

23. I am also aware that Dr Brearey made a number of points when he gave evidence about the analytical effectiveness of the MBRRACE-UK RTDM and benefits of an integrated system that brought together the MBRRACE-UK RTDM and MOSS. In summary, I understand that he suggested:

- a. An integrated platform that enabled signals for both preterm and term babies to be analysed together would be beneficial, rather than them running in parallel;
- b. The MBRRACE-UK RTDM does not have any statistical tools that allow one to interpret the data;
- c. The data is shown by unit of birth, even if the baby was transferred to another unit and subsequently died there (with the death attributed to the unit of birth);
- d. The data shows all deaths of babies and does not, for instance, distinguish between babies who are born with signs of life but who die shortly after birth (not on a neonatal unit) and those who die of a similar gestation on a neonatal unit.

24. I have responded to point (a) at paragraphs 26-30 below.

25. In terms of (b), (c) and (d), Figure 2 (above), sets out the MBRRACE-UK RTDM analytical tools that are available to use. These tools enable data to be filtered (e.g. by gestation/ethnicity/live or stillbirth) and different types of analytical interpretation (days between deaths, run charts and histograms, for example).

Could MOSS measure pre-term neonatal deaths and are there limitations on the effectiveness of the data analysis in including premature babies as a separate group within any joint data analysis?

26. The Inquiry has asked whether it would it work to combine the work of MBRRACE-UK Real Time Data Monitoring Tool and MOSS systems to include premature babies (i.e. those less than 37 weeks' gestation) and what the limitations would be on the effectiveness of the data analysis in including premature babies as a separate group within any joint data analysis. I have addressed these questions together because they are linked.

27. MOSS (deliberately) does not measure preterm deaths (or stillbirths) because it was designed to support the improvement in maternity and neonatal outcomes at term. Deficiencies in the delivery of intrapartum critical safety is not a key factor in premature neonatal deaths. In order to be effective as a safety signalling system, MOSS needs to remain sufficiently sensitive to generate accurate signals of the reliable delivery of intrapartum critical safety standards, which is a key cause of avoidable critical outcomes