

Local Requirements for PMRT Investigations SOP	
Summary statement: How does the document support patient care?	To support the investigation process of stillbirth and neonatal death via the Perinatal Mortality Review Tool (PMRT).
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For use by:	Clinical Governance Team, Matrons
Purpose:	This pathway supports the communication and processes required to completing an investigation carried out via PMRT
This document supports:	MBRRACE-UK, PMRT, CNST
Key related documents:	CNST Year 4
Approved by:	JOGG
Date:	20 th December 2023 Date uploaded: 20 th December 2023
Ratified by Board of Directors/ Committee of the Board of Directors	Not applicable – Divisional Ratification only required
Ratification Date:	Not applicable – Divisional Ratification only required
Expiry Date:	January 2026
Review date:	July 2025
If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	UHS-SP-0003-2023

Version	Date	Author	Status	Comment
1.0	Jan 2023	Claire Parr - Clinical Governance Lead Kate Hasson - Women's Services Governance Lead	DRAFT	First edition
1.1	December 2023	Claire Parr - Clinical Governance Lead	LIVE	Updated Patient Review Letter in appendix 3.

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Local Requirements for PMRT Investigations SOP

1.0 Aim of this document

The aim of this standard operating procedure (SOP) is to support the investigation process of stillbirth and neonatal death via the Perinatal Mortality Review Tool (PMRT).

2.0 Scope

This SOP applies to:

- Clinical Governance Team
- Matrons

3.0 Abbreviations used within this document

BSL - British Sign Language	CNST - Clinical Negligence Scheme for Trusts
CQC - Care Quality Commission	DOC - Duty of Candour
EN - Early Notification	HIMS - secure HSIB Investigation Management System
HQIP - Healthcare Quality Improvement Partnership	HSIB - Healthcare Safety Investigation Branch
HIE - Hypoxic Ischaemic Encephalopathy	ICB - Integrated Care Board
LMNS - Local Maternity and Neonatal System	MDT - Multidisciplinary Review
MBRRACE-UK - Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries	MIS - Maternity Information System
MOC - Manager On-Call	MRI - Magnetic Resonance Imaging
NHSR - NHS Resolution	NND - Neonatal Deaths
PMA - Professional Midwifery Advocates	PMRT - Perinatal Mortality Review Tool
SBAR - Situation, Background, Assessment and Review	SI - Serious Incident
SIRG - Serious Incident Review Group	SOP - Standard Operating Procedure
STEIS - Strategic Executive Information System	TRiM - Trauma Risk Management

4.0 Background

A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT). The PMRT was designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

4.1 PMRT Criteria

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation;
- Babies who die in the community 28 days after birth or later who have not received neonatal care;
- Babies with brain injury who survive.

4.2 Aim of PMRT approach

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

5.0 Clinical Negligence Scheme for Trusts (CNST)

Safety Action 1 outlines the requirements for local trusts in relation to MBRRACE-UK and PMRT. This is to provide assurance that the national PMRT is being used to review perinatal death to the required standard.

Within the Year 4 CNST document, deadlines for each component of the Safety Action are given.

In response to lessons learned, PMRT will be included as a mandatory item on the monthly divisional Governance agenda to align with the monthly reporting required by PMRT and CNST. A tracker will support this process of which an example template can be seen in [Appendix 1](#). Risk noted that if monthly governance meeting is postponed/stood down this may impact on the ability to pick up on issues with reporting deadlines relating PMRT and deadlines required of MBRRACE-UK - if this occurs SOP should address how this is reported within the management team.

To further mitigate risk around potentially missed deadlines a PMRT item will be added to the daily call collection sheet, review every Friday to positively ascertain any events which relate to PMRT and escalate any issues which may impact on meeting PMRT reporting deadlines. This should include the neonatal matrons from each site updating on any recently deceased baby over the last 24-72 hours.

The Clinical Governance Leads' hold overall responsibility for the PMRT processes including chairing the monthly MDT meetings. In their absence, a member of the Governance team or Matron team will support the running of the meeting, ensuring deadlines continue to be monitored.

The administrative processes should be supported by a dedicated administrator, as per MBRRACE-UK recommendations.

6.0 Identification of Incident

Any death is reported by the health care professional to the online incident reporting system, Datix and also via the Bereavement email group. The Clinical Governance team will pick up reported incidents that meet the criteria for PMRT through this method. However, as a failsafe, a report is run via the Maternity Information System (MIS) to pick up any eligible cases that might not have been reported via Datix. This failsafe is carried out every week and cases not reported are done so in retrospect. Additionally the Badgernet Data

Coordinator will inform the Clinical Governance team of any cases of neonatal deaths (NND) at each month end.

Any cases which may not have been reported via the incident reporting method, are those babies who die elsewhere. Local Clinical Governance teams do not have jurisdiction over this notification, however the team communicate regularly with the Child Death team who can also support notification of any deaths relevant to the trust should they become aware of them.

7.0 Reporting to MBRRACE-UK

7.1 MBRRACE-UK Notification

The MBRRACE-UK online reporting form is a data collection tool for national surveillance. Deaths should be reported to MBRRACE-UK via the online reporting form within 7 working days of a death (in accordance with Safety Action 1 of CNST, year 4 standards).

The MBRRACE-UK reporting form is completed by the trust where the baby died. Therefore, if a baby was transferred to another hospital outside of the trust whilst alive but they subsequently died under their care, they are responsible for notification. The local trust will support their PMRT review processes by completing the relevant questions around care provided locally, once they are notified and the transfer of the PMRT has occurred.

Where this is not possible, due to delay in notification for example, surveillance should be completed as soon as possible, once it is known and has been communicated to the Clinical Governance team as described in [section 5.0](#).

7.2 MBRRACE-UK Surveillance

When a notification is complete the notification status will show whether surveillance (and review) is required for each case. Surveillance information must be completed within one month of the death. This is undertaken through the MBRRACE-UK reporting website.

8.0 Duty of Candour (DOC) and communication to parents'

The Care Quality Commission (CQC) Regulation 20 outlines a provider's responsibility for Duty of Candour (DOC). The aim of this regulation is to ensure that health services are open and transparent, and was introduced in direct response to recommendation 181 of the Francis inquiry into Mid-Staffordshire NHS Foundation Trust.

The trust is responsible for carrying out DOC to the family. Engaging bereaved parents in the review process and including their views and any concerns and questions they have about their care will enhance the process and ensure that from the outset the review addresses their questions. Parents, particularly mothers, are the only individuals who were present for the whole of the pregnancy and therefore have a unique perspective on everything that happened to them and their baby.

There is an expectation that DOC is completed within 72-hours where possible.

The standard from Safety Action 1 of the Year 4 CNST requires 95% of all deaths of babies who have died within the local trust, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns about their care and that of their baby has been sought.

The flow chart for parent engagement during this process can be found in [Appendix 2](#).

8.1 Verbal DOC

As soon as reasonably possible, the Clinical Governance team will speak with the family, preferably face-to-face to inform them that their baby's death will be investigated. The person carrying out DOC will explain the perinatal mortality review process and the offer of parents' engagement.

Should the family have been discharged prior to verbal DOC, a telephone call can be attempted. Sensitivity must be ensured at all times and boundaries of the grieving parents respected. [Appendix 3](#) and outlines the letter for making contact with parents after discharge and [Appendix 4](#) and [Appendix 5](#) are parent feedback forms which are designed to help parents think about any questions or comments they may have about aspects of their care.

8.2 Written DOC

Following verbal DOC, a letter or email (dependent on family preference) will be sent to the family outlining the discussion made. This will include written information leaflet about perinatal reviews for the family.

Occasionally parents withdraw from any communication with the local trust. Their well-being is paramount so liaison with their community midwife and/or GP regarding this should be made to reassure the team that they remain as well as can be expected. A letter should be sent to parents when they cannot be reached and no other communication has been possible ([Appendix 6](#)).

Parents should be signposted to 'Information for Bereaved Parents' page found here:

[Information for bereaved parents | SHEER | NPEU > Perinatal Mortality Review Tool \(ox.ac.uk\)](#)

8.3 Communication needs

Families should receive high-quality services which meet their individual needs. This is at the heart of the trust's values and is also a requirement under law and the regulatory inspection regime. For many patients, English is not their first language or they may have specific communication needs because they are deaf, have a dual sensory loss or a learning

disability. We have a duty of care to these patients to provide appropriate support to aid their communication when attending or liaising with our hospitals.

The Clinical Governance team should review booking information to determine any communication difficulties for the family. If this is not easily apparent, the named community midwife should be contacted to determine communication needs.

Easy access to appropriate British Sign Language (BSL) interpreters is available. This can also be delivered virtually through Action Deafness and Sign Live. Textphone and SMS text messaging are also available to help people with hearing and speech difficulties to communicate over the phone. Face-to-face overseas language interpreters are available from Sussex Interpreting Services, Language Line and Vandu Language Services. The ReciteMe and CardMedic Services also help people when they have a sensory impairment, learning disability or where English is not their first language.

Using the interactive toolkit will help staff to decide which service to use and how to access it.

<https://nww.bsuh.nhs.uk/EasysiteWeb/getresource.axd?AssetID=415664&servicetype=Attachment>

If a family cannot read English, the trust Communication team should be contacted to translate any letters sent to the family.

8.4 Anticipated or unexpected delays

Whilst every effort is made to ensure the outlined timeframe for completing a review given during the DOC process is adhered to, there are times where this may not be possible. This could be due to the availability of an external panel member; business continuity; additional information required to support the review process etc. Parents should be kept updated when it becomes evident that a delay in finalising the review is apparent. [Appendix 7](#) outlines the letter template for this communication.

9.0 Initial review process

All bereavement cases that meet the criteria for PMRT review should be initially classified as 'moderate harm' on the incident reporting system, Datix, to trigger the serious incident review process.

1. The medical record should be scanned and saved into a secure folder as soon as possible. Administration team will complete the disclosure of records check list ([Appendix 8](#)) to ensure all records are available electronically.
2. An initial review of the case should be carried out within 72-hours where possible, requesting opinion from appropriate multidisciplinary healthcare professionals, to establish contributory factors and any immediate learning from the incident.

3. Complete Serious Incident Review Group (SIRG) Situation, Background, Assessment and Review (SBAR) document to present at the weekly SIRG meeting.
4. Presentation to the SIRG meeting will review the information provided to establish an initial classification of harm. If there are concerns that the death was preventable at this point, the incident trigger the formal serious incident notification process.
5. Complete SI notification form and 72-hour document, sending to the Director of Midwifery (or Head of Midwifery, if unavailable) for approval and submission by the trust Patient Safety Team via the Strategic Executive Information System (STEIS).

9.1 Healthcare Safety Investigation Branch (HSIB)

HSIB investigated cases of early neonatal deaths under the following criteria:

- Babies born at term (at least 37 weeks gestation).
- Early neonatal death, when the baby died within the first week of life (0-6 days) of any cause.

Where cases meet the criteria for reporting to HSIB, the usual process for adding cases and fulfilling the requirements with the Surveillance, Factual Questions should be completed. The PMRT for the individual can be 'paused' for cases undergoing HSIB investigation. This option should be chosen within the PMRT to ensure the deadlines for completion are paused.

Once HSIB have completed their investigation, the lead investigator should complete the PMRT in collaboration with the Governance team.

For detailed information on the HSIB reporting process, see Local Requirements for HSIB Investigations SOP.

10.0 Multidisciplinary Review (MDT)

Safety Action 1 of Year 4 CNST standards, states that 50% of babies who have died who are eligible for PMRT, including homebirths, will be reviewed by a MDT review team. Terms of Reference for the PMRT panel should be agreed on an annual basis and shared to the team, including any external panel members that are invited as part of their specialty. These can be found in [Appendix 9](#).

Safety Action 1 of Year 4 CNST standards state that the team conducting the review should include at least one and preferably two professionals relevant to the care of the woman and her baby. This will include at least midwifery and obstetric representation.

10.1 External Panel Reviewers

Safety Action 1 of Year 4 CNST standards states that ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. [Appendix 9](#) is the local LMNS, PMRT reporting process.

It is recommended that the MDT PMRT panel involves an external member to provide a 'fresh eyes' review of the care provided and to provide robust challenge. The external member should be external to your trust with relevant clinical expertise. The Local Maternity and Neonatal System (LMNS) has set up a 'buddy system' of support from other neighbouring LMNS'. Where cases have a unique speciality element to the outcome additional external specialists may be sought to attend or offer a review of the notes to give their factual review and opinion of the case i.e. cardiologists; fetal medicine etc.

10.2 PMRT Panel Review

At least 1 week in advance of the meeting, scanned medical records will be provided to the PMRT panel to review ahead of the meeting.

The important and relevant facts of the case will be presented via slide, along with sharing of local guidance which would have been applicable to the case. This information should assist the panel to explore causation and determine what learning there is to achieve from the review.

10.3 Commencing and completing the PMRT online tool

Those professionals who attended the MDT review should be registered within the tool.

A review using PMRT should be made for 95% of all deaths of babies, suitable for review using the PMRT, and have been started within two months of each death. This includes deaths after home births where care was provided by the local trust. At a minimum all the 'factual' questions in the PMRT should be completed for the review to be regarded as started.

Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

11.0 Staff support

11.1 Individual support

Staff should be signposted to all possible support avenues that they may require.

At the time of the incident, especially outside of 'normal' hours, the Manager on Call (MOC) can be contacted for immediate support. Their rota and telephone numbers are found in the clinical areas. Anyone is able to contact the MOC and there is no requirement to go through the labour ward coordinator to do this.

Information can be found in the Psychological Support for Staff leaflet which identifies Trauma Risk Management (TRiM) practitioners in the trust. Support can also be obtained from Professional Midwifery Advocates (PMA) which are identified in each clinical area as well as the midwife counsellor.

Access to Mental Health Escalation for Managers can be found on the link below, which can be used as a signposting resource for low mood and anxiety support as well as requirements for immediate assistance, including the suicide risk protocol.

<https://nwww.uhsussex.nhs.uk/wp-content/uploads/2021/11/mental-health-info-sheet-Nov-10.pdf>

11.2 Group support

Consideration by the senior team, PMA's and obstetric team should be made with regards to the benefit of a group debrief. This decision should be made on a case by case basis. Should a debrief be required, then it is important to have a chairperson for the meeting who was not directly involved in the incident or who is responsible for investigating the incident. When planning a group debrief it is essential that all staff involved in the case are invited, including those that may have cared for the individual during pregnancy.

At the time of the incident, especially outside of 'normal' hours, the Manager on Call can be contacted for immediate support. Their rota and telephone numbers are found in the clinical areas.

11.3 Coronial requirements

During the investigation staff may be asked for statements by the coroner. Support will be provided by the Legal Services Manager for Inquests, alongside support from the senior midwifery and obstetric team, during this process.

12.0 On-going support for family

As part of the DOC process, families are provided with 2 contacts from the Governance team to liaise with should they wish to. The bereavement lead will support the family, separate to the investigation process. Within the letter the midwife counsellor's details are also given too.

12.1 Trust obligations

The Governance team will keep in touch with the family should they wish contact from us. In some cases, families wishes will be respected during the investigation process.

The trust will arrange a debrief appointment with the appropriate lead professional, usually the consultant obstetrician. This is to ensure they are physically well and to discuss any plans or concerns they may wish to consider should they want to get pregnant in the future.

12.2 Sources of support

- LMNS Sussex <https://sussexlmns.org/after-the-birth/feeling-depressed/>
- Birth Trauma Association <https://birthtraumaassociation.org.uk/>
- Making Birth Better <https://www.makebirthbetter.org/>
- PANDAS PND Awareness & Support <https://pandasfoundation.org.uk/what-is-pnd/birth-trauma/>
- Maternity Action <https://maternityaction.org.uk/about-us/>
- Best Beginnings <https://www.bestbeginnings.org.uk/>
- Tommy's <https://www.tommys.org/>
- Bliss <https://www.bliss.org.uk/>
- Multiple Births Foundation <https://www.multiplebirths.org.uk/>
- Twins Trust <https://twintrust.org/>
- Maternal Mental Health Alliance <https://maternalmentalhealthalliance.org/resources/mums-and-families/covid-19-looking-after-your-mental-health-during-pregnancy-and-after-birth/>
- Dad Matters <https://dadmatters.org.uk/>

Bereavement specific:

- Child Bereavement <https://www.childbereavementuk.org/>
- SANDS <https://www.sands.org.uk/>
- Petals <https://petalscharity.org/>

13.0 PMRT Report

The PMRT report is shared with the family. The preference is to share this face-to-face, especially where there is learning. This is to ensure that the family is supported in person when sharing information around findings. They may have further questions regarding the findings which should be answered and the family should be encouraged to contact the Governance team should questions arise some time later when they have had an opportunity to digest the information provided.

The learning from the final report and action plan is shared at the Maternity Quality and Safety to the multidisciplinary team and embedded within the report for dissemination.

The findings are summarised and shared on the Safety Boards within the clinical areas.

The actions are shared to the action tracker and monitored monthly for completion and to evidence embedding or any safety recommendations.

14.0 Monitoring

Monitoring is carried out by quarterly audit in line with NHS Resolution (CNST) Safety Action 10 (Year 4) which states-

- All perinatal deaths eligible to be notified to MBRRACE-UK must be notified within seven working days and the surveillance information where required must be completed within one month of the death.
- A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.
- At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.
- For at least 95% of all deaths of babies who died in your Trust, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.
- Quarterly reports will have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

[MIS-year-4-relaunch-guidance-May-2022-converted.pdf \(resolution.nhs.uk\)](#)

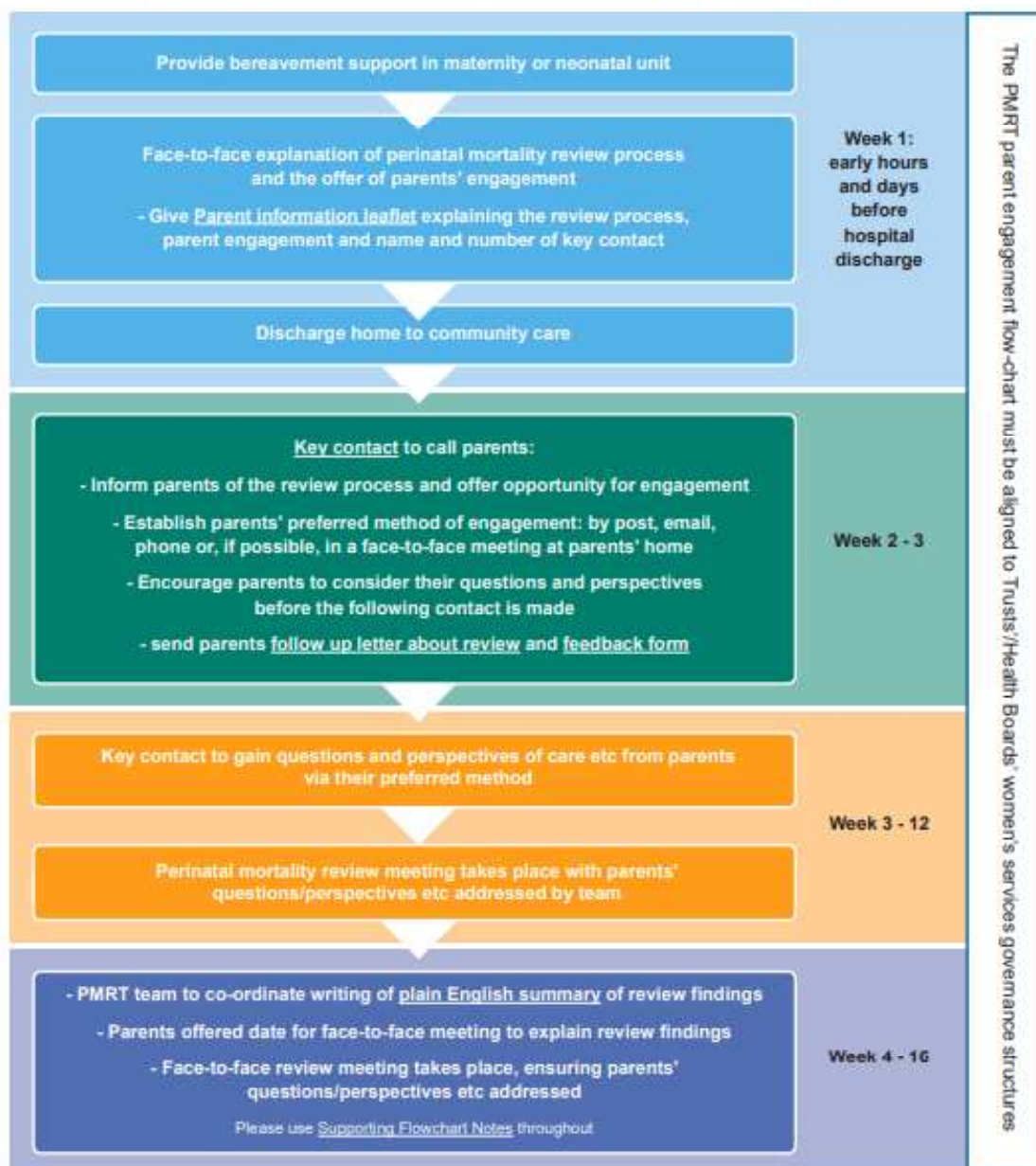
Appendix 1: PMRT Tracker Template

[illegible]


Appendix 2: PMRT Parent Engagement Flow Chart

PMRT Parent Engagement Flow Chart

for reviewing deaths from 22 weeks gestation (>500grammes) up to 28 days after birth and post neonatal deaths where the baby spent time in NICU but may have died elsewhere



Appendix 3: Parents review letter after discharge



The Child Death Review Process in England & Wales

Information for Parent/s

Dear

We are so sorry to hear about the death of your baby and hope you will receive all the support that you need at this difficult and traumatic time. The death of your baby is a devastating loss which will profoundly affect yourself as bereaved parents, the loss to any siblings, your extended family, and friends, as well as professionals who were involved in caring for baby. It is important to make sure that you have access to services and bereavement support when, and if needed. Both your midwife and doctor can give you advice and details of local organisations to support you, and your family.

We understand all parents want to know what happened to their baby, and recognise the importance that professionals will learn, from what happened. There is a statutory process for reviewing all baby and child deaths with the intention of helping to prevent future child deaths. This process is grounded in deep respect for the rights of children and their families and recognises the importance of hearing the voices of those who have been affected by these tragic events.

What is the Child Death Review Process?

A Child Death Review (CDR) is the legal process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. This begins the moment of your baby's death to the completion of the final review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have been involved in the care of your child during their life and the investigation after death to identify changes that could save the lives of babies in the future. Information will be gathered from a range of health providers including your GP and is treated in the strictest confidence to facilitate the most comprehensive review for your child.

Hospital Review

As a bereaved parent, the hospital where your baby died will explain to you that a professional multi-disciplinary review will take place. You will be invited to send in any questions or provide any information you feel is important about your care and the care of your baby for the panel to consider. This hospital review is carried out using the National Perinatal Mortality Review Tool (PMRT). More details about this review are enclosed. In addition to Specialist Midwifery support you may also have contact with a Child Death Review Nurse.

Better health and care for all

Sussex Child Death Overview Panel (CDOP)

This final review for all deaths of babies and children who live in Sussex, occurs at a panel called the Child Death Overview Panel (CDOP). This final review looks at all the facts, without any personal or identifiable details. It occurs after all other reviews and investigations are completed. CDOP has an independent chair and senior professional leads, from health and public services. They consider information about each baby and the circumstances of their death. The purpose of this review is to confirm or clarify the cause of death, to determine any contributory factors, and to identify both local and national learning arising from the child death review process, which may prevent future child deaths. The Panel will also make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety, and wellbeing of children. CDOP produces an annual public report which anyone can read, it does not contain any details that could identify an individual child or their family.

Further information

Please contact your Specialist Midwife or Child Death Review nurse if you would like any further information or support.

Further information can also be found in the booklet: "When a child dies":
[ES708565 CCS269 CCS1118084732-001 A guide for parents and carers.pdf \(england.nhs.uk\)](#)

Appendix 4: Feedback form for parents following stillbirth

Feedback Form for Parents

This form is designed to help you think about any questions or comments you may have about aspects of your and your baby's care. You do not have to use this form or limit yourself to the spaces in these boxes. The form is just a way of triggering your thoughts.

Any feedback you give us will help the hospital team to review your care and ensure we address your questions as best as we can.

You can post the feedback form back to us, using the self-addressed envelope or call us to discuss your questions or concerns using the details of your key contact. You can also access the form online at [*insert link*].

Care during pregnancy

- Please use this section for comments on and questions about the care you received during your pregnancy

Care during the birth of your baby

- Please use this section for comments on and questions about the care you received during the birth of your baby

The care of you, your family and your baby after birth

- Please use this section for comments on and questions about how our maternity team cared for you after the birth of your baby

Please use this section to tell us about the care you received from any other team. This may include other medical teams, community midwives, your GP, counsellors, chaplains, The Patient Advice and Liaison Service (PALS), Patient Experience Team, or a hospital complaint system

Please use this section to tell us about any aspects of your care that were most supportive

Are there any other comments you would like to make?

Appendix 5: Feedback form for parents following neonatal death

Feedback Form for Parents

This form is designed to help you think about any questions or comments you may have about aspects of your and your baby's care. You do not have to use this form or limit yourself to the spaces in these boxes. The form is just a way of triggering your thoughts.

Any feedback you give us will help the hospital team to review your care and ensure we address your questions as best as we can.

You can post the feedback form back to us, using the self-addressed envelope, call us to discuss your questions or concerns, using the details of your contact. You can also access the form online at [*insert link*].

Care during pregnancy

- Please use this section for comments on and questions about the care you received during your pregnancy

Care during the birth of your baby

- Please use this section for comments on and questions about the care you received when you were in labour and when your baby was born

The care of you, your family and your baby after birth

- Please use this section for comments on and questions about your care, and how your baby was cared for after birth, including if your baby was admitted to a neonatal unit

If you would like to comment on the support you received around the time your baby died, please do so here

Please use this section to tell us about the care you received from any other team. This may include other medical teams, community midwives, your GP, counsellors, chaplains, The Patient Advice and Liaison Service (PALS), Patient Experience Team, or a hospital complaint system

Please use this section to tell us about any aspects of your care that were most supportive

Are there any other comments you would like to make?

Appendix 6: When parents cannot be reached letter

[Template 'When parents cannot be reached letter' – please read through again once adapted for use]

Insert parent/s' address

Insert date

Dear *[insert parent or parents' name]*

I am/We are *[delete as appropriate]* sorry for the death of your *[insert son/daughter, or name if known]*. I/We *[delete as appropriate]* realise this letter comes at a very difficult time for you and your family. We have tried to reach you by phone/email *[delete as appropriate]* but have not been successful.

I want/We wanted *[delete as appropriate]* to be in touch to reassure you that we take the death of a baby at *[insert name of Trust/Health Board]* seriously. It is important to find out as much as we can about what happened and why your baby/babies *[delete as appropriate]* has/have *[delete as appropriate]* died. In the coming weeks, a hospital team will hold a meeting to review your care.

Reviewing your care

The hospital team discussing your care may include doctors who care for women in pregnancy (obstetricians), doctors who look after newborn babies (neonatologists), midwives and nurses. If there are any other health professionals specific to your care we will also invite them. The aim of the review is to try to understand as much as possible about what happened and why your baby/babies *[delete as appropriate]* died. The team will:

- Look at medical records, tests and results, including post mortem results if you have consented to one
- Answer any questions you may have and address any concerns
- Talk to staff involved
- Look at guidance and policies to ensure the care you received was appropriate

The team will do this using a national review process developed by a group including the parent charity Sands. The review may tell us that we need to change the way we do things or that good and appropriate care was given to your family.

Involving you

As *[insert the name/s of the baby/babies]* parent/s *[if addressing only one parent keep singular]*, your thoughts and questions are important and it would be extremely helpful if you felt able to share your experience or any questions you have about your care with us before we carry out the review. You can do this through your key contact:

Insert name and contact details of the key contact

I/We [*delete as appropriate*] enclose a feedback form with this letter to help you think about any aspects of your care you may want to share. These may be about:

- Your care during pregnancy
- Your care during the birth of your baby/babies [*delete as appropriate*]
- The care of you, your family and your baby/babies [*delete as appropriate*] after birth

You could post the feedback form back to us, using the self-addressed envelope, or call us to discuss your views, using the details of your key contact above.

Keeping you informed

It may take up to [*insert number of weeks*] weeks for the review meeting to take place. This is to ensure that all the information is available and that the right professionals can attend. You will not be asked to attend the meeting in person.

We will write a report to summarise the review findings and try to address any questions and comments you have made to the best of our ability. You will then have a meeting with a consultant to discuss the findings of the review, or alternatively we can telephone, email or write to you.

If you have any questions about this letter please do not hesitate to call your key contact on the number or email [*adapt as appropriate*] in the box above. If you would like to know more about the national review process we use you can go to:

<https://www.npeu.ox.ac.uk/pmrt/information-for-bereaved-parents>

I/We [*delete as appropriate*] have included with this letter information about both local and national support organisations should you like any further support.

If we do not hear back from you in the next few weeks, we will keep the review report with your medical notes. You can receive a copy whenever you wish by contacting us on [*provide admin contact telephone/email*]

Yours sincerely,

[*Name*]
Role

Appendix 7: Keeping in touch letter or email

[Template 'Keeping in touch letter or email' – please read through again once adapted for use]

Insert parent/s' address

Insert date

Dear *[insert parent or parents' name]*

I/We *[delete as appropriate]* are sorry that there has been a delay in finalising the review report of your care. We understand that long waits can be distressing.

The reason for this delay is *[give clear reasons]*

I/We *[delete as appropriate]* hope to be in touch with you in the next *[insert number of weeks]* weeks. If you have any questions please contact *[insert key contact details]*.

Yours sincerely,

Role

Appendix 8: Disclosure of Records Checklist

DISCLOSURE OF RECORDS CHECKLIST

ALL PAPER RECORDS / PATHWAYS (For Mother & Baby)

- AN Record (inc diabetes/ BMI pathway etc)
- Ultrasound scans
- Labour Record
- Theatre Record (inc instrumental/ OASIS etc)
- Baby Delivery Record
- Baby PN Record
- Maternal PN Record
- Baby Medical Record

Scanned	Saved to File

MEDWAY JOURNALS/ Badgernet

PDF downloaded	Saved to File

SEMA/ Outpatient/Admission dates

Screen Shot Saved to file

EVOLVE DOCUMENTS PDF OPTION INCLUDING SEC LETTERS

PDF or screenshot	Saved to File

CTG

Copied and Scanned	Saved to File

ACUITY DATA (Patient Safety Midwife or Band 7 to access)

Screen Shot Saved to file

PREGNANCY REFERRAL

Scanned	Saved to File

AFINITY RESULTS / Lab tests

Screen Shot Saved to file

TRIAGE Recordings/ Telephone logs (patient safety midwives to access recordings)

Copied and Scanned	Saved to File

Appendix 9: PMRT Panel - Terms of Reference

TEMPLATE FOR MODIFICATION

Perinatal Mortality Review Meeting Terms of Reference*

University Hospitals Sussex

The aims of our stillbirth and neonatal mortality review meetings include:

- Identifying the cause of each baby's death by robustly and comprehensively reviewing each case and the quality of care provided;
- Working through the care for each baby who died to identify contributory factors where issues are identified and assessing whether different care may have made a difference to the outcome (grading of care);
- Developing action plans that aim to address the contributory factors identified and achieve organisational change and service improvements;
- Recognising a 'just culture' of accountability for individuals and organisations;
- Incorporating the parents' perspective of their care and addressing any questions and concerns they have;
- Providing parents with a robust explanation of why their baby died (accepting that in all instances, despite full clinical investigations, it is not always possible to determine this);
- Improving the care we provide for mothers, babies and families in the future.

The conduct of our stillbirth and neonatal mortality review meetings include:

- Making every effort to gather the relevant information/evidence about each death in advance of the meeting;
- Attending and arriving on time to the meeting;
- Participating actively in discussions;
- Respecting everyone's ideas and way of expressing them;
- Accepting robust discussion and disagreement;
- Agreeing to be comprehensive, open and transparent throughout;
- Trying as much as possible (recognising this can be challenging) to accept that your own actions can be questioned;
- Respecting the confidentiality of the documents and discussions that take place during the meetings and record/dispose of them appropriately;
- If gaps are identified in the information there may be a need to go away and gather more information before completing the review;
- Using the national Perinatal Mortality Review Tool (PMRT) to support the conduct of each review.
- Monitoring deadlines for each Safety Action to ensure these are met.

**Modified: World Health Organisation. Making Every Baby Count: audit and review of stillbirth and neonatal death. Geneva: WHO, 2016.*