PMRT

Supporting high quality local perinatal reviews

National Perinatal Mortality Review Tool

Learning from Standardised Reviews When Babies Die

Eighth Annual Report 2026

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.

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UCL

NHS University Hospitals of Leicester NHS Trust

UNIVERSITY OF LEICESTER

NHS East Suffolk and North Essex NHS Foundation Trust

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NUFFIELD DEPARTMENT OF WOMEN'S & REPRODUCTIVE HEALTH

UNIVERSITY OF OXFORD

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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
ICBs	Integrated Care Boards
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	Pregnancy and baby loss charity

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Learning from Standardised Reviews When Babies Die
2026 PMRT 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, 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

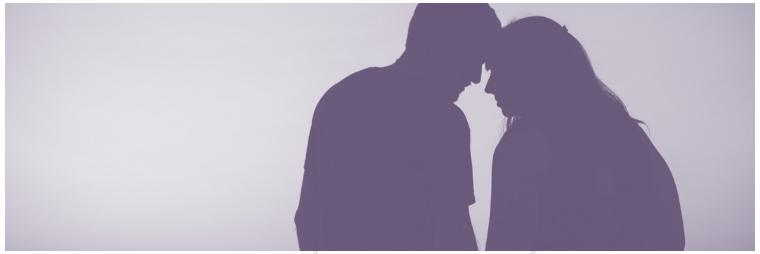
Use the findings from local PMRT summary reports and the national report, alongside data from the MBRRACE-UK real-time data monitoring tool to prioritise resources for key care quality improvement activities identified as requiring action

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



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. 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.

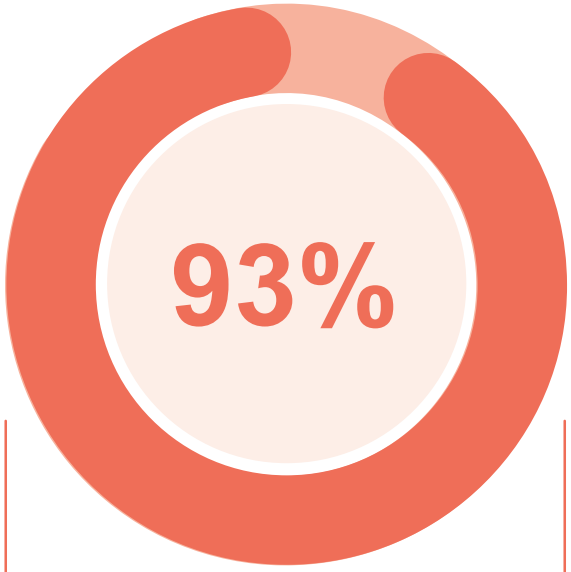
With my first child I was started on [name antibiotic] straight away. Why did I need to wait until 28 weeks in this pregnancy?

.... 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?

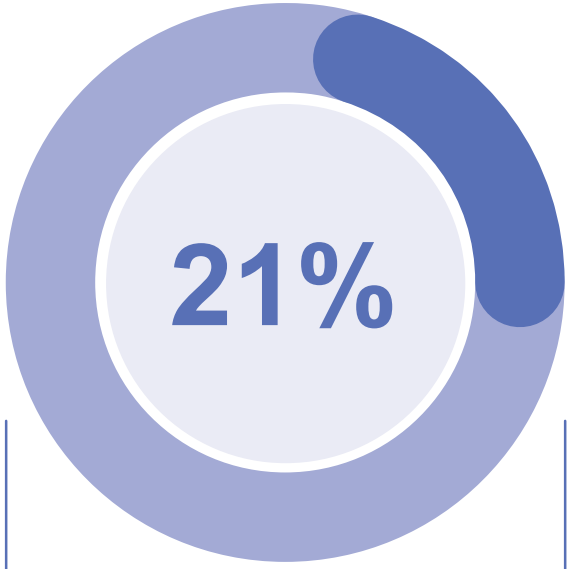
The care from midwives, sonographers, medical staff was warm, professionals, personal, kind and informative.

Care and the review team, PMRT Reviews 2025



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 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 multi-disciplinary 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%	Intermediate 39%	Strong 9%
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	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	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
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.	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	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
A reminder of action without controls	**A new support system in place but still without controls**	**Control system designed to eliminate human error**

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Executive Summary

In the UK when a baby dies during pregnancy or soon after birth, the care should be reviewed using the Perinatal Mortality Review Tool (PMRT). The PMRT was designed to support the local perinatal mortality review process to ensure each review is robust, standardised and systematically covers all aspects of the care provided. The primary purpose of each review is to provide answers for bereaved parents and families about the care they received, why their baby died, and whether different care may have resulted in a different outcome. The review is carried out primarily for parents. A secondary purpose is to draw wider learning from review findings to identify where service improvements are needed to prevent future baby deaths, improve care for all mothers and babies, and improve care when a death has occurred.

A local review following a baby's death is a routine part of maternity and neonatal care. For 93% of baby deaths, the PMRT review is the only hospital review that will take place, underlining the importance of completing it to a high standard.

This report focuses on the trends since the PMRT was launched in 2018. In 2025, for the vast majority of baby deaths during pregnancy and soon after birth, a perinatal mortality review using the PMRT was completed. This represents a major improvement since 2018, however, for about 3% of deaths a review was not started and for 13% the review was not fully completed to publication of the report.

Providing information for bereaved parents about their baby's death and answers to their questions about their care is essential. Supporting parents through their bereavement and the review process is a critical part of maternity and neonatal care. Meaningful, sensitive and empathic engagement with parents in the review process will improve the quality of the review and parents' confidence in the process and findings. A failure to engage openly and respectfully, and listen to parents at all stages of the review can lead to a loss of trust.

To understand what a review means, how they can contribute their perspective, and how they can ask questions, parents need a straightforward, trauma-informed verbal explanation in a language they understand, supported by plain-language parent-facing written information. Parents need to be treated with dignity, listened to with respect and the communication with parents must remain open during the review process 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. It is not possible to know from this information whether all parents actually understood what this meant and research suggests some parents will need several 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 has the capacity to improve the quality of their review from which they will benefit directly.

The membership of the PMRT review panel is critical in ensuring good quality reviews are conducted. There has been a steady improvement in the proportion of reviews having the appropriate healthcare professionals present across all professional groups. Nevertheless, some reviews were carried out without both obstetricians and midwives being present and, strikingly, 14% of reviews of neonatal deaths did not involve a neonatologist/paediatrician. Since it is not possible to fully review a neonatal death without a neonatologist/paediatrician, including neonatal deaths which occurs on labour ward immediately after birth, this raises serious questions about the quality and value of such reviews.

Some professional groups continue to be underrepresented on review panels, which may be a consequence of limited resource. The presence of at least one senior clinical professional external to the trust/health board is strongly advised to provide a 'fresh eyes view', to challenge where care delivery has become inward looking and to provide reassurance to parents that trusts and health boards are not simply "marking their own homework."

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 team 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 change reflects poorer care, an improvement in robust, objective reflections during the review process, or a combination of the two.

With a small number of notable improvements, including screening and provision of antenatal aspirin, screening for gestational diabetes and carbon monoxide levels, the issues with care identified in this report remain largely the same as those identified in previous years. Not only have the same issues recurred over time, the proportion of reviews in which they have been identified has remained largely unchanged. This is concerning and, whilst overall stillbirth and neonatal mortality rates have decreased since 2018, this does suggest that wider learning arising from local reviews and from the amalgamation of the findings in these national reports has not resulted in major improvements in practice.

The most common recurring issues are: mothers booking late or arriving in labour unbooked; inadequate surveillance of fetal growth; management of reduced fetal movements; diagnosis and management of maternal medical, surgical and social issues during pregnancy; 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 a peak in 2023. Importantly this issue continued to be identified in at least one review in about half of all trusts and health boards.

These recurring issues, along with specific recurring issues identified by trusts and health boards from their own PMRT summary reports, must remain a focus of quality improvement activities to implement 'strong' or at least 'intermediate' strength system level actions which do not simply rely on the actions of individuals in the absence of system controls.

Care, for all reviews, prior to the baby's death was graded as C or D in just over 1 in 5 (21%) reviews. This holistic grading of care gives the best overall indicator of the proportion of deaths that may have been prevented had different care been provided. However, in view of the need to improve the quality of some reviews by ensuring that all the appropriate professionals are present and that all review panels include at least one external senior clinician, the proportion of 1 in 5 (21%) should probably be best regarded as a minimum estimate of potentially preventable deaths.

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 a commensurate increase in other grades, particularly care graded as 'B' (care issues which would have made no difference to the outcome) continued in 2025. Since the launch of the tool there has been a 1.7-times increase in the proportion of reviews graded as C to 17% ('issues which may have made a difference to the outcome') or D to 5% ('issues which were likely to have made a differ-ence to the outcome'). It might be

expected that with an increasingly robust, objective approach to the review of the care provided, more reviews having external members present, and despite organisations seeking to improve future care, this trend to a more stringent level of grading may continue.

Best practice standards issued by the PMRT collaboration in June 2026 are also intended to support trusts and health boards in improving the quality of their reviews. Included as standard six, is the requirement to undertake the free on-line PMRT training which is available to all staff involved in PMRT reviews.

The final critical step of any review is to identify the issues that require action to prevent future deaths and improve 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 action has been taken and care has been improved as a consequence of their experiences and their subsequent review. Whilst not all issues can benefit from 'strong', system level actions, and 'strong' actions can be supported by both 'intermediate' and 'weak' actions, the continuing trend of about half of actions being strong/intermediate is encouraging. As mentioned previously however, of concern is that the same issues have continued to recur, affecting similar proportions of baby deaths.

These national findings, released soon after the publication of the National Maternity and Neonatal Investigation in England led by Baroness Amos, the Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust, and the Public Inquiry into events at the Countess of Chester Hospital chaired by Lady Justice Thirlwall, underline that multiple improvements across all stages of the pregnancy, labour, birth, postnatal and bereavement journey are required to reduce local and national perinatal mortality rates and improve care for all mothers, babies and families. The PMRT national findings should inform the work of the Maternity and Neonatal Taskforce in England to address the recommendations of these investigations and inquiries.

Given the total number of perinatal deaths across the UK each year, an external investigation of each death is not a realistic proposition. Funds would perhaps be better directed instead on improving care and the quality of local PMRT reviews. Local PMRT reviews conducted to a high standard have the capacity to address a number of recommendations in the Amos report.

The findings from this national report, alongside local PMRT findings, and regular review of the surveillance data presented by the MBRRACE-UK real-time data monitoring tool should inform the prioritisation and funding of quality improvement activities in trusts and health boards, including providing the resources needed to conduct high-quality reviews and reduce the risk of inadequate care provision in the future.

Recommendations

1. 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 **(updated recommendation for 2026)**

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

2. 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 involving attempted resuscitation, are reviewed by a team including neonatologists/paediatricians and neonatal nurses. Confirm this with appropriate documentation for every review **(new recommendation for 2026)**

   Action: Trusts and health boards, service commissioners

3. 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 **(updated recommendation for 2026)**

   Action: Trusts and health boards, service commissioners

4. Provide adequate resources and make the support arrangements necessary to ensure the participation of independent senior external clinicians at multi-disciplinary PMRT review meetings **(updated recommendation for 2026)**

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

5. 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 **(new recommendation for 2026)**

   Action: Trusts and health boards, service commissioners

6. Use the findings from local PMRT summary reports and this 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 **(updated recommendation for 2026)**

   Action: Trusts and Health Boards, service commissioners, regional/network support systems, governments

1. Background

The Perinatal Mortality Review Tool (PMRT) was launched in England, Wales and Scotland in 2018 (and in 2019 in Northern Ireland) to support high-quality reviews of care when babies have died during pregnancy or soon after birth. Developed in collaboration with clinicians and bereaved parents, the PMRT aims first to enable trusts and health boards to answer parents' questions, and them with clear answers about their baby's death, the care they and their baby received, whether different care may have resulted in a different outcome, and any implications for future pregnancies. The finding also supports wider local and national learning to prevent future baby deaths and improve care for all mothers and babies.

Local PMRT reviews sit alongside other review and investigation processes. For example, in England, Maternity and Newborn Safety Investigations (MNSI) focus on only specific deaths of babies born at term (and term babies with brain injury) with the aim of system-level safety learning. For most parents whose baby dies, however, the PMRT is the only hospital review of their baby's death that will take place.

Before the PMRT was launched, there was no national standard tool for the review of baby deaths across the UK. Full reviews were rarely conducted, and when they were, parents were not routinely invited to contribute questions and comments. In many instances, 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, systematic and standardised local reviews of the whole pathway of care from preconception onwards. It supports the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. The tool prompts review panels to include parents' perspectives so their questions they have can be addressed as the review progresses. The PMRT is regularly reviewed, refined and updated with support from clinicians and collaborators, including parent support organisations, to ensure the tool remains comprehensive, covering all the relevant elements of care.

This eighth annual report presents an analysis of reviews completed from January and December 2025 inclusive. Since the 2024 report, which reported on reviews completed in 2023, the PMRT reports have been presented on a calendar-year basis. A separate Tables Report document is also available. This includes data from the current year and previous years for comparison. An infographic summarising the main findings, a short plain-English version of the main findings, and a technical report describing the development, content, and use of the tool are also available from the *PMRT webpages*.

2. Findings

2.1 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 July 2026 over 34,000 reviews had been started using the tool since its launch.

During 2025, across the UK, a review of care was started for 99% of stillborn babies and those babies who died in the late second trimester of pregnancy (late miscarriages), and 95% of babies who died in the neonatal period (first four weeks after birth); overall, reviews of 97% of perinatal deaths were started. These figures vary by country as illustrated in Figure 1 (see also Tables 1.1 to 1.4 in the Tables Report). Across the UK, for 92% of stillbirths and late miscarriages, and 80% of neonatal deaths the reviews were completed and the report produced (referred to as 'published'); thus overall, reviews for 87% of perinatal deaths were completed.

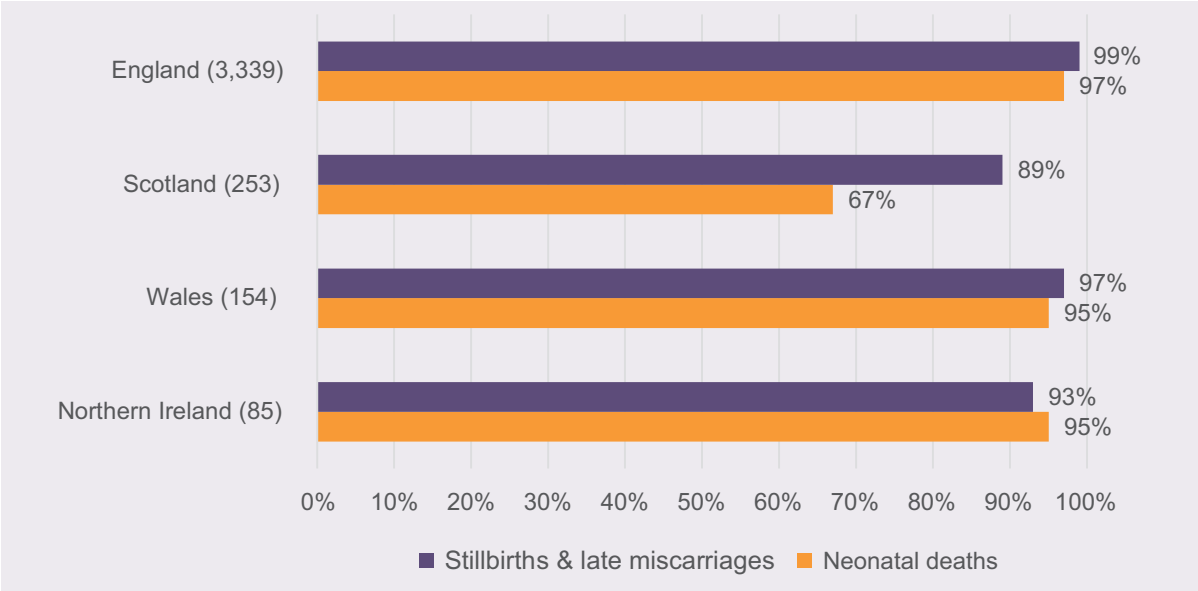

Figure 1: Proportion of deaths where a review was started by country and type of death, Jan 2025 to Dec 2025

2.2 Reviews completed

The findings reported throughout the report come from the information entered into the PMRT when reviews are carried out. From this point of the report onwards the information presented relates to the to the 4,110 reviews that were carried out to completion, and where the final review report was produced (referred to as published) in the period January 2025 to December 2025. These figures do not align directly with the total number of deaths in 2025 as reviews take several months to complete. Hence, the review of the care of a death in late 2024 is likely to be completed in 2025 and similarly the review of the care of a death in late 2025 may not be completed until early 2026.

Findings from reviews which were started, but not completed during this period, are not included in this and later sections of the report. 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, by year Jan 2023 to Dec 2025

		Reviews Jan 2023 to Dec 2023		Reviews Jan 2024 to Dec 2024		Reviews Jan 2025 to Dec 2025	
		Number of reviews completed N=4,311	Percentage of reviews	Number of reviews completed N= 4,166	Percentage of reviews	Number of reviews completed N=4,110	Percentage of reviews
Country	England	3,806	88%	3,768	90%	3,683	90%
	Wales	154	4%	165	4%	168	4%
	Scotland	176	4%	143	3%	162	4%
	Northern Ireland	175	4%	90	2%	97	2%
Type of death	Late miscarriages	395	8%	361	9%	369	9%
	Stillbirths	2,327	54%	2,214	53%	2,176	53%
	Neonatal deaths	1,589	37%	1,591	38%	1,565	38%

2.3 Parent engagement

Parents' voices are central to the PMRT review process. Reviews are intended to be conducted primarily to provide parents with clear answers about their baby's death and whether different care may have led to a different outcome. Parents' questions, views and experiences cannot be addressed unless they are actively sought. Their perspectives also provide a fuller understanding of the care received and can support learning to improve future care. We refer to this as parent engagement.

In PMRT reviews engaging parents means:

1. **Communicating sympathetically and transparently:** telling parents clearly and sensitively at the earliest opportunity that a review of their care and their baby's care will take place. This includes using plain language, tailored to the individual needs of the parents, avoiding medical jargon, taking a trauma-informed approach[1], [2], offering interpreters where needed, and using a method of communication which respects parents' needs, preferences and circumstances.

2. **Supporting parent input:** giving parents more than one opportunity to share questions, comments, or feedback about their care using plain and considered language and their preferred method of communication. Parents should be given sufficient time to respond, recognising that they may need more time or may not wish to engage with the process.

3. **Sharing review outcomes:** Ensuring all parents are offered the opportunity to discuss the review findings and any implications for future pregnancy plans. All parents should receive a clear, accessible, plain language summary of the review findings, regardless of whether they choose to meet with the review team. If parents request a copy of the full PMRT clinical report, this should be provided only after an appropriate plain language explanation of its contents has been given verbally and in writing.

1 Emsley E, Smith J, Martin D, Lewis NV. Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. BMC Health Services Research 2022;22:1164. https://doi.org/10.1186/s12913-022-08461-w

2 *Working definition of trauma-informed practice - GOV.UK* (Downloaded 30th Sept 2026)

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 remaining transparent, receptive and compassionate, the key contact can create space for parents to raise questions or share feedback when they are ready. This may be valuable for both the parents as they deal with their grief and for the quality of their review.

Engaging parents in reviews

Engaging parents with reviews is a very sensitive process. To be effective, it depends on staff in trusts and health boards building and maintaining empathic, trusting relationships with the parents, rather than simply following a set of procedural steps. Sands (Pregnancy and baby loss charity) has explored parents' experience of reviews following the death of their baby through a survey of its members. The results of this survey, alongside the 'Listening Project' documenting the experiences of Black and Asian groups, are available on the *Sands website*.[3] The 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.[4]

In 2019 the PMRT collaboration 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*. The materials include:

- 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 to gather parents' comments or questions if they wish to write them down,
- a follow-up template for use if no reply has been received,
- 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?

Clinicians reported through the PMRT that 96% of UK parents were informed that a review of their care and that of their baby would take place. This varies across the UK from 97% in England, 92% in Scotland, 92% in Wales and 100% in Northern Ireland (Figure 2). Overall, this represents a small overall decrease from the 2025 report (98%) reflecting a decrease in England, but increases in Scotland, Wales and Northern Ireland. Despite this overall small decline, the figures remain substantial higher than in 2018 when only 75% of trusts and health board reported engaging with parents.

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3 *www.sands.org.uk/get-involved/get-involved-research/sands-listening-project-learning-experiences-black-and-asian* (Downloaded 22nd Sept 2025)

4 Personal Communication A Heazell, MAT-REP project *MATREP | The University of Manchester* (Downloaded 22nd Sept 2026)

Nevertheless, it would appear from PMRT data that 4% of parents across the UK were not told that a review of their care would take place even though a review was conducted. These parents may have been unable to provide questions ahead of the review and may have found any later invitation to discuss the findings difficult to understand, furthermore they may not have been told that a review had taken place at all, and therefore may not have had the opportunity to discuss the finding.

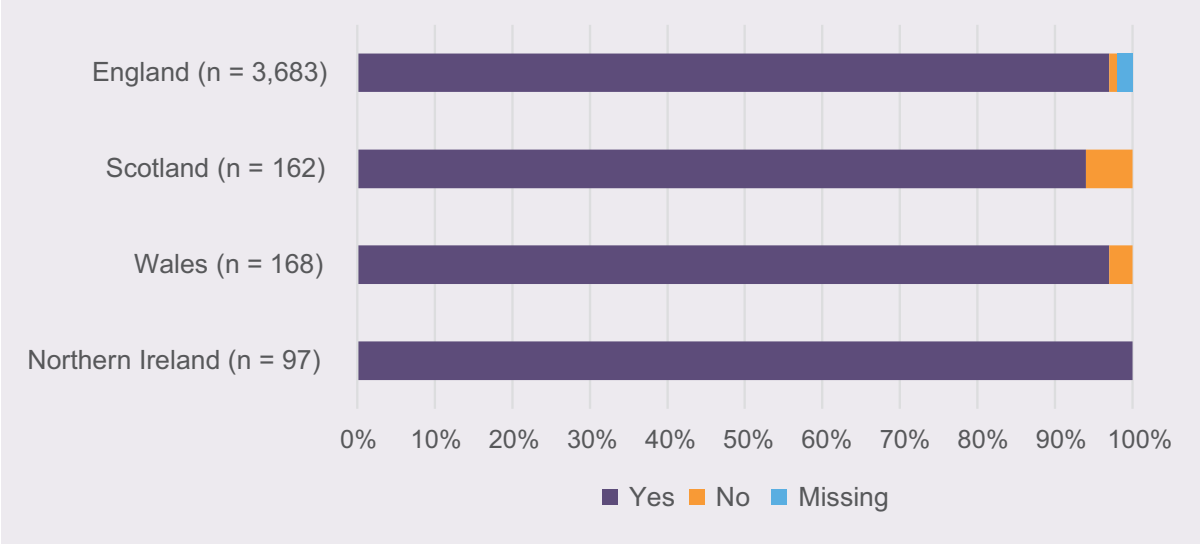


Figure 2: Proportion of parents who were told a review would take place, by country reviews completed Jan 2025 to Dec 2025

Were parents' views of their care sought?

Among parents who were told that a review would take place, clinicians reported that the parents' perspectives of their care were sought from 96%. This ranged from 96% in England, 92% in Scotland, 92% in Wales and 100% in Northern Ireland (Figure 3). It is important to note that in Northern Ireland that because of NI Privacy legislation a review using the PMRT cannot take place without the explicit consent of parents.

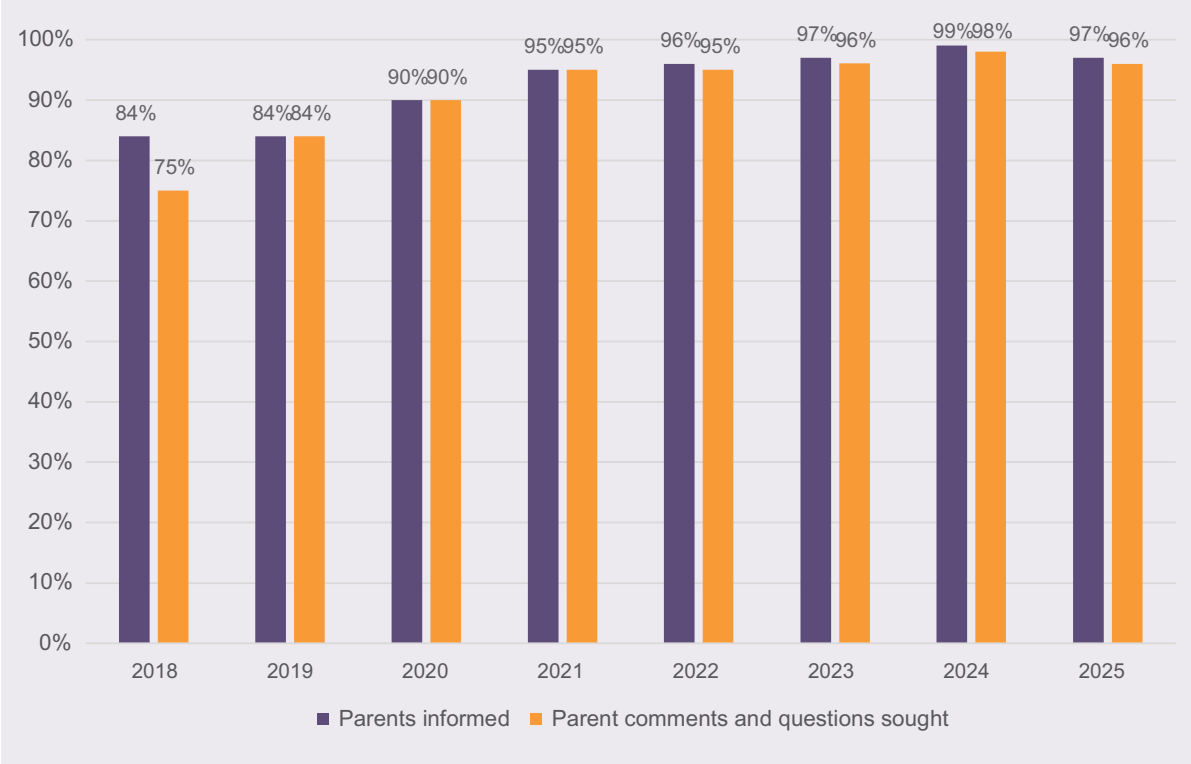


Figure 3: Proportion of UK parents informed about the PMRT and their comments and questions about their care sought, reviews completed 2018 to 2025

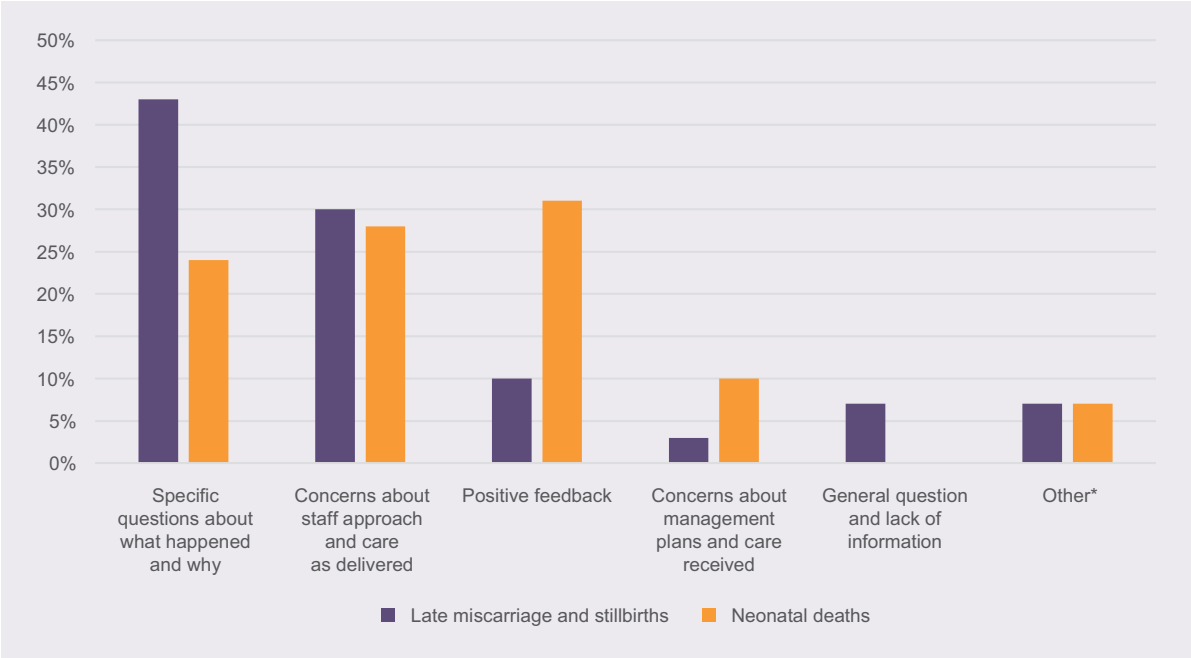
Did parents express their views?

The information recorded in the PMRT concerning parents view of their care is entered into the PMRT by staff in trusts and health boards. In some reviews it appears as a verbatim transcript of their comments and questions and in other reviews it appears as a paraphrased version of what parents said or wrote. Because of the way this information is recorded in the PMRT it is not always possible to distinguish between different types of parent responses. For example, where the recorded note stated “no concerns” or “no issues”, it is not clear whether parents had explicitly said they had no questions, whether they had been approached and felt there were no issues with their care, or whether they had not replied to requests for feedback. During the data cleaning comments which lacked clarity were removed. Thus, the proportion of reviews with explicit parent comments or questions which could be analysed reduced from 96% to 64%. This included parents who made one or more comments and a small number who explicitly declined to provide comments or questions. From the information available it is not possible to identify why the apparent 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 some of the comments included in the PMRT.

To improve the recording and reporting of parent engagement, the parent feedback sections of the PMRT have been modified. However, this change was not implemented in time to be reflected in the extract of data relating to reviews conducted in 2025.

Parental comments, feedback and concerns expressed to staff

In line with previous reports a proportional random sample of 200 parent comments and questions about their care were analysed using a thematic approach. The coding groups were largely based on the coding groups used in previous reports (Figure 4, note the axis maximum is 50%). The proportional sampling took into account the country level distribution of PMRT reviews (see Table 1). For example, 90% of the 200 comments were randomly sample from England, and so on for the devolved nations. The qualitative nature of the data meant that only a small indicative sample could be analysed. Furthermore, these data should be interpreted with caution because, as noted above, the information was entered into the PMRT by staff in trusts and health boards, rather than being collected directly from 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 2025 to Dec 2025

The most common theme was parents asking about specific aspects of their care and why their baby had died. These comments were recorded in 37% of the sampled comments. Examples included:

> "……..[name of mother] received morphine and diazepam for pain relief. Would that have caused [Baby's name] heart rate to slow down? [Baby's name] died later that night"
>
> "Were there any signs that baby was unwell from the scans? Can you detect [name of specific infection] by scan and could she have been treated?"
>
> "Why wasn't my pregnancy marked as high risk?"

Questions about specific aspects of care and why the baby died were recorded more frequently in reviews of stillbirths or late miscarriages (43%) than in reviews of neonatal deaths (24%).

Concerns about the approach of staff and the care received were recorded in 27% of sampled comments. These included comments about feeling left alone, not being listened to, poor communication, and a lack of compassion or empathy. Examples of these comments and questions include:

"…admitted in labour and just left alone. I heard laughing outside the room";

……I complained of some 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";

"We'd like to know what care was given to our baby when we weren't there - what was explored or done in that time."

Positive comments about treatment and support were recorded in 17% of sampled comments. These were more common in reviews of neonatal deaths (31%) than in reviews of stillbirths and late miscarriages (10%). Examples included:

"Thank you so much for everything that all people involved did to help to try to save our baby"

"[The] care from midwives, sonographers, medical staff was warm, professional, personal, kind & informative."

Concerns about management plans and the care received including procedural questions were recorded in 13% of sampled comments from late miscarriages or stillbirths and 10% of sampled comments from neonatal deaths. Examples included:

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

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

A range of other comments and questions were recorded in 7% of sampled comments. These included general comments about a lack of information, as well as questions about administrative and organisational issues. Examples included:

"… why was I not given my test results before I was discharged from triage?"

"Is it normal to have different midwives throughout pregnancy? Is there a way to attempt continuity of same midwife to create bond between mother and midwife?"

2.4 Issues with care identified

As each PMRT review progresses, review panels identify any issues with care. An issue is recorded where the care provided in the specific circumstances did not meet national or local guidelines, standards or best practice.

Overall, at least one issue with care was identified at some stage of care in 93% of reviews (Table 3.1 Tables Report). In 36% of reviews at least one issue with care was identified and may have been relevant to the outcome as judged by the review panel. The latter, is the same proportion as in 2024 and higher than the 30% proportion reported in 2023.

In PMRT annual reports up to 2024 (reviews in 2023) issues with care were presented solely as a proportion of all completed reviews. However, this does not show how widely these issues occurred across trusts and health boards. To provide additional context last years' report and this report also include the proportion of trusts and health boards where each issue was identified in at least one review. It should be noted however, that larger trust and health boards are more likely to have at least one review with an individual issue identified by virtue of the larger number of women they provide care for.

Preconception and antenatal care

Overall, in the 4,110 reviews a total of 5,613 issues with pre-conception and antenatal care were identified. Of these 1,530 (27%) were judged by reviews panel as relevant to the outcome (see Table 3.2 in the Tables Report). The most common issues were similar to those reported in the 2025 report and in earlier PMRT reports. These were also the issues reported by the highest proportion of trusts/health. The five most common issues with pre-conception and antenatal care since the launch of the PMRT are shown in Figure 5 (note the axis maximum is 40%).

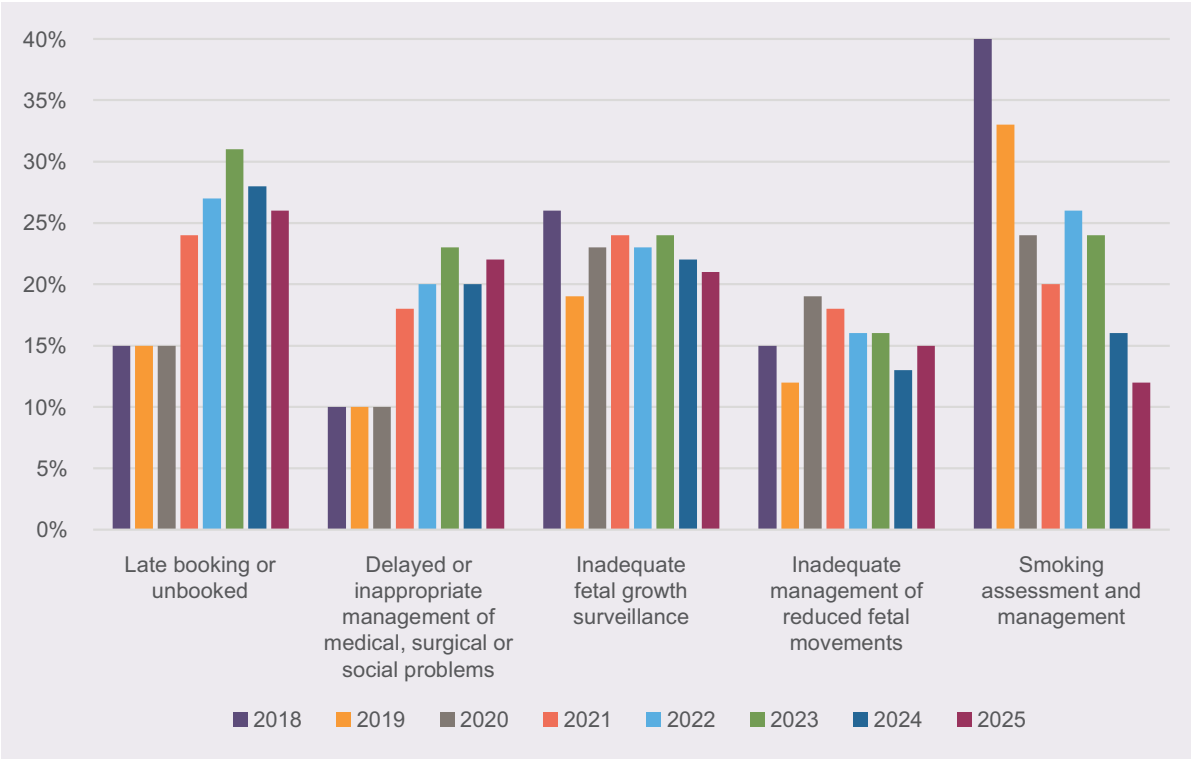


Figure 5: The five most common issues identified during pre-conception and antenatal care, for reviews completed Jan 2018 to Dec 2025

With the exception of smoking assessment and management, the frequency with which the most of these issues were identified has changed little since 2022, with limited evidence of improvement since 2018.

Late booking or not having booked at all remains the most common issue with care. It was identified in 26% of reviews in 2025, compared with 28% in 2024 and 31% in 2023. The proportion of reviews where this issue was judged relevant to the outcome was 10%, similar to 13% the previous year. The proportion of reviews in which this issue was identified has increased from 15% in 2018-2019. Overall, 125 (85%) trusts/health boards identified this as an issue in at least one review. Staff in trusts and health

boards have previously suggested that for some mothers, late booking may be related to relocation during pregnancy and the need to re-book at a new hospital. It has been speculated previously that the dispersal and re-dispersal of asylum seekers may have contributed to this. In this report, to explore this further, we used the only information related to this issue we have available in the PMRT, which is the duration of time the mother had been resident in the UK at booking. Mothers who had been resident in the UK for <1 year at booking accounted for only 15% of the reviews for which there was an issue with late booking or not having been booked at all. However, among these recently resident mothers, late booking or not having booked at all was identified in 47% of reviewed, compared with 12% of reviews for mothers who had been resident in the UK for one year or longer. This reflects the fact that whilst late or not having booked affected nearly half of recently resident mothers, as a group they represent a small proportion of all mothers giving birth and therefore do not wholly explain this factor being the most common issue with antenatal care identified.

Delay in diagnosis or inadequate management of maternal medical, surgical or social problems was the second most common issue with antenatal care. It was identified in 22% of reviews, compared with 20% in the previous report, and has more than doubled since 2018, when it was identified in 10% of reviews. This issue was identified in at least one review by 114 (78%) trusts and health boards.

Inadequate fetal growth surveillance was the third most common issue with antenatal care, identified in 21% of reviews. Since 2018, this issue has been identified in between one fifth and one quarter of all reviews, with no clear evidence of improvement over time. Overall, 128 (87%) trusts and health boards reported this issue in at least one review, making it yet again the most widely reported issue across trusts and health boards.

Inadequate investigation and management of reduced fetal movements was identified in 15% of reviews and in at least one review by 110 (75%) trusts and health boards. The proportion of reviews in which this issue was identified has remained effectively unchanged since 2018.

Smoking assessment and management issues have reduced substantially, from 33% of reviews in 2018 to 12% in 2025, showing a generally steady decrease as an issue overtime apart from the years affected by the COVID-19 pandemic. The proportion of reviews where this issue was judged relevant to the outcome has also declined steadily, from 13% in 2018 to 2% in 2025. Nevertheless, smoking assessment and management was identified in at least one review in 107 (73%) trusts and health boards.

Assessment and management of the need for antenatal aspirin has also continued to improve. This issue affected 4% of reviews in 2025, compared with 17% in 2018. However, it was still reported in at least one review by 69 (47%) trusts and health boards, and is unchanged from 2024.

Labour and birth

Across the 4,110 reviews, 2,992 issues with labour and birth were identified. Of these 907 (30%) were judged by review panel as relevant to the outcome (see Table 3.3 in the Tables Report).

The five most common issues identified during labour and birth were similar to those reported in earlier PMRT reports. With the exception of maternal monitoring in labour, the proportions affected have remained largely unchanged since 2018. These issues are shown from the launch of the PMRT in Figure 6 (note the axis maximum is 35%).

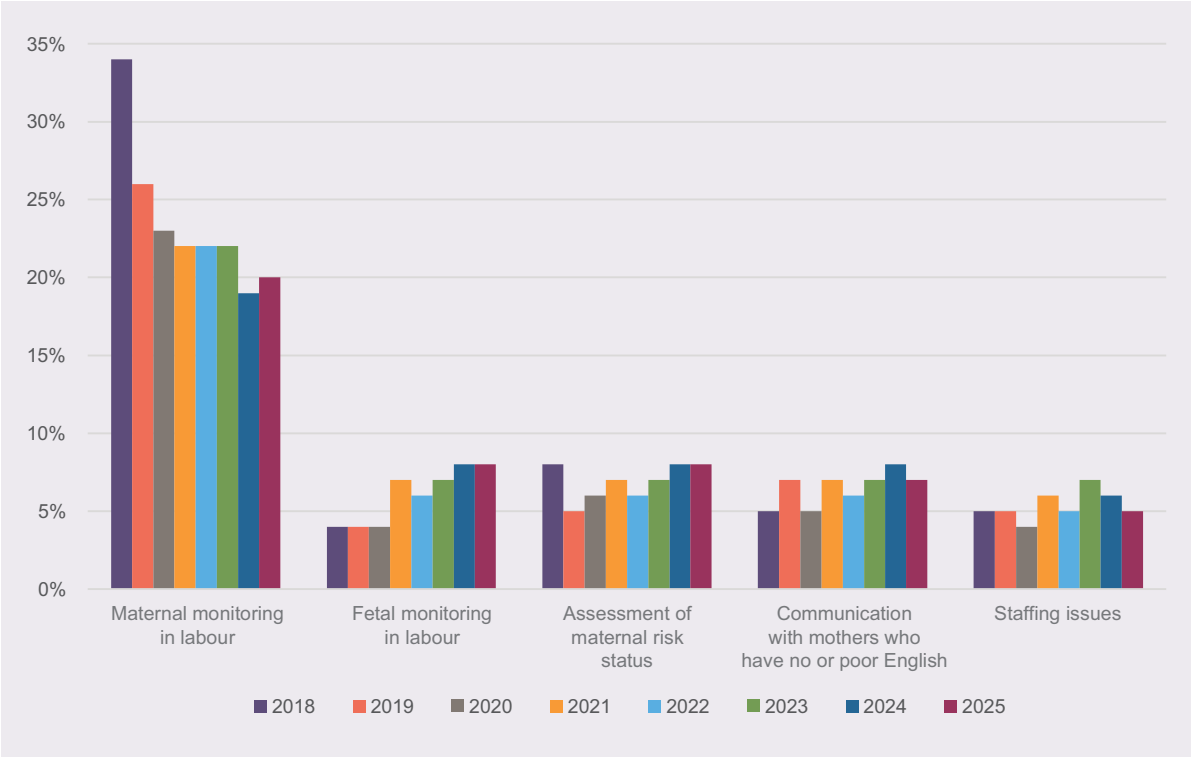


Figure 6: The five most common issues with care identified during labour and birth care, reviews completed Jan 2018 to Dec 2025

Maternal monitoring during labour remained the most common issue with care during labour and birth. It was identified in 20% of reviews in 2025 and in at least one review by 122 (83%) of trusts/health boards, the same proportion as in 2024.

The remaining four most common issues were identified in largely the same proportion of reviews with no evidence of improvement over time. These were:

- **fetal monitoring in labour** – identified in 8% of reviews and by 54% of trusts/health boards in at least one review;
- **the assessment of maternal risk status** – identified in 8% of reviews and by 52% of trusts/health boards in at least one review;
- **communication with mothers who are unable to speak English or have limited English** – identified in 7% of reviews and by 61% of trusts/health boards in at least one review;
- **staffing issues** – identified in 5% of reviews and by 44% of trusts/health boards in at least one review.

Preconception, antenatal, labour and birth care by type of death

For the first time, this report presents the most common issues identified during the antenatal and intra-partum periods by type of death in 2025 (see Table 3.8 in the Tables Report). These frequencies were compared using the Chi square test of statistical significance which produces a P value; $P<0.05$ represents a statistically significance difference indicating the difference is unlikely to be due to chance.

Several issues were identified in same proportion of reviews of late miscarriages or stillbirths and reviews of neonatal deaths:

- The management of medical, surgical or social problems - 22% late miscarriages/stillbirths and 22% neonatal deaths;
- smoking assessment and management - 12% and 12% respectively;
- communication with mothers who are unable to speak English or have limited English – 7% and 7% respectively.

Two issues were identified in similar proportions of reviews of late miscarriages or stillbirths and reviews of neonatal deaths however, these small differences were statistically significantly different:

- Late booking/unbooked - 27% late miscarriages/stillbirths and 24% neonatal deaths (P=0.012);
- intrapartum assessment of maternal risk status – 7% and 9% respectively (P=0.005).

Other issues were identified significantly more frequently in reviews of late miscarriages or stillbirths than in reviews of neonatal deaths:

- Inadequate fetal growth – 26% late miscarriages/stillbirths versus 12% of neonatal deaths (P<0.001);
- Inadequate management of reduced fetal movements – 18% and 8% respectively (P<0.001);
- Maternal monitoring in labour – 23% and 16% respectively (P<0.001).

In contrast, the following issues were identified significantly more frequently in reviews of neonatal deaths than in reviews of late miscarriages or stillbirths:

- Fetal monitoring in labour – 19% of neonatal deaths versus 1% of late miscarriages/stillbirths (P<0.001);
- Intrapartum staffing issues – 11% and 2% respectively (P<0.001).

Neonatal care

Across the 1,565 neonatal reviews, 2,852 issues with care of the newborn baby were identified. Of these, 585 (21%) were identified as relevant to the outcome for the baby (see Table 3.4 in the Tables Report for the most common issues). The six most common issues found during neonatal care are shown in Figure 7 (note axis maximum is 90%).

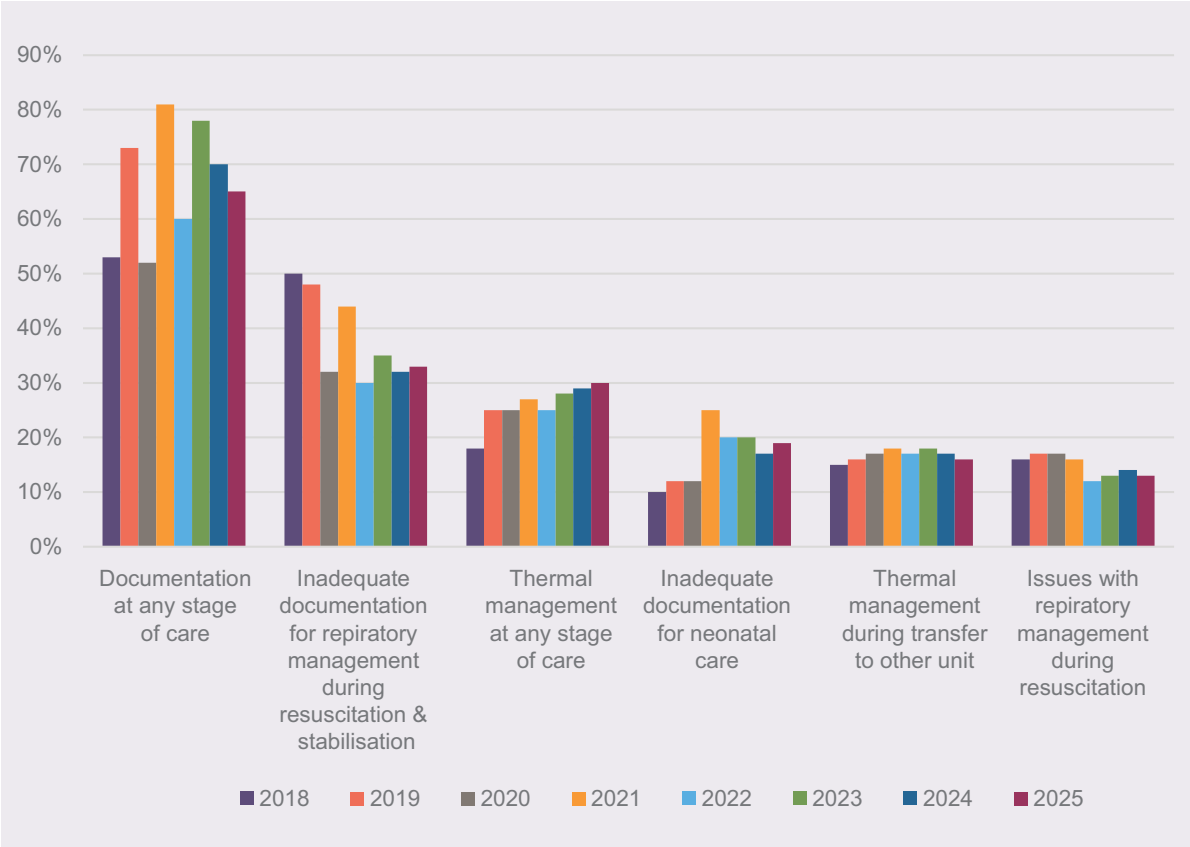


Figure 7: The six most common issues identified with neonatal care including resuscitation and stabilisation (excluding end of life care), reviews completed Jan 2018 to Dec 2025

The issues identified during neonatal care were similar to those reported in earlier PMRT reports. Problems with documentation at any stage of care have reduced slightly since 2023. Documentation of respiratory management during resuscitation and stabilisation has shown a general downward trend since 2018, although there has been little change since 2022. Problems with documentation of neonatal care overall have remained unchanged since 2021; of note this refers to poor quality of documentation in the neonatal notes such that it is difficult for the PRMT panels to review the care provided. In 2025, issues with documentation during resuscitation and stabilisation were identified in at least one review by 88 (60%) trusts and health boards.

Thermal management at any stage of care was again one of the six most common issues identified during neonatal care, and the frequency of this issue has increased over time. Issues with thermal management during neonatal care were identified in 18% of reviews in 2018 and in 30% of reviews in 2025. Where thermal management was identified as an issue, it was also increasingly judged to be relevant to the outcome: 17% in 2018 compared with 25% in 2025 (see Table 3.4 in the Tables Report). Issues with thermal management during transfer to another unit have remained broadly unchanged over time, affecting around 15% of reviews. In 2025, issues with thermal management during neonatal care were identified in at least one review by 46 (31%) trusts and health boards, an increase from 21% in 2024.

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

The most common issue identified with **end-of-life care** in reviews completed in 2025 was the absence of a discussion recorded in the notes about post-mortem examination before the baby's death. This was identified in 14% of reviews and has remained effectively unchanged since 2018 (see Table 3.5 in the Tables Report; Figure 8, note the axis maximum is 25%). Not discussing organ donation before the baby's death has shown a downwards trend since 2018 and was identified in 11% of reviews in 2025. Inadequate documentation of end-of-life care has halved in frequency since 2018/19. Issues with poor documentation of end-of-life care were identified in at least one review by 41 (28%) trusts and health boards, unchanged from 2024.

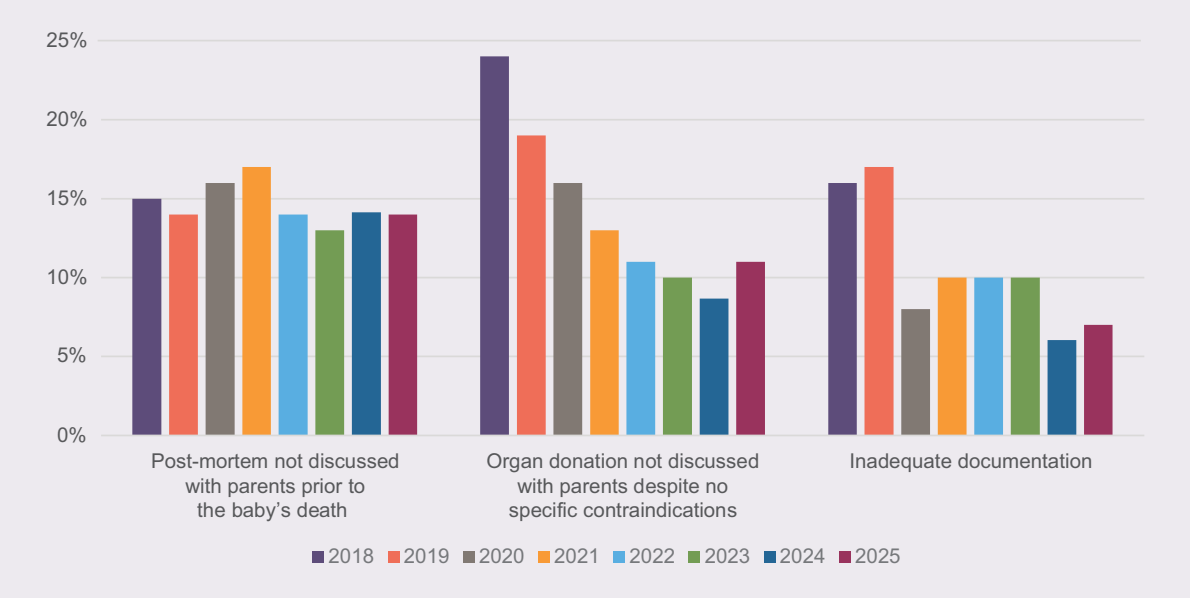


Figure 8: The three most common issues with care identified during end-of-life care, reviews completed Jan 2018 to Dec 2025

The need to transfer the baby to another hospital for post-mortem examination remained the most common issue recorded during **postnatal investigations**. This was reported in 21% of reviews and by 96 (65%) trusts and health boards. The proportion of trusts and health boards reporting this issue decreased from 82% in 2024 (Figure 9, note the axis maximum is 30%; Table 3.6 in the Tables Report). Other issues recorded during postnatal investigations have remained effectively unchanged over time. Placental histology being carried out by someone other than a perinatal or paediatric pathologist was identified in 6% of reviews and by 44 (30%) trusts and health boards. Not sending the placenta for histological examination was identified in 2% of reviews; most of these reviews (71%) related to neonatal deaths.

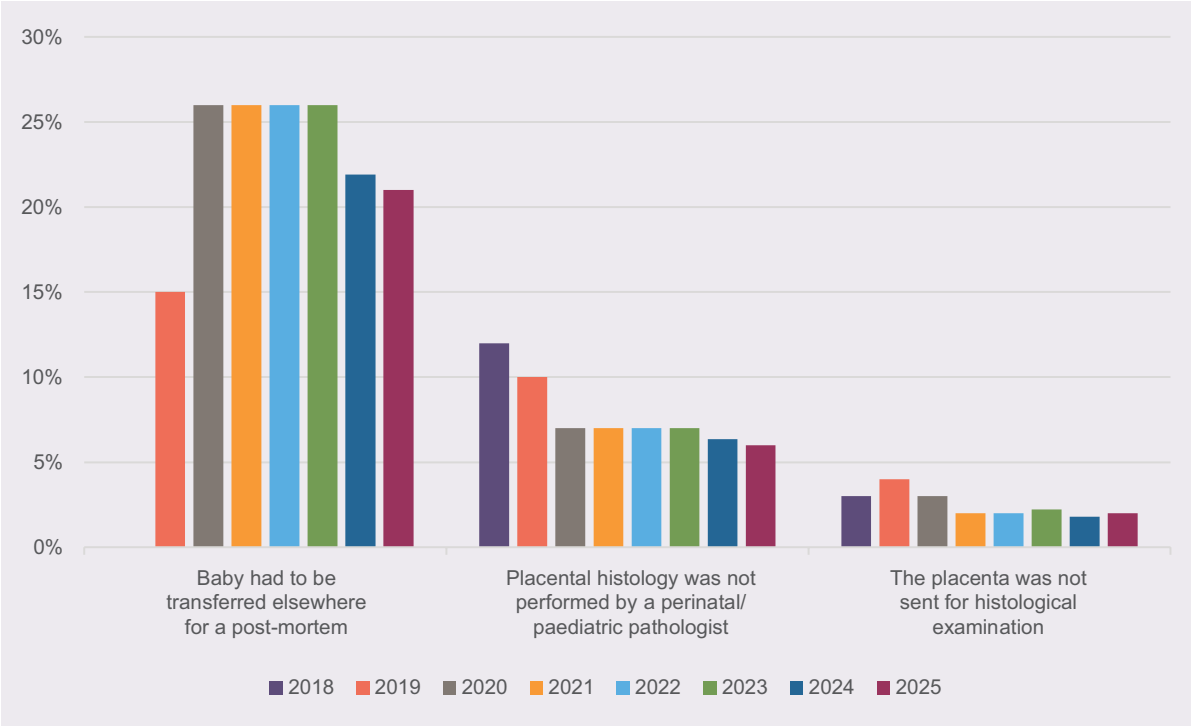


Figure 9: The three most common issues identified with postnatal care and investigations, reviews completed Jan 2018 to Dec 2025

For **bereavement care**, the most commonly reported issues remained the absence of a policy, support or practical help to enable parents to take their baby home, and inadequate documentation about taking the baby home. Both have decreased since bereavement-related questions were incorporated into the PMRT in 2020. The absence of a policy, support or practical help reduced from 24% in 2020 to 13% in 2025, while inadequate documentation reduced from 18% to 9% over the same period (Figure 10; Table 3.7 in the Tables Report). However, these issues remain common across trusts and health boards. The absence of a policy was identified in at least one review in 81 (55%) trusts and health boards, and inadequate documentation was identified in at least one review in 88 (50%); neither proportion has improved since 2024.

There is some evidence of a small improvement since 2020 in the proportion of reviews where the location or quality of the bereavement suite was identified as an issue. This was identified in 6% of reviews in 2025, compared with 9% in 2020. However, it was still identified in at least one review in 69 (47%) trusts and health boards, which has not improved from 48% in 2024.

Other issues continued to affect a similar proportion of reviews over time. These included inadequate documentation to enable the review panel to assess whether cultural, religious or spiritual wishes were respected, poor quality bereavement care, and the absence of a bereavement checklist in the notes.

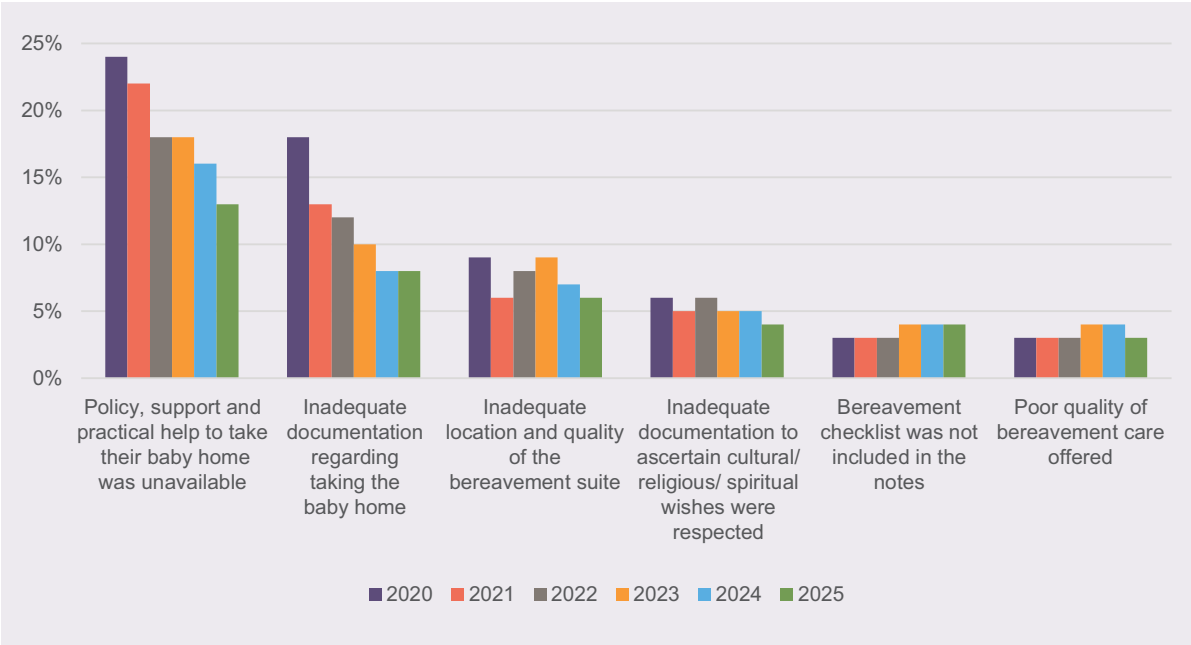


Figure 10: The six most common issues identified with bereavement care, reviews completed Mar 2020 to Dec 2025

2.5 Grading of Care

Towards the end of the final review session, the review team grades the overall care provided at each stage of the care pathway, including bereavement and other aspects of postnatal care. These grades represent the multidisciplinary review team's judgement using the PMRT grading framework. The gradings are intended to provide a holistic assessment of care and indicate how much difference potential improvements in care might have made to the outcome (Tables 4.1 to 4.6 Tables Report). Here, 'outcome' refers both to the death of the baby and to the experiential and psychosocial outcomes for parents. The proportions shown exclude the generally very small number of reviews where care was not graded.

Grading of care prior to the death of the baby

For late miscarriages and stillbirths, care during pregnancy, labour and birth in reviews completed in 2025 was graded as follows: 33% grade A (no issues with care identified), 44% grade B (care issues that would have made no difference to the outcome), 17% grade C (care issues that may have made a difference to the outcome) and 5% grade D (care issues that were likely to have made a difference to the outcome).

Since 2018, the distribution of grades for this stage of care has changed substantially. The proportion of care graded A has fallen from 62% in 2018 to 33% in 2025. Over the same period, care graded B increased from 25% to 44%, and care graded C increased from 10% to 17%. The proportion graded D has remained broadly similar over time, at 5% in 2025 compared with 3% in 2018 (Table 4.1 Tables Report; Figure 11, note the axis maximum is 70%).

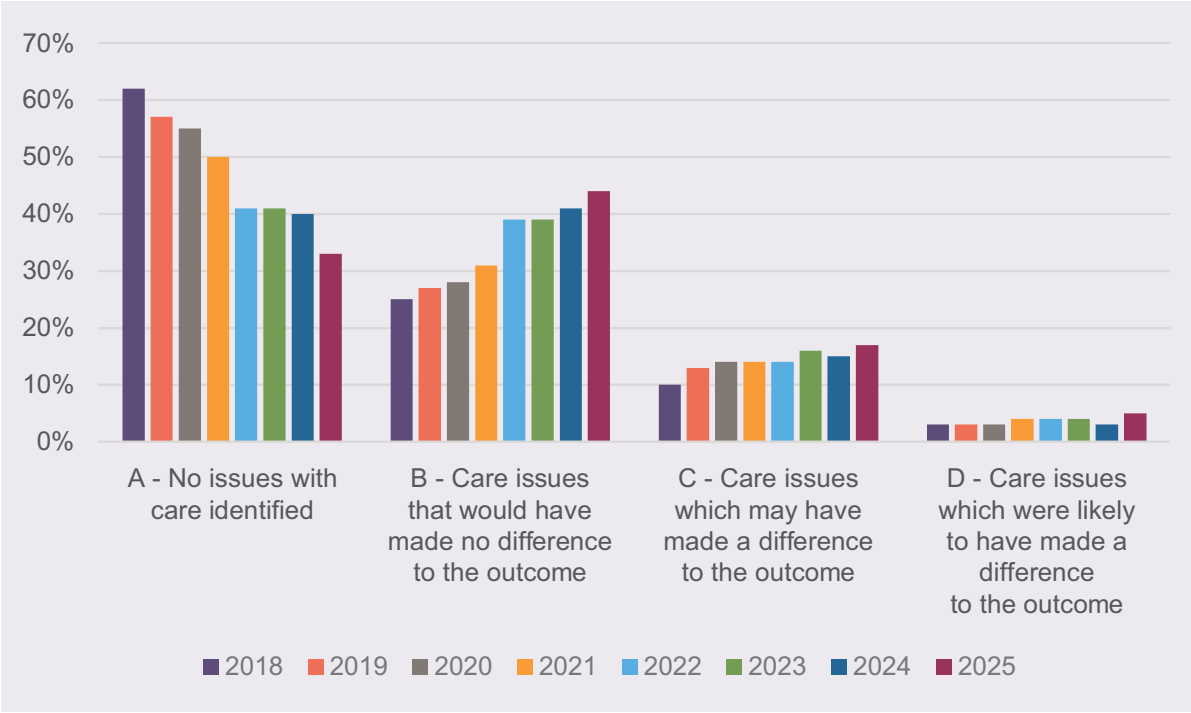


Figure 11: Grading of care during pregnancy, labour and birth for late miscarriages and stillbirths, reviews completed Jan 2018 to Dec 2025

For neonatal deaths, the most serious grading of care during pregnancy, labour, birth and neonatal care in reviews completed in 2025 was as follows: 18% grade A, 55% grade B, 16% grade C and 5% grade D. In 2025, 7% of reviews were not graded for this aspect of care, which is a higher proportion than in previous years. It is not possible to assess from the PMRT information why the grading was not carried out as part of these reviews.

Since 2018, the distribution of grades for this stage of care has also changed substantially. The proportion graded A decreased from 45% in 2018 to 18% in 2025, while the proportion graded B increased from 42% to 55%. The proportion graded C increased from 7% to 16%, and the proportion graded D increased from 2% to 5% (Table 4.4 Tables Report; Figure 12, note the axis maximum is 60%).

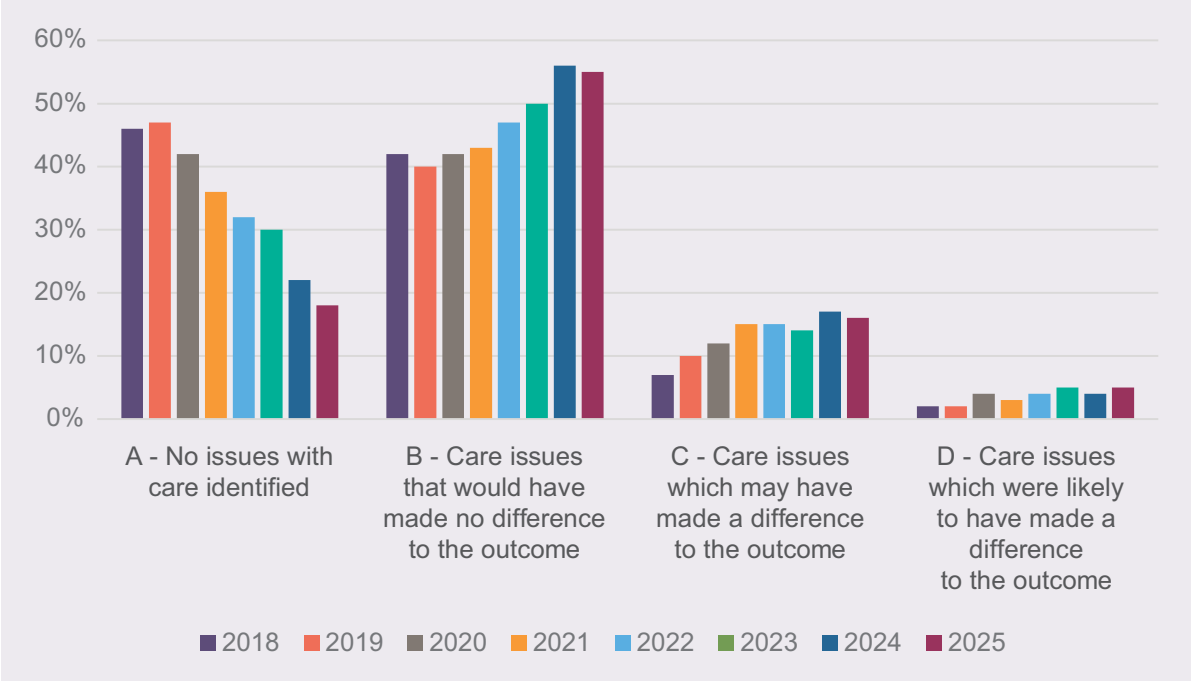


Figure 12: Most serious grading of care during pregnancy, labour, birth and during the neonatal period for neonatal deaths, reviews completed Jan 2018 to Dec 2025

Grading of care following the death of the baby

For late miscarriages and stillbirths, care of the mother or parents following the death of the baby in reviews completed in 2025 was graded as follows: 55% grade A, 32% grade B, 8% grade C and 4% grade D.

Since 2018, the distribution of grades for this stage of care has changed substantially. The proportion graded A decreased from 83% in 2018 to 55% in 2025. Over the same period, the proportion graded B increased from 12% to 32%, the proportion graded C increased from 2% to 8%, and the proportion graded D increased from 1% to 4% (Table 4.5 Tables Report; Figure 13, note the axis maximum is 90%).

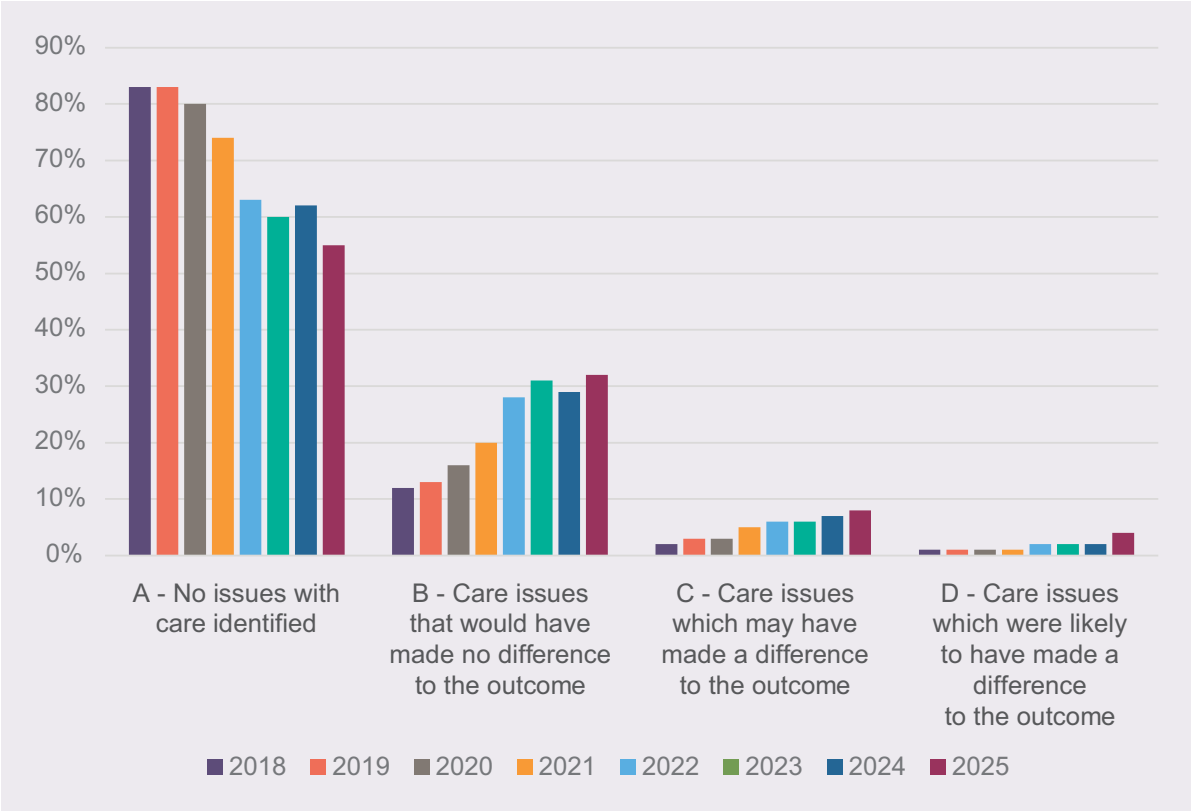


Figure 13: Grading of maternal/parental care following the death of the baby, late miscarriages and stillbirths, reviews completed Jan 2018 to Dec 2025

For neonatal deaths, care of the mother or parents following the death of the baby in reviews completed in 2025 was graded as follows: 63% grade A, 20% grade B, 6% grade C and 2% grade D. In 2025, 9% of reviews were not graded for this aspect of care.

Since 2018, the distribution of grades for this stage of care has also changed substantially. The proportion graded A decreased from 90% in 2018 to 63% in 2025. Over the same period, the proportion graded B increased from 6% to 20%, the proportion graded C increased from 1% to 6%, and the proportion graded D increased from 0% to 4% (Table 4.6 Tables Report; Figure 14, note the axis maximum is 90%).

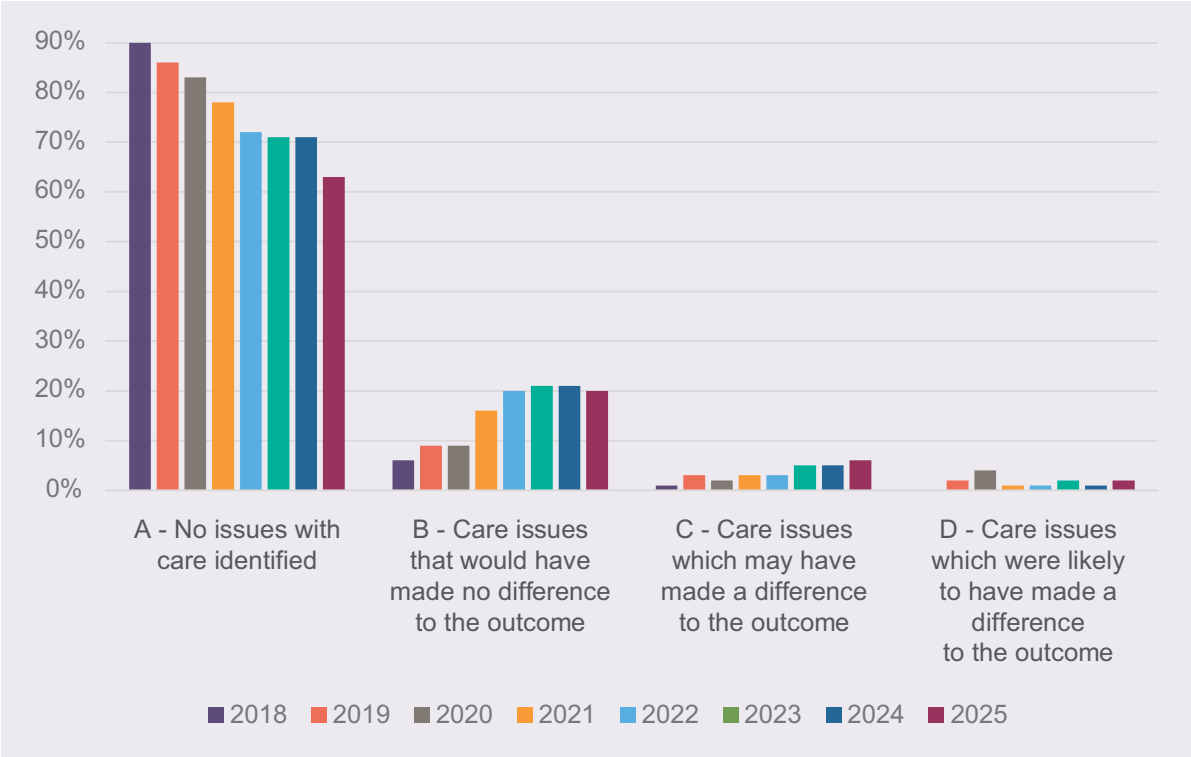


Figure 14: Grading of maternal/parental care following the death of the baby, for neonatal deaths, reviews completed Jan 2018 to Dec 2025

2.6 The review teams

Multidisciplinary review panels

Conducting a high-quality PMRT review requires multidisciplinary input. Review panels should reflect the breadth of professionals involved in the delivery of maternity and neonatal care, so that all relevant aspects of care can be assessed appropriately and objectively. A panel with only a small number of staff is unlikely to have the range expertise needed to identify all relevant issues with care, where these are present, or to develop appropriate action plans for improvement. Further detail about recommended panel composition and roles is provided in Appendix A – Recommended composition of review teams and roles.

The composition of review teams has improved steadily over time, and review panels are now more multidisciplinary than in earlier years (Tables 5.1 and 5.2 Tables Report). This is reflected in the median number and the diversity of staff present at review meetings. For late miscarriages and stillbirths, the median number of staff present increased from five in 2018 to 10 in 2025. In 2025, 71% of reviews of late miscarriages and stillbirths had eight or more staff present, compared with 23% in 2018. For neonatal deaths, the median number of staff present increased from six in 2018 to 13 in 2025. In 2025, 79% of neonatal death reviews had eight or more staff present, compared with 31% in 2018.

The proportion of review panels with three or fewer members has also decreased. For late miscarriages and stillbirths, 4% of review panels in 2025 had three or fewer members, compared with 6% in 2024, 9% in 2023 and 35% when the PMRT was launched in 2018. For neonatal death reviews, the corresponding proportions were 8% in 2025, 9% in both 2024 and 2023, and 31% in 2018.

The increasing multidisciplinary nature of review teams is also shown by the wider range of professional roles represented at PMRT reviews (Tables 5.3 and 5.4 Tables Report). In 2025, among reviews of late miscarriages and stillbirths, 97% included at least one midwife, 95% at least one obstetrician and 26% at least one neonatologist or paediatrician. In addition, 84% included a member of the risk management or governance team, 72% a bereavement midwife, 53% a management team member, 20% a neonatal nurse and 36% administrative support (Figure 15). Other professionals were present in smaller numbers. In England, 14% of reviews included a lead Maternity and Neonatal Voices Partnership (MNVP) member. For technical reasons, we are unable to report the proportion of reviews with an external member present for 2025; these figures will be reported next year for the 2026 data. Guidance on the definition and inclusion of an external panel member is provided in Appendix A.

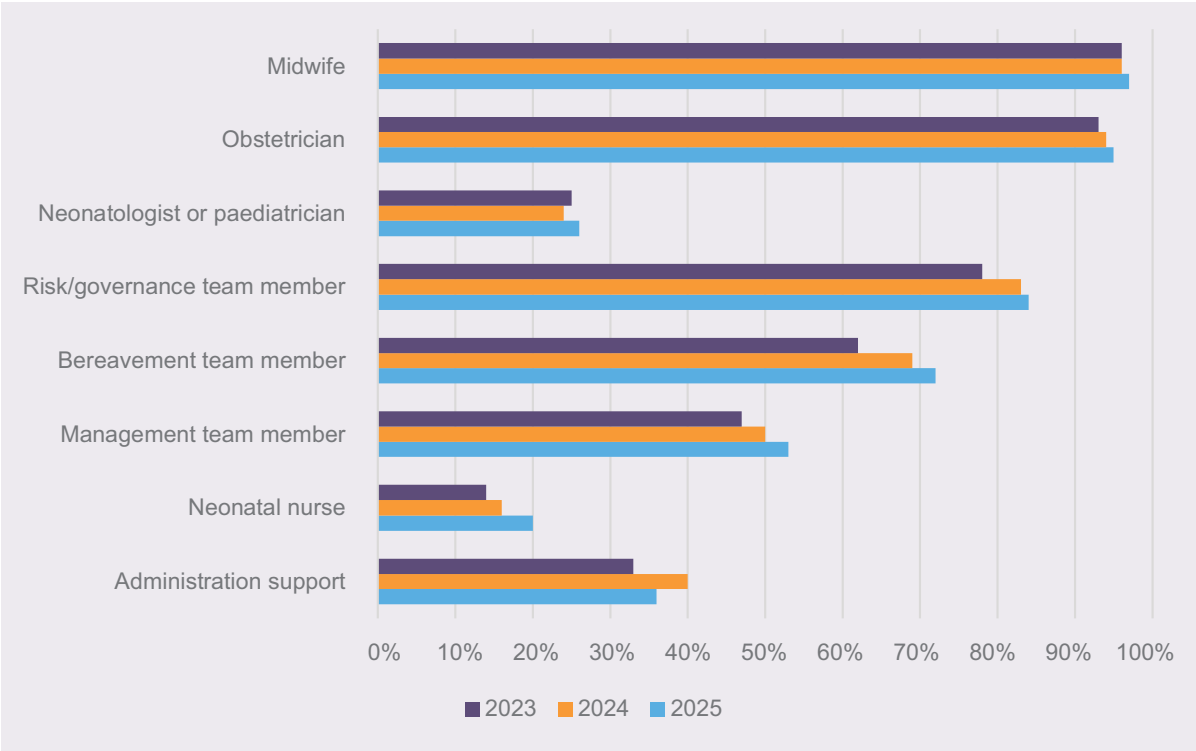


Figure 15: Proportion of reviews with specific professionals present for the review of late miscarriages and stillbirths, reviews completed Jan 2023 to Dec 2025

For reviews of neonatal deaths completed in 2025, 92% included at least one midwife, 86% at least one obstetrician and 86% at least one neonatologist or paediatrician. In addition, 82% included a member of the risk management or governance team, 72% a bereavement midwife, 70% a neonatal nurse, 47% a management team member and 35% administrative support (Figure 16). Other professionals were present in smaller numbers. In England, 11% of neonatal death reviews included a lead MNVP member.

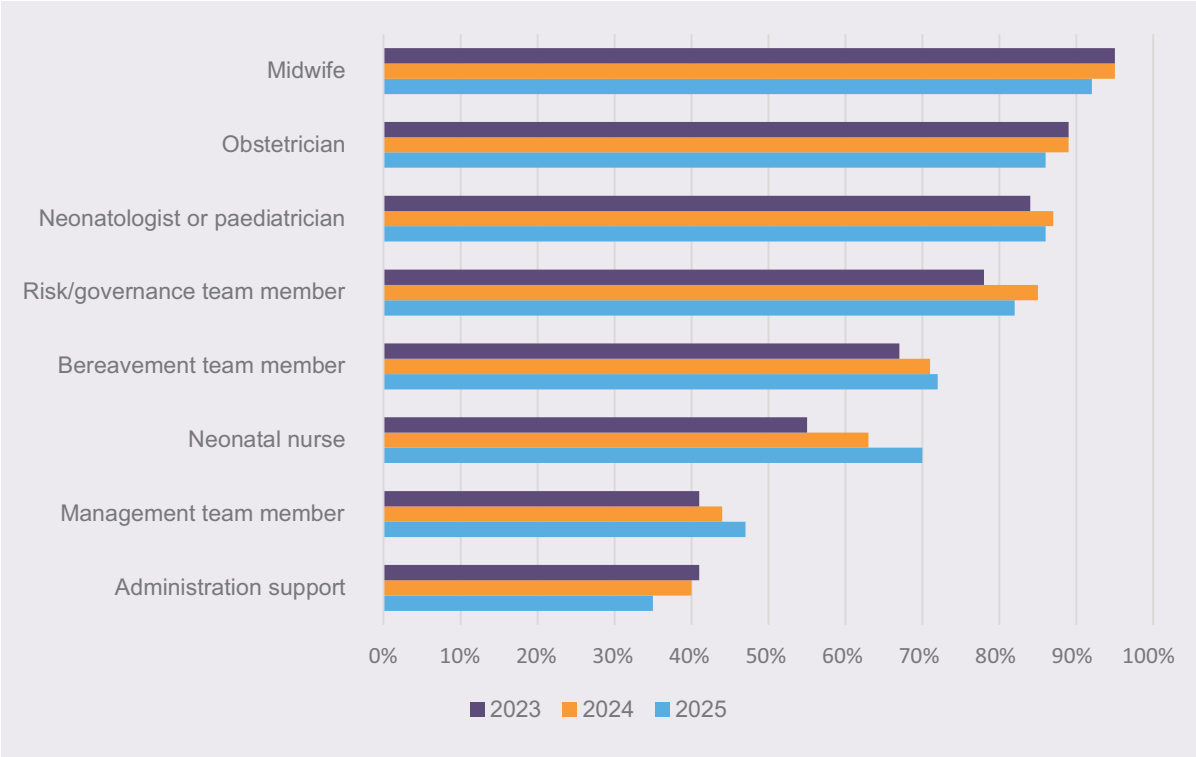


Figure 16: Proportion of reviews with specific professionals present for the review of neonatal deaths, reviews completed Jan 2023 to Dec 2025

2.7 Action plans

At the end of each PMRT review, where issues with care have been identified, the review team should consider each issue in turn and agree:

- Whether the issue was likely to have been relevant or not to the outcome for the mother and baby;
- whether action is need to improve future care for all mothers and babies, regardless of whether the issue was relevant to the outcome in that individual review.

For example, screening for gestational diabetes may have been indicated but not carried out, and but baby may have died from an unrelated cause. Although this omission may not have contributed to that baby's death, the reasons it occurred still need to be investigated. Learning from the review should then be used to strengthen local systems so that all eligible women are screened in future.

Across the 4,110 completed reviews, 10,510 separate actions were recorded. This represents a mean of just over 2.5 actions per review, although not all reviews resulted in an action plan and some reviews recorded more than two action plans.

The strength of actions

Action plans can be categorised as "weak, intermediate or strong". Where possible, actions should be strong. Strong actions reduce reliance on individuals remembering to do the right thing in particular circumstances.[5] They do this by introducing system-level changes, such as automated processes, standardisation, or permanent physical or digital design changes that make the desired action easier, more reliable or unavoidable. These are sometimes referred to as 'forcing actions' (See Appendix C – Action plan strength, for further information). Examples of action strength are shown in Box 1.

5 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 missed several of her antenatal appointments including her glucose tolerance testing appointment and was not followed up as per the local DNA policy	A new failsafe system to check missed appointments has been implemented within the EPR. Reports are reviewed weekly by the antenatal clinic manager to ensure follow-up occurs
	This mother smoked throughout 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
Intermediate actions	This mother was in threatened preterm labour but was not offered magnesium sulphate for fetal neuroprotection when this was indicated	Relaunch of the PERIPrem care bundle to be arranged by PERIPrem Quad
	This mother presented with reduced fetal movements; the written material about reduced fetal movements available to give her during her antenatal care was not written in a language that she could read	Currently partnering up with a group called 'Good Things Foundation' to help those women for whom English is not their first language and those who experience digital poverty to access this information
Weak actions	This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	Reminder to all staff via the maternity shared learning infographic - all staff must complete the fetal movement checklist when any patient attends with RFM.
	Although indicated this mother was not offered a Kleihauer test	Reminder at consultant meeting and on labour ward that this must be a consultant request in cases of Rhesus +ve women

Box 1: The strength of actions associated with illustrative examples from reviews completed Jan 2025 to Dec 2025

A random sample of 100 action plans were extracted in proportion to the number of reviews by country and coded by action strength using the US Department of Veterans Affairs action strength framework (Figure 17).

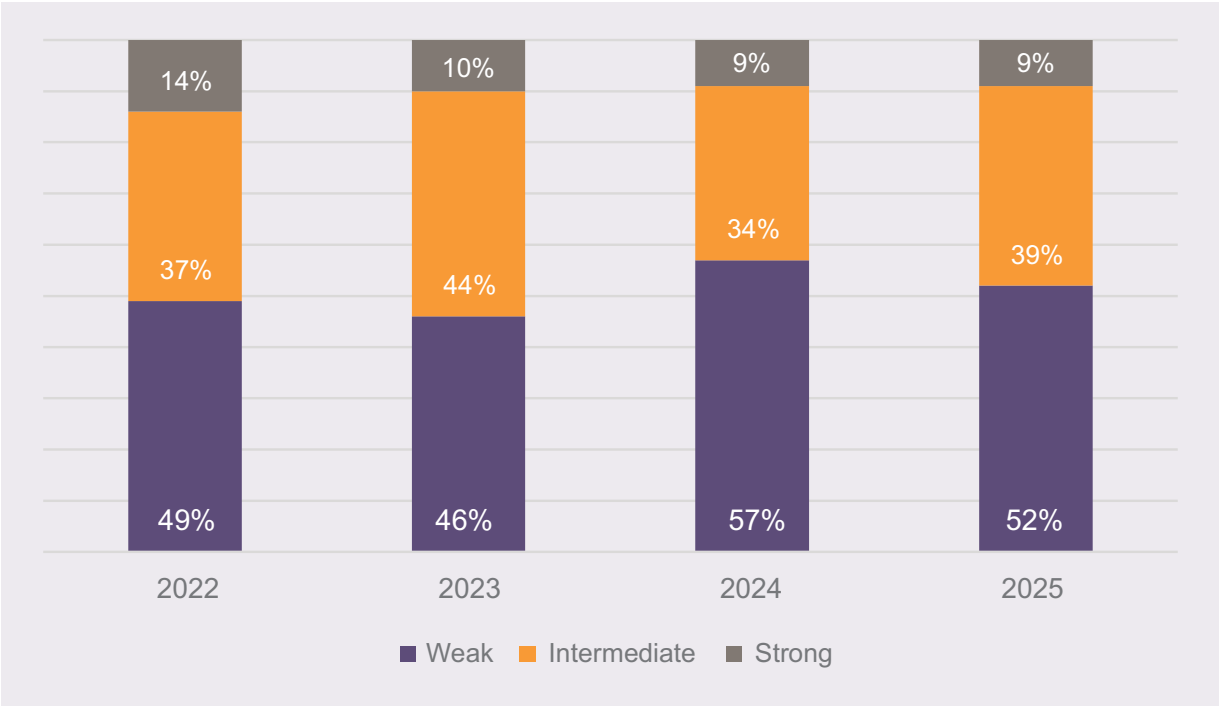


Figure 17: Strength of actions in random samples of 100 action plans per year, reviews completed Mar 2022 to Dec 2025

Figure 17 illustrates that, based on random samples of 100 actions plans per year, the proportion of strong or intermediate actions has remained essentially unchanged since 2022.

2.8 PMRT developments

Training

Since the beginning of 2024, we have provided free online training to support staff in using the PMRT to carry out reviews. Initially, this was delivered as a live online course covering all aspects of the PMRT review process. In 2024, we delivered the course on four occasions to a total of 146 PMRT users, and demand exceeded available places several fold.

To address this high demand, and the challenges busy clinical staff face in attending live sessions, we launched a free online, on-demand PMRT training course in April 2025. The on-demand course covers the same content as the live online course, with recorded presentations delivered by experts in the field and supported by additional materials. Individuals wishing to participate are *able to register* and complete the course at their own pace, at a time that suits them, and can re-visit the materials whenever needed. 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 review findings to parents;

- generating action plans; and
- using review outputs to support service quality improvements.

As part of the course, we convene live on-line quarterly question and answer sessions with presenters. These sessions provide an opportunity to discuss the presentations, address areas of concern, ask general questions and offer advice to attendees. They also provide a forum for PMRT users who have completed the training to share experiences and advice on PMRT-related matters.

At the time of writing this report July, 2025, nearly 700 people had registered for the new on-demand online course. This is more than four times the number of participants reached through the live online course in a similar period of time.

Reducing the duplication of notifications of perinatal deaths

Working with QES, the software provider of 'eCDOP', and the National Child Mortality Database (NCMD) team, we launched the Cascade system in January 2025. Cascade means that when a neonatal death is notified to MBRRACE-UK the information is automatically forwarded to the appropriate Child Death Overview Panel (CDOP) and then to the NCMD. This has removed the need to notify neonatal deaths separately to MBRRACE-UK and to the local CDOP. Instead, notification information is submitted once to MBRRACE-UK and then flows directly through Cascade to the relevant CDOP and on to the NCMD. Cascade is operational only in England.

In September 2025 the phased launch began in England for the Submit Perinatal Event Notification (SPEN) portal, developed by NHS England. Fully launched in November 2025 SPEN enables a single notification of a perinatal or maternal death to be sent to relevant national organisations including MBRRACE-UK/ PMRT, NHS Resolution Early Notifications, and the Maternity and Newborn Safety Investigation programme (MNSI formerly HSIB). For neonatal deaths, Cascade continues to forward data from MBRRACE-UK/PMRT via SPEN to CDOPs and the NCMD.

Best practice standards for the conduct of PMRT reviews

Drawing on eight years of experience of operating the PMRT, we developed a series of best practice standards to support the delivery of high-quality PMRT reviews. These standards are intended to guide trusts and health boards through the PMRT review process and help ensure that each review meets its primary purpose:

> "...to provide bereaved parents with a timely explanation of what happened with their care, why their baby died (accepting that it is not always possible to ascertain this), whether different care may have resulted in a different outcome, and whether there are any implications for their care in future pregnancies."

Meeting these standards will also support the timely achievement of the secondary purpose of reviews, enabling:

> "..trusts and health boards to identify and implement learning to prevent future perinatal deaths and improve future care for all mothers and babies."

The standards are broadly based on the year seven NHS Resolution maternity incentive scheme (MIS) standards, which applied in England only. The six PMRT best practice standards were launched on 1st June 2026 and are operational across the UK.

Trusts and health board PMRT users are able to download a report for their trust/health board from the PMRT case management screen showing their current achievement against these standards enabling staff to track annual progress in real time. We are planning to publish Metrics for each trust and health board as a separate report alongside the 2027 PMRT annual report and will show data from the reviews completed since June 2026.

Box 2 provides a summary of the standards. Further detail including required timelines is given in the *full guidance*.

Best Practice Standards

1. Notify all eligible perinatal deaths
2. Seek parents view of their care
3. Review the death and publish the report
4. Include an external member in your review panel
5. Offer parents/families a feedback meeting with relevant specialists
6. Ensure that PMRT review staff undertake the PMRT online training course

Box 2: Summary of the Best Practice Standards for conducting a PMRT review; published 1st June 2026

While it is too early to assess the full impact of the standards on PMRT reviews, we have already seen an increase in the number of trust and health board staff registering for the PMRT on-demand, online training.

3. Conclusions and recommendations

When a baby dies a high-quality local review of care is essential. It helps parents to understand why their baby died, what happened during their care, whether different care may have led to a different outcome for their baby, and whether there are implications for any future pregnancy they may plan. High-quality local reviews are also essential for identifying where services need to improve to prevent future baby deaths and morbidities, to improve care for all mothers and babies and improve care when a death has occurred.

For 93% of parents who experience a late miscarriage or stillbirth, a PMRT review is the only hospital review of care they will receive. In England, it is a statutory requirement that all parents whose baby dies in the neonatal period should have a local PMRT review which is then submitted to their local Child Death Overview Panel (CDOP) to be considered alongside additional information which the CDOP receives. There are different arrangements in Scotland, Wales and Northern Ireland when a neonatal death occurs.

3.1 The role of PMRT reviews in supporting the achievement of the Amos recommendations

This report was written following the publication of the Amos National Maternity and Neonatal Investigation in England and the Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust, and while publication of the Thirlwall Inquiry was awaited. This section focuses specifically on the role of local PMRT reviews in supporting achievement of two of the eight Amos recommendations.

Carrying out a high quality PMRT review requires staff "systematically listening to the voices of women, birthing people and families" (Amos recommendation 2). The PMRT engagement materials available on the *PMRT website* support an open and transparent process of parent engagement by helping staff communicate with and listen to families after their baby has died.

Not all baby deaths are the result of avoidable harm. Nevertheless, the learning from the reviews of all deaths can result in improvements in services for all mothers and babies, help prevent future deaths and improve care when a death has occurred. This can only happen if staff in trusts/health boards understand the different review and investigation processes that may follow a baby's death, and are able to explain these clearly to parents (Amos recommendation 3(ii)).

It is essential that parents understand that a local PMRT review is not an investigation, but that the review is conducted primarily for their understanding of why their baby died. Wider learning and service improvements may follow for the review and these may provide assurances to parents that the death of their baby has been meaningfully considered and actions to prevent future harm taken. If parents are not clear about the PMRT process, their capacity to contribute to the process will be seriously impeded and their expectations of the findings are unlikely to be met. This may reduce parental trust in the process. *The free PMRT online, on-demand training*, for all NHS staff addresses these aspects and explicitly places families at the centre of the review process.

For the vast majority of parents - 93% of those whose baby dies as a late miscarriage, stillbirth or neonatal death - a PMRT review is the only hospital review of care that will take place (Figure 18). The conduct of PMRT reviews, the findings they generate, and the implementation of learning from those reviews are therefore central to "Improving how the system responds and learns when something goes wrong." (Amos recommendation 3).

Regional staff and organisations need to take responsibility for engaging with local trusts and health boards to ensure that learning from PMRT reviews is shared regionally and, where appropriate, nationally (Amos recommendation 3(v)). PMRT users in trusts and health boards can download summary reports at any time. These reports combine findings from all reviews completed within a user-defined period. We recommend that they form the basis of reporting at Board level within organisations. Because they do not contain personally identifiable information, they can also be used to support regional reporting of learning.

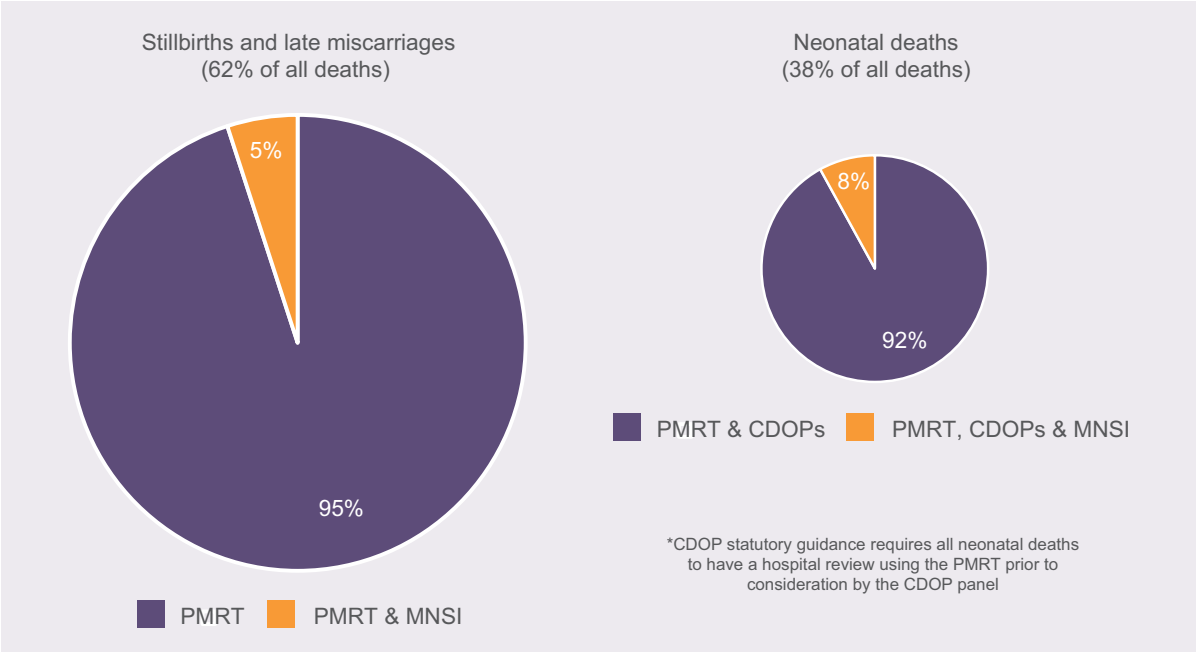


Figure 18: Summary of reviews and investigations for perinatal deaths since the inception of the NHS England Submit a Perinatal Event Notification (SPEN) portal in 2025, England only

As illustrated by Figure 18, the PMRT is the only feasible mechanism for reviewing all perinatal deaths which supports the Amos recommendation that, "when death or harm occurs families should be offered a full explanation of what happened" (Amos recommendation 3). However, this can only be achieved if the tool is implemented and used properly by review panels to conduct high quality reviews. Whilst the PMRT collaboration can provide guidance, it cannot control the review activities in individual trusts and health boards. This requires regional and commissioning oversight. The recent expansion of access to the MBRRACE-UK Real-time Data Monitoring Tool to regional organisations in England, Wales and Northern Ireland will help support this oversight.

When the PMRT was commissioned, funding was allocated only for the original and ongoing development of the tool. No specific resources were allocated to support its use by trusts and health boards. Dedicated resources will be required to meet Amos recommendation 3(iv), which highlights the need for "protected time needed to carry out reviews". The NIHR-funded MATREP study provides indicative estimates of the financial and person-time resources required.[6]

We have recommended the involvement of external members in the PMRT panel review process since launch in 2018. In England, this has been reinforced through the Maternity Incentive Scheme since 2022. However, specific resources were not allocated to cover the costs of incorporating this additional work into consultant job plans and other staff roles. Some trusts in England used Ockenden-related system development funds to support these costs, and some neonatal networks have allocated resources to support the inclusion of neonatologists as external reviewers. Now that independent challenge has been identified as an Amos recommendation - "all current investigation types must include independent challenge at every stage" (Amos recommendation 3(iii)) - full resourcing may follow.

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The *online, on-demand PMRT training* could, with further development, provide the starting point for the creation of a national specialist training programme to equip staff with the skills needed to carry out PMRT reviews, as envisaged in Amos recommendation 3(iv). Sands staff training relating to conducting reviews and on engaging parents in the reviews of their care is also available.

3.2 The proportion of deaths reviewed

Audit and review are part of routine maternity and neonatal care and, as highlighted by the Amos Investigation, are not optional extras. It is therefore reassuring that, in 2025, a PMRT review was started for the vast majority of baby deaths: 97% overall. However, reviews were completed and final reports generated for only 87% of deaths. Although there was variation by country, this represents a major improvement since the launch of the PMRT in 2018. This is particularly evident in England, where the Maternity Incentive Scheme (MIS) has doubtless provided an impetus for PMRT activity in trusts. Nevertheless, these figures also show that 3% of parents appear not to have received the benefit of a review. This represents approximately 120 perinatal deaths in 2025. In addition, 13% of reviews appear not to have been completed and the final review report produced.

3.3 Parent engagement with reviews

Providing information 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 local PMRT review. This can only be achieved by effective engagement with parents. Parents need to know that a review will take place, what this means, what the review is intended to achieve, and how they can share any questions or concerns they would like addressed. These questions should then be considered during the review so that, once the review is complete, these original questions can be addressed when the findings are fed back to parents.

This requires a straightforward, trauma-informed verbal explanation of the review process, in a language parents can understand, supported by plain-language written information. Communication with parents should remain open throughout the review process, so they can ask further questions as they arise and understand what is happening with their review. The PMRT collaboration has developed parent engagement materials, recently updated with input from bereaved parents and clinical staff, which are available on the *PMRT website*. These materials are designed to be adapted by trusts and health boards to reflect their own local processes. It is vital that parent engagement is done well, to avoid additional trauma and further distress for bereaved parents.

PMRT data indicate that 96% of parents were told that a review would take place. There are valid reasons why some parents would not be told about the local review process, for example, parents involved in safeguarding or criminal proceedings. Nevertheless, this is unlikely to explain why 4% were not told.

Of those parents told a review would take place, 96% 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 bereaved in 2021-2023, in which only 78% of respondents said they were aware that a review would be carried out, and only 64% reported being given the opportunity to share their concerns and questions.

The MATREP study [7], which explored parents' experiences of PMRT reviews and MNSI investigations, sheds some light on the discrepancy between what clinical staff record in the PMRT and parents' lived experience. Its findings suggest that, even when parents are provided with information about the PMRT review process, they do not always understand what this means. Some parents did not recall receiving any information at all and only realised that a review had taken place once they were presented with the findings. Bereaved parents reported needing multiple opportunities to understand what a review involves and to ask questions or provide comments, both before the review starts and while it is underway.

The timing of these discussions, and the way parents' questions and comments are incorporated into the PMRT, remain areas of concern. When the information recorded in the parent engagement section of the tool was analysed, only 64% appeared to represent actual questions or comments from parents. In many instances, it was unclear whether parents had been approached, how they had been approached, or how their responses had been received. Changes have since been made to how comments and questions are incorporated into the PMRT process, which may help address this discrepancy and these will be analysed in next year's report.

Good engagement with parents and families is essential for their wellbeing, and it also improves the quality of their review from which they should benefit directly. Several sessions in the *PMRT online training programme* highlight what effective parent engagement looks like. Sands also provides *training and resources* to support clinical staff in discussing reviews with parents. They also provide *guidance for parents* to support them in raising concerns and understanding the different review and investigation processes, including PMRT reviews, that may take place after their baby has died.

When parents provided feedback, they continued to report problems with communication, a lack of compassion, and not being listened to. These concerns are also reflected in the Amos and Ockenden investigations. In the analysis of a small sample of parent comments and questions, most parents who had questions were reported as asking either specific or general questions about their care or about why their baby had died. Around one in six parents provided positive comments about their care and the staff who cared for them. While this is encouraging, it is a lower proportion that in recent previous years. Communication with parents needs to be an ongoing process, not a single event, and continuing communication is important for many parents. [8]

3.4 The issues with care identified

Overall, at least one care issue was identified in 93% of reviews. In 36% of reviews, at least one issue was judged by the review teams to have been relevant to the outcome. This was the same proportion as in 2024 and an increase from 30% in 2023. It is not possible to extrapolate directly from this as to the proportion of deaths which may have been prevented with different care, since there may have been more than one such issue present for some deaths.

The issues with care identified in this report are largely focused on the same areas as in previous PMRT reports. It is particularly disappointing to see that, for most of these areas of care, there has been little or no improvement in the proportion of reviews identifying the same issues year after year. For example, despite the introduction and subsequent update of the Saving Babies' Lives Care Bundle in England, issues with inadequate fetal growth surveillance and inadequate management of reduced fetal move-

7 Personal Communication A Heazell, *MAT-REP project MATREP | The University of Manchester* (Downloaded 22nd Sept 2026)

8 Personal Communication A Heazell, *MAT-REP project MATREP | The University of Manchester* (Downloaded 22nd Sept 2026)

ments have recurred in broadly the same proportion of reviews of deaths since the PMRT was launched. Although these aspects of care were not always judged relevant to the outcome for the individual baby whose death was reviewed, the lack of improvement in their delivery remains concerning.

During labour and birth, four of the five most common issues with care have also remained essentially unchanged overtime. Only maternal monitoring has shown evidence of a reduction in the proportion of reviews where it was identified. Nevertheless, maternal monitoring remains the leading issue at this stage of care, identified in 20% of reviews. This was more than twice the proportion for each of the other four common issues: fetal monitoring, assessment of maternal risk status, staffing issues, and communication with mothers who had limited or no English language skills.

After birth, the main issues identified with neonatal care continue to relate to thermal and respiratory management and the quality of documentation. These findings continue to mirror issues identified in national investigations and reviews, including those concerning the former *Cwm Taf University Health Board*. Of further concern is the steady increase in the proportion of neonatal deaths where thermal management was identified as an issue, reaching 30% in 2025. Again, although this may not have been relevant to the outcome for the individual baby whose care was reviewed, it is concerning that nearly a third of these babies became cold at some stage during their care. Good thermal management is essential to prevent a range of serious neonatal complications.

There are a small number of notable exceptions where the proportion of reviews identifying specific issues has continued to improve. These include assessment and management of smoking, which has improved from being identified in 33% of reviews in 2018 to 12% in 2025. One of the example action plans illustrates a system-level approach to improvement for this issue, with all women identified as smoking automatically referred to smoking cessation services, changing referral from an opt-in to an opt-out process. Assessment and management of the need for antenatal aspirin has also continued to improve, being identified in only 4% of reviews in 2025, down from 17% in 2018. Similarly, issues with screening for gestational diabetes were identified in only 2% of reviews, compared with 7% in 2018.

The issues identified in this national report need to remain a focus of service improvement. A local gap analysis of care in relation to the nationally identified issues would help trusts and health boards prioritise local quality improvement activity (Appendix C – using PMRT evidence to improve care).

The single most common issue with clinical investigations carried out after the baby had died continued 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 recorded has decreased slightly but remains at over 20%. This proportion would be higher 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 that it remains a widespread issue. The need for transfer reflects access to specialist perinatal pathology services, which are largely centralised because of the small number of pathologists with these skills now available although planning to improve the situation is underway in England. Transfer may be distressing for parents and, although this should not necessarily be the case, it can lengthen their wait for review findings. Maintaining contact with parents and keeping them updated while they wait may alleviate some of this distress.[9]

9 Personal Communication A Heazell, *MAT-REP project MATREP | The University of Manchester* (Downloaded 22nd Sept 2026)

The inadequate location or quality of the bereavement suite was identified in over one in twenty reviews. It is also disappointing to see that this issue was identified in at least one review in half of trusts and health boards, with no improvement since the previous report. Although improvements may 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 before the funeral, while others may not. Whatever parents decide, they have the right to make an informed choice and may need support in deciding what to do. Support and practical help were identified as inadequate for 13% of parents, and this issue was identified in at least one review in more than half of trusts and health boards. Importantly, PMRT review teams' ability to assess the quality of bereavement care was adversely affected where they could not access bereavement care notes, which anecdotally appear to be stored separately from general maternity notes in many places.

3.5 Grading of care

Since 2018, the proportion of reviews where care prior to the baby's death was graded A ("no issues with care identified") has approximately halved for both late miscarriages/stillbirths and neonatal deaths. This has been accompanied by an increase the proportion of reviews assigned grades B ("issues that would have made no difference to the outcome"), C ("issues which may have made a difference to the outcome") or D ("care issues which were likely to have made a difference to the outcome"). Although the proportions graded C and D have increased, most of the reduction in grade A reviews is reflected in the increase in grade B reviews.

The grading of care following the death of the baby has followed a similar pattern for both late miscarriages/stillbirths and neonatal deaths, with a decrease over time in care graded A and an increase in care graded B, C or D.

Care for all reviews prior to the baby's death was graded as C or D in just over 1 in 5 reviews. This holistic grading of care gives the best overall indicator of the proportion of deaths that may have been prevented had different care been provided. However, in view of the need to improve the quality of some reviews by ensuring that all the appropriate professionals are present and that all review panels include at least one external senior clinician, the proportion of 1 in 5 (20%) should probably be best regarded as a minimum estimate of potentially preventable deaths.

It is not possible to determine from the available information whether these changes in grading reflect a decline in the quality of care, more robust and objective reflections during the review process, or a combination of both. Improvements in the constitution of review panels may have resulted in more stringent review processes, particularly where external members have been involved. In previous reports, the presence of an external professional on the multidisciplinary review panel was associated with a different distribution of grades, with a greater proportion of B, C, and D grades. For technical reasons, we were not able to assess the presence of external members in reviews completed in 2025. Nevertheless, their presence in the multi-disciplinary review meeting, and the independence they bring, provides important reassurance for parents.[10]

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3.6 Review teams

A thorough, robust, standardised and systematic review of the pregnancy, birth and neonatal care pathway requires the involvement of the range of health professionals who deliver care in this complex clinical setting. Conducting a high-quality review is therefore a multidisciplinary activity. Ideally, it should also involve someone external to the organisation.

The external member provides the "fresh pair of eyes" of an independent senior professional with the clinical authority to provide challenge where needed during discussions about care. Parents particularly welcome the involvement of external panel members because they provide independent scrutiny in a process that might otherwise be perceived as the trust or health board "marking its own homework".10[11]

Clinical leadership is also needed to drive the local PMRT process. This requires appropriate resourcing, including recognition of PMRT review activity in consultant job plans and in role descriptions for other staff. This work is too important be treated as an additional, un-resourced activity, sometimes carried out in staff members' spare time[12]. *Additional guidance*, based on real-life examples of how organisations coordinate external reviewers, has also been provided.

There has been a steady improvement in the number and range of healthcare professionals involved in review teams across all professional groups. Notably, 86% of reviews of neonatal deaths now involve a neonatologist or paediatrician, and 70% involve a neonatal nurse. However, despite these improvements, this also means that 14% of reviews of the care of a baby who died in the neonatal period apparently did not involve a neonatologist or paediatrician, and 30% did not include neonatal nursing expertise. Given it is not possible to robustly review a neonatal death without the expertise of at least one neonatologist/paediatrician, including a death which occurs on labour ward immediately after birth, this raises serious questions about the quality and value of such reviews.

Similarly, not all reviews of late miscarriages/stillbirths and neonatal deaths recorded the involvement of a midwife or obstetrician. Midwives were absent from 3% of reviews of late miscarriages and stillbirths and 8% of reviews of neonatal deaths. Obstetricians were absent from 5% and 14% of these reviews respectively. We are aware that not all review reports include full documentation of who was present at the review, despite this being a function of the tool and something that should be recorded. We also know from anecdotal reports that reviews of neonatal deaths are sometimes carried out without a neonatologist or paediatrician present.

Midwives and obstetricians may also not always both be present. However, each profession brings different expertise and their roles are not interchangeable. Examples from the confidential enquiries into perinatal deaths illustrate what happens when reviews are conducted by too few staff or without the appropriate professional expertise: important issues with care may be being missed, incorrect conclusions may be reached, and parents' questions may not be addressed. Appendix D provides an illustrative example of where this occurred.

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Only 35% of reviews benefited from administrative support. This is a decrease from previous years and is far from ideal. Administrative support helps ensure that reviews are timely and that panels have all the relevant information available at the meeting. Without this support, these tasks will fall to clinical members of the team, which is an inappropriate use of a more expensive clinical 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, implemented and subsequently audited. These team members were present for about 82% of reviews, representing a small decrease from the previous year.

Similarly, the proportion of reviews with a member of the bereavement team present, at about 70%, has not meaningfully improved since the report of reviews in 2022. This remains concerning given the potential impact that poor bereavement care can have on a family's future psychosocial wellbeing. During the review process, the bereavement midwife is expected to advocate on behalf of parents, ensuring that their questions, concerns and comments are addressed. It is unclear how this happens if bereavement team members are not present.

3.7 Action plans

The final essential step in any review is to identify which issues require action to improve future care for all mothers, babies and families. This should happen regardless of whether the issue was judged to have affected the outcome for the specific baby whose death was reviewed. For example, screening for gestational diabetes may have been indicated but not offered to the mother. Whether or not this was relevant to that baby's death, the gestational diabetes screening pathway should still be reviewed to ensure that all eligible pregnant women are offered appropriate screening in the future.

Parents, in particular, want to know that care has been improved as a result of their experiences and the subsequent review.[13] Analysis of a random sample of 100 reviews showed no overall increase in action strength over the past four years. However, it is important to note that not all issues require strong or even intermediate actions. For example, changing equipment is a strong action, but it may need to be supported by staff training, an intermediate action, and communication to staff about the change, a weaker action. We would therefore not expect 100% of actions to be strong. With more than 40% of actions coded as strong or intermediate strength, the current position is encouraging. What cannot be assessed from the information recorded in the PMRT is whether these action plans are actually implemented. This requires both internal and external oversight.

13 Personal Communication A Heazell, *MAT-REP project MATREP | The University of Manchester* (Downloaded 22nd Sept 2026)

Recommendations

1. 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 **(updated recommendation for 2026)**.

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

2. 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 involving attempted resuscitation, are reviewed by a team including neonatologists/paediatricians and neonatal nurses. Confirm this with appropriate documentation for every review **(new recommendation for 2026)**

   Action: Trusts and health boards, service commissioners

3. 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 **(updated recommendation for 2026)**.

   Action: Trusts and health boards, service commissioners

4. Provide adequate resources and make the support arrangements necessary to ensure the participation of independent senior external clinicians at multi-disciplinary PMRT review meetings **(updated recommendation for 2026)**.

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

5. 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 **(new recommendation 2026)**.

   Action: Trusts and health boards, service commissioners

6. Use the findings from local PMRT summary reports and this 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 **(updated recommendation for 2026)**.

   Action: Trusts and Health Boards, service commissioners, regional/network support systems, governments

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 neonatologist/paediatrician and neonatal nurse should be present for the review of neonatal deaths and a neonatologist/paediatrician should be present for any stillbirth where resuscitation was attempted.

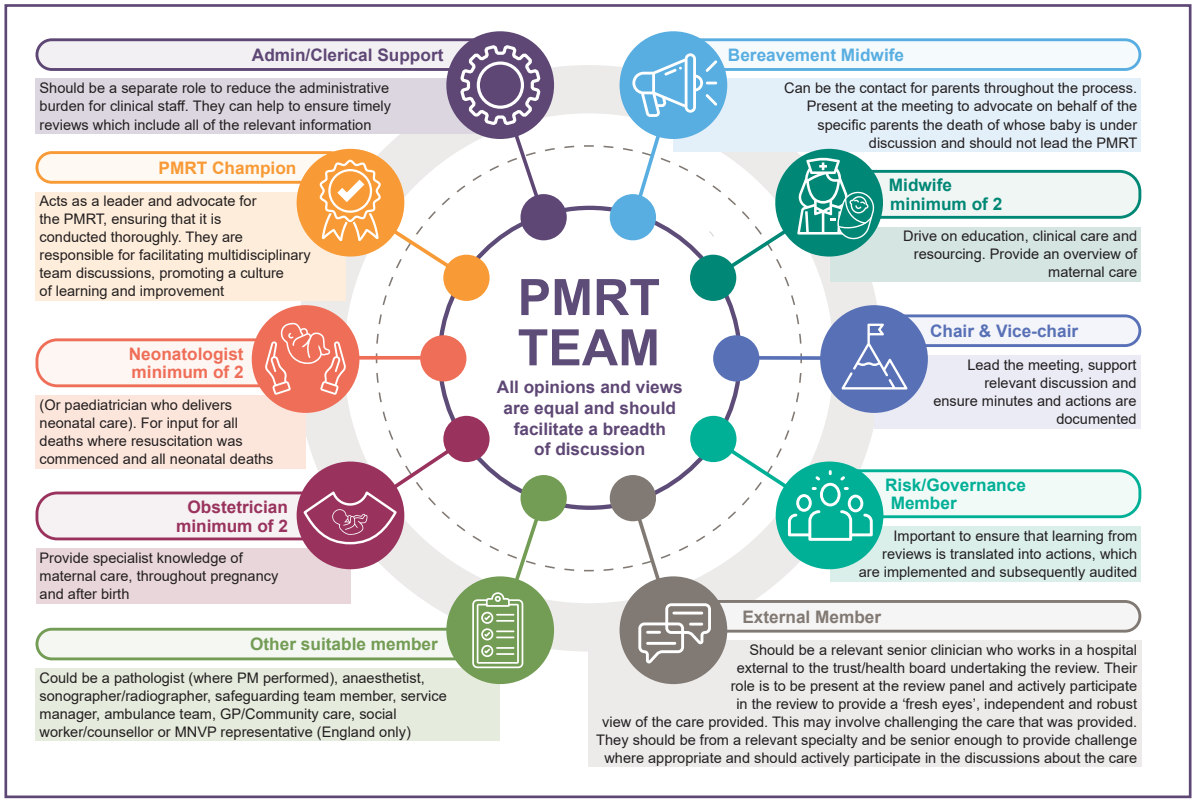
In the event that a particular aspect of care which should have been provided was not, then it is essential to ensure that the particular discipline is represented in the review team so that the impact of this absence on the care provided can be assessed.

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 60% of reviews, see Safety Action C, the *Maternity Incentive Scheme* guidance, year 8.

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.



Appendix B - Action plan strength

The US Veterans Affairs root cause analysis tool 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 C - Using PMRT evidence to improve care

The PMRT system can 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 F 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.

Appendix D - Example of a review when the panel constitution is incomplete

Confidential enquiry vignette:[i]

A woman in her third pregnancy self-referred at 23 weeks' gestation with mild back pain and a mild pyrexia. After a wait of 2 hours for an initial midwifery assessment she waited 4 hours for an obstetric review. She was 4 cm dilated with bulging membranes. An **initial plan for active intervention** was made and she was commenced on magnesium sulphate, IV antibiotics and was given steroids.

She was seen by a member of the neonatal team the following day. The next day she had progressed to 8cm and her membranes had ruptured. **She remained on labour ward for a further four days, with two consultant obstetric reviews per day and no change in the plan of watchful waiting until her baby was confirmed as having died in utero at 24 weeks**. After her baby had died, she waited two and a half hours for a confirmation scan. Following the birth, she had a manual removal of placenta in theatre and a two-litre postpartum haemorrhage.

The review panel consisted of midwifery staff only; none of the parents' questions were directly addressed; none of the specific issues relevant to the outcome were identified

i Draper ES, Gallimore ID, Kurinczuk JJ, Kenyon SL (Eds), on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Confidential Enquiry, A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death: State of the Nation Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Population Health Sciences, University of Leicester. 2023.

PMRT

Supporting high quality local perinatal reviews

MBRRACE-UK/PMRT Collaboration

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