Deaths during childbirth reduced by half

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In their latest report a team of academics, clinicians and charity representatives, called MBRRACE-UK, has looked at the quality of care for stillbirths and neonatal deaths of babies born at term who were alive at the onset of labour, singletons (sole births) and who were not affected by a major congenital anomaly. This type of death occurred in 225 pregnancies in 2015 in the UK. It is important to study the deaths of these babies as any normally formed baby who is alive at the onset of labour at term would be expected to be alive and healthy at birth.

A random representative sample of 78 of these babies who were born in 2015 was selected. The care provided for these mothers and babies was reviewed in detail against national care guidelines by a panel of clinicians, including midwives, obstetricians, neonatologists, neonatal nurses and pathologists who considered every aspect of the care.

Professor Elizabeth Draper, Professor of Perinatal and Paediatric Epidemiology at University of Leicester said: "The premise of the enquiry was that these babies would be born alive and healthy. Findings from the panels indicated that improvements in care may have made a difference to the outcome for almost 80% of cases.

"The main issues identified were care before labour was established including induction, monitoring during labour, delay in expediting birth, heavy workload of the units, a lack of joint obstetric and neonatal input into bereavement care and a lack of rigour in the local review of the deaths."

Main findings from the expert enquiry included:

- 'service capacity' affected over a fifth of the deaths reviewed.
- heavy workload contributed to delays in induction in one third of cases being induced
- there was a significant delay in both the decision to expedite the birth and in actually achieving birth in approximately a third of the deaths reviewed.
- there was a failure to recognise the transition to the active phase of labour and to institute appropriate monitoring in one-eighth of cases
- there were errors in the method, interpretation, escalation and response to fetal monitoring during labour.

  * two fifths of babies had intermittent auscultation. This was not compliant with national guidance in a third of cases in the first stage of labour and a quarter in the second stage.

  * continuous electronic fetal monitoring was not commenced in a quarter of cases where abnormalities were detected by intermittent auscultation

  * there were delays in referral in nearly half of cases where escalation was required

- for most cases resuscitation was delivered effectively by clinical staff present at the delivery based on the Neonatal Life Support programme
- overall the quality of bereavement care was variable, with a lack of joint obstetric and neonatal input
- although the majority (95%) of intrapartum-related deaths were reviewed, many of the reviews were lacking in quality. Review should be undertaken using the 'Serious Incident Framework'

which should include review of contributory factors / root causes.

Professor Sara Kenyon, Professor of Evidence Based Maternity Care at the University of Birmingham and joint author of the report said "While fewer babies at term die after care in labour starts than previously, this report has identified that there remain problems with the quality of care. The recommendations for improvement in service provision and local review of the death, the development of new national guidance and of training for staff provide an opportunity to reduce this further. The forthcoming introduction of a national standardised tool to support staff reviewing perinatal death in their Trusts is an important step forward. If we learn the lessons and implement the changes the report has highlighted, the numbers of babies like this that die should reduce."

Professor Jenny Kurinczuk, Director of the National Perinatal Epidemiology Unit and National Programme Lead for MBRRACE-UK said: "The mother of a baby at term who is alive when care in labour starts quite reasonably expects to be safely delivered of a healthy infant. Sadly we know that for about 225 parents each year the outcome will be rather different. Some of these babies will die despite every possible effort of the staff involved in caring for the mother. However our report also highlights that for about four-fifths of the deaths reviewed there were areas for improvement in care which may have made a difference to the outcome for the baby. Importantly the findings of the report provide a blueprint for improvements which are likely to reduce serious complications in newborn babies as well as reducing the number of babies who die, provided that we learn the lessons and implement the changes which the in-depth review of these deaths has highlighted."

More information: Read the full report 'MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death' at: oxfile.ox.ac.uk/oxfile/work/ex …d=51617712C089CB0839

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