sands

For families living in England

These are the reviews and examinations you could expect if you live in England and your baby was 37 weeks of pregnancy and was alive at the start of labour but died before birth or within 7 days of being born

Saving babies' lives.
Supporting bereaved families.

Our vision is for a world where fewer babies die and when a baby does die, anyone affected receives the best possible care and support for as long as it is needed.

This guide is designed to help you to understand the reviews and investigations that may help explain why your baby died.

It explains the processes in England following the death of a baby from 37 weeks of pregnancy (full-term), who died during labour but before birth, as well as the death of a full-term baby within the first 7 days after birth in England.

Contents:

Placental examination – page 4

Hospital post-mortem – page 5

Coronial post-mortem – page 6

Hospital review – page 7

Hospital review: a step-by-step guide – page 8

Hospital reviews: what the grading of care means – page 9

Patient Safety Incident Investigations (PSII) – page 10

Patient Safety Incident Investigations: a step-by-step guide - page 11

A Maternal and Newborn Safety Investigation (MNSI) – page 12

Maternal and Newborn Safety Investigation (MNSI): a step-by-step guide – page 13

Sands Bereavement Support Information– page 14

Placental Examination

sands

You may be offered an examination of the placenta (also called placental histology). The placenta connects you to your baby in the womb. Examining the placenta may help explain why your baby died. Staff at the hospital can answer any questions you have about a placental exam and how long it should take. You can have a placental exam even if you don't want a post-mortem for your baby. **Placental exams, like hospital post-mortems are optional.**

Getting your results

You will receive the results of your placental examination either as part of your hospital review letter or as a separate report. In some cases, you may be offered a hospital appointment to discuss the results. Your doctor should help you understand what the results mean and should explain anything in the report that you don't understand. They should also be able to tell you if they have found anything that could possibly impact future pregnancies.

Hospital Post-Mortem

sands

A hospital post-mortem is an examination of your baby's body which may help understand why they died. A senior member of staff will explain the different types of post-mortem available for your baby and will ask which type you agree to. This is called post-mortem consent. You can ask any questions you need to ensure you make the right decision for you. Unfortunately, a post-mortem might not always tell you why your baby died.

Hospital post-mortems are optional. It is entirely your decision whether your baby has one.

Getting your results

It often takes several months to get the post-mortem results. The time it takes varies from hospital to hospital. The person who does the post-mortem consent can tell you how long it may take to get the report to you.

The post-mortem report is likely to be very technical and contain medical language which you might find distressing, or hard to understand. You should be offered an appointment with a senior member of staff who will go through the report and explain it to you. If you do not receive a copy of the report, you can ask for one.

Coronial Post-Mortem

sands

Any unexpected or unexplained death of a baby after they are born must be referred to the coroner. If the coroner investigates your baby's death, they will order a post-mortem to help them understand what happened.

A coroner's post-mortem is mandatory. You cannot say no.

Getting your results

Once the post-mortem is finished, the coroner will write a report about what if anything, was found. Coronial reports often take 6-12 months to finish.

Hospital Review

sands

This review looks at the care the hospital gave you during pregnancy, labour, and birth to see if different care might have changed the outcome for your baby. If your baby was born alive, your baby's care will also be reviewed.

Sometimes this review is called a perinatal mortality review (PMRT). It can also be called a child death review (CDR) if your baby was born alive.

Getting your results

You will receive the results in a letter which states clearly what the hospital review panel found. You can ask your bereavement midwife to explain anything you don't understand. You should be offered a meeting to speak with a senior clinical staff about your results. This process can take several months. More information on the hospital review/PMRT is below.

A step-by-step guide to hospital reviews

1 Starting a hospital review

The hospital should tell you who your key contact is for the review. This might be a bereavement midwife, your community midwife or someone else from the maternity team. This person will be your main point of contact for information about the review. They should explain the review process to you, the purpose, and how long it might take

2 How you can be engaged in the process

If you have any questions or concerns about your care, speak to your key contact or send them an email with your questions. If there are any questions they can't answer, they will submit them to the panel of clinicians reviewing your care.

If you don't have questions but want the review team to know about your experience of care, you can let your key contact know that too.

If you do have questions, but don't know exactly what to ask, you can use this parent feedback form. The form was developed by bereaved parents to help you think of any questions you would like the hospital review to answer.

3 Hospital information gathering for the review

The hospital review team will gather your medical records, along with any post-mortem and placental examination results you have consented to.

The review team will review your notes and your questions to see if you and your baby received the right care. The review panel should also address any questions, concerns or comments you have asked about your care. This may take multiple meetings.

You can't attend these meetings, but your bereavement midwife or key contact can represent you and your questions will be part of the review.

4 Receiving the results

When the review meeting is finished, you will be offered a meeting to discuss the results. You can get the results in a face-to-face meeting at the hospital, or an online meeting or phone call if you prefer. You can have people with you at this meeting to help support.

You aren't required to ask questions or be part of the review if you don't want to. Even if you aren't involved in the review, you can still get the results sent to you.

5 What the results mean

After the hospital review meeting, a senior clinician should write a letter explaining their findings. This letter should be clear and should answer your questions. It should also give you a 'grade' of the quality of the care the hospital provided to you and your baby. Getting to this point can take several months.

There are 4 grades, **A, B, C & D**.

These are explained in more detail in the chart below.

You can ask for a copy of the PMRT report. It is in technical language which you may find distressing or hard to understand.

Hospital reviews: What the gradings of care mean

Grade A	Grade B	Grade C	Grade D
If your care is graded an **A or B**, the PMRT review team believe the care you received did not impact the outcome for your baby.		If your care is graded a **C or D** this means that the PMRT Review team believe the care you received might have impacted on the outcome for your baby.	

Care rated a **B**, **C**, or **D** should mean that the service will create SMART actions to learn from any mistakes and prevent them from happening again. (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-Bound).

PMRT

PMRT review care that is **graded C** may trigger a new review.
PMRT reviews where care is **graded D** will always trigger a new review.

These reviews are carried out by hospital staff and are called a **Patient Safety Incident Investigation (PSII).**

There is more information on PSIIs below.

Patient Safety Incident Investigations

sands

Depending on the circumstances of your baby's death or the PMRT review findings, the hospital may conduct a Patient Safety Incident Investigation (PSII).

Like the hospital review, this investigation also looks at the care the hospital gave you during pregnancy, labour, and birth to see if different care might have changed the outcome for your baby. If your baby was born alive, your baby's care will also be part of this investigation.

Getting your results

Someone senior within the hospital will write the report. The report will include how the hospital will fix any failures in their care. Your key contact, bereavement or community midwife will deliver a letter to you summarising the findings. It might also be emailed or posted to you. This process can take some months to finish. More information is below.

A step-by-step guide to PSIIs

1 Why a PSII might happen

If your baby's death has triggered a PSII, this might have been because of:

- the circumstances of your baby's death, or
- the PMRT graded your care as C or D.

Who leads the investigation?

A senior member of staff will lead this review. Ideally this should be someone who wasn't involved in your care, but this is not always the case.

2 Starting a PSII

If a PSII is started, a member of the hospital team will explain the process and how you can be involved. They should explain:

- The support services available to you.
- How the investigation will be carried out.
- How long the investigation will take.
- When you will receive the report(s) & responses.

You can ask questions at any time, and the team should answer them. You do not have to take part if you don't want to.

The PSII investigation may run alongside other processes, such as the Hospital Review (PMRT), and–if you have consented–post-mortem and placental examinations. If you have questions or wish to share information about your or your baby's care, you can speak with your key contact or bereavement midwife, who can pass this on to the review team.

3 The Investigation process

The PSII team will develop the Terms of Reference (ToR), which outline what the review will cover and the key questions it aims to answer. You should be given the opportunity to view and comment on the ToR.

To understand what happened, the hospital will review your and your baby's medical records, relevant hospital policies, and any available results from post-mortems, placental examinations, and other reviews. They may also speak with staff involved in your care.

If you provided feedback as part of the Perinatal Mortality Review Tool (PMRT) process, this will be included to help the team understand what happened from your perspective.

4 Receiving the results

The review Lead will write a draft report that they will share with you. You can respond to the draft report to correct anything you feel is wrong. You can tell them any other questions or concerns that you have.

Any points you raise about the draft report should be addressed in the final report. This may involve the team asking you for further clarification.

The final report will outline safety actions to stop future incidents.

5 Concluding the PSII Review

The team should ask you how you would like to receive the final report: in person at the hospital, online, or over the phone

You can discuss the final report, any safety actions, and ask any questions you have with your key contact. The final report will be sent to the Trust and the PSII will be done.

If you are unhappy with the outcome of the review, you may find it helpful to refer to Sands' guide on what to do if you are dissatisfied with a review outcome. How to raise concerns give feedback or make a complaint.

Maternity and Newborn Safety Investigations

sands

The Maternity & Newborn Safety Investigation Programme (MNSI) investigates cases where a full-term baby dies during birth or in the first week of life. They do an independent investigation and suggest ways to make care safer–both at your local hospital and across the country. It's your choice whether you want MNSI to investigate your baby's death. If you decide not to, the hospital will carry out its own investigation, called a Patient Safety Incident Investigation (PSII), alongside a Perinatal Mortality Review (PMRT).

Getting your results

The MNSI investigation team will write the final report which will include how the hospital should fix any failures in their care. You can receive an electronic or paper copy of the report. The MNSI aim to complete all investigations within 6 months. More information about these investigations is below.

A step-by-step guide to MNSI investigations

1 Starting an MNSI Investigation

Your key contact at the hospital should offer you the options of an MNISA Investigation if you were at least 37 weeks pregnant and:

- Your baby was alive at the start of labour but died before they were born or
- Your baby died within the first week after birth (0-6 days).

Because MNSI investigations are done by an independent organisation, you will need to give permission for this investigation to take place and for your and your baby's medical records to be shared with the MNSI.

2 Deciding to have an MNSI investigation

If you want to be involved, your main point of contact for the investigation will be an investigator from MNSI. You have the right to take part in the investigation and ask questions, but you don't have to.

If you want more information before deciding, you can watch this video: https://www.mnsi.org.uk/for-families/investigation-overview-for-families/

3 Telling your story

Your investigator will speak with you (and your partner if appropriate) to hear about your pregnancy, labour, and any concerns you have about the care you received. The investigator should be flexible about how and where this conversation is held. You can have someone with you for support.

You will also have an opportunity to tell them about yourself or your baby.

They then analyse your story and information from the hospital to find any factors that may have contributed to your baby's death.

4 The draft report

The Investigator will write a draft report and share it with you and the hospital. You can respond to it to correct anything you feel is inaccurate. The draft may also bring up more questions. You can mention any questions or concerns with your investigator so they can be addressed in the final report. This may involve the investigator asking you for further information or clarification.

The final report will not use your or your baby's name and will be anonymous. But you do have the option for the report to be personalised, so your name and your baby's name are included if you want this.

5 Report findings

You should be able to discuss the final report and the safety actions with the hospital. After their investigation is complete the maternity team will use the information from the MNSI investigation to complete the hospital review. You do not need to do anything. There will not be a PMRT meeting as the MNSI replaces it.

If the MNSI investigator is aware that there will be further investigations, such as a Coroner's Inquest, they should tell you.

6 The Final Report

MNSI investigations take between 4-6 months to complete. You should be asked how you would like to receive the final report.

A face-to-face meeting at the hospital with the MNSI investigator and staff from the hospital will be offered. This is sometimes referred to as the tri-partied meeting. It can be an online meeting or phone call if you prefer.

sands

Sands is here for anyone affected by pregnancy loss or the death of a baby.

If you need support, Sands offers confidential trauma-informed support for anyone affected by pregnancy loss or the death of a baby in the UK.

Free helpline 0808 164 3332

Email helpline@sands.org.uk

Sands support chat via our website sands.org.uk

Saving babies' lives.
Supporting bereaved families.