

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



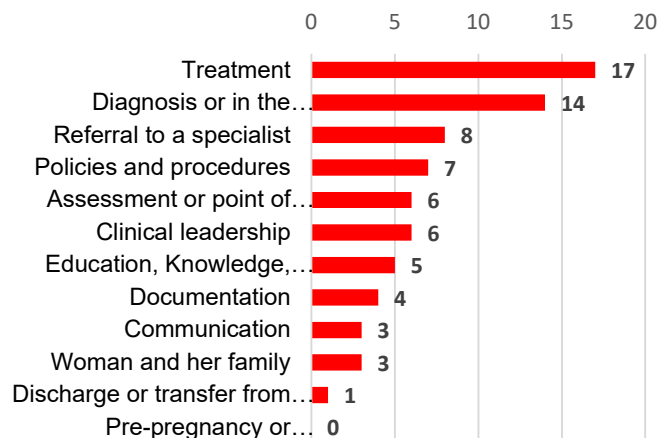
Most Common Clinical Scenarios Which Were Not Recognised or Not Acted Upon:

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



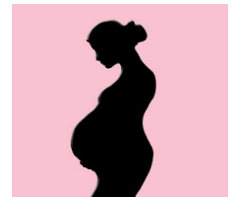
The most common high risk factors which were not acted on appropriately were fetal heart rate and/or fetal growth.



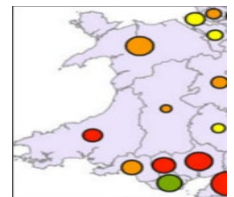
More effective action to reduce the adverse impact of smoking and raised blood pressure could often have reduced the risk of stillbirth.



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.

