Maternity Governance Meeting
July - September 2024

Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q2			
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 October 2024 Neonatal Governance meeting October 2024 Learning from deaths committee November 2024			
Executive summary:	There were 3 stillbirths and 1 late fetal loss in quarter 2. External Obstetric Consultants have been present at each PMRT review of care. Compliance with CNST Safety Action 1 is confirmed in this report. A higher rate of ethnic minorities has been noted amongst PMRT cases when compared to the ethnicity data in Shropshire, however, the issues identified in reviews do not disproportionately affect ethnic minorities.			
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 July 2024 to the 30th of September 2024, there were 3 stillbirths and 1 late fetal loss at SaTH. Reporting to MBRRACE was completed in line with reporting guidelines.

Late fetal losses

The late fetal loss this quarter was an antepartum stillbirth at 22+5 weeks gestation. The mother attended maternity triage with absent fetal movement for 5 days and an intrauterine fetal death was confirmed on ultrasound scan.

Stillbirths

The first stillbirth that took place this quarter was an antepartum stillbirth at 40+2 weeks gestation. The mother attended her community midwife appointment and was referred to triage due to an unstable lie. The mother arrived in triage and the fetal heart was not heard. An intrauterine death was confirmed on ultrasound scan and the baby was found to be a recent stillbirth following birth.

The second stillbirth this quarter was an unattended stillbirth at home at 34+3 weeks gestation. The mother was late accessing maternity care and had her booking appointment and her first scan in the third trimester. The mother birthed her baby at home and was attended by paramedics shortly after. The baby was examined on arrival at the hospital and moderate maceration was noted. The police attended to carry out interviews and a joint agency review took place the following day.

The third stillbirth this quarter was an antepartum stillbirth at 31+5 weeks gestation. The mother contacted maternity triage with reduced fetal movements and an intrauterine death was identified on ultrasound scan. Mild macerations noted after the birth of the baby.

Neonatal deaths

There were no neonatal deaths in Quarter 2.

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 2, (Jul, Aug, Sep) there were 3 stillbirths and 1 late fetal loss 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 2.

Quarter 1	**Notified to MBRRACE**	**Reported to MBBRACE within 7 working days?**	**Surveillance information completed**	**Surveillance completed within one calendar month?**
Late fetal loss 1: 93568/1	31/05/2024	Yes	31/05/2024	Yes
Stillbirth 1: 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
Quarter 2				
Stillbirth 1: 94316/1	16/07/2024	Yes	16/07/2024	Yes
Stillbirth 2: 95124/1	12/09/2024	Yes	12/09/2024	Yes
Stillbirth 3: 95236/1	20/09/2024	Yes	20/09/2024	Yes
Late fetal loss 1: 95376/1	30/09/2024	Yes	30/09/2024	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 2, 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 2.

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
Quarter 2			
Stillbirth 1: 94316/1	Yes	23/07/2024	08/08/2024
Stillbirth 2: 95124/1	Yes	12/09/2024	Outstanding due to mother being inpatient.
Stillbirth 3: 95236/1	Yes	23/09/2024	26/09/2024
Late fetal loss 1: 95376/1	Yes	30/09/2024	Outstanding due to mother being inpatient

(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	Report Published	Compliance
Late fetal loss 1: 93568/1	01/07/2024	15/08/2024	TBC	Review started within 2 months – Yes. Final report outstanding due to clarity being sought re the cause of death.
Stillbirth 1: 93799/1	18/06/2024	15/08/2024	18/09/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.
Neonatal death 1: 92914/1	20/05/2024	17/07/2024	24/07/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.
Neonatal death 2: 92915/1	19/04/2024	15/05/2024	03/07/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.
Quarter 2				
Stillbirth 1: 94316/1	16/07/2024	18/09/2024	27/09/2024	Review started within 2 months – Yes. Completed to draft within 4 months – Yes. Published within 6 months – Yes.
Stillbirth 2: 95124/1	13/09/2024			Review started within 2 months – Yes.
Stillbirth 3: 95236/1	08/10/2024			Review started within 2 months – Yes.
Late fetal loss 1: 95376/1	08/10/2024			Review started within 2 months – Yes.

Quarter 2 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 2.

(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 2 report will be presented to Maternity Governance on the 18th of October 2024 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

4.0 Quarterly overview

	Quarter 3	Quarter 4	Quarter 1	Quarter 2
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 2 of the 2024/2025 financial year.

Equality Diversity and Inclusivity

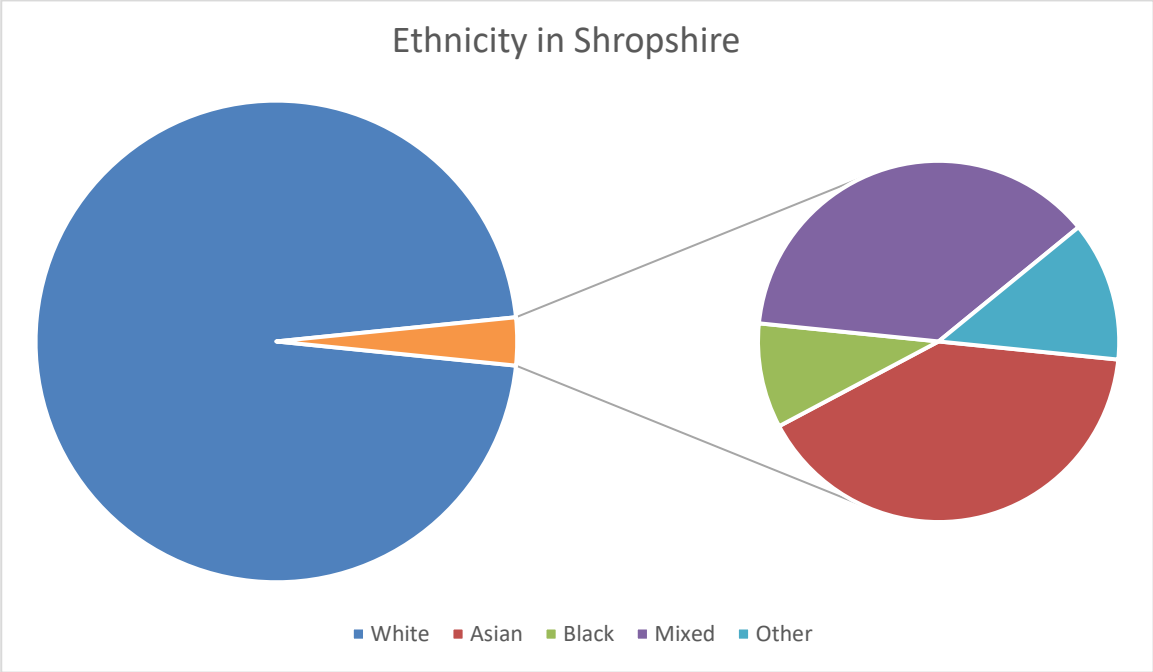
In July 2024 MBRRACE-UK published the annual perinatal mortality surveillance paper – UK perinatal deaths of babies born in 2022. The report highlighted significant disparities in perinatal mortality rates between white and minority ethnicities.

Stillbirth rates by ethnicity decreased in all groups after a rise in 2021, but wide ethnic inequalities remain; babies of Black ethnicity are still more than twice as likely to be stillborn than babies of White ethnicity (Black: 6.19 per 1,000 total births; White: 2.99 per 1,000 total births).
Neonatal mortality rates decreased for babies of Black and White ethnicity, with rates for babies of Black ethnicity decreasing after a two-year period of increase. However, neonatal mortality for babies of Asian ethnicity increased for the second year. Babies of both Asian and Black ethnicity continue to have much higher rates of neonatal mortality than babies of White ethnicity (Asian: 2.50 per 1,000 live births; Black: 2.41 per 1,000 live births; White: 1.56 per 1,000 live births) (MBRRACE-UK 2024).

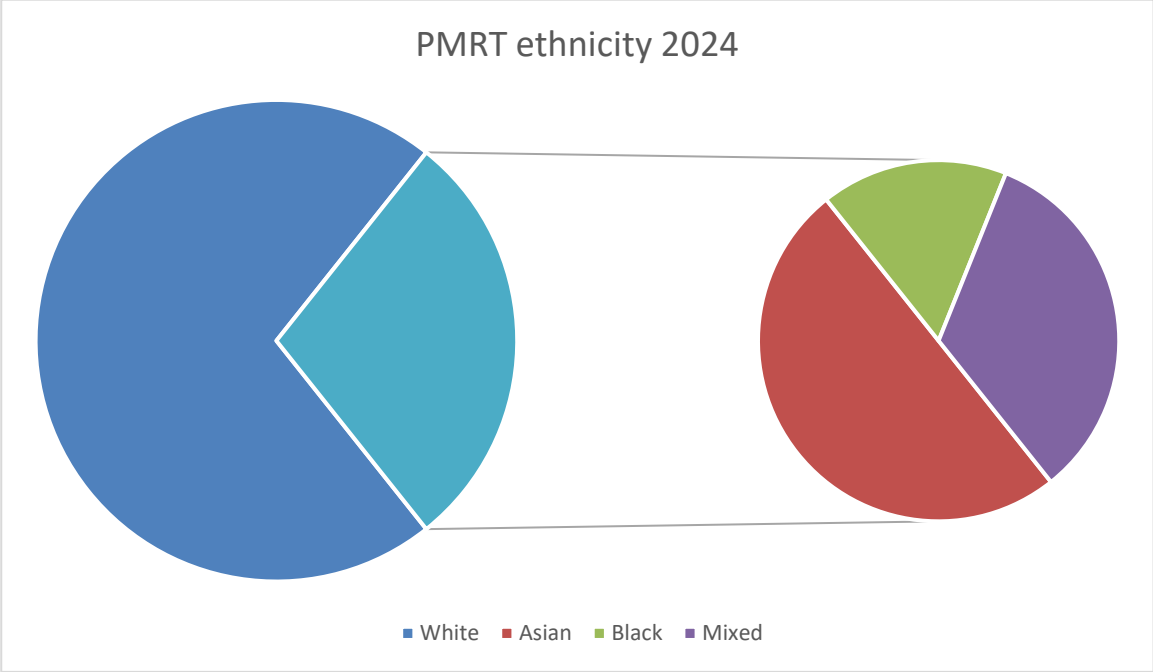
MBRRACE-UK made the following recommendation:

- Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.

In the reports being generated as per Quarter 2 2024, the ethnicity data of late fetal losses, stillbirths, and neonatal deaths will be analysed to determine any deviations from the ethnic distribution in Shropshire. The ethnicity data of all perinatal mortality cases in 2024 have been reviewed and compared to the ethnicity data for Shropshire as a whole. Please be aware that due to the small number of cases reviewed, the accuracy of the data will improve with time.



* Ethnicity data taken from the Shropshire Council Census 2021 Bulletin – published April 2023



** Ethnicity data includes PMRTs led by SaTH and joint PMRTs with other trusts. Numbers include all PMRT's from 2024. Data will become more accurate as time passes and number increase.

5.0 Issues from reviews and completed reports undertaken in Quarter 2

The learning identified from PMRT reviews in September include:

- The pain relief was not managed appropriately for a woman in labour with a stillbirth. She requested an epidural early in her labour but due to delays we were unable to provide this. Learning will be shared with staff.
- Several reviews have identified cases where women are not asked about domestic abuse during pregnancy. Training is available for all staff, learning is being shared, and a trial to identify women at risk when they are providing urine samples is being discussed.

- Labour observations are not always being completed in line with guidance or being documented on the partogram for women in labour following diagnosis of an intrauterine death or with a baby with an expected poor outcome. Learning regarding observations to be included in bereavement training.
- A review highlighted that a woman who disclosed substance misuse in pregnancy was not managed in line with guidance. A urine toxicology was not completed, the risk assessment was not accurate, and she was not booked for serial growth scans. Learning is being shared with all staff.

None of the issues identified from reviews disproportionately affected women from minority ethnic backgrounds.

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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