Our Ref: 247/2023
MAY 2023

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Please provide data for each question for the years 2018 - 2022, broken down by calendar year (i.e. 2018, 2019, 2020, 2021 and 2022).

1. Please provide the number of term stillbirths (37 weeks or more) at your trust

2018 – 3
2019 – 1
2020 – 4
2021 – 2
2022 – 7

2. Please provide the review process for each stillbirth recorded, e.g.. X number of PMRTs, X number of SIIs, X number referred to the coroner. If relevant, please include the number that led to no review.

2018 – PMRT x3. SI x2. Coroner x0.
2019 – PMRT x1. SI x1 (later de-logged). Coroner x0
2020 – PMRT x4. SI x1 (x1HSIB). Coroner x0.
2021 - PMRT x2. SI x2 (x1 HSIB). Coroner x0.
2022 – PMRT x7. SI x3 (x1 HSIB). Coroner x0.

3. In any reviews done following a stillbirth please list how many times each of the following was a contributing factor, concluded from the investigation.

a. Failing to monitor reduced foetal movements - 4
b. Wrongly interpreting test results during pregnancy - 2
c. Failing to act on test results which highlight a problem - 6
d. Failure to treat infections in the mother - 0
e. Poor staffing levels - 0
f. Failure to notice vital signs of distress - 2

4. Please provide the number of neonatal deaths at your trust: All gestations from 16 weeks onwards where maternity care has been provided, including those with congenital abnormalities and medical terminations)

2018 – 9 (1x <24 weeks gestation, x5 @ term)
2019 – 6 (1x <24 weeks gestation, x1 @ term)
2020 – 7 (x2 @ term)
2021 – 2 (x1 <24 weeks gestation, x1 @ term)
2022 – 2 (no term)

5. Please provide the review process for each neonatal death, e.g. X number of SIIs, X number referred to the coroner. If relevant, please include the number that led to no review.

2018 – x2 SI, x8 PMRT, x9 Coroner – x1 accepted referrals
2019 - x1 SI, x5 PMRT, x6 Coroner – x2 accepted referrals
2020 – x2 SI, x7 PMRT, x7 Coroner – x1 accepted referrals
2021 – x1 SI, x2 PMRT, x2 Coroner – x1 accepted referrals
2022 – x0 SI, x2 PMRT, x2 Coroner – x0 accepted referrals

6. In any reviews following a neonatal death, please list how many times each of the following was a contributing factor, concluded from the investigation.

g. Failing to monitor reduced foetal movements - 0
h. Wrongly interpreting test results during pregnancy - 0
i. Failing to act on test results which highlight a problem – 1
j. Failure to treat infections in the mother - 0
k. Poor staffing levels - 2
l. Failure to notice vital signs of distress - 7
m. Failing in antenatal care - 10
n. Insufficient or inaccurate handovers - 0
o. Failing to recognise need for caesarean – 1

7. Please provide the number of maternal deaths at your trust

2018 – 2 (x1 direct, x1 indirect)
2019 – 1 (indirect)
2020 – 3 (x1 direct, x2 indirect)
2021 – 1 (Indirect)
2022 - 0

8. Please provide the number of midwifery staffing red flags at your trust

2018 – 18
2019 - 18
2020 – 17
2021 – 33
2022 - 20

If the request exceeds costing limits set out under the act, please advise how I can refine my request. If you do not hold data in calendar years, please provide data in financial years from 2018-19 through to 2022-23.