Working Together To Save Babies: Establishing A Stillbirth Working Party at Lister Hospital (DGH)

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INTRODUCTION: Antepartum still birth is a very emotional and devastating event for any pregnant woman, her family and care providers. In the latest MBBRACE report (2015) our local stillbirth rate was 4.13/1000 births, which was lower than the national average of 7.3/1000. GAP was introduced in September 2014. In 2014-15 our maternity unit delivered 5600 babies. During this period 25 stillbirths occurred. It was felt that our process of stillbirth review could improve in an attempt to facilitate learning and further reduce our still birth rate

AIM: To review the process of the multidisciplinary (MDT) approach to still birth reviews.

METHOD: In August 2015 we introduced a Stillbirth Working Party and *Figure 1* illustrates the overall review process. All cases of stillbirths are reviewed within 24 hours of presentation. This initial review is carried out by an obstetrician and a Band 8 senior midwife from the stillbirth group, to ensure that it does not warrant being declared a serious incident. If not declared an incident the case is then reviews in the monthly multidisciplinary stillbirth working party (*Figure 2)*. This consists of both obstetricians and midwifery staff; both clinicians and at managerial level. A proforma from the National Safety Patient Agency is used to grade the level of clinical care provided in each case of stillbirth. If deemed suboptimal; whether the outcome was potentially avoidable through different management. We identify any commonly associated risk factors e.g. growth restriction, as well as case-specific complications. All pathology results are reviewed including the post mortem (if undertaken), to permit a complete thorough review of the situation. . If areas of improvement are identified, action plans are formulated and implemented within a timely fashion. A summation of the case and recommendations are shared with the department via clinical governance meetings. They are also shared openly with the patient when they are debriefed by their named consultant. A plan of care for any future pregnancies is discussed.

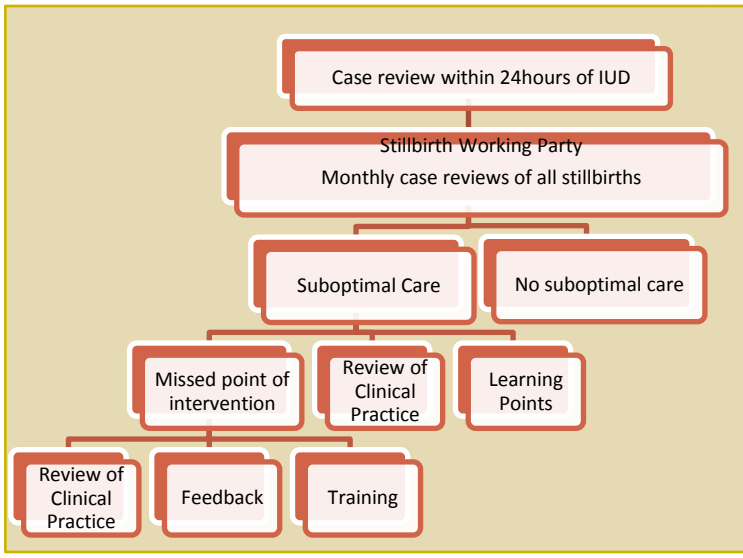

Figure 1: Structure of the review process for all stillbirths

RESULTS: Over the course of 18 months there have been 15 cases of stillbirths, all occurring antepartum. Although the majority occurred in "low risk" pregnancies henceforth would now all be considered "high risk" . The only common demographic risk factor identified was maternal obesity (BMI >30). None of them had suffered previous losses, in fact they were all primigravidas. An underlying cause was positively identified in 10 cases (*Table 1*). This still leaves 1/3 stillbirths unexplained. However, only 8/15 opted for a full postmortem.

Fetal growth restriction was the most common contributing factor, but was missed in 50% of cases antenatally. We missed 3 cases through inadequate fetal surveillance i.e. not offering serial growth scans in women of higher BMI or those with suspected reduced growth velocity. The latter is according to their personalised symphysis-fundal height measurement charts (GROW). 12/15 women reported reduced fetal movements in the pregnancy, worryingly 7 of which waited >24hour before seeking medical advice. 2/12 of those with reduced fetal movements had presented previously, been reassured appropriately at the time of assessment, but failed to return despite ongoing concerns.

Contributing Factor/Cause of Stillbirth	Number of Cases (/15)
Unexplained	5
Reduced Fetal Movements	12
Growth Restricted Fetus	6
Infection	1 Listeria 1 Herpes Simplex Virus
Maternal Disease	2 Diabetes (poor control)
Congenital Abnormality	1 Cardiac (known)

Table 1: Identified causes/ significant contributory factor to the stillbirth

Clinical management was deemed appropriate in the majority of cases or if suboptimal, unlikely to have affected the outcome. E.g. Through the review process we highlighted the need to offer additional support to those with learning disabilities to ensure they had a full understanding of terminology and necessary support in pregnancy. We identified 2 cases which were potentially avoidable. One was due to patient factor, she had declined to follow medical recommendations throughout her pregnancy including treatment for gestational diabetes and induction of labour. The other case involved failure to follow hospital protocol and offer serial growth scans to a woman with elevated BMI and who had a previous SGA pregnancy. This was unfortunately missed by both medical and midwifery staff on numerous occasions. This may have changed the final outcome because her stillborn child was growth restricted. If identified earlier she would have been recommended an early induction of labour at 37weeks. In this situation feedback was given to individuals involved and presented as a learning exercise to the department.

Divisional Chair of Womens Services*
Head of Midwifery*
Clinical Director of Obstetrics
Labour Ward Lead Obstetrician
Supervisor of Midwives
Consultant Midwife*
Bereavement Specialist Midwife
Clinical Governance/ Risk Management Midwife*
Obstetric Trainees*

Figure 2: Multidisciplinary members of the working party present at both the initial and subsequent review*

CONCLUSION: The MDT approach to still birth review is a more robust process for still birth review

RECOMMENDATIONS from case reviews: Our review process has highlighted the need for improving our management of those with reduced fetal movements and identifying fetal growth restriction. We hope our actions will gradually reduce our stillbirth rate. Despite our small numbers, we have identified recurring trends which has permitted us to make recommendations and change the service:

•All GROW charts to be reviewed at each antenatal contact to ensure appropriate projected fetal growth.

•Further GROW training sessions to be provided; especially among the community midwives to ensure appropriate use and management of growth concerns.

•All sonographers to highlight any history of previous SGA (small for gestational age) pregnancies when generating GROW charts.

•All sonographers able to book required serial growth scans directly, to avoid delayed referral to clinic.

•Outcome of all stillbirth case reviews to be published in the clinical governance newsletter to reach a wider audience.

•Provision of the RCOG patient information leaflet on reduced fetal movements.

•Emphasis on fetal movements at each antenatal contact, and patients encouraged to return if persistent concerns about movements.

The prevention of all stillbirths remains a challenge to our speciality. Through increased awareness and MDT approach to the review of stillbirths we hope to continue reducing stillbirths in our unit.