Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 14 May 2025

TB2025.35

Title:	**Perinatal Mortality Quarter 4 Report 2024-2025**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee (MCGC) (14/04/2025)**

Board Lead:	**Chief Nursing Officer**
Author:	**Milica Redfearn, Director of Midwifery**
Chantal Percy, Perinatal Mortality Midwife	
	Claire Litchfield, Maternity Clinical Governance Lead
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 4 of 2024-2025.
2. The Perinatal Mortality Review Tool (PMRT) reviewed 10 cases in Quarter 4, which included 5 cases which were reported in Quarter 3.
3. Demographic data in respect of women and birthing people affected by perinatal death during Quarter 4 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.

Recommendations

5. The Trust Board is asked to:
    - Note the summary of the perinatal deaths that occurred during Quarter 4.
    - 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 4 Report 2024-2025

1. Purpose

1.1. This paper provides a quarterly summary of perinatal deaths reported to MBRRACE-UK.

1.2. It includes a review of cases reviewed using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT) that occurred in the fourth quarter of 2024/25.

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 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 outlined in Appendix 1.

3. Perinatal Mortality Quarter 4

3.1. In the fourth quarter, there were 16 perinatal deaths reported, an increase of 3 from Quarter 3. The 16 cases include 9 intrauterine deaths and 7 neonatal deaths. Appendix 2 summarizes these cases. Among them, 8 involved tertiary referrals from another Trust where specialist care was needed during pregnancy or after birth.

3.2. In Quarter 4, a total of 10 cases were reviewed using the Perinatal Mortality Review Tool (PMRT). Five of these cases were reported in Quarter 3, while the remaining five were reported in Quarter 4. 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 4, excluding tertiary referrals (n=8)	OUH Perinatal Mortality including tertiary referrals, Quarter 4 (n=16)
White	81.7%	86.87%	37.5% (3)	43.7% (7)
Asian or Asian British	9.3%	6.39%	50% (4)	25% (4)
Black or Black British	4.0%	2.05%	0% (0)	6% (1)
Mixed	2.9%	3.12%	12.5% (1)	12.5% (2)
Other	2.1%	1.57%	0% (0)	0% (0)
Missing/Declined	N/A	N/A	0% (0)	12.5% (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, Black and mixed 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 with 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 (10)	Actions/Comments
1	This mother lives with family members who smoke but they were not offered referral to smoking cessation services	10% (1)	The Chair and Head of Midwifery will meet to explore opportunities for learning
2	It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	20% (2)	To remind staff to offer and document parents' choice.
3	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	30% (3)	Not local policy to offer
4	This mother's progress in labour	20 % (2)	Reminder sent to staff of importance of filling partogram in for bereavement

	was not monitored on a partogram		
5.	The interpretation of the fetal heart rate monitoring in established labour was not correct	10% (1)	Bedside USS by 2x doctors diagnosed IUD, difficult scan due to raised BMI and gestation of 22/40 therefore fetal monitoring not performed, when born baby had heart rate.
6.	This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out	10% (1)	20 week scan showed normal growth, IUD prior to next appointment, therefore no opportunity to measure fundal height.

4. Exceptions

4.1. Nine cases were graded A and B. One case is being brought back to the group to be reviewed.

4.2. 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. Conclusion

6.1. There were 16 perinatal deaths reported to MBRACE-UK by maternity during Quarter 4. 10 cases were reviewed during Quarter 4.

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 4.
- 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: 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 4

MBRRACE-UK ID	Date of death	Gestation/outcome	Tertiary referral to OUH
96787	06/01/2025	30+0 Intrauterine death	Yes- Hillingdon
96995	18/01/2025	27+6 Neonatal death	Yes- Reading
97015	19/01/2025	35+5 Intrauterine death	No
97119	27/01/2025	36+1 Neonatal death	Yes- Northampton
97158	28/01/2025	27+3 Intrauterine death	No
97223	06/02/2025	27+2 Neonatal death	No
97263	05/02/2025	25+2 Intrauterine death	No
97413	20/02/2025	23+3 Neonatal death	Yes- Stoke Mandeville
97450	22/02/2025	30+3 Neonatal death	Yes-Wexham Park
97481	25/02/2025	31+2 Neonatal death	Yes-Reading
97556	27/02/2025	39+2 Intrauterine death	No
97638	02/03/2025	36+2 Intrauterine death	No
97690	09/03/2025	25+6 Intrauterine death	Yes-Stoke
97819	18/03/2025	40+2 Intrauterine death	No
97865	21/03/2025	20+6 Neonatal death	No
97880	22/03/2025	23+2 Intrauterine death	Yes- Stoke

Appendix 3 – Summary of Cases Reviewed by Perinatal Mortality Review Panel in Quarter 4

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 assigned at meeting	Action status /deadline
96335	P2 MLC. 39+2 Called MAU in early labour and reduced movements. Arrived on MAU in active labour, IUD confirmed. Referred to MNSI	For regrade	N/A	B	Community matron to check whether consultant referral was required in this case.	Complete – the AN guidance would not support a consultant referral for this case.
96553	P1 Referred to OUH for diaphragmatic hernia, under FMU. ELCS at 37+3. NND D1.	A	B	B	Additional bereavement support/training for L6 staff	Complete
96610	P1 MLC 36+3 One episode of reduced movements at 33+5,	B	N/A	A	Consultant to discuss reg current reduced	Complete

	Attended 36-week scan IUD confirmed.				movements advice.	
96498	P0 booked at Reading MLC moved house to OUH at 34+5 transferred to OUH. Attend MAU at 38+3 with reduced movements IUD confirmed.	B	N/A	A	To explore creating information and new resident pack for women transferring to OUH.	Ongoing – deadline 30/05/2025
96559	P0 MLC 22+2 Attended MAU with bleed, found to having bulging membranes. 22+4 Preterm rupture of membranes and cord prolapse. IUD confirmed. Spontaneous labour and delivery. NND at 30mins of age.	B	A	A	No actions	N/A
97015	P0 under FMU for anhydramnios and talipes, planned palliative care. Attended MAU at 36+2 with reduced movements, IUD confirmed.	A	N/A	B	Reminder to staff to use partogram	Complete
96787	P1 transferto OUH for cerebellar hemangioblastoma, under silver star. Severe	A	N/A	A	No actions	N/A

	IUGR. 29+6 IUD confirmed.					
97119	P0 referred to OUH for congenital myotonic dystrophy. ELCS at 36+1 Compassionately extubated on D4	A	B	A	No actions	N/A
97158	P1 MLC Attended MAU with reduced FM at 27+0 IUD confirmed	B	N/A	A	Feedback to MAU midwives to document timings for attending	Complete
97223	P1 Under FMU for IUGR, absent/ reversed EDF, EMCS at 27+2. NND at 20 hours old	B	B	B	Joint work with neonates to produce bereavement paperwork	Ongoing – deadline 30/05/2025