Highlighting lessons

When babies die before labour at term

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
Maternal Newborn and Infant Clinical Outcome Review Programme

Lay Summary 2015

Term stillbirths – how often in the UK?

One in 200 births ends in stillbirth

One in three stillbirths occurs at term (37+ weeks' gestation) when a baby has the greatest chance of surviving.

Every day around three families in the UK are devastated by the death of their baby at term before labour begins. By using confidential enquiries to review quality of care in a sample of term stillbirths, our aim was to identify if there were critical gaps in care and to suggest how babies' lives might be saved in the future.

Background

We selected a random representative sample of 133 normally formed babies from singleton pregnancies at term who were stillborn in 2013. The pregnancy notes were assessed for all 133 and 85 were reviewed in detail against national care guidelines by a panel of clinicians, including midwives, obstetricians and pathologists.

Based on the information recorded in the medical notes, the panels reviewed the antenatal care women received to understand where improvements in care could be made. They also assessed the quality of care the woman received around the confirmation of her baby's death as well as in labour and postnatally, as this may have affected her psychological wellbeing and future fertility.

MBRRACE-UK is a team of researchers, clinicians and charity representatives.

The lay report was written by Charlotte Bevan. Writing group members included:
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University of Oxford · HQIP Healthcare Quality Improvement Partnership · University of Leicester · TIMMS · University of Birmingham · Sands Stillbirth & neonatal death charity · UCL · NHS Bradford Teaching Hospitals NHS Foundation Trust · npeu National Perinatal Epidemiology Unit

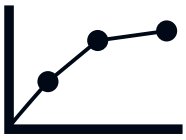
Findings: Antenatal care

The panels found that in half of the term stillbirths there were critical gaps in care. Poor record keeping meant that women were described as low risk when they weren't. Opportunities were missed in three main areas:

Diabetes: around half of the women had at least one risk factor for developing diabetes in pregnancy – mainly women who were obese or from a high risk ethnic group - but two out of three of these women were not offered testing.

Missed Opportunity: Developing Diabetes in Pregnancy

- Glucose tolerance testing not offered in cases with an identified risk factor and so there was no opportunity for closer monitoring



Poor growth of the baby in the womb: in nearly two thirds of cases reviewed national guidance for screening and monitoring the growth of the baby was not followed.

Missed Opportunity: Monitoring Growth

- Woman's abdomen not measured to check how her baby was growing
- Measurements not plotted on a graph
- Woman not referred for closer monitoring when the baby's growth didn't follow a normal pattern

Baby's movements: almost half the women had contacted their maternity units concerned that their baby's movements had slowed, changed or stopped. In half of these there were missed opportunities to potentially save the baby.

Missed Opportunity: Identifying Reduced Fetal Movements

- Not investigating when a woman presents with concerns about her baby's movements
- Misinterpreting the fetal heart trace
- Not responding appropriately to additional risk factors, including the woman returning with further concerns about her baby's movements

Findings: Investigations to understand why the baby died

Maternal: there was wide variation as to whether all the nationally recommended tests, that might indicate why the stillbirth had occurred, had been offered to women before they were discharged.

Baby: In one in three stillbirths there was no record of whether the parents had been offered a post mortem or not; only half of the babies had a post mortem.

Placenta: One in five stillbirths had no placental examination undertaken by a pathologist.

Where carried out post mortems and placental examinations were of good quality.

Local review of care: the panels found that for three quarters of stillbirths there was no evidence in the notes that a local review of the care had been carried out. Where a review had been done very few followed standards set out in national guidance or involved parents' views of their care. All stillbirths should be reviewed to understand whether the quality of care was associated with the baby's death and to put actions in place to prevent this happening in the future.

Standards for local review (Department of Health and Sands)

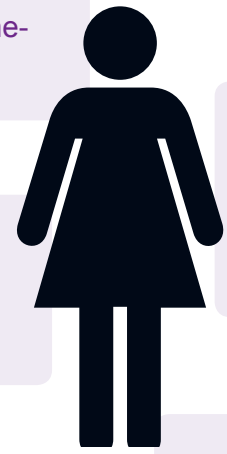
- Multidisciplinary
- Offer parents the chance to give their perspective of care received
- Classification of the cause of death
- Grading the quality of care
- Root cause analysis
- Development of an action plan to improve future care, defining responsibilities and timings
- Evidence of organisational learning
- Results fed-back to parents

Findings: Confirmation of the baby's death and the woman's subsequent care

The death of a baby around birth is devastating for parents and a challenging area of care for all health professionals. The charity Sands has outlined standards for bereavement care so that health professionals can support families. Women also need follow up midwifery and obstetric care. The panels reviewed all these areas and found that for two out of three women care could have been improved.

Care in labour: one in four stillbirths had major issues related to the woman's labour, particularly in relation to monitoring progress, resulting in prolonged labours for some women. Most women received one-to-one midwifery care in labour.

Language difficulties and barriers: a number of women needed the support of interpreting services but only half received it.



Breast milk suppression: for half of women there was no record that there was a discussion about how to stop the production of breast milk.

Bereavement care: for three out of four women and families bereavement care was of a high standard.

Follow-up letter: only two thirds of women received a follow up letter summarising what was said at their consultant appointment. These letters were sometimes worded insensitively.

Follow-up care: in almost half of cases there was no record of continuing midwifery support once the woman was discharged from hospital.

Messages from this enquiry for all pregnant women

This enquiry shows that there were critical gaps in care which if improved might save babies' lives in the future.

- After 24 weeks, at each antenatal check-up, midwives should assess your baby's growth. The measurements should be plotted on a graph that will show the baby's progress. The graph should be explained to you.
- If you have risk factors for developing diabetes during pregnancy you should be offered a test to see if you have diabetes and if you do then you should be offered closer monitoring during your pregnancy.
- If your baby's movements change, slow down or stop, call your maternity unit straight away. From 26 weeks' gestation, your midwife should arrange for a full antenatal check-up.

You have a higher chance of developing diabetes in pregnancy if you:

- are overweight
- had a previous baby weighing 4.5 kg (10 lbs) or more
- have a history of diabetes in pregnancy
- have a family history of diabetes
- have an ethnic family origin with a high risk of developing diabetes

Messages from this enquiry for women whose baby has died

When a baby dies before he or she is born, women are often alarmed to be told that the safest option for them and any future pregnancy is to plan to give birth vaginally. The support you have in labour should not be any different to women having a healthy baby and you should be monitored to check progress.

- You should be offered a post mortem and written information about what it entails. This may give more information about why your baby died and help you plan the future.
- If you do not want a post mortem, specialist pathologists should still examine your placenta, as it may also provide important information.
- Before you are discharged you should be offered tests, as these might help explain why your baby died and monitor your health.
- After leaving hospital you should be offered on-going support from a midwife or health visitor to ensure you are recovering physically and emotionally. This care should continue for as long as you need. Your health visitor and GP are also there to provide you with ongoing support, and may be able to refer you to local bereavement services.
- A multidisciplinary team at your maternity unit should review all the care you received against national standards. The staff should ask your views of your care and you should be offered a summary of the findings.
- You should be offered a follow-up appointment with a consultant obstetrician, between 6 to 12 weeks after your baby died, to discuss what happened. Any results should be available at this appointment and these should be clearly explained to you. You will have the opportunity to discuss future pregnancies if you so wish.
- After the follow-up appointment both you and your GP should receive a letter summarising the meeting and the support available.

For further information about stillbirth and risks associated with stillbirth go to the NHS Choices website at: www.nhs.uk/conditions/Stillbirth. If you or your partner aren't happy with how you are being cared for ask to see a more senior midwife or doctor. Support services for families whose baby has died at any stage of pregnancy and early life are available at www.uk-sands.org and www.bliss.org.uk