**Understanding what happened – a guide to the Northern Ireland HSC Trust Perinatal Mortality Review Tool (PMRT) review process following a stillbirth or neonatal death.**

On behalf of the Trust and in particular the staff of our maternity and paediatric/neonatal teams, we would like to extend our sincere and heartfelt sympathies on your recent loss.

We want to let you know that the death of a baby is taken very seriously by the maternity and paediatric/neonatal teams. The Perinatal Mortality Review Tool(PMRT) process is used in all cases from 22 weeks gestation where a baby has died. A full review of the care received by you and your baby during pregnancy, birth and the post-natal period is undertaken by an appropriate multidisciplinary review team.

In the coming weeks the review team will meet to examine in detail the care that you and your baby received. The main aim of the review is to try to explain why your baby died and answer any questions that you may have. Information relevant to any future pregnancies may also be identified and shared. The team will:

* look at all relevant health care records, tests and results, including pathology and post mortem results, if undertaken
* to the best of our ability, answer fully any questions you may have and address any concerns and
* look at guidance and policies to ensure the care you received was appropriate and if we need to change the way we do things.

More information about the review process and how you will be involved is provided below.

**Involving you**

Understanding the view point of parents and families is a vital part of the review process. We understand that this can be a very difficult time to receive and process information. We will work closely with you to ensure that you and your family are supported to tell us your story and can ask any questions you have.

It would be helpful if you could share your feelings and thoughts about your care, with us before we start the review process, however you will still be able to ask questions at any stage. You may find it helpful to write down any questions that you may have as they come to mind.

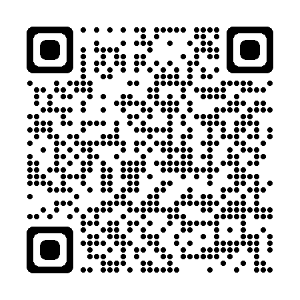
To support you, we have provided you with a key contact:

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| **Sarah Crilly** (Midwife Coordinator for Perinatal Mortality Review)  Tel. 07824 587889/ 02894424000 x 336461  <sarahcrilly@northerntrust.hscni.net>  Room 10, Bush House  45 Bush Rd, Antrim BT41 2QB |

Your key contact will work closely with the staff who cared for you and the bereavement support team to explain the options and agree how you would like to be involved in the review process. They will also ensure that any questions you may have are forwarded to the review team.

Please scan the QR code or use the link below to provide your feedback in an online format, alternative options to engage in the review process are available and can be discussed with your key contact.

[Perinatal Mortality Review Tool (PMRT) - Parental Engagement Form - NI Direct - Citizen Space](https://consultations2.nidirect.gov.uk/hsc/copy-of-pmrt-feedback-form/)

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**Why is a review important?**

A review of your care and the circumstances leading up to and surrounding the loss of your baby is undertaken to confirm why your baby may have died and also to ensure the care provided was appropriate and if different management may have prevented the loss. The review is also important in allowing us to address any questions that you might have. The review may also provide information that may be useful for planning any future pregnancies.

The learning from the review of every baby’s death is important to help us improve services for women and their babies in the future.

**How is the review done?**

All Trust records relating to both you and your baby will be shared with a review team who will use a specific computer-based tool called PMRT (Perinatal Mortality Review Tool) to assist in assessing the care provided. Your written consent is required to store data on the PMRT system. Without your consent we cannot use this tool which has been developed nationally by experts and parent groups to allow comparison with expected standards of care.

The Tool has been developed and is run by the National Perinatal Epidemiology Unit (NPEU) team who are based in Oxford.

If the review team identifies any areas where the care provided was outside of expected good practice and may have been a contributory factor in your baby’s death, the review team may ask that a more detailed investigation is undertaken. In such instances, the Trust will also inform the Strategic Planning and Performance Group (SPPG) who are responsible for ensuring that any learning is shared with all Trusts through the Serious Adverse Incident (SAI) process.

**Who does the review?**

The review is carried out by a team of expert professionals which may include obstetricians, midwives, paediatricians, neonatologists, neonatal nurses and perinatal pathologists who have been trained to do this. Other relevant professionals may also be invited, when required. In order to be as objective as possible, the staff who looked after you and your baby will not lead on the review process but will be asked to contribute to the review

Health care professionals from another hospital may also be asked to participate in the review as independent experts.

**Will I get a copy of the review report?**

Following the completion of the review process, a senior member of the medical team will offer to meet with you to discuss the review findings which we hope may help explain why your baby died. Following this meeting you will be given a written record summarising the discussions and findings.

The review report often includes technical and medical terminology which may require some interpretation, which is why the findings may be translated into a summary or letter for parents, however if you would still like a copy of the original report, please ask.

We understand that this is a very difficult time for you and your family and you may not be ready to talk about your loss. If this is the case, please let us know when you feel you would like to go ahead with the meeting and we will arrange a suitable time.

**How long will the review process take?**

The full review process can take some time as all of the information needs to be available before the review can be completed. For example, it will generally take a minimum of 3 months before the findings of a post mortem are available. The Trust will aim to have the review of your care completed within 6 months. Your key contact will keep you updated throughout the process.

Any actions or recommendations that the review team identify will be implemented and monitored by the Trust governance team.

**How is my information used and stored?**

We are required to store all patient information in a secure and confidential way which is fully compliant with the law including the Data Protection Act (DPA17 from May 2018) and the Common Law Duty of Confidentiality. A summary of the review of your care will form part of your patient record which is held by your Trust.

It is also important that we collect the learning from all reviews to help us continue to improve services for mothers and babies across the UK. Therefore, in addition to your own personal patient record, we will seek your written consent to store the data collected using the Perinatal Mortality Review Tool (PMRT) to support regional and national learning to make maternity and neonatal services as safe as possible for women and babies.

The information from your review is held on the PMRT secure electronic database held in Oxford by the NPEU team. Information on all reviews will be held centrally by the NPEU. In order to ensure a comprehensive review, any member of the clinical team(s) that has provided input into your care will have access to relevant information. The ability to share information will ensure that the right information is available at the right place at the right time. You can find out more about the PMRT at: <https://www.npeu.ox.ac.uk/pmrt>

**HSC TRUST \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_ HOSPITAL UNIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **CONSENT FOR YOUR RECORDS TO BE STORED & USED FOR PERINATAL REVIEW – *consent form to be retained by Trust*** |
| **Personal details (or pre-printed label)** |
| Patient’s full name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient’s date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient’s H&C no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient’s address :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Statement of healthcare professional** |
| I have explained the perinatal mortality review process to the above named patient and have given her a copy of the leaflet explaining the process.  **Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **Statement of interpreter (where appropriate)** |
| I have explained the perinatal mortality review process to the above name patient to the best of my ability and in a way which I believe she can understand. I have given her a copy of the leaflet explaining the process.  **Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| **Statement of patient** |
| I understand that a full review of the care received by myself and my baby during pregnancy, birth and the post-natal period will be undertaken by the appropriate professional team.  I **agree/do not agree (**delete as appropriate) that this information can be stored by the Trust on a secure electronic database held by the NPEU in Oxford and will be used to support learning and service improvement within Northern Ireland.  **Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |