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Establishing a multidisciplinary perinatal death review committee
The Oxford experience

J Hirst*, N Manley, M Whitfield, S Chakravarti, K Bartlett, P Gallacher, A Williams, P Munro, G Vass

Background

The OUHFT is a large tertiary referral hospital in the Thames Valley region. Whilst perinatal deaths have always been reviewed through clinical case presentations, in 2016 we decided to formalise the process by adopting a structured and systematic approach to perinatal death review. This ensures all deaths are reviewed by a multidisciplinary panel with the quality of care graded and final cause of death agreed. Key learnings and action points arising from the meetings are disseminated.

Database development and implementation

A cornerstone of the process was establishing a confidential database to record details about each case and the decisions of the committee. The database is prepopulated before the meeting by a midwife or obstetrician. During the meeting the database is projected to guide discussion. A short summary of each case is given by the person who reviewed the notes prior to the meeting.

We have now transitioned to the PMRT.

Meeting attendees

Key to good discussion is the multidisciplinary team. Terms of reference were established early in the process.
Attendees are:

- Consultant obstetricians/ Fetal medicine consultants (minimum 2)
- Midwives (minimum 2)
- Bereavement midwives, MBRRACE reporter, EBC reporter
- Governance team (minimum 1)
- Neonatologist
- Anaesthesist (if required)
- Perinatal psychiatrist (if required)
- Perinatal pathologist (support given with hisotopathology reports and interpretation. Do not attend meeting.)

External observers and trainee doctors and midwives are welcome.

Parents are encouraged to make written submissions or give feedback via their obstetrician or midwife prior to the meeting with information from the bereavement midwife and consultant obstetrician.

Post meeting actions

After the meeting, each consultant obstetrician is given a letter summarising the key findings with any recommendations. They are responsible for feeding this information this back to parents, as deemed appropriate for each individual case. Organisational level changes and general feedback to other staff occur through Trust and department governance forums.

Output

Between November 2016 and March 2018; 52 cases were reviewed (figure 1). All cases of death after 22 weeks are discussed, excluding terminations of pregnancy for confirmed fetal anomaly (for which there is a separate fetal review committee).

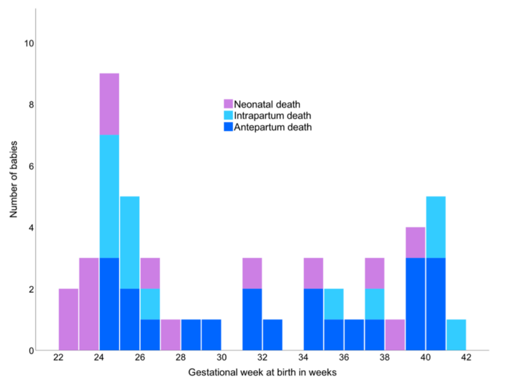

Figure 1: Cases by gestational age and timing of death

Grading of care

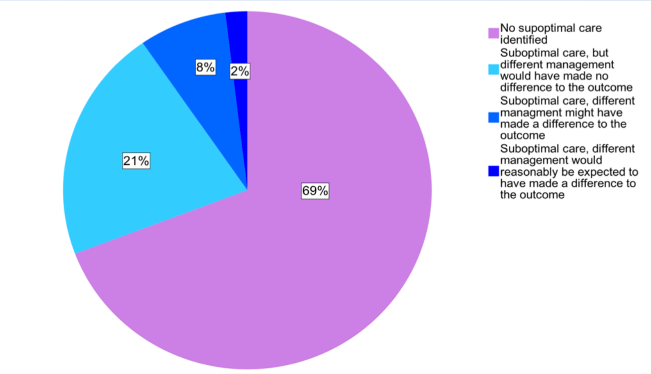

Figure 2: Grade of care allocated at the meetings, (including findings from 4 SIRI investigations graded through that review process).

Conclusions

We demonstrate how a multi-disciplinary perinatal death review committee has been established and the central role of a database to monitor progress in improving patient care. Challenges for 2018 include transition to the PNMRT, particularly recording data for babies transferred to the OUH from other Trusts (30% of deaths), and ensuring a mechanism of timely and appropriate feedback for parents.

**Corresponding author: Dr Jane Hirst, Consultant Obstetrician.*
jane.hirst@ouh.nhs.uk