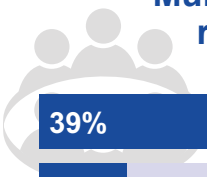
Learning from Standardised Reviews
When Babies Die – 2020 Annual Report

Key Messages – October 2021

PMRT
Supporting high quality local perinatal reviews

Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 14,000 reviews have been started. This third annual report presents the findings for reviews completed from March 2020 to February 2021 coinciding with the first year of the SARS-CoV-2 global pandemic. Here are the key messages from the 3,981 reviews completed during this period.

Multi-disciplinary group review is essential



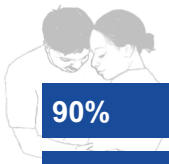
39%	Met recommended minimum review group composition
14%	Only 1 or 2 individuals carried out the review
46%	Neonatal nurse present for the review of neonatal deaths
81%	Neonatologist present for the review of neonatal deaths
22%	Had administrative support
71%	Risk manager/governance team member present

Issue with care and areas for improvement identified at review

19 out of 20 reviews identified areas for improvement

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

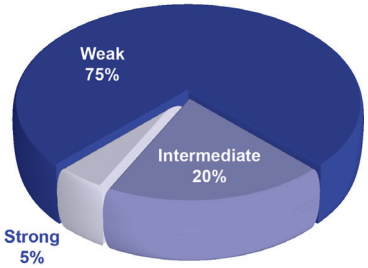
Parent engagement improves the quality of reviews



90%	Parents told about the review
40%	No concerns or questions about care raised
16%	Communication was poor
54%	Concerns/questions about management plans
16%	Concerns/questions about technical aspects of care e.g. scans

Comments, question and concerns raised by parents

Action plans need to be strong[1]



Examples of the strength[1] of actions planned

Weak	Intermediate	Strong
"Distribute communication to maternity staff regarding the necessity for intra-partum antibiotics in preterm labour and the importance of this."	*"Major review which led to a new staffing model and a newly appointed Lead for Triage and Induction."*	*"Process for assessing need for aspirin developed and implemented via EPR[3]"*
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 electronic design to eliminate human error

1. 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'.
2. Artificial rupture of membranes
3. Electronic patient record