Reduced Fetal Movements

Classification:	Guideline
Authors Name:	Melissa Coles, Miss Faryal Nizami
Authors Job Title:	ADAU Lead Midwife, Consultant Obstetrician & Gynaecologist
Authors Division:	Women's and Children's Health
Departments/Group this Document applies to:	Maternity

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Guideline to be followed by (target staff): Midwives and obstetricians providing care for a woman who reports reduced fetal movements.

To be read in conjunction with the following documents:

Milton Keynes University Hospital, *Fetal Monitoring Guideline,* MIDW/GL/48, version 8, 2022 Milton Keynes University Hospital, *Antenatal Care Pathway,* MIDW/GL/137, version 10.1, 2022 Milton Keynes University Hospital, *Antenatal Corticosteroids to reduce Neonatal Morbidity and Mortality,* MIDW/GL/53.version 6,2021 Fetal Growth Ultrasound SOP, Fetal Growth Assessment Guideline

Are there any eCARE implications? No

CQC Fundamental standards:

Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

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Guideline Statement

To enable staff to care for women who have reduced fetal movements.

Executive Summary

To standardise care and management for a woman referred with reduced fetal movements and ensure all women receive adequate information regarding normal fetal activity. It is important to establish the normal pattern of movement in a woman in order to identify changes in fetal activity.

Studies of fetal physiology using ultrasound have demonstrated an association between reduced fetal movements and poor perinatal outcome. The majority of women (55%) experiencing a stillbirth perceived a reduction in fetal movements prior to diagnosis. (Royal College of Obstetricians and Gynaecologists, 201, p.2.)

Improved vigilance, identification and management of these pregnancies may improve the outcomes. Concerns regarding fetal movements need to be taken seriously and dealt with in a research-based, consistent and timely manner.

Definitions

- BMI - Body Mass Index
- cCTG - Computerised Cardiotocograph
- FGR – Fetal Growth Restriction
- IUGR - Intrauterine growth restriction
- PAPP A - Pregnancy Associated Plasma Protein A
- PIH - Pregnancy-induced hypertension
- RFM - Reduced Fetal Movement
- SBLCBv3 – Saving Babies Lives Care Bundle Version Three
- SB – Stillbirth
- SFH - Symphysis-fundal height
- SGA - Small-for-gestational age
- USS - Ultrasound Scan

1.0 Roles and Responsibilities:

It is the midwives' and obstetricians' responsibility to ensure they are conversant with the contents of this guideline and how they access it. Where they are unable to comply with the guideline, this should be clearly documented with reasons for their actions.

Findings and plan of care should be explained and discussed with the woman and her family with reference to risk factors and management options.

Assessments, actions, rationale and plan of care should be clearly documented in the woman's electronic maternity notes.

2.0 Implementation and dissemination of document

This document can be accessed via the Trust's Intranet.

3.0 Processes and procedures

Most women are aware of fetal movements by 18 – 20 weeks gestation. A significant reduction or sudden alteration in fetal movement is a potentially important clinical sign. It has been suggested that reduced or absent fetal movements may be a warning sign of impending fetal death.
All pregnant women must be provided with information and accompanied by an advice leaflet, for example the Tommy's leaflet see appendix 1) on reduced fetal movements by 28 weeks gestation. This must be clearly documented in the electronic records that this has been given.

Fetal movements must be discussed at every subsequent antenatal contact.
The presentation of reduced fetal movements or a sudden change in the pattern of fetal movements must always be taken seriously.

3.1 Assessment and Management of Reduced Fetal Movements

Due to the paucity of robust epidemiological studies on fetal activity patterns and maternal perception of fetal activity in normal pregnancies, there is currently no universally agreed definition of reduced fetal movements. Fetal movements are most commonly assessed by maternal perception alone.

Women should be advised to be aware of their baby's individual pattern of movements.
Fetal movements have been defined as any discrete kick, flutter, swish or roll. (RCOG,2011)

Women who are concerned about reduced or sudden alteration of fetal movements, should be advised not to wait until the next day for assessment of fetal wellbeing and contact their maternity unit straight away.

For any woman who self refers with a history of reduced fetal movements from 18 weeks gestation is to be invited in without delay, to be seen in maternity triage and the appropriate assessment undertaken based on the woman's gestation and history. Any woman that reports no fetal movements from 24 weeks is to be seen on labour ward rather than triage.
.

There is insufficient evidence to recommend formal fetal movement counting using specified alarm limits.

Clinicians should be aware (and should advise women) that although fetal movements tend to plateau at 32 weeks of gestation, there is no reduction in the frequency of fetal movements in the late third trimester.

Risk factors:

- Known SGA/IUGR
- Previous SGA/SB
- Hypertension, Severe PIH or Pre-eclampsia
- Smoker/Drug Misuse
- Age>40
- BMI>35
- Diabetes
- Renal impairment
- Antiphospholipid syndrome
- PAPP-A<0.415 MoM
- PreviousCaesarean Section
- IVF

This list is not exhaustive.

3.1.1 Reduced Fetal Movements 18- 24 weeks gestation

From 18–20 weeks of gestation, most pregnant women become aware of fetal activity, although some multiparous women may perceive fetal movements as early as 16 weeks of gestation and some primiparous women may perceive movements much later than 20 weeks of gestation.

- Take relevant history to assess a woman's risk factors for stillbirth and FGR
- Perform routine antenatal check to include
    - Abdominal palpation
    - Auscultation of fetal heart

CTG should not be performed at this gestation.

This assessment can be undertaken by the community midwife in an appropriate setting i.e. antenatal clinic at the GP surgery or the woman's home.

If fetal movements have ***never*** been felt by 24 weeks of gestation, please book scan with **Fetal Medicine team** to look for evidence of fetal neuromuscular conditions.

3.1.2 Reduced Fetal Movements between 24+0 - 27+6 weeks gestation

- Take relevant history to assess a woman's risk factors for stillbirth and fetal growth restriction (FGR).
- Perform routine antenatal check to include:
    - Abdominal palpation
    - Fundal height measurement (as per fetal growth assessment guideline)
    - Auscultation of fetal heart

- Senior Obstetric review for all women with risk factors for FGR
- There is no evidence on which to recommend the routine use of ultrasound assessment in this group. However, USS for fetal growth, liquor volume and fetal activity should be performed if suspicion of FGR, risk factors for FGR or if normal fetal movements still not felt.

Clinicians should be aware that placental insufficiency may present at this gestation.

3.1.3 >28 weeks gestation

Perform routine antenatal check to include:

- Abdominal palpation.
- Fundal height measurement (as per fetal growth assessment guideline)/ or review of GROW chart
- Auscultation of fetal heart to exclude absence of fetal heart.
- Commence cCTG with Dawes Redman Criteria

Please ensure that you complete the RFM checklist on eCare in line with SBLCBv3 **(Appendix 2)**

3.1.4 First episode of reduced fetal movements after 28 weeks with a normal computerised CTG- no risk factors for SGA/FGR

Women should be reassured that *70% of pregnancies with a single episode of RFM are uncomplicated.*

A normal reassuring cCTG in association with an active fetus carries a very high likelihood of normality and the women can be reassured and discharged home with Tommy's leaflet *Tommy's and NHS England, 2019 Feeling your baby move is a sign that they are well* **(see appendix 1)**

There are no data to support formal fetal movement counting (kick charts) after women have perceived reduced fetal movements in those who have normal investigations.

If unable to provide a computerised CTG an ultrasound scan to assess growth, dopplers and liquor volume should be offered.

If cCTG is normal, and the woman perceives fetal movements → resume planned routine antenatal care;

- Discuss and explain findings with the woman
- Give advice about reduced fetal movements (including Tommy's leaflet Tommy's and NHS England, 2020 Feeling your baby move is a sign that they are well see appendix 1) –outlining the importance of focused awareness.
- Check for understanding and emphasise need to report any deviations or change in nature or pattern of movements.
- Midwives can discharge a woman without the need for medical review at the first visit.
- All visits must be clearly documented with appraisal of CTG / investigations, actions taken, and plan of care recorded in the maternity electronic records (eCare).

If decreased movements persist or the woman remains concerned about fetal movements, obstetric review should be sought and an emergency fetal ultrasound requested for when the service is next available, preferably within 24 hours, to assess growth, doppler and liquor volume.

If an appropriate scan has been performed within the previous 2 weeks and was normal a repeat scan is not indicated.

Women, who have normal investigations after one presentation with reduced fetal movements, should be advised to contact their maternity triage if they have another episode of reduced fetal movements.

3.1.5 Normal cCTG but reduced SFH/or any additional risk factors for SGA/FGR

Risk Factors for FGR / SGA

- Chronic Kidney Disease
- Chronic hypertension
- Congenital cardiac disease, post fontan
- Auto immune disease: e.g. systemic lupus erythema-tosus (SLE) or antiphospholipid syndrome (APLS)
- Hypertensive disease (PET/PIH) in previous or current pregnancy
- Previous FGR (<3RD centile)
- Previous stillbirth (SGA/FGR birthweight)
- EFW <10th in this pregnancy
- Low PAPPA in this pregnancy
- Significant bleeding
- Echogenic bowel
- Diabetes – any (no doppler, serial scans from 28/40)
- Single umbilical artery
- Previous SGA (<10th centile)
- Previous stillbirth (AGA birthweight)
- Smoker
- BMI <18.5 kg / m^2 & other features e.g eating disorder, bowel disorder causing weight loss
- Gastric bypass surgery
- Drug misuse
- Age ≥40 years old at booking
- Previous preterm birth / second trimester miscarriage (placental mediated)
- IVF pregnancy
- Hyperemesis with weight loss >5% with dehydration and electrolyte imbalance (persisting >14/40 gest)
- BMI ≥35kg/m^2 at booking
- Uterine abnormalities

Reduced Fetal Movements

Any absence of, or sudden change in fetal movements, should be referred to maternity triage regardless of risk factors

<24 weeks

Antenatal Assessment

Auscultation

Reassurance

If FMs not felt by 24 weeks for USS with fetal medicine

24 -27+6 weeks

Antenatal Assessment

SFH (After 26 weeks)

Auscultation

Consider CTG if additional clinical concerns

Reassurance

RFM leaflet
Assess risk factors for FGR and arrange scan if required

28-38+6 weeks

Antenatal Assessment
SFH- if required
Perform computerised CTG

CTG normal

First Episode of

Prev or new Risk factors for FGR?

N

SFH with acceptable range

Discussion regarding movements

Discharge home with FM Tommys leaflet with advice to call if RFMs persist.

Yes

≥2nd episode of

Ye s

SFH reduced and/or risk factors for FGR

For urgent obstetric review

For US scan by the end of the next working day

ANC consultant appointment within a week??

PLEASE NOTE:

If a CTG does not meet Dawes Redman criteria or is abnormal before 60 minutes this must be escalated to the on-call registrar and the service user transferred to labour ward if appropriate.

If it is the second or more episode of reduced fetal movements after 26 weeks the service user is for obstetric review prior to discharge and ongoing plan made.

RFMs ≥39+0 weeks

- Single episode with normal CTG, no risk factors and FMs now normal, **NO IOL**
- Single episode with normal CTG but WITH risk factors for FGR, or FMs remain reduced, **discuss IOL**
- ≥2 episodes RFM both over 28 weeks regardless of risks / CTG / USS findings **offer IOL**

Obstetric review

Offer a referral for an **URGENT fetal growth ultrasound**, doppler & liquor volume. This should be performed **by the end of the next working day**, if not performed within the previous 2 weeks. If the ultrasound cannot be performed within this time frame**, consider offering the service user a, once a day cCTG**, until such time the ultrasound has been performed. A Radar incident should be performed on each occasion a ultrasound cannot be performed in the timeframe suggested.

Please not that it the reason for the urgent USS needs to be clearly documented on the urgent request as **"next working day recurrent RFM"**.

If scan normal: the sonographer can send the pregnant person home. Refer to Fetal Growth Ultrasound SOP.

If scan abnormal: refer USS report and/or pregnant person to Triage. Refer to Fetal Growth Ultrasound SOP and Fetal growth assessment Guideline.

- Same day review and discussion with on call Consultant in ADAU
  - Discuss findings with woman.
  - Implement plan of care.
  - Document rationale and plan of care
- CTG surveillance in ADAU may be required, depending on the scan results and on call consultant's assessment.
- All visits should have clear documentation of appraisal of CTG / investigations, actions taken, and plan of care recorded in the electronic maternity records (eCare).

3.1.6 Abnormal Antenatal CTG

- Transfer to labour ward if safe to do so.
- Urgent review by Obstetric Consultant or Registrar who will determine and discuss further action and plan of care
- May need to expedite birth
- Discuss findings with woman.
- Implement plan of care as directed by Consultant.
- Document rationale and plan of care.

If at any time there is any concern regarding fetal wellbeing, request URGENT obstetric review and transfer to labour ward for ongoing care.

3.2 Second and subsequent presentation for Reduced Fetal Movements >26 weeks defined as "*two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation".*

- Repeat assessment for reduced fetal movements as outlined in section 3.1.3
- Refer for emergency growth scan, to be performed by the next working day if not had scan in previous 2 weeks
- Referral, review and plan of care by Consultant or Senior Registrar.

The AFFIRM study, published September 2018 (*Awareness of fetal movements and care package to reduce fetal mortality*) was a stepped wedge, cluster-randomised trial using a package of interventions with strategies for increasing pregnant women's reporting when they perceived RFM, combined with a management plan to identify and minimize further risk, including early delivery where relevant. This trial did not reduce the incidence of stillbirth at or beyond 24 weeks' gestation or perinatal mortality***. The intervention increased the frequency of labour induction and birth by caesarean section and prolonged neonatal unit admission period.***

The decision whether or not to induce labour at term in a woman who presents with recurrent reduced fetal movements when the growth, liquor volume and CTG appear normal must be made after careful Consultant-led counselling of the pros and cons of induction on an individualised basis.

It is important that women presenting with recurrent reduced fetal movements are informed of the association with an increased risk of stillbirth. In accordance with the recommendations of SBLCBv3, **women should not be offered induction or caesarean earlier than 39/40 in the absence of other pathology because of the established risks to the neonate associated with delivery at this gestation and the absence of clear evidence that intervention is of benefit.**

3.3 Informed Choice

Explanations and discussion with a woman should include:

- Promote awareness and importance of fetal movements.
- Encourage daily focus on nature and frequency of fetal movements.

- Explain and discuss the increased risk factors of recurrent reduced fetal movements and the associated complications to include:
  - Fetal growth Restriction, preterm birth, severe neonatal compromise or demise, immediate admission for observation, induction or emergency delivery

3.4 Information and education regarding normal activity

Education

a) All antenatal women will be given an information leaflet (*Tommy's and NHS England, 2020 Feeling your baby move is a sign that they are well see appendix 1)* on normal fetal activity at booking. This will provide women with evidence-based information on variations and encourage them to develop an increased awareness of fetal activity.
b) Formal enquiries about fetal movements will be made and documented at each antenatal visit from 26 weeks gestation.

3.5 Rationale for main recommendations

There is much controversy about supporting evidence for the clinical significance of monitoring reduced fetal movements. This guideline will enable a woman to take control of her pregnancy and assess activity on an individual basis enabling the selective use of technology.

4.0 Statement of evidence/references

NHS England (2019) *Saving Babies' Lives Version Two: a care bundle for reducing perinatal mortality.* [Online]. [s.l.]: NHS England. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/03/saving-babies-lives-care-bundle-version-two-final-version-4.pdf [Accessed 17 Aug 2022]

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Royal College of Obstetricians and Gynaecologists (2011) Reduced fetal movements. [Green-top guideline No.57]. [Online]. [s.l.]: RCOG. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_57.pdf [Accessed 17 Aug 2022]

Note: The second edition of this guideline is currently in development (as advised at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/) [Accessed 17 Aug 2022]

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Armstrong-Buisseret, L., Mitchell, E., Hepburn, T., Duley, L., Thornton, J.G., Roberts, T.E., Storey, C., Smyth, R. and Heazell, A.E.P. (2018) Reduced fetal movement intervention Trial-2 (ReMIT-2): protocol for a pilot randomised controlled trial of standard care informed by the result of a placental growth factor (PlGF) blood test versus standard care alone in women presenting with reduced fetal movement at or after 36+ 0 weeks gestation. Trials 19:531 https://doi.org/10.1186/s13063-018-2859-1

Alfirevic, Z., Stampalija, T. and Dowswell, T. (2017) Fetal and umbilical Doppler ultrasound in high-risk pregnancies. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD007529. DOI: 10.1002/14651858.CD007529.pub4. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007529.pub4/full

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
9	**August 2022**	**Melissa Coles and Faryal Nizami**	Reviewed and updated
9.1	New Evidence approved 25/02/2022	By Katie Selby, Qualiuty and Risk Lead Midwife	Any absence of, or sudden change in fetal movements should be referred to maternity triage regardless of risk factors
9.2	SBLCBV3 November 2023	Authors, Katie Selby, Alex Fry	Added definition of recurrent RFMs, added management of recurrent RFMs to include USS reccomentations

5.2 Consultation History

Include staff in consultation who will be required to ensure the Guideline is embedded. This table should be completed in full even if no comments are received

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Maternity staff	Maternity	26/09/2023	02/09/2023	Comments to remove requiring CTG from 26 weeks for rFMs. Changed to 'consider'	Yes
Women's Health Review Group	Women's Health	04/10/2023	04/10/2023	To revisit management of when scan is required by, as well as offering cCTGs in cases where this cannot be achieved. To come back to next month's review group	Yes
Women's Health Review Group	Women's Health	01/11/2023	01/11/2023	Approved	

5.3 Audit and monitoring

How will compliance of this Guideline be evidenced?.

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Percentage of service users attending with recurrent RFM who recommended emergency ultrasound are as stipulated in the guideline, but who do not receive this by the end of the next working day	RADAR	Maternity risk and governance team	As per event	*
1.Percentage of women over 28+0 weeks of gestation in whom history confirms RFM having a CTG to exclude fetal compromise 2.Percentage of women having ultrasound scan assessment as part of the preliminary investigation of women presenting with confirmed RFM if the perception of RFMpersists despite a normal CTG or if there are any additional risk factors for FGR/stillbirth. 3.Percentage of women presenting with recurrent RFM referred for a growth scan and liquor volume assessment.	SBL3 Audit tool	ADAU lead midwife	Quarterly	Governance meeting

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	**Women and Children's Health**	**Department**	**Maternity**
Person completing the EqIA	**Melissa Coles**	**Contact No.**	**86482**
Others involved:		**Date of assessment:**	**17/08/2022**
Existing policy/service	Yes	**New policy/service**	**No**

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be effected?	All maternity staff

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	Yes	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	**Email**
How are the changes/amendments to the policies/services communicated?	**Women's Health Guideline Review Group minutes, monthly memo CSU meeting**
Review date of EqIA	