

Learning From Stillbirths

A Brief Summary of The Thematic Stillbirth Category Report

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1. What Did We Do?

To experience a stillbirth during pregnancy or birth is thankfully rare, but for those women and families who are affected, the consequences can be traumatic, far reaching and long term. This briefing note summarises the most recent thematic report published by the Independent Maternity Services Oversight Panel. This is the Panel's second thematic report and it focuses on the care of mothers and their babies who sadly, were stillborn. It highlights the key findings and lessons learnt from the clinical review of 63 individual episodes of care which were provided by the Health Board to 58 mothers, mainly between 01 January 2016 and 30 September 2018.

3. Why Did We Do It?

When the Royal Colleges produced their report in 2019, they said that there should be an independent programme to review the maternity and neonatal care provided by the former Cwm Taf University Health Board and that women and families should be placed at the heart of this process. The aim is to ensure that lessons are learned which would prevent the things that went wrong from happening in the future and to provide answers, if those answers exist, for women and their families.

4. How Did We Do It?

Each of the 63 episodes of care were reviewed by an independent team of obstetricians, midwives and other health professionals. They looked at the care given to see whether it was appropriate and met national standards. They then prepared a report to identify any 'modifiable factors' – in other words, things which could or should have been done differently - and assessed the impact of those factors on the eventual outcome for mothers and their babies.

2. Stillbirth: The Facts

A stillbirth is the death of a baby that happens before or during birth once a pregnancy has reached 24 weeks. An 'ante-partum' stillbirth is a baby delivered after 24 weeks who was known to have died before the start of labour; an 'intra-partum' stillbirth is a baby delivered after 24 weeks showing no signs of life but was known to have been alive at the start of labour. In the Cwm Taf Morgannwg University Health Board area, the stillbirth rate is around 1 in 300 births and in Wales as a whole it is around 1 in 250 births. The absolute stillbirth rate across the United Kingdom as a whole is around 1 in 285 births. Unfortunately, women from Black or Asian communities are at increased risk of their baby being stillborn as well as those in the most deprived areas.



WANT TO KNOW MORE?



THEMATIC REPORT

The Panel's full report can be accessed [here](#) from 05 October 2021 onwards.



HEALTH BOARD RESPONSE

The Health Board has published a response to the Panel's report. It can be accessed [here](#) from 05 October 2021 onwards.

Please Note. The detailed analysis which supports the conclusions in this document is contained within the full thematic report which can be accessed via the link above.

Learning from Stillbirths

Key Findings

5. What Did We Find?

- In a third of the episodes of care which were reviewed, major modifiable factors were identified which may have contributed to the stillbirth;
- At least one minor modifiable factor was identified in nearly three out of five episodes of care reviewed, although those factors did not contribute to the stillbirth;
- In three quarters of episodes of care, there was wider learning which can be shared to improve maternity care;
- There was no learning identified in 4 of the 63 episodes of care which were reviewed.

Quality of care was assessed by multidisciplinary clinical review teams



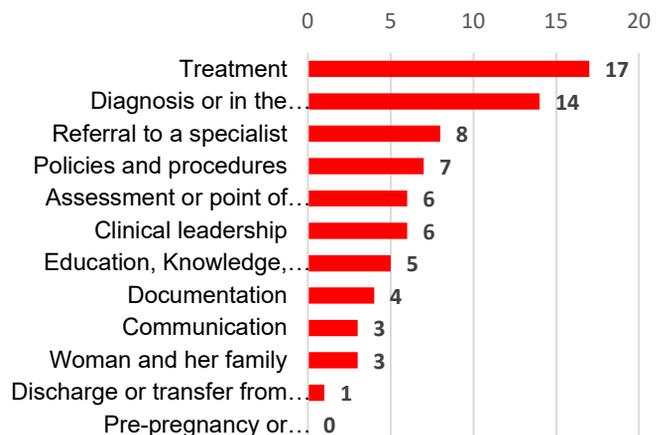
Most Common Clinical Scenarios Which Were Not Recognised or Not Acted Upon:

- Fetal growth restriction;
- Reduction in fetal movements;
- Abnormal fetal heart rate monitoring;
- Raised blood pressure;
- Cigarette smoking.

Most Frequently Reported Major Modifiable Factors:

- Incorrect **diagnosis and/or the recognition of high-risk problems** was identified as a major modifiable factor in over 14 (22%) of reviews;
- The **treatment** provided was identified as a major modifiable factor in 17 (27%) of the episodes of care reviewed;
- **Clinical leadership** was often identified as an issue where there were major modifiable factors.

Major Modifiable Factors Identified - By Theme:





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Key Findings

Inadequate and/or inappropriate treatment and the failure to diagnosis a high-risk problem were the factors most often associated with a poor outcome.



The most common high risk factors which were not acted on appropriately were fetal heart rate and/or fetal growth.



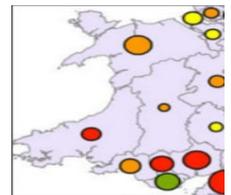
More effective action to reduce the adverse impact of smoking and raised blood pressure could often have reduced the risk of stillbirth.



Most modifiable factors occurred in the antenatal period; in over 50% of the episodes of care, antenatal care was assessed as being of poor quality.



Opportunities to improve stillbirth rates should be explored by the Health Board based on evidence elsewhere in Wales and the United Kingdom.



Clinical guidelines were not always in place and where they were, they were not used consistently.



Over a third of the episodes of care were not reviewed by the Health Board as expected; where reviews were undertaken, they were not always of a high quality.





6. Listening to Women and Families

20 women and families shared their stories and from those, five common themes were identified:

- Monitoring, missed opportunities and escalation;
- Failure to listen to and value women's concerns;
- Diagnosis and/or response to high risk status;
- Staff attitudes and the use of language;
- Bereavement support and care after birth.

"My fear is that we will share our stories and nothing will happen as a result and we will be slowly forgotten about. This has opened old wounds and we hope that it will result in change."

"We were just given books and leaflets on bereavement. No one sat and talked to us."

"We had no say as our wishes were always overruled by staff."

"This was even though I told him again that I did not feel right and therefore that I was uncomfortable with his decision. They did not take my concerns on board at all and I was left with the decision that they made."



NEED TO TALK TO SOMEONE?



We know that technology is no substitute for a one to one conversation so if you have any questions or concerns that you would like to discuss with a member of the Panel or someone from the Health Board, please contact us. You can leave a message on our mailbox OversightPanelMaternity@gov.wales or contact the Health Board on 01685 728741. The helpline is staffed 09:00-17:00 and a voicemail option is available out of hours. We will get back to you so that we can contact you in the best way that meets your needs. All contact will be completely confidential.

