Our Ref: 238/2020
September 2020

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Re: Your request made under the Freedom of Information Act 2000

I would like to know how many term stillbirths and neonatal deaths there have been at Bassetlaw District General Hospital in each year over the past decade (2010 - 2020).

a) How many were internally investigated using the Perinatal Mortality Review Tool.
b) How many of these deaths were subject to an NHS Serious Incident Investigation or Healthcare Safety Investigation Branch review.
c) How many have been found to be potentially avoidable.

BDGH	*SB at term*	*Serious Incident /HSIB*	*Avoidable*
2010	Not easily available	Not easily available	Not easily available
2011	Not easily available	Not easily available	Not easily available
2012	Not easily available	Not easily available	Not easily available
2013	2	Not easily available	Not easily available
2014	2	1: None SI 2: None SI	1: No 2: No
2015	1	SI	Yes
2016	2	1: None SI 2: SI	1: No 2: No
2017	0		
2018	1	PMRT completed None SI	No
2019	1	PMRT completed None SI	No
2020	1	PMRT: Yes SI: No HSIB: No	No

BDGH	*Neonatal Death Term*	*Serious Incident /HSIB*	*Avoidable*
2010	0	Not easily available	Not easily available
2011	0	Not easily available	Not easily available
2012	0	Not easily available	Not easily available
2013	1	Not easily available	Not easily available
2014	0		
2015	0		
2016	0		
2017	1	PMRT Completed SI	Yes
2018	4	1: PMRT Completed None SI 2: PMRT Completed, None SI moderate report, HMC: Natural causes 3: PMRT Completed SI Homebirth against advice 4: PMRT Completed SI	1: No 2: No 3: No 4: No
2019	0		
2020	0		

The PMRT commenced January 2018 and all stillbirths and Neonatal deaths within the required gestations are investigated using this tool, excepting where the stillbirth or NND occurs after a termination of pregnancy for abnormality. HSIB was introduced in 2018.

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d) How many maternal deaths there have been at the hospital in each year of the past decade and how many of those were found to be potentially avoidable.

BDGH	*Maternal Deaths*	*Serious Incident /HSIB*	*Avoidable*
2010	0		
2011	0		
2012	0		
2013	0		
2014	0		
2015	0		
2016	0		
2017	0		
2018	1 Indirect*: 0 Direct*: 1	SI = 1	Yes
2019	0		
2020	0		

2) How many term stillbirths and neonatal deaths have there been Doncaster Royal Infirmary in each year over the past decade (2010 - 2020)?

a) How many were internally investigated using the Perinatal Mortality Review Tool.
b) How many of these deaths were subject to an NHS Serious Incident Investigation or Healthcare Safety Investigation Branch review.
c) How many have been found to be potentially avoidable.

DRI	*SB at term (37+)*	*Serious Incident /HSIB*	*Avoidable*
2010	Not easily available	Not easily available	Not easily available
2011	Not easily available	Not easily available	Not easily available
2012	Not easily available	Not easily available	Not easily available
2013	6	Not easily available	Not easily available
2014	6	1: None SI 2: SI 3: None SI 4: None SI 5: None SI 6: None SI	1: No 2: No 3: No 4: No 5: No 6: No
2015	3	1: None SI 2: None SI 3: SI	1: NO 2: No 3: Yes
2016	3	1: None SI 2: SI 3: None SI	1: No 2: Yes 3: No
2017	3	1: None SI 2: None SI moderate report 3: None SI	1: No 2: Yes 3: No
2018	2	1: PMRT complete none SI 2: PMRT Completed SI	1: No 2: No
2019	1	PMRT completed None SI	No
2020	2	1: PMRT: Yes Grade C 2: HSIB and PMRT: Ongoing none SI	1: Potentially 2: Ongoing

DRI	*NND (37+)*	*Serious Incident /HSIB*	*Avoidable*
2010	0	Not easily available	Not easily available
2011	1	Not easily available	Not easily available
2012	1	Not easily available	Not easily available
2013	1	Not easily available	Not easily available
14	3	1: SI 2: None SI 3: None SI	1: Yes 2: No 3: No
2015	1	SI	Yes
2016	0		
2017	0		
2018	1	PMRT completed SI	Yes
2019	1	1: PMRT Grade A, HSIB investigation none SI preventable (awareness of skin to skin not care related)	Yes
2020	2	1: PMRT: Ongoing none SI 2: PMRT: Ongoing none SI known cardiac abnormality	1: Ongoing No 2: Ongoing No

The PMRT commenced January 2018 and all stillbirths and Neonatal deaths within the required gestations are investigated using this tool, excepting where the stillbirth or NND occurs after a termination of pregnancy for abnormality. HSIB was introduced in 2018.

d) How many maternal deaths there have been at the hospital in each year of the past decade and how many of those were found to be potentially avoidable.

DRI	*Maternal Deaths*	*Serious Incident /HSIB*	*Avoidable*
2010	0		
2011	0		
2012	0		
2013	0		
2014	0		
2015	0		
2016	0		
2017	0		
2018	0		
2019	0		
2020	1 Indirect*: 1 Direct*: 0	SI = 0 HSIB = 1	No

** Direct= related to hospital admission. Indirect= not related to hospital admission*