

Reviews of care when babies die

PMRT annual report 2026 - Short report



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

- The reviews in this report look at the care of mothers whose babies died in 2025.
- Their care was looked by hospital review teams who used the Perinatal Review Mortality Tool (PMRT).
- A review was carried out for nearly all babies who died in 2025. This is better than when PMRT reviews were first started in 2018.

PMRT reviews started for the first time in 2018.

Since 2018 nearly 34,000 PMRT reviews have been carried out.

This report includes the findings from the 4,110 reviews completed from January to December 2025 in the UK.



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

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

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

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

Findings from the reviews in 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

- Most parents were told about their review (99%).
- Most parents were asked if they had any questions (96%)
- But it is not clear if all parents really knew what this meant.
- Parents had questions about a lot of different things.
- Some parents were happy with their care (17%).



Parent engagement improves the quality of reviews



Some parents' comments and questions about their care

..... 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.

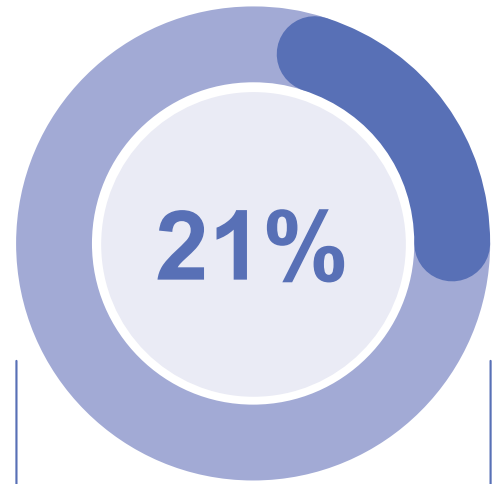
The care from midwives, sonographers, medical staff was warm, professionals, personal, kind and informative.

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

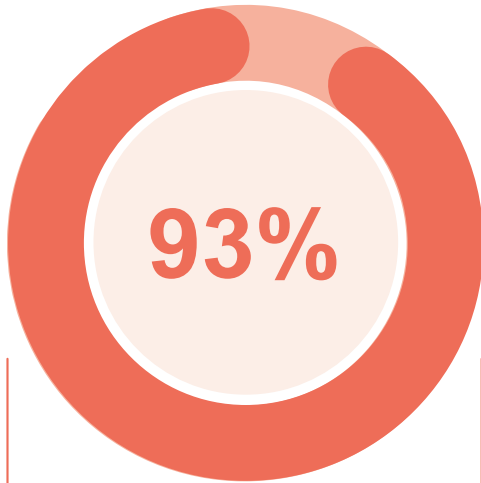
.... I complained of stomach ache when I was 13 weeks and I was told to come into triage unit, but no findings were discussed with me. I only had to find out from my badger app that I had Strep B infection. This made me feel ignored and I didn't know what to do.

Why wasn't my pregnancy marked as high risk?

- Good reviews are important.
- Reviews are better quality now than when PMRT reviews started in 2018.
- Nearly 1 in 5 (21%) of reviews found care that may or was likely to have made a difference to the outcome for the baby.

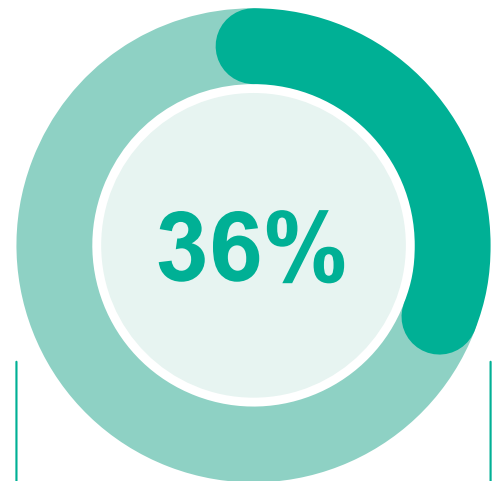


of reviews were holistically graded as having care issues that may or were likely to have made a difference to the outcome for the baby



of reviews identified at least one issue with care

- In 19 out of every 20 reviews (93%) a problem with care was found, although this may not have affected the baby.



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

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

Some care has improved since last years' report and a lot of good care was given. Some problems with care are the same for several years. These include checking if the baby is growing and moving properly. Other problems were with looking after the mother and baby during labour and when the baby is born.

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

A full version of the report is available on the [PMRT website](#).



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