Freedom of Information Request: Our Reference CTMUHB_230_26

You asked:

I am writing to request information under the Freedom of Information Act 2000 regarding the use of the **Perinatal Mortality Review Tool (PMRT)** within your Health Board.

I understand that PMRT is used as a standardised national tool to review perinatal deaths, including assessment of the quality of care, grading of care (A–D), and identification of learning and actions. I also understand that PMRT enables the generation of summary reports identifying themes, grading of care, and learning from perinatal deaths, and I am requesting aggregated outputs from these reports.

The purpose of this request is to understand patterns in PMRT findings over time, including the extent to which reviews identify opportunities where improvements in care may have impacted outcomes.

1. PMRT Activity (5-Year Period)
For each of the past five full financial years (or calendar years if more readily available), please provide:

- **Total number of perinatal deaths reported to PMRT**
- **Number of cases:**
  - **Not suitable for PMRT review**
  - **Reviews in progress**
  - **Reviews completed (and/or published where applicable)**

Please see information provided in the table below.

	Total Number Perinatal Deaths Reported to PMRT*	Total not suitable for PMRT Review	Reviews in Progress**	Reviews Completed
2021	26	6	0	20
2022	23	7	1	14
2023	25	4	1	19
2024	24	9	0	15
2025	26	8	7	11

*Late fetal losses, stillbirths, and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.
** If a review has been started but has not been completed and published then the information from that review does not appear in the rest of this summary report.

2. PMRT Grading of Care (A–D)
For all completed PMRT reviews, please provide the number of cases by grading of care:

- **Category A – Good care**
- **Category B – Care issues, but no impact on outcome**
- **Category C – Care issues which *may have made a difference* to the outcome**
- **Category D – Care issues which *would reasonably be expected to have made a difference* to the outcome**

Please see attachment 1. Noting - Where numbers are low, we have considered that there is the potential for the individuals to be identified from the information provided, when considered with other information that may also be in the public domain and have therefore redacted numbers less than 5.

In our view disclosure of these low figures would breach the General Data Protection Regulation (GDPR) and Data Protection Act 2018 and its disclosure would be contrary to the data protection principles and constitute as unfair and unlawful processing in regard to Articles 5, 6, and 9 of GDPR**.** We are therefore withholding this detail under Section 40(2) of the Freedom of Information Act 2000. This exemption is absolute and therefore there is no requirement to apply the public interest test.

Please provide this data for each year, and where available include:

- **The percentage (%) of total reviewed cases in each category**

Information not collated.

3. Key Focus – Categories C & D
To support understanding of potential avoidable or modifiable factors, please confirm:

- **Whether Categories C and D are routinely monitored, analysed, or reported internally**

  Yes.

- **Whether there are any internal targets, benchmarks, or improvement goals relating to reducing:**
  - **Category C cases**
  - **Category D cases**

    Yes.

4. Contextual Breakdown (if readily available)
Where this information is already recorded within PMRT outputs, please provide breakdowns of Categories C and D by:

- **Type of death (e.g. stillbirth, neonatal death)**
- **Phase of care:**
  - **Antenatal**
  - **Intrapartum**
  - **Neonatal/postnatal**

Not readily available.

5. Learning, Themes and Governance
Please confirm:

- **Whether PMRT findings are reported to Board level or equivalent governance structures**

  Yes.

- **Whether thematic reviews or trend analyses of PMRT findings are undertaken**

  Yes.

- **Whether any reports, summaries, or learning outputs can be shared-**

  No – due to the detail and low numbers involved.

6. PMRT Coverage and Timeliness
Please confirm:

- **Whether PMRT reviews are completed for all eligible perinatal deaths-**

  Yes.

- **The estimated percentage coverage of eligible cases reviewed**

  100%.

- **The average timeframe for completion of PMRT reviews**

  This is variable and is dependant on the level of investigation the family request. Reviews cannot be completed until the results of placental histology results are available (approx. 6 weeks) and/or the result of postmortem examinations (approx. 12 weeks). Monthly Perinatal Loss Forum meetings are held to discuss cases as results become available cases are reviewed the following month. Reviews subject to internal Level 3 Datix investigations are reviewed and finally graded upon completion of the investigation.

- **Whether there are any targets or standards relating to review timeliness**

  No local targets or standards. Reviews are completed as timely as possible, pending the returning of results and investigations.