

FOI REF: 25/742

27th October 2025

Eastbourne District General Hospital

Kings Drive Eastbourne East Sussex BN21 2UD

Tel: 0300 131 4500 Website: www.esht.nhs.uk

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

This is a Freedom of Information request regarding your trust's use of the Perinatal Mortality Review Tool (PMRT). This tool is used in almost all cases of late miscarriages, stillbirths, and neonatal deaths, and your maternity department will be familiar with it.

For the calendar year 2024, please provide the following information:

- 1. How many late miscarriages, stillbirths and neonatal deaths were identified as meeting the criteria for a PMRT review?
 - 11 cases of SB/late miscarriages reported to PMRT, but only 9 fit the criteria for Reviews, 6 Neonatal deaths reported, none fit the criteria due to gestation.
- 2. Of these, the percentage of cases that resulted in a report being produced (i.e. where the review was completed, closed, and a final report generated)?
 - Of the 9 cases for review, 100% were reviewed and generated final published report.
- 3. In what percentage of PMRT reviews was a clinician external to the trust part of the reviewing team?
 - Of the 9 cases reviewed, 7 had external member present (77%). In 2024 the expectation was 65% (this is now 50%).
- 4. In what percentage of PMRT reviews (including cases which were identified as meeting the criteria but not completed), were the parents invited to provide comments about care?
 - 100% of parents were invited to provide comments about their care.

5. For completed reports, the number of cases graded as follows (using the standard PMRT definitions):

Stillbirths & Late Fetal Losses:

A. No issues with care identified B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the outcome Grading of care of the mother following confirmation of the death of her baby: A. No issues with care identified B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the		
B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the outcome Grading of care of the mother following confirmation of the death of her baby: A. No issues with care identified B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the	Grading of care of the mother and baby up to the point that the baby was conas having died:	firme
C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the outcome Grading of care of the mother following confirmation of the death of her baby: A. No issues with care identified B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the	A. No issues with care identified	3
D. Care issues identified which were likely to have made a difference to the outcome Grading of care of the mother following confirmation of the death of her baby: A. No issues with care identified B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the	B. Care issues identified that would have made no difference to the outcome	4
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B. Care issues identified that would have made no difference to the outcome C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the	Grading of care of the mother following confirmation of the death of her baby:	
C. Care issues identified which may have made a difference to the outcome D. Care issues identified which were likely to have made a difference to the	A. No issues with care identified	6
D. Care issues identified which were likely to have made a difference to the	B. Care issues identified that would have made no difference to the outcome	3
· .	C. Care issues identified which may have made a difference to the outcome	0
	D. Care issues identified which were likely to have made a difference to the outcome	0

Neonatal Deaths:

Not applicable as none fit criteria for review. All were reported to CDOP.

Grading of care of the mother and baby up to the point of the birth of the baby:	
A. No issues with care identified	
B. Care issues identified that would have made no difference to the outcome	
C. Care issues identified which may have made a difference to the outcome	
D. Care issues identified which were likely to have made a difference to the outcome	
Grading of care of the baby from birth up to the death of her baby:	
A. No issues with care identified	
B. Care issues identified that would have made no difference to the outcome	
C. Care issues identified which may have made a difference to the outcome	
D. Care issues identified which were likely to have made a difference to the outcome	
Grading of care of the mother following the death of her baby:	
A. No issues with care identified	
B. Care issues identified that would have made no difference to the outcome	
C. Care issues identified which may have made a difference to the outcome	
D. Care issues identified which were likely to have made a difference to the outcome	

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (eshtr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office Wycliffe House Water Lane Wilmslow Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department esh-tr.foi@nhs.net