Learning from Standardised Reviews When Babies Die – 2024 Annual Report

Key Messages – December 2024

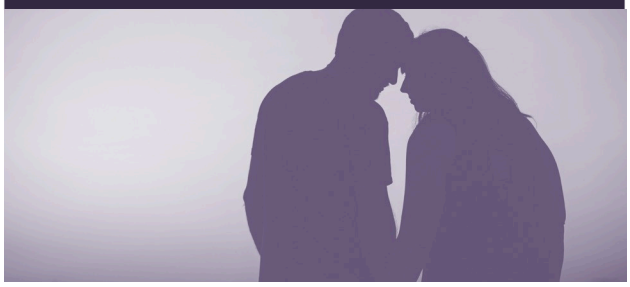
PMRT
Supporting high quality local perinatal reviews

Since the launch of the national Perinatal Mortality Review Tool (PMRT) in early 2018, over 27,000 reviews have been completed. This report presents the findings for reviews completed from January to December 2023. Here are the key messages from the 4,311 reviews completed during this period.

96% of parents were invited to provide comments or questions about their care

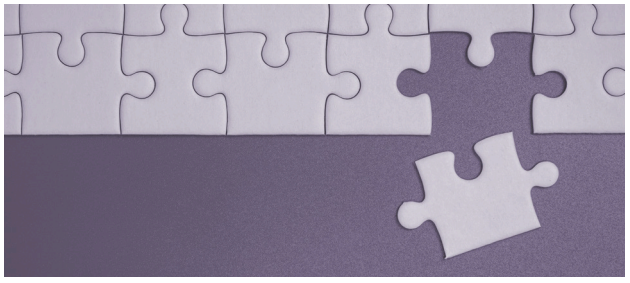
- **33%** had specific questions about what happened and why
- **22%** had concerns with management plans and care received
- **16%** had general questions, or commented on a lack of information or communication issues
- **5%** had concerns about staff approach and how care was given
- **25%** provided positive comments about care and staff

Parent engagement improves the quality of reviews



Multidisciplinary group review is essential

- **9%** of reviews had three or fewer individuals to carry out the review
- **55%** of reviews of neonatal deaths included a neonatal nurse
- **84%** of neonatal death reviews included a neonatologist
- **36%** of reviews had administrative support
- **78%** of reviews had a risk manager /governance team member present
- **51%** of reviews included a relevant external professional panel member present



Approximately 55% of parents had questions, comments or concerns

"Why was I induced 3 weeks earlier?"

"Is there anything that could have been done to prevent this? Or is there anything that was missed?"

"Lack of compassion from the consultant"

"I really couldn't fault the care I received during this nightmare and that's truly what it was and still is"

"From the minute we found out about my baby having no heartbeat, me as her mum, her dad and us all as a family - we were all looked after."

"The placenta came away and why did this happen?"

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30% of reviews identified at least one issue with care that may have made a difference to the outcome for the baby

95% of reviews identified areas for improvement in care

Action plans need to include strong actions

Weak	Intermediate	Strong
"Learning point highlighted on learning point poster."	"The antenatal notes include information about fetal movements and women are being updated with videos of actions to take if reduced fetal movements."	"Currently no soundproof facilities on NNU. Plans in place to get soundproof walls and door. Awaiting estates to compile quotes. Money in place."
46%	44%	10%
A reminder of action without controls	A new support system in place but still without controls	Eliminates any human error

PMRT TEAM

All opinions and views are equal and should facilitate a breadth of discussion

Admin/Clerical Support
Should be a separate role to reduce the administrative burden for clinical staff. They can help to ensure timely reviews which include all of the relevant information

PMRT Champion
Acts as a leader and advocate for the PMRT, ensuring that it is conducted thoroughly. They are responsible for facilitating multidisciplinary team discussions, promoting a culture of learning and improvement

Neonatologist minimum of 2
(Or paediatrician who delivers neonatal care). For input for all deaths where resuscitation was commenced and all neonatal deaths

Obstetrician minimum of 2
Provide specialist knowledge of maternal care, throughout pregnancy and after birth

Other suitable member
Could be a pathologist (where PM performed), anaesthetist, sonographer/radiographer, safeguarding team member, service manager, ambulance team, GP/Community care, social worker/counsellor or MNVP representative (England only)

Bereavement Midwife
Can be the contact for parents throughout the process. Present at the meeting to advocate on behalf of the specific parents the death of whose baby is under discussion and should not lead the PMRT

Midwife minimum of 2
Drive on education, clinical care and resourcing. Provide an overview of maternal care

Chair & Vice-chair
Lead the meeting, support relevant discussion and ensure minutes and actions are documented

Risk/Governance Member
Important to ensure that learning from reviews is translated into actions, which are implemented and subsequently audited

External Member
Should be a relevant senior clinician who works in a hospital external to the trust/health board undertaking the review. Their role is to be present at the review panel and actively participate in the review to provide a 'fresh eyes', independent and robust view of the care provided. This may involve challenging the care that was provided. They should be from a relevant specialty and be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care.