Health and Social care Committee
Inquiry into stillbirths in Wales
SB 11 – Royal College of Obstetricians and Gynaecologists

There are approximately four stillbirths in Wales every week. Unlike many other high-income countries, Wales has not seen a fall in the number of stillbirths per year over the past 20 years. This is similar situation to the rest of the UK, who lie 33rd out of 35 high income countries in terms of a high stillbirth rate.

The causes of stillbirths are complex - there are probably no quick solutions and action to reduce the stillbirth rate in Wales will be required across a number of areas, including understanding the underlying causes, identification of high-risk pregnancies and ensuring lessons are learned. Generally, the discriminating factors for stillbirth risk are poorly understood. Many women are unaware that between 24 and 43 weeks of gestation the risk of stillbirth is approximately 1 in 200. Stillbirth is more common than SIDS (cot death) and Down syndrome, yet education is poor - for example in women understanding the importance of poor fetal growth, responding to decreased fetal movements, recognising risks such as obesity or age. This is not surprising given that there is a lack of information on stillbirth from official sources and many health professionals are reluctant to give information for fear of scaremongering. There is a challenge to create a clinical environment where discussion about stillbirth can be normalised, as it is for cot death and Down syndrome.

Although a number of risk factors are known, 98% of pregnancies in the top 5% at risk do not end in stillbirth yet 95% of stillbirths occur in pregnancies not predicted to be at risk at all. A greater understanding is needed of the discriminating risk factors for stillbirth and better tools are needed to stratify risk - for example, a tape measure is still used to measure fundal height (SFH) as a surrogate of fetal growth, with a detection rate of less than a third for poorly grown babies. Indeed this practice has been dropped in Norway where there is a much lower stillbirth rate, as SFH measurement is not clinically effective.

The 1000 Lives Plus Transforming Maternity Services formally adopted a stillbirth work stream from April 2012 and there is a national Stillbirth Working Group now within this framework. This is supported by the Welsh Executive Committee of the RCOG. It is proposed that action to reduce stillbirths in Wales can be classified under the following four headings

1. Identification of risk factors.

Risk assessment for stillbirth is not very advanced. It may be helpful to look at what test and interventions currently provided for pregnancies assessed as high risk could be provided to all women - for example, a third trimester scan. However, any additional tests or interventions would need to be supported by evidence of their effectiveness. Growth restriction has a known association with stillbirth, but its identification in pregnancy is currently very poor. There is also a lack of knowledge of pathology – for example, a small baby within normal limits may still not be reaching its growth potential. In Wales, we suggest it may be reasonable to start by focusing on unexpected stillbirths a term. Most term stillbirths are of otherwise healthy babies and should be preventable, given induction at term is relatively safe and has been shown not to increase caesarean section rates whilst reducing perinatal mortality. Intrapartum deaths should also be preventable and all intrapartum stillbirths should be regarded as sentinel events.

2. Increased awareness

The need for greater awareness of the risk of stillbirth by pregnant women and health professionals is not disputed. Risks such as inequalities in care and social background, awareness of what is normal fetal movement, risks associated with obesity, maternal age and smoking should be discussed.

There is a need to ensure health professionals are made fully aware of the risk of stillbirth as part of their education. Although providing bereavement support is recognised, we are not so good at talking to parents about stillbirth as part of antenatal education and this is the key to increasing awareness.

Many high risk women do not attend antenatal education classes, so more needs to be done to increase wider society's awareness of stillbirth, for example by including stillbirth in the curriculum taught by schools, featuring information about stillbirth on television and other media.

3. Clinical Networks and Commissioning

We would recommend that Health Boards consider stillbirth as part of their quality indicators for commissioning for maternity services. It may be appropriate for antenatal care to include an assessment of risk throughout a pregnancy in much the same way as for venous thromboembolism and and improved perinatal pathology services in those pregnancies that end in stillbirth.

Obstetricians in Wales are keen to see the development of a maternity network. Other examples of such a clinical network, in maternity care and beyond, have been effective at improving coordination and standardisation of care through the sharing of best practice. We believe that a maternity network, similar to the Neonatal network in Wales, would add value to co-ordination, standardise practices and implement clinical and management changes, all of which may be important factors in any attempt to reduce the number of stillbirths in Wales.

4. Improving perinatal review

We believe that perinatal mortality reviews in Wales are currently variable, leading to failures to learn lessons from potentially avoidable deaths. There are examples of Standardised Clinical Outcome Reviews to improve the understanding of causes and factors leading to stillbirths, and other adverse incidents. Such standardised review would improve action plans and strategies for stillbirth prevention. We recommend that a Welsh Stillbirth Register, improvements in Post Mortem Uptake and Consent Post Mortem Reporting be part of future plans to review all perinatal deaths, including stillbirths.