Writing a Plain English Perinatal Mortality Review Report summary/ letter: Guidance for clinicians

This guide is designed to support health care professionals in writing a plain English summary of the perinatal mortality review report for parents. A plain English summary can also be used as the basis for writing a follow-up letter after the parents' visit to discuss the review findings.

We are providing this guidance because the PMRT itself does not generate a plain English summary report. Evidence from Confidential Enquiries shows that letters written to parents summarising review reports are often of very poor quality, using insensitive and inappropriately technical language.

While the language you use should be kind and sensitive, it's important to remember that parents value honesty and clarity about what has happened to their baby and why their baby died.

Who should write the plain English summary/letter

- The PMRT plain English summary/letter should be written by a designated person from the PMRT review team in collaboration with the key contact, ideally this should be someone who has met the parents in person
- Remember when writing the summary/letter that parents are still likely to be grieving their dead baby, even if the mother is pregnant again

Saying Sorry

Parent support groups routinely express the significance for bereaved parents of hearing health professionals express sadness or sorrow at the death of their baby. UK law and GMC Guidance are clear that saying sorry or expressing an 'apology', does not mean an admission of legal liability:

GMC and NMC guidance
Openness and honesty when things go wrong 2015 (p.3)
"Apologising to a patient does not mean that you are admitting legal liability for what has happened. This is set out in legislation in parts of the UK and the NHS Litigation Authority also advises that saying sorry is the right thing to do."
https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand____pdf-61540594.pdf

England Wales:
Compensation Act 2006 Section 2
"An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty."
http://www.legislation.gov.uk/ukpga/2006/29/section/2?view=extent

Scotland:
Apologies (Scotland) Act 2016 Section 1
"In any legal proceedings to which this Act applies, an apology made (outside the proceedings) in connection with any matter

(a) is not admissible as evidence of anything relevant to the determination of liability in connection with that matter, and

(b) cannot be used in any other way to the prejudice of the person by or on behalf of whom the apology was made." http://www.legislation.gov.uk/asp/2016/5/section/1?view=extent

Content

- Ensure parents' questions are directly answered and any conflicting accounts of care are resolved
- It should adhere to relevant Duty of Candour requirements and Being Open Scotland.
- It should offer support and information if parents wish to discuss future pregnancies, but should not assume all parents we will wish to become pregnant again: 'When and if you feel ready to talk about whether you would like to get pregnant again, please..'
- It should signpost to bereavement support, provide local links and support networks in your area, as well as national organisations.

Use of language

- Use language that is kind
- If the parents have named their baby, use the baby's name/babies' names.
- Beware of insensitive language – do not use the words fetus, fetal remains or fetal demise, for instance unless the parents appear to be deliberately using this term themselves.
- Acknowledge that this is the parent's child and do not talk about their baby or events in abstracts terms
- Use clear, straightforward language and avoid euphemisms such as 'event', 'outcome'
- Try to avoid jargon; phrases such as 'risk factor/s' could be described differently as 'more likely to have', 'a greater likelihood of having'
- Do not use acronyms such as IUD or FGR/IUGR/SGA – see below.

Lay explanations for medical terms

If clinical terms are necessary paraphrase to ensure they are described in terms families can understand. Terminology and phrases health professionals use in daily practice such as induction, booking appointment, low risk, high risk, spontaneous labour - are not necessarily familiar to families. A mother who has gone into pre-term labour may not know what 'dilation' means and its relevance in cm. When their baby dies, there are even more terms health professionals will use and families must become familiar with. Some examples are shown below.

Medical Term	Clinical Description	Plain English description
Obstetrician	On arrival you were assessed by an obstetrician	On arrival to the maternity unit you were seen by an obstetrician (a doctor who specialises in caring for pregnant mothers).
Neonatologist	After your baby was born he was resuscitated by the consultant neonatologist	After your baby was born he/she was resuscitated by the consultant neonatologist (a senior doctor who provides care for newborn babies).
Preterm baby / Premature baby	At 25 weeks your baby was extremely preterm.	Your baby was born at 25 weeks of pregnancy which is very early. Normally, babies are born after 37 weeks of pregnancy.

Post-dates / Post-mature	You were offered routine induction of labour for being post-dates.	You were offered induction of labour (when labour is started artificially by the use of drugs or a balloon) as you were over 41 weeks of pregnancy.
Spontaneous labour	You presented at 37 weeks' gestation in spontaneous labour	Your labour started naturally at 37 weeks of pregnancy.
Antepartum	You had an antepartum haemorrhage.	You had some bleeding before labour started.
Intrapartum	Your baby's brain scan showed findings consistent with intrapartum hypoxia.	Your baby's brain scan showed signs of damage relating to a shortage of oxygen during labour.
Neonatal	Your baby had signs of neonatal infection.	Your baby had signs of infection following his/her birth.
Low-risk	You had a low-risk pregnancy.	We anticipated from your health that you had a low-risk of pregnancy complications.
High-risk	You had a high-risk pregnancy.	We anticipated from your health that you had a higher than average risk of pregnancy complications.
Gestational diabetes	Your oral glucose tolerance test found you had gestational diabetes.	Your glucose tolerance test found that you had a condition called gestational diabetes, when your blood sugar is increased in pregnancy.
Hypoxic ischaemic encephalopathy	Your baby had hypoxic-ischaemic encephalopathy.	Your baby's brain showed signs of damage due to a shortage of oxygen.
Fetal growth restriction / Intrauterine growth restriction	Your ultrasound scans showed evidence of fetal growth restriction.	Your ultrasound scans in pregnancy showed that you baby was not growth at the rate we would expect.
Placental pathology	Your baby was smaller than expected due to placental pathology.	Your baby's growth was less than expected due to problems within the placenta (afterbirth) which transfers oxygen and nutrients from your blood to the baby.
Reduced Fetal Movements	You presented with reduced fetal movements at 30 weeks' gestation.	You attended the maternity unit at 30 weeks of pregnancy because you felt your baby was moving less than normal.
Meconium	Your baby had passed meconium before he was born.	Before your baby was born she/he had passed meconium which comes from his intestines, this can be an indication she/he was under stress. If meconium is inhaled into a baby's lungs it can damage them.