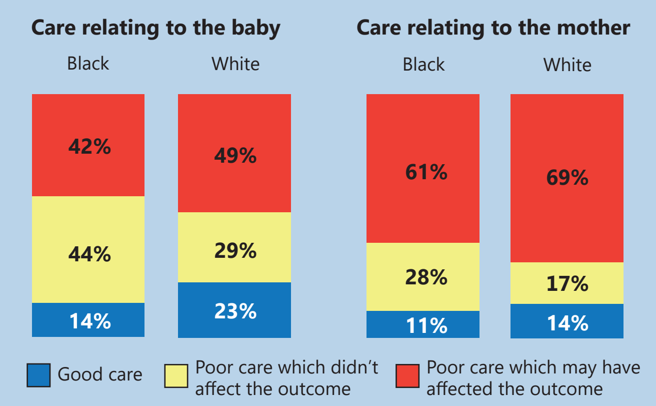
Comparing the care of Black and White women whose babies died

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Baby deaths in 71 pregnancies reviewed → 36 Black women / 35 White women → Medical notes reviewed by clinical experts →



Women's ethnicity, nationality and citizenship status was not always recorded well.	All women should be asked about their ethnicity, nationality and citizenship status, to help provide care that is tailored to their specific needs.
When a woman's first language wasn't English and she needed an interpreter, this wasn't always provided.	Women should be offered information about maternity care in different ways. An interpreter should be offered at each appointment, if the woman needs it to understand the information she is given or to talk to her doctor or midwife.
Some women faced challenges in their personal lives which were not always recognised or taken into account when planning their care. These challenges were more common for White women.	Information about women's personal and social risk factors should be written in the notes, and updated throughout the pregnancy, so that extra support can be provided if it is needed.
Some Black women found it difficult to get certain types of care or advice, even if it was offered to them.	Maternity care should be personalised to the needs of each woman. Women should be helped to overcome any problems that make it hard for them to get the care they need.
Blood tests to check for gestational diabetes were not offered to 1 in 3 Black women. Almost all White women who should have been tested were offered a test.	All women with risk factors for gestational diabetes, which includes all Black women, should be offered a test between 24 and 28 weeks of pregnancy.
All the Black women should have been offered a high dose of Vitamin D to take during their pregnancy, but none of them were.	All women should be offered Vitamin D to take during pregnancy, and women with darker skin or a BMI over 30 may be offered a higher dose.
Bereavement care was good for most parents.	Family-centred bereavement care, in line with the National Bereavement Care Pathway, should be offered to all parents.
Almost all baby deaths were reviewed using the Perinatal Mortality Review Tool. The hospital reviews were more positive than the conclusions reached by the confidential enquiry panels.	Hospitals should make sure that reviews are carried out by enough people from the right specialties. At least one of these people should be from another hospital.
When a review did take place, most parents didn't have any questions or talk about their experience, especially if they didn't speak English.	As part of the review process, parents should be supported to ask questions and talk about their experience, to ensure they receive answers about why their baby died.
Most parents had a follow-up meeting with their consultant to review their care, but not all had a letter summarising what they talked about. Black parents were less likely to receive a letter than White parents.	All parents should have a follow-up meeting (jointly with their obstetrician and neonatal doctor, if appropriate) to review their and their baby's care, and a clear and personalised written summary should be given to the parents.

Source: Draper ES, Gallimore ID, Kurinczuk JJ, Kenyon SL (eds), on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Confidential Enquiry: A comparsion of the care of Black and White women who have experienced a stillbirth or neonatal death - State of the Nation Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Population Health Sciences, University of Leicester. 2023.