Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MBRRACE-UK
Perinatal mortality surveillance

UK perinatal deaths of babies born in 2024

State of the nation report

June 2026

HQIP Healthcare Quality Improvement Partnership
University of Leicester
The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
sands Saving babies' lives. Supporting bereaved families.
Chelsea and Westminster Hospital NHS Foundation Trust
NPEU
Women's & Reproductive Health
University of Oxford

Funding

The Maternal, Newborn and Infant Clinical Outcome Review Programme, delivered by MBRRACE-UK, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales, Northern Ireland, Jersey, Guernsey, Scotland and the Isle of Man as part of the National Clinical Audit and Patient Outcomes Programme.

Stakeholder involvement

Groups that support parents and families play a vital role in the MBRRACE-UK programme. They are part of a special group called the 'Third Sector' stakeholders. These organisations help us in a few key ways:

- They help us figure out what new research we should focus on in the future.
- They are crucial in sharing our important findings and messages with parents, families, the wider public, and those who make policy decisions. This includes helping us create easy-to-understand summaries of our reports.

There is a full list of organisations in the acknowledgements.

Deaths included in this report

The deaths in this report are of babies who were born in England, Wales, Scotland, Northern Ireland, and the Crown Dependencies, between 1 January and 31 December 2024.

Version history

Version	Details of changes	Release date
1.0.	First published.	11 June 2026

Design by: Ian Gallimore

This report should be cited as:

Gallimore ID, Matthews RJ, Page GL, Smith LK, Fenton AC, Knight M, Smith PW, Redpath S, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2024 - State of the Nation Report. Leicester: TIMMS, School of Healthcare, University of Leicester. 2026.

Published by: TIMMS
School of Healthcare
University of Leicester
George Davies Centre
University Road
Leicester LE1 7RH

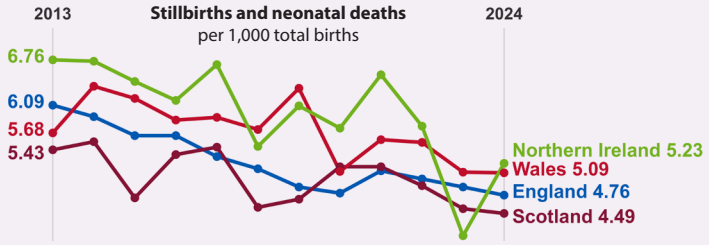
State of the nation report

UK perinatal deaths of babies born in 2024

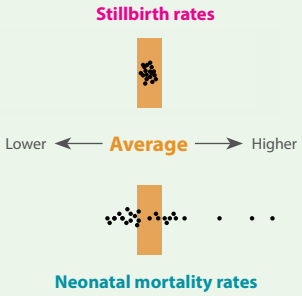
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Fewer babies are dying than in the past

➔ Since 2013, the number of babies who die shortly before, during, or soon after birth has fallen across the UK. In 2024, rates continued to decrease.



Rates were more consistent for stillbirths than for neonatal deaths

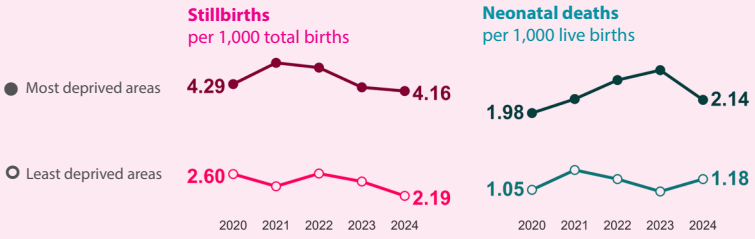


➔ When trusts and health boards were grouped by the level of care they provide, they all had a stillbirth rate which was **around the average** for their group.

➔ Neonatal mortality rates varied more, particularly in the group of trusts and health boards providing the most complex care.

Where families live still makes a big difference

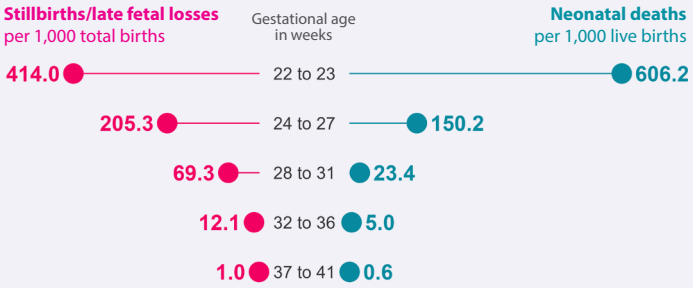
➔ Babies born to mothers who live in the most deprived areas continue to face much higher risks, despite recent improvements.



Being born early remains the highest risk

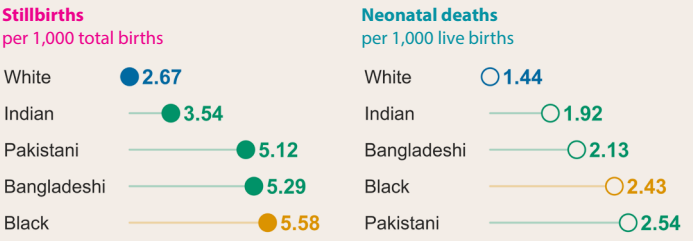
➔ Outcomes have improved, particularly for babies born later in pregnancy.

➔ The highest rates of stillbirths and neonatal deaths occur before 37 weeks of pregnancy, especially at the earliest gestations.

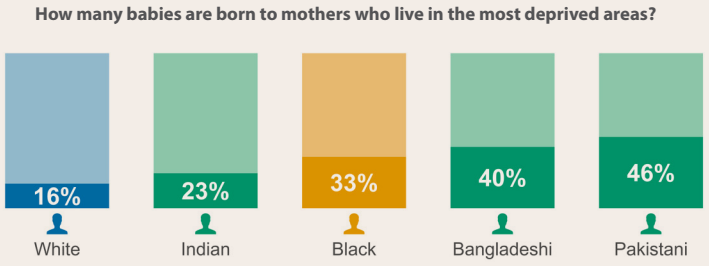


Not all ethnic groups are affected in the same way

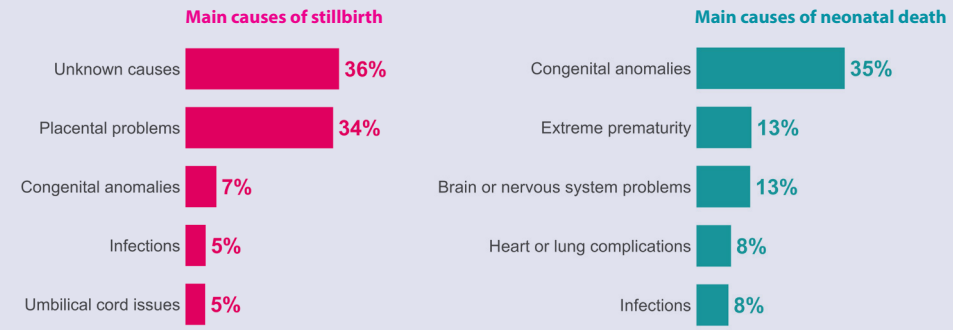
➔ Babies of Black and Asian ethnicity continue to experience higher mortality rates.



➔ A higher proportion of Black and Asian families live in the most deprived areas.

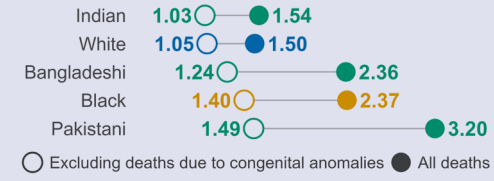


The main causes of baby death have remained the same



Congenital anomalies make up a large share of deaths

➔ Congenital anomalies contribute to deaths in all ethnic groups, but account for a particularly large share of neonatal deaths among Bangladeshi, Pakistani and Black babies.



HQIP Healthcare Quality Improvement Partnership
University of Leicester
The Newcastle upon Tyne Hospitals NHS Foundation Trust
TIMMS
sands Saving babies' lives. Supporting bereaved families.
Chelsea and Westminster Hospital NHS Foundation Trust
NPEU
University of Oxford

Baby deaths in the UK: 2024

Summary

1. Rates of baby death continued to decrease in 2024

Compared with 2023, stillbirth, neonatal mortality and extended perinatal mortality rates were lower in England and for the UK as a whole. Since MBRRACE-UK began in 2013, the number of babies who died shortly before, during, or soon after birth has been falling across all UK nations. In 2024, the UK extended perinatal mortality rate was 4.77 baby deaths for every 1,000 births, which is 21% lower than in 2013.

2. Stillbirth rates were similar across most trusts and health boards, but neonatal mortality rates varied more

For stillbirths, all trusts and health boards had a stabilised and adjusted stillbirth rate within 5% of the average rate for their comparator group. There was more variation in neonatal mortality rates, with only 24% falling within that range.

3. Most baby deaths occurred before 37 weeks, despite improving outcomes

Over the past five years, rates of baby death have generally fallen, especially for babies born later in pregnancy. There has also been a recent reduction in neonatal mortality rates for babies born at 28 to 31 weeks, following several years of little change. Most stillbirths and neonatal deaths were of babies born before 37 weeks of pregnancy, particularly at the earliest gestations.

4. Inequalities in perinatal mortality remain large despite recent improvements

Differences linked to the level of financial disadvantage in an area (socioeconomic deprivation) continue to be a major concern. Stillbirth rates remain highest among babies born to mothers living in the most deprived areas, although the rate for this group has fallen since 2023. For neonatal mortality, the gap between the most and least deprived areas narrowed slightly after several years of widening. Even so, rates for babies born to mothers who live in the most deprived areas were still much higher than for those in the least deprived areas. This is despite a 14% reduction in neonatal mortality rates for the most deprived group..

5. Ethnic differences in mortality rates continued

Between 2023 and 2024, stillbirth rates continued to fall across all ethnicities, reflecting a longer-term improvement since 2020. Over the same period, neonatal death rates fell for babies of Asian and White ethnicity but were slightly higher for babies of Black ethnicity. Despite overall progress, babies of Black and Asian ethnicity continue to experience higher mortality rates than babies of White ethnicity.

6. Socioeconomic deprivation affects some ethnic groups more than others

Babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity already have the highest rates of stillbirth and neonatal death when looking at ethnicity alone. These three groups also have a much larger proportion of babies born to mothers living in the most deprived areas. This means that the effects of socioeconomic deprivation add to these already higher rates.

7. The most common causes of baby death were unchanged

The main causes of stillbirth were problems with the placenta, congenital anomalies (health conditions or differences a baby is born with that affect how their body develops or works), infections and issues with the umbilical cord. Neonatal deaths were most often caused by congenital anomalies, problems with the brain or nervous system, extreme prematurity, heart or lung complications, and infections.

8. Congenital anomalies affect mortality rates differently across ethnic groups

Congenital anomalies contributed to baby deaths in every ethnic group, but their impact was not the same for all babies. They had the largest effects on neonatal mortality rates for babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity. When deaths caused by congenital anomalies were excluded, the neonatal mortality rates for these groups fell by around half.

9. What this means

These findings show that progress is being made in reducing baby deaths, but there is still important work to do—especially to tackle the gaps linked to deprivation, ethnicity, and how early in pregnancy a baby is born. We have previously made national recommendations to help with this, but local services, networks, and commissioners may need to take a closer look at their own areas to understand what is happening and take action that works for their communities.

Previous recommendations that are still relevant
P1. Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care. (MBRRACE-UK 2024)
P2. Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation. (MBRRACE-UK 2023)
P3. Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes. (MBRRACE-UK 2023)
P4. Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities. (MBRRACE-UK 2023)

Baby deaths in the UK: 2024

Contents

1. Introduction

1.1. About this report

This is the twelfth report from MBRRACE-UK looking at baby deaths in the UK shortly before, during, or soon after birth. It is broken down into five main parts:

- How many baby deaths happen across the UK.
- How rates of baby deaths for different types of trusts and health boards vary.
- How rates of baby deaths vary depending on how far along the pregnancy was.
- How ethnicity and socioeconomic factors (such as the area someone lives in) affect baby deaths.
- A look at the causes of these deaths.

1.2. More information and resources

To help you understand this report better, we have also provided:

- Reference tables with more detailed numbers.
- An interactive data viewer that shows mortality rates for individual trusts and health boards, and other types of organisation.
- A guide to our methods that explains exactly how we collect and analyse our data.

You can also read an online version of this report. This includes interactive versions of the charts and links to more information.

Important words we use

We use different words to refer to different times when a baby dies:

- A **late fetal loss** is when a baby is born at 22 to 23 weeks gestational age without any signs of life.
- A **stillbirth** is when a baby is born at 24 or more weeks gestational age without any signs of life.
- A **neonatal death** is when a baby is born at any gestation who lives, even briefly, but dies within 4 weeks of birth.
- Stillbirths and neonatal deaths combined are known as **extended perinatal deaths**.

Gestational age is how far along the pregnancy was when the baby was born. This is measured in completed weeks of pregnancy. We mostly report on deaths of babies born at 24 weeks or later. Since babies born before 24 weeks are at much higher risk of dying, we look at them separately to better understand the risks for that group. We also do this to avoid confusion, as clinical practice has varied for babies born before 24 weeks, which has affected whether these deaths were recorded as a neonatal death or a late fetal loss.

The **mortality rate** is the number of baby deaths compared to the number of births in a year. We calculate separate rates for each type of death and show them as the number of deaths for every 1,000 births. For example, a stillbirth rate of 3.0 means that for every 1,000 babies born, three were stillborn. We do not include terminations of pregnancy in any of the rates we report.

In this report and the supporting materials we use the terms 'women' and 'mothers'. However, we acknowledge that not everyone who uses perinatal services identifies as a woman or mother. Our recommendations apply to all people who are pregnant or have given birth. Similarly, when we say 'parents' we mean anyone who has the main responsibility of caring for a baby.

You can find a full list of the important words we use, and what they mean, in our methods guide. You will also find a list of all the abbreviations we use, and what they stand for.

2. Baby deaths across the UK: 2024

We looked at data on stillbirths, neonatal deaths and extended perinatal deaths across the UK. This information is broken down by the mother's country of residence for the entire UK and for each nation (England, Scotland, Wales, and Northern Ireland) from 2013 to 2024. We do this to show how these rates have changed over time and help each nation track the effectiveness of their efforts to reduce the number of babies who die.

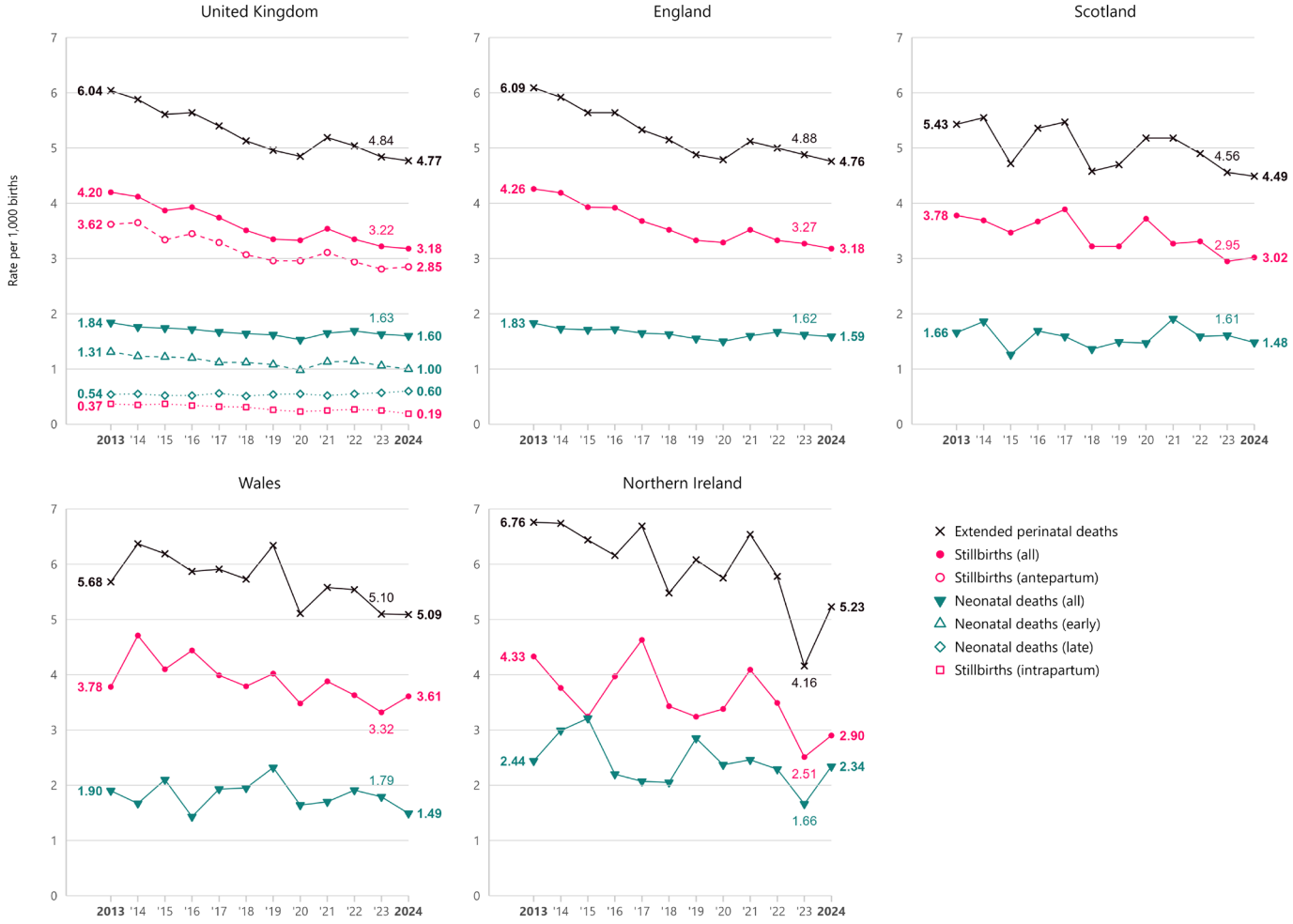
Rates of baby death continued to decrease in 2024

Compared with 2023, stillbirth, neonatal mortality and extended perinatal mortality rates were lower in England and for the UK as a whole.

In Scotland, Wales and Northern Ireland, rates tend to vary more each year because there are fewer births in these countries. This means that changes seen over a single year do not always reflect longer-term patterns, so it is important to look at trends over a longer period of time.

Since MBRRACE-UK began in 2013, the number of babies who died shortly before, during, or soon after birth has been falling across all UK nations. In 2024, the UK extended perinatal mortality rate was 4.77 baby deaths for every 1,000 births, which is 21% lower than in 2013.

Figure 1: Stillbirth, neonatal, and extended perinatal mortality rates by country of residence: United Kingdom, 2013 to 2024



Description of Figure 1: Line charts showing trends in stillbirth, neonatal mortality and extended perinatal mortality rates for the UK, England, Scotland, Wales and Northern Ireland between 2013 and 2024. Stillbirth rates are shown overall and separately for antepartum and intrapartum deaths. Stillbirth and extended perinatal mortality rates are shown per 1,000 total births. Neonatal mortality rates are shown per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded.

Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey

3. Perinatal mortality rates for trusts and health boards

To make comparisons between trusts and health boards fairer, we place them into five **comparator groups** based on the level of care they provide—for example, whether they have a neonatal intensive care unit (NICU). Some hospitals care for pregnant women with higher health risks or look after babies who are sicker, either because they offer specialist services or serve communities with specific social or health challenges. Even with excellent care, this can lead to higher mortality rates.

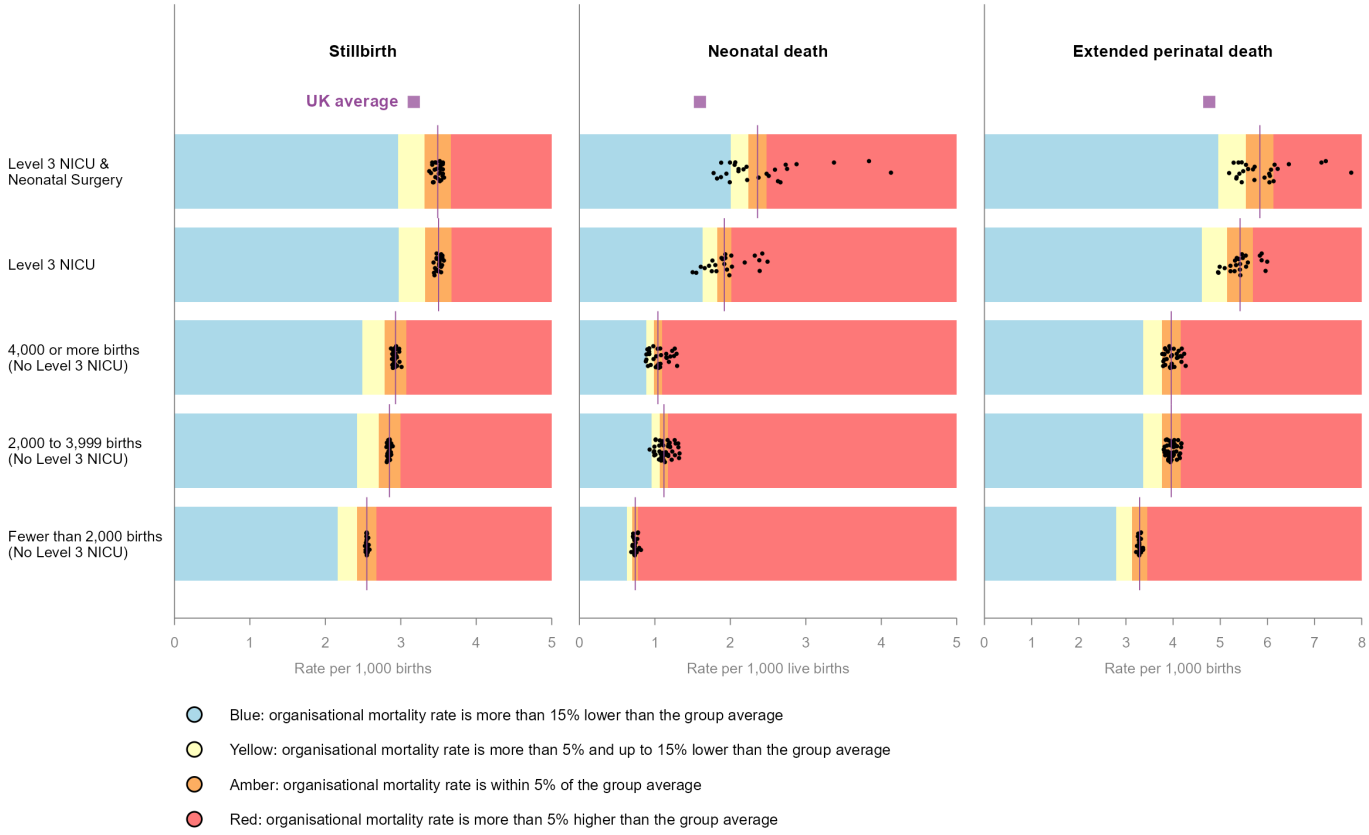
Because the number of deaths at a hospital can vary from year to year just by chance, we use a statistical process called **stabilisation** to smooth out this random variation. We also **adjust** the rates to account for important risk factors such as the mother's age, socioeconomic background, the baby's ethnicity and sex, whether it was a twin or triplet, and how early in pregnancy the baby was born. These **stabilised and adjusted** rates give us a clearer picture of whether a trust or health board has a higher or lower rate than expected. We then compare their rates to the average in their group to help us understand how they are doing.

Stillbirth rates were similar across most trusts and health boards, but neonatal mortality rates varied more

For stillbirths, all trusts and health boards had a stabilised and adjusted stillbirth rate within 5% of the average rate for their comparator group. There was more variation in neonatal mortality rates, with only 24% falling within that range. You can explore individual trust and health board rates in our data viewer.

It is important to remember that mortality rates describe what happened over a period of time, but they may not reflect the quality of care. To understand these numbers properly, it is essential to consider the type of population being cared for and how services are organised in different areas. This is especially important for neonatal mortality, as trusts and health boards with the highest rates often care for the sickest and most premature babies.

Figure 2: Stabilised and adjusted stillbirth, neonatal and extended perinatal mortality rates for trusts and health boards by comparator group: United Kingdom and Crown Dependencies, 2024



Description of Figure 2: Scatter charts showing the variation in stabilised and adjusted stillbirth, neonatal mortality and extended perinatal mortality rates within trust and health board comparator groups in 2024. Trusts and health boards are grouped according to the level of services they provide. Each dot represents an individual trusts or health board, and a vertical line shows the average rate for that comparator group. Stillbirth and extended perinatal mortality rates are shown as rates per 1,000 total births. Neonatal mortality rates are shown as rates per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded.

Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

4. Mortality rates by gestational age

We looked at mortality rates based on the gestational age when the baby was born. We do this to keep an eye on how well national programs are working to improve outcomes for babies born prematurely.

Most baby deaths occurred before 37 weeks, despite improving outcomes

Over the past five years, mortality rates have generally fallen, especially for babies born later in pregnancy. There has also been a recent reduction in the neonatal mortality rate for babies born at 28 to 31 weeks, following several years of little change.

Most stillbirths and neonatal deaths were of babies born before 37 weeks of pregnancy, particularly at the earliest gestations. Babies born very early will always face higher risks because of how early they are born. As a result, they continue to account for a large share of deaths, even as outcomes improve overall.

Figure 3: Late fetal loss, stillbirth and neonatal mortality rates and proportions by gestational age at birth: United Kingdom and Crown Dependencies, 2020 to 2024

Description of Figure 3: Combined line and bar charts showing rates and proportions of late fetal losses, stillbirths and neonatal deaths for babies born in the UK from 2020 to 2024, by gestational age group in completed weeks: 22 to 23, 24 to 27, 28 to 31, 32 to 36, 37 to 41. Deaths of babies born at 42 weeks and above are not shown because there are very small numbers of births at this gestation. Late fetal loss and stillbirth rates are shown per 1,000 total births, and neonatal mortality rates are shown per 1,000 live births. Terminations of pregnancy are excluded. **The scale on the left-hand vertical axis differs between gestational age groups.**

Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

5. Mortality rates by socioeconomic deprivation and ethnicity

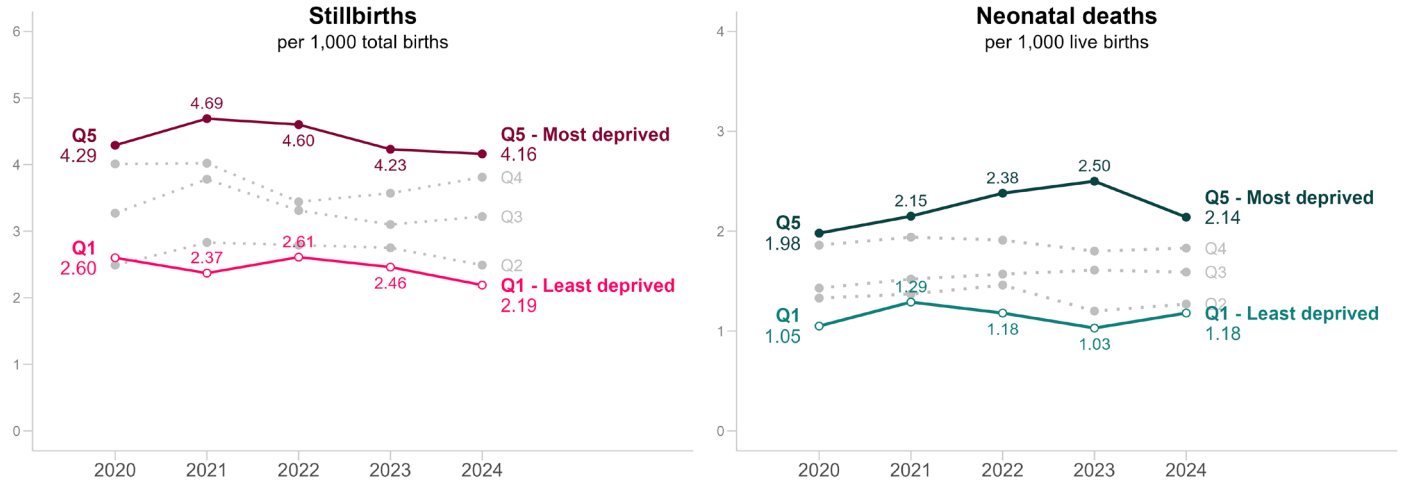
We looked at differences in stillbirth and neonatal death rates to understand if there are inequalities. We compared these rates based on two factors: where the mother lives, using her postcode to understand the level of financial disadvantage (**socioeconomic deprivation**) of that area, and the baby's ethnic group.

Inequalities in perinatal mortality remain large despite recent improvements

Differences linked to socioeconomic deprivation continue to be a major concern. Stillbirth rates remain highest among babies born to mothers who live in the most deprived areas, although the rate for this group has fallen since 2023.

For neonatal mortality, the gap between the most and least deprived areas narrowed slightly after several years of widening. Even so, rates for babies born to mothers who live in the most deprived areas were still much higher than for those in the least deprived areas. This is despite a 14% reduction in neonatal mortality rates for the most deprived group.

Figure 4: Stillbirth and neonatal mortality rates by mothers' socioeconomic deprivation quintile of residence: United Kingdom, 2020 to 2024



Description of Figure 4: Line charts showing stillbirth and neonatal mortality rates by level of socioeconomic deprivation, between 2020 and 2024. Deprivation is shown by quintiles numbered 1 to 5, and the most deprived quintile (Q5) is compared to the least deprived quintile (Q1). Stillbirth rates are shown per 1,000 total births, and neonatal mortality rates are shown per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded. **The scale on the left-hand vertical axis differs for each chart.**

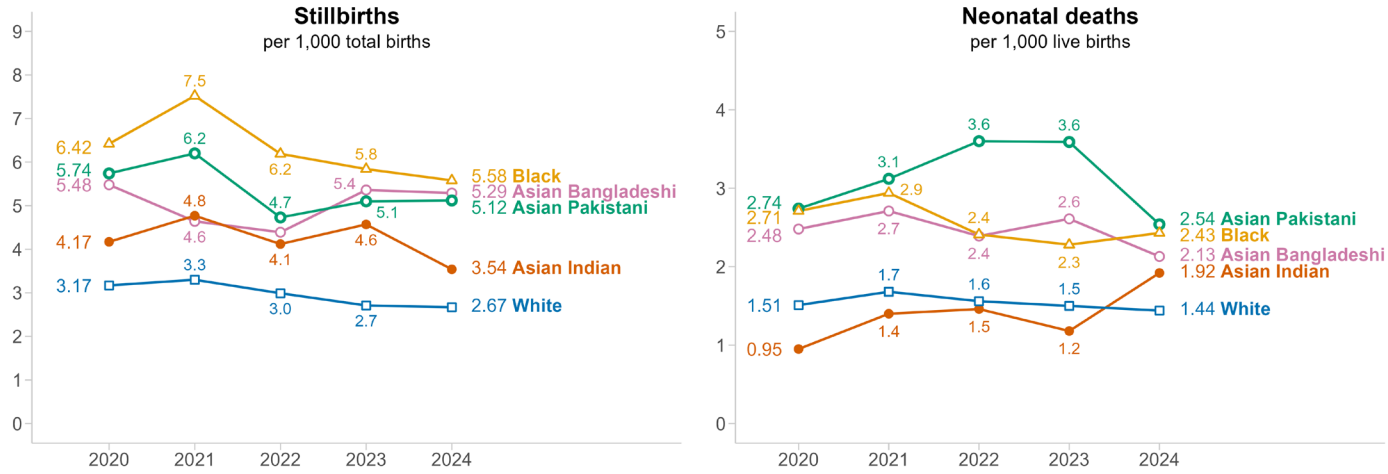
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS.

Ethnic differences in mortality rates continued

Between 2023 and 2024, stillbirth rates continued to fall across almost all ethnicities, reflecting a longer-term improvement since 2020. For neonatal mortality, the overall pattern shows only small shifts despite recent improvements in some ethnic groups.

Despite overall progress, babies of Asian and Black ethnicity continue to experience higher mortality rates than babies of White ethnicity.

Figure 5: Stillbirth and neonatal mortality rates by babies' ethnicity: United Kingdom and Crown Dependencies, 2020 to 2024



Description of Figure 5: Line charts showing stillbirth and neonatal mortality rates by babies' ethnicity, between 2020 and 2024. Rates for babies of Black ethnicity combine several smaller subgroups because the numbers of deaths for babies of Black Caribbean and Other Black ethnicities are too small to report separately. Stillbirth rates are shown per 1,000 total births, and neonatal mortality rates are shown per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded. **The scale on the left-hand vertical axis differs for each chart.**

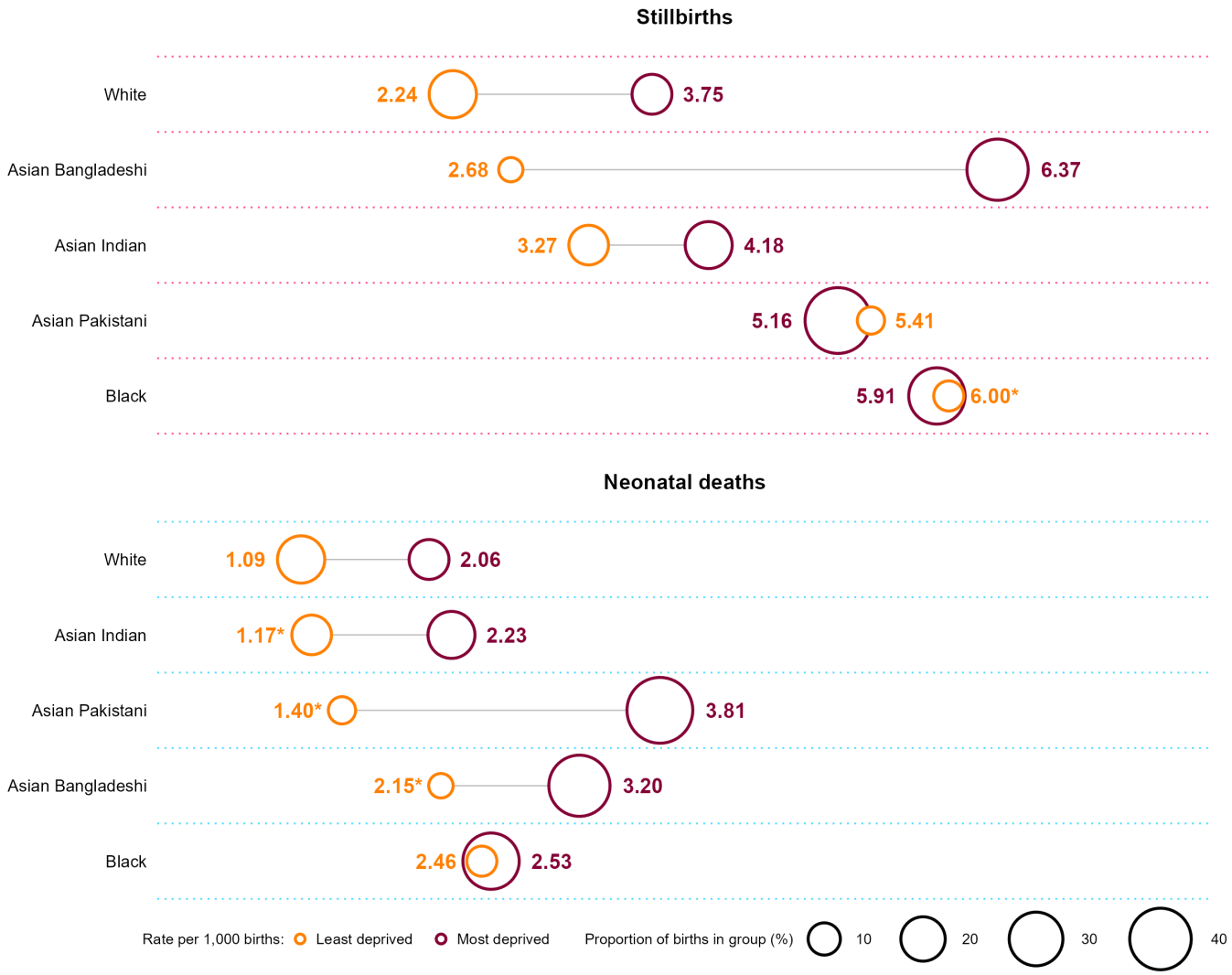
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

Socioeconomic deprivation affects some ethnic groups more than others

Babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity already have the highest rates of stillbirth and neonatal death when looking at ethnicity alone. These three groups also have a much larger proportion of babies born to mothers living in the most deprived areas. This means that the effects of socioeconomic deprivation add to these already higher rates.

For some ethnic groups, very few births occur in the least deprived quintile. When the number of births is small, even a small change in the number of deaths can cause large swings in the mortality rate. As a result, in some groups, the rate for the least deprived quintile can occasionally appear higher than the rate for the most deprived quintile, simply because the numbers are so small.

Figure 6: Stillbirth and neonatal mortality rates by babies' ethnicity and level of socioeconomic deprivation: United Kingdom, 2022 to 2024 (combined data)



Description of Figure 6: Dumbbell charts showing stillbirth and neonatal mortality rates by babies' ethnicity and level of socioeconomic deprivation, for babies born in the UK between 2022 and 2024. Deprivation is shown in quintiles comparing the most deprived quintile with the least deprived. Each dumbbell shows the difference between the most deprived to the least deprived within an ethnic group. Bubble sizes represent the proportion of births to mothers living in each deprivation quintile for that ethnic group; the smallest bubble represents the smallest share of births. Rates for babies of Black ethnicity combine several smaller subgroups because the numbers of deaths for babies of Black Caribbean and Other Black ethnicities are too small to report separately. Stillbirth rates are shown per 1,000 total births, and neonatal mortality rates are shown per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded. Data for 2022 to 2024 are combined because the number of deaths in some ethnic and deprivation groups is small, and combining the years makes the rates more reliable. **Rates marked with an asterisk are based on fewer than 20 deaths and should be interpreted with caution.**

Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS.

6. Causes of perinatal death

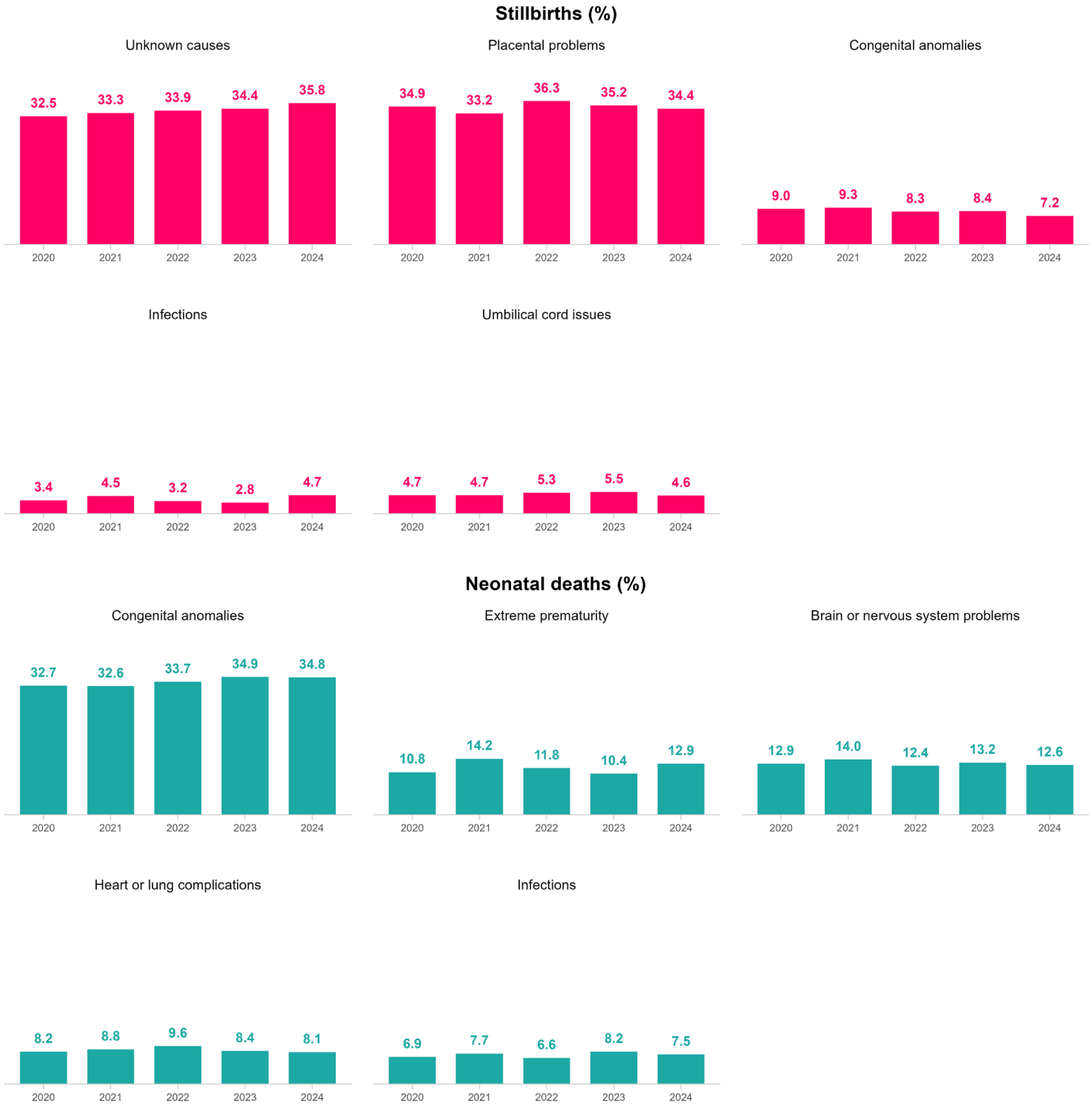
We looked at the reasons babies died, using a system called CODAC to classify both the main reason a baby died and any other related health conditions that might have played a role. We also looked at how congenital anomalies (health conditions or differences a baby is born with that affect how their body develops or works) affect baby deaths in different ethnic groups.

The most common causes of baby death were unchanged

The main causes of stillbirth were problems with the placenta, congenital anomalies, issues with the umbilical cord, and fetal health conditions that developed during pregnancy—such as problems with the baby's organs, blood or immune system. For a large proportion of stillbirths the cause of death was unknown.

Neonatal deaths were most often caused by congenital anomalies, problems with the brain or nervous system, extreme prematurity, heart or lung complications, and infections.

Figure 7: Most common causes of stillbirth and neonatal death: United Kingdom and Crown Dependencies, 2020 to 2024



Description of Figure 7: Bar charts showing the five most common causes of stillbirth and neonatal death, between 2020 and 2024. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded.

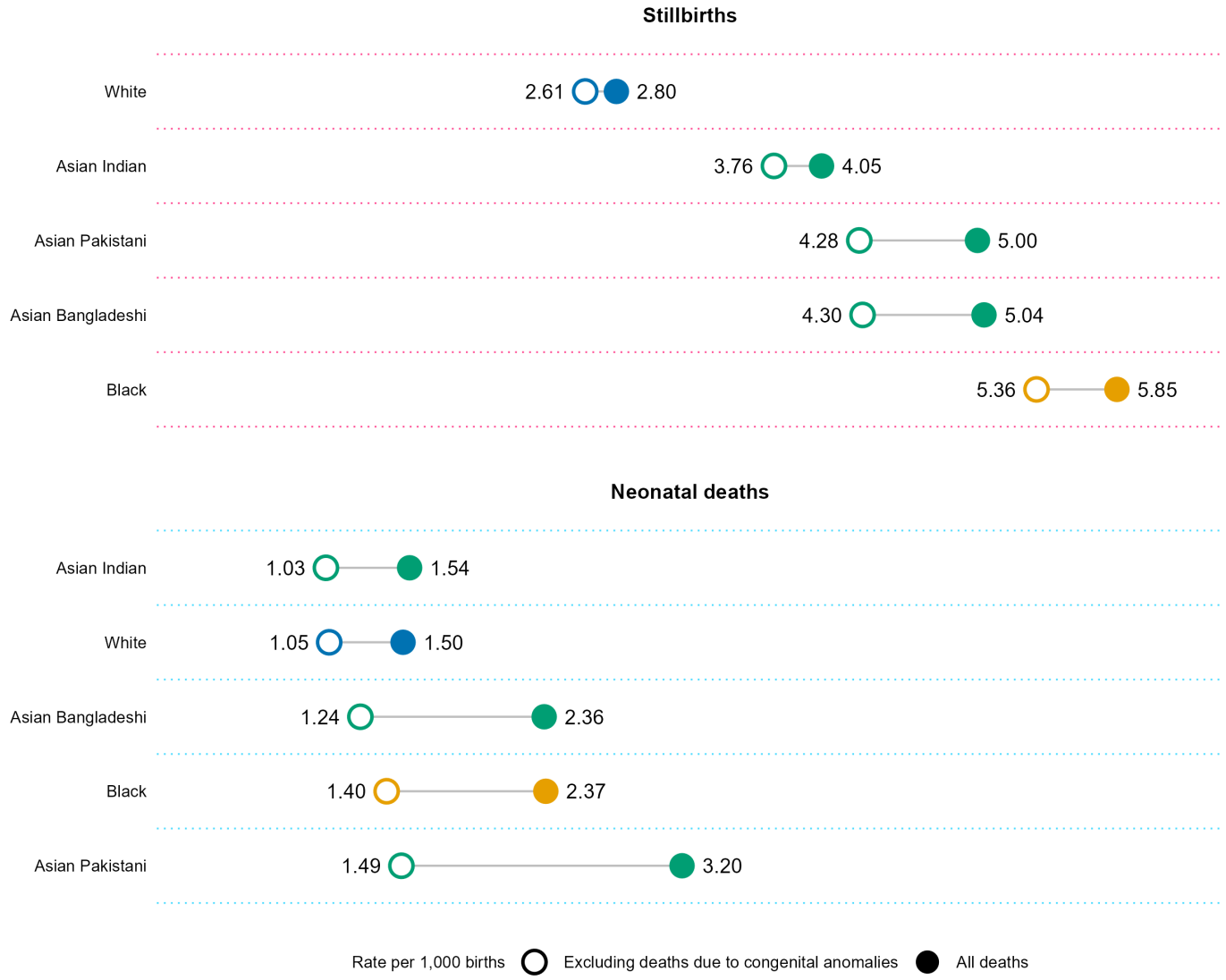
Data source: MBRRACE-UK.

Congenital anomalies affect mortality rates differently across ethnic groups

Congenital anomalies contributed to baby deaths in every ethnic group, but their impact was not the same for all babies.

They had the largest effects on neonatal mortality rates for babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity. When deaths caused by congenital anomalies were excluded, the neonatal mortality rates for these groups fell by around half.

Figure 8: Stillbirth and neonatal mortality rates by babies' ethnicity – all deaths and excluding deaths due to congenital anomalies: United Kingdom and Crown Dependencies, 2022 to 2024 (combined data)



Description of Figure 8: Dumbbell charts showing stillbirth and neonatal mortality rates by babies' ethnicity, for babies born in the UK between 2022 to 2024, presented with and without deaths due to congenital anomalies. Each dumbbell shows the difference in mortality rates when deaths due to congenital anomalies are included or excluded. Rates for babies of Black ethnicity combine several smaller subgroups because the numbers of deaths for babies of Black Caribbean and Other Black ethnicities are too small to report separately. Stillbirth rates are shown per 1,000 total births, and neonatal mortality rates are shown per 1,000 live births. Babies born at less than 24 completed weeks' gestational age and terminations of pregnancy are excluded. Data for 2022 to 2024 are combined because the number of deaths in some ethnic groups is small, and combining the years makes the rates more reliable.

Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.