MBRRACE-UK confidential enquiry 2017 into babies who died as result of something happening in labour

A confidential enquiry looks for common themes where care can be improved. The last MBRRACE-UK confidential enquiry looked in detail at babies who were stillborn before labour began close to their due dates in 2013. This confidential enquiry looked at babies who were stillborn or died shortly after birth after 37 weeks of pregnancy, as a result of something that happened during labour or birth. The babies in this confidential enquiry died in 2015.

For the enquiry, panels of clinicians, including midwives, obstetricians, neonatologists and pathologists reviewed the medical notes of 78 mothers and babies, and compared them with national guidelines describing the care that is expected in the NHS. The panels were looking to understand what had happened and if guidelines had been followed. They looked for common errors or difficulties that may have contributed to the babies' deaths. And they assessed the quality of care the mother received after the baby had died.

To see the full report go to: http://bit.ly/2A8umKs

Key findings – preventing the death

The panels found that the deaths of 8 out of 10 babies might have been prevented with better care. In at least 1 in 4 cases inadequate staffing or resources was a factor; busy workloads were most common on the delivery suite

National guidelines during antenatal care were not followed for half of women, meaning opportunities were missed to care for them on the right pathway:

- 2 out of 3 women weren't offered carbon monoxide testing to identify if they smoked and could be referred to smoking cessation services
- 1 in 4 women didn't get proper screening to monitor their baby's growth
- 1 in 3 women who had concerns about their baby's movements were not properly followed up
- while most women with risk factors were screened for gestational diabetes, not all were cared for in a joint antenatal and diabetes clinic, meaning opportunities to monitor them were missed
- not all women who'd had a previous caesarean section were given the opportunity to make informed choices about their birth plan. Four mothers in the enquiry experienced a ruptured uterus during labour, resulting in their baby's death. In two of these cases, panels agreed that lack of discussion around risks for these women may directly have caused harm to both mother and baby.

In 7 out of 10 deaths there were problems in how labour or birth were managed, including:

- delaying the decision to induce labour when it was indicated
- recognising when a woman had moved from the early (latent) stage of labour to established labour
- intermittent and continuous monitoring leading to delays in making the decision to urgently deliver the baby
- difficulty for staff in being able to stand back, assess the situation clearly and make good decisions

In just over 1 in 10 deaths there were problems with resuscitation including:

- delays in finding the right staff
- confusion over the use of the Neonatal Life Support protocols

Key findings – learning by reviewing care

Although 74 of the 78 deaths were reviewed by the local hospital team, the quality of many reviews was poor:

- 9 out of 10 reviews didn't consider all factors that may have contributed to the death according to standards for serious incident investigations
- only 1 in 10 reviews for babies who died shortly after they were born included the perspective of a neonatologist
- only 2 reviews included the input of a pathologist, a doctor specialising in post-mortem investigations
- only 9 had an external reviewer to offer an independent analysis
- only 5 recorded that parents had been involved in the reviews in some way

Key findings – preventing further distress to bereaved mothers

For 1 in 2 bereaved mothers, care after her baby had died was considered poor enough to have affected her psychosocial wellbeing and any plans she might have had for a future baby, including:

- for some babies who died after birth, there was a lack of communication between the obstetric and neonatal units
- in half of the deaths of newborns, the absence of bereavement checklists in the medical notes meant it was hard to know if care was good or not. These checklists mostly did exist for babies who were stillborn
- some women had no documented follow-up care by community midwives
- it was not clearly documented that all health care professionals in the community had been informed of the baby's death, particularly health visitors who were only informed in under half of cases
- in the medical notes for 1 out of 3 women there was no documented evidence that a follow up meeting with their consultant took place
- in the medical notes for 2 out of 3 women there was no documented evidence that they received a letter summing up this meeting. If letters were sent, they were not always sensitively written.

Sands' role in the confidential enquiry

Sands supported the submission of this topic for enquiry to the MBRRACE-UK Independent Advisory Group (IAG). These deaths were thought to be a vital follow on from the previous enquiry into stillbirths of term babies before labour began. We sat on the enquiry panels as an observer and helped write the enquiry lay report.

What next?

In light of this report and many others showing that baby deaths at term are poorly investigated by NHS Trusts, the Department of Health has announced that in future all labour-related deaths, at term, as well as harm to babies during labour, will be independently investigated by England's Health Safety Investigation Branch. The DH is also proposing that the coronial law is extended to include any term stillbirth. A private members Bill around coronial law is getting a second reading in the Commons in February 2018. Before any change, however, there will be a public consultation which Sands will contribute to.

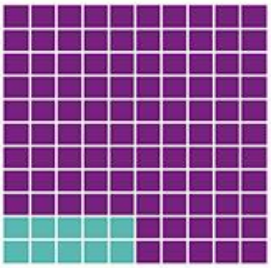
In the meantime, the Perinatal Mortality Review Tool, which will support high quality reviews of any stillbirth or baby death will be free to use in England, Wales and Scotland from 2018. This initiative to improve hospital reviews has emerged as a result of work initiated by Sands. Research with the Manchester and Bristol Universities PARENTS team, supported by Sands, will help develop an understanding of how parents might be sensitively engaged in the review process. For more information go to: www.npeu.ox.ac.uk/pmrt

When babies die at term as a result of something that happened during labour

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

1 in 20 stillbirths and deaths of babies within 4 weeks of birth is labour-related

In 80% of cases different care might have prevented the baby's death



In 1 in 4 deaths there were problems with adequate staffing and resources

What needs to be done to prevent future labour-related deaths

In at least a quarter of deaths there were problems with adequate staffing and resources to provide safe care		Adequate staffing and resources to support safe care, particularly on the delivery suite, needs to be addressed
Not all women with previous caesarean sections had clear discussions about their birth plan		Women with previous caesarean sections must have clear discussions about their birth plan so they can make informed decisions
There were problems recognising when a women moved from early to established labour		National guidance should be developed around managing the early stage of labour
Guidelines weren't followed when monitoring the baby's heart rate during labour, leading to delays when babies needed to be delivered urgently		Improvements in training for fetal monitoring and situational awareness are required for staff caring for women in labour
1 in 3 neonatal deaths had no post-mortem examination or placental histology		All families must be offered consent for post-mortem with written material provided to support their decision
9 out of 10 reviews of care didn't follow national guidance for serious incidents		Units should adopt the national Perinatal Mortality Review Tool and put aside time for training so that reviews can be carried out robustly

Awareness by Luis Prado, Business Presentation by Gan Khoon Lay, Error by Creative Stall, Group Discussion by Drishya, Microscope by Pedro Santos, Monitor by Astonish and Pregnant Woman by Robiul Alam, all from the Noun Project.

What Sands says

When care goes wrong

There are important messages for improvements that could be made to every aspect of care, from the antenatal clinic to the labour ward and neonatal unit. But while the need for better training and improved guidelines for monitoring women in labour are clear, the enquiry also highlights the fact that staff were working in busy units, where senior staff were not available and equipment was not always readily accessible.

Inadequate staff levels and resourcing contributed to at least 1 in 4 deaths, with strains felt most acutely on the delivery suite. It is not surprising that 'situational awareness' - the ability to stand back, assess a situation and make the right decision - was also highlighted as a significant issue. This finding echoes the Each Baby Counts Report 2017[1], which looked at avoidable harm and death in term babies due to events in labour, and found that 'situational awareness' was also a key factor.

Dr Clea Harmer says: *Reading the stories of women in this latest confidential enquiry is heart-breaking. All the mothers' stories contained in the report arrived at the unit with a baby who was alive, and close to being born. And yet sadly something went wrong. It is deeply worrying to hear that if care for 8 out of 10 of those mothers and babies had been better, the baby may have lived.*

While this report is full of immediate and practical messages and recommendations about how care might improve to save future lives, it is clear from its findings that lack of resourcing and staffing is at the core of the problem with a quarter of deaths being associated with inadequate resources and staffing levels. We support the report's call for this issue to be addressed by policy makers across the UK.

Learning lessons

The babies in the enquiry had gone through a full pregnancy and died during labour – something that should never happen. Yet too often, while reviews were done, there was no evidence that they were thorough enough to show clearly what had happened, give parents clear and honest answers as well as identify where improvements in care were needed for future parents.

In this report, as in so many other recently published on baby deaths most of the reviews did not include all the relevant health professionals, an external viewpoint, nor parents' own perspective of their care. Only 1 in 10 examined all the factors that might have contributed to the death, as outlined in standards for serious incident reporting. If lessons aren't learned when things go wrong, then future lives are potentially put at risk.

Dr Clea Harmer says: *The death of every baby is a tragedy for parents who will carry that grief in one form or another for the rest of their lives. While the report rightly points out that these deaths are rare and rates must be set against the backdrop of an increasingly complex pregnant population, we at Sands also know from parents that a culture of defensiveness exists within the NHS, of not taking every death as seriously as it merits and giving parents adequate answers.*

Sands therefore welcomes the proposal by the Secretary of State for Health to extend coronial powers to investigate stillbirths. Hospitals' internal review processes should involve parents and answer their questions about why their baby has died. But when those questions are not answered, we believe the coroner may play a vital role in providing answers, ensuring that lessons are learned and mistakes are not repeated.

But the inquest process will not be appropriate in many cases of stillbirth: coronial investigation into stillbirths should happen in close consultation with parents. In ensuring the rights of some bereaved parents it's important to avoid unintended negative consequences for other parents who may not want an inquest.

Taking on board the views of any public consultation before this law is adopted will be key to ensuring a clear pathway is set out for these investigations so that coronial processes, which can be extremely prolonged and painful for families, do not cause additional emotional harm to bereaved parents.

[1] Each Baby Counts full report on intrapartum-related death and harm in term babies can be found here: www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts-2015-summary-report-june-2017.pdf

Bereavement care and care after the baby had died

Every woman in this enquiry required bereavement support, the offer to consent to post mortem, care in the community when she went home, and feedback about the review of her baby's death. In some instances this was done well, but mostly care after the baby had died was variable.

The report recommends that Trusts and Health Boards work to improve bereavement care for parents. All parents should be offered the opportunity to consent to post mortem with clear written information to guide that decision. Sands has developed a post mortem consent package for both parents and professionals which is endorsed by the Human Tissue Authority and is available from our website www.sands.org.uk.

We have outlined what good bereavement care should like in our *Pregnancy Loss and the Death of a baby: Guidelines for professionals* currently in its 4th edition. We also provide a Sands Audit Tool for units to measure their care by. Along with several other baby charities, we are currently supporting the development of a National Bereavement Care Pathway which is being piloted in 11 sites across England. This will set out the standards for excellent care for all families whose baby or child dies. For more information go to: www.nbcpathway.org.uk

Clea Harmer says: *Good bereavement care is rooted in simple acts of kindness and respect, giving a family whose world has fallen apart the time they need with their baby, and minimising anything that could add to their suffering. We believe every parent should be offered the bereavement support they need, when they need it, for as long as they need it. It is long overdue that the NHS makes the provision of excellent bereavement care mandatory across the UK. Despite claims that it is a priority, there is still a shortage of dedicated bereavement rooms and too few health care professionals are getting the essential training they need to sensitively support grieving parents. One way to make this happen is for a National Bereavement Care Pathway to be included in the Government's Mandate to NHS England, and to ensure a similar approach is taken across the UK. I urge all those responsible to make sure no parent is left to cope with the death of their baby alone.*

Messages from this enquiry for pregnant women

- You should be offered carbon monoxide testing at your first antenatal visit. Even if you're not a smoker, carbon monoxide is a poisonous gas that may exist in your household, from a leaky boiler for instance, and may be affecting your health without your knowledge.
- If you have had previous complications in a pregnancy or a caesarean section this will be taken into account and may affect your birth plan. Your midwife or hospital doctor should discuss these with you.
- In a singleton, as opposed to a twin or multiple pregnancy, midwives should measure your abdomen to assess your baby's growth each time you go for an antenatal check-up after 24 weeks. The measurements should be plotted on a graph that will show the baby's progress. Your midwife can explain the graph to you.
- Your baby's movements are a sign of their wellbeing and your midwife should discuss this with you as your pregnancy progresses. If your baby's movements change, slow down or stop, call your maternity unit straight away. If you have reached 26 weeks' gestation, your midwife should arrange to give you a full antenatal check-up.
- Unforeseen problems can arise at any time in pregnancy. Should you develop problems you should be part of any decision making about how your pathway of care may change as a result. Some women, for instance, may be at risk of developing pregnancy-related diabetes. If you do develop gestational diabetes you should be cared for in a joint antenatal and diabetes clinic.

For more information about risks in pregnancy and what to be aware of please visit: www.saferpregnancy.org.uk

Messages for anyone supporting a woman and family whose baby has died

- All parents should be offered a post-mortem and be given written information about what it entails to support any discussion. A post-mortem may provide more information about why their baby has died and help them plan their future.
- If parents do not want a post-mortem, specialist pathologists should examine the placenta, as it may also provide important information.
- After discharge mothers should be offered on-going support from a midwife or health visitor. Health visitors and GPs should be notified of the death of their baby and any on-going investigations. Support in the community should be available for as long as parents want it.
- Events leading up to a baby's death should be reviewed by a multi-disciplinary group at the hospital to inform parents clearly about what happened. Parents should be told about the hospital review and given the opportunity to give their perspective or ask questions.
- Parents should be offered a follow-up appointment with a consultant obstetrician and/or neonatologist to discuss the conclusions of any review or post-mortem and to talk about a future pregnancy if they wish. This may be several months after the baby's death because of the complexity of information that needs to be gathered.

Find support services for families whose baby has died at any stage of pregnancy and early life via:
www.sands.org.uk/support-you/how-we-offer-support/useful-links-and-organisations