Learning from Standardised Reviews When Babies Die – 2023 Annual Report

Key Messages – December 2023

PMRT
Supporting high quality local perinatal reviews

Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018, over 23,000 reviews have been started. This fifth annual report presents the findings for reviews completed from March 2022 to February 2023 coinciding with the third year of the global health emergency due to the COVID-19 virus. Here are the key messages from the 4,111 reviews completed during this period.

Multi-disciplinary group review is essential

10%	Three or fewer individuals carried out the review
61%	Neonatal nurse present for the review of neonatal deaths
84%	Neonatologist present for the review of neonatal deaths
35%	Had administrative support
74%	Risk manager/governance team member present
45%	External[1] panel member

Issue with care and areas for improvement identified at review

Over 19 out of 20 reviews identified areas for improvement

4 out of 20 reviews identified at least one issue with care that may have made a difference to the outcome for the baby

Parent engagement improves the quality of reviews

95%	Parents comments about their care sought
27%	Specific questions about what happened and why
23%	Concerns about management plans and care received
14%	General questions, lack of information and communication issues
10%	Concerns about staff approach and how care was given
17%	Positive comments about care and staff

Comments, questions and concerns raised by parents

Why did they send me home when my blood pressure was high?

Midwife advised "it was normal for the baby's movements to slow down as the baby has less room".

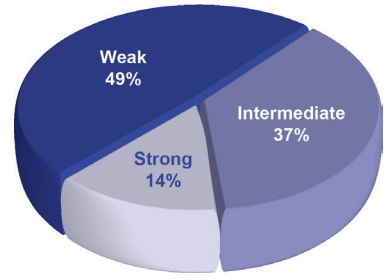
Once we got the worst news of our life we saw Professor [name] again and I can't explain how much that meant to us. He came along to explain why he felt this had happened and say how sorry he was. This is something that I will always remember.

If the baby had been born when I first came in with reduced movements and I had been induced, would the outcome have been different?

Was my weight to blame? I was advised to stop running by my GP due to a couple of early bleeds, so put on some weight and stopped the main form of regular exercise I took.

I have no concerns with my care. In particular I had good diabetic care.

Action plans need to be strong[2]



Examples of the strength[2] of actions planned

Weak

"Feedback and re-education to the medical staff member involved and all medical staff"

A reminder for individual action without any controls

Intermediate

"A standard operating procedure (SOP) is being developed to support Intensive Care Unit (ICU) staff with caring for pregnant patients"

A new support for the system is in place but this still requires individuals to act without controls

Strong

"New IT system includes bereavement care module which requests a Kleihauer test automatically as part of routine postnatal investigations"

A system level design to eliminate human error

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'.