

Title page

## **The Confidential Enquiry into Maternal Deaths 2015**

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## **Introduction**

The long-standing Confidential Enquiry into Maternal Deaths began in 1952 and has led to major improvements in care for pregnant and postnatal women. Since 2012 the maternal death enquiry has run from the National Perinatal Epidemiology Unit (NPEU) in Oxford, through the collaboration MBRRACE-UK. MBRRACE-UK produces an annual report and in 2015 (1) covered mental health, thromboembolic disease, cancer, late deaths, homicides and domestic violence.

Between 2011 and 2013 there were 240 maternal deaths during or up to six weeks after pregnancy, giving a maternal death rate of 9/100,000 women, a statistically significant decrease compared with 2009-12. Two thirds of the deaths were due to medical and mental health co-morbidities and one-third were due to obstetric causes. There has been no significant change in deaths from medical and mental health conditions causes over the last 10 years. In this paper the focus will be on thromboembolic disease, mental illness, homicide, domestic violence and late deaths.

## **Prevention of thromboembolic disease**

Forty eight women died from pregnancy-related venous thrombosis or thromboembolism (VTE) during or up to six weeks after pregnancy between 2009 and 2013. One quarter died in the first trimester of pregnancy, before usual maternity booking, although many had risk factors. GPs need to be aware of RCOG green top guidelines (2); if they see a woman prior to booking and consider that she is high or medium risk, they should refer urgently for advice on thromboprophylaxis.

On several occasions, despite being assessed as at high risk and needing a prolonged course of low molecular weight heparin postnatally, women were not given the full prescription prior to discharge from hospital; the expectation was for the GP to prescribe the remainder of the course. This creates extra barriers for the woman who may find it hard to visit her GP and pharmacy to obtain the medication; and the potential for a prescribing error. The report therefore recommends that prescriptions for the entire postnatal course of LMWH should be issued in secondary care.

### **Lessons on maternal mental health**

One hundred and sixty women died from mental health problems over the 5 year period 2009-2013: 101 died by suicide, 58 from substance misuse and 2 from other causes.

### **Suicide**

Over half of the women who died by suicide and in whom there was adequate information to make a diagnosis, had a diagnosis of a recurrent mental illness. A quarter of them were psychotic at the time of their suicide. This emphasises the importance of midwives being able to access past medical history either from GP records or by good communication with GPs. The women who died had often been ill for weeks or months, with escalating symptoms before they took their own lives. Many had been assessed on several occasions, usually in A&E or by Crisis Teams and no-one had taken a holistic view or communicated with the GP. Suicidal thoughts were put down as “impulsive” or “no planning” and downplayed, sometimes in the face of serious evidence to the contrary. For example:

*A woman died by violent means several months after the birth of her second child. She had a history of depression and self-harm prior to her first pregnancy. None of this information was passed on to maternity services. Her health visitor found her to be depressed three weeks after delivery and she subsequently expressed suicidal ideation to her GP. It was felt that her problems were stress-related and she was commenced on antidepressants. Subsequently, a relative contacted her GP to express significant concerns about her mental state. On review she described ongoing thoughts of self-harm. She was referred for psychiatric assessment but did not attend and was not followed up by the GP. A few weeks later she was seen at the Emergency Department following an overdose. The mental health assessment described a number of depressive symptoms but concluded that the overdose was impulsive. She was discharged to GP care. Six weeks later she presented to out of hours primary care with self-injury. She was described as having multiple suicidal ideas but no fixed plans, and her self-harm as described as 'impulsive'. Five days later a mental health crisis team concluded that there was no requirement for follow-up. She died four weeks later.*

This woman displays all the issues mentioned above; her GPs did not miss the diagnosis, but clearly did not appreciate the severity of her symptoms and suicidal ideation; neither did the mental health team. Follow-up by the GP when she did not attend the psychiatrist would have been appropriate, knowing that she was suicidal. We do not know if there was local access to a specialist perinatal mental health team, as services are patchy.

If the women who died by suicide became ill today 40% would not be able to get any specialist perinatal mental health care and only 25% would get the highest standard of care.

The following are 'red flag' signs for severe maternal illness and require urgent referral and senior psychiatric assessment:

- Recent significant change in mental state or emergence of new symptoms,
- New thoughts or acts of violent self-harm,
- New and persistent expressions of incompetency as a mother or estrangement from the infant

### **Substance misuse**

Seventy two women who died were known to be substance misusers. Records were assessed for 29 of these women. All of them were vulnerable for multiple psycho-social reasons, such as historic child abuse, domestic violence, self-harm, homelessness, depression, personality disorder and many were known to Childrens' Social Services and had children in care. They booked late for their pregnancy, were poor attenders and although multiple agencies were involved in their care, none were under the care of adult or specialist perinatal mental health services. They often died after their child had been taken into care because no-one considered that this might be a time of greater vulnerability for the mother.

Pregnancy is a window of opportunity for these women to be engaged in treatment and the Enquiry recommended that guidelines for these women should be developed.

## **Homicide and Domestic violence**

A history of domestic violence was documented for only 25 (5%) of all the women who died between 2009 and 2013 during pregnancy and up to 6 weeks after birth.

NICE (3) recommends that “healthcare professionals need to be alert to the symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment in which they feel secure”.

Almost half of these women (n=12) were murdered or died from psychiatric causes. They often had multiple morbidities.

All GPs should have training in domestic abuse; in addition they may receive information sharing alerts from the police about domestic incidents, especially if there are safeguarding concerns (4). This may give them a unique holistic opportunity to recognise a deteriorating situation and to offer support and referral to other agencies.

## **Late deaths**

There were 553 late deaths of women between 2009 and 2013. 23% of these deaths were due to mental illness, discussed above, and the majority of the rest were due to medical conditions (see figure1). Many of the women who died between six weeks and one year after pregnancy had long-standing and multiple morbidities occurring prior to, during and after pregnancy, and they often led socially complex lives. Only 16% of women who died late had **no** additional factors associated with their death and 30% had three or more additional co-morbidities. Many of the factors that led to death were known about at the time of contact with maternity services. Before these women died they had often had multiple contacts with other health services, including general practice. One recommendation is that repeated presentations to

the GP or others should be considered a 'red flag' and warrant a thorough holistic assessment by the GP, leading to on-going review, if appropriate.

Other recommendations were that these women often required additional care following discharge from hospital and needed a clear, detailed postnatal care plan. The senior obstetrician should send a comprehensive summary to the GP flagging up all the medical issues that have arisen in pregnancy and delivery, rather than being written by a junior midwife. If they needed appointments at other services, for example a neurology clinic if a woman had epilepsy, the appointment should be made before discharge and not left to the GP to arrange.

## **Conclusions**

When a mother dies it is a tragedy for a family. Although GPs now have little to do with routine maternity care, there are still important messages that are relevant for general practice, especially with deaths from mental illness and medical complications. These are the deaths we need to prevent if we are to meet the UK Government's new ambition to reduce the rate of maternal deaths in England by 50% by 2030 (5).

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## **References**

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## **Additional learning resources**

**Three P's in a pod** <https://rcpsg.ac.uk/college/influencing-healthcare/policy/maternal-health>

**Medical problems in pregnancy** <http://www.e-lfh.org.uk/programmes/medical-problems-in-pregnancy/>

**Perinatal mental health** <http://www.e-lfh.org.uk/programmes/perinatal-mental-health/open-access-sessions/>

**RCGP Perinatal mental health toolkit** <http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx>