UK Report: Recommendations for reducing inequities, improving care for babies of Asian and Black mothers

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The MBRRACE-UK collaboration, which is co-led by The Infant Mortality and Morbidity Studies (TIMMS) group at the University of Leicester and Oxford Population Health's National Perinatal Epidemiology Unit (NPEU), has today (Dec. 14) published the results of a confidential inquiry into the care of Black and Asian babies born in the U.K. in 2019.

The report, which is compiled using anonymized medical notes, builds on the annual Perinatal Mortality Surveillance reports into babies who die before, during, or shortly after birth. Although the overall proportion of babies who die has reduced over the past five years, there are still big differences in the proportion of babies from different ethnic groups who are dying.

Among all ethnic groups, Black babies now have the highest mortality rates and are twice as likely to be stillborn or die within the first 28 days after birth. Asian babies are more than one and a half times more likely to be stillborn or die within the first 28 days after birth when compared with white babies.

This inquiry looked at the pregnancies of 34 Asian women, 36 Black women, and 35 white women where the baby was stillborn or died within 28 days of being born. The aim of this inquiry was to review the quality of care, as it was recorded in the medical notes, and to find out whether different care may have made a difference for the baby and the mother.

The care the babies and their mothers received was compared with care outlined by national guidelines for best practice, assessed by a group of clinical experts. The inquiry also compared the care given to Asian and Black women with the care given to white women.

The clinical experts looked at whether the care the babies received may have contributed to the babies' deaths. They also looked at the quality of

emotional and psychological help and support provided for women, both during pregnancy and when their baby died. This included the offer of a post-mortem and the quality of local hospital death reviews to understand why the baby died.

This inquiry could only look at what was written in the medical notes, meaning that experts could not take into account things that aren't generally written down such as how care staff spoke to women or how they behaved. As the medical notes are anonymized, the experts also couldn't get feedback from the families involved.

A separate report was also published today (14 December) by the U.K.'s leading baby loss charity Sands. The Listening Project report highlights barriers, biases and poor care that may be contributing to inequalities in baby deaths in the U.K. Sands' report ensures that the voices of bereaved Asian and Black parents are heard alongside learning about clinical care.

Key findings:

- For all three groups of women, high quality care was found in a minority of baby deaths which were reviewed. Many deaths may have been prevented with better care;
- For Asian women, in around one in four baby deaths, the care was assessed as poor. For Black and white women the care was poor in around one in two baby deaths. If care had been better, it may have prevented the baby from dying;
- Women's ethnicity, nationality, and citizenship status was not always correctly recorded in the notes, and professional interpreters were not always provided when a woman's first language wasn't English. This may have made it harder for clinicians and care staff to provide the personalized care that the woman needed;
- Some women faced challenges in their personal lives that were

not always recognized or taken into account when planning their care. This meant that some women didn't receive the additional support they needed. These challenges were more common for white women than for Asian or Black women, but language barriers may have made recognizing these challenges more difficult in Asian women.

- For around three in five mothers, care after their baby died was assessed as poor. If it had been better, it may have meant that bereaved mothers were likely to be better supported in terms of physical and emotional health;
- Almost all deaths were reviewed by the hospital using the Perinatal Mortality Review Tool (PMRT), but many reviews were carried out by only one doctor or midwife, instead of a group, or by a small group without enough of the right specialists. Parents were given the opportunity to ask questions and say how they felt about the care they received, but they were not always answered by the review group. Most parents didn't have any questions, especially if their first language wasn't English.

The report has set out a series of key recommendations for clinicians and health care providers to address these findings and improve the care of all mothers and babies. The recommendations center around planning and personalizing maternity care around each woman's specific needs and that women should be helped to overcome any problems that make it hard for them to get the care that they need, such as asking all women about their ethnicity, nationality, and citizenship status, and providing translated information and interpreters at every appointment if required.

The report also makes recommendations for offering family-centered bereavement care when a baby has died and that parents should be supported to ask questions and talk about their experience as part of a hospital review process to ensure that they receive answers about why

their baby died.

Elizabeth Draper, professor of perinatal and pediatric epidemiology at the University of Leicester, said "This confidential inquiry has identified a number of areas where care inequities are experienced by Black and Asian mothers in the U.K. The provision of personalized care for all pregnant women and their babies, as well as improvements in communication and information provision, are urgently needed and we hope that the recommendations set out by the report are widely adopted and adhered to."

Clea Harmer, Sands' chief executive, said "The Sands Listening Project and MBRRACE-UK confidential enquiries provide powerful insights and evidence that can help reduce inequalities in maternity safety. The voices of bereaved parents were instrumental in backing our call on the Government to fund the confidential inquiry into Asian baby deaths, alongside the confidential inquiry into Black baby deaths, in the U.K.

"Sands is committed to ensuring that the voices of Black and Asian bereaved parents, as well as those from other minoritized groups, are heard and acted upon. Listening to parents saves babies' lives and the Government and NHS must act on the recommendations from both these confidential enquiries and our Listening Project report."

More information: MBRRACE-UK Perinatal Confidential Enquiries reports. timms.le.ac.uk/mbrrace-uk-peri … fidential-enquiries/

The Sands Listening Project report. www.sands.org.uk/sites/default … ing_Project_2023.pdf

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