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NHS culture must change to prevent deaths of babies

Reports this week that hundreds of babies' lives might be saved if the NHS learnt from its mistakes are shocking. And it's not the first time we've heard such findings. In 2015 a review of stillbirths at the end of pregnancy found that 60 per cent might have been prevented if care had been different. Then and now the recommendations remain the same. Fifteen babies die each day in the UK before, during or shortly after birth. My organisation — Sands, the stillbirth and neonatal death charity — represents thousands of parents whose babies have died in this way and who believe there needs to be more urgency about finding a solution.

Numerous initiatives to save babies' lives have been launched in the past five years. There are government-backed stillbirth and perinatal working groups in Scotland, Wales and Northern Ireland. Two years ago, Jeremy Hunt, the health secretary, called for a 20 per cent reduction in deaths by 2020, rising to 50 per cent by 2030, which would put the UK's rates of perinatal death closer to countries such as Norway and Sweden.

The NHS needs to change its culture, not just its policy on the issue. Human errors are inevitable. No clinician has all-seeing eyes to prevent every tragedy and many baby deaths are due to causes that we still don't know enough about to influence. But when errors occur the failure to learn from them is the greatest error of all. This week's *Each Baby Counts* report from the Royal College of Obstetricians and Gynaecologists tells us three quarters of cases of labour-related harm or death of a term baby were potentially avoidable, while too many hospitals are failing to examine and admit how things go wrong and where care might improve. We need to look at the systems and environments maternity professionals work in, making it easier for them to do the right thing.

But a change in culture will require time and resources. Units will have to be adequately funded and staffed to make meaningful use of a new standardised perinatal mortality tool, which collaborators including Sands have been commissioned to create. It will help ensure that every baby death is taken seriously and mistakes are reviewed, so that lessons are learnt and parents get adequate answers about why their baby died.

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