Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 12 March 2025

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Title:	**Perinatal Mortality Quarter 3 Report 2024-2025**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee (MCGC) (10/02/2025)**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper provides an update to the Board about perinatal deaths which were reportable and reviewed during Quarter 3 of 2024-2025.
2. The Perinatal Mortality Review Tool (PMRT) reviewed 8 cases in Quarter 3, which included 2 cases which were reported in Quarter 2.
3. Demographic data in respect of women and birthing people affected by perinatal death during Quarter 3 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.
5. In January 2025 the MBRRACE 2023 data was released and showed a slight increase in stillbirth rates at OUH compared to the previous year. Maternity Service is working with MBRRACE to analyze these figures, and a detailed review will be presented to the Integrated Assurance Committee in April 2025.

Recommendations

6. The Trust Board is asked to:
    - Note the summary of the perinatal deaths that occurred during Quarter 3.
    - 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 3 Report 2024-2025

1. 1. Purpose

1.1. This paper provides a quarterly summary of perinatal deaths reported to MBRRACE-UK. It includes a review of cases reviewed using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT) that occurred in the third quarter of 2024/25.

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, and the Oxford University Hospitals (OUH) Maternity and Neonatal Services contribute to this national surveillance by reporting eligible deaths. They utilize the Perinatal Mortality Review Tool (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 that performs multidisciplinary systematic reviews of care related to intrauterine deaths (IUDs) occurring after 22 weeks of gestation, neonatal deaths (NNDs), and deaths in the first 28 days of life for babies.

2.3. The OUH PMR panel includes obstetricians, midwives, anaesthetists, neonatal specialists, 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 who have received some or all antenatal and intrapartum care at other hospitals. OUH is responsible for reporting these deaths and jointly reviewing cases with other Trusts as appropriate.

2.5. The PMR process involves engaging with bereaved parents to seek their views, feedback, and questions regarding 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. During the review process, aspects of care are graded using the four categories below:

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 3

3.1. In the third quarter, there were a total of 13 perinatal deaths reported, comprising 5 intrauterine deaths and 8 neonatal deaths. Appendix 1 provides a summary of these cases. Among the 13 cases, 5 involved tertiary referrals from another Trust where specialist care was required during pregnancy or following birth.

3.2. During Quarter 3, a total of 8 cases were reviewed using the using the Perinatal Mortality Review Tool (PMRT). 2 of the cases reviewed were reported in Quarter 2, with the 6 remaining cases reported in Quarter 3. 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. Appendix 2 provides a summary of the reviews.

3.3. 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 *	OUH Perinatal Mortality Quarter 3, excluding tertiary referrals (n=8)	OUH Perinatal Mortality including tertiary referrals, Quarter 3 (n=13)
White	81.7%	86.87%	30.7% (4)	61.5% (8)
Asian or Asian British	9.3%	6.39%	15.3% (2)	15.3% (2)
Black or Black British	4.0%	2.05%	7% (1)	7% (1)
Mixed	2.9%	3.12%	0% (0)	0% (0)
Other	2.1%	1.57%	0% (0)	0% (0)
Missing/Declined	N/A	N/A	7% (1)	15% (2)

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

3.4. Although the figures informing the table are very small the Asian and Black population is represented at a higher rate than local and national prevalence.

3.5. To ensure a thorough analysis of these figures the service has reviewed the data from Quarter 1 and 2. This process involved comparing perinatal

mortality rates, identifying emerging trends, and assessing the effectiveness of interventions implemented in the previous quarter.

3.6. The analysis reveals that the number of perinatal deaths remained stable, with 13 cases in Quarter 3 as in quarter 2, compared to 10 cases in Quarter 1. Additionally, tertiary referrals showed consistency at 5 cases.

3.7. 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. Strategies include the provision of Active bystander unconscious bias training, dedicated continuity of carer teams in OX4 and improved accessibility to translation services.

Care issues identified by the Perinatal Mortality Tool

3.8. The MBRRACE Perinatal Mortality Review Tool generates care issues automatically based on the responses provided.

	Issue generated by the tool	Percentage and (n) total number of reviewed cases (8)	Actions/Comments
1	Routine Enquiry Questions not asked at booking	12 (1)	The tool flags where the questions have not been asked at the booking appointment. This forms part of the risk assessment process and should be evidenced in all women's notes. If it is not possible to ask the question due to the presence of partners/others this also should be routinely recorded. Feedback to staff involved in cases is provided and wider learning shared via maternity safety huddles and learning of the week on this topic.
2	Soundproof bereavement facilities not available	12 (1)	Delivery suite has one soundproofed bereavement suite which opened in November – however the room was in use by another family.
3	Carbon monoxide not taken at booking.	12 (1)	Community teams have been issued with new equipment to improve accessibility. Learning from this case has been shared with the community teams.
4	Low temperature of baby on admission to SCBU	12 (1)	A project is underway in maternity to reduce instances of babies with low temperatures, including a review of estates and contributory factors.

			Learning has been shared regarding best practice thermoregulation and how to effectively take temperatures.

4. Exceptions

4.1. Seven cases were graded A and B. One had an element of care graded C.

4.2. The case with the element of care graded C related to care following the death of the baby. This related to postnatal arrangements for bladder care review leading to the woman having to come back to the postnatal ward for bladder care, which caused distress. For bereavement cases plans should be made for follow up to take place in a more appropriate setting.

4.3. Case Excellence identified though feedback - 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.

5. Maternity (and Perinatal) Incentive Scheme Compliance

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

5.2. 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.

6. MBRACE Data 2023

6.1. In January 2025 MBRRACE 2023 data was published. This data indicates a slight increase in the rate of stillbirths at OUH compared to the previous year and in relation to other similar Trusts.

6.2. The stillbirth figures presented in the data are very small and may be influenced by natural variations that occur by chance, which means they might not accurately represent any care issues. The Maternity Service is actively collaborating with MBRRACE to gain a clearer understanding of these figures.

6.3. A detailed review of the MBRACE data including stillbirths in 2023 will be completed and presented to the Integrated Assurance Committee in April 2025.

7. Conclusion

7.1. There were 13 perinatal deaths reported to MBRACE-UK by maternity during Quarter 2. 8 cases were reviewed during Quarter 3.

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

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

8. Recommendations

8.1. The Trust Board is asked to:

- Note the summary of the perinatal deaths that occurred during Quarter 3.
- 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 3

MBRRACE-UK ID	Date of death	Gestation/outcome	Tertiary referral to OUH
95635	11/10/2024	23+4 Neonatal death	No
95809	12/10/2024	Day 10 neonatal death	No
95935	10/10/2024	23+5 neonatal death	Yes – from Warwick
95973	03/11/2024	26+1 neonatal death	Yes – from Stoke Mandeville
95975	22/11/2024	38+3 intrauterine death	No
96036	10/11/2024	39+5 neonatal death	No
96175	22/11/2024	38+3 intrauterine death	No
96125	18/11/2024	30+1 neonatal death	Yes- from Stoke Mandeville
96335	01/12/2024	39+2 Intrauterine death	No
96498	18/12/2024	38+6 Intrauterine death	Yes – from Royal Berkshire
96553	18/12/2024	37+3 neonatal death	Yes- from Frimley Health
96559	23/12/2024	22+4 neonatal death	No
96610	23/12/2024	36+4 intrauterine death	No

Appendix 2 – Summary of Cases Reviewed by Perinatal Mortality Review Panel in Quarter 3

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- Graded by neonates	Grading of care of the mother following the death of her baby	Actions	Action status
94753	P0, large fibroids. Screening diagnosis of high risk of Trisomy 13/18. Declined further testing, continued with pregnancy and palliative care plan. . Baby died at home D21.	B	A	A	No actions derived from PMR	N/A
95635	P0, prem delivery at 23+4 weeks. NND at 4 days. COD Intraventricular haemorrhage with left temporo-parietal haemorrhagic infarct, extreme prematurity, early onset sepsis.	B	C (graded by neonatal team)	A	Feedback to MAU that PMR have noted a trend of women at a certain gestation with the symptom of pain not being invited in for assessment	Completed
95123	P1 G4, uncontrolled type 2 diabetic, mental health history, congenital abnormality diagnosed at 14+4. Continue with pregnancy. Suspected chorioamnionitis, IUD at 24+2	B	N/A	B	Explore what psychological support Adult Diabetic Services can offer in similar cases.	Ongoing
95975	P0, ELCS for tokophobia, presented at 32+5 for RFM, IUD diagnosis.	B	N/A	B	Follow up Kleihauer being taken but not reaching lab	Completed
96036	P0 GDM, APH at home baby born in poor condition at 39+5, NND on day 2 from severe HIE secondary to presumed placental abruption.	A	A	A	No actions derived from PMR	N/A
95809	P0, history of mental health illness, IOL at 36+1 for PIH. Baby admitted to NNU for low blood sugar and temps. Poor bowel motility diagnosed and rectal	B	D (Graded by neonatal team- action required)	IB	Explore use of intergrowth chart on badgerNet.	Ongoing

	suction biopsy performed. Discharged home same day. Was found to be morbidly ill at routine day 10 PN check the following day. Resuscitated and died following admission to hospital.					
96125	IUT from SMH at 22+2 for PROM. Presented at MAU at 30+1 in TPTL. Born in good condition, transferred to NNU. NND on day 6.	A	B	B	Request microscopy from histology department.	Complete
96175	P0 Asylum seeker. GDM. Difficulty engaging with care as poor English, LL sometimes declined. Presented to triage at 38+2 for bleeding, IUD diagnosed. Bladder care guidance not followed PN leading to prolonged catheterisation.	B	N/A	C	For bereavement cases plans should be made for follow up appointments to take place in a more appropriate setting	Complete