Maternity Governance Meeting
PMRT October-December 2024

Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q3			
Executive Lead	Paula Gardner, Interim Executive Director of Nursing			
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 January 2024 Neonatal Governance meeting January 2024			
Executive summary:	There have been 3 stillbirths and 1 neonatal death in quarter 3. 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			

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.

Late fetal loss
In this report, a baby born between 22 and 23 weeks of pregnancy, who shows no signs of life regardless of when the baby died, is referred to as a late fetal loss (sometimes referred to as a late miscarriage).

Neonatal death
A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born. Neonatal deaths of babies born at <22 weeks gestation are not reviewed via the PMRT tool.

Stillbirth
A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks.

2.0 Deaths reported to MBRRACE

In the time-period from the 1st of October to the 30[1st] of December 2024, there were 3 stillbirths and 1 neonatal death at SaTH. Reporting to MBRRACE was completed in line with reporting guidelines.

Late fetal losses

There were no late fetal losses in October to December 2024 at SaTH.

Stillbirths

The first stillbirth that took place this quarter was an antepartum stillbirth at 38+5 weeks gestation. The mother contacted maternity triage with reduced fetal movements for > 24 hours and an intrauterine death was identified on ultrasound scan. Mild maceration was noted after the birth of the baby.

The second stillbirth this quarter was an intrapartum stillbirth at 37+6 weeks gestation. The mother contacted maternity triage in suspected labour and was asked to attend. On arrival she was found to have constant abdominal pain, a rigid abdomen, and the fetal heart was absent. The baby was born via an emergency caesarean section due to a placental abruption. This stillbirth has been reported to MNSI and will be reviewed by them.

The third stillbirth this quarter was an antepartum stillbirth at 38+3 weeks gestation. The mother attended for a routine antenatal check and the midwife was unable to auscultate the fetal heart. The mother was seen in maternity triage and an intrauterine death was confirmed on ultrasound scan.

Neonatal deaths

There was 1 neonatal death at SaTH in October 2024. The mother was diagnosed with PPROM at < 30 weeks gestation and was an inpatient with a suspected infection. The mother was seen in the fetal medicine clinic at 31 weeks and referred to DAU and triage due to fetal tachycardia and tightenings. The baby was born via emergency caesarean section due to CTG concerns and required extensive resuscitation at birth. The neonatal team were unable to successfully stabilise the baby, and the decision was made to reorient care. The baby passed away at < 4 hours of age.

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 3, (Oct, Nov, Dec) there were 3 stillbirths and 1 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 3.

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
Quarter 3				
Stillbirth 1: 95933/1	06/11/2024	Yes	06/11/2024	Yes
Stillbirth 2: 96092/1	19/11/2024	Yes	25/11/2024	Yes
Stillbirth 3: 96096/1	19/11/2024	Yes	25/11/2024	Yes
Neonatal death 1: 95544/1	10/10/2024	Yes	10/10/2024	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 3, 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 3.

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
Quarter 3			
Stillbirth 1: 95933/1	Yes	08/11/2024	02/12/2024
Stillbirth 2: 96092/1	Yes	19/11/2024	05/12/2024
Stillbirth 3: 96096/1	Yes	18/11/2024	02/12/2024
Neonatal death 1: 95544/1	Yes	14/10/2024	23/10/2024

(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	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	20/11/2024		Review started within 2 months – Yes.
Stillbirth 3: 95236/1	08/10/2024	17/10/2024		Review started within 2 months – Yes.
Late fetal loss 1: 95376/1	08/10/2024	17/10/2024		Review started within 2 months – Yes.
Quarter 2				
Stillbirth 1: 95933/1	19/11/2024			Review started within 2 months – Yes.
Stillbirth 2: 96092/1	26/11/2024			Review started within 2 months – Yes.
Stillbirth 3: 96096/1	26/11/2024			Review started within 2 months – Yes.
Neonatal death 1: 95544/1	14/10/2024	19/12/2024		Review started within 2 months – Yes.

Quarter 3 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 3.

(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 3 report will be presented to Maternity Governance on the 17th of January 2025 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

4.0 Quarterly overview

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

Equality Diversity and Inclusivity

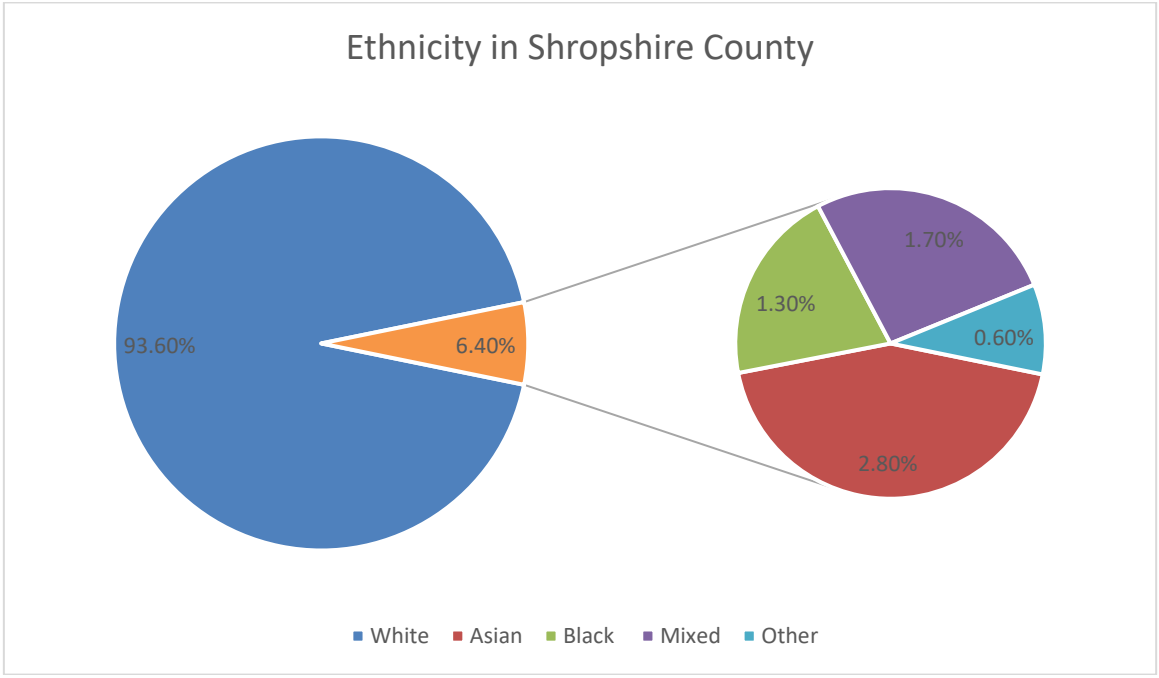
In July 2024 MBRRACE-UK published the annual perinatal mortality surveillance paper – UK perinatal deaths of babies born in 2022. The report highlighted significant disparities in perinatal mortality rates between white and minority ethnicities.

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).

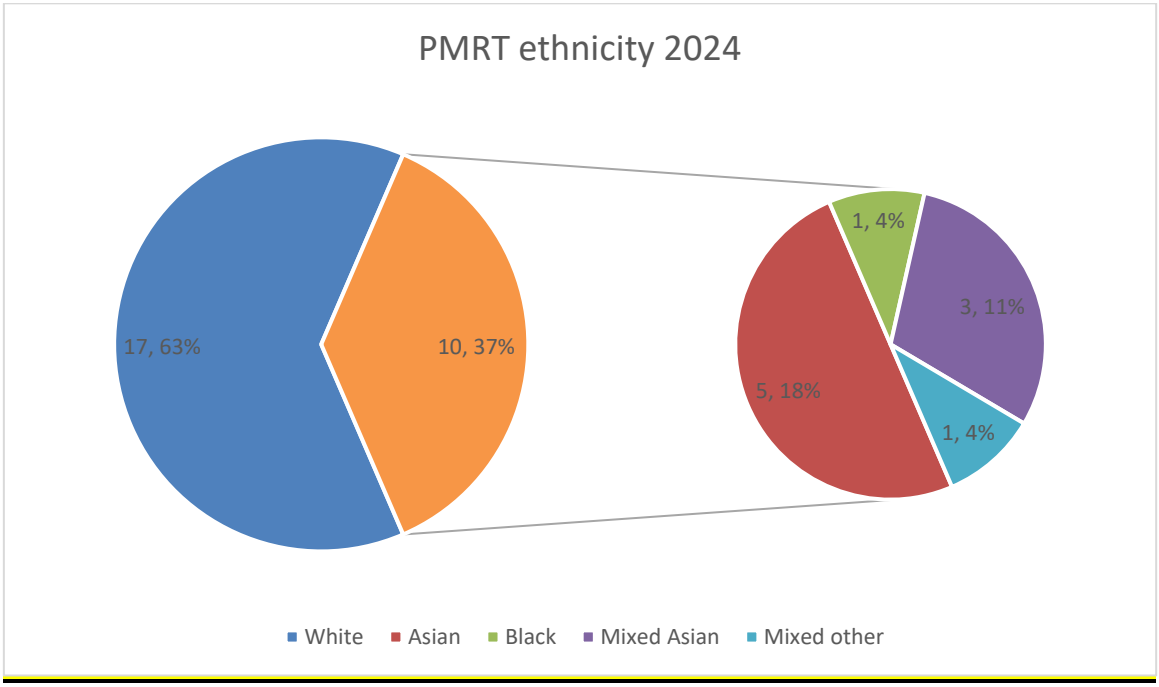
MBRRACE-UK made the following recommendation:

- 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.



*Data taken from the Shropshire **County** 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 3

The learning identified from PMRT reviews in Quarter 3 include:

- Differential diagnoses are not always clearly documented in medical notes. It is not always clear what the doctor was considering as the main diagnosis, what else had been considered, and how this had been ruled out.
- When women access care late in pregnancy, they need urgent booking and screening tests completing. This is not always completed. The screening guideline is being amended to include a referral to the manager on call when women present late in pregnancy for care.

- Reviews have shown that the definition of the golden hour for the neonate is unclear. Guidance has been updated and learning has been shared that the golden hour commences at the time of birth.
- A review highlighted that staff in maternity/neonates were unfamiliar with the SUDIC protocol. Learning and resources have been shared with 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 3.

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