

5. How many women underwent peripartum hysterectomy where the primary recorded indication was PAS or suspected PAS?

If available, please differentiate between planned and emergency hysterectomies.

	DRI	Bassetlaw
2021	#	0
2022	0	0
2023	0	0
2024	0	0
2025	0	0

6. How many deliveries involved Manual Removal of Placenta (MROP)?

2021		2022		2023		2024		2025	
DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw
47	17	58	30	47	27	66	20	52	22

7. Of the MROP cases in Question 6, how many also recorded a postpartum haemorrhage (PPH) of 1,000ml or more?

2021		2022		2023		2024		2025	
DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw	DRI	Bassetlaw
13	5	15	9	13	5	18	7	16	#

Where figures are fewer than five, these have been replaced with '#'. This is because disclosure of small numbers, particularly in combination with other information, could lead to the identification of individuals. This information is therefore withheld under Section 40(2) of the Freedom of Information Act 2000, as it constitutes personal data and disclosure would be unfair and unlawful under UK GDPR.

8. Is diagnostic and management training for Placenta Accreta Spectrum (PAS) a mandatory requirement for frontline maternity staff?

(Yes/**No**. If Yes, please specify which staff groups this applies to.)

9. In the last 24 months, has the Trust included a PAS-specific scenario (distinct from general haemorrhage) in mandatory Skills & Drills, PROMPT, or other obstetric emergency training? **No**

10. Does the Trust have a written "Hard Stop" protocol for manual removal of a sticky or retained placenta (for example, a defined time limit or limit on number of attempts before escalation to a suspected PAS pathway)? **No**

11. In the Trust's maternity electronic patient record system, is "suspected PAS" captured as:

Our Ref: 94
February 2026

- a structured field,
- free text only, or
- not recorded at all?

12. Which ultrasound guideline or reporting template does the Trust use when identifying or documenting suspected PAS? RCOG
(For example, RCOG guidance, FIGO guidance, an internal Trust guideline, or other.)

This request follows the recent confirmation by the Minister of State for Health (Ref: 106183) that the Department of Health and Social Care does not hold national PAS diagnostic data. This request is intended to support transparency and help address that recognised data gap.

Given that this request relates directly to maternal morbidity, near-miss events and patient safety, I kindly ask that any concerns about burden or complexity be considered in light of the significant public interest in transparency and learning in maternity care.

If this request exceeds the statutory cost limit, please prioritise Questions 1, 2, 3, 4, 5, and 8, and confirm which remaining elements can be completed within the limit.

If you are not satisfied with the handling of your request, you have the right to request an internal review. Requests for an internal review should be submitted within 40 working days from the date of this response, and should be addressed to d.wraith@nhs.net.

If you remain dissatisfied after the internal review, you have the right to appeal to the Information Commissioner's Office (ICO). The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
Website: <https://ico.org.uk/make-a-complaint/>

Our Ref: 94
February 2026