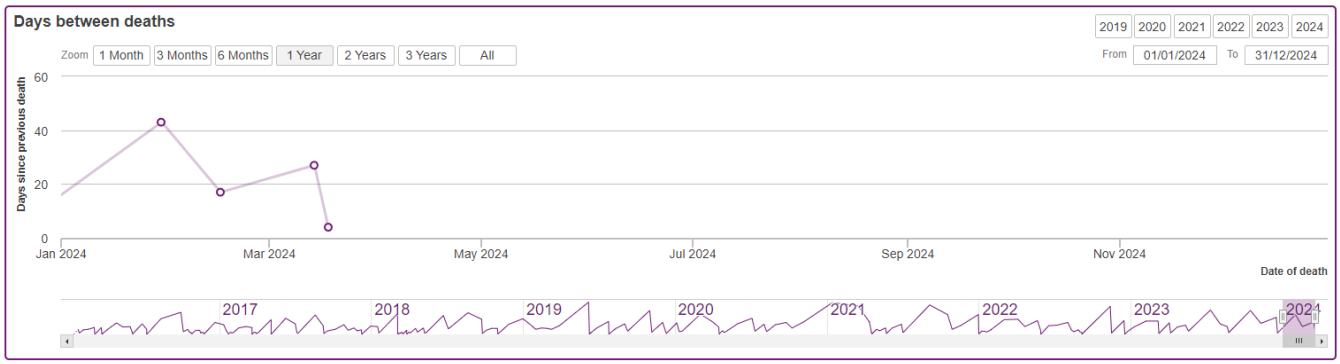
The Shrewsbury and Telford Hospital NHS Trust

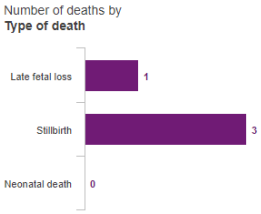
Maternity Governance Meeting
January - March 2024

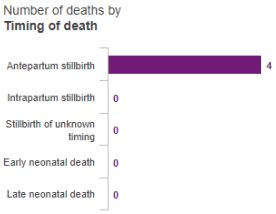
Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q4			
Executive Lead	Hayley Flavell			
Report Author	Lesley Stokes			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance April 2024 Neonatal Governance meeting April 2024 Learning from deaths committee May 2024			
Executive summary:	There was 1 Late Fetal Loss, 3 Still Births and no Neonatal Deaths in quarter 4. External Obstetric Consultants have been present at each PMRT review of care. Compliance with CNST Safety Action 1 is confirmed in this report.			
Appendices	MBRRACE generated Trust Board Report			
Executive Lead	Hayley Flavell			

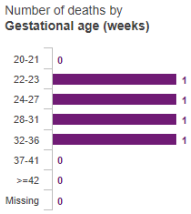
1.0 Deaths reported to MBRRACE

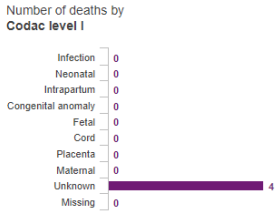
In the time period from the 1st of January 2024 to the 31st of March 2024 there were 3 stillbirths, 1 Late Fetal Loss and 1 Early Fetal Loss.











Stillbirths

The first stillbirth reported from this quarter was an antepartum stillbirth at 28+1 weeks gestation. The mother attended a routine appointment, and the fetal heart could not be heard. The PMRT review took place March 20th and the overall grading of care was agreed as a "B", care factors identified that would not have made a difference to the outcome.

The second stillbirth reported this quarter was an antepartum stillbirth at 36+6 weeks gestation. The mother attended due to reduced fetal movements and the fetal heart could not be heard. The PMRT review is scheduled to take place on the 18th of April 2024.

The third stillbirth this quarter was an antepartum stillbirth at 24+2 weeks gestation. The mother attended due to reduced fetal movements for over one week and the fetal heart could not be heard. The PMRT review is scheduled to take place on the 18th of April 2024.

Late Fetal Loss:

A late fetal loss at 22+4 was reported, the mother's pregnancy had been complicated by abnormal scan findings and fetal growth restriction. The mother attended maternity triage with absent fetal movements and fetal demise was confirmed. The PMRT review took place on the 20th of March 2024 where the grading of care was agreed as an "A" no care issues identified.

Neonatal Deaths:

There were no neonatal deaths reported in March 2024.

2.0 Safety Action 1 Compliance: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

(Y6 Relaunch) All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days.

In Quarter 4, (Jan, Feb and March) there were 3 stillbirths and 1 Late Fetal Loss that fitted the criteria for review using PMRT. These cases were reported to MBRRACE within the specified timeframe of 7 working days. SATH is 100% compliant with this target for quarter 4.

Quarter 4	Notified to MBRRACE	Reported to MBBRACE within 7 working days?	Surveillance information completed	Surveillance completed within one calendar month?
Stillbirth 1: 91966/1	19/02/2024	Yes	19/02/2024	Yes
Stillbirth 2: 92385/1	15/03/2024	Yes	15/03/2024	Yes
Stillbirth 3: 92440/1	18/03/2024	Yes	18/03/2024	Yes
Late Fetal Loss: 91636	31/01/2024	Yes	31/01/2024	Yes

(Y6 Relaunch) For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

In Quarter 4, all parents were given the opportunity to ask questions and have their perspectives included in the PMRT review. SATH are 100% compliant with this target for quarter 4.

Quarter 4	Families informed	Source
Stillbirth 1: 91966/1	Yes	Bereavement Midwives – PMRT letters sent, and parents questions/comments added to the tool.
Stillbirth 2: 92385/1	Yes	Bereavement Midwives - PMRT letters sent, and parents questions/comments added to the tool.
Stillbirth 3: 92440/1	Yes	Bereavement Midwives - PMRT letters sent, and parents questions/comments added to the tool.
Late Fetal Loss: 91636	Yes	Bereavement Midwives - PMRT letters sent, and parents questions/comments added to the tool.

(Y6 Relaunch) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 8 December 2023; 95% of reviewed should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

Quarter 4	Review started	MDT review date	Draft report commenced	Report Published	Compliance
Stillbirth 1: 91966/1	19/02/2024	20/03/2024	21/03/2025	25/03/2023	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.
Stillbirth 2: 92385/1	15/03/2024	18/04/2024			Review started within 2 months – Yes. Report written before review
Stillbirth 3: 92440/1	18/03/2024	18/04/2024			Review started within 2 months – Yes. Report written before review
Late Fetal Loss: 91636	31/01/2024	20/03/2024	21/03/2024	25/03/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.

Quarter 4 provides assurance that all reportable cases have had a review started within 2 months of the death, all cases have had an MDT review with the report completed to draft within 4 months and all reports published within 6 months. SATH are 100% compliant with these targets for quarter 4.

(Y6 Relaunch) Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

Quarter 4 report will be presented to Maternity Governance on the 19th April 2024 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

3.0 Quarterly overview

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Deaths are reported to MBBRACE within 7 working days.	100%	100%	100%	100%
Parents should have their perspectives of care and any questions they have sought.	100%	100%	100%	100%
Reviews started within 2 months.	100%	100%	100%	100%
MDT reviews completed to draft stage within 4 months.	100%	100%	100%	100%
Final reports are published within 6 months.	100%	100%	100%	100%

SATH has achieved 100% of all required targets for CNST safety action 1 throughout the financial year 2023/24.

4.0 Issues from reviews and completed reports undertaken in Quarter 4

From the completed review in quarter 4 it was found that the mother's progress in labour was not monitored on a partogram. Learning has been shared with all staff via the weekly safety brief, staff have been reminded to monitor the partogram and where to document to ensure that information pulls through to the partogram on the maternity information system. The review concluded that this did not make a difference to the outcome.

5.0 Conclusion

Compliance has been met with the CNST safety action 1 requirements, and this report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard in Quarter 4.

Author name and title
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Quality Governance Team
Date: 12/04/2024