House of Commons
London SW1A OAA
All-Party Parliamentary Group on Baby Loss

Monday 6th March, 2.00pm – 4.00pm
Room C 1 Parliament Street & Online

Chair: Helen Morgan MP

MINUTES

Members and representatives in attendance:

- Helen Morgan MP (Chair)
- Olivia Blake MP
- Representative of Rosie Duffield MP
- Representative of Margaret Greenwood MP
- Representative of Alicia Kearns MP
- Representative of Lilian Greenwood MP
- Representative of Natalie Elphicke MP

Speaker:

- Dr Bill Kirkup CBE

Guests in person:

Megan Ball	Sands, APPG on Baby Loss Secretariat
Jess Reeves	Sands
Jane Denton	Multiple Births Foundation
Lauren Braithwaite	Petals
Fiona Gosden	TimeNorfolk
Angie Rice	Midwife, EPAU Nurse
John Mancini	Early Pregnancy Unit
Charlotte Wright	BBC South East
Kate Mulley	Sands
Ruby Earle	Office of Olivia Blake MP

Guests attending online:

Abby King	East Kent Hospitals University NHS Foundation Trust
Aileen Lawrie	NHS Fife
Aimee Middlemiss	University of Exeter
Aleesha Khaliq	Sands
Amanda Cushing	Mid and South Essex NHS Foundation Trust
Anna Nella	Bereavement Midwife
Becky Bolton	North West Anglia NHS Foundation Trust

Ben Curran	Parent Infant Foundation
Beth Duffell	Twins Trust
Caroline Brogan	Irwin Mitchell
Cathy Brewster	Manchester Home Birth
Celia Burrell	Barking, Havering and Redbridge University Trust
Charlotte Edun	AIMS
Derek Somers	
Diane Gaston	Royal College of Pathologists
Erin McCloskey	University of Liverpool
Geoff Heaps	The Lily Mae Foundation
Georgia Stevenson	Sands
Heidi Eldridge	MAMA Academy
Jacque Dunkley-Bent	NHS England
Jake Poulton	Nursing and Midwifery Council
Jane Plumb	Group B Strep Support
Jane Scott	West Hertfordshire Teaching Hospitals NHS Trust and
Janet Scott	Sands
Jenny Poirier	Teddy's Wish
Jo Dickens	University of Leicester
Josie Anderson	Bliss
Julia Clark	Sands
Julia French	Somerset NHS Foundation Trust
Kara Davey	Dr Davey Coaching
Kirri Gooch	The Lily Mae Foundation
Lucy Smith	University of Leicester
Lynne Sheridan	Abigail’s Footsteps
Marc Harder	Sands
Marcus Green	Action On Pre-Eclampsia
Maria Viner	Mothers For Mothers
Mark Norman	
Mary Newburn	Kings College London
Megan McGovern	University of Leicester
Mehali Patel	Sands
Michael Buchanan	BBC News
Michelle Tolfrey	The Loss Collective
Myra Kinnaird	NHS Grampian
Natalie McKie	Lullaby Trust
Nicky Lyon	Baby Lifeline
Nikita Vaghjiani	NHS England
Oliver Plumb	Group B Strep Support
Richard Boyd	Department for Business, Energy & Industrial Strategy
Sarah Phillips	Kings College Hospital NHS Foundation Trust
Shahida Mehrban	The Rotheram NHS Foundation Trust
Sharon Darke	Twins Trust
Srinivas Annavarapu	Royal College of Pathologists
Sylvia Stoianova	National Child Mortality Database
Tanya Gupta	BBC News
Victoria Morrell	Twins Trust
Zoe Jones	Office of National Statistics
Zoe Russell	Royal College of Obstetricians and Gynaecologists

Welcome & introductions (Helen Morgan MP)

Helen opened the meeting and welcomed everyone attending both in person in Westminster and online over Teams. Helen explained that she would be Chairing today's meeting in Cherilyn's absence due to travel difficulties.

APPG on Baby Loss updates (Helen Morgan MP)

Updates on the Safe Staffing campaign
Helen outlined that the Government had announced in the Autumn Statement the commitment to recruit 2,000 more midwives and release a 5, 10 and 15 year workforce plan. This is a step in the right direction and the APPG will follow up with the Government on this.

There is the intention to host a Backbench Business Debate focused on the progress of the APPG report since it was published, which the APPG hope to organise in April. Further details will be shared once this is confirmed.

Updates on perinatal pathology workforce issues
Dr Sri Annavarapu, Chair of the Specialty Advisory Committee of Paediatric and Perinatal Pathology at the Royal College of Pathologists and Consultant, Perinatal & Paediatric Pathology at Alder Hey Children's NHS Foundation Trust, provided an update on the work to reduce workforce gaps in the profession.

Sri explained the sheer gap in the service – only 55 out of 80 consultant spaces are filled. The service is understaffed and only a few consultants retiring away from being at breaking point. Measures to solve workforce shortages have been divided into two categories - short-term (stop-gap) measures and long-term measures.

The short-term measures aim to reduce the demand on staff in the service whilst maintaining quality. A placental tissue pathway has been rolled out, as well as mutual aid between hospitals and departments where there are good levels of staffing. These measures have been carried out successfully since implementation in October.

The long-term measures aim to fill staff gaps in the service. There is an international recruitment drive to find candidates. A new fellowship is also being established which would train established pathologists in 12 months. The College and NHSE are also developing a 3-year diploma in placental pathology for non-medical candidates with experience in science or reproductive health. This has already been successfully used in gastrointestinal, skin and cyto pathology. Online training modules are also being considered, to improve training opportunities.

A question was received from Sands regarding communication about the new triage system which dictates which babies receive post-mortems. Concerns were raised that healthcare professionals have not been made aware of the new system leading to cases where consent has been obtained only for a post-mortem to then not be approved. There is also no information available in a format suitable for families. This is distressing for parents & families.
ACTION: APPG will raise this issue with NHS England.

Angie Rice raised a question about retention. Sri explained that some retired pathologists are returning to the service to support in the meantime.

Pregnancy Loss Review
Olivia Blake MP provided the group with an update on the Pregnancy Loss Review.

Olivia outlined that in 2021, the Minister agreed to consider two of three Lancet Series recommendations ("ensure that designated miscarriage services are available 24/7 to all" and "acknowledge that miscarriage matters to parents and take steps to record every miscarriage in England"(, in the Women's Health Strategy. It was then assured that this would be addressed in the Pregnancy Loss Review, however, this is not certain and it is yet to be released.

ACTION: The APPG agreed to write to the Minister to ask for an update on the Pregnancy Loss Review and its commitments to miscarriage-specific care.

Angie Rice raised a point around miscarriage care still being regulated under the Abortion Act 1967, highlighting how nurses and midwives cannot provide medical management as it must be prescribed by a doctor. Olivia Blake agreed this was outdated, and highlighted how this would be covered in the graded model of care suggestions.

Investigation into East Kent Maternity Services – reflections and progress since publication (Dr Bill Kirkup CBE)

Dr Bill Kirkup CBE, Chair of the East Kent Review, started the presentation by sharing quotes. Firstly, from mothers and families outlining low-quality and harmful care. Secondly, from staff members showing poor working culture and relationships. Finally, quotes from various stakeholders that were from after a baby had died highlighting insensitive remarks and unacceptable levels of care.

The review found the following underlying themes:

- Failures in teamworking
    - Lack of trust and respect, dominant egos & informal hierarchies, bullying and intimidation, inexperienced clinicians were left isolated, there was a lack of common purpose
- Failures of Professionalism
    - Disrespecting women & colleagues, shifting blame to colleagues & women, incidents played out publicly in front of families
- Failures of Compassion and Listening
    - There were examples in almost every account of women not being listened to. Attitudes were dismissive and uncaring which led directly to poor outcomes and left a permanent legacy with families
- Failures after safety incidents
    - There were similar attitudes around a lack of compassion, blame-shifting and defensiveness. Centred around denial, deflection, dishonesty and a failure to learn

202 families came forward to be involved in the investigation, although Bill admitted that this is likely an underestimation. The investigation found that 97 (48%) of the families could have or would be expected to have had different outcomes if suboptimal care wasn't present. The investigation also found a series of missed opportunities to read signals and improve care.

Bill outlined that the report called for a different approach, stopping this cycle of catastrophic failures but not providing detailed operational recommendations. Instead, the report gave four areas for action:

1. A maternity signalling system
    a. There is data, but it is analysed poorly. This should be shifted to an outcomes-based output, which is meaningful and risk adjustable but allows for natural variation and is accessible to not only trusts and regulators but women as well
2. Standards of behaviour
    a. Aggression, hostility and rudeness must stop being normalised. It is appearing in trusts in members of staff that are role models which is damaging to the future of the professions. Effective clinical leadership is crucial.
3. Flawed teamworking
    a. Bullying, intimidation and neglect must be removed. Trainee staff members were unsupported and put in positions beyond their competence, which was dangerous. A common purpose must be achieved, and there must be leadership and training that communicates shared goals.
4. Organisational behaviour
    a. Current disincentives are ineffective. Duty of Candour is not always effectively and sympathetically applied. The NHS serves as a revolving door for CEOs and Chairs, which must be stopped as it does not prevent or address deep routed cultural issues.

Bill reiterated that we owe it to the families involved to learn and improve from this investigation.

Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer for England, followed up on Bill's presentation and outlined that NHS Trusts and integrated care boards are learning from recommendations and ensuring implementations are sustainable.

Nicky Lyon asked how a common purpose can be built in midwifery and neonatal services. Bill highlighted how professional leadership is crucial in this, as well as education and input from Colleges.

Kirri Gooch queried how parents can have a voice in these situations and raise concerns effectively. Helen outlined how the APPG can be involved in raising issues at a policy level. Jacqueline outlined how concerns can be raised clinically, highlighting routes through Maternity Voices Partnerships and independent senior advocates; a pilot scheme which was an Immediate and Essential action in Ockenden. Jacqueline acknowledged that this was a challenging space. Kirri asked if this could be streamlined, and Bill shared his support for this.

Charlotte Wright asked what has happened in the months since the publication of the East Kent. Bill emphasised that whilst not in his role to monitor the implementation of learning from the report, he understands that East Kent has accepted the severity of the report and is making changes, acknowledging that this is not a quick process.

Celia Burrell updated the group on a voluntary role from Sands, Hospital Liaison Volunteers, that may provide support for healthcare professionals working with bereaved women and families.

Jane Scott reiterated the point around a plethora of reports and systems for reporting and investigating losses, and how confusing this is. There is a need to collaborate around this.

Mary Newburn asked for Bill Kirkup's slides to be circulated.
ACTION: Secretariat will circulate the slides with the minutes.

Aimee Middlemiss asked Bill if there was space for other types of monitoring such as qualitative data. Bill agreed that this in addition to other systems would make for strong outcomes.

Cathy Brewster asked if the Government were planning to respond to the East Kent Report. Bill explained he had a meeting with the Health Minister a month ago and that he believes there may be a response soon.
ACTION: APPG will follow up on a response to the East Kent review from the Government
Note: An initial response from the Government was announced on Tuesday 7th March 2023, which can be read here: https://questions-statements.parliament.uk/written-statements/detail/2023-03-07/hcws606

Kara Davey asked whether tasking NHS management with finding solutions and implementing findings was the sticking point in progress. Bill reiterated that it is not about reinventing solutions, but rather about national leaders speaking together with one voice.

Derek asked whether East Kent can make the required changes with the right support from NHS England and the Government. Bill highlighted that East Kent need support in addressing the cultural issues at the trust.

Mary Newburn raised the idea of senior independent facilitators who are involved in finding solutions within Trusts. Bill agreed that this would be interesting.

Any other business
Lucy Smith asked if the APPG could confirm the publication date or status of the Pregnancy Loss Review. Helen explained that we could not confirm, but we would share anything with the group as soon as we do.

Helen thanked all who attended and spoke, and apologised for sound and technical issues. The Secretariat will be in touch about the next meeting in due course.