Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 10 September 2025

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Title:	**Perinatal Mortality Quarter 1 Report 2025-2026**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee (MCGC) (11/08/2025)**

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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 1 of 2025-2026.
2. During Quarter 1, there were 8 perinatal deaths, a decrease of 8 from the previous quarter.
3. The Perinatal Mortality Review Tool (PMRT) reviewed 8 cases in Quarter 1, which included 6 cases which were reported in Quarter 4.
4. Demographic data in respect of women and birthing people affected by perinatal death during Quarter 1 is presented for context.
5. Instances of excellent care were highlighted through parental feedback, emphasising kind and compassionate care, teamwork and going above and beyond.

Recommendations

6. The Trust Board is asked to:
    - Note the summary of the perinatal deaths that occurred during Quarter 1.
    - 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.

Contents

Perinatal Mortality Quarter 1 Report 2025-2026

1. Purpose

1.1. This paper provides a quarterly summary of perinatal deaths reported to MBRRACE-UK for quarter of 2025/26.

1.2. It includes a review of cases reviewed using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT) that occurred in the first quarter of 2025/26.

1.3. 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 utilise 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 engages bereaved families by inviting their perspectives, feedback, and questions regarding their experiences. Parents' views are considered at each meeting, and the PMR panel communicates responses, findings, and assessments in a manner that is sensitive to the family's needs.

2.6. During the review process, aspects of care are graded using the four categories outlined in Appendix 1.

3. Perinatal Mortality Quarter 1

3.1. In the first quarter, there were 8 perinatal deaths reported, a decrease of 8 from Quarter 4. The 8 cases include 4 intrauterine deaths and 4 neonatal deaths. Appendix 2 summarises these cases. Within these cases, none had been referred for tertiary care from another Trust.

3.2. In Quarter 1, a total of 8 cases were reviewed using the Perinatal Mortality Review Tool (PMRT). Six of these cases were reported in Quarter 4, while the remaining 2 were reported in Quarter 1. The extended review period enables the examination of varying numbers of cases compared to recent deaths, allowing for a thorough assessment of all relevant factors. Appendix 3 includes 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 1, excluding tertiary referrals (n=8)
White	81.7%	86.87%	87.5% (7)
Asian or Asian British	9.3%	6.39%	0% (0)
Black or Black British	4.0%	2.05%	0% (0)
Mixed	2.9%	3.12%	0% (0)
Other	2.1%	1.57%	12.5% (1)
Missing/Declined	N/A	N/A	0% (0)

**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 other population is represented at a higher rate than local and national prevalence. To ensure a thorough analysis of these figures the service has reviewed the data from previous quarters. This process involved comparing perinatal mortality rates, identifying emerging trends, and assessing the effectiveness of interventions implemented in the previous quarter.

3.5. To address potential disparities in perinatal mortality, the Trust has implemented various strategies including staff training (active bystander/cultural competency), improvement of access to translation services using video technology and analysing and reviewing patient safety incidents alongside demographic data to identify any emerging trends.

3.6. Care issues identified by the Perinatal Mortality Tool

3.6.1. The MBRRACE Perinatal Mortality Review Tool generates care issues automatically based on the responses provided. The table below provides a summary of care issues identified by the MBRRACE Perinatal Mortality Review Tool alongside actions for improvement.

	Issue generated by the tool	Percentage and (n) total number of reviewed cases (8)	Actions/Comments
1	During this mother's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	12.5% (1)	Blood pressure was not monitored hourly during labour, as the patient was resting. Learning action: Emphasise the importance of communicating that routine observations should be maintained for individuals on bereavement pathways.
2	This mother did not have Kleihauer test despite it being requested	12.5% (1)	Learning actions: A poster was created to illustrate test administration. In addition, in collaboration with the blood transfusion team, there are plans to contact the bereavement team if the reason for Kleihauer is unclear.
3	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	12.5% (1)	This is not provided under local policy.
4	This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	12.5% (1)	Learning action: Reminder sent to staff about the importance of using interpreting services and how to access them.

5.	In view of this mother's risk factors there should have been senior involvement in the management plans for her birth once labour was established	12.5% (1)	Efforts continue on neonatal team call timings, as taught in NLS.
6.	Although indicated this mother was not offered initial blood tests to assess maternal wellbeing immediately after birth	12.5% (1)	For dissemination to all staff through learning of the week

4. Exceptions

4.1. Five cases were graded A and B. One case from Quarter 4 is being brought back to the group to be reviewed, this has been delayed due to absences and a reduced number of meetings due to Bank Holidays. Three cases were graded C for the care up until confirmation of IUD or delivery:

4.2. One case was graded a C due to unclear local trust policies about offering a further scan for patients with new onset hypertension with additional risk factors. From this an action was created to update the hypertension guideline to ensure clear guidance and this is in progress.

4.3. A grade C was given to the second case due to incorrect advice about fetal movements, which was addressed with the clinician directly. The review suggested that earlier patient assessment could have been beneficial, as the patient contacted but did not attend the maternity assessment unit (MAU). Matrons were asked to consider ways to follow up with patients who miss MAU appointments. The service now uses a call logging system to monitor calls which will support this action.

4.4. The third case received a grade of C because the panel determined that delivery could have been expedited by transferring directly to theatre rather than to a delivery room first. A SMART action plan is in development in conjunction with the fetal monitoring team, focusing on the timely identification, escalation, and management of abnormal CTGs.

4.5. Two of these cases are MNSI cases and actions will be generated from these reports.

4.6. 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 7 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 1 December 2024 to 30 November 2025 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 1st December 2024 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 from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, **OUH are 95% compliant** c. and a minimum of 75% of multidisciplinary reviews should be completed. and published within six months. **OUH are on track to be compliant.** For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. **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. **OUH are on track to be compliant.**

6. Conclusion

6.1. There were 8 perinatal deaths reported to MBRACE-UK by maternity during Quarter 1. 8 cases were reviewed during Quarter 1.

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

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

7. Recommendations

7.1. The Trust Board is asked to:

- Note the summary of the perinatal deaths that occurred during Quarter 1.
- Note the summary of the reviews undertaken by the PMR.
- Note the required standards set by the Year 7 Maternity (and Perinatal) Incentive Scheme relating to the perinatal mortality reviews and the statements from Oxford University Hospitals regarding compliance.

Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

- A – The review group concluded that there were no issues with care identified.
- B – The review group identified care issues which they considered would have made no difference to the outcome.
- C – The review group identified care issues which they considered may have made a difference to the outcome.
- D – The review group identified care issues which they considered were likely to have made a difference to the outcome.

Appendix 2- Summary of perinatal deaths reported during Quarter 1

Date of death	Gestation/outcome	Tertiary referral to OUH
22/04/2025	38+0 NND	No
06/05/2025	31+3 IUD	No
10/05/2025	28+6 IUD	No
10/05/2025	23+4 IUD	No
15/05/2025	37+6 NND	No
25/05/2025	28+2 IUD	No
18/06/2025	28+3 NND	No
26/06/2025	27+2 NND	No

Appendix 3 – Summary of Cases Reviewed by Perinatal Mortality Review Panel in Quarter 1

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 assigned at meeting	Action status /deadline
P0 Attended CMW at 24+4, IUD.	B	N/A	B	Reminder sent to staff re observations in labour. Poster completed re how the send Kleihauer.	Complete
P0 OC and PIH. 39+2 IUD MNSI case	C	N/A	B	Update PIH guideline regarding criteria for extra scan.	Ongoing, currently being reviewed- deadline 31/08/25
P0 SGA and polyhydramnios 36+2 IUD.	A	N/A	A	No actions	N/A
P0 PROM at 20 weeks and heart abnormality. IUD at 25+5	B	N/A	A	Feedback sent to SMH regarding scan	Complete

P0 23+3 PROM and chorioamnionitis, IUD	B	N/A	B	Confirmation over when to give cabergoline	Complete
P0 40+1 IUD known T18	B	N/A	B	Feedback to interpreting services about interpreters not being in suitable places	Complete
P0 31+3 Attended MAU with RFM, IUD.	C	N/A	A	To create guidance for DNAs	Ongoing
P1 MLC, spont lab, abnormal CTG, EMCS, NND day 1 MNSI case	C	A	B	Need for action and learning regarding abnormal CTGs	To develop SMART action plan following meeting with fetal monitoring team