

## **Inquiry into stillbirths in Wales**

### **Key conclusion and recommendations**

The Health and Social Care Committee's inquiry into stillbirths in Wales was undertaken during 2012. The Committee reported its findings in February 2013. This sheet summarises the Committee's key conclusion and recommendations. A copy of the full report can be accessed on the Committee's website: [www.assemblywales.org/hsc-committee](http://www.assemblywales.org/hsc-committee)

#### **Key conclusion**

There is no single step which, if taken, would remedy the risk of stillbirths in Wales. Yet, we believe that progress towards that end has been held back by a frame of mind in which the search for the perfect has driven out the possible. Consideration of the relatively small steps that have already been devised – or can be devised relatively straightforwardly – to make a difference to the rates of stillbirth in Wales is long overdue. These steps need to be taken now.

#### **Recommendations**

##### **Recommendation 1**

Public awareness of stillbirth and its risk factors is essential to reducing stillbirth rates in Wales. We recommend that the Welsh Government take an active lead – via the recently established National Stillbirth Working Group – in developing key public health messages as a matter of priority. This will raise the awareness of expectant parents and those planning to start a family of the risks of stillbirth and allow them to make more informed choices about their health and pregnancy.

##### **Recommendation 2**

We recommend that the Welsh Government work with professional bodies and health boards in Wales to ensure that all expectant parents receive adequate information from clinicians and midwives about stillbirth and its associated risks. Discussion of stillbirth should form a routine part of the conversation held between health professionals and expectant parents during the course of a pregnancy.

##### **Recommendation 3**

We recommend that the Welsh Government work with professional and regulatory bodies, and relevant academic institutions, to ensure that stillbirth, its associated risk factors and interventions, and bereavement training are more prominently featured in Welsh midwifery and obstetric training curricula. The Welsh Government should work with health boards to monitor and regularly review the training needs and competence of health professionals in relation to stillbirth.

##### **Recommendation 4**

We recommend that the Welsh Government scope the viability of establishing a maternity network to drive the standardisation of care across Wales. We believe that at least a virtual clinical network should be established within the next 12 months.



### **Recommendation 5**

We recommend that the Welsh Government undertake a review of the number of women in Wales who deliver more than thirteen days after their due date. The outcome of those pregnancies and the factors that led to the decision not to induce within the recommended guideline time should be considered in every case. Further consideration ought to be given to whether women with other high risk factors such as advanced maternal age, smoking or weight should be induced closer to their due date.

### **Recommendation 6**

We recommend that the Welsh Government investigate and report on evidence presented to the Committee that having to seek specialist foetal medicine consultations outside Wales now exceeds the cost of providing the service within Wales. The Welsh Government should also explore the proposal that specialist foetal medicine services should be commissioned at the tertiary rather than secondary level.

### **Recommendation 7**

We recommend that a national minimum standard for reviewing perinatal deaths should be developed and rolled out across Wales. We also recommend that a wider, more imaginative approach to Welsh Government funding for medical research and investigation is adopted, and that the Welsh Government seek detailed costings for a national perinatal audit for Wales from the All Wales Perinatal Survey. We believe that the initial investment in this audit could yield significant benefits in the future detection and prevention of stillbirth.

### **Recommendation 8**

We recommend that the Welsh Government publish a detailed plan of how it proposes to tackle the problem caused by the low rate of post-mortem for stillborn babies. The plan should include:

- details of how training will be delivered to health professionals in order that they are better equipped to raise this very difficult issue with grieving parents;
- details of what improved information will be developed for parents so that they are able to make more informed decisions; and
- an assessment of the actions needed to improve the provision of perinatal pathology.

### **Recommendation 9**

In the absence of the large charities and interested industry that fund the bulk of research for other health conditions, we recommend that the Welsh Government, through the National Institute for Social Care and Health Research's Clinical Research Centre, commission a comprehensive piece of work on the underlying causes of stillbirth. This work should be undertaken in cooperation with health professionals and academics with expertise in this field, and should draw on international knowledge of stillbirth. This work should be completed by the end of this Assembly.

**The Health and Social Care Committee will return to this topic during this Assembly, in order to monitor progress against the recommendations made.**

