More rigorous investigating needed to improve maternity safety

Health Secretary Jeremy Hunt has announced new plans to investigate stillbirths and life-changing injuries at birth. Alistair Quaile reports progress made on the Safer Maternity Care action plan

Coroners could be given powers to investigate stillbirths and help improve maternity safety, Health Secretary Jeremy Hunt has said. Currently, coroners only have jurisdiction to investigate deaths of babies who were alive at birth. The announcement comes after a recent report showed that three-quarters of birth-related deaths or brain injuries might have been avoided (Royal College of Obstetricians and Gynaecologists (RCOG), 2017).

Hunt also revealed that independent investigations are to be offered to families who suffer stillbirth or life-changing injuries to their babies. The Healthcare Safety Investigation Branch will look at 1000 cases each year to find out what went wrong and why, and encourage system improvements that will lead to fewer deaths and injuries in the future.

Commenting on the plans, Hunt said:

> ***'The tragic death or life-changing injury of a baby is something no parent should have to bear, but one thing that can help […] is getting honest answers quickly from an independent investigator. Too many families have been denied this in the past, adding unnecessarily to the pain of their loss.***
> ***'Countless mothers and fathers who have suffered like this say that the most important outcome for them is making sure lessons are learnt so that no-one else has to endure the same heartbreak. These important changes will help us to make that promise in the future.'***

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Alongside the devastating impact of death or serious injury to mother or child at birth, maternity incidents dominate the NHS' litigation expenditure. Half of the £1 billion negligence claims the NHS paid out in 2016/17 were in maternity services, largely due to the high value of claims arising from brain injuries at birth (NHS Resolution, 2017).

The Government's maternity safety plans will also see its ambition to halve the number of stillbirths and deaths among neonates and mothers brought forward from 2030 to 2025 (Department of Health, 2017), saving an estimated 4000 lives.

The rate of premature births is also hoped to fall from 8% to 6% by 2025.

Gill Walton, chief executive officer and general secretary at the Royal College of Midwives (RCM), said:

> ***'Midwives are in a unique position to help achieve this, as they are the one healthcare professional whom all women will see during their pregnancy and birth, and therefore have a clear role in ensuring care is coordinated, safe and, most importantly, personal.***
> ***'Much has been done already through an array of initiatives to improve the safety of maternity care, and this revised strategy will give everyone involved in maternity care the opportunity to reflect on past successes and focus on key areas where more still needs to be done.'***

The RCOG 'Each Baby Counts' programme has used local investigations into stillbirths, neonatal deaths and brain injuries to inform national data and identify lessons learned across maternity services. One-quarter of local reports were deemed inadequate by the RCOG, with many NHS institutions listed as not sufficiently investigating incidents and learning from mistakes in their maternity services. Commenting on the proposals, Professor Lesley Regan, RCOG president, added:

> ***'We are delighted that the Government has agreed to expand the RCOG's Each Baby Counts programme, which has been hugely successful in securing the trust of both the midwifery and obstetric communities, with 100% of Trusts involved in providing maternity services engaging in this important work.***
> ***'We are committed to sharing the expertise we have gained […] and our understanding of the complex interplay of factors that lead to stillbirths, neonatal deaths and brain damage during term labour, to work with partners such as NHS Improvement to expand the work and reach of the Maternal and Neonatal Safety Collaborative and the Healthcare Safety Investigation Branch as they undertake their investigations.***
> ***'Expansion of the national strategy to include a focus on preterm birth and brain injury will likewise help provide a more complete picture of maternity safety, strengthening our evidence base to help us deliver ever more effective care.'*** BJM

Department of Health and Social Care. Safer Maternity Care: The National Maternity Safety Strategy— Progress and Next Steps. London: The Stationery Office; 2017

NHS Resolution. Annual report and accounts 2016/17. London: The Stationery Office; 2017

Royal College of Obstetricians and Gynaecologists. Each Baby Counts: 2015 Summary Report. London: RCOG; 2017