Humber, Coast and Vale
Local Maternity System

Perinatal Mortality Review Tool (PMRT) Guidance

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Approval by:	Uma Rajesh and Aparna Manou, LMS Clinical Leads
Owner:	HCV LMS Guidelines Group
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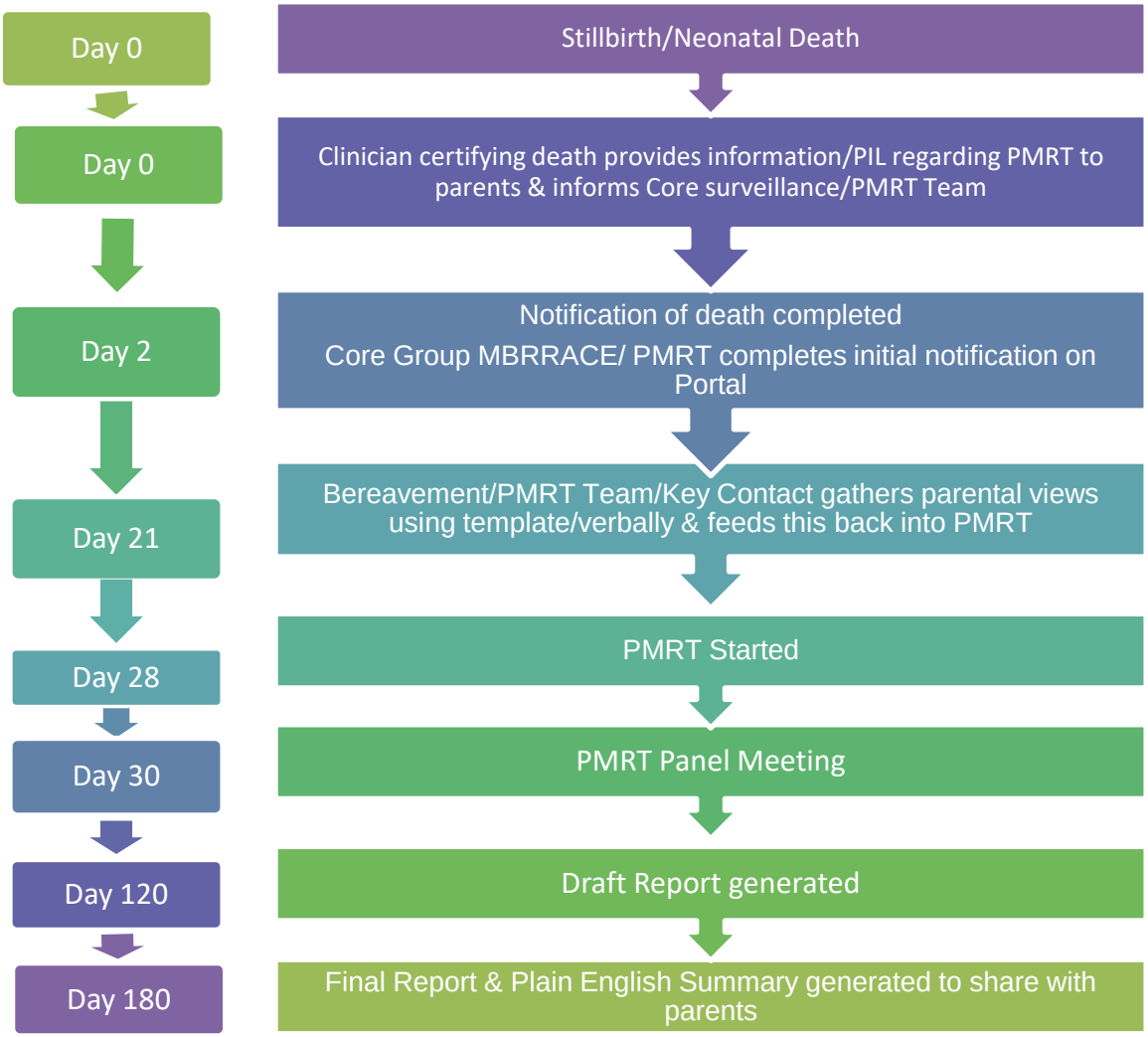
1. INTRODUCTION

The following guidance summary has been produced by the HCV LMS Clinical Leads to define what an ideal PMRT process should look like to ensure good practice and be compliant with the current CNST year 4 criteria.
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/.

The document is intended to serve as guidance and support and **does not replace any Trust level guidance/processes around this.**

2. SUGGESTED TIMELINE TO ENSURE COMPLIANCE



3. CNST YEAR 4 CRITERIA AND SUGGESTED APPROACHES

MIS Y4 Guidance	Suggested process	Link to relevant resources
Notification to MBRRACE-UK 2 working days.	Dedicated admin or assigned group of people for data entry; robust system of information to and communication within the group to ensure compliance.	
Surveillance information where required must be completed within 1 month of death.	Mortality/Bereavement Leads in maternity & neonates to monitor surveillance fortnightly.	Key contacts should have bereavement training, this could be through Sands https://www.sands.org.uk/ and Child Bereavement UK https://childbereavementuk.org
A review using the PMRT of 95% of all deaths of babies, suitable for review from 8 August 2021 will have been "started" within two months of each death.	Specific time allocation for midwives, obstetricians, neonatal nurses and neonatal doctors for monthly review of cases to ensure data entry complies with **PMRT STARTED**.	At a minimum all the 'factual'questions in the PMRT should be completed for the review to be regarded as started; it is not sufficient to just open the PMRT tool, this does not meet the criterion of having started a review (page 13).
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, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. **Each review 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.**	At least monthly multi-disciplinary meetings of PMRT Panel to ensure that reviews are conducted in a robust timely way. We recommend that the perinatal mortality review group agree terms of reference. A dedicated Bereavement Midwife & Bereavement Neonatal Nurse Lead to support the process. Recent HCV LMS attendance at PMRT across sites showed variable compliance in this aspect of the standard. All units are encouraged to ensure they comply with this MDT attendance requisite to ensure best practice.	Membership composition & PMRT Implementation Guide. https://www.npeu.ox.ac.uk/assets/downloads/pmrt/3b_Guidance%20for%20using%20the%20PMRT%20July%202018%20v6.pdf **Minimum of 2 of each of the following:** • Obstetricians • Midwife • Neonatologist and Neonatal Nurse in all cases where resuscitation was commenced and all neonatal deaths. **At least 1 of** • Bereavement team • Risk manager/governance team member • External panel member • Other members as appropriate to the organisation of care in the Trust/Health Board e.g. Service Manager. **Named and invited to attend or contribute where applicable**:

		• Pathologist • GP/Community healthcare staff • Anaesthetist • Sonographer/radiographer • Safeguarding team • Service manager • Any other relevant healthcare team members pertinent to case.
"For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. **If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.** **Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required."**	Adopt PMRT PIL & templates and use them in bereavement packs. Designated leads to collate parental feedback & communicate effectively with teams. Suggest generic email for parents to provide feedback – accessible by Mortality Leads. Mortality Leads to be informed of any planned bereavement updates from clinicians ensuring effective 2-way communication. Plain English summaries to be generated by clinician responsible for bereavement follow up to share with the family in a timely manner. Key contacts should receive bereavement training. Generic letter templates to be issued in case delay expected can be created and disseminated appropriately.	Parent Engagement Materials https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials Completion of up to date bereavement training for example through Sands https://www.sands.org.uk/ and Child Bereavement UK https://childbereavementuk.org