The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting
April - June 2024

Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q1			
Executive Lead	Hayley Flavell			
Report Author	Silje Almklow			
	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 July 2024 Neonatal Governance meeting July 2024 Learning from deaths committee August 2024			
Executive summary:	There were 2 stillbirths, 1 late fetal loss, and 2 neonatal deaths in quarter 1. 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 The babies whose care should be reviewed using the PMRT

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6.
- All antepartum and intrapartum stillbirths.
- All neonatal deaths from birth at 22+0 to 28 days after birth.
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

2.0 Deaths reported to MBRRACE

In the time-period from the 1st of April 2024 to the 30th of June 2024, there were 2 stillbirths, 1 late fetal loss, and 2 neonatal deaths at SaTH. Reporting to MBRRACE was completed in line with reporting guidelines. The stillbirth at 26 weeks was reported to MBRRACE, but a review was not supported due to it being a medical termination.

Late fetal losses

The late fetal loss this quarter was an antepartum stillbirth at 23+1 weeks gestation. The baby had been diagnosed with multiple abnormalities in the antenatal period, and the intrauterine demise was confirmed on ultrasound scan at a follow up fetal medicine appointment. The PMRT review is scheduled to take place 15th of August 2024.

Stillbirths

The first stillbirth that took place this quarter was an antepartum stillbirth at 38 weeks gestation. The mother was scheduled for an elective caesarean section at 39 weeks, but attended with absent fetal movements and the fetal heart could not be heard. The PMRT review is scheduled to take place 15th of August 2024.

The second stillbirth this quarter was a medical termination at 26 weeks gestation due to congenital anomalies. The loss was reported to MBRRACE, but the review was not supported due to it being a medical termination. Bereavement support is being provided by the bereavement midwives.

Neonatal deaths

The first neonatal death this quarter was a baby who had been diagnosed with congenital abnormalities in the antenatal period, and whose parents had been extensively counselled regarding a potential poor outcome. The birth was planned to take place in a tertiary unit, but the mother presented in labour at 29 weeks gestation and transfer was not appropriate. The baby was born via caesarean section as per the antenatal plan, and sadly died the same day. The PMRT is scheduled to take place the 17th of July 2024.

The second neonatal death this quarted was a baby who was born in poor condition after complications occurred during the induction of labour at 37 weeks gestation. The baby suffered a significant blood loss, collapsed on the neonatal unit, and developed DIC. Care was withdrawn the following day and baby sadly passed. The PMRT review took place the 15th of May 2024, and the grading of care in the antenatal period and in the postnatal period for the baby was a B. The grading of care for the mother after the birth was a C due to a deterioration in her condition and a delay in recognising, escalating, and actioning this deterioration.

3.0 Safety Action 1 Compliance: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

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

In Quarter 1, (Apr, May, Jun) there were 2 stillbirths and 2 neonatal death that met 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 1.

Quarter 1	Notified to MBRRACE	Reported to MBBRACE within 7 working days?	Surveillance information completed	Surveillance completed within one calendar month?
Stillbirth 1: 93568/1	31/05/2024	Yes	31/05/2024	Yes
Stillbirth 2: 93799/1	14/06/2024	Yes	14/06/2024	Yes
Neonatal death 1: 92914/1	19/04/2024	Yes	25/04/2024	Yes
Neonatal death 2: 92915/1	19/04/2024	Yes	25/04/2024	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 1, 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 1.

Quarter 1	Families informed	Date parents contacted	Date of second contact
Stillbirth 1: 93568/1	Yes	31/05/2024	14/06/2024
Stillbirth 2: 93799/1	Yes	19/06/2024	28/06/2024
Neonatal death 1: 92914/1	Yes	19/04/2024	08/05/2024
Neonatal death 2: 92915/1	Yes	19/04/2024	08/05/2024

(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 1	MDT review date	PMRT date	Draft report commenced	Report Published	Compliance
Stillbirth 1: 93568/1	01/07/2024				Review started within 2 months – Yes. Report written before review
Stillbirth 2: 93799/1	18/06/2024				Review started within 2 months – Yes. Report written before review
Neonatal death 1: 92914/1	20/05/2024				Review started within 2 months – Yes. Report written before review
Neonatal death 2: 92915/1	19/04/2024	15/05/2024	24/06/2024	03/07/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.

Quarter 1 provides assurance that all reportable cases have had a review started within 2 months of the death, and all reports published within 6 months. SATH are 100% compliant with these targets for quarter 1.

(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 1 report will be presented to Maternity Governance on the 19th of July 2024 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

4.0 Quarterly overview

	Quarter 2	Quarter 3	Quarter 4	Quarter 1
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%
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 and into quarter 1 of the 2024/2025 financial year.

5.0 Issues from reviews and completed reports undertaken in Quarter 1

From the completed review in quarter 1 it was found that the neonatal unit does not have a skincare bundle in use. The external consultant attending agreed to share the skin care bundle used in the tertiary unit. The consultant and neonatal nurse were not in attendance at the time of birth due to communications issues between the teams. The massive haemorrhage protocol was not initiated, and learning will be shared with all staff.

The mother was given Terbutaline during the fetal bradycardia, despite an abruption/vasa praevia being suspected. The mother's fluid balance was also not managed appropriately following the birth and she developed a significant kidney injury, DIC, and required ITU admission and kidney dialysis. Work is being undertaken to review the bladder care guideline, MEOWS, and fluid balance documentation as part of a deep dive into postnatal deteriorating adults and oliguria/anuria.

6.0 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 1.

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Date 11/07/2024.