Dear Colleague


Summary

1. The Fifth Report of the UK Confidential Enquiries into Maternal Deaths covering the period 1997 – 1999 has now been completed and this letter marks its publication. A limited number of copies of the report are currently being distributed, however the Report, Executive Summary and a booklet specifically aimed at Midwives are available on the internet on www.cemd.org.uk.

Background

2. The findings and recommendations of the Confidential Enquiries are of relevance to all NHS Boards and Trusts and to all healthcare professionals responsible for the planning and provision of care to pregnant and recently delivered women. These professionals include health service managers, general practitioners, midwives, obstetricians, anaesthetists, staff in Accident and Emergency departments, pathologists and psychiatrists. All NHS organisations and staff are advised to consider the recommendations within the CEMD report and to form individual action plans for any necessary changes in their own service or personal practice.

From the Chief Medical Officer, Chief Nursing Officer and

Dr E M Armstrong
FRCS(Ed) FRCP (Glas, Ed)
FRCGP FFPHM
Miss Anne Jarvie CBE
RGN RM BA

St. Andrew’s House
Edinburgh EH1 3DG
Telephone 0131-244-2836
Fax 0131-244-2835

5 December 2001

For action
Directors of Public Health
Medical Directors
Directors of Nursing, NHS Boards
Directors of Nursing, NHS Trusts

For information
See distribution list attached

Further enquiries
Dr I R Bashford
Senior Medical Officer
St Andrew’s House
Edinburgh EH1 3DG
Tel: 0131-244-2289
Fax: 0131-244-2069
e-mail: ian.bashford@scotland.gsi.gov.uk

Mrs J Swaffield
Nursing Officer
St Andrew’s House
Edinburgh EH1 3DG
Tel: 0131-244-2310
Fax: 0131-244-2853
e-mail: jean.swaffield@scotland.gsi.gov.uk

Further copies of the report can be obtained from
RCOG Bookshop
Tel: 020 77726275
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Key findings

3. During the 1997-99 triennium, 378 deaths during pregnancy or within one year of delivery were reported to the Enquiries throughout the United Kingdom. Of these deaths, 106 were classified as direct and 136 as indirect, giving a maternal mortality rate for the triennium of 11.4 per 100,000 maternities. The direct rate was 5.0 per 100,000 maternities and the indirect rate was 6.4 per 100,000 maternities. Comparable rates per 100,000 maternities for the 1994-96 triennium were a maternal mortality rate of 12.2, a direct mortality rate of 6.1 and an indirect mortality rate of 6.1 per 100,000 maternities.

4. The major causes contributing to the overall maternal mortality rate (all expressed per 100,000 maternities) were similar to the previous triennium:

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Rate per 100,000 maternities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1997-99</td>
</tr>
<tr>
<td>thromboembolism</td>
<td>1.65</td>
</tr>
<tr>
<td>early pregnancy inc. ectopic</td>
<td>0.80</td>
</tr>
<tr>
<td>hypertensive disorders</td>
<td>0.71</td>
</tr>
<tr>
<td>sepsis</td>
<td>0.66</td>
</tr>
<tr>
<td>amniotic fluid embolism</td>
<td>0.38</td>
</tr>
<tr>
<td>haemorrhage</td>
<td>0.33</td>
</tr>
</tbody>
</table>

5. However, when all deaths up to one year after delivery are considered, including those identified by record linkage but not reported to the Enquiries, suicide is the leading cause overall. Deaths from thromboembolism and from sepsis after Caesarean section have fallen since the previous triennium. Numbers of maternal deaths are now so small that, even when considered on a UK-wide basis, differences seldom reach the requirements for statistical significance. Nevertheless, falling rates of these causes of death are encouraging and increased availability and use of local protocols may have contributed to these improvements.

6. Associations between various risk factors and maternal death were examined in this report. It is of concern that socially excluded women are over-represented among maternal deaths. For example, women in lower social class categories, women from the traditional travelling community, non-white and non-English-speaking women, victims of domestic violence, poor attenders for antenatal care and young women aged under 18 years were all over-represented.

7. Among the direct maternal deaths, instances of substandard care were identified by the assessors in 54% of cases. Lessons to be learnt from these instances of substandard care are reflected in the Enquiry recommendations.

Key recommendations

8. The CEMD Report includes 95 specific recommendations grouped under 13 headings. Many of these recommendations relate to the management of specific clinical conditions or to
professional education and training. The Report authors have highlighted specifically certain recommendations under the *Local guidelines and auditable standards for maternity care* and *Commissioning for maternal health services* headings as essential issues for all readers:

- Each unit should identify a lead professional to develop, audit and update local multidisciplinary guidelines for the management of obstetric problems. Nine topics for which guidelines should be available, as a minimum, are listed within the Executive Summary.

- The planning and delivery of maternity services should focus on approaching each woman as an individual with different social, physical and emotional needs as well as any specific clinical factors that may affect her pregnancy. Her pregnancy must not be viewed in isolation from other important factors that may influence her health or that of her developing baby.

- Antenatal services should be flexible enough to meet the needs of all women, bearing in mind that the needs of those from the most disadvantaged, vulnerable and less articulate groups in society are of equal if not more importance. Many women who died found it difficult to access, or maintain access with the services, and follow up mechanisms for those who failed to attend were poor. Women who regularly fail to attend clinics should be actively followed up.

- When planning new methods of service provision it is helpful to involve those women who might have difficulties in using the services in their design. Where this has been done, antenatal clinic attendances have significantly improved. Such flexibility may require imaginative solutions in terms of the timing and setting for antenatal clinics and the provision of outreach services.

**Action by NHS Boards and Trusts**

9. Health Boards, Trusts and individual healthcare professionals are encouraged to use the findings and recommendations of CEMD to:

- Review and, where necessary, modify existing arrangements for the provision of maternity services, including comprehensive services for postnatal depression.
- Ensure that all deaths directly related to pregnancy, and those from suicide, are subject to a local risk management review. In future, local critical incident reports should be included in the confidential material made available to CEMD(Scotland).
- Develop and regularly update local multidisciplinary guidelines or protocols for pregnancy-related complications
- Promote local audit and clinical governance.

10. For over 50 years, CEMD has had the support of professionals involved in caring for pregnant and recently delivered women. It is a Scottish Executive requirement that all maternal deaths should be subject to this form of confidential review. Currently, CEMD(Scotland) is administered on behalf of the Chief Medical Officer by the Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH). All health professionals have a duty to provide the Enquiry team with the information required. SPCERH is notified automatically by the Registrar
General of maternal deaths known to him. However, to ensure complete ascertainment, any health professional who is aware of a maternal death is requested to notify the national co-ordinator, Dr Gillian Penney (g.c.penney@abdn.ac.uk or 01224 552614 or 0131 229 2575 ext 2317) from whom further information on the conduct of CEMD(Scotland) can be obtained.

11. NHS Boards and Trusts are asked that the report is given wide circulation and are asked to ensure that private health care providers are informed of it through their registration and inspection function.

Acknowledgements

12. The Scottish Executive Health Department is grateful to all those who have contributed material relating to individual cases for this report and also to the Scottish subgroup of clinical assessors, chaired by Professor Marion Hall. Women and their families rightly expect us to learn lessons when a tragedy occurs and to apply these lessons widely and effectively.

Yours sincerely

[Signature]

DR MAC ARMSTRONG MISS ANNE JARVIE
Chief Medical Officer Chief Nursing Officer