Health and Social care Committee
Inquiry into stillbirths in Wales
SB 8 – The Holly Martin Stillbirth Research Fund

Evidence for The National Assembly One day Inquiry into Stillbirth-28/6/12

Isobel Martin, Founder of The Holly Martin Stillbirth Research Fund

My evidence is based on my own personal story and the shortcomings which led to my baby Holly being stillborn. I started The Holly Martin Stillbirth Research Fund in 2010 to raise money and awareness for stillbirth. I was shocked that the stillbirth statistics in the UK have remained static for at least 20 years and the stillbirth rate in the UK is one of the 3 worst in Europe out of 35 countries. All the money I raise goes to support the work of Dr. Alexander Heazell at St. Mary's Hospital in Manchester. I have recently joined The National Stillbirth Working Group for Wales, looking at stillbirth as part of the 1000 Lives Campaign .

I was pregnant with my first baby in 1985. It was considered to be a low risk pregnancy. I was 25, a professional physiotherapist, married and living in my own home in an affluent town. I was of normal weight, never smoked, never took drugs and never drank alcohol during my pregnancy. I attended every ante-natal visit. I had no health problems.

Everything was completely normal up to 37 weeks. At that point I noticed reduced movements and immediately informed the midwife. I was started on a kick chart where I had to record the time it took for the baby to move 10 times in a day. At no time was I told the risk with reduced movements or that there was chance that the baby might be stillborn. Quite often it was mid- afternoon before I had felt 10 kicks but no- one was concerned.

I started having regular CTGs(cardiotocographs) to check the baby's heart rate. I went to the hospital every 2 days. The tracing was very flat and I was told to move around more and prod the baby to make it move. Again, no-one seemed to be concerned and I trusted they knew what they were doing.

This went on for nearly 3 weeks. At one tracing done by a junior doctor at the hospital, the heart rate dipped to 60 beats a minute, which is about half what it should be. I was told to go home and get my things and return to the hospital for monitoring later in the day. This was on Friday 23rd August, 1985, the start of a bank holiday weekend. When I returned to the hospital, no doctor came to see me. She had gone off on holiday and had not handed me over to another doctor. I did not see any doctors for the rest of that day.

The next morning I felt the baby moving at 7.30 in the morning. The kick chart counting did not start until 9am so I was waiting for that to start counting. My husband came to visit me at 10am. Shortly after, a midwife came to monitor me. She hunted round for a heartbeat and then left the room. Another midwife came and also hunted for a hear beat. No-one said anything. They left without saying anything. After a while my husband went to find them to see what was happening. They said I needed an

ultrasound scan to confirm what they feared, that the baby had died. The scan did indeed confirm that there was no heartbeat and it was the worst moment of my life.

At that point they called in the consultant. This was the first time I had seen him. Up to then I had seen a variety of different midwives and doctors. I was induced. The labour went on for 16 hours. During the pushing stage, the baby refused to come out. I was told that as it was Bank Holiday, there was only one doctor in the hospital and he was busy with a lady whose baby was alive and therefore more urgent than I was. I was pushing for 3 hours and ended up with a forceps delivery and a lot of stitches. My husband was sent to find an oxygen cylinder when I needed some oxygen.

I went home the next morning. There was no bereavement service at the hospital. I saw 2 midwives after that, one who was extremely kind and the other who told me I wouldn't be complaining about the stitches if I had a baby to look after. It was a very isolating experience following Holly's death. People crossed the street to avoid me. Friends who had babies at the same time were concerned that if they saw me I would want their babies. Former colleagues changed the subject instantly if I mentioned my baby had died. I felt as if I was the only person in the world who didn't have their baby.

We spoke to the consultant afterwards and he said the baby was apparently normal and the placenta had a few infarcts. The baby was a bit small compared with subsequent babies. He said he should have delivered the baby 3 weeks early.

I went on to have six more babies. The same thing nearly happened with baby number 6 when the movements reduced at 36 weeks. The scans were flat. I went to the hospital and insisted to the doctor that she got the baby out. To her credit she did, and it was just in time. The baby was small and the placenta grey. However the baby was healthy, didn't need special care and is living a very busy life. It was very nearly a different story. All my babies since Holly were delivered at 37 or 36 weeks by caesarean section.

The fact that I am here fighting for action to prevent stillbirth 27 years later, shows that it is not something that goes away. Just because the baby wasn't born alive doesn't mean she wasn't a person who we loved. Not a day goes by when I don't think about Holly. She has been very much a part of our lives for 27 years. In Wales there are 190 stillborn babies every year. This means there are 190 families grieving for those lost children for the rest of their lives. These are not statistics, these are Welsh people's lives.

Points to Consider

1. A low-risk mother doesn't mean a low-risk baby

2. Stillbirth is rarely mentioned to the mother at any stage during pregnancy for fear of upsetting her. When 1/200 pregnancies ends in stillbirth, the mother has a right to know the facts. She can then play a more informed part in monitoring her pregnancy. The parents are informed in detail about other less common problems such as Down's Syndrome and this is widely accepted.

3. Kick charts are widely used when reduced movements are reported. However, their use is not fully explained. The purpose and relevance of the kick chart should be clear to the mother. There need to be clear criteria for intervention when using kick charts.

4. Stillborn babies are often small. The intra-uterine growth of a baby should be monitored with a more accurate method than a tape measure. Lack of sufficient growth of the baby should initiate a protocol and closer investigation.

5. CTG is used to monitor heart rates. There needs to be a criterion for intervention.

6. There needs to be continuity of care. All of the health professionals should be very well informed on stillbirth and better information should be provided to the parents on all the tests.

7. Clear protocols need to be in place and all the health professional should be aware of them and follow them.

   Until further research can be carried out to find definitive causes for stillbirth, we must use the resources we have to the best advantage to save babies' lives. This initiative gives us the opportunity to pilot a different way of working that would make a real difference to families here in Wales.

Isobel Martin
On Behalf of The Holly Martin Stillbirth Research Fund