EACH BABY COUNTS reports on labour-related harm

each baby COUNTS.

Sands
Stillbirth & neonatal death charity

Each Baby Counts (EBC) is a national project from the Royal College of Obstetricians and Gynaecologists (RCOG). It aims to halve the number of babies who reach the end of pregnancy but die or are left with a brain injury as a result of something that happens during labour, by 2020.

Now in its second year, EBC focuses on assessing the hospital reviews of care for babies who died or were brain injured at term to see if anything can be learned. Independent experts check the quality of the reviews and pick out common themes of care that could have been better.

By doing this, the EBC team can make recommendations to improve care for both mother and their babies across the UK.

Key findings from the Each Baby Counts report, June 2017

(on babies who were brain injured or died in 2015 at term)

- 282 babies died during labour or shortly after as a result of something that happened in labour (at 37 weeks' gestation or more)
- A further 854 babies suffered a severe brain injury during labour
- For 1 in 4 babies, the hospital's review of care was either too poor to understand what happened or the hospital did not provide a review
- For 3 out of every 4 babies that did have a review that could be assessed by Each Baby Counts experts, at least one expert felt that different care might have saved the baby's life or prevented harm
- Only 1 in 3 families were invited to be involved in the hospital's review of their care
- When a baby was born alive, 1 in 3 reviews of care did not ask the opinion of a neonatologist (a doctor specialising in the care of newborns)

Sands role in Each Baby Counts

The Each Baby Counts project was established in 2014 by the RCOG in response to Sands' campaigning work to reduce stillbirths, focussing on term labour-related harm as the most avoidable group of baby deaths.

We are on the Independent Advisory Group for the project, putting forward parents' views and experiences. We contribute to the reports, writing about parents' involvement in reviews in 2016 and a parent commentary in 2017.

What next?

A new national tool, the Perinatal Mortality Review Tool (PMRT) for carrying out good-quality hospital reviews is being developed. This comes from work led by the Sands and Department of Health England on reviewing care and we are part of the team developing the PMRT. It will be available, for free in Scotland, Wales and England, by the end of 2017.

Find out more: **www.npeu.ox.ac.uk/pmrt/programme**

Each Baby Counts will publish a report with fuller details about the cases that were reviewed in 2015 and the recommendations, later in 2107. In 2018 they will report on cases from 2016, drawing out more themes.

Find out more: **www.rcog.org.uk/eachbabycounts**

What does Each Baby Counts recommend?

Babies were affected by poor monitoring in labour. Women and babies need the right monitoring method for their level of risk. Risks can change, sometimes quickly

There were problems both with intermittent auscultation (listening to the baby's heart rate with an ear trumpet) and continuous cardiotocography (CTG) (recording the baby's heart rate using ultrasound).

- Staff need to re-assess risk when a woman is admitted to hospital in labour, and make regular checks to re-assess the risks as labour continues, to inform which kind of monitoring is needed
- Staff who monitor women using CTG should have annual training in how to interpret the CTG results
- Decisions about care should be based not only on CTG results but on all the information about the mother's health and how she and her baby are coping.

When a baby needed neonatal care following delivery it wasn't always properly provided

- Staff need to get better and faster at telling the specialist paediatric or neonatal team all the important information about a baby who might be unwell at birth
- The care for babies who are cooled (brain cooling therapy after birth helps limit brain damage) needs to improve

Staff had problems coping with difficult situations, with their behaviour and the way they interacted with each other contributing to mistakes. Sometimes stress and tiredness play a part

- Staff need to keep aware of the whole situation for a woman in labour, and not get too focused on one aspect of care or overlook important information
- Staff should be able to seek advice from colleagues outside the situation and a senior staff member should always have an overview of what's happening
- For complicated deliveries, when care is moving between different teams of staff, there should be short meetings of team leaders to make sure everyone understands what they should do.

The report repeated recommendations in EBC's 2016 report to improve local quality-of-care reviews after a baby dies or is harmed

- Every baby's care should be investigated robustly by a team that includes staff from different professions (midwives, doctors, anaesthetists etc.), with staff given time off from normal duties so they can take part
- Parents should be told that a review is taking place and invited to take part if they would like to
- Reviews should involve a healthcare professional from outside the team/Trust who can give an independent perspective
- Reviews should spend more time looking at problems with systems (the way things are done in the Unit/Ward) than at individual staff.

What Sands says

Lessons must be learned when things go wrong. The babies covered by this report had gone through a full pregnancy and suffered harm or death during labour – something that should never happen. Yet too often there was no evidence of a thorough review or investigation to show where improvements were needed. For more than 25% of the Each Baby Counts babies, the expert assessors couldn't tell anything about the quality of the care the mum or baby received because information from the hospital simply wasn't supplied or was of such poor quality no assessment could be made. Sands believes there needs to be a cultural shift in taking these tragedies more seriously.

Only a third of families were invited to contribute to the hospital's review. Sands has long called for parents' views and thoughts about their care to be central to the review process: the parents are the only people who are there throughout. They have a valuable part to play in vividly recalling events directly affecting them.

Each Baby Counts also found that investigation reports tended to blame individual staff members, rather than identify what might be improved in the wider system or delivery of care. Cases of professional misconduct must be dealt with seriously, but mistakes are more likely if staff are too busy, tired or stressed. It's vital Trusts and Health Boards provide adequate time and resources so staff are supported to do their jobs safely.