Reviews of care when babies die

PMRT annual report 2025 - Short report

PMRT
Supporting high quality local perinatal reviews

When a baby dies during pregnancy or soon after birth, doctors and midwives will look at the care the mother and baby were given. This is called a hospital review. Hospital reviews help provide answers to parents' questions about why their baby died. The findings can also help prevent future baby deaths by checking if anything could have been done differently to stop the baby from dying. Hospital reviews help hospitals learn from mistakes to help make care better for all mothers and babies and help to stop babies from dying in the future.

- The reviews in this report look at the care of mothers whose babies died in 2024.
- Their care was looked by hospital review teams who used the Perinatal Review Mortality Tool (PMRT).
- A review was carried out for nearly all babies who died in 2024. This is better than when PMRT reviews were first started in 2018.

PMRT reviews started for the first time in 2018.

Since 2018 nearly 29,000 PMRT reviews have been carried out.

This report includes the findings from the 4,166 reviews completed from January to December 2024 in the UK.

It is important that parents know about the hospital review before it starts. This is so they can ask questions about their and their baby's care. The review is carried out to help parents understand why their baby died. Any questions or concerns parents have about their care should be looked at in the review. By being able to ask questions, parents can be part of the review process. This is also important because parents may know key details about what happened that doctors and midwives may not know about

Parents might not always know which questions they want answered and may need help with this. Learning more about what caused their baby's death may lead to more questions. Parents should feel they can have an ongoing conversation with the hospital review team.

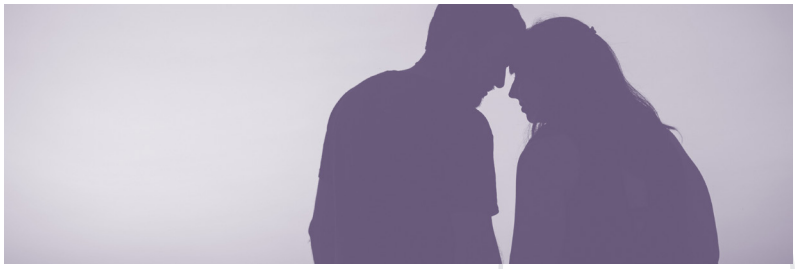
The review should help answer parents question although, unfortunately, a review will not always pinpoint a baby's cause of death.

Help for hospitals in speaking with parents about their care is available on the PMRT website. We call this 'parent engagement'. Good parent engagement means telling parents about the review process, asking if they have any questions about their care and talking to parents about the review findings and answering any further questions parents have even after the review is finished.

Findings from the reviews in 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



- Most parents were told about their review (99%).
- Most parents were asked if they had any questions (98%).
- But it is not clear if all parents really knew what this meant.
- Parents had questions about a lot of different things.
- Some parents were happy with their care (18%).

Parent engagement improves the quality of reviews

Some parents' comments and questions about their care

"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."

"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."

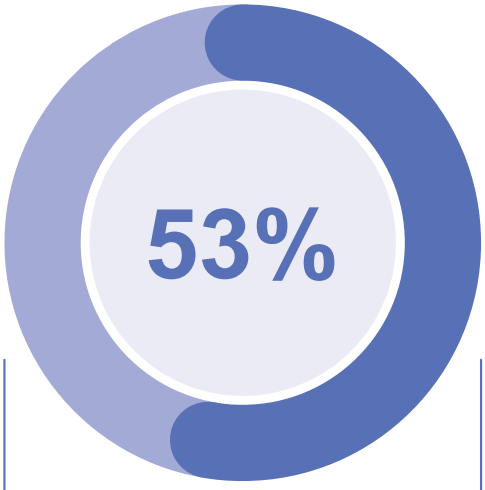
"Why wasn't my pregnancy marked as high risk?"

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

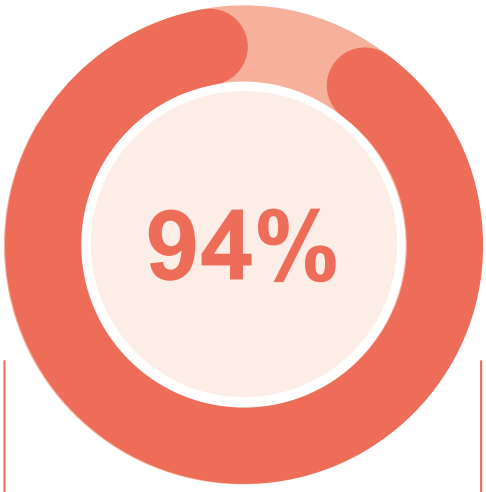
"Failure to listen to my concerns about having no fetal movement, I wasn't offered an ultrasound, and there was an on-call doctor who could have been called as there was no doctor on the ward."

"What happened to my baby?"

- Good reviews are really important.
- Reviews are better quality now than when PMRT reviews started in 2018.
- Over half (53%) of reviews in 2024 had someone from outside the hospital in the review team. These are called ‘external reviewers’. This is an important improvement.



of reviews included an external reviewer



of reviews identified at least one issue with care

- In 19 out of every 20 reviews (94%) a problem with care was found, although this may not have affected the baby.

- In 7 out of every 20 reviews (36%) the problem may have affected the baby or the mother.

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

Some care has improved since last years’ report and a lot of good care was given. Some problems with care are the same as last years’ report. These include checking if the baby is growing and moving properly. Other problems were with looking after the mother and baby during labour and when the baby is born. Lots of hospitals gave good bereavement care. Some hospitals could give better bereavement care.

Hospitals should use their review findings to provide better care for mothers and babies. The findings from this report will also help hospitals plan better care for the future. Some hospitals carry out good reviews and some need to improve their review process.

A full version of the report is available on the PMRT website.

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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