Introduction

This document has been prepared by the Queensland Maternal and Perinatal Quality Council (the Council) in consultation with the Queensland Department of Health, Patient Safety and Quality Improvement Service, as a guide for Hospital and Health Services (HHSs) in relation to a recent change to section 29(1) of the Hospital and Health Boards Regulation 2012 (the Regulation). Stillbirths are now included in the Regulation as a reportable event within the Queensland Severity Assessment Code (SAC) matrix for clinical incident management. This inclusion enables an HHS the option to use Root Cause Analysis (RCA) methodology to investigate a stillbirth. It will also align HHSs to the National Safety and Quality Health Services Standards 1 and 2.

The Council is a gazetted quality assurance committee and as such is a prescribed patient safety entity. It reviews the management of pregnancies, births, maternal and perinatal deaths and apparent risk factors for such events. In doing so, it attempts to identify areas of maternal and neonatal care where service providers might focus attention to prevent future deaths and adverse outcomes. To assist in this purpose, the Council highly recommends that all HHSs initiate clinical incident methodology to analyse stillbirths identified within an incident category.

There is no legislation or binding policy in Queensland prescribing which form of analysis HHSs must undertake for SAC1 events. In deciding which form of analysis is applicable for each SAC1 incident, for example, RCA or clinical review, HHSs should be aware of the enabling provisions of the Hospital and Health Boards Act 2011. In addition, the Council recommends that all perinatal deaths be reviewed at the local level by a multidisciplinary committee as part of standard practice, according to the Perinatal Society of Australia and New Zealand Perinatal Mortality Guidelines https://psanz.com.au/guidelines/, and that consideration also be given to undertaking other available forms of analysis outside the legislation, for example, Human Error and Patient Safety (HEAPS) analysis.

Criteria for stillbirth analysis

The Council’s Perinatal Mortality Sub-Committee suggests the following criteria for stillbirth analysis:

1. All cases in which a stillbirth occurs beyond 28 weeks of gestation (excluding those with major congenital anomalies in which stillbirth is not unexpected). In general, the later gestation stillbirths are more likely to have contributory factors and beyond 36 weeks, a clinical incident analysis should seriously be considered as standard practice.

2. All cases beyond 24 weeks of gestation in which there is an unexpected intra-partum stillbirth.

3. Any other cases resulting in stillbirth where concerns are raised by a clinician, mother or family that inappropriate clinical decisions were made that could have contributed to the outcome.
Background

The stillbirth rate in Queensland is not different from the national average and is approximately seven per 1000 births. This means that there are approximately 420 babies stillborn each year.

Not all stillbirths are preventable. International literature indicates that over the last two years, 20-30% of late gestation stillbirths may have some contributory factors which, if mitigated, could possibly have prevented the outcome. For example, around three out of every seven stillbirths occur before 24 weeks of gestation and are either the result of termination of pregnancy for lethal or severe congenital anomalies, or they occur before the fetus reaches a viable gestational age or size. In contrast, the rate of stillbirth at post-28 weeks of gestation is three per 1000 births and these may often have some element of preventability.

The Council encourages HHSs to invest time in implementing best practice methodology to evaluate clinical incident analyses, which will assist in improved measurement and further develop (system and processes) effectiveness, inform decisions and/or increase understanding in relation to complex maternity issues. Council members are available to provide assistance in clinical incident analysis as required, for example, as panel members for RCAs or to offer expert advice. Requests for advice can be made via email: QMPQC@health.qld.gov.au

By adopting the recommendations and suggested criteria for stillbirth analysis within this guidance document, it is expected that the numbers of stillbirths subjected to analysis review will be less than three per 1000 births, or 180 cases each year across Queensland. Increasing the frequency and rigour of review of this tragic clinical outcome should help improve our understanding of the circumstances leading to stillbirth and hopefully contribute to ending preventable stillbirths.

This guidance document and further information on the activities of the Council, can be found electronically at https://www.health.qld.gov.au