# Learning from Standardised Reviews When Babies Die – 2021 Annual Report

Key Messages – September 2022

Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 18,000 reviews have been started. This fourth annual report presents the findings for reviews completed from March 2021 to February 2022 coinciding with the second year of the SARS-CoV-2 global pandemic. Here are the key messages from the 4,199 reviews completed during this period.

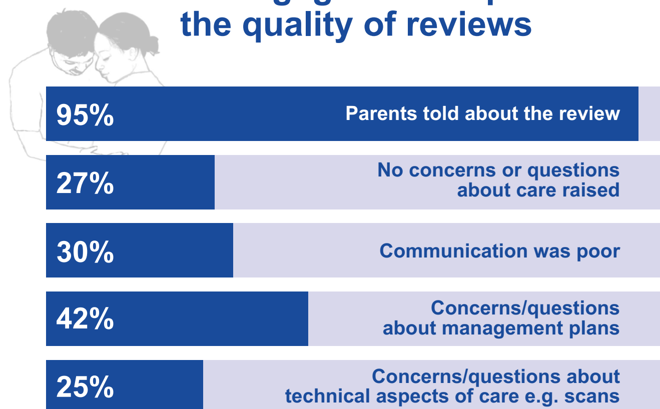
## Multi-disciplinary group review is essential

## Issue with care and areas for improvement identified at review

Over 19 out of 20 reviews identified areas for improvement

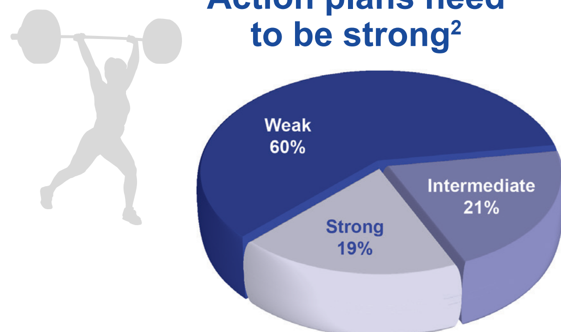
3 out of 20 issues identified may have made a difference to the outcome

## Parent engagement improves the quality of reviews




## Comments, question and concerns raised by parents

## Action plans need to be strong[2]




1. A relevant professional external to the trust/health board to provide a 'fresh eyes' independent perspective of care.
2. Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardised and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'.

## Examples of the strength[2] of actions planned

| Weak | Intermediate | Strong |
|---|---|---|
| *"Individual debrief and staff education. Present case at perinatal mortality and morbidity meeting."* | *"SGA and Grow guidelines to be amalgamated to make the process clearer for serial scans."* | *"Incubators were reviewed and a different type of incubator was needed to admit extreme preterm babies; commissioned and operational."* |
| A reminder for individual action without any controls | A new system in place but still requires individuals to act without any controls | A system level design to eliminate human error |