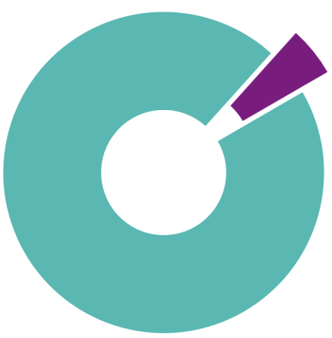
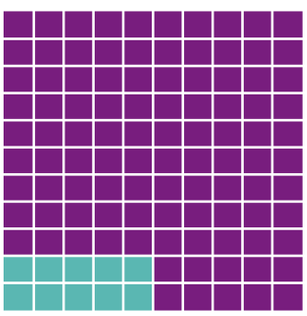
When babies die at term as a result of something that happened during labour

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

1 in 20 stillbirths and deaths of babies within 4 weeks of birth is labour-related



In 80% of cases different care might have prevented the baby's death



In 1 in 4 deaths there were problems with adequate staffing and resources

What needs to be done to prevent future labour-related deaths

In at least a quarter of deaths there were problems with adequate staffing and resources to provide safe care

Adequate staffing and resources to support safe care, particularly on the delivery suite, needs to be addressed

Not all women with previous caesarean sections had clear discussions about their birth plan

Women with previous caesarean sections must have clear discussions about their birth plan so they can make informed decisions

There were problems recognising when a women moved from early to established labour

National guidance should be developed around managing the early stage of labour

Guidelines weren't followed when monitoring the baby's heart rate during labour, leading to delays when babies needed to be delivered urgently

Improvements in training for fetal monitoring and situational awareness are required for staff caring for women in labour

1 in 3 neonatal deaths had no post-mortem examination or placental histology

All families must be offered consent for post-mortem with written material provided to support their decision

9 out of 10 reviews of care didn't follow national guidance for serious incidents

Units should adopt the national Perinatal Mortality Review Tool and put aside time for training so that reviews can be carried out robustly

Awareness by Luis Prado, Business Presentation by Gan Khoon Lay, Error by Creative Stall, Group Discussion by Drishya, Microscope by Pedro Santos, Monitor by Astonish and Pregnant Woman by Robiul Alam, all from the Noun Project.