

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 March 2026

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Title: Perinatal Mortality Quarter 3 Report 2025-2026

Status: For Information

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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 2025-2026.
2. During Quarter 3, there were 15 perinatal deaths.
3. The Perinatal Mortality Review Tool (PMRT) reviewed 12 cases in Quarter 3, which included seven cases which were reported in Quarter 2 and one case that delivered at OUH and sadly passed away in Leicester. This case was reported by Leicester in quarter 1.
4. Demographic data in respect of women and birthing people affected by perinatal death during Quarter 3 is presented for context.
5. Instances of excellent care were highlighted through parental feedback, emphasising kind and caring staff and exceptional bereavement care.

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 Year 7 Maternity (and Perinatal) Incentive Scheme relating to the perinatal mortality reviews and statements from the maternity service in respect of compliance with these standards.
 - Note that actions are ongoing, in place, and being actively monitored to address gaps identified in care, with the aim of improving service delivery and the overall experience for families.

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Perinatal Mortality Quarter 3 Report 2025-2026

1. Purpose

- 1.1. This paper provides a quarterly summary of perinatal deaths reported to MBRRACE-UK for quarter 3 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 Perinatal Mortality Review (PMR) panel includes obstetricians, midwives, anaesthetists, neonatal specialists, and an external reviewer from another Trust or the Local Maternity and Neonatal system.
- 2.4. Due to ongoing changes to leadership within the Oxford Maternity and Neonatal Voices Partnership (MNVP) representation was absent from some PMR meetings. Their new lead has now undertaken the Perinatal Mortality training for MNVP leaders and will be joining PMR meetings in quarter 4.
- 2.5. 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.
- 2.6. 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.
- 2.7. During the review process, aspects of care are graded using the four categories outlined in Appendix 1.

3. Perinatal Mortality Quarter 3

- 3.1. During this quarter, 15 perinatal deaths reported, compared with 19 cases reported in Q2, and 13 cases from Q3 last year (2024/25). The 15 cases include 9 intrauterine deaths and 6 neonatal deaths. Appendix 2 summarises these cases. Of the 15 cases, 9 had been referred to OUH for tertiary care from another Trust. The remaining 6 booked and delivered at OUH, which when compared to the same quarter last year is a decrease of two cases.
- 3.2. In Q3, a total of 12 cases were reviewed using the Perinatal Mortality Review Tool (PMRT) compared with 10 cases reviewed in Q2. 10 of the 12 cases were reported in Q2, one was by Leicester in Q1, while the remaining case was reported in Q3. 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. Included this quarter is the proportion of women who booked for antenatal care by ethnicity, and then the proportion of women booked for antenatal care (not tertiary referrals) at OUH experiencing a perinatal death.

Ethnicity	National prevalence *	Oxfordshire prevalence *	Proportion of women birthed OUH in Q3 by ethnicity, excluding tertiary referrals (total n=1636) n (%)	OUH Perinatal Mortality Quarter 3, excluding tertiary referrals (n=6) n (%)
White	81.7%	86.87%	1038 (63.4%)	3 (0.2%)
Asian or Asian British	9.3%	6.39%	196 (11%)	2 (1%)
Black or Black British	4.0%	2.05%	65 (4%)	1 (1.5%)
Mixed	2.9%	3.12%	42 (2.5%)	0% (0)
Other	2%	1.57%	31 (1.8)	0% (0)
Not stated/known	N/A	N/A	264 (16%)	0% (0)

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

- 3.4. This quarter, further data is presented to demonstrate the actual proportion of births by ethnicity (excluding tertiary referrals) to compare with those

experiencing perinatal death to provide further context. Although the figures informing the table are very small it is important to recognise that local data supports national evidence that women with ethnicities from the global majority experience poorer perinatal outcomes than white women.

- 3.5. The service has several strategies aimed at improving outcomes for women and birthing people from the global majority and those who are at highest risk of perinatal morbidity.
- 3.6. The service is supporting Equal start Oxford, [Equal Start Oxford - Flo's | The Place in The Park](#) to provide antenatal education, clinics and obstetric outreach to support women and families in OX4. This includes supporting community-based maternity advocates to assist in navigating the NHS and ensuring that families can access care.
- 3.7. Clinical risk assessments in the early stages of pregnancy include consideration of ethnicity (e.g. pre-eclampsia screening, diabetes screening).
- 3.8. The service is committed to providing accessible and immediate language services and ensuring that this is available at every appointment and in the acute setting.
- 3.9. To support ongoing engagement and improve the experiences of families using our service, a planned schedule of community listening events has been developed, this is in collaboration with the Equality, Diversity and Inclusion midwives to ensure representation from all communities.

Care issues identified by the Perinatal Mortality Tool

- 3.10. 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 (12)	Actions/Comments
1	Mother did not give birth in an appropriate setting	8.3% (1)	Patient was not invited back into MAU when experiencing period pains, then went on to have a BBA 45 minutes later.
2	Postnatal care not being provided in a designated bereavement room.	25 % (3)	Level 7, home to the specialty bereavement suite, is now open 24/7 for postnatal patients.

3	The partogram was not completed in labour	8.3% (1)	Reminder sent in delivery suite round up letter.
4.	Mother did not have a kleihauer test despite it being requested	8.3% (1)	Kleihauers have been sent using EPR stickers and therefore rejected by lab. Reminder sent out to all staff using the bereavement "At A Glance".
5.	There is no evidence in the notes that this mother was asked about domestic violence at booking	16.6% (2)	Learning has been disseminated using "Learning of the week".
6.	Baby was cold on arrival in the neonatal unit	8.3% (1)	Baby delivered at home and was admitted with unrecordable temperature.

4. Exceptions

- 4.1. Eleven cases were graded A and B, these are reported in appendix 3. One case was graded a C up until the point of birth.
- 4.2. The C case was a monochorionic twin pregnancy with TTTS and unfortunately an IUD was diagnosed. Care was graded a C up to the time of birth as mother was not advised to attend MAU when she rang with abdominal pain, which then led to her birthing in an inappropriate setting. The care following birth was graded B as her postnatal care was provided on level 6 whilst level 7 was closed.
- 4.3. Key issues identified were delays in assessment and identification of women with FMU plans who should be invited into the unit for assessment when calling MAU. An alert system on BadgerNet has now been created that is easily identified on the home screen of women's notes. All actions are monitored by the Maternity Clinical Governance Committee.

Excellence identified through 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 comforting care, and exceptional bereavement care.

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
<p>a. Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE UK within seven working days.</p> <p>OUH are 100% compliant to date.</p>
<p>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.</p> <p>OUH are 100% compliant.</p>
<p>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 multidisciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death,</p> <p>OUH are 98% compliant</p>
<p>c. and a minimum of 75% of multidisciplinary reviews should be completed. and published within six months.</p> <p>OUH are 93% compliant</p> <p>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.</p> <p>OUH are 80% compliant</p>
<p>d. Report to The Trust Executives: Quarterly reports should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis for all deaths from 01 December 2024.</p> <p>OUH are on track to be compliant.</p>

6. Conclusion

- 6.1. There were 15 perinatal deaths reported to MBRRACE-UK by maternity during Quarter 3. 12 cases were reviewed during Quarter 3.

- 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 3.
- Note the summary of the reviews undertaken by the Perinatal Mortality Review Panel.
- Note the required standards set by the Year 7 Maternity (and Perinatal) Incentive Scheme relating to the perinatal mortality reviews and statements from the maternity service in respect of compliance with these standards.
- Note that actions are ongoing, in place, and being actively monitored to address gaps identified in care, with the aim of improving service delivery and the overall experience for families.

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 3

Date of birth	Gestation/outcome	Tertiary referral to OUH
02/10/2025	23+5 NND	Yes
10/10/2025	26+3 IUD	No (AB)
10/10/2025	32+2 IUD	Yes
12/10/2025	23+1 IUD	No (BA)
13/10/2025	38+4 NND	Yes
16/10/2025	33+1 IUD	No (wb)
17/10/2025	22+6 IUD	Yes
20/10/2025	34+5 NND	Yes
10/11/2025	23+4 NND	Yes
15/11/2025	26+1 NND	No wb
01/12/2025	23+6 NND	Yes
18/12/2025	24+6 IUD	No indo OX4
20/12/2025	32+4 IUD	No WHITE
22/12/2025	24+0 IUD	Yes
29/12/2025	27+5 IUD	Yes

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

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	Issues identified	Actions assigned at meeting	Action status /deadline
Para 1 (P1), consultant led care (CLC), attended follow up appointment for management of her gestational diabetes and was diagnosed with IUD. (28+5)	B	N/A	B	Out of date folic acid was given by the community midwife.	Learning of the week was sent out in the monthly newsletter	Complete
P0. Unbooked transfer managed for preterm rupture of membranes. Delivered via emergency caesarean at 26+2 for abnormal CTG and bleeding.	A	B	A	N/A	N/A	N/A
P0 IVF pregnancy – triplets. Preterm rupture of membranes at 21+6. Emergency caesarean section at 23+1 for chorioamnionitis.	A	B	A	Peripheral artery cannulated causing dusky toes	Fed back to the individual	Complete
P1 monochorionic twin pregnancy with Twin to Twin Transfusion Syndrome (TTTS). One twin sadly diagnoses as an intrauterine death the other was sadly a neonatal death.	C	B	B	Patient was not invited into MAU for assessment and had a BBA 45 minutes later. The respiratory management of the	Alerts to be placed onto the notes of all Fetal Medicine Unit patients so that staff on MAU know to invite them in when they make contact. Reminder sent to staff	Complete Complete

				<p>baby during the first 24 hours was not appropriate.</p> <p>Bereavement checklist incomplete</p> <p>Delay in recognition of perforation on x ray.</p>	<p>Reminder sent to staff</p> <p>Radiology team to support member of staff +/- arrange training.</p>	<p>Complete</p> <p>With neonates</p>
P0 31+2 IUD diagnosed upon presentation with reduced fetal movements.	A	N/A	B	Patient did not have an obstetric review in the postnatal period.	Reminder sent to obstetricians that all bereavement patients require postnatal review prior to discharge home.	Complete
P0 termination planned for fetal hydrops and abnormal posture, however IUD occurred prior to procedure.	B	N/A	B	Routine enquiries regarding domestic violence were not asked.	Learning of the week disseminated reminding staff to complete routine enquiries at every appointment.	Complete
P0 26+2 History of chronic hypertension and stage 3 kidney disease. Severe Intrauterine Growth Restriction and abnormal dopplers. EMCS for abnormal ultrasound scan.	B	B	A	Routine enquiries regarding domestic violence were not asked.	Discussed at community team leaders meeting.	Complete
P0 23+3 induction of labour (IOL) for chorioamnionitis.	B	B	B	The ongoing fluid management of the baby on the neonatal unit was not appropriate	Guideline to be updated regarding how to assess fluid responsiveness in neonatal shock.	With neonates

				Wrong hospital number is used in medical notes	Reminder sent to staff.	Complete
				Delay in IV antibiotics being administered as mother was on SCBU	Reminder sent to staff.	Complete
P1 monochorionic diamniotic (MCDA) twin pregnancy, twin 1 diagnosed with right diaphragmatic hernia. Joint care between trusts. Planned caesarean section at 35+5. NND following surgery at another unit.	A	B	N/A	N/A	N/A	N/A
P1 MCDA twins with TTTS. Twin 2 (ex donor) diagnosed as an IUD at 24+3. TOP of Twin 1 at 29+5.	A	N/A	B	Patient did not have an obstetric review in the postnatal period.	Reminder sent to obstetric staff regarding postnatal reviews for bereavement patients prior to discharge home.	Complete
P2 reported reduced fetal movements at her community midwife appointment. Attended MAU and diagnosed with IUD.	B	N/A	B	Postnatal care provided on level 6.	Level 7 is now open to provide bereavement care	Complete
				Kleihauer not processed	Bereavement "At A Glance" letter sent out to remind staff not to use EPR labels for Kleihauer bloods	Complete
				Delay in being seen at MAU prior to diagnosis of IUD.	Discussed at MAU forum.	Complete

P0 attended MAU with absent fetal movements. Diagnosed with IUD. 26+3	B	N/A	B	Routine enquiries regarding domestic violence were not asked.	Discussed at community team leaders meeting.	Complete
				Postnatal care provided on level 6.	Level 7 is now open to provide bereavement care	Complete
				No 25 week gestation appointment offered with the community midwife as per national guidance.	Discussion has been had with community team leads regarding systems in place to prevent missed appointments.	Complete