Tees Law report into:

Stillbirths and neonatal deaths and coroner referrals in NHS Trusts (2019-22)

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Introduction

This report analyses (and sets out conclusions from) the responses provided by NHS Trusts to Freedom of Information requests made by law firm Tees on matters of patient safety during maternity and neonatal care.

In 2015, the UK government set an ambition to halve rates of stillbirths, neonatal deaths and maternal deaths in England by 2030[1]. Jeremy Hunt, Health Secretary at the time, announced, *"We will ensure every mother and baby receives the best and safest care, 24 hours a day, 7 days a week."*

The ambition to halve the number of stillbirths set a target rate of 2.3 per thousand live births, which, according to NHS England, could potentially avoid more than 1,500 such deaths every year.

Despite these pledges, improvements in maternity services have been slow since 2015. Regular high-profile media cases have continued to reveal concerns in several NHS Trusts, with the publication of:

- the Ockendon report on 30 March 2022 following an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust – this included recommendations for immediate and essential actions to improve patient care and safety
- the 'Reading the signals' report on East Kent Hospitals University NHS Trust – this highlighted four areas to be addressed to *"break the cycle of endlessly repeating supposedly one-off catastrophic failures"* and
- the awaited inquiry into maternity care at Nottingham University Hospitals NHS Trust.

Meanwhile:

- The Care Quality Commission downgraded maternity services at **Airedale General Hospital** near Keighley[2] to *"requires improvement"* and called for *"immediate improvements"* at the **William Harvey Hospital** in Ashford, Kent[3].
- In early June 2023, Greater Manchester Police started investigating the *"possible gross negligence manslaughter"* of a baby who died less than a day after being born at Manchester's Saint Mary's Hospital[4].
- The maternity department in Hinchingbrooke Hospital[5], Cambridgeshire, had '87 red flag' incidents, which put women's safety at risk, in just six months.

"We will ensure every mother and baby receives the best and safest care, 24 hours a day, 7 days a week."

Jeremy Hunt, Health Secretary, 2015

The failures at Shrewsbury and Telford Hospital NHS Trust[6], which hit the news in early 2022, led to the independent inquiry which found that mothers and babies died or suffered major injuries due to *"repeated failures"* at the Trust, with the report calling this the UK's biggest maternity scandal, although this may well be superseded by the investigations at Nottingham.

The data published by the Office for National Statistics (ONS), for calendar year 2022, showed a stillbirth rate of 4.0 (per thousand live births). However, while this data does provide a breakdown by, for example, baby gender, mother's age and area of usual residence, it doesn't provide figures for each NHS Trust.

In this context, and having handled many medical negligence claims, law firm Tees undertook its own research to investigate the progress that individual NHS Trusts are making towards their targets – at roughly the halfway mark to 2030. Tees' lawyers have seen first-hand the disparities and devastation that poor maternal care across different NHS Trusts has to both families and staff.

[1] www.england.nhs.uk

[2] www.bbc.co.uk/news

[3] www.bbc.co.uk/news

[4] www.bbc.co.uk

[5] www.cambridge-news.co.uk

[6] www.staffordshire-live.co.uk

Introduction (cont.)

When taking cases to inquest, a lack of consistency has been characteristic of the way in which neonatal deaths or maternal deaths have been dealt with.

Following the publication of Tees' report on Maternal Request Caesarean Section in Dec. 2021[7], this new report sheds light on the state of stillbirths, neonatal deaths and maternal deaths across NHS Trusts.

Gathering the data involved sending a freedom of information (FOI) survey to NHS Trusts in England, Scotland, Wales and Northern Ireland in late 2022 and collating their replies over the following year. The responses have been analysed to assess, as far as possible, the current situation for stillbirths, neonatal deaths and maternal deaths across NHS Trusts. Trusts were also asked to provide a copy of any policies relating to when cases should be referred to the Coroner.

The results of this FOI request support the findings of other reports into maternal and neonatal care. For example, a progress report released by Sands & Tommy's in May 2023 highlighted *"variations in the standard of care experienced at each stage of pregnancy, birth and in the neonatal period."* As that report laments, *"Too often avoidable losses continue to occur as a result of care that is not in line with recommendations in NICE guidance and other nationally-agreed standards."*

Tees' intention was, using the results of the FOI responses, to provide a detailed analysis of the levels of stillbirths, neonatal deaths and maternal deaths in each Trust, along with an insight into a little-discussed topic – the referral of neonatal deaths to Coroners.

As is explained in the following narrative, a lack of response, delayed responses and incomplete responses, means that this has been difficult. This, in itself, is concerning.

The results of the FOI survey reveal an equally inconsistent picture across the country. This report details the major disparities between Trusts in terms of both neonatal and stillbirth rates and referrals of neonatal deaths to the Coroner.

Sands & Tommy's in May 2023 highlighted *"variations in the standard of care experienced at each stage of pregnancy, birth and in the neonatal period. Too often avoidable losses continue to occur as a result of care that is not in line with recommendations in NICE guidance and other nationally-agreed standards."*

Sands & Tommy's, May 2023

[7] https://www.teeslaw.com/media/uploads/files/Tees_Law_MRCS_Report_kouhZJ0.pdf

Methodology

The FOI request was submitted to more than 160 NHS Trusts in December 2022 and January 2023. In total, responses for more than 90 Trusts (~56%) were received.

The request contained questions about (1) live births, (2) stillbirths (including intrapartum stillbirths), (3) neonatal deaths (including early neonatal deaths), (4) Hypoxic Ischemic Encephalopathy and (5) maternal deaths, all within four periods:

- 1 April 2019 to 31 March 2020
- 1 April 2020 to 31 March 2021
- 1 April 2021 to 31 March 2022
- 1 April 2022 to 31 December 2022

For neonatal and maternal deaths, Trusts were asked how many such deaths occurred, in how many cases the medical cause was identified and in how many cases the death was referred to a Coroner. In respect of live births, Trusts were asked to report on home births separately.

The process of compiling accurate contact information for each Trust was itself protracted. Many Trusts have a separate FOI email address for submitting requests, though some do not (or do not clearly) signpost where requests should be sent. Given the number of 'bounce backs' and 'undeliverable' responses received after the request was submitted, it seems some Trusts regularly change their FOI email address.

As per rules set out by the Freedom of Information Act 2000, '*a public authority must comply [with the FOI request] promptly and in any event not later than the twentieth working day following the date of receipt*' (10.1). The majority of respondents to the Tees FOI took longer than 20 workings days to reply. In some cases, it took nearly five months to receive a response. One Trust replied in February 2024.

Some Trusts stated that they did not hold the relevant information or lacked the resources to investigate. For example, **East Kent Hospitals University NHS Foundation Trust** stated that *"we are unable to comply with your request as the cost of responding to all parts would exceed the appropriate cost limit of £450 for NHS bodies, as defined in section 12(1) of the Freedom of Information Act."*

Similarly, **Great Western Hospitals NHS Foundation Trust** responded that *"The only way in which we could locate and extract some of the information would be by a complex process of searching and looking up through multiple patient notes […] The effort involved in doing this is estimated to far exceed the cost limit of £450."*

Somerset NHS Foundation Trust explained that *"To identify this information would require a manual trawl of paper and electronic records which would exceed the timescales allowed by the Freedom of Information Act."* In another case, **Sandwell and West Birmingham Hospitals NHS Trust** replied that *"Some of the requests including yours unfortunately cannot be retrieved due to issues with our I.T. system."*

Where the number of cases involved was fewer than five, some (but not all) Trusts provided the response '<5'. One Trust explained, *"The Trust is unable to respond to all or specific elements of your request where the response would indicate five or less individuals. The Trust is withholding this information under Section 40 (Personal Information) of the Freedom of Information Act (FOIA) 2000 to reduce the risk of any individuals being identified. The Trust is of the view that disclosure of such information would significantly increase the risk of individuals being identified and as such would constitute a breach of their personal data."*

However, other Trusts did provide precise numbers where there were fewer than five cases. One Trust didn't provide answers where the number was less than 10.

Of the Trusts that did reply, responses were analysed and three specific areas were identified as requiring further investigation:

(1) stillbirth rates

(2) referrals of neonatal deaths to Coroner

(3) referrals to the Healthcare Safety Investigation Branch (HSIB), an independent investigator into NHS-funded care across England.

These areas were chosen based on their especially inconsistent results. Other areas such as maternal deaths and neonatal deaths from Hypoxic Ischemic Encephalopathy either had insufficient responses or hard-to-analyse data (with many Trusts quoting '<5' rather than specific figures).

In particular, (1) several Trusts had stillbirth rates that were significantly above the national average, (2) there were significant discrepancies in how Trusts dealt with referrals of neonatal deaths to the Coroner, and (3) there was confusion around the role of HSIB and when cases should be referred to HSIB.

In the sections that follow, these findings will be presented and discussed in more detail. For context, some results will be discussed alongside similar data collected by ONS.

Key findings

The absence of a response from around 70 Trusts, as well as some incomplete responses from those which did reply, is representative of the highly variable range of responses. In some cases, Trusts stated that they did not know or were not able to locate the data – a worrying sign as the deadline for the national target approaches.

Despite incomplete and patchy results, a picture of clear disparities between Trusts is evident. The lack of uniformity in responses heightens the conclusion that inconsistencies abound.

One

A concerning rate of stillbirth in some Trusts

Two

Significant inconsistencies in how Trusts deal with referrals of neonatal deaths to the Coroner, including in cases where the cause of death was unknown

Three

Confusion around the role of HSIB and when cases should be referred to HSIB

Stillbirths

Stillbirth, as defined by the NHS and in the FOI sent to Trusts, occurs when a baby is born dead after 24 completed weeks of pregnancy. The FOI asked Trusts to provide data for four periods between 2019 and 2022 (as detailed above) on "*How many stillbirths were there at your hospital Trust?*"

Follow-up questions also probed Trusts on intrapartum stillbirths. An intrapartum stillbirth is defined by HSIB as: *'when a baby was thought to be alive at the start of labour but was born, beyond 37 weeks of gestation, with no signs of life'.* Unfortunately, due to the level of responses to this question, detailed analysis was not possible.

Tees has represented a number of clients who suffered an intrapartum stillbirth. In one case, the mother was told that she was in the latent phase of labour, but wasn't examined. When she reported reduced foetal movements and an Intrauterine Death (IUD) was confirmed, she was examined and found to be fully dilated. The Trust fully admitted liability. In another case, Tees represented a mother who suffered hypertension and required early delivery of her first baby. Upon her second pregnancy – at a different Trust – she was classed as low risk, despite her history. The mother suffered an Intrauterine Death (IUD). The Trust fully admitted liability.

The Government's target is to cut stillbirths nationally to 2.3 per 1,000 births (0.23%). Data received from the FOI request reveals that nearly all of the Trusts that responded remain well above this target, with some consistently and significantly above 5 per 1,000 births (0.5%).

For example, **Barts Health NHS Trust** recorded levels of stillbirths ranging between 4.98 and 18.05 deaths per 1,000 births (0.5% to 1.81%) for the four periods analysed (between April 2019 and December 2022). Most recently, the figure for the period April-December 2022 of 1.81% is nearly eight times higher than the target rate.

Bradford Teaching Hospitals NHS Foundation Trust was above 5.6 deaths per '000 births (0.56%) in each of the four periods, with especially high readings in 2019-20 (8.07 per '000/0.81%) and 2022 (7.34 per '000/0.73%). Similarly, **The Northern Care Alliance NHS Foundation Trust** (which covers Salford, Rochdale, Bury and Oldham) was 5.44 per '000 (0.54%) or above in each period, while Belfast – **Royal Jubilee Maternity Hospital** was 5.61 per '000 (0.56%) or above in the last three periods. **Liverpool Women's Hospital** recorded rates of 6.21 per '000 (0.62%) or above in three of the four periods, while **NHS Greater Glasgow and Clyde** was above 4.5 deaths per '000 births (0.45%) in the past three periods.

Some Trusts recorded one-off figures that were significantly higher than other periods. The **Rotherham NHS Foundation Trust** recorded 0.54% in 2020-21, **Cwm Taf Morgannwg University Health Board – Princess of Wales Hospital** recorded 0.63% in 2019-20 and 0.58% in 2020-21. In its most recent period, **University Hospitals Plymouth NHS Trust** recorded 0.78% in Apr-Dec 2022, along with above average figures in two of the previous three periods.

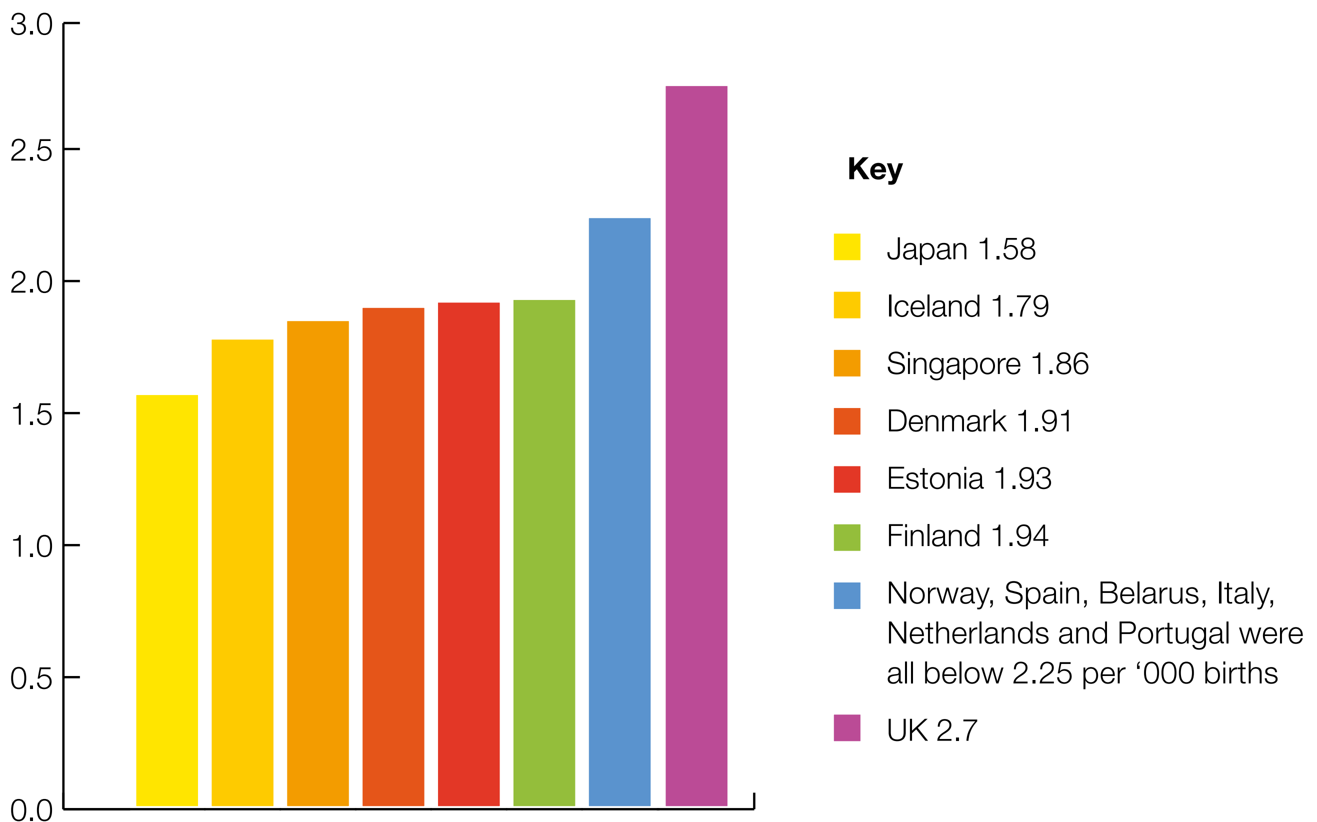
Stillbirths (cont.)

Other Trusts with consistently raised figures include **Mid Cheshire Hospitals NHS Foundation Trust – Leighton Hospital**, which was between 0.42% and 0.46% in three periods and **Tameside and Glossop Integrated Care** between 0.46% and 0.51% in three periods.

According to the World Health Organization[8], in 2021 many countries reported rates of fewer than two deaths per '000 births. These included Japan (1.58), Iceland (1.79), Singapore (1.86), Denmark (1.91), Estonia (1.93) and Finland (1.94). Meanwhile, in the same year, the reported rates for Norway, Spain, Belarus, Italy, Netherlands and Portugal were all below 2.25 per '000 births.

Of the Trusts that responded to the FOI, few showed real progression or improvements between 2019 and 2022, with many Trusts results getting gradually worse during that time.

World Health Organization reported stillbirth deaths, 2021 (per '000 births)



[8] https://apps.who.int/gho/data/view.main.STILLBIRTHv?lang=en

Stillbirths (cont.)

NHS Trusts, who responded to the FOI, whose rates exceeded 3.9 deaths per ’1000 in at least three of the four periods.

	Live births	Live births	Live births	Live births	Still births	Still births	Still births	Still births	Deaths per '000	Deaths per '000	Deaths per '000	Deaths per '000	Deaths per '000 %	Deaths per '000 %	Deaths per '000 %	Deaths per '000 %
	1 April 2019 to 31 March 2020	1 April 2020 to 31 March 2021	1 April 2021 to 31 March 2022	1 April 2022 to 31 Dec 2022	1 April 2019 to 31 March 2020	1 April 2020 to 31 March 2021	1 April 2021 to 31 March 2022	1 April 2022 to 31 Dec 2022	1 April 2019 to 31 March 2020	1 April 2020 to 31 March 2021	1 April 2021 to 31 March 2022	1 April 2022 to 31 Dec 2022	1 April 2019 to 31 March 2020	1 April 2020 to 31 March 2021	1 April 2021 to 31 March 2022	1 April 2022 to 31 Dec 2022
Bradford Teaching Hospitals Foundation Trust	5331	4956	5063	3405	43	28	29	25	8.07	5.65	5.73	7.34	0.81%	0.56%	0.57%	0.73%
Liverpool Women’s Hospital	7888	7539	7742	5689	49	30	54	36	6.21	3.98	6.97	6.33	0.62%	0.40%	0.70%	0.63%
Barts Health NHS Trust	14634	14347	14647	2659	86	72	73	48	5.88	5.02	4.98	18.05	0.59%	0.50%	0.50%	1.81%
Northern Care Alliance	4964	4677	5056	3701	27	31	30	21	5.44	6.63	5.93	5.67	0.54%	0.66%	0.59%	0.57%
Royal Wolverhampton Hospital NHS Trust - New Cross Hospital	4888	4761	5032	3883	24	20	21	12	4.91	4.20	4.17	3.09	0.49%	0.42%	0.42%	0.31%
University Hospitals Plymouth NHS Trust - Derriford Hospital	3902	3607	3848	2678	19	6	18	21	4.87	1.66	4.68	7.84	0.49%	0.17%	0.47%	0.78%
Belfast - Royal Maternity	4818	4903	4754	3562	23	29	32	20	4.77	5.91	6.73	5.61	0.48%	0.59%	0.67%	0.56%
Tameside and Glossop Integrated Care	2186	2173	2184	1576	10	11	11	5	4.57	5.06	5.04	3.17	0.46%	0.51%	0.50%	0.32%
Mid Cheshire Hospitals NHS Foundation Trust - Leighton Hospital	2755	3011	3095	2301	12	14	13	4	4.36	4.65	4.20	1.74	0.44%	0.46%	0.42%	0.17%
Northampton General Hospital NHS Trust - Northampton General Hospital	4391	4058	4161	3199	18	16	10	15	4.10	3.94	2.40	4.69	0.41%	0.39%	0.24%	0.47%
NHS Greater Glasgow and Clyde (Across the entire health board)	13759	12980	13316	9988	46	61	61	49	3.34	4.70	4.58	4.91	0.33%	0.47%	0.46%	0.49%

Although, the figures may have been affected by the pandemic, ONS[9] reported that, *“There were 2,597 stillbirths in England and Wales in 2021. This is a 9.5% increase compared with 2020 and similar to the 2,522 stillbirths seen pre-coronavirus (COVID-19) in 2019.’* However, it went on to say, *‘The stillbirth rate increased to 4.1 stillbirths per 1,000 total births in 2021, from 3.8 in 2020. This is higher than the pre-coronavirus rate (3.9 stillbirths per 1,000 total births) in 2019…”*. In 2022, the stillbirth rate decreased slightly to 4.0 stillbirths per 1,000.

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables

Stillbirths (cont.)

Worryingly, it is feasible that some Trusts that cited an inability to locate data, like **Sandwell and West Birmingham Hospitals NHS Trust**, which stated that *"Some of the requests including yours unfortunately cannot be retrieved due to issues with our I.T. system"*, could have stillbirth rates even higher than many of those discussed above.

Data published by ONS could be interpreted as supporting this possibility. Their data for live births and stillbirths (by area of usual residence of mother) highlights that, in 2021, 20 areas (as defined by ONS) report rates in excess of seven stillbirths per 1,000 total births. Of these, all but five areas reported more than 1,000 live births in the 12 month period.

The table below highlights the nine areas with recorded rates of more than eight stillbirths per 1,000 births. It should be pointed out that the number of stillbirths per area is relatively low and therefore one or two additional/ fewer stillbirths in any one year could affect the rate significantly. For reference, the 2020 stillbirth rates for the nine areas are also shown[10].

Live births and stillbirths by area of usual residence of mother, numbers, and stillbirths rates, 2021 (ONS)

Area of usual residence Name	Number of live births	Number of stillbirths	Stillbirth rate 2021 (stillbirths per 1,000 live births and stillbirths)	Stillbirth rate 2020
Maldon	591	6	10.1	5.6
South Ribble	1,008	10	9.8	3.1
Watford	1,373	13	9.4	n/a (0 stillbirths)
Rugby	1,204	11	9.1	5.2
Nuneaton and Bedworth	1,531	14	9.1	7.3
Stafford	1,256	11	8.7	5.1
Mendip	1,049	9	8.5	3.2
Carmarthenshire	1,540	13	8.4	2.4
Swale	1,669	14	8.3	2.6

[10] www.ons.gov.uk

Referrals to Coroner

Before detailing the findings, it is worth highlighting some of the guidance previously offered to Trusts and Coroners.

In 2019, the Government consulted and requested views on proposals for introducing Coronial investigations of stillbirth cases in England and Wales. They stated that, *"A stillbirth is a tragedy which has a profound effect upon bereaved families. We are committed to ensuring that, wherever possible we do all we can to ensure that when such a tragedy occurs, lessons are learnt and changes made to prevent avoidable stillbirths in the future."*[11]

The Civil Partnerships, Marriages and Deaths (Registration Etc) Act 2019 placed a duty on the Secretary of State to make arrangements for the preparation and publication of a report on whether, and if so how, Coroners should investigate stillbirths. However, five years later, in 2024, Coroners still do not have jurisdiction to investigate a stillbirth[12].

The issue of Coroner referrals is clearly not new. In 2021, Narendra Aladangady[13] and Philippa Chisholm[14], both Consultant Neonatologists at Homerton University Hospital NHS Foundation Trust, London, published an article in Infant magazine, entitled: *'When should a neonatal death be referred to the Coroner? Initiation of a guideline to aid decision making'.*[15] The article highlighted the *"huge variation in practice between settings regarding the Coroner referral process."* They went on to describe a guideline they had produced which included recommendations that the following scenarios should be referred to the Coroner: any scenario resulting in HIE; baby born in poor condition after normal labour; planned home birth; complication of a low risk neonatal procedure; or any complication of a high risk neonatal procedure with clarification whether the death was as a result of that procedure or the underlying condition failing to improve.

"In the challenging period after the death of a baby there can be uncertainty over whether referral to a Coroner is appropriate; clear and consistent guidelines can help alleviate this. Since implementing this guideline in our neonatal unit there has been less confusion in what is communicated to families at the time of death. This aids both families and practitioners in navigating a painful period. Not all referrals are accepted by the coroner but there is a systematic, transparent approach that is equal for all infants."

Consultant Neonatologists, Narendra Aladangady and Philippa Chisholm, at Homerton University Hospital NHS Foundation Trust, London, 2021

[11] https://consult.justice.gov.uk/digital-communications/coronial-investigations-of-stillbirths/

[12] https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/

[13] Narendra Aladangady FRCPCH, PhD, Consultant Neonatologist and Honorary Clinical Professor in Child Health, Neonatal Unit, Homerton University Hospital NHS Foundation Trust, London, and Queen Mary University of London

[14] Philippa Chisholm FRCPCH, Consultant Neonatologist, Neonatal Unit, Homerton University Hospital NHS Foundation Trust, London

[15] https://www.infantjournal.co.uk/journal_article.html?id=7227

Referrals to Coroner (cont.)

The conclusion of the article was: *"In the challenging period after the death of a baby there can be uncertainty over whether referral to a Coroner is appropriate; clear and consistent guidelines can help alleviate this. Since implementing this guideline in our neonatal unit there has been less confusion in what is communicated to families at the time of death. This aids both families and practitioners in navigating a painful period. Not all referrals are accepted by the coroner but there is a systematic, transparent approach that is equal for all infants."*

When one Trust replied to our FOI request concerning referrals of neonatal deaths to the Coroner, this article was provided as their guidance.

Responses to the FOI request show that the conditions under which a case of neonatal death should be referred to the Coroner are being applied differently across different Trusts. Neonatal deaths are defined as a baby that dies within 28 days of birth of any cause. For the purposes of this research, babies who died within 28 days that had not left hospital since birth were included.

Inconsistencies abound in both theoretical understanding and practical application of Coroner referrals for neonatal deaths. Some Trusts referred all cases of neonatal deaths; others referred all cases in which the cause of death was not known; others referred most cases where cause of death was not known, and yet others referred only a small percentage of unexplained neonatal deaths.

The variety of interpretations that different Trusts are taking to guidance around Coroner referrals is further symptomatic of the inconsistencies and confusion in maternity services. This confusion is perhaps partly fuelled by the fact that there is no definition of a death by unnatural causes. Tees has seen instances where neonatal deaths as a result of HIE are deemed to be a death from natural causes, despite the HIE being caused by negligent care during labour and delivery. The Coroners Courts Support Service say that: *"It is usually prudent to report any death where there have been allegations of medical mismanagement or alleged negligence."*[16] The failures to refer deaths to Coroners in such circumstances is a lost opportunity to learn from medical errors.

[16] https://coronerscourtssupportservice.org.uk/faq/

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"There is no statutory obligation to report all deaths to the Coroner, unless there is any concern that the death was unnatural."

Barnsley Hospital NHS Foundation Trust

Some Trusts provided up-to-date guidance (as was requested) on the processes and practices in place for dealing with the aftermath of a neonatal death. **Barnsley Hospital NHS Foundation Trust** stated that, *"There is no statutory obligation to report all deaths to the Coroner, unless there is any concern that the death was unnatural."* Many others, however, sent no such document or guidance.

Expert advice on Coroner referrals adds further confusion. In a letter dated August 2022, the **Gateshead and South Tyneside Senior Coroner** sets out that not all infant deaths need to be referred, explaining that, *"I am only interested / required to investigate deaths where there is a reason to suspect the deceased died a violent or unnatural death."*

"

"I am only interested / required to investigate deaths where there is a reason to suspect the deceased died a violent or unnatural death."

Gateshead and South Tyneside Senior Coroner

Referrals to Coroner (cont.)

Elsewhere, referring cases to the Coroner is interpreted differently. For example, at **The Dudley Group NHS Foundation Trust - Russells Hall Hospital**, no deaths were referred to the Coroner, despite the cause of three deaths being unidentified.

Other low referral rates include **Princess Anne Hospital in Southampton** (11 out of 103). **Thames Valley & Wessex** is unequivocal in its guidelines: *"The Coroner should be informed about any death where the cause is unknown or uncertain"*, indicating a potentially concerning discrepancy between theory and practice.

Thames Valley & Wessex is unequivocal in its guidelines: *"The Coroner should be informed about any death where the cause is unknown or uncertain"*

Thames Valley & Wessex

Bradford Teaching Hospitals Foundation Trust recorded a total of 80 neonatal deaths in the four periods. However, it could only report referrals to the Coroner for the most recent period because, *"Data relating to medical cause and referral to the coroner is not available electronically before 2022 therefore unavailable."* The Trust noted in its reply that, *"there is nothing specific in place at present but it will be being incorporated into a new guideline in the next few months."*

Of the total of six neonatal deaths at **Princess Alexandra Hospital NHS Trust, Harlow** in the four periods (all of which were early neonatal deaths), the cause was identified in all cases. However, three were referred to the Coroner and three weren't.

In contrast, **Mid and South Essex NHS Foundation Trust – Broomfield, Basildon and Southend** referred more than 90% of cases to the Coroner, including many cases where the cause of death was identified. All but three of the neonatal deaths in the four periods were 'early neonatal deaths'. The Trust referred six of the early neonatal deaths to HSIB during the four periods.

The **Rotherham NHS Foundation Trust** now refers all neonatal deaths to the Coroner.

In cases where Trusts did not provide details of any guidelines on referrals to Coroner, it is unclear whether (1) the Trust does not have any such (written) policy or (2) the Trust chose not to send it. One Trust **(Chelsea and Westminster Hospital NHS Foundation Trust)** emailed to say that they were *'chasing for the policy if we have one'* – but never sent it.

Once again, the figures and analysis of referrals to Coroner were limited by the lack of responses. As with rates of stillbirths, one answer which may be extrapolated is that those whom did not reply might have a deeper lack of transparency than those that did. Nevertheless, even from the Trusts that responded, a clear pattern of inconsistency emerged.

In a number of cases, the figures provided are contradictory. For example, **Blackpool Victoria Hospital** quoted a total of 16 neonatal deaths in the four periods. In response to the question, *"In how many cases was the medical cause identified?"* the answer was 21.

However, this is probably explained by the fact that these are centres of excellence and will be accepting difficult maternity cases from across their respective regions.

The highest total number of recorded neonatal deaths across the four periods

Location	Deaths
Barts Health NHS Trust	140
NHS Greater Glasgow and Clyde (across the entire health board)	114
Princess Anne Hospital	103
Bolton NHS Foundation Trust	85
Bradford Teaching Hospitals NHS Foundation Trust	80

Referrals to HSIB

HSIB was an independent investigator, formed in 2017, funded by the Department of Health and Social Care. From October 2023, it is now the Maternity and Newborn Safety Investigation Programme, hosted by the CQC. At this time, HSIB investigated cases of early neonatal deaths, intrapartum stillbirths and severe brain injury in cases referred by NHS Trusts. To meet the criteria for HSIB investigation, babies must have been born following labour (at least 37 completed weeks of gestation), with one of the following outcomes:

1. intrapartum stillbirth
2. early neonatal death
3. potential severe brain injury.

The data from the FOI request shows that, of those that replied with useable data, all recorded cases of early neonatal death were referred to HSIB. Many Trusts provided an answer of <5, making it impossible to check whether all cases were referred.

Of those that replied with useable data, not all recorded cases of intrapartum stillbirth were referred. For example, at **Barts Health NHS Trust**, there were eight intrapartum stillbirths in 2019-20 but only six of these were referred to HSIB. However, this may be explained by HSIB's criterion for babies to have been born following labour (at least 37 completed weeks of gestation). Similarly, only one of the two intrapartum stillbirths at **Dartford and Gravesham NHS Trust – Darent Valley Hospital** in 2019-20 was referred to HSIB. As above, a large number of answers of <5 (and one of <10) make verification impossible in many cases.

Moreover, for both of these questions, a significant number of Trusts were unable to disclose how many cases they had referred to HSIB. In one case, a trust asked, *'What is meant by HSIB?'*

As above, therefore, poor consistency and transparency regarding referrals to HSIB could be having a damaging effect on maternity services. Tees has experience of neonatal deaths that met the criteria for referral to HSIB but the families were not informed of this and instead the Trusts concerned carried out internal investigations.

If cases are not being referred when they should, the opportunity to learn and improve both locally and nationally are being lost.

A separate FOI was sent to HSIB asking for the number of referrals from each Trust, in the same periods as used for the FOI sent to Trusts, and how many were investigated by HSIB. The FOI specifically asked about:

- Intrapartum stillbirths
- Early neonatal deaths
- Maternal deaths
- Severe brain injury

HSIB's reply stated:

"Please note where the numbers of cases are less than 5, we are unable to disclose the exact number of cases under section 40(2) of the FOI Act, which relates to personal information of third parties.

We consider that the disclosure of this information could breach an individual's confidentiality, as there is a risk that individuals may be identified if this data is put together with other information that is, or may become, available on that individual."

Based on this approach, HSIB were able to quote numbers for an extremely small number of cases. Therefore, it wasn't possible to conduct meaningful analysis of the figures or cross-reference against the responses provided by Trusts.

Monitoring progress towards targets

Behind every figure is a life lost too soon. It is hoped that this report's evidence will help spur improvements and better transparency in maternity services across the board. Clear and transparent guidelines could help ensure national standards are adhered to countrywide. Otherwise, monitoring of progress towards 2030 targets will remain difficult for Government, Trusts and FOI enquirers such as Tees.

To recap on Trust obligations and FOI responses to Tees:

1. Hospital Trusts are obliged to make appropriate data available and FOI requests are the specified process. The lack of response, delayed responses and incomplete responses made it impossible to obtain a consistent and complete picture of progress so far.
2. Some Trusts reported that they were not able to respond because it would take longer than the time permitted within NHS guidelines. It is unclear why some hospitals can seemingly report much more readily than others. Factors may include Trust size, relative resources and administrative agility.
3. Obviously, this report has focused on those Trusts that have responded and it has highlighted in particular those with disappointing and concerning figures. Of course, those Trusts that did not respond (~ 44%) may well have had better or worse figures – we simply do not know.
4. Given that those that did not respond were not subjected to scrutiny, it seems there may be little incentive to respond to such requests. It appears that if a Trust wanted to avoid scrutiny it would be easy to do so.
5. The absence of guidelines relating to referrals to Coroner or the inability to locate these guidelines, coupled with the previously mentioned limited responses, paints a worrying picture at a time when there have been many concerning maternity-related issues highlighted by the media.
6. Of those Trusts that did respond, some had particularly concerning results. For example, the stillbirth rates of Trusts including **Barts Health NHS Trust**, **Bradford Teaching Hospitals NHS Foundation Trust** and the **Northern Care Alliance NHS Foundation Trust** were particularly alarming. The Trusts have not been approached to further question them about their stillbirth rates and whether there is any reasonable explanation for these and given that there was no/incomplete replies from other Trusts a full comprehensive pattern cannot be drawn.
7. The Trusts were not approached to question them further about the discrepancies in referring neonatal deaths to Coroners, and therefore we don't know the reasons behind the figures. Nonetheless, it seems difficult to explain why a Trust would not refer all neonatal deaths where the cause is unknown, to a Coroner. This is especially perplexing when some Trusts are referring the vast majority of all neonatal deaths to Coroners. There is clearly inconsistency, and potentially a Coroner lottery which means that some parents will forever be left not really knowing why their baby didn't live.
8. It is also unclear who, within a Trust or otherwise, takes the decision whether or not to refer a neonatal death formally to a Coroner. In some cases, it appears to be the Coroner's decision, in others it may well be the Trust's. It is hoped that a more consistent approach will be adopted through the medical examiners role now reviewing and assessing potential referrals.
9. There is clearly a general need for (a) better reporting, (b) greater transparency and (c) greater consistency of approach.
10. This report also intended to investigate other areas such as maternal deaths. While it has not highlighted any issues, this is not necessarily a reflection that the results warrant closer scrutiny, but instead that the reporting was very limited and incomplete.

Conclusions

Conducting a survey based on FOI requests to numerous NHS Trusts was frustrated to a significant extent by a patchy response. With nationally set targets to work towards, Trusts have a responsibility to record and make available accurate information on stillbirths, neonatal deaths and maternal deaths. Given that the response rate to the FOI requests was only around 56% and in the wake of media attention on failing maternity services, it is not unreasonable to assume that some Trusts would prefer not to publicise their data. If that is the case, Tees would like to see significant change.

Beyond the FOI process, the data and other information aired in the report itself have revealed the extent of the confusion and inconsistencies that have developed in maternity services around the UK. It is hard to gain a full picture from the limited number of complete responses to the FOI requests; however, the Trusts that did reply did help to provide a reasonable overview of performance and an opportunity to focus on any disparities.

The findings did indeed reveal a mixed picture across the country, with inconsistent stillbirth rates between Trusts and significantly different attitudes to Coroner referrals. On stillbirths, nearly all Trusts remain above the target rate of 2.3 per 1,000 live births, with some consistently and significantly above 5 per thousand. On Coroner referrals, rates range from 0% to 100%, amidst a confused picture of contradictory advice. On HSIB referrals, it appears that not all cases that should necessitate a referral are being referred, while many Trusts are either unsure of, or unwilling to, provide up-to-date information. These stillbirth and referral rate variations remain a matter of significant concern.

Tees recognises the pressures that maternity and neonatal services are under, in terms of funding, facilities and human resources. However, the commitment made by the Health Secretary in 2015 was an important one that needs to be set and maintained on a realistic course for halving those tragic death rates by 2030. Key to this is close monitoring of case numbers and identification of underlying causes, so that new lessons learned in one Trust area can be swiftly applied across the country to help prevent avoidable loss of life.

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Janine Collier
Executive Partner
Head of Medical Negligence
Tees Law

I welcome this report and the forensic analysis that Tees Law have undertaken to establish continuing concerns with stillbirths and neonatal deaths across NHS Trusts.

"The Government's ambition, made in 2015, to halve the number of stillbirths could potentially save the lives of 1,500 newborn babies a year. This report shows, in stark terms, just how far we continue to fall short of this ambition so causing heartache to so many families. And alongside this, the report also highlights continuing inconsistencies in how Trusts report cases of neonatal deaths to the Coroner and for independent investigation so missing opportunities to learn and improve. Sadly, this is something we hear about first-hand from the many families that we support and help after such distressing events."

Paul Whiteing
Chief Executive of Action against Medical Accidents (AvMA)

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