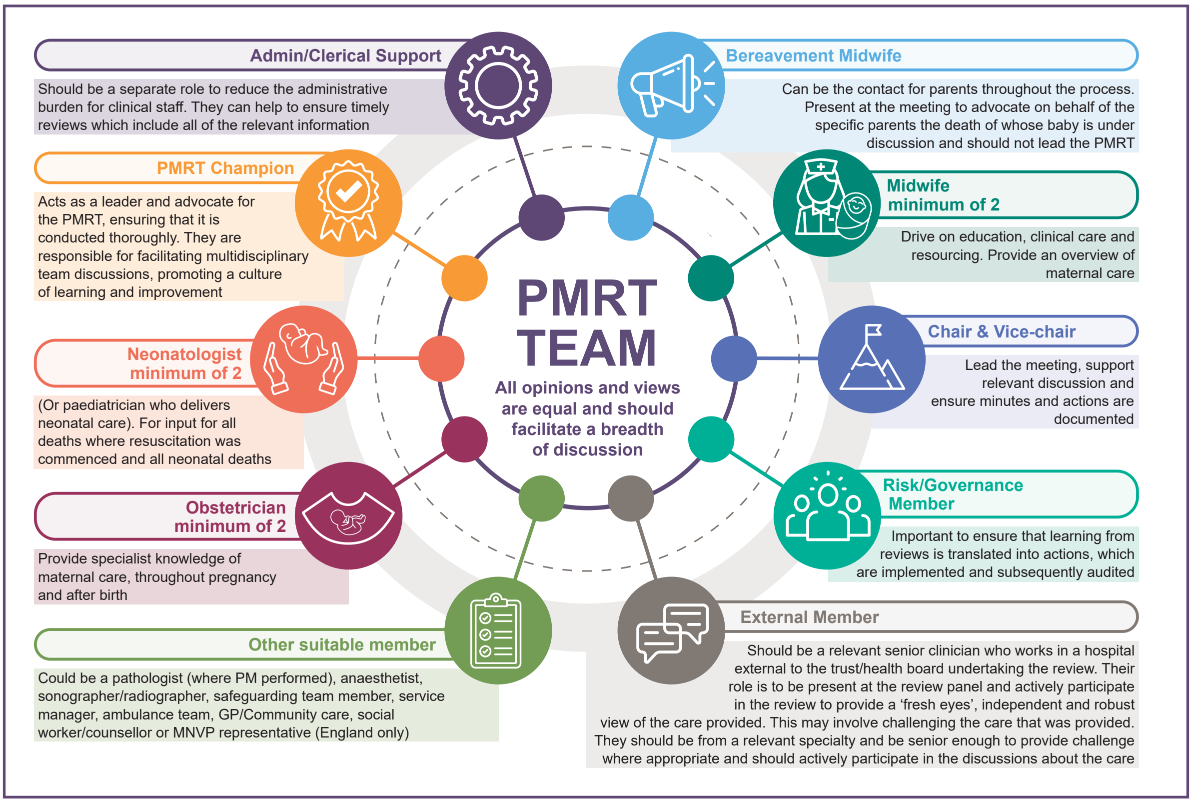
In the event that a particular aspect of care which should have been provided was not, then it is essential to ensure that the particular discipline is represented in the review team so that the impact of this absence on the care provided can be assessed.

The role of the **bereavement team member**(s) is to contribute to the review of care and to advocate on behalf of the parents by presenting their questions, concerns and comments; they should not be required to take responsibility for the PMRT review process unless they are specifically employed to do so. The infographic below was included in our 2024 annual report. You can download it from the *PMRT website*.

An **external panel member** should be a relevant senior clinician who works in a hospital external to the trust and health board undertaking the review. In England an external panel member should be present for at least 50% of reviews, see Safety Action 1, the *Maternity Incentive Scheme* guidance, year 7.

The role of an external is to participate in the review panel to provide a 'fresh pair of eyes', independent and robust view of the care provided. This may involve challenging the care that was provided by the trust/health board when the death occurred. The external should be from a relevant speciality, be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care. Given the nature of the clinical care being reviewed in a PMRT review, it would not be possible for a non-clinician to fulfil this role. However, the external reviewer could, for example, be a member of another trust/health board governance team. However, they must possess relevant clinical knowledge, be up-to-date with training and continuing professional development (CPD), and either currently undertake clinical shifts or be in a position to do so if required. This is crucial because externality demands clinical credibility, requiring the experience and current knowledge necessary to reflect on care provision and offer authoritative, robust, objective challenge.

In assessing who is appropriate to fulfil the role of an external, the trust/health board involved must assure themselves that the individual acting as an 'external' has the appropriate level of clinical competence and is sufficiently up to date to assess the care provided and, where necessary, participate in robust discussions with the internal members of the panel.



PMRT TEAM

All opinions and views are equal and should facilitate a breadth of discussion

Admin/Clerical Support

Should be a separate role to reduce the administrative burden for clinical staff. They can help to ensure timely reviews which include all of the relevant information

PMRT Champion

Acts as a leader and advocate for the PMRT, ensuring that it is conducted thoroughly. They are responsible for facilitating multidisciplinary team discussions, promoting a culture of learning and improvement

Neonatologist minimum of 2

(Or paediatrician who delivers neonatal care). For input for all deaths where resuscitation was commenced and all neonatal deaths

Obstetrician minimum of 2

Provide specialist knowledge of maternal care, throughout pregnancy and after birth

Other suitable member

Could be a pathologist (where PM performed), anaesthetist, sonographer/radiographer, safeguarding team member, service manager, ambulance team, GP/Community care, social worker/counsellor or MNVP representative (England only)

Bereavement Midwife

Can be the contact for parents throughout the process. Present at the meeting to advocate on behalf of the specific parents the death of whose baby is under discussion and should not lead the PMRT

Midwife minimum of 2

Drive on education, clinical care and resourcing. Provide an overview of maternal care

Chair & Vice-chair

Lead the meeting, support relevant discussion and ensure minutes and actions are documented

Risk/Governance Member

Important to ensure that learning from reviews is translated into actions, which are implemented and subsequently audited

External Member

Should be a relevant senior clinician who works in a hospital external to the trust/health board undertaking the review. Their role is to be present at the review panel and actively participate in the review to provide a 'fresh eyes', independent and robust view of the care provided. This may involve challenging the care that was provided. They should be from a relevant specialty and be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care

Appendix B - Maternity and neonatal voices partnership - England only

In England, as part of Safety Action 7 (SA7) of the year 7 Maternity Incentive Scheme (MIS), trusts are required to work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the *Delivery Plan for Maternity and Neonatal Services* and *MNVP Guidance*.

As part of the year 7 MIS evidence requirements for SA7, trusts need to provide terms of reference for safety and governance meetings showing the MNVP Lead as a member, including PMRT review meetings, to provide the wider 'parent voice'. If this has not yet been achieved, trusts need to provide evidence of working towards this goal. The MNVP role is different from the role of the Bereavement Midwife who is there to advocate on behalf of the specific parents the death of whose baby is under discussion. Although the MNVP member may not be employed directly by the trust, they are not classed as an 'external' member of the PMRT MDT panel.

Appendix C - Action plan strength

The US Veterans Affairs root cause analysis tools defines the strength of an action by describing how well the action would eliminate human error.

Strong actions

Strong actions are system-level changes that remove reliance on individuals to choose the correct action. They use standardisation and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing' actions.

Intermediate actions

Intermediate actions are those actions that put systems in place, but those systems still require individuals to make choices about the correct actions to take without any controls in place.

Weak actions

Weak actions involve reminders to individuals for action and training and require individuals to make choices about the correct actions to take, without controls in place. They are often single activities without repetition, which take no account of the fact that new staff are appointed. They can involve debrief discussions with an individual involved in a patient safety incident. They have no effect on other members of staff.

See: US Department of Veterans Affairs. Root Cause Analysis Tools. VA National Center for Patient Safety. REV.02.26.2015. (Pgs 26-29) *RCA Step by Step Guide* REV 07.01.2016 (va.gov) and Bagian JP, Gosbee J, Lee CZ, et al. The veterans affairs root cause analysis system in action. *Jt Comm J Qual Improv.* 2002;28(10):531–545

Appendix D - Using PMRT evidence to improve care

Following the completion of a review for a specific mother and baby, the review is closed and a final report of the review is produced. This should be used for discussion of the review findings with the parents and as the basis for writing the 'plain language' follow-up letter to parents. The letter should cover the review findings and the discussion they had in the follow-up meeting. We do not recommend that the parents are sent a copy of the review report which is a technical, clinical document. If they request a copy of the PMRT review report this should only be provided once a verbal explanation of the findings has been given in the feedback meeting and alongside a plain language summary and letter.

The PMRT system can also be used to produce summary reports of the findings of all reviews carried out over a period of time, with the period of time defined by the person generating the summary report from the PMRT system. Many teams in trusts and health boards use this summary report as a basis of quarterly mortality reporting to their Executive Board which, for trusts in England, can form part of the compliance with Safety Action 1 of the national *Maternity Incentive Scheme*.

Recurring issues identified as requiring action but for which there is no immediate solution are identified in these summary reports. These can be used as a means of prioritising which issues need action to improve care and to highlight any resource implications and for writing the business case for the resources necessary to improve care and outcomes.

The implementation of care quality improvements which are identified as a consequence of a PMRT review happens once the review is closed. As a consequence, where there is information about action plans included in the PMRT system, whether or not the planned actions led to care quality improvements cannot be determined from the PMRT system.

PMRT
Supporting high quality
local perinatal reviews

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