**From the Chief Medical Officer**
**Professor Sir Michael McBride**
**and the Chief Nursing Officer**
**Ms Maria McIlgorm**

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**HSS(MD) 1/2023**

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**BY EMAIL**

Chief Executives, HSC Trusts for cascade to:
*Medical Directors*
*Directors of Maternity Services*
*Directors of Nursing*
*Heads of Midwifery*
*Supervisors of Midwives*
*Directors of Mental Health Services*
Chief Executive, PHA
Deputy Secretary, SPPG
Chief Executive, NIMDTA
Chief Executive, RQIA

**For Information to:** Distribution as listed at the end of this letter

Dear Colleagues

**MBRRACE-UK PERINATAL MORTALITY REPORTS**

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and the MBRRACE-UK / PMRT collaboration have recently published the following reports on perinatal mortality -

- Perinatal mortality surveillance: UK perinatal deaths for births from January to December 2020. A copy of the full report can be accessed here https://www.npeu.ox.ac.uk/mbrrace-uk/reports

- Learning from Standardised Reviews When Babies Die: National Perinatal Mortality Review Tool: Fourth Annual Report. A copy of the full report can be accessed here https://www.npeu.ox.ac.uk/pmrt/reports

**ACTION REQUIRED**

**Chief Executives of HSC Trusts should:**

- Consider the key findings and recommendations set out in these two reports and bring these to the attention of relevant staff, to further inform service improvement and service development.

- Ensure that a multi-disciplinary standardised mortality review is progressed in every stillbirth and neonatal death and that the findings of each review are shared with respective parents.

- Ensure that Executive Teams receive a regular report on the progress and outcomes of the standardised mortality review of stillbirths and deaths on a quarterly basis. This reporting should continue until there is evidence that the perinatal mortality review process is fully embedded and is underpinning service improvement.

- Ensure that Trust Boards receive a regular report on the progress and outcomes of the standardised mortality review of stillbirths and neonatal deaths for their Trust on a 6 monthly basis. Reporting should commence in January 2023.

- Ensure that Trust level structured perinatal mortality review learning reports are shared on a regular basis with the Strategic Planning and Performance Group (SPPG) in DoH, the Public Health Agency (PHA) and the Maternity Collaborative.

**Deputy Secretary, Strategic Performance and Planning Group should:**

- Disseminate this letter to all relevant staff to inform and underpin commissioning and improvement of services.

- Report progress on the required actions through the established arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports. This should include, with PHA support, reporting on the commencement and completion of perinatal mortality reviews at Trust and regional level.

- With the support of PHA and the Maternity Collaborative, review the findings of Trust structured perinatal mortality review learning reports - to identify, share and support the implementation of learning and improvement across the region.

**Chief Executive Officer, Public Health Agency should:**

- Disseminate this letter to all relevant staff.

- Continue to work with SPPG colleagues to report progress on the required actions through the established arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports, including reporting on the commencement and completion of perinatal mortality reviews at Trust and regional level.

- Ensure relevant professionals work with colleagues in SPPG and the Maternity Collaborative to review the findings of Trust structured perinatal

mortality review learning reports to identify, share and support implementation of learning and improvement across the region.

- Continue to carefully monitor data relating to stillbirths and neonatal deaths at both Northern Ireland and individual Trust level.

**Chief Executive, RQIA should:**

- Disseminate this letter to all relevant staff and Independent Sector providers.

**Chief Executive, NIMDTA should:**

- Disseminate this letter to doctors in training in all relevant specialties

## BACKGROUND

### PERINATAL MORTALITY SURVEILLANCE REPORT

This report focuses on the surveillance of all late fetal losses, stillbirths, and neonatal deaths occurring in the United Kingdom during 2020.

The stillbirth rate in Northern Ireland for 2020 was 3.38 per 1,000 total births, compared to the overall UK rate of 3.33. The stabilised and adjusted stillbirth rates, excluding congenital anomalies, for all five NI Trusts (based on place of birth) were within 5% of their group average.

Northern Ireland had the highest neonatal mortality rate of the four UK countries in 2020, at 2.37 per 1,000 live births. This was lower than the NI rate for 2019 which was 2.85 per 1,000 live births. The difference in the neonatal mortality rate between NI and the rest of the UK in 2020 was due to the higher rate of deaths in the first week of life (referred to as early neonatal mortality); this rate was 1.81 per 1,000 live births in NI compared to 0.98 per 1,000 live births for the UK. It is recognised that annual rates in NI are based on relatively small numbers and are subject to year-to-year variation.

The stabilised and adjusted neonatal mortality rates excluding congenital anomalies for the Northern, Southern and Western Trust (based on place of birth) were within 5% of their group average while the rate for the Belfast and South Eastern Trusts was more than 5% higher than their group average.

### NATIONAL PERINATAL MORTALITY REVIEW TOOL: 4TH ANNUAL REPORT

The national Perinatal Mortality Review Tool (PMRT) was developed by the MBRRACE-UK / PMRT in collaboration with clinicians and bereaved parents. The tool supports objective, robust and standardised review of stillbirths and deaths in the newborn period to provide answers for bereaved parents about why their baby died as well as local and national learning to improve care and, where possible, prevent future baby deaths.

This report provides information on the number of reviews and the percentage of deaths where a review has been carried out and reported using the PMRT, by year, for each of the four UK countries (as of 27 June 2022). While the PMRT was implemented in Northern Ireland later than the other countries (late 2019), **the continuation of comparatively poor figures relating to use of the PMRT in Northern Ireland is a matter of serious concern.**

In July 2021, following a review by the PHA of the findings of the standardised mortality review of all stillbirths in Northern Ireland, we wrote to Trust Chief Executives asking them to ensure that a multi-disciplinary standardised mortality review occurs in every stillbirth and neonatal death and that the findings of these reviews are shared with parents. We advised that the learning from standardised mortality reviews of stillbirths and neonatal deaths should be shared through the Trust's internal governance system and with the regional Maternity Collaborative on a regular basis, and at least annually.

In early 2022, at the Department's request, regional reporting on the commencement and completion of the PMRT following stillbirth or neonatal death was established. The most recent available data indicates unacceptable variation at Trust level, with low levels of commencement and completion of PMRT in a number of Trusts, particularly with regard to the review of neonatal deaths.

## ACTIONS REQUIRED

We have identified a series of actions which we believe are urgently required to ensure that every bereaved parent receives the answers they deserve about why their baby died and that the service identifies, shares and implements learning to improve the care of pregnant women and newborn babies. **We urge you to ensure these actions are implemented as a matter of immediate priority.**

Yours sincerely

**Professor Sir Michael McBride**
**Chief Medical Officer**

**Ms Maria McIlgorm**
**Chief Nursing Officer**

**For Information to:**
Executive Medical Director /Director of Public Health, PHA
Director of Nursing and AHPs, PHA
Director of Performance Management, HSCB
Alerts Office, HSCB
Prof Donna Fitzsimons, Head of Nursing and Midwifery, QUB
Prof Pascal McKeown, Head of Medical School, QUB
Dr Sonja McIlfatrick, Head of School of Nursing, UU
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