PMRT

Supporting high quality local perinatal reviews

National Perinatal Mortality Review Tool

Learning from Standardised Reviews When Babies Die

Seventh Annual Report 2025

Tables of Findings

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Funding

The Perinatal Mortality Review Tool, delivered by the MBRRACE-UK/PMRT collaboration, is funded in England by the Department of Health and Social Care and commissioned by the Department on behalf of NHS Wales, the Health and Social Care Division of the Scottish Government and the Northern Ireland Department of Health.

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

This report should be cited as:

Adele Krusche, Peter Smith, Ian Gallimore, Tracey Johnston, Christy Burden, Jo Dickens, Rachel Drain, Alan Fenton, Julie Hartley, Alexander Heazell, Sara Kenyon, Marian Knight, Bradley Manktelow, Miguel Neves, Sarah Prince, Dimitros Siassakos, Lucy Smith, Claire Storey & Jennifer J Kurinczuk. National Perinatal Mortality Review Tool. Learning from Standardised Reviews When Babies Die. Seventh Annual Report 2025 – Tables of Findings. Oxford: National Perinatal Epidemiology Unit, University of Oxford. 2025.. Oxford: National Perinatal Epidemiology Unit, University of Oxford. 2025. ISBN: 978-1-9191819-3-6

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ISBN: 978-1-9191819-3-6

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1. Conducting Reviews

Table 1.1: Number of reviews and the percentage of deaths where a review has been carried out using the PMRT by year, England 2018 to 2024 (as at 2nd June 2025)

	Type of death		
	Stillbirths & late miscarriages n (%)[2]	Neonatal deaths n (%) [2]	Total n (%) [2]
2018			
Review at least started	2,256 (85%)	1,094 (80%)	3,350 (83%)
Review published[1]	2,069 (78%)	889 (65%)	2,958 (74%)
2019			
Review at least started	2,458 (98%)	1,330 (99%)	3,788 (99%)
Review published[1]	2,293 (92%)	1,128 (90%)	3,421 (91%)
2020			
Review at least started	2,277 (9%)	1,273 (96%)	3,550 (98%)
Review published[1]	2,163 (95%)	1,086 (82%)	3,249 (90%)
2021			
Review at least started	2,459 (99%)	1,391 (99%)	3,850 (99%)
Review published[1]	2,185 (88%)	1,024 (73%)	3,209 (83%)
2022			
Review at least started	2,240 (99%)	1,445 (99%)	3,685 (99%)
Review published[1]	2,017 (89%)	1,190 (82%)	3,207 (86%)
2023			
Review at least started	2,184 (99%)	1,405 (96%)	3,589 (99%)
Review published[1,3]	2,130 (97%)	1,319 (92%)	3,449 (95%)
2024			
Review at least started	2,114 (99%)	1,342 (98%)	3,456 (99%)
Review published[1]	1,986 (94%)	1,131 (82%)	3,117 (89%)

1. Published means that the review is complete, has been closed and the final report has been produced. Until this happens it is not possible discuss the review findings with the parents nor generate action plans.
2. Percentages based on the notifications of eligible deaths to the MBRRACE-UK system as at 2nd June 2025; some of the reviews in 2024 will still be in progress at this stage of reporting
3. The number and percentages of published reviews have been updated for 2023; thus, the figures have changed from those reported in the 2024 annual report

Table 1.2: Number of reviews and the percentage of deaths where a review has been carried out using the PMRT by year, Scotland 2018 to 2024 (as at 2nd June 2025)

	Type of death		
	Stillbirths & late miscarriages n (%)[2]	Neonatal deaths n (%) [2]	Total n (%) [2]
2018			
Review at least started	93 (45%)	35 (38%)	128 (43%)
Review published[1]	59 (29%)	27 (29%)	86 (29%)
2019			
Review at least started	160 (82%)	65 (75%)	225 (80%)
Review published[1]	127 (65%)	53 (61%)	225 (80%)
2020			
Review at least started	162 (81%)	51 (56%)	213 (73%)
Review published[1]	150 (75%)	44 (48%)	194 (67%)
2021			
Review at least started	163 (88%)	76 (62%)	239 (78%)
Review published[1]	148 (80%)	49 (40%)	197 (64%)
2022			
Review at least started	162 (89%)	62 (63%)	224 (80%)
Review published[1]	116 (64%)	44 (44%)	160 (57%)
2023			
Review at least started	126 (84%)	84 (79%)	210 (81%)
Review published[1,3]	105 (70%	58 (55%)	163 (64%)
2024			
Review at least started	135 (83%)	56 (61%)	191 (78%)
Review published[1]	91 (56%)	18 (20%)	109 (43%)

1. Published means that the review is complete, has been closed and the final report has been produced. Until this happens it is not possible discuss the review findings with the parents nor generate action plans.
2. Percentages based on the notifications of eligible deaths to the MBRRACE-UK system as at 2nd June 2025; some of the reviews in 2024 will still be in progress at this stage of reporting
3. The number and percentages of published reviews have been updated for 2023; thus, the figures have changed from those reported in the 2024 annual report

Table 1.3: Number of reviews and the percentage of deaths where a review has been carried out using the PMRT by year, Wales 2018 to 2024 (as at 2nd June 2025)

	Type of death		
	Stillbirths & late miscarriages n (%)[2]	Neonatal deaths n (%) [2]	Total n (%) [2]
2018			
Review at least started	92 (72%)	47 (78%)	139 (74%)
Review published[1]	75 (59%)	24 (40%)	99 (53%)
2019			
Review at least started	93 (73%)	73 (99%)	166 (82%)
Review published[1]	67 (52%)	43 (58%)	110 (54%)
2020			
Review at least started	97 (89%)	65 (100%)	162 (87%)
Review published[1]	89 (82%)	30 (51%)	119 (71%)
2021			
Review at least started	97 (80%)	55 (100%)	152 (87%)
Review published[1]	58 (48%)	6 (11%)	64 (37%)
2022			
Review at least started	99 (82%)	59 (100%)	158 (88%)
Review published[1]	84 (69%)	13 (22%)	97 (54%)
2023			
Review at least started	94 (98%)	31 (49%)	108 (69%)
Review published[1,3]	88 (90%)	41 (65%)	129 (80%)
2024			
Review at least started	107 (100%)	49 (94%)	156 (99%)
Review published[1]	95 (90%)	30 (58%)	125 (79%)

1. Published means that the review is complete, has been closed and the final report has been produced. Until this happens it is not possible discuss the review findings with the parents nor generate action plans.
2. Percentages based on the notifications of eligible deaths to the MBRRACE-UK system as at 2nd June 2025; some of the reviews in 2024 will still be in progress at this stage of reporting
3. The number and percentages of published reviews have been updated for 2023; thus, the figures have changed from those reported in the 2024 annual report

Table 1.4: Number of reviews and the percentage of deaths where a review has been carried out using the PMRT by year, Northern Ireland 2020 to 2024 (as at 2nd June 2025)

	Type of death		
	Stillbirths & late miscarriages n (%)[2]	Neonatal deaths n (%) [2]	Total n (%) [2]
2020¥			
Review at least started	73 (84%)	23 (35%)	96 (63%)
Review published[1]	43 (49%)	11 (17%)	54 (35%)
2021			
Review at least	81 (77%)	20 (30%)	101 (59%)
Review published[1]	23 (22%)	3 (4%)	26 (15%)
2022			
Review at least started	80 (94%)	30 (48%)	110 (74%)
Review published[1]	76 (89%)	19 (30%)	95 (64%)
2023			
Review at least started	61 (97%)	47 (96%)	108 (96%)
Review published[1,3]	58 (92%)	36 (73%)	94 (84%)
2024			
Review at least started	64 (93%)	45 (90%)	109 (92%)
Review published[1]	35 (51%)	8 (16%)	43 (36%)

¥ Trusts in Northern Ireland adopted the PMRT for the conduct of reviews during autumn 2019. As a consequence the reviews carried out in Northern Ireland in 2019 and 2020 were during the implementation phase of the use of the PMRT and few reviews were completed or published in 2019. This table therefore only includes information about reviews carried out from January 2020

1. Published means that the review is complete, has been closed and the final report has been produced. Until this happens it is not possible discuss the review findings with the parents nor generate action plans.
2. Percentages based on the notifications of eligible deaths to the MBRRACE-UK system as at 2nd June 2025; some of the reviews in 2024 will still be in progress at this stage of reporting
3. The number and percentages of published reviews have been updated for 2023; thus, the figures have changed from those reported in the 2024 annual report

Table 1.5: Characteristics of completed reviews by country and type of death for the seven time periods of review from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Reviews Mar 2021 to Feb 2022		Reviews Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Reviews Jan 2024 to Dec 2024	
	Number of reviews	% of reviews	Number of reviews	% of reviews	Number of reviews	% of reviews	Number of reviews	% of reviews	Number of reviews	% of reviews	Number of reviews	% of reviews	Number of reviews	% of reviews
	N = 1,500		N = 3,693		N = 3,981		N = 4,199		N = 4,111		N = 4,311		N = 4,166	
Country:														
England	1,416	94%	3,642	94%	3,621	91%	3,746	89%	3,583	87%	3,806	88%	3,768	90%
Wales	23	2%	81	2%	146	4%	171	4%	186	5%	154	4%	165	4%
Scotland	61	4%	150	4%	176	4%	235	6%	190	5%	176	4%	143	3%
Northern Ireland[1]	--	--	--	--	38	1%	47	1%	152	4%	175	4%	90	2%
Type of death:														
Late miscarriages	143	10%	449	12%	385	10%	416	10%	383	9%	395	9%	361	9%
Stillbirths	1,011	67%	2,158	58%	2,215	56%	2,394	57%	2,248	55%	2,327	54%	2,214	53%
Neonatal deaths	346	23%	1,086	29%	1,381	35%	1,389	33%	1,480	36%	1,589	37%	1,591	38%

1. Northern Ireland adopted the PMRT in autumn 2019

2. Parents' perspectives of their care and that of their baby

Table 2.1: Number and percentage of reviews indicating parents' perspectives of care were sought and comments recorded for the seven time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019				Reviews Mar 2019 to Feb 2020				Reviews Mar 2020 to Feb 2021				Reviews Mar 2021 to Feb 2022				Reviews Mar 2022 to Feb 2023				Reviews Jan 2023 to Dec 2023				Reviews Jan 2024 to Dec 2024			
	Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]		Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]		Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]		Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]		Reviews Jan 2023 to Dec 2023		Reviews with parents' comments recorded[2]		Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]		Reviews where parents' perspectives were indicated as having been sought		Reviews with parents' comments recorded[2]	
	N	%	N	%[3]	N	%	N	%[3]	N	%	N	%[3]	N	%	N	%[3]	N	%	N	%[3]	N	%	N	%[3]	N	%	N	%[3]
Country:																												
England	1,070	76%	1,037	73%	2,916	84%	2,899	84%	3,277	90%	3,244	90%	3,620	97%	3,109	83%	3,450	96%	1,917	54%	3714	98%	2119	56%	3,721	99%	2,112	56%
Wales	19	82%	18	78%	70	86%	70	86%	98	67%	98	67%	140	82%	120	70%	154	83%	83	45%	133	86%	66	43%	146	88%	62	38%
Scotland	35	57%	34	56%	130	87%	130	87%	160	91%	160	91%	201	86%	163	69%	180	95%	95	50%	160	91%	89	51%	128	90%	68	48%
Northern Ireland[1]	--	--	--	--	--	--	--	--	34	89%	34	89%	44	94%	38	81%	122	80%	79	52%	138	79%	93	53%	89	99%	73	81%
Overall	1,124	75%	1,089	73%	3,116	84%	3,099	84%	3,569	90%	3,536	89%	4,005	95%	3,430	82%	3,906	95%	2,174	53%	4145	96%	2367	55%	4,084	98%	2,315	56%
Type of death:																												
Late miscarriages	100	70%	98	69%	365	81%	365	81%	344	89%	344	89%	398	96%	332	81%	365	95%	199	52%	381	96%	187	47%	357	99%	188	52%
Stillbirths	781	77%	755	75%	1,879	87%	1,875	87%	2,041	92%	2,039	92%	2,309	96%	1,922	80%	2,173	97%	1217	54%	2282	98%	1309	56%	2,190	99%	1,212	55%
Neonatal deaths	243	70%	236	68%	872	80%	859	79%	1,184	86%	1,153	83%	1,298	93%	1,176	85%	1,368	92%	758	51%	1482	93%	871	55%	1,537	97%	915	58%

1. Trusts in Northern Ireland adopted the PMRT for the conduct of reviews during autumn 2019. As a conse¬quence the reviews carried out in Northern Ireland in 2019 and 2020 were during the implementation phase of the use of the PMRT and few reviews were completed or published in 2019. This table therefore only includes information about reviews carried out from March 2020. Reviews are included from the Isle of Man as of 2023.
2. A small number of the comments were not actually parental comments
3. This is the percentage of reviews where parents' views were sought, not the percentage of the total reviews carried out

Table 2.2: Themes from a sample of those parents who had questions, comments or expressed concerns about their care by 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		
Questions and concerns – main themes	Sub-themes	Number of responses	Number of responses	Number of responses	Number of responses	Number of responses	Number of responses	Number of responses	Number of responses	Number of responses
		Late miscarriages and stillbirths	Neonatal deaths	All deaths	Late miscarriages and stillbirths	Neonatal deaths	All deaths	Late miscarriages and stillbirths	Neonatal deaths	All deaths
		N=128 n (%)	N=72 n (%)	N=200 n (%)	N=114 n (%)	N=86 n (%)	N=200 n (%)	N=116 n (%)	N=84 n (%)	N=200 n (%)
Staff approach and care received	Lack of compassion or inadequate care	8 (6%)	6 (8%)	14 (7%)	3 (3%)	2 (2%)	5 (3%)	8 (7%)	3 (4%)	11 (6%)
	Loss of control – not listened to/felt ignored	4 (3%)	1 (1%)	5 (3%)	3 (3%)	0 (0%)	3 (2%)	8 (7%)	4 (5%)	12 (6%)
Questions, confusion or complaints	General 'why' or 'how' questions	14 (11%)	3 (4%)	17 (9%)	11 (10%)	2 (2%)	13 (7%)	11 (9%)	5 (6%)	16 (8%)
	Lack of information	7 (5%)	3 (4%)	10 (5%)	10 (9%)	8 (9%)	18 (9%)	5 (4%)	1 (2%)	6 (3%)
	Specific 'why' or 'how' questions	39 (30%)	15 (20%)	54 (27%)	37 (33%)	28 (33%)	65 (33%)	36 (31%)	20 (24%)	56 (28%)
	Concerns about management plans and care received	26 (20%)	19 (26%)	45 (23%)	20 (18%)	24 (28%)	44 (22%)	22 (19%)	21 (25%)	43 (22%)
Positive feedback	Positive comments about care generally	6 (5%)	9 (13%)	15 (8%)	12 (11%)	12 (14%)	24 (12%)	16 (14%)	14 (17%)	30 (15%)
	Specific positive comments about staff	12 (9%)	6 (8%)	18 (9%)	17 (15%)	8 (9%)	25 (13%)	1 (1%)	5 (6%)	6 (3%)
Other	Procedural comments	3 (2%)	5 (7%)	8 (4%)	1 (1%)	2 (2%)	3 (2%)	1 (1%)	3 (4%)	4 (2%)
	Self-blame or guilt	3 (2%)	3 (4%)	6 (3%)	0 (0%)	0 (0%)	0 (0%)	2 (2%)	0 (0%)	2 (1%)
	Administrative feedback	4 (3%)	1 (1%)	5 (3%)	0 (0%)	0 (0%)	0 (0%)	6 (5%)	8 (10%)	14 (7%)
	Grief	2 (2%)	1 (1%)	3 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

3. Issues with care identified in the reviews

Table 3.1: Number and proportion of reviews with issues with care identified and the average number of issues identified per death reviewed, for the seven time periods from Jan 2018 to Dec 2024

	Review Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2022 to Feb 2023	Reviews Jan 2023 to Dec 2023	Reviews Jan 2024 to Dec 2024
	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified	Number of reviews with at least one issue identified
	N (row %)	N (row %)	N (row %)	N (row %)	N (row %)	N (row %)	N (row %)
Country:							
England	1,334 (94%)	3,238 (89%)	3,456 (95%)	3,624 (97%)	3,376 (94%)	3,538 (93%)	3,559 (94%)
Wales	23 (100%)	68 (84%)	144 (99%)	171 (100%)	181 (97%)	150 (97%)	153 (93%)
Scotland	59 (97%)	131 (87%)	160 (91%)	230 (98%)	188 (99%)	175 (99%)	135 (94%)
Northern Ireland[1]	--	--	37 (97%)	46 (98%)	151 (99%)	172 (98%)	88 (98%)
Overall	1,416 (94%)	3,437 (93%)	3,797 (95%)	4,071 (97%)	3,896 (95%)	4,035 (94%)	3,935 (94%)
Type of death:							
Late miscarriages	127 (89%)	399 (88%)	360 (94%)	386 (93%)	351 (91%)	356 (90%)	338 (94%)
Stillbirths	940 (93%)	1,980 (92%)	2,465 (96%)	2,346 (98%)	2,141 (95%)	2,178 (94%)	2,077 (94%)
Neonatal deaths	341 (99%)	1,058 (97%)	1,332 (97%)	1,339 (96%)	1,404 (95%)	1,501 (94%)	1,520 (96%)

1. Northern Ireland adopted the tool in autumn 2019

Table 3.2: The most common Issues with care identified relevant to the outcome in reviews of pre-conception and antenatal care, for the seven time periods from Jan 2018 to Dec 2024

Issue group	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Reviews Mar 2021 to Feb 2022		Reviews Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Reviews Jan 2024 to Dec 2024	
	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome
	N=1,500	N=883	N=3,693	N=1,871	N=3,981	N=1,650	N=4,199	N=1,789	N=4,111	N=1,749	N=4,311	N=1,680	N=4,166	N=1464
	n (%)	n (%[4])	n (%)	n (%[4])	n (%)	n (%[4])	n (%)	n (%[4])	n (%)	n (%[4])	n (%)	n (%[4])	n (%)	n (%[4])
Inadequate growth surveillance	384 (26%)	269 (30%)	712 (19%)	448 (24%)	748 (19%)	371 (23%)	1,029 (25%)	428 (24%)	966 (23%)	398 (23%)	983 (24%)	360 (21%)	907 (22%)	321 (22%)
Late booking/ unbooked pregnancy	220 (15%)	65 (7%)	568 (15%)	201 (11%)	588 (15%)	139 (8%)	1,000 (24%)	160 (9%)	1,095 (27%)	174 (10%)	1,274 (31%)	160 (10%)	1,186 (28%)	185 (13%)
Smoking assessment and management of exposure to tobacco smoke	604 (40%)	113 (13%)	1,226 (33%)	196 (11%)	973 (24%)	129 (8%)	834 (20%)	62 (3%)	1,057 (26%)	91 (5%)	1,002 (24%)	79 (5%)	680 (16%)	48 (3%)
Delay in diagnosis or inappropriate management of significant medical/ surgical/social problems during pregnancy[3]	155 (10%)	106 (12%)	363 (10%)	343 (18%)	408 (10%)	334 (20%)	759 (18%)	440 (25%)	822 (20%)	462 (26%)	957 (23%)	508 (30%)	838 (20%)	412 (28%)
Inadequate investigation or management of reduced fetal movements[2]	230 (15%)	142 (16%)	456 (12%)	273 (15%)	462 (12%)	314 (19%)	702 (17%)	322 (18%)	560 (14%)	280 (16%)	564 (14%)	273 (16%)	545 (13%)	213 (15%)
Lack of appropriate referral for social issues[1] or screening for domestic abuse at booking	196 (13%)	11 (1%)	808 (22%)	51 (3%)	636 (16%)	39 (2%)	407 (10%)	30 (2%)	379 (9%)	23 (1%)	373 (9%)	19 (1%)	367 (9%)	26 (2%)
Poor preconception advice, counselling or management	**[5]	**[5]	**[5]	**[5]	173 (4%)	27 (2%)	219 (5%)	23 (1%)	189 (5%)	23 (1%)	234 (6%)	23 (1%)	216 (5%)	21 (1%)

Poor antenatal communication with parents	**[5]	**[5]	**[5]	**[5]	213 (5%)	32 (2%)	212 (5%)	39 (2%)	186 (5%)	37 (2%)	222 (5%)	35 (2%)	255 (6%)	40 (3%)
Assessment and management of aspirin requirement	339 (23%)	66 (7%)	628 (17%)	128 (7%)	467 (12%)	101 (6%)	332 (8%)	70 (4%)	275 (7%)	72 (4%)	201 (5%)	53 (3%)	170 (4%)	49 (3%)
Screening for, or management of, gestational diabetes mellitus (GDM)	164 (11%)	17 (2%)	246 (7%)	38 (2%)	235 (6%)	30 (2%)	269 (6%)	43 (2%)	268 (7%)	31 (2%)	248 (6%)	31 (2%)	202 (5%)	25 (2%)
Antenatal risk assessment and management	**[5]	**[5]	**[5]	**[5]	**[5]	**[5]	**[5]	**[5]	157 (4%)	53 (3%)	179 (4%)	42 (3%)	127 (3%)	30 (2%)

1. Includes: housing, benefits, social support, teenager, other vulnerabilities
2. Includes: no risk assessment; investigations indicated not carried out; poor quality, or incorrectly interpreted CTGs; lack of appropriate written information for mother
3. Includes: inappropriate management according to guidelines
4. This percentage is the proportion of all relevant issues identified including issues affecting a small proportion of reviews which are not listed in the table.
5. Not reported in the results in these years

Table 3.3: The most common issues with care identified during intrapartum care, for the seven time periods from Jan 2018 to Dec 2024

Issue group	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Reviews Mar 2021 to Feb 2022		Reviews Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Reviews Jan 2024 to Dec 2024	
	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome
	N=1,500	N=346	N=3,693	N=869	N=3,981	N=1,037	N=4,199	N=979	N=4,111	N=792	N=4,311	N=1,023	N=4,166	N=1,059
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Issues with monitoring of the mother[1]	507 (34%)	52 (15%)	944 (26%)	114 (13%)	904 (23%)	115 (11%)	914 (22%)	92 (9%)	886 (22%)	84 (11%)	936 (22%)	89 (9%)	802 (19%)	93 (9%)
Fetal monitoring issues[2]	53 (4%)	67 (19%)	162 (4%)	180 (21%)	162 (4%)	177 (17%)	311 (7%)	185 (19%)	244 (6%)	121 (15%)	319 (7%)	157 (15%)	330 (8%)	159 (15%)
No assessment of mother's risk status or inadequate management at the start of her care in labour or during the course of her labour	118 (8%)	41 (12%)	198 (5%)	83 (10%)	221 (6%)	122 (12%)	281 (7%)	108 (11%)	266 (6%)	85 (11%)	311 (7%)	103 (10%)	336 (8%)	115 (11%)
Staffing issues[3]	82 (5%)	40 (12%)	289 (5%)	132 (15%)	169 (4%)	136 (13%)	233 (6%)	121 (12%)	194 (5%)	88 (11%)	296 (7%)	153 (15%)	263 (6%)	125 (12%)
Issues with communication with mothers with poor/no English	77 (5%)	13 (4%)	244 (7%)	45 (5%)	193 (5%)	22 (2%)	283 (7%)	23 (2%)	260 (6%)	33 (4%)	289 (7%)	28 (3%)	320 (8%)	32 (3%)
Issues in management of preterm and threatened preterm labour	27 (2%)	22 (6%)	73 (2%)	28 (3%)	93 (2%)	50 (5%)	166 (4%)	69 (7%)	198 (5%)	70 (9%)	238 (6%)	112 (11%)	241 (6%)	119 (11%)
Inappropriate setting/location of birth	53 (4%)	24 (7%)	138 (4%)	50 (6%)	178 (5%)	84 (8%)	179 (4%)	97 (10%)	201 (5%)	104 13%)	217 (5%)	97 (9%)	239 (6%)	125 (12%)
Issues with birth mode(s)[4]	42 (3%)	19 (5%)	101 (3%)	68 (8%)	108 (3%)	81 (8%)	120 (3%)	79 (8%)	130 (3%)	68 (9%)	147 (3%)	81 (8%)	143 (3%)	74 (7%)

1. Includes: infrequent observations and/or lack of partogram
2. Includes: incorrect method of fetal monitoring, interpretation or management, from the latent phase of labour through to established labour and birth
3. Includes: insufficiently senior staff involved in care and lack of one-to-one care in established labour
4. Includes: inappropriate choice, timing and management

Table 3.4: The most common issues with care identified during neonatal care (excluding end of life care), for the seven time periods from Jan 2018 to Dec 2024

Issue group	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Reviews Mar 2021 to Feb 2022		Reviews Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Reviews Jan 2024 to Dec 2024	
	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome	Number and percentage of reviews with each issue	Number of issues relevant to the outcome
	N=346	N=81	N=1,086	N=446	N=1,381	N=440	N=1,389	N=453	N=1,480	N=468	N=1,589	N=552	N=1,591	N=660
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Inadequate documentation:														
At all stages of care	185 (53%)	32 (40%)	791 (73%)	125 (28%)	721 (52%)	154 (35%)	1,132 (81%)	73 (16%)	882 (60%)	77 (18%)	1,237 (78%)	75 (14%)	1,114 (70%)	109 (17%)
Resuscitation & stablisation	172 (50%)	**[4]	525 (48%)	**[4]	441 (32%)	**[4]	609 (44%)	**[4]	447 (30%)	51 (12%)	563 (35%)	51 (9%)	506 (32%)	77 (12%)
Transfer to neonatal unit	25 (7%)	**[4]	107 (10%)	**[4]	92 (7%)	**[4]	91 (7%)	**[4]	54 (4%)	8(2%)	77 (5%)	5 (1%)	58 (4%)	7 (1%)
Neonatal care	5 (10%)	**[4]	134 (12%)	**[4]	162 (12%)	**[4]	353 (25%)	**[4]	297 (20%)	15 (4%)	311 (20%)	16 (3%)	275 (17%)	22 (3%)
Transfer to an external neonatal unit	14 (4%)	**[4]	25 (2%)	**[4]	26 (2%)	**[4]	79 (6%)	**[4]	84 (6%)	<10	96 (6%)	3 (1%)	72 (5%)	3 (%)
Thermal management issues:														
At all stages of care	61 (18%)	14 (17%)	272 (25%)	88 (20%)	345 (25%)	138 (31%)	376 (27%)	123 (27%)	367 (25%)	108 (26%)	439 (28%)	140 (25%)	464 (29%)	151 (23%)
Resuscitation	18 (5%)	**[4]	24 (3%)	**[4]	51 (4%)	**[4]	48 (3%)	**[4]	26 (2%)	<10	50 (3%)	24 (4%)	52 (3%)	16 (2%)
Neonatal care	14 (4%)	**[4]	64 (5%)	**[4]	64 (5%)	**[4]	78 (6%)	**[4]	91 (6%)	33 (8%)	103 (6%)	26 (5%)	137 (9%)	41 (6%)
Transfer to neonatal unit/ other location	50 (15%)	**[4]	174 (16%)	**[4]	230 (17%)	**[4]	250 (18%)	**[4]	250 (17%)	69 (16%)	286 (18%)	90 (16%)	275 (17%)	94 (14%)

Issues during resuscitation with:														
Respiratory management[1]	56 (16%)	<10	183 (17%)	55 (13%)	218 (16%)	71 (16%)	209 (15%)	66 (15%)	174 (12%)	57 (14%)	214 (13%)	62 (11%)	228 (14%)	65 (10%)
Delayed cord clamping	**[4]	**[4]	**[4]	**[4]	**[4]	**[4]	61 (4%)	6 (1%)	76 (5%)	16 (4%)	98 (6%)	14 (3%)	88 (6%)	17 (3%)
Resuscitation not in line with NLS	**[4]	**[4]	**[4]	**[4]	**[4]	**[4]	49 (4%)	21 (5%)	29 (2%)	14 (3%)	53 (3%)	21 (4%)	52 (3%)	15 (2%)
Issues during neonatal care with:														
Cardiovascular management[2]	21 (6%)	<10	45 (4%)	43 (10%)	60 (4%)	10 (2%)	60 (4%)	6 (1%)	64 (4%)	16 (4%)	58 (4%)	15 (3%)	88 (6%)	27 (4%)
Respiratory management	**[4]	**[4]	**[4]	**[4]	**[4]	**[4]	69 (5%)	18 (4%)	86 (6%)	25 (6%)	92 (6%)	25 (5%)	102 (6%)	20 (3%)
Issues with communication with parents[3]	13 (4%)	<10	43 (4%)	56 (3%)	52 (4%)	11 (3%)	108 (8%)	11 (2%)	85 (6%)	9 (2%)	95 (6%)	10 (2%)	105 (7%)	11 (2%)

1. Includes: issues around establishing ventilation, intubation, positive pressure respiratory support, oxygen saturation monitoring and administration of surfactant
2. Includes: line placement and radiological confirmation of line position
3. Includes: mothers/parents with poor/no English and at any stage of resuscitation, transfer and neonatal care
4. Not reported in the results in these years

Table 3.5: The most common issues with care identified during end of life care, for the seven time periods from Jan 2018 to Dec 2024

Issue group	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2022 to Feb 2023	Reviews Jan 2023 to Dec 2023	Reviews Jan 2024 to Dec 2024
	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue
	N=346	N=1,086	N=1,381	N=1,389	N=1,480	N=1,589	N=1,591
	n (%)	n (%[4])	n (%)	n (%4)	n (%)	n (%[4])	n (%)
Post-mortem not discussed with parents prior to the baby's death	52 (15%)	151 (14%)	217 (16%)	237 (17%)	209 (14%)	209 (13%)	225 (14%)
Organ donation not discussed with parents despite no specific contraindications	82 (24%)	209 (19%)	225 (16%)	184 (13%)	167 (11%)	155 (10%)	138 (9%)
Inadequate documentation	57 (16%)	180 (17%)	114 (8%)	117 (8%)	153 (10%)	160 (10%)	96 (6%)

Table 3.6: The most common issues with care identified after the baby had died, for the seven time periods from Jan 2018 to Dec 2024

Issue group	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2022 to Feb 2023	Reviews Jan 2023 to Dec 2023	Reviews Jan 2024 to Dec 2024
	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue	Number of reviews with each issue
	N=1,500	N=3,693	N=3,981	N=4,199	N=4,111	N=4,311	N=4,166
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Baby had to be transferred elsewhere for a post-mortem	**[1]	546 (15%)	1,024 (26%)	1,081 (26%)	1,057 (26%)	1,078 (26%)	913 (22%)
Placental histology was performed but not by a perinatal/ paediatric pathologist	177 (12%)	351 (10%)	287 (7%)	275 (7%)	279 (7%)	280 (7%)	265 (6%)
The placenta was not sent for histological examination	38 (3%)	136 (4%)	132 (3%)	99 (2%)	87 (2%)	96 (2%)	75 (2%)
The parents were not offered a hospital post-mortem	16 (1%)	63 (2%)	77 (2%)	41 (1%)	44 (1%)	76 (2%)	59 (1%)
It is not possible to assess from the notes whether the parents were offered a hospital post-mortem	19 (1%)	39 (1%)	30 (1%)	46 (1%)	40 (1%)	42 (1%)	35 (1%)
The placenta was sent for histological examination but there is no result in the notes	27 (2%)	52 (1%)	40 (1%)	34 (1%)	41 (1%)	50 (1%)	33 (1%)
The parents consented to a full or limited post-mortem examination but this was not carried out	17 (1%)	7 (<1%)	4 (<1%)	9 (<1%)	2 (<1%)	1 (<1%)	1 (<1%)

1. Not reported in the findings in 2018-19

Table 3.7: The most common issues with bereavement care[1] identified from Aug 2020 to Dec 2024

Issue group	Reviews Aug 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2022 to Feb 2023			Reviews Jan 2023 to Dec 2023			Reviews Jan 2024 to Dec 2024		
	Number of reviews	Number of reviews	Number of reviews of late miscarriages and stillbirths	Number of reviews of neonatal deaths	Number of all reviews	Number of reviews of late miscarriages and stillbirths	Number of reviews of neonatal deaths	Number of all reviews	Number of reviews of late miscarriages and stillbirths	Number of reviews of neonatal deaths	Number of all reviews
	N=2,322[1]	N=4,199	N=2,631	N=1,180	N=4,111	N=2,722	N=1,589	N=4,311	N=2,575	N=1,591	N=4,166
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Policy, support and practical help to take their baby home was not available	542 (24%)	917 (22%)	459 (17%)	289 (24%)	748 (18%)	484 (18%)	297 (19%)	781 (18%)	370 (14%)	313 (20%)	683 (16%)
Inadequate documentation regarding taking the baby home	413 (18%)	566 (13%)	312 (12%)	201 (17%)	513 (12%)	245 (10%)	176 (11%)	421 (10%)	200 (8%)	152 (10%)	352 (8%)
Inadequate documentation regarding access to a cold cot	237 (10%)	321 (8%)	77 (3%)	144 (12%)	221 (5%)	53 (2%)	111 (7%)	164 (4%)	42 (2%)	96 (6%)	138 (3%)
Inadequate documentation regarding transfer to mortuary care	187 (8%)	306 (7%)	111 (4%)	100 (8%)	211 (5%)	77 (3%)	90 (6%)	167 (4%)	62 (2%)	57 (4%)	119 (3%)
Location and quality of the bereavement suite inadequate including being affected by service modifications due to the pandemic[2]	207 (9%)	267 (6%)	243 (9%)	104 (9%)	347 (8%)	273 (11%)	116 (7%)	389 (9%)	160 (6%)	114 (7%)	274 (7%)
Inadequate documentation to tell if bereavement care respected cultural, religious and spiritual wishes of the parents	134 (6%)	228 (5%)	124 (5%)	107 (9%)	231 (6%)	113 (4%)	94 (6%)	207 (5%)	116 (5%)	81 (5%)	197 (5%)
Bereavement care adversely affected by service modifications due to the pandemic[2]	**[4]	218 (5%)	82 (3%)	34 (3%)	116 (3%)	31 (1%)	16 (1%)	47 (1%)	6 (<1%)	3 (<1%)	9 (<1%)

Inadequate documentation to tell if bereavement care provided included practical help and/or emotional support	95 (4%)	169 (4%)	76 (3%)	80 (7%)	156 (4%)	64 (2%)	96 (6%)	160 (4%)	52 (2%)	76 (5%)	128 (3%)
Inadequate documentation to assess the location and quality of the bereavement care	**[4]	149 (4%)	50 (2%)	128 (11%)	178 (4%)	25 (1%)	104 (7%)	129 (3%)	18 (1%)	87 (5%)	105 (3%)
Poor quality of the bereavement care offered	64 (3%)	118 (3%)	51 (2%)	92 (8%)	143 (3%)	56 (2%)	99 (6%)	155 (4%)	46 (2%)	120 (8%)	166 (4%)
Inadequate documentation to tell if a named contact for questions after bereavement was identified	69 (3%)	83 (2%)	25 (1%)	29 (2%)	54 (1%)	27 (1%)	13 (1%)	40 (1%)	9 (<1%)	15 (1%)	24 (1%)
Bereavement checklist was not included in the notes	51 (3%)	110 (3%)	60 (2%)	79 (7%)	139 (3%)	71 (3%)	83 (5%)	154 (4%)	82 (3%)	86 (5%)	168 (4%)
Parents were not offered the use of a cold cot	36 (2%)	68 (2%)	11 (<1%)	54 (5%)	65 (2%)	11 (<1%)	67 (4%)	78 (2%)	14 (1%)	51 (3%)	65 (2%)
Bereavement care did not provide practical health and/or emotional support	**[4]	**[4]	63 (2%)	36 (3%)	99 (2%)	47 (2%)	45 (3%)	92 (2%)	27 (1%)	18 (1%)	45 (1%)
Bereavement care not provided by trained staff	**[4]	**[4]	42 (2%)	16 (1%)	58 (1%)	27 (1%)	12 (1%)	39 (1%)	13 (1%)	4 (<1%)	17 (<1%)
A named contact was not identified for questions after discharge/inadequate documentation to tell if a named contact was identified	**[4]	**[4]	67 (3%)	42 (4%)	109 (3%)	8 (<1%)	30 (2%)	38 (1%)	9 (<1%)	23 (1%)	32 (1%)
Other[3]	135 (6%)	314 (7%)	59 (2%)	95 (8%)	154 (4%)	67 (2%)	92 (6%)	159 (4%)	70 (3%)	86 (5%)	156 (4%)

1. Bereavement care questions were incorporated into the PMRT in August 2020
2. Specific pandemic related questions were incorporated into the PMRT in August 2020
3. Includes six additional issues each affecting 50 or fewer reviews overall
4. Not reported in the results in these years

4. Grading of care

Table 4.1: Grading of care during pregnancy care, labour and birth for late miscarriages & stillbirths, with and without an external present, for the seven review time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 1,154	N = 2,607	N = 2,600	N = 2,810	N = 938	N = 2,631	N = 1,180	N=2,722	N=1,362	N=2,575	N=1,325
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	710 (62%)	1,496 (57%)	1,434 (55%)	1,400 (50%)	435 (46%)	1,087 (41%)	461 (39%)	1,104 (41%)	524 (38%)	1,025 (40%)	467 (35%)
B - Care issues that would have made no difference to the outcome	291 (25%)	705 (27%)	721 (28%)	867 (31%)	322 (34%)	1,023 (39%)	467 (40%)	1,069 (39%)	533 (39%)	1,054 (41%)	569 (43%)
C - Care issues which may have made a difference to the outcome	114 (10%)	329 (13%)	357 (14%)	394 (14%)	135 (14%)	388 (14%)	187 (16%)	422 (16%)	228 (17%)	393 (15%)	224 (17%)
D - Care issues which were likely to have made a difference to the outcome	30 (3%)	72 (3%)	83 (3%)	124 (4%)	45 (5%)	115 (4%)	63 (5%)	117 (4%)	71 (5%)	89 (3%)	61 (5%)
Unrecorded	9 (1%)	5 (<1%)	5 (<1%)	25 (1%)	1 (<1%)	18 (<1%)	2 (<1%)	10 (<1%)	6 (<1%)	14 (1%)	4 (<1%)

1. These are reviews where an external member is present as part of the review team

Table 4.2: Grading of care during pregnancy, labour and birth for neonatal deaths, with and without an external present, for the seven review time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 346	N = 1,086	N = 1,381	N = 1,389	N = 478	N = 1,480	N = 667	N=1,589	N=836	N=1,591	N=902
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	214 (62%)	678 (62%)	751 (54%)	713 (51%)	237 (50%)	700 (47%)	303 (45%)	692 (44%)	343 (41%)	595 (37%)	304 (34%)
B - Care issues that would have made no difference to the outcome	102 (29%)	278 (26%)	406 (29%)	445 (32%)	162 (34%)	518 (35%)	241 (36%)	640 (40%)	345 (41%)	723 (45%)	442 (49%)
C - Care issues which may have made a difference to the outcome	20 (6%)	84 (8%)	111 (8%)	148 (11%)	64 (13%)	159 (11%)	90 (13%)	157 (10%)	99 (12%)	182 (11%)	110 (12%)
D - Care issues which were likely to have made a difference to the outcome	7 (1%)	18 (2%)	41 (3%)	37 (3%)	12 (3%)	46 (3%)	26 (4%)	63 (4%)	42 (5%)	59 (4%)	36 (4%)
Unrecorded	3 (1%)	28 (3%)	72 (5%)	46 (3%)	3 (1%)	57 (4%)	7 (1%)	37 (2%)	7 (1%)	32 (2%)	10 (1%)

1. These are reviews where an external member is present as part of the review team

Table 4.3: Grading of care from birth to the death of the baby for neonatal deaths, with and without an external present, for the seven review time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 346	N = 1,086	N = 1,381	N = 1,389	N = 478	N = 1,480	N = 667	N=1,589	N=836	N=1,591	N=902
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	237 (68%)	679 (63%)	852 (62%)	791 (57%)	276 (58%)	827 (56%)	371 (56%)	823 (52%)	446 (53%)	732 (46%)	410 (45%)
B - Care issues that would have made no difference to the outcome	92 (27%)	342 (32%)	446 (32%)	452 (33%)	156 (33%)	511 (35%)	240 (36%)	606 (38%)	311 (37%)	707 (44%)	409 (45%)
C - Care issues which may have made a difference to the outcome	11 (3%)	46 (4%)	68 (5%)	100 (7%)	41 (9%)	83 (6%)	41 (6%)	104 (7%)	61 (7%)	115 (7%)	69 (8%)
D - Care issues which were likely to have made a difference to the outcome	1 (<1%)	8 (1%)	10 (1%)	7 (<1%)	1 (<1%)	13 (1%)	9 (1%)	19 (1%)	12 (1%)	13 (1%)	9 (1%)
Unrecorded	5 (1%)	11 (1%)	5 (<1%)	39 (3%)	4 (1%)	46 (3%)	6 (1%)	37 (2%)	6 (1%)	24 (2%)	5 (1%)

1. These are reviews where an external member is present as part of the review team

Table 4.4: Most serious level of grading of care during pregnancy, labour, birth and during the neonatal period for neonatal deaths, with and without an external present, for the seven review time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 346	N = 1,086	N = 1,381	N = 1,389	N = 478	N = 1,480	N = 667	N=1,589	N=836	N=1,591	N=902
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	159 (46%)	507 (47%)	582 (42%)	501 (36%)	167 (35%)	477 (32%)	199 (30%)	471 (30%)	240 (29%)	351 (22%)	177 (20%)
B - Care issues that would have made no difference to the outcome	147 (42%)	439 (40%)	586 (42%)	600 (43%)	205 (43%)	696 (47%)	319 (48%)	794 (50%)	407 (49%)	894 (56%)	522 (58%)
C - Care issues which may have made a difference to the outcome	26 (7%)	111 (10%)	161 (12%)	213 (15%)	91 (19%)	214 (15%)	116 (17%)	225 (14%)	139 (17%)	263 (17%)	159 (18%)
D - Care issues which were likely to have made a difference to the outcome	8 (2%)	24 (2%)	50 (4%)	42 (3%)	13 (3%)	55 (4%)	32 (5%)	75 (5%)	49 (6%)	68 (4%)	42 (5%)
Unrecorded	6 (2%)	5 (<1%)	2 (<1%)	33 (2%)	2 (<1%)	38 (3%)	1 (<1%)	24 (2%)	1 (%)	15 (1%)	2 (%)

1. These are reviews where an external member is present as part of the review team

Table 4.5: Grading of bereavement care following late miscarriage and stillbirth, with and without an external present, for the seven time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 1,154	N = 2,607	N = 2,600	N = 2,810	N = 938	N = 2,631	N = 1,180	N=2,722	N=1,362	N=2,575	N=1,325
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	955 (83%)	2,175 (83%)	2,072 (80%)	2,075 (74%)	655 (70%)	1,662 (63%)	750 (64%)	1,643 (60%)	818 (60%)	1,584 (62%)	782 (59%)
B - Care issues that would have made no difference to the outcome	141 (12%)	336 (13%)	427 (16%)	550 (20%)	221 (24%)	747 (28%)	331 (28%)	846 (31%)	414 (30%)	754 (29%)	405 (31%)
C - Care issues which may have made a difference to the outcome	23 (2%)	70 (3%)	65 (3%)	126 (5%)	44 (5%)	158 (6%)	68 (6%)	174 (6%)	93 (7%)	169 (7%)	102 (8%)
D - Care issues which were likely to have made a difference to the outcome	8 (1%)	22 (1%)	34 (1%)	35 (1%)	17 (2%)	47 (2%)	30 (3%)	47 (2%)	31 (2%)	58 (2%)	34 (3%)
Unrecorded	27 (2%)	4 (<1%)	2 (<1%)	24 (<1%)	1 (<1%)	17 (<1%)	1 (<1%)	12 (%)	6 (%)	10 (%)	2 (%)

1. These are reviews where an external member is present as part of the review team

Table 4.6: Grading of bereavement care following neonatal deaths, with and without an external present, for the seven time periods from Jan 2018 to Dec 2024

	Reviews Jan 2018 to Feb 2019	Reviews Mar 2019 to Feb 2020	Reviews Mar 2020 to Feb 2021	Reviews Mar 2021 to Feb 2022	Reviews Mar 2021 to Feb 2022 with external present[1]	Reviews Mar 2022 to Feb 2023	Reviews Mar 2022 to Feb 2023 with external present[1]	Reviews Jan 2023 to Dec 2023	Reviews Jan 2023 to Dec 2023 with external present[1]	Reviews Jan 2024 to Dec 2024	Reviews Jan 2024 to Dec 2024 with external present[1]
	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Number of reviews	Reviews Jan 2023 to Dec 2023	Number of reviews	Number of reviews
	N = 346	N = 1,086	N = 1,381	N = 1,389	N = 478	N = 1,480	N = 667	N=1,589	N=836	N=1,591	N=902
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
A – No issues with care identified	312 (90%)	933 (86%)	1,147 (83%)	1,086 (78%)	374 (78%)	1,071 (72%)	491 (74%)	1,124 (71%)	592 (71%)	1,133 (71%)	629 (70%)
B - Care issues that would have made no difference to the outcome	22 (6%)	94 (9%)	131 (9%)	219 (16%)	72 (15%)	296 (20%)	140 (21%)	326 (21%)	175 (21%)	330 (21%)	198 (22%)
C - Care issues which may have made a difference to the outcome	5 (1%)	28 (3%)	30 (2%)	38 (3%)	26 (5%)	47 (3%)	25 (4%)	73 (5%)	45 (5%)	73 (5%)	51 (6%)
D - Care issues which were likely to have made a difference to the outcome	0 (0%)	21 (2%)	59 (4%)	3 (<1%)	3 (1%)	15 (1%)	8 (1%)	26 (2%)	16 (2%)	21 (1%)	14 (2%)
Unrecorded	7 (2%)	10 (1%)	14 (1%)	43 (3%)	3 (1%)	51 (3%)	3 (<1%)	40 (3%)	8 (1%)	34 (2%)	10 (1%)

1. These are reviews where an external member is present as part of the review team

5. The review team

Table 5.1: Number and percentage of staff recorded as present at the review session with the largest number of participants, by type of death, for the seven review time periods from Jan 2018 to Dec 2024

Number of staff recorded as present	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Review Mar 2021 to Feb 2022		Review Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Review Jan 2024 to Dec 2024	
	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths
	N = 1,154	N = 346	N = 2,607	N= 1,086	N = 2,600	N = 1,381	N = 2,810	N = 1,389	N = 2,631	N =1,480	N = 2,722	N = 1,589	N = 2,575	N = 1,591
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
1	94 (8%)	23 (7%)	224 (9%)	89 (8%)	160 (6%)	110 (8%)	164 (6%)	96 (7%)	86 (3%)	80 (5%)	84 (3%)	67 (4%)	65 (3%)	61 (4%)
2-3	316 (27%)	87 (25%)	605 (23%)	188 (17%)	405 (16%)	161 (11%)	250(9%)	101 (8%)	167 (6%)	84 (6%)	153 (6%)	79 (5%)	85 (3%)	86 (5%)
4-7	447 (39%)	129 (37%)	1,031 (40%)	434 (40%)	1,089 (42%)	448 (32%)	976 (35%)	326 (23%)	915 (35%)	268 (18%)	847 (31%)	275 (17%)	776 (30%)	205 (13%)
8+	265 (23%)	107 (31%)	601 (22%)	323 (30%)	874 (34%)	627 (45%)	1,358 (48%)	832 (60%)	1,382 (53%)	1,005 (68%)	1,571 (58%)	1,130 (71%)	1,595 (62%)	1,212 (76%)
None recorded	2 (<1%)	0 (0%)	147 (6%)	52 (5%)	72 (3%)	35 (3%)	62 (2%)	34 (2%)	81 (3%)	43 (3%)	67 (2%)	38 (2%)	54 (2%)	27 (2%)
Median	5	6	4	5	6	7	7	9	8	10	8	11	9	12

Table 5.2: Number and percentage of reviews involving each type of professional, by type of death, for the seven review time periods from Jan 2018 to Dec 2024

Professional role	Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)		Number of reviews in any review session (% of reviews)	
	Reviews Jan 2018 to Feb 2019		Reviews Mar 2019 to Feb 2020		Reviews Mar 2020 to Feb 2021		Review Mar 2021 to Feb 2022		Review Mar 2022 to Feb 2023		Reviews Jan 2023 to Dec 2023		Review Jan 2024 to Dec 2024	
	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths	Late miscarriages & stillbirths	Neonatal deaths
	N = 1,154	N = 346	N = 2,607	N= 1,086	N = 2,600	N = 1,381	N = 2,810	N = 1,389	N = 2,631	N =1,480	N = 2,722	N = 1,589	N = 2,575	N = 1,591
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
External panel member	105 (9%)	29 (8%)	496 (19%)	206 (19%)	539 (21%)	304 (22%)	938 (33%)	478 (34%)	1,180 (45%)	667 (45%)	1,362 (50%)	836 (53%)	1,325 (51%)	902 (57%)
Midwife	972 (84%)	267 (77%)	2,174 (83%)	826 (76%)	2,295 (88%)	1,128 (82%)	2,658 (95%)	1,198 (86%)	2,474 (94%)	1,347 (91%)	2,606 (96%)	1,503 (95%)	2,477 (96%)	1,517 (95%)
Neonatologist/paediatrician	140 (12%)	204 (59%)	468 (18%)	766 (71%)	592 (23%)	1,112 (81%)	795 (28%)	1,148 (83%)	733 (28%)	1,247 (84%)	680 (25%)	1,332 (84%)	608 (24%)	1,391 (87%)
Obstetrician	893 (77%)	253 (73%)	2,050 (79%)	778 (72%)	2,269 (87%)	1,024 (74%)	2,540 (90%)	1,153 (83%)	2,435 (93%)	1,261 (85%)	2,526 (93%)	1,410 (89%)	2,420 (94%)	1,420 (89%)
Bereavement team member	495 (43%)	145 (42%)	1,444 (55%)	526 (48%)	1,353 (52%)	703 (51%)	1,602 (57%)	828 (60%)	1,548 (59%)	879 (59%)	1,691 (62%)	1,062 (67%)	1,775 (69%)	1,127 (71%)
Risk manager/governance team member	749 (65%)	206 (60%)	2,452 (94%)	918 (85%)	1,889 (73%)	920 (67%)	2,060 (73%)	1,003 (72%)	1,940 (74%)	1,121 (76%)	2,116 (78%)	1,245 (78%)	2,143 (83%)	1,345 (85%)
PMRT/maternity safety champion[1]	125 (11%)	24 (7%)	454 (18%)	139 (14%)	410 (18%)	269 (21%)	581 (24%)	300 (23%)	549 (25%)	318 (24%)	562 (15%)	337 (23%)	528 (14%)	366 (25%)
Neonatal nurse	56 (5%)	83 (24%)	226 (9%)	779 (71%)	209 (8%)	632 (46%)	376 (13%)	740 (53%)	361 (14%)	905 (61%)	394 (14%)	879 (55%)	421 (16%)	998 (63%)
Management team member	288 (25%)	65 (19%)	1,130 (43%)	366 (34%)	967 (37%)	404 (29%)	1,214 (43%)	505 (36%)	1,141 (43%)	578 (39%)	1,290 (47%)	651 (41%)	1,287 (50%)	693 (44%)
Administrative support staff	122 (11%)	48 (14%)	448 (17%)	230 (21%)	545 (21%)	320 (23%)	760 (27%)	502 (36%)	847 (32%)	592 (40%)	902 (33%)	657 (41%)	1022 (40%)	635 (40%)
Pathologist	26 (2%)	4 (1%)	120 (5%)	16 (1%)	152 (6%)	47 (3%)	228 (8%)	94 (7%)	185 (7%)	94 (6%)	178 (7%)	106 (7%)	239 (9%)	101 (6%)
Anaesthetist	39 (3%)	4 (1%)	52 (2%)	19 (2%)	49 (2%)	33 (3%)	89 (3%)	57 (4%)	110 (4%)	71 (5%)	96 (4%)	6 (4%)	72 (3%)	55 (3%)
Other	223 (19%)	67 (19%)	764 (29%)	558 (51%)	623 (24%)	466 (34%)	803 (29%)	564 (41%)	904 (34%)	694 (47%)	937 (34%)	759 (48%)	1001 (39%)	817 (51%)
Unknown (in addition to other)	938 (81%)	297 (86%)	406 (16%)	252 (23%)	357 (14%)	305 (22%)	555 (20%)	415 (30%)	590 (22%)	474 (32%)	670 (25%)	575 (36%)	1056 (41%)	880 (55%)

1. England only

PMRT

Supporting high quality local perinatal reviews

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ISBN: 978-1-9191819-3-6