Barking, Havering and Redbridge University Hospitals NHS Trust

The Perinatal Review Toolkit – Sharing Lessons Learnt at Barking, Havering and Redbridge University Teaching Hospital NHS Trust (BHRUT) January – April 2018

Author/s: Louise Brodrick and Bereavement Midwifery Team, Zofia Kropiwnicka (Registrar), Celia Burrell (Consultant Obstetrician)

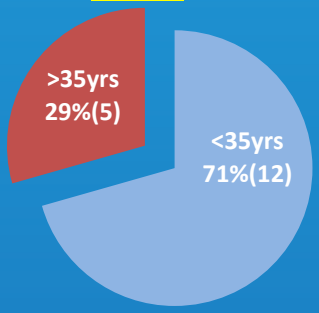
AIM: Barking Havering and Redbridge University Teaching NHS Trust (BHRUT) Hospital delivers almost 9,000 women per year, with about 60 IUD and stillbirth cases per year. Data from the MBRRACE Report 2015 showed that :

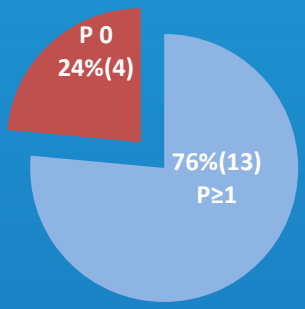
MBRRACE 2015 Report	MBRRACE National Perinatal Mortality Indices per 1,000	BHRUT Perinatal Mortality Indices per 1,000
Stillbirth Rate	3.87	3.28
Neonatal Death	1.74	1.4
Perinatal Death	5.61	4.64

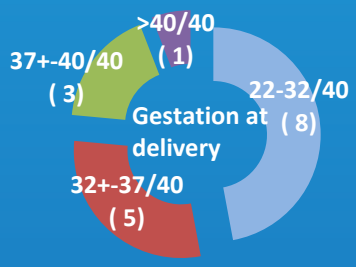
BHRUT was pleased to be a pilot site when the PMRT Quality Improvement Strategy was launched last year. When the PMRT was introduced across the UK, BHRUT reviewed a backlog of 17 cases from January to April 2018.

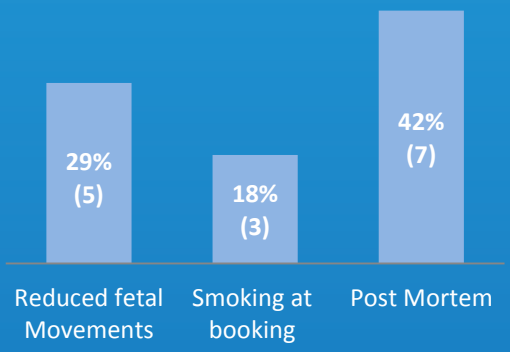
METHOD: The Maternity Bereavement team and the director of Midwifery were robust and dynamic in introducing the PMRT toolkit. Meeting occurred on 19/03/18; 26/03/2018; 27/03/2018; 28/03/2018 and 04/04/2018 to review the retrospective cases. Fourteen (14) additional meetings (fortnightly) are planned for the rest of the year to review new cases using the PMRT. The Lead Bereavement midwife gathered the notes, prepared the chronology, and chaired these MDT meetings facilitating comprehensive, open and transparent and robust discussions, while balancing and respecting everyone's views.

RESULTS: Total 17 cases with 12 classified as High Risk. This cohort included 1 case of Serious Incident resulting in RCA.









Significant Findings and Action Plan

(1)Antenatal Clinic DNA Policy - was correctly followed, however no appointment was available for 3 weeks and the baby died just before the appointment;

2. National Diabetes Screening Guideline - this mother met the criteria for screening but was not offered screening;

3. Missed IUGR and SGA - this mother had risk factors at booking for having a growth restricted baby but serial scans were not performed at correct times/intervals;

4 Baby was SGA at birth and ultrasound growth scans were indicated but not done;

5. Management of Thyroid Disease in Pregnancy Guideline - mother has a history of thyroid disease which was not managed appropriately;

6. This mother presented with reduced fetal movements and there is no evidence that she had been given written information about what to do if she experienced a change in fetal movements

DISCUSSION: Before the PMRT, BHRUT Risk Management Team had a robust system in place to review all cases of fetal loss >24weeks at the multidisciplinary Serious Incident Group (SIG) meeting which is held twice weekly. However the PMRT complemented this comprehensive system already in place.

For SI cases, a full comprehensive RCA is still needed to address all the issues.

In this cohort of 17 cases – the significant themes were missed IUGR/SGA, Missed screening for diabetes and reduced fetal movements.