

Learning from Standardised Reviews When Babies Die

2026 PMRT Annual Report Key Messages



Since the launch of the national Perinatal Mortality Review Tool (PMRT) in early 2018, over 34,000 reviews have been started. This report presents the findings for the 4,110 reviews completed from January to December 2025.

RECOMMENDATIONS FROM THE ANNUAL REPORT 2026



REVIEW PARENT ENGAGEMENT UPDATED

Maximise the engagement of parents in reviews by ensuring all parents are approached respectfully, that staff are trained to listen to parents with compassion and empathy, and to enable parents to provide their perspectives and any questions they have about their care.

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



ADEQUATE RESOURCING NEW

Ensure that PMRT review panels are adequately staffed to enable all deaths to be reviewed by a team including obstetricians and midwives, and all neonatal deaths and stillbirths requiring resuscitation, are reviewed by a team including neonatologist/paediatricians and neonatal nurses. Confirm this with appropriate documentation

Action: Trusts and health boards, service commissioners



JOB PLANS AND ROLES UPDATED

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

Action: Trusts and health boards, service commissioners



INCLUDE EXTERNAL REVIEWERS UPDATED

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

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



BEST PRACTICE STANDARDS NEW

Comply with the PMRT best practice standards; this includes ensuring that all members of staff regularly involved in the PMRT review panel in trusts and health boards complete the PMRT online training and relevant sands training

Action: Trusts and health boards, service commissioners



PRIORITISE CARE IMPROVEMENTS UPDATED

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

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

Parent engagement in PMRT reviews 2025

96% of parents were invited to provide comments or questions about their care

37%

had specific questions about what happened and why

13%

had concerns with management plans and care received

7%

had general questions, or commented on a lack of information or communication issues

27%

had concerns about staff approach and how care was given

17%

provided positive comments about care and staff

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. This should happen as many times as parents require. It also means providing them with verbal and written feedback about the review findings and what the findings mean.



..... received morphine and diazepam for pain relief. Would that have caused [Baby's name] heart rate to slow down?

On the night before our baby was born, I was bleeding and in pain and despite making a request no medical review occurred.

... was admitted in labour and just left alone. I heard laughing outside the room.

With my first child I was started on [name antibiotic] straight away. Why did I need to wait until 28 weeks in this pregnancy?

.... I complained of stomach ache when I was 13 weeks and I was told to come into triage unit, but no findings were discussed with me. I only had to find out from my badger app that I had Strep B infection. This made me feel ignored and I didn't know what to do.

Why wasn't my pregnancy marked as high risk?

The care from midwives, sonographers, medical staff was warm, professionals, personal, kind and informative.

Parent engagement improves the quality of reviews

Care and the review team, PMRT Reviews 2025

93%

of reviews identified at least one issue with care

36%

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

21%

of reviews were holistically graded as having care issues that may or were likely to have made a difference to the outcome for the baby

At least one external reviewer should be present for the multidisciplinary review panel meeting. External reviewers should be relevant senior clinicians who work in hospitals 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 clinical specialty, and senior enough to provide authoritative, robust, objective challenge where appropriate.



Multidisciplinary review is essential

6%

of reviews had three or fewer people to carry out the reviews

70%

of reviews of neonatal deaths included a neonatal nurse

86%

of neonatal deaths included a neonatologist

35%

of reviews had administrative support

83%

of reviews had a risk/governance team member present

Actions planned following PMRT reviews 2025

Examples of actions planned following PMRT reviews 2025

Weak 52%

Mother presented with reduced fetal movements (RFM), management was not appropriate and not in line with national guidance:

Reminder to all staff via the maternity shared leaning infographic, to complete the fetal movements checklist when anyone attends with RFM

Although indicated this rhesus positive mother was not offered a Kleihauer test:

Reminder at the consultant meeting and on labour ward that this must be a consultant request when indicated.

A reminder of action without controls

Intermediate 39%

Mother presented in threatened preterm labour but was not offered magnesium sulphate for baby neuroprotection even though indicated:

Relaunch of PERIPrem care bundle to be arranged

Mother presented with reduced fetal movements. The written material available to give to her during antenatal care was not in a language she could understand:

Partnering with the "Good Things Foundation" to help women for whom English is not their first language and those who experience digital poverty, to access this information

A new support system in place but still without controls

Strong 9%

This mother missed several of her antenatal appointments including her glucose tolerance test and was not followed up as per the 'did not attend' policy:

A new failsafe system to check missing appointments has been implemented within the electronic patient record system. Reports are reviewed weekly by the antenatal clinic manager to ensure follow-up occurs

This mother smoked throughout her pregnancy and was never offered referral to the smoking cessation service:

All women who smoke are now automatically enrolled in the smoking cessation service; moving this from an opt-in to an opt-out process

Control system designed to eliminate human error