AIMS For a better birth...

Perinatal mortality

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Beverley Beech comments on the MBRRACE Perinatal Surveillance Report

This is the first UK perinatal surveillance report produced by MBRRACE-UK (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries), a collaboration led by the National Perinatal Epidemiology Unit (NPEU) in Oxford together with members from leading universities, a retired GP from Oxford and representatives from Sands (Stillbirth and neonatal death charity).

The report focused on surveillance of all late fetal losses (between 22+0 and 23+6 weeks' gestation), stillbirths and neonatal deaths1 and was launched at a packed day-long conference at the Royal College of Obstetricians and Gynaecologists. The new statistics now include all late fetal losses - it has been particularly difficult to ascertain these statistics because there are such wide variations in definition and subsequent registration and reporting across the UK. 1 in 1000 babies are born at 22 or 23 weeks and, as few survive, these deaths make up a high proportion (a fifth) of all babies dying in the first month of life.

Jenny Kurinczuk, the Director of the NPEU, introduced Janet Scott from Sands who gave the opening address, pointing out that 'By understanding why babies die today the data can be used to help prevent deaths in the future' and that while there has been a fall in mortality rates over the last ten years there are unacceptable variations in mortality around the UK. She was followed by Christian Cook, whose baby Talia was stillborn. He performed his very moving poem about that experience, highlighting the fact that every one of these baby deaths is a personal human tragedy for the families. (Christian can be viewed performing his poem at: http://www.youtube.com/watch?v=O3155YPItk0).

We were reminded that CMACE (Centre for Maternal and Child Enquiries) last produced a report in 2011 relating to deaths in 2009. The 2010 data revealed large amounts of under-reporting from England, some from Wales and no Scottish data. Over a third did not match Office for National Statistics (ONS) data and the returns for 2011 and 2012 had possibly 30-40% missing. Because the data for these years was incomplete and unreliable the collaborators decided to focus on 2013 onwards. They hope to introduce the ReCoDe system (www.ncbi.nlm.nih.gov/pmc/articles/PMC1283273/) to improve classifications and allow international comparisons. English, Welsh and Scottish reports can be found at:
www.hqip.org.uk/assets/Downloads/Report-on-2010- 2011-2012-perinatal-mortality-data-FINAL.pdf
www.medicine.cf.ac.uk/awps/awps_reports/
http://www.healthcareimprovementscotland.org/default.aspx?page=14046
www.healthcareimprovementscotland.org/our_work/reproductive,_maternal_child/programme_resources/spimmr_2011.aspx

Pauline Hyman-Taylor explained how the data was collected and by whom, with over 250 units in the UK participating with a Lead Reporter in each Trust and Health Board. There are 450 reporters across the UK - the majority are midwives. There is now an established MBRRACE-UK reporting structure to be further refined, meaning that the main cause of death for over 1,500 babies, currently classified as unknown, will be completed with more accurate information. There are YouTube downloads which show the details of the collection of data. Note that the 'standard of care' is now a collectable piece of data.

The report reveals that while the rate and number of stillbirths and neonatal deaths fell in the UK, there were, nonetheless, over 5,700 babies who died either before, during or shortly after birth in 2013 - equivalent to 15 babies dying every day.

There is a map of the UK showing the organisations responsible for local health care, with dots representing the number of babies born in hospitals run by that organisation; the mortality rates have taken into account the number of high-risk pregnancies that are cared for by each organisation. There are a few red dots indicating mortality is 10% higher than the UK average and only two areas of green dots (Dorset and Barnet) indicating 10% lower than the UK average. Yellow and orange dots make up the rest, none achieving the lowest mortality rates in Europe.

The report recommends that national aspirational targets should be set for the UK for reducing the number of babies who die, aiming for a rate closer to that achieved in the best-performing European countries; and that those Care Commissioning Groups in the red dot areas are required to have specific local reviews. The report found that local mortality rates varied across the UK from 5.4 to 7.1 per 1,000. The variation is not explained by differences in poverty, ethnicity or the age of the mother. However, women living in poverty experience 57% more stillbirths or neonatal deaths.

Perinatal mortality was 50% higher for Black, Black British, Asian and Asian British babies, whilst the rate for teenage mothers and mothers over 40 is 39% higher. The report recognised that while being born too early is a risk, one in three babies who died in 2013 had reached term (37 weeks' gestation or more) and

speculated that 'in some cases, issues to do with care may play a role': 1 in 12 babies died either during or after birth because of a complication in labour.

The RCOG 'Each Baby Counts' (see page 4) is pushing for local investigations into these deaths so that meaningful data can be collected to prevent deaths in the future.

As well as the local reviews mentioned above, the report recommends that post-mortems should be offered in all cases of stillbirth, neonatal death and extended perinatal death in order to improve future pregnancy counselling of parents.

All of those who have been involved with gathering and analysing the data and preparing this report deserve our most heartfelt thanks for a superb document. It is crammed with valuable information detailing the wide variation around the UK in the numbers and rates of babies who die and gives pointers to future action.

One hopes that this information will enable professionals to understand better the issues in their area and work collectively to reduce the incidence of these sad deaths. We look forward to future reports exploring trends and characteristics as the data improves, for example, better understanding of the effects of increased BMI, previous obstetric history and addictions. This work, however, is only one side of the coin: while NHS staff work to save babies, little effort is being made by our Government to act effectively to address the huge levels of social deprivation, poor housing, poverty and other inequalities.

A copy of the Report can be downloaded from www.npeu.ox.ac.uk/mbrrace-uk/reports

Beverley A Lawrence Beech

Note

Neonatal death - a live born baby (born at 20+0 weeks' gestation or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died before 28 completed days after birth.