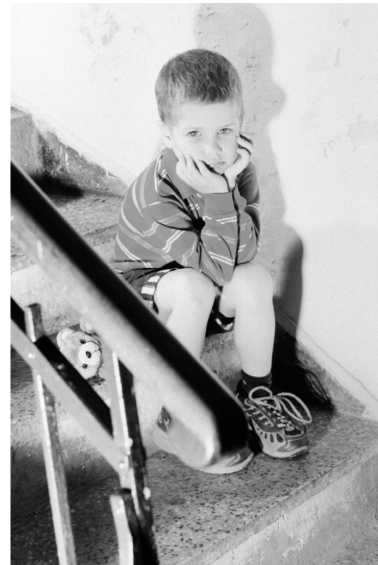
Section 7



APPENDICES

APPENDIX 1
Method of Enquiry

JOAN NOBLE on behalf of CEMACH

Historical background

This is the sixth Report to cover the whole of the United Kingdom. The English and Welsh reports were published at 3-yearly intervals from 1952 until 1984. The Reports for Scotland were published at different intervals from 1965 to 1985, the last covering both maternal and perinatal deaths. Northern Ireland Reports were started in 1956 and were published 4-yearly until 1967; because of the small number of maternal deaths the next Report covered 10 years from 1968 to 1977 and the last Report covered the 7-year period 1978–1984. The relatively small number of deaths in Scotland and Northern Ireland led to the decision of the four Chief Medical Officers to change to a combined United Kingdom Report after 1984.

From 1984 to 1999 the combined UK Reports were produced by The Confidential Enquiry into Maternal Deaths (CEMD). In April 2003, the CEMD and the Confidential Enquiry into Stillbirths and Infant Deaths (CESDI) merged to form the new Confidential Enquiry into Maternal and Child Health (CEMACH). CEMACH operates with a central office in London and regional offices (nine in England and one each in Wales and Northern Ireland). The central office coordinates the activity of the regional offices, provides the central databases and the direction and leadership for the Enquiry. The management structure of the Enquiry consists of the Board, the Enquiry staff and distinct committees for each area of work. The Board has representation from the Royal College of Obstetricians and Gynaecologists (which hosts the Enquiry), Royal College of Midwifery, Royal College of Pathologists, Faculty of Public Health Medicine, Royal College of Paediatrics and Child Heath and the Royal College of Anaesthetists. This is the first Report of the Maternal Deaths' Enquiry (MDE) to be produced under CEMACH.

CEMACH is commissioned by the National Institute of Clinical Excellence (NICE) to conduct the MDE in England and Wales. Northern Ireland does not come under NICE but contributes funds to cover its participation. In Scotland, the Scottish Programme for Clinical Effectiveness in Reproductive Health acting on behalf of NHS Quality Improvement Scotland (NHSQIS) conducts its own Enquiry programme but sends its cases to be included in the triennial Report and NHSQIS contributes funds towards its participation in the Enquiry.

England and Wales

In the first year of this triennium, the responsibility for initiating an enquiry into a maternal death remained with the Director of Public Health (DPH) of the district in which the woman was usually resident. In the second year before CEMACH was established, this became the responsibility of the CESDI Regional Coordinator and then, once CEMACH was established, it was assumed by the CEMACH Regional Manager (RM).

It is a government requirement that all maternal deaths should be subject to this Confidential Enquiry and all health professionals have a duty to provide the information required. All relevant hospital professionals must participate in the Confidential Enquiries. In participating in the Confidential Enquiry, the professionals concerned are asked for three things:

(i) to provide a full and accurate account of the circumstances leading up to the woman's death, with supporting records

(ii) to reflect on any clinical or other lessons that have been learned, either personally or as part of the wider institution

(iii) to describe what action may have followed as a result.

Notification of maternal deaths are usually made directly by one or more of the health professionals concerned to the CEMACH RM of the region where the woman was resident. Cases are also reported by coroners, local supervising authority midwifery officers (LSAMO) and others. Ascertainment is checked biannually with the Office of National Statistics for all deaths coded as a maternal death according to the International Classification of Diseases, Injuries and Causes of Death tenth revision (ICD10) and an enquiry is initiated for any case not already reported to CEMACH. Once a case has been notified, a case number is assigned and the enquiry is initiated using a standard form (MDR-UK1) by the CEMACH RM. The enquiry form is sent by the RM to obstetricians, anaesthetists, pathologists, general practitioners, midwives and any other professionals who were concerned with the care of the woman. Copies of case notes are obtained where relevant. Prior to the involvement of CESDI and CEMACH, this information was gathered by the DPH and then circulated by the Regional Obstetrics Assessor to the Regional Assessors. From 2003, under CEMACH, a policy of anonymisation of records has been introduced and once all available information about the death has been collected, all records are anonymised and then circulated by the RM to the Regional Assessors. The Obstetric and Midwifery Assessors review all cases. Anaesthetic Assessors review cases where there was involvement of an anaesthetist or intensive care. Every possible attempt is made to obtain full details of any autopsy and pathological investigations, and these are reviewed by the Pathology Assessor. The Assessors add their comments and opinions regarding the cause or causes of death. The completed form is returned to the CEMACH Central Office by the RM after which it is reviewed by the Director of the MDE and circulated to the Central Assessors. The Central Assessors in obstetrics and gynaecology, midwifery, anaesthetics, pathology, psychiatry and general medicine review, as required, all available recorded facts about each case and assess the factors that may have led to death (Figure A1.1).

Regional assessment

There are 16 sets of Regional Assessors in England and Wales and each set has an obstetrical, anaesthetic, pathology and midwifery assessor. There are between one and three sets of Assessors per region depending on requirements. Assessors are appointed for the term of a triennium (about 4 years, allowing for completion of assessment). Nominations for medical Assessors are sought from presidents of Royal Colleges and nominations for midwives are sought from the Local Supervisory Authority Midwifery Officer. A Regional Assessor must be an active clinical practitioner in the NHS in the

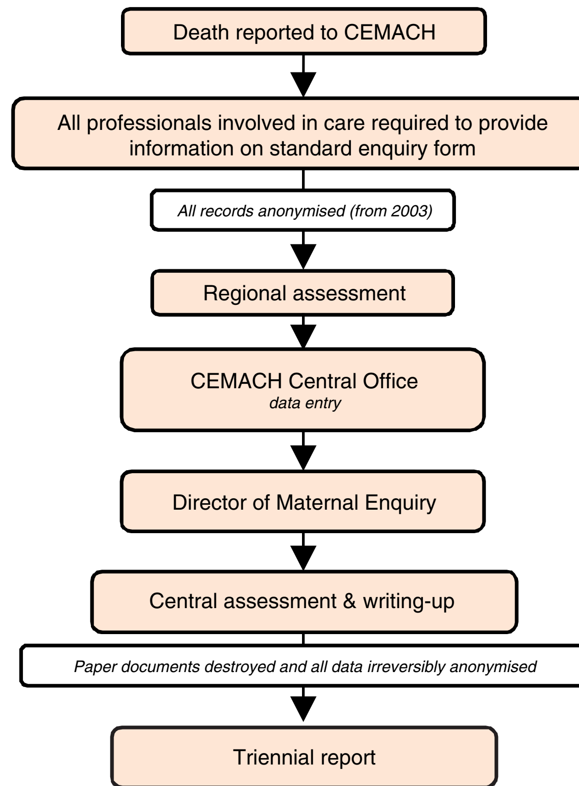


Figure A1.1 Process of enquiry 2000–02

relevant specialty and in good standing with the relevant Royal College or Faculty, consultant level (if medical) or a supervisor of midwives with knowledge and experience of organisation of care. They must be a professional who is well respected by peers, able to realistically commit enough time to assess and return enquiry forms in a timely manner. The position of Regional Assessor is honorary.

The role of Regional Assessor is to review the information reported in the MDE form and any other case documents that have been assembled by the CEMACH RM and make a short report in the relevant section of the enquiry form. This includes a comment on the case, an evaluation of the clinical management and the resources of the organisation responsible for the care. The assessor is also asked to make a judgement as to whether the care was substandard and if so, if this was a contributing factor in the death of the mother.

Since 2003, under CEMACH, all records (including the enquiry form and case notes) are anonymised before regional assessment is undertaken. All information that might identify the mother, the personnel and institutions involved in her care is removed and the case is identified by an assigned number. The anonymised enquiry form and relevant notes are circulated to the Regional Assessors by the CEMACH RM. Once the regional assessment is completed the documents are sent to the CEMACH Central Office for data entry. All cases are then reviewed by the Director of the Maternal Enquiry and circulated to the relevant Central Assessors.

Central assessment

The Central Assessors review each case thoroughly, taking into account the case history, the results of pathological investigations and findings at autopsy given in the enquiry

report form before allotting the case to be counted in a specific chapter in the Report. Their assessment occasionally varies with the underlying cause of death as given on the death certificate and classified by the Registrars General using the ICD10. This is because, for example, although the death may have been coded for multiple-organ failure as the terminal event, it could have been precipitated by an obstetric cause, such as septicaemia from an infected caesarean section. Although each maternal death reported to this Enquiry is only counted once and assigned to one chapter, it may also be referred to in other chapters; thus, a death assigned to hypertensive disorder of pregnancy, in which haemorrhage and anaesthesia also played a part, may be discussed in all three chapters.

Authors

Chapters are initially drafted by individual Central Assessors and then discussed in detail by the whole panel before the Report is finalised. Other acknowledged professionals who have a particular and expert interest in specific diseases or areas of practice may be asked to review and comment on the recommendations prior to publication.

Confidentiality

After preparation of the Report and before publication, all maternal death report forms, related documents and files relating to the period of the Report are destroyed and all electronic data is irreversibly anonymised.

Denominator data

Denominator data and other relevant statistical data are supplied by the Office for National Statistics.

Northern Ireland

Maternal deaths are reported to the DPH of the health and social services board in which the woman was resident. The DPH is responsible for organising completion of the maternal death form MDR(UK)1 by those involved in the care and obtaining the autopsy report when one has been conducted. On completion, forms are sent to the Medical Coordinator at the Department of Health, Social Services, and Public Safety. The Medical Coordinator, acting on behalf of the Chief Medical Officer, anonymises the forms and then coordinates the input of the Pathology, Anaesthetic, Midwifery and Obstetric Assessors. A single panel of Assessors deals with all cases, commenting on the case, evaluating the clinical management and the resources of the organisation responsible for the care as well a making a judgement as to whether the care was substandard and if so, if this was a contributing factor in the death of the mother. Assessed case forms are forwarded to the central CEMACH Office and submitted by the MDE Director for central assessment. All papers relating to the cases are destroyed once the reports have been received by the Central CEMACH Office.

Scotland

In Scotland, the system of enquiry is broadly similar except that a single panel of Assessors covers the whole country. A single Assessor representing each of anaesthetics, pathology and midwifery comments on all cases, and each of three Obstetric Assessors comments on cases from a defined geographical area. The panel of assessors meets twice a year (in April and October) to assess and classify each case. The Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH) administers the Enquiry on behalf of NHS Quality Improvement Scotland. The Programme office receives copies of the death certificates of all relevant deaths from the General Registrar's Office (Scotland) and then sends an enquiry form to the DPH of the health board of residence of the woman concerned. The enquiry form used is MDR(UK)1. The DPH takes responsibility for organising completion of the form by all professional staff involved in caring for the woman. When this is achieved, it is passed to the appropriate Obstetric Assessor, who determines whether further data are required before the case is submitted for discussion and classification to the full panel of Assessors. In cases where an anaesthetic had been given, an autopsy or pathological investigation undertaken or where there were significant midwifery issues, the Obstetric Assessor passes the form to the Assessors from relevant disciplines for their further comments. The form is then returned to the SPCERH medical coordinator, who retains it from that time until it has been fully considered, classified and used for preparation of the Report. As for the other countries, at all times each form is held under conditions of strict confidentiality and is anonymised before being provided to the UK Central Assessors compiling the Report. Additional information is obtained from statistics collected and analysed by the Information and Statistics Division of NHS Scotland. This is available from routine hospital discharge data collected by general and maternity hospitals. The coverage by Form SMR2, the maternal discharge summary, is now almost universal at 98% of registered births. General practitioners and hospital and community medical and midwifery staff assist in ensuring that deaths occurring at home are included in the MDE.