

DISCERN study published: How to improve discussions with families when things go wrong in maternity care

15 October 2024  Freya Feghali

A DISCERN study, led by a team at King's College London and working with Sands (a baby loss charity which campaigns in saving babies' lives and supporting bereaved families), BirthRights, the Birth Trauma Association (UK) and The University of Manchester, was released in August 2024.

The study, funded by the National Institute for Health and Care Research (NIHR), sets out actions for improving communication with families after things go wrong while receiving NHS maternity care. This is particularly relevant given that it is Baby Loss Awareness Week.

Researchers, led by Professor Jane Sandall and Dr Mary Adams, reviewed existing research on how open disclosure currently works in healthcare settings (including review of hospital policies and guidance), interviewed families who had been through the hospital review process and interviewed healthcare staff and managers. Focus groups also took place with families, healthcare professionals and policy makers to consider how best to improve open disclosure in practice.

The study highlights that effective open disclosure discussions with families, who have received NHS maternity care which has caused harm, should provide families with open and honest answers to ensure that the same mistakes do not happen to others.

[The full report can be accessed here](#) →

A [video has also been released with the study](#) which demonstrates the difference that effective open disclosure can make for families that have suffered the loss of a child. The video delivers a powerful message, stating *"It's not just about organisations 'saying this is how we should work with families', everybody needs to be on the same page. It needs to be the culture. It's about this being our moral compass"*.

Study findings

The study found that there are five main areas of particular importance when it comes to there being open and honest disclosure with bereaved families:

1. Meaningful acknowledgment of harm- recognising the pain and loss experienced by families, including an understanding that the death has had a profound impact on the lives of the parents and family members;
2. Understanding what happened- ensuring that families are supported in understanding exactly what occurred in order to provide clarity to them;
3. Involvement of family in investigations- acknowledging that families should be central to investigations/reviews that follow the death of a baby;
4. Compassionate and skilled communication- focussing on training of healthcare staff to handle discussions with families sensitively and with compassion;
5. Commitment to change- recognising the importance to learn from these incidents and make necessary changes to prevent harm occurring in the future.

Study recommendations

Recommendations from the study include the following:

- Highlighting the importance of there being ongoing communication with families during and following reviews;
- Developing a standard approach to open and honest discussions with families;
- Developing training for healthcare staff to ensure effective and compassionate communication with families during reviews/investigations.

Our team

At Browne Jacobson we welcome this study which focusses on an important area of maternity care. Ensuing healthcare staff work openly with families when distressing and harmful outcomes occur is of paramount importance. The effect of such events on families and staff cannot be underestimated.

We are committed to assisting healthcare organisations with delivering on their strategy to improve maternity outcomes. Our specialist maternity division can provide advice, support and training to Trusts in building on their practices of effective communication with families who suffer harm. Please do get in touch to discuss how we may be able to help your organisation.

Browne Jacobson's [maternity resources hub](#) also provides resources and information about our specialist team and includes our contact details.

Key contact

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