Mariposa Trust

Mariposa Trust Press Release – 21.6.17 – for immediate release

‘RCOG report believes 3 out of 4 Neonatal deaths & injuries could have been prevented.’

A report by the Royal College of Obstetricians and Gynaecologists has been published this week, reviewing over 700 recent neonatal deaths and injuries. The ‘Each Baby Counts’ inquiry was set up to establish if more could be done to reduce the numbers of babies who sadly pass away or are left with injuries.

The report looked at the 1,136 stillbirths, neonatal deaths and brain injuries that occurred on UK maternity units during 2015 and found:

- **126 babies were stillborn**
- **156 died within the first seven days after birth**
- **854 babies had severe brain injury (based on information available within the first seven days after birth. It is not known how many might have significant long-term disability)**

(Local investigations into a quarter of the cases were not thorough enough to allow the report authors to do a full assessment of what might have gone wrong.)

In many of the 727 cases that could be reviewed in-depth, problems with accurate assessment of the foetal wellbeing during labour and consistent issues with staff understanding and processing of complex situations, including interpreting baby heart-rate patterns (on traces from CTG machines), were cited as significant factors. It also found that only one-third of parents were invited to be involved in local reviews.

The ‘Each Baby Counts’ report has recommended the following:

- **All low-risk women are assessed on admission in labour to see what foetal monitoring is needed**
- **All staff must receive annual training on interpreting baby heart-rate traces (CTG’s)**

- **A senior member of staff must maintain oversight of the activity in the delivery suite**
- **All trusts and health boards should inform parents of any local review taking place and invite them to contribute**

Zoe Clark-Coates, CEO of the Mariposa Trust commented, “This report highlights discrepancies and sadly failures in the monitoring of babies, resulting in deaths and significant injuries. As an organisation, supporting so many of these parents who have tragically lost their longed-for baby, it is extremely hard to come to terms with the fact that even one of these tragedies could have been prevented, let alone hundreds. The recommendations of the report must now be a benchmark by which all trusts and maternity staff now operate from.”

Co-principal investigator, Prof Zarko Alfirevic, consultant obstetrician at Liverpool Women's Hospital, said, "We urge everyone working in maternity care to ensure the report's recommendations are followed at all times."

Prof Lesley Regan, president of the RCOG and Ambassador for the Mariposa Trust, added, "The fact that a quarter of reports are still of such poor quality that we are unable to draw conclusions about the quality of the care provided is unacceptable and must be improved as a matter of urgency."

In October 2016, the government launched a Maternity Safety Action Plan to provide resources for trusts to improve their approach to maternity safety, including an £8m fund for maternity safety training. Health Secretary Jeremy Hunt said, "While maternal and neonatal deaths are falling, together we need to do even more to make sure fewer families suffer the heartache of losing a baby..."

This message is echoed by the Mariposa Trust, which supports people who have been affected by the loss of a child at any stage of pregnancy, at birth or in infancy, whether the loss is recent or historic. The charity works with Health Professionals and Organisations to improve the care and support of people pre, during and post baby loss, and provides a multi-level support service that reaches over 50,000 people per week. For more information on the work of the Mariposa Trust visit www.sayinggoodbye.org.

Editor's Notes: For interview requests or further information, please email or contact Andy Clark-Coates at directors@sayinggoodbye.org.