

Section

4



Coincidental and Late deaths

CHAPTER 14

Coincidental deaths and domestic violence

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Domestic violence: key recommendations

Service provision

Enquiries about violence should be routinely included when taking a social history at booking or at another opportune point in the antenatal period.

Where possible, all women should be seen alone at least once during the antenatal period to enable disclosure more easily if they wish.

When routine questioning is introduced, this must be accompanied by the development of local strategies for referral to a local multidisciplinary support network to which the woman can be referred if necessary.

Local Trusts and community teams should develop guidelines for the identification of and provision of further support for these women, including developing multi-agency working to enable appropriate referrals or provision of information on sources of further help.

Information about local sources of help and emergency help lines such as provided by Women's Aid should be displayed in suitable places in the antenatal clinic, for example in the women's toilets or printed as a routine at the bottom of handheld maternity notes or cooperation cards.

It must be remembered that health professionals, too, may be victims of violence.

Individual practitioners

Women with known significant features of domestic violence should not be regarded as 'low risk' and should be offered multidisciplinary care in a supportive environment. If they choose midwifery-led care, the midwife should receive support and advice from an experienced superior.

All health professionals should make themselves aware of the importance of domestic violence in their practice. They should adopt a non-judgemental and supportive response to women who have experienced physical, psychological or sexual abuse and must be able to give basic information to women about where to get help. They should provide continuing support, whatever decision the woman makes made concerning her future.

Training

Programmes for the routine enquiry about violence must not be started until all local staff have received the appropriate training.

Midwifery and obstetric staff should be aware of the role of social services and child protection issues and work in liaison with all appropriate support services.

Introduction

By international definition, deaths unconnected with pregnancy or the puerperium that occur before delivery or up to 42 days postpartum are called *Fortuitous*. They are not considered maternal deaths and do not contribute to maternal mortality statistics. However, as described in the last Report, in the opinion of the authors, the term *Fortuitous* is seen as out-dated, inappropriate and insensitive. Therefore definition was replaced with the term *Coincidental*. Even this word is an imperfect description for some such maternal deaths, which are related to pregnancy in the wider sense of public health, and which may have important implications for appropriate healthcare delivery.

Although many *Coincidental* deaths are considered unrelated to pregnancy it has long been standard practice to include them in this Report. These deaths may have important lessons for the management of certain nonpregnancy-related conditions, such as coincidental carcinomatosis (discussed in Chapter 13), and they also identify some wider public health issues of which health professionals need to be aware. Deaths from suicide following perinatal mental illness or deaths from domestic violence aggravated or directly caused by pregnancy cannot be regarded as coincidental. Neither can deaths where women were ill advised or unaware of the correct use of car seat belts during pregnancy. However, for the purposes of comparative data these deaths will continue, for the time being, to be counted as *Coincidental* and counted in this chapter.

Summary of findings for 2000–02

In this triennium 36 *Coincidental* deaths occurring during pregnancy or within 42 days of delivery or termination were notified to the Enquiry. These are shown in Table 14.1. Eight of these were from malignancies and these are discussed in Chapter 13. In addition, there 45 *Late Coincidental* deaths are counted in Chapter 15. The figures for the previous triennium were 29 *Coincidental* and 61 *Late Coincidental* deaths, respectively.

The majority of the deaths counted in this chapter again occurred among vulnerable and socially excluded women, and the general lessons to be drawn from these deaths are discussed in Chapter 1. The leading cause of death was murder, followed by road traffic accidents. These two causes of death are discussed further here.

Road traffic accidents: seat belts in pregnancy

Altogether, eight women died from road traffic accidents. Of these seven women died as a result of road traffic accidents while still pregnant and one died after delivery. Another

Table 14.1 *Coincidental deaths; United Kingdom 2000–02*

Cause of death	Deaths (n)
Neoplastic disease (see Chapter 13)	8
Infections:	
Meningitis	3
Pneumonia	1
Subdural abscess	1
Unnatural deaths:	
Murder	11
Road traffic accident	8
Overdose of street drugs	2
Carbon monoxide poisoning from faulty heater	1
Burns case unknown	1
Total	36

four cases are counted in Chapter 15 **Late deaths**. There was one death which, although due to a road traffic accident, is classified as psychiatric and counted in Chapter 11.

Four of the women who died were not wearing seat belts. Three of these were still pregnant and one died after delivery. Uterine rupture occurred in two cases where the woman was still pregnant. In contrast to the other women who died, and in whom death was unavoidable, the women who were not wearing seat belts, and whose lives might have been saved, were young girls or others with marked features of social exclusion.

A survey on pregnant women's knowledge and use of seat belts showed that, while 98% of pregnant front-seat passengers wore a seat belt, only 68% wore them in the back of the car.¹ The survey also found that only 48% of women correctly identified the correct way to use a seat belt, with only 37% reporting they had received information on the correct use of seat belts while pregnant. Although the survey was conducted several years ago, and the last two CEMD Reports have highlighted the need for pregnant women to be informed of the correct way to wear a seat belt in pregnancy, these findings in relation to young and socially excluded women cause concern and the recommendations made in the last Report are again repeated.

Recommendations for the use of seat belts in pregnancy

All pregnant women should be given advice about the correct use of seat belts as soon as their pregnancy is confirmed.

“Above and below the bump, not over it”

Three-point seat belts should be worn throughout pregnancy, with the lap strap placed as low as possible beneath the ‘bump’, lying across the thighs, with the diagonal shoulder strap above the bump lying between the breasts. The seat belt should be adjusted to fit as snugly as comfortably possible and, if necessary, the seat should be adjusted to enable the seat belt to be worn properly.

Domestic violence and murder

Domestic violence: summary of key points

- 11 women whose deaths were reported to the Enquiry were murdered by their partner during or shortly after pregnancy. One woman died later after delivery. Another 43 women had either voluntarily reported violence to a healthcare professional during their pregnancy or were already known to be in an abusive relationship.
- These 55 women represent 14% of the 391 women whose deaths were reported to this Enquiry. As none of the women in this Report had been routinely asked about violence as part of their social history, the 14% is probably an underestimate.
- All of the women who were murdered had one or more major characteristics of abused women, as shown in Table 14.1.
- 62% of the schoolgirls or young women under the age of 18 years whose deaths were considered by this Enquiry had suffered violence in the home.
- 71% of the women reporting violence booked late or were poor or non-attenders at the antenatal clinic. It was unusual for these women to be actively followed up.
- Nearly 50% the women who were murdered had very complex social circumstances yet had midwifery-led care with no referral or liaison between services.
- Women known to be in abusive relationships continue to be seen with their partners present at every visit.
- In many cases it appears that little or no help concerning the violence was offered to the woman.
- Family interpreters were used inappropriately.
- There was evidence of family 'secret keeping' in some cases.

Fourteen percent, 55 of the 391 women whose deaths were assessed this triennium, had either self-reported a history of domestic violence to a healthcare professional caring for them or the abuse was already known to health and social services.

Domestic violence was fatal for 12 of these women, all of whom were murdered by their partner. Of the 43 cases where the woman died of other causes, 29 were due to either *Direct* or *Indirect* causes, giving a known prevalence rate of 11%. Among *Coincidental* and *Late* deaths the rates were 6% and 10%, respectively. This percentage is undoubtedly an underestimate of the true prevalence of violence among this group of women as, in none of the 391 cases, was a history of violence actively sought through routine questioning as part of the social or family history at booking. Also the notes were incomplete for some of the cases assessed.

Of the 12 women who were murdered, all but one died either during pregnancy or within 6 weeks of delivery. Six of the eight girls or young women aged less than 18 years who died were in violent, dependent relationships and four had been sexually abused in the past. Three of the girls who had suffered sexual abuse were aged 16 years or under. Five women were living in, or had just left, women's refuges.

Currently, routine reporting of such cases to the Enquiry does not always take place, although the association between pregnancy and increasing domestic violence is well known. The cases described in this chapter should be regarded as being representative of other cases of murder and domestic violence that have not been reported to the Enquiry. From the cases that were reported, the warning signs were all too obvious in most cases. Several features of the women's cases illustrate the already described features of domestic violence as described in the Annex to this chapter. Some of these features will be illustrated by the cases in this Report.

Murder

Murder by a partner or ex-partner is the extreme end of the spectrum of domestic violence, an extremely important, but often overlooked, cause of maternal and child morbidity and mortality. Some of the cases in this Report are still *sub judice* so it is not possible to give details of the exact circumstances, but they underline the need for vigilance, especially when there may be a high index of suspicion.

In all the deaths there were readily identifiable risk factors of domestic violence. A summary of the characteristics of these women is shown in Tables 14.2 and 14.3.

The notable points are:

- All the women who were murdered had a known history of domestic violence.
- Nearly 50% the women who were murdered had low-risk midwifery-led care with no liaison between health professionals or services.
- All the women who were murdered after 20 weeks of gestation were either late bookers or poor attenders for care.
- Many had 'overbearing' partners who were present at all visits and sometimes disruptive.

Table 14.2 Deaths in women known to be suffering domestic violence (DV) and who were delivered or were 20 weeks pregnant or more; United Kingdom 2000–02

	Total deaths in women with DV (n)	Late booker >22 weeks (n)	Poor attender at ANC (n)	No antenatal care at all (n)	Total of late or non-attenders (n)	Total of all deaths in women with known DV (%)
<i>Direct</i>	14	6	4	2	12	86
<i>Indirect</i>	15	4	4	1	9	60
Murdered	12	4	3	3	10	83
Other						
<i>Coincidental</i>	4	1			1	25
<i>Late</i>	10	3	4		7	70
Total	55	18	15	6	39	71

Table 14.3 Characteristics of women who were murdered or suffered domestic violence (DV) during their pregnancy; United Kingdom 2000–02*

	Murdered (n = 12)		Other deaths associated with DV (n = 43)		Total (n)	Women with known DV (n = 55) (%)
	(n)	(%)	(n)	(%)		
Murdered while pregnant	9	75			12	22
Booking late (after 22 weeks)	4	33	16	37	20	36
Poor attendance	3	25	10	23	13	24
Concealed pregnancy/no attendance	3	25	3	7	6	11
Murdered before 20 weeks of gestation	3	25			3	5
History of severe depression/mental illness	5	42	13	30	18	33
Domineering partner present at all visits	8	66	4	9	12	22
Repeated miscarriage	4	33	6	14	10	18
Self discharge from hospital	2	17	3	7	5	9
Vaginal bleeding in pregnancy or PROM*	4	33	3	7	7	13
Admissions for minor complaints	3	25	4	9	7	13
Known to social services	7	58	6	14	13	24
Known to have been abused as child	3	25	7	16	10	18
Children known to child protection team or in care	5	42	4	9	9	16
Midwifery-led care	6	50	5	12	11	20

* Many had more than one characteristic

- Many women were known to social services and the local child protection team; some had all their previous children in care. One had a partner who, after her death, was found to have been a known juvenile sex offender and on the local sex offenders register.
- Several partners had visited the family GP alone, expressing their concerns about the woman's low self-esteem and jealousy.
- Some women appeared reluctant to give addresses but gave mobile phone numbers instead.
- Several had had episodes of gonorrhoea from their partner either just before or during pregnancy.
- Some had histories of multiple miscarriages or unexplained vaginal bleeding in pregnancy. The reasons for this were not followed up, despite the known history of violence.

The characteristics of domestic violence in relation to pregnancy were discussed in detail in an Annex to this chapter in the last Report and are not repeated here. Readers are referred to the last Report and the ever growing more updated literature on this important subject.²

What is of critical concern is that 71% of the women in abusive relationships who died found it difficult to access or maintain contact with antenatal care services. Over

Box 14.1 Indicators of domestic violence, relevant to maternity care

- Late booking.
- Poor/non attendance at antenatal clinics.
- Repeat attendance at antenatal clinics, the GP's surgery or accident and emergency departments for minor injuries or trivial or nonexistent complaints.
- Repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms.
- Minimalisation of signs of violence on the body.
- Poor obstetric history.
- Recurrent sexually transmitted infections.
- Unexplained admissions.
- Non-compliance with treatment regimens/early self discharge from hospital.
- The constant presence of partner at examinations, who may answer all the questions for her and be unwilling to leave the room.
- The woman appears evasive or reluctant to speak or disagree in front of her partner.

85% of the women who were murdered or who were in violent relationships and died of *Direct* causes found it difficult to access care. Table 14.2 shows more the detailed characteristics of this. It also shows that the rates for late booking, poor or no attendance at all were even higher among women who were murdered or who died of *Direct* causes of maternal death.

Box 14.1, taken from the last Report, details some known indicators of domestic violence relevant to maternity care. Table 14.2 shows the characterises and percentages of the women who suffered violence in this Report against these and other indicators identified during the course of this triennial Enquiry. The findings are stark and point to the urgent need for health services to address these issues. The National Service Framework for Maternity and Children's Services in England has also recognised the importance of this, and many of its recommendations are similar to those in this Report.³

The circumstances of three women murdered by their partner while still pregnant illustrates many of the key features of abused women, and they are described further here:

One woman who was murdered was already known to be in an abusive relationship by her GP, the child protection coordinator and her community midwives. She was booked for midwifery-led care but never provided with an opportunity to be seen without her partner being present. He was also present while she was admitted with vaginal bleeding some months into her pregnancy. The cause of this bleeding was not investigated, neither was she identified as being at any degree of risk. Her partner was described as "over possessive" in several of the healthcare worker reports. She was murdered by him shortly afterwards.

Another with a known history of partner violence booked for midwifery-led care. Again her partner seemed overbearing and was present throughout all visits. She had had several previous miscarriages and repeated episodes of sexually transmitted infections (STIs). Her midwife did not appear to appreciate the significance of her history and she was not offered further help or referrals.

Another woman who was murdered by her partner during pregnancy was booked for midwifery-led care. Again, her history of abuse was also well known and her existing children had all been taken into care by the child protection team. The notes say that these issues were not raised or discussed during her booking or subsequent visits.

Yet another woman who had midwifery-led care and was known to suffer from both violence and a severe pre-existing mental illness was murdered by her partner shortly after delivery. The delivery was premature and possibly precipitated by a violent episode. She had booked late and again there was no communication between her midwife, the mental health services, the social services or the child protection team. Indeed, there is some doubt as to whether they knew she was pregnant. Further, on discharge her health visitor was not informed of her past medical or social history.

In all of these cases the clear warning signs were present but the midwife did not liaise with any other health or social care professionals.

References

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3. Department of Health, Department for Education and Skills. *National Service Framework for Children, Young People and Maternity Services*. London: DoH; 2004 [www.doh.gov.uk].