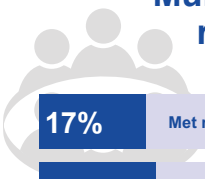
Learning from Standardised Reviews
When Babies Die – 2019 Annual Report

Key Messages – December 2020

PMRT
Supporting high quality local perinatal reviews

Since the launch of the Perinatal Mortality Review Tool (PMRT) in early 2018 over 11,000 reviews have been started. Following implementation in 2018, this annual report presents the findings from reviews completed during the embedding phase from March 2019 to February 2020. Here are the key messages from the 3,693 reviews carried in this period.

Multi-disciplinary group review is essential



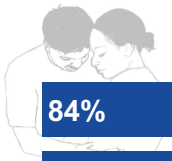
- 17% Met recommended minimum review group composition
- 19% Only 1 or 2 individuals carried out the review
- 29% Neonatologist/neonatal nurse not present for neonatal death reviews
- 18% Had administrative support
- 92% Risk manager/governance team member present

Issues with care and areas for improvement identified

19/20 reviews identified areas for improvement

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

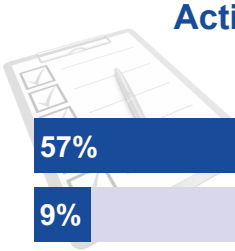
Parent engagement improves the quality of review



- 84% Told about the review
- 84% Parent's perspective sought
- 78% No concerns with care raised
- 9% Received good care
- 13% Questions and concerns raised

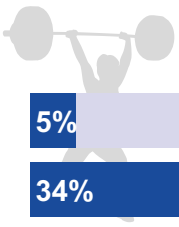
Comments, questions and concerns raised by parents

Action plans need to be SMART



- 57% Specific
- 9% Measureable
- 97% Achievable
- 87% Realistic
- 31% Timebound

Action plans need to be strong*



- 5% Strong
- 34% Intermediate
- 61% Weak
- 0% Nil

*Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardisation and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'.