Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Perinatal Mortality Quarter 2 Report 2024-2025**

Status:	**For Information**
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Board Lead:	**Chief Nursing Officer**
Author:	**Milica Redfearn, Director of Midwifery** **Chantal Percy, Perinatal Mortality Midwife** **Claire Litchfield, Maternity Clinical Governance Lead**
Confidential:	**Yes**
Key Purpose:	Assurance

Executive Summary

1. This paper provides an update to the Board about perinatal deaths which were reportable and reviewed during Quarter 2 of 2024-2025.
2. The Perinatal Mortality Review Tool (PMRT) reviewed 9 cases in Quarter 2, which included 3 cases from Quarter 1. The review identified one case with care issues graded as C and another case graded as D, indicating a potential effect on outcomes.
3. Demographic data in respect of women and birthing people affected by perinatal death during Quarter 2 is presented for context.
4. Instances of excellent care were highlighted through parental feedback, emphasising kind and compassionate care, teamwork and going above and beyond.

Recommendations

5. The Trust Board is asked to:
   - Note the summary of the perinatal deaths that occurred during Quarter 2.
   - Note the summary of the reviews undertaken by the Perinatal Mortality Review Panel.
   - Note the required standards set by the Maternity (and Perinatal) Incentive Scheme relating to the perinatal mortality reviews and statements from the maternity service in respect of compliance with these standards.

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Perinatal Mortality Quarter 2 Report 2024-2025

1. Purpose

1.1. This paper presents a quarterly summary of perinatal deaths that are reportable to MBRRACE-UK. A summary of cases reviewed using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT) that occurred in Quarter 2 of 2024/25 is also included.

1.2. Additionally, this report supports the requirements of the Maternity and Perinatal Incentive Scheme.

2. Background

2.1. MBRRACE-UK monitors all eligible perinatal deaths in the UK. The OUH Maternity and Neonatal Services contribute to this national surveillance by reporting eligible deaths and using the PMRT system hosted by MBRRACE-UK to conduct mortality reviews.

2.2. All Trusts and Health Boards in the UK have a Perinatal Mortality Review (PMR) panel, which carries out multidisciplinary systematic reviews of the care leading up to and surrounding all intrauterine deaths (IUD) that occur after 22 weeks' gestation, neonatal deaths (NND), and that of babies who die in the first 28 days of life.

2.3. The OUH PMR panel consists of obstetric, midwifery, anaesthetic, and neonatal colleagues and an external reviewer from another Trust or the Local Maternity and Neonatal system.

2.4. As a tertiary care unit, OUH receives babies who may have been born elsewhere or have received some or all antenatal and intrapartum care at other hospitals. OUH has the responsibility to report these deaths and jointly review cases with other Trusts as appropriate.

2.5. The Perinatal Mortality Review (PMR) process involves engaging with bereaved parents by seeking their views, feedback, and questions about their care and experiences. Parents' perspectives are discussed at each meeting, and the PMR panel shares the responses, findings, and assessments with the families.

2.6. Aspects of care are graded by the following four categories during the review process:

2.6.1. A – The review group concluded that there were no issues with care identified.

2.6.2. B – The review group identified care issues which they considered would have made no difference to the outcome.

2.6.3. C – The review group identified care issues which they considered may have made a difference to the outcome.

2.6.4. D – The review group identified care issues which they considered were likely to have made a difference to the outcome.

3. Perinatal Mortality Quarter 2

3.1. In the second quarter, there were a total of 13 perinatal deaths reported, comprising 6 stillbirths and 7 neonatal deaths.

3.2. Among these cases, 5 involved babies who received antenatal care and were born in neighbouring Trusts, later transferring to OUH for specialised neonatal care.

3.3. Additionally, one case involved a baby who received antenatal care at another Trust and was transferred to OUH for intrapartum care and delivery. Further details can be found in Appendix 1.

3.4. Out of the 13 perinatal deaths reported in Quarter 2, 9 cases were reviewed using the Perinatal Mortality Review Tool (PMRT). The PMRT process includes an extended review period of 6 weeks, which allows for the review of cases from previous months or quarters. Specifically, 3 of the cases evaluated during this period involved babies who died in Quarter 1, while the remaining 6 cases were from Quarter 2. This extended review period may lead to the examination of a different number of cases compared to recent deaths, allowing for a comprehensive assessment of all relevant factors.

4. Demographic Data

4.1. The table below describes the ethnicity of the women who experienced a perinatal death and the proportion of those ethnicities at a national and local level to provide context. The final column includes those affected by perinatal death attending OUH as a tertiary unit.

Ethnicity	National prevalence *	Oxfordshire prevalence *	Oxfordshire Perinatal Mortality Quarter 2 (n=7)	OUH Perinatal Mortality including tertiary referrals, Quarter 2 (n=13)
White	81.7%	86.87%	71.4% (5)	61.5% (8)
Asian or Asian British	9.3%	6.39%	0% (0)	15.4% (2)
Black or Black British	4.0%	2.05%	0% (0)	0% (0)
Mixed	2.9%	3.12%	28.6% (2)	15.4% (2)
Other	2.1%	1.57%	0% (0)	0% (0)
Missing/Declined	N/A	N/A	0% (0)	7.7% (1)

**The national and local ethnicity prevalence has been sourced from the 2021 National Census.*

4.2. Although the figures informing the table are small the in this quarter Asian or Asian British group display a higher perinatal mortality rate at OUH at 15.4% (n=2) compared to national and local prevalence. Additionally, the Mixed ethnicity group in Oxfordshire also demonstrate a higher perinatal mortality relative to local prevalence at 28.2% (n=2).

4.3. To ensure a thorough analysis of these figures the service has reviewed the data from Quarter 1. This process involved comparing perinatal mortality rates, identifying emerging trends, and assessing the effectiveness of interventions implemented in the previous quarter.

4.4. The analysis indicates a slight rise in perinatal deaths in Quarter 2, totalling 13, compared to 10 in Quarter 1. This relates to an increase in tertiary referrals during Quarter 2, with a total of 4 additional referrals compared to the previous quarter. This rise in tertiary referrals indicates a growing need for specialised care and underscores the importance of targeted interventions and resource allocation to meet this demand.

4.5. To address potential disparities in perinatal mortality, the Trust has implemented various strategies including the provision of cultural engagement with communities and cultural competency training for healthcare professionals to facilitate equitable access to high quality care. One strategy involves the implementation of the Continuity of Carer (CoC) Ivy team, based in the OX4 area, which focuses on providing personalised and consistent care to pregnant women from ethnic minority backgrounds. This team aims to build trust and improve communication, thereby enhancing the overall care experience and outcomes.

4.6. By assessing interventions from the previous quarter and analysing the data, the service can identify areas requiring further improvement. This review helps measure progress, adjust strategies and enhance care for all ethnic groups.

5. Care issues identified by the Perinatal Mortality Tool

5.1. The MBRRACE Perinatal Mortality Review Tool generates care issues automatically based on the responses provided. The table below presents the findings from the cases reviewed in Quarter 2. Details of the cases can be found in Appendix 2.

	Issue generated by the tool	% and number of cases (total 9)	Actions/Comments
1	Questions not asked at booking	44% (n=4)	Questions about domestic violence and safety should be asked at booking – it is not always possible if the woman is accompanied at appointments.

2	Bereavement facilities not available	44% (n=4)	Delivery suite has a new soundproofed bereavement suite which opened in November.
3	Carbon monoxide level not appropriately managed	33% (n=3)	Community teams have been issued with new equipment to improve accessibility.
4	IUD bloods not taken	11% (n=1)	Guideline is clear which bloods should be offered. Feedback provided to teams
5	Family member used as interpreter	11% (n=1)	Feedback given to teams – QI project to improve access to language line has been completed.
6	Neonatal temperature not taken on arrival to neonatal unit	11% (n=1)	This should be taken routinely. Findings of PMR shared to team.
7	Placenta not sent to histology	11% (n=1)	Guideline updated with posters to identify placentas which should be sent to histology circulated.

6. Exceptions

6.1. Seven cases were graded A and B. One case had an element of care graded C, and another case had elements of care graded D and C.

6.1.1. Case ID94434

This case was graded C for care of mother up to the point that the baby had died. It has previously been reported to the Board, with the PMR process highlighting the need for improved referral to pre-term birth clinics and better intrapartum care for pre-term breech births.

6.1.2. Case ID94004/ PSII (2324-015)

This case was graded a D for care of the mother up to the point the baby died. This case has previously been reported to the Board and is under investigation as a PSII. The PSII and PMR process identified learning around recognition of accumulation of risk and how the electronic patient record can support this recognition. The final report was submitted to the Trust patient safety team in December 24.

7. Excellence identified though feedback

7.1. The Perinatal Mortality Review Panel heard several instances of excellent care being received by women through parental feedback. Themes emerging from excellence reports include kind and compassionate care, going above and beyond, and teamworking.

8. Maternity (and Perinatal) Incentive Scheme Compliance

8.1. Year 6 of the Maternity and Perinatal Incentive Scheme safety action 1 relates to perinatal mortality reviews, reporting and use of the PMRT.

8.2. Safety action 1: 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?

Required Standards
a. **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE UK within seven working days. **OUH are 100% compliant to date.** b. **Seek parents' views of care:** 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 onward. **OUH are 100% compliant.** c. **Review the death and complete the review:** For deaths of babies who were born and died in your trust multidisciplinary reviews should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death. **OUH are 100% compliant.** and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months. **OUH are on track to be compliant.** d. **Report to The Trust Executives:** Quarterly reports should be submitted to the Trust Executive Board on an ongoing basis for all deaths from 8 December 2023. **Evidenced with this report and previous Q1 report.**

9. Conclusion

9.1. There were 13 perinatal deaths reported to MBRRACE-UK during Quarter 2. 9 cases were reviewed during Quarter 2.

9.2. Actions are underway to address identified gaps in care and improve both service delivery and experience.

9.3. OUH are compliant or on track to be compliant with the requirements of the Maternity and Perinatal Incentive Scheme.

10. Recommendations

10.1. The Trust Board is asked to:

- Note the summary of the perinatal deaths that occurred during Quarter 2.
- Note the summary of the reviews undertaken by the PMR.
- Note the required standards set by the Year 6 Maternity (and Perinatal) Incentive Scheme relating to the perinatal mortality reviews and the statements from Oxford University Hospitals regarding compliance

Appendix 1- Summary of perinatal deaths reported during Quarter 2

MBRRACE-UK ID	Date of death	Gestation/outcome	Other NHS Trust involvement
94386	18/07/2024	26+4 Intrauterine death	No
94430	22/7/2024	23+6 Neonatal death	Yes Royal Berkshire NHS FT
94434	24/07/2024	24+6 Intrauterine death	No
94599	03/08/2024	38+3 Neonatal death	No
94634	05/08/2024	24+3 Intrauterine death	No
94659	02/08/2024	33+4 Intrauterine death	No
94753	13/08/2024	Day 21 Neonatal death	No
94998	30/08/2024	Day 3 Neonatal death	Yes Buckinghamshire NHS FT
94842	21/08/2024	Day 2 Neonatal death	Yes Milton Keynes NHS FT
94843	21/08/2024	5 weeks Neonatal death	Yes Buckinghamshire NHS FT
95253	20/09/2024	Day 9 Neonatal death	Yes Frimley NHS FT
95404	28/09/2024	39+1 Intrauterine death	Yes Royal Berkshire NHS FT
95123	07/09/2024	24+2 Intrauterine death	No

Appendix 2 – Summary of Cases Reviewed by Perinatal Mortality Review Panel in Quarter 2

Case Number	Summary	Grading of care of the mother and baby up to the point that the baby was confirmed as having died (IUD) or the point of birth of the baby	NND- Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Actions	Action status
93732	P0 attended for IOL at 41+4, IUD confirmed.	A	N/A	B	No action plan	n/a
93334	P0+2 Booked at OUH. Attended MAU at 22+4 for reduced movements IUD confirmed.	B	N/A	B	To ensure women have access to bereavement mental health support.	All women and families have access to Petals Bereavement support counselling.
94430	P0 Booked at RBH. Diagnosed with pyelonephritis- under urology. 23+6 Transferred to OUH in labour. NND at 48hours of age.	B	B	A	Ensure pain is being scored as a 1 on the MEOWs chart	Learning of the week to all maternity staff, sent via email 19/11/24
94386	P0+2 Booked at OUH. MLC. Attended MAU, IUD confirmed.	B	N/A	A	Raise awareness of parvo virus pathway in community.	Learning shared to community teams and LMNS.
94599	P0 Neonatal death day 5. MNSI Case ongoing.	A	A	A	To include safe sleeping in antenatal education.	Ongoing
94659	P0 33+4 attended MAU with reduced movements, IUD confirmed.	B	N/A	B	Bereavement facilities not available	New bereavement room available on delivery suite.
94634	P0+2. 24+2 Attended CMW, no FH. Attended MAU, IUD confirmed.	A	N/A	A	Bereavement facilities not available	New bereavement room available on delivery suite.
94004	P1 36+6 IUD following placental abruption	D	N/A	C	See Paragraph 7 “Exceptions” These cases have been presented to Board in the Maternity Performance Dashboard.	
94434	P2 24+3 IUD pre-term breech birth	C	N/A	A		