

## Common Trends in Stillbirth Cases

At the end of 2008 Sands asked me to carry out a study and report into common trends in stillbirth cases. I considered 20 cases involving stillbirths and neonatal deaths that I had dealt with in my capacity as a clinical negligence solicitor over the previous four years. I looked at the general statistics in relation to each of the cases, the conditions prior to the stillbirth or neonatal death and the outcome in terms of compensation, legal fees and action taken by the Trusts. Written consent to participate in the study was obtained from all of the parents.

Of the cases considered, 55% were stillbirths and 45% were neonatal deaths. 50% of the cases reviewed concerned babies who were 39 weeks gestation and over. 25% were between 36 and 39 weeks, 20% under 24 weeks and 5% between 29 and 32 weeks gestation. All cases bar one were taken against an NHS Trust. The exception was a claim against an independent midwife dealing with a home delivery. An issue which arose in that case, of which I had previously been unaware, is that it is not possible for independent midwives to obtain professional indemnity insurance. Therefore, any negligence claim has to be pursued against the midwife personally.

The purpose of the study was to ascertain if there was a link between various pre-existing conditions and the stillbirth or neonatal death. I looked at the age of the mother, gestation period, ethnicity, whether the pregnancy was induced, whether the pregnancy was high risk, whether there was a lack of monitoring of the fetal heart rate, lack of fetal movements or a reduction in fetal growth.

I also looked at whether there were alleged staff shortages and whether deliveries were made during holiday periods. The reason for this focus is because there has been much media attention in relation to over-stretched maternity resources in the United Kingdom leading to sub-optimal care. Midwifery caseloads are increasing such that midwives have to deal with far more deliveries than they did historically.

Finally, I analysed the outcome in terms of financial damages and non-monetary remedies taken by the Trust i.e. formal written apology, changes to protocol, introduction of/further training and disciplinary action.

The overwhelming trend that was found in each of the areas considered was the lack of fetal heart rate monitoring. This was particularly so for mothers aged 40 years and over. In all of these cases bar one, there was a lack of fetal heart rate monitoring and, in the other case, there was a lack of monitoring of fetal movements. Cases with mothers over 40 years old are by their very nature high risk due to the maternal age. Therefore, in most of those pregnancies this would have been the last opportunity for the mother to have a child. In two thirds of those cases, the gestational age of the baby was above term and my conclusion, therefore, was that the outcome must have been avoidable.

When I looked at the lack of fetal heart rate monitoring in more detail, I saw a trend of staff shortages and weekend deliveries in those cases. Three quarters of the total cases looked at involved a lack of fetal heart rate monitoring and two thirds of those had been identified as high risk pregnancies. Nearly two thirds were deliveries at the weekend or involved alleged staff shortages. A particularly concerning factor was that of the five pregnancies that were induced, three then had staff shortages issues. On the premise that inductions are usually pre-planned, it surely must have been the case that this could have been avoided?

The conclusion drawn in respect of common trends with the cases considered is that the majority concerned a lack of fetal monitoring in high risk pregnancies with delivery during a holiday period/weekend and involving staff shortages.

In relation to outcomes, the level of damages changes from case to case and depends on whether or not the parents have a claim for post traumatic stress disorder and a claim for loss of earnings. In stillbirth claims, it is now accepted that parents should receive a statutory bereavement damages equivalent award of £11,800 plus any financial losses suffered. The average compensation payable in the cases I looked at was £30,000. The average legal costs were half this amount.

It is my observation that the complaints process does not tend to yield results for parents and, in general, defendants do not investigate claims fully at an early stage. Therefore, litigation tends to be protracted. If matters were investigated sooner and admissions made at an earlier stage, this would reduce the level of legal costs. Speedier resolution of cases would also be beneficial for parents as they would not

have to endure the stresses of ongoing litigation which can have an impact on the grieving process.

The aim of the majority of parents who contact me for legal advice is not to obtain financial compensation but to seek information, obtain answers and obtain reassurances in relation to future care to ensure lessons are learned and future care improved. I consider litigation can be an aid to change and in all cases seek not only financial compensation but a package of non monetary remedies depending on the families' wishes. It is hoped that this process raises the standard of care given as well as providing the family with answers to their questions.

The NHSLA (National Health Service Litigation Authority) undertook a study of 100 stillbirth files logged onto their system on or before 31<sup>st</sup> December 2007. The key finding of their study was that 34% of cases involved misinterpretation of CTG traces and 25 of these cases involved a failure by midwives. The NHSLA did not find that more stillbirths occur over the weekend or during holidays but the study does accept that their results may be misleading because their results record the day of delivery and not the date of death. The NHSLA did find, however, that there was the highest rate of stillbirths in September. Trainee NHS doctors usually start work in new departments in August which may explain the peak in September.

In relation to reduced fetal movements, the study found that women were not always asked about their perception of fetal wellbeing and when they reported a decrease in fetal movements, they were not always listened to and/or there was a delay or failure to act on the information they provided. This is of particular concern as it is well known that there is a link between reduced fetal movements and the incidence of stillbirth.

59% of the deaths occurred during the intrapartum period. There were 129 breaches of duty within the CNST Maternity Standards 2 concerning clinical care. The highest number of alleged breaches were in relation to continuous electronic fetal monitoring and care of women in labour (carrying out observations). These two criteria account for 100 of the alleged breaches of duty out of 129 and reflect the CEMACH Perinatal Mortality Report 2009 that sub-standard intrapartum care has been found to be a high cause of both intrapartum related stillbirths and neonatal deaths occurring at term.

The second highest number of alleged breaches of duty relates to communication. There were 88 alleged breaches, 61 of which concern a breach in relation to carrying out antenatal clinical risk assessments and clinical risk assessments when in labour. These account for 78 of the 88 alleged breaches of duty and highlight the need to perform risk assessments in the antenatal period and at the start of labour.

The NHSLA have recommended that where there are adverse outcomes, an investigation should be performed, guidelines updated and re-education or training of the clinicians carried out. Sub-standard care should be identified along with the cause and lessons learned should be shared amongst maternity services.

The CNST Maternity Standards provide direction for healthcare professionals. Approved guidelines should be in place in all maternity services which should be assessed and monitored to ensure healthcare professionals use them and to, therefore, reduce the number of stillbirths.

Claire Stoneman is a clinical negligence lawyer at Foot Anstey and can be contacted on Tel: 01823 625641

Email: [cjs@footanstey.com](mailto:cjs@footanstey.com)