Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/251c*	Date: 08/02/2024		
Report Title	Mortality and Learning from Deaths Report Quarter 2, 2023/24			
Prepared by	**Chris Dewhurst, Deputy Medical Director.** Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and			
Presented by	**Lynn Greenhalgh, Medical Director**			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. *As per The Learning from Deaths framework requirements the Board is requested to note:* • *number of deaths in our care* • *number of deaths subject to case record review* • *number of deaths investigated under the Serious Incident framework* • *number of deaths that were reviewed/investigated and as a result considered due to problems in care* • *themes and issues identified from review and investigation* • *actions taken in response, actions planned and an assessment of the impact of actions taken.*			
Supporting Executive:	Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒				
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☒						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This “Mortality and Learning from Deaths” paper presents the mortality data for Q2 2023/24. The learning from review of deaths will be from deaths that occurred in Q1 2023/24 or earlier if deaths have been subjected to external reviews such as Maternity and Neonatal Safety Investigations (MNSI) or Coronial investigations.

In quarter 2 there were the following deaths:

Adult deaths	**0 (1 who was operated on at LWH but died in RLUH)**
Direct Maternal Deaths	**1**
Stillbirths	**4 (excluding ToP, rate 2.2/1000births)**
Neonatal deaths (inborn)	**8 (4.8/1000 live births)**

There was 1 **maternal death** of a woman who gave birth in August 2023 who died in the postnatal period with presumed sepsis. The case is being investigated by the coroner and through MNSI. The cause of death has not yet been provided to the trust. The care was impacted upon by lack of co-located services.

The MNSI report for case HO who died in Q4 22/23 from post-natal sepsis has been provided to the trust. The MNSI report provides several findings for the trust and a wide ranging action plan has been developed. The learning form this death is also part of the trust wide anti-racism strategy.

There is an additional paper embedded in this report providing an overview of maternal mortality over the past 10 years

There were no **gynaecology deaths** in Q2 2023/24.

There were 4 **stillbirths**, excluding terminations of pregnancy (TOP) in Q2 2023/2024. This has resulted in an adjusted stillbirth rate of 2.2/1000 live births for Q2 23/24 and continues the trend of being lower than in previous years.

There were 8 deaths on the NICU. 4/8 (50%) of the deaths were from pregnancies originally booked outside of Liverpool. There were 7 babies who were inborn and died at LWH resulting in a **neonatal mortality** rate of 3.8/1000 livebirths. There were 4 deaths in preterm in-born infants (24 to 31+6 weeks), resulting in an annual mortality of 10.9% in this population. This is above the NWODN benchmark of 6.3%, however there are ongoing discussions with the appropriateness of this benchmark with both the ODN and the National Neonatal Audit Project (NNAP).

The review of neonatal deaths from Q1 23/24 (n=10) did not identify any care issues which may have made a difference to the outcome. There were 3 cases with issues identified which would not have affected the outcome in the antenatal and neonatal care. Two of the issues identifed related to not being co-located with neonatal services.

Of the 13 stillbirths/neonatal deaths, 4 (31%) were **in non-white mothers**. This is higher than the birthing population for 2021-22 (c 15.5%). 8/13 (62%) stillbirths/neonatal deaths resided in the most deprived decile for Index of multiple deprivation. Given the small numbers, these data will need to be reviewed in larger data sets for meaningful assessment.

Recommendation: It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

As per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

MAIN REPORT

This is the quarter 2 2023/24 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to Q2 2023-24. The learning relates to deaths in Q1 22/23 or earlier. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data/information relating to mortality is presented in the embedded word documents.

1 Adult Mortality

The data relating to adult mortality is pure data and is not standardised mortality data (such as SHMI) due to the low number of deaths in our care and the complexity of the patients cared for by the Trust. The use of pure data and not standardised mortality rates has been previously agreed with the CCG/ICB as the Trusts approach to monitoring mortality rates.

The requirement is to report adult deaths that occur at LWH. However given the isolated nature of our services, women who deteriorate whilst an in-patient at LWH will be transferred to other hospitals for ongoing care any may die at external trusts. The learning from deaths report now also includes information related to these deaths. These deaths may not be reported the quarter after the death occurs due to data collection and sharing and this is highlighted.

1.1 Obstetric Mortality Data Q2 2023/24

There was **1 maternal death in Q2 2023/24**.

G was a 29-year-old Black African woman in her third pregnancy who delivered by elective caesarean section at 40 weeks. She was non-English speaking and interpreter services were used throughout her pregnancy and postnatal period. The delivery and initial postnatal period were uncomplicated. G was admitted with suspected urosepsis on day 9 of her postnatal period. She was treated as per the red sepsis guidance and discharged after 48 hours with oral antibiotic cover.

The patient attended LWH again in the late afternoon of the postnatal day 23 with the signs of severe sepsis. She was commenced on red sepsis pathway as per Trust protocol but did not respond to the initial treatment and due to rapid deterioration in her clinical condition she was transferred to the Royal Liverpool and Broadgreen University Hospital (RLBUH) for intensive care treatment. G died in intensive care at RLBUH in the early morning of day 24 postnatally. The cause of death has yet to be confirmed, but it is presumed to be related to sepsis of currently unknown origin.

Initial review identified lack of co-location of Adult services as a contributory factor. The case has been referred to the Coroner and to HSIB for investigation. Learning from these investigations will be included in future reports.

1.2 Learning from Obstetric Mortality Data

Due to the significant time delay for investigations to conclude following a maternal death, the deaths will continue to be reported through this paper until the learning is concluded.

Case AS Q3 2021/22

In Q3 2021/22, there was one death of a white British woman who died approximately 8 weeks after delivery. This case was subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed with learning presented in previous reports. The Coroner's inquest was undertaken in November 2023 and concluded:

> A died from natural causes, most probably due to sudden arrhythmic cardiac event with morphologically normal heart, possibly caused by A having suffered from anorexia nervosa for an extended period, and unwell during pregnancy, when she ultimately delivered her daughter Poppy on [date]."
>
> The formal cause of death is as follows:
>
> 1a) Sudden Arrhythmic Death Syndrome (SADS) with a morphologically normal heart
>
> The Coroner explicitly confirmed to the family that there was no neglect from the hospital in relation to As care.

Hill Dickinson has fed back that *Dr Clement-Jones was an incredibly positive witness for the Trust as he showed a willingness to reflect on A's care and accept where changes in the care may have been warranted, but was robust and comprehensive in his explanations of A as having been a complex case, with the management of low potassium being a difficult task.*

As the learning from this case has concluded it will not be included in future Learning From Deaths Reports.

Case HO Died Q4 2022/23

This related to the death of a black African woman at 18 weeks gestational age who deteriorated whilst an in-patient at LWH. She was transferred to LUFHT where she sadly died. This death has been investigated via a Serious Untoward Incident investigation (led by the Gynaecology division due to her presenting the GED) a HSIB investigation and is also being investigated by the Coroner. The cause of death has been recorded as

1A- acute intestinal ischaemia
1B- Thrombophilia and pregnancy.

The SI report (2023/5813) identified the following as a root cause of the incident:

- The lack of onsite surgical team and managing the patient in isolation and not 'shared care' with other acute specialties.
- Lack of co-location of LWH with acute trust.

The finalized HSIB report was provided to the Trust in December 23. This report included multiple findings including the following:

1. It is likely that culture, ethnicity, or health inequalities impacted upon the diagnosis, escalation and the care that the Mother received.
2. The pain scoring system used to document the Mother's pain was inaccurate, incomplete and not in line with local guidance. A standardised approach to pain scoring supports holistic review and care planning.
3. The gynecology ward routinely uses the national early warning score version 2, rather than the Maternity Early Warning score and this impacted upon recognition and escalation of deteriorating condition.
4. Due to sickness, there were less staff on the ward than expected.
5. The national junior doctors' industrial action impacted upon on escalation and decision making as staff did not escalate up the hierarchical chain as all the
6. The gynecology clinicians were consultant level (acting down) and this impacted upon the timing of imaging, diagnosis, and surgery.

There is an extensive action plan associated with this report which will be monitored through the Family Health Divisional Board and Safety and Effectiveness committee. The findings from this report have also fed into the trust wide anti-racism strategy and deteriorating patient collaborative.

Socio Demographic characteristics of Maternal Mortality over the past 10 years

The three most recent maternal deaths have all occurred in non-white women. Circa 1 in 6 (14% in MSDS submission 2022) of LWH mothers are non-white.

In the 2022 MBRRACE report the risk of maternal death was nearly four times higher among women from Black ethnic minority backgrounds compared with White women and this continues to be the case in the most recent report. The risk was almost twice as high for women from Asian backgrounds and it has not changed since 2018 report

As the number of deaths are small caution must be taken with interpreting the ethnicity data. A recent paper by the Maternal safety Champion has reviewed maternal mortality in the last 10 years at LWH (see Appendix for the paper). Reviewing the last 10 years of maternal deaths identifies that all of the other 13 deaths were in white women. Thus in the last 10 years the maternal mortality in non-white women (3/16 or 18%) is similar to our current booking population. However, the recent deaths may be indicating a shift in the mortality demographics.

From the review of the last decade of maternal mortality 13/16 (81%) maternal deaths lived in 20% of the most deprived areas. In the total booking population 69% of mothers were in the bottom quintile. 11/16 (68%) lived in the most deprived 10% of areas. Compared to a booking population of 55%. There is therefore an excess mortality seen at LWH related to deprivation, however this is not statistically significant (p =0.30 at the quintile level).

This report has been made available to Board members via AdminControl.

1.3 Gynaecology Mortality data Q1 2022/23

There were 0 expected deaths within Gynaecology Oncology in Q2 2023/24.
There was 0 unexpected death within Gynaecology services in Q2 2023/24.

2023/24	Expected	Unexpected	Deaths of LWH patients transferred as in-patients
Q1	1	0	0
Q2	0	0	0
Q3			
Q4			
ANNUAL	**1**	**0**	**1**

Table 1 Gynaecology Mortality LWH

1.4 Learning from Gynaecology Mortality Q1 22/23 2022/23

There were no deaths in Q1 2022/23. The learning from the case HO is included in the section on maternal mortality above.

2 Stillbirths

2.1 Stillbirth data

There were 4 stillbirths, excluding terminations of pregnancy (TOP) in Q2 2023/2024. This has resulted in an adjusted stillbirth rate of 2.2/1000 live births for Q2 23/24.

STILLBIRTHS	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May - 23	June - 23	July - 23	Aug - 23	Sept - 23	TOTAL 2023/24
Total Stillbirths	3	2	2	6	2	4	1	5	4	10	5	3	3	30
Stillbirths (excluding TOP)	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**	**1**	**0**	**7**
Births	656	649	596	619	630	519	613	613	599	554	629	612	587	3594
Overall Rate /1000	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	7.9	4.9	5.1	8.3
Rate (excluding TOP)/1000	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**4.8**	**1.6**	**0**	**1.9**
Pregnancy loss 22-24 weeks (excluding TOP)	1	1	1	1	1	0	0	1	0	2 (twins)	0	1	0	4

Table 1 Stillbirth rates for past 12 months . The stillbirth rate for this 23/24 so far is 1.9/1000 births.

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	2.2
Q3	1.5	2.7	5.1	4.3	
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations)

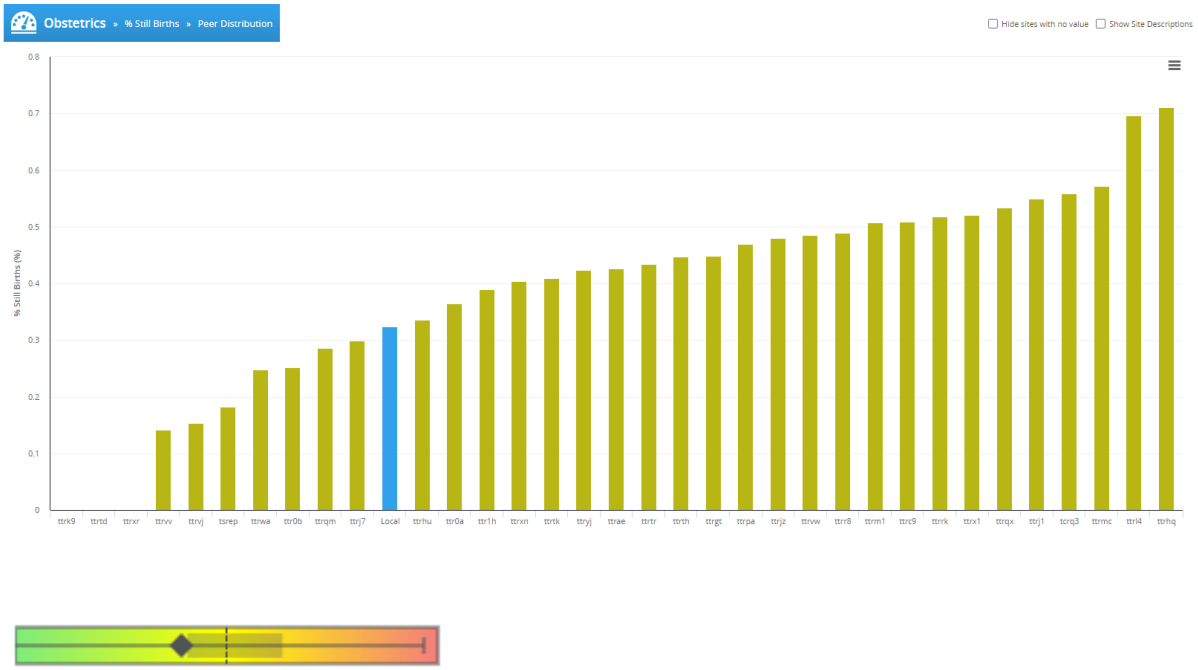


Figure 1 and 2. Stillbirth data with LWH benchmarked against other large maternity services (>7000 deliveries) Q2 2023-24. The blue bar LWH data demonstrating the observed rate is within the lowest quartile for stillbirths.

When benchmarked against similar large organisations, we are below the interquartile range and at the lower end for stillbirth mortality. Whilst this is encouraging, the numbers are small, and this is encouraging particularly given the low stillbirth rate seen in Q1.

2/5 women were BAME. This is higher than the booking population but caution needs to be taken given the small numbers. In the past we have not seen an excess of BAME representation in the stillbirth population and annual data is required to make any meaningful assessment.

4/5 (80%) of stillbirths occurred in women residing in the most deprived IMD deciles.

2.1 Learning from Stillbirth and PMRT reviews Q4 22/23 2022-23 N=11

All eligible cases (Stillbirths > 22 weeks but excluding ToPs) underwent a full multidisciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The reviews of Q1 23/24 stillbirths (n=6) identified that 1 (17%) case had antenatal care issues which would not have changed the outcome of the pregnancy. This related to midwifery reviews when patients are under the care of the FMU service.

There was one issue in the postnatal care related to external noise in the bereavement room.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	5	83.3	5	83.3
B	1	16.7	1	16.7
C	0	0	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=6)

The attached appendices provide information on progress with on-going actions from related to prior stillbirths.

3. Neonatal Mortality

3.1 Neonatal mortality Data Q2 2022/23

Neonatal deaths can be reported in several ways. The population can include in-born babies only (includes in-utero transfers), LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days (reported in MBRRACE), those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The population examined may be defined by weight and/or gestational age. The data may include or exclude babies with congenital anomalies.

The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age. This last group is reported national by the national neonatal audit project and monitored locally by the ODN. The benchmark of 6.3% is locally derived by the ODN. The threshold was the overall mortality in the UK between 2015 – 2018 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. This issue is being discussed with the ODN to identify a more suitable benchmark.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	Total
Births	613	599	554	629	612	587							3594
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1							20
Total mortality on NICU	3	1	6	3	4	1							18
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1							16
IUT Mortality	0	0	5*	0	4	0							9
PNT Mortality	1	0	0	1	0	0							2
INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7							4.5
MBRRACE eligible deaths *Excl. congenital anomaly*	*0* *0*	*1* *1*	*3* *2*	*1* *0*	*4* *2*	*1* *1*							*10* *6*
Benchmark: MBRRACE data 2021 *3.36/1000LBs* *(excl. congenital anomaly) 1.44/1000LBs*	*0* *0*	*1.7* *1.7*	*5.4* *3.6*	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*							*2.8* *1.7*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*							*7*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*							*10.9%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*							*4*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*							*17.4%*

**Includes babies inborn at LWH then transferred to another hospital who died in the neonatal period prior discharge*

Table 4: NICU Mortality by month for the past 12 months. Red indicates breaching the NWODN threshold. This threshold however is being challenged as not appropriate for level 3 NICUs.

Quarter	NMR *in born*
Q1 (23_24)	5.1
Q2 (23_24)	3.8
Q3 (23_24)	
Q4 (23_24)	

Table 5: Neonatal Mortality Rate per quarter. (born and deid at LWH)

In this quarter there were 8 deaths on the NICU. 4/8 (50%) of the deaths were from pregnancies originally booked outside of Liverpool.

There were 4 deaths in the in-born preterm population (24 to 31+6 weeks). This resulted in a 10.9% mortality figure. The benchmark figure of 6.3% is derived from the overall mortality in this population nationally, however as LWH receives the majority of extreme preterm babies from Cheshire and Merseyside, the mortality in our inborn population would be expected to be higher than the national average. The use of this benchmark continues to be discussed with the ODN.

6/8 babies (75%) were white British. 1 was of Asian background and 1 black African.

Half (4/8) deaths occurred in families who live in the most deprived decile (similar to the booking population).

3.3. Learning from neonatal mortality reviews for Q1 23/24

There were 10 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome.

There were 3/10 (50%) cases whereby issues were identified in the antenatal care provided by LWH that would not have affected the outcome.

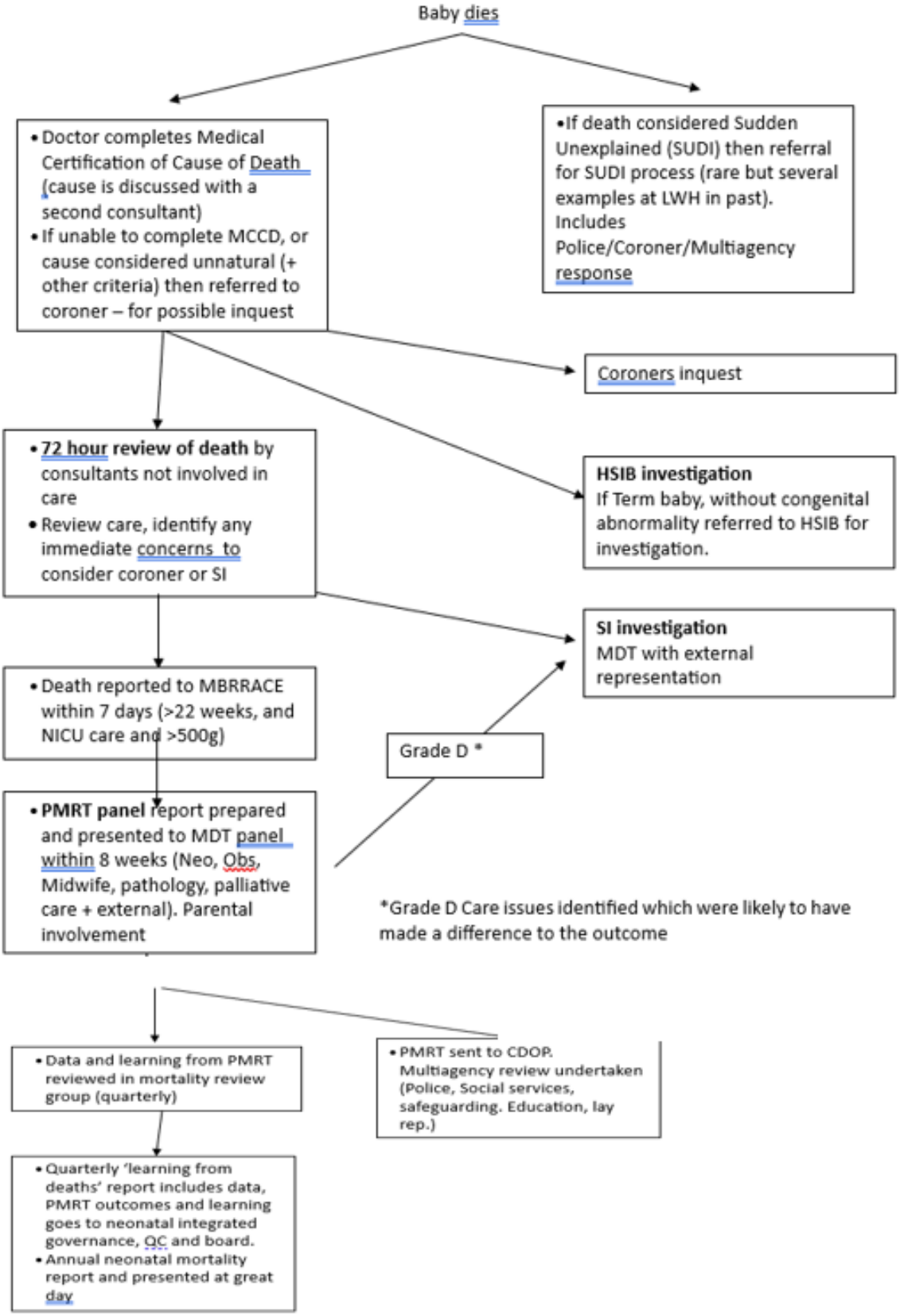
There were 4/10 (40%) cases whereby issues were identified in the neonatal care provided by LWH that would not have affected the outcome. Two of these cases related to not being co-located with neonatal surgical services.

One baby (not included in the LWH PMRT data) died at AHCH and underwent review there. Non-colocation of NICU and surgical services were identified as impacting upon the care provided. This case has been presented at the LNP board.

3.4 Assurance Process around Neonatal Mortlaity.

In October 2023, the board requested an update around the oversight framework in place at the trust , system and regional levels for neonatal mortality. The oversight and assurance is multifaceted and will depend upon the circumstances of the death.

The process is mapped out below.



Notes relating to the oversight of Neonatal Deaths.

Role of the Medical Examiner

Medical examiners are senior medical doctors provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The medical examiner system is currently set up for adult deaths and as of April 24 will be also providing additional scrutiny for neonatal deaths. The medical examiner for neonatal deaths will be undertaken by two paediatric intensive care consultants operating under the ME examiner system at LUFHT.

Sudden Unexpected Death in Infancy (SUDI)

SUDI is defined as a death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. SUDI is a descriptive term used at the point of presentation, and will include those deaths for which a cause is ultimately found (‘explained SUDI) and those that remain unexplained following investigation Whilst this definition is more readily associated with unexpected deaths in the community setting, it also applies to deaths of infants in the hospital setting. However, there are situations that would not trigger a SUDI protocol, such as the infant who is well but deteriorates with overwhelming sepsis. National guidance also includes the following: *When a newborn infant suddenly collapses and dies on a neonatal unit, consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.* (Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation, November 2016)

For any cases considered to be a SUDI, a discussion with the coroner is held who will decide if the SUDI protocol is initiated.

Perinatal Mortality Review Tool (PMRT) panel

Since January 2018, all perinatal deaths of babies born from 22+0 weeks gestational age are reviewed using a standardised perinatal mortality review tool. This tool assigns grading to the care in the antenatal, neonatal and post-bereavement care. All PMRT review panels at LWH have external representation of clinicians including neonatologists, obstetricians and midwives.

The PMRT data is presented in the LWH Learning from Deaths quarterly report and also to the NW ODN.

Child Death Overview Panel (CDOP)

Child Death Overview Panels became a statutory function in 2008. The over-riding purpose of reviewing all child deaths is to reduce the risk of future deaths or harm to children. CDOP is the final stage of the Child Death Review (CDR) process. CDOPs undertake reviews of all deaths of children normally resident within any of the local authority areas where a death certificate has been issued. CDOPs are multiagency and hold strategic partners to account in relation to any identified matters relating to the death, or deaths, that are relevant to the welfare, public health and safety of children. Merseyside CDOP hold neonatal specific panels which are attended by am LWH neonatal consultant.

Benchmarking

MBRRACE collect and report “extended perinatal mortality” data (stillbirths and deaths within 28 days for babies born at >22+0 weeks. The MBRRACE report however focusses on births from 24 weeks gestational age). The MBRRACE report allows benchmarking of mortality for stillbirths, neonatal mortality and both combined between similar organisations. It adjusts for several confounding variables.

LWH also participate in benchmarking through the **Vermont Oxford Network**. This is a voluntary network providing data for babies less than 1500g or 29+6 weeks gestational age. It includes 1086 centres around the world including a number in the UK. This data base allows us to benchmark mortality with similar centres in the UK and around the world.

4. Recommendations

It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

As per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

5. Appendices

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – Q2 (July – Sept 2023)
- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template