# CHAPTER 18

# Issues for midwives

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## Introduction

This chapter highlights the issues that have arisen in this Report which relate to the care and services for pregnant or recently delivered women that are provided by midwives. Although, in the majority of deaths, midwifery practice did not directly contribute to the woman's loss of life, there are still many examples of what indirect effects midwives can have on influencing care and outcomes. There were also a number of examples of truly outstanding midwifery care.

The aim of this chapter is to stimulate debate on what lessons can be learned from the management of the women who died during this triennium, 2000–02, and how midwives can further help in the development of maternity services to improve the health of all pregnant women and their babies. In England, the findings of this Report are particularly timely, as they coincide with the publication of the National Service Framework for Maternal and Child Health, which gives impetus both to design and implement maternity services that equally meet the needs of all pregnant women and places an increasing emphasis on midwifery-led care.[1]

This chapter cannot provide an exhaustive overview of all the key findings and recommendations contained within this Report and, although many midwives will want to read the whole Report, all should read and act on the findings and recommendations contained both in this chapter and:

- highlighted in Chapter 1, which details the overall risk factors for maternal deaths and the underlying rationale for many of the recommendations made here
- given in the summary of key overall recommendations and those for the management of particular conditions provided at the start of this Report, and
- provided in Chapter 11 and Chapter 14 relating to psychiatric illness, drug and/or alcohol misuse and domestic violence.

## Summary of overall key findings for 2000–02

- The maternal mortality rate for both *Indirect* and *Direct* causes of death shows a slight increase for this triennium as compared with the last Report, although this is not statistically significant.
- As with the previous Report, the overall maternal death rate for *Indirect* causes of death is higher than for deaths from *Direct* causes.
- The most common cause of *Direct* deaths was again thromboembolism, the rates for which remain largely unchanged since 1997–99. There have been increases in

the mortality rates from haemorrhage and those associated with anaesthesia and no significant decreases in deaths from other causes. There was no under-reporting of these deaths.

- The most common cause of *Indirect* deaths, and the largest cause of maternal deaths overall, was psychiatric illness, although not all of these were reported to the Enquiry and many were identified from linkage with the Office for National Statistics (ONS) as discussed later in this chapter. Cardiac disease remains the second most common cause and most of these cases were reported to the Enquiry.

## Summary of risk factors for maternal deaths

### Social disadvantage

Women living in families where both partners were unemployed, many of whom had features of social exclusion, were up to 20 times more likely to die than women from the more advantaged groups. In addition, single mothers were three times more likely to die than those in stable relationships.

### Poor communities

Women living in the most deprived areas of England had a 45% higher death rate compared with women living in the most affluent areas.

### Minority ethnic groups

Women from ethnic groups other than White were, on average, three times more likely to die than White women. Black African women, including asylum seekers and newly arrived refugees, had a mortality rate seven times higher than White women and had major problems in accessing maternal health care.

### Late booking or poor attendance

Twenty percent (50) of the women who died from *Direct* or *Indirect* causes booked for maternity care after 22 weeks of gestation or had missed over four routine antenatal visits.

### Obesity

Thirty-five percent (78) of the all women who died were obese: 50% more than in the general population.

### Domestic violence

Fourteen percent (51) of all the women who died self-declared that they were subject to violence in the home.

### Substance abuse

Eight percent (31) of all the women who died were substance misusers.

### Suboptimal clinical care

Sixty-seven percent of the 261 women who died from *Direct* and *Indirect* causes were considered to have some form of suboptimal clinical care.

### Lack of interprofessional and/or inter-agency communications

In many cases, the care provided to the women who died was hampered by a lack of crossdisciplinary working. There were a number of cases in which crucial clinical information, which may have affected the outcome, was not passed from the general practitioner to the midwifery or obstetric services at booking or shared between consultants in other specialties, including staff in accident and emergency departments and the obstetric team. There were also cases where significant information, particularly regarding a risk of self-harm and child safety, were not shared between the health and social services.

## Summary of findings and recommendations in relation to midwifery practice

### Antenatal care

*Key finding*

In some instances the clinical antenatal care provided did not follow best practice guidance or meet the needs of individual women. There were also many examples of poor follow-up arrangements for women known to be at higher risk of medical or complex social problems who found it difficult or hard to attend arranged antenatal appointments.

*Recommendations*

- The National Institute for Clinical Excellence (NICE) for England and Wales, has recently produced evidence-based clinical guidelines for the management of antenatal care for healthy pregnant women, which also supports the development of individual care plans to meet each women's own needs.[2] NICE has also recently published guidelines for caesarean section[3] and are in the process of producing guidelines for the management of intrapartum and postnatal care. All NHS health professionals, including midwives, should include the recommendations from these guidelines, or their other country equivalents, as a routine part of clinical practice.
- Many of the women in this Report found it difficult to access or to maintain access with the services and follow-up for those who failed to attend was poor. Midwives have an important role in ensuring that local maternity services reach and maintain contact will all pregnant women. It is important that women who find it difficult to attend appointments should be actively followed up. This may require imaginative solutions in terms of the timing and setting for antenatal clinics and the provision of outreach services. As a large number of women appear to change their address during pregnancy, the midwife should re confirm contact details at every consultation.
- Women with complex pregnancies and who receive care from a number of specialists or agencies should receive the support and advocacy of a known midwife throughout their pregnancy. Her midwife will help with promoting the normal

aspects of pregnancy and birth as well as supporting and advocating for the woman through the variety of services she is being offered. Midwives should be able to directly refer women they are concerned about to a consultant obstetrician or other specialist.

- Flexible programmes of care should be based on available evidence with clear protocols agreed and communicated across acute and primary care settings. These should include the early detection and management of pre-eclampsia, other medical or psychiatric needs and social problems. These may result in referrals for specialist medical and psychiatric care as well as liaison with social services, other local government services and the voluntary sector.
- Midwives should advocate for professional interpreters to be provided for women who do not speak English. The use of family members, including children and partners as interpreters, should be avoided if at all possible.

## At booking

*Key finding*

Women who booked late appeared to have increased risks of complications and maternal mortality. Other women had an inadequate initial risk assessment and therefore inadequate care planning, of whom some were booked for midwifery-led care although risk factors clearly indicated the need for their care to be shared with an obstetrician and other specialist medical or social services.

*Recommendations*

- At booking, a risk and needs assessment should take place to ensure every woman will be offered the type of care that most suits her own particular requirements. This chapter contains the key recommendations made in the Report concerning women with a past history of mental illness, those who have a problem with substance misuse or who are experiencing violence at home.
- Women should be encouraged to book at the earliest opportunity. Midwives should explore ways of educating hard to reach, vulnerable women to book as soon as they suspect or are aware of their pregnancy.
- Booking provides a unique opportunity for midwives to advise and support women on developing healthy lifestyles as mothers and their partners are often most receptive to health messages at this time. Midwives will need to ensure they are up to date with current health promotional information and can utilise the skills of other specialist staff to obtain the best outcomes for woman and baby; for example, smoking cessation services.
- Midwives must apply clear risk assessment criteria when booking women for midwifery-led care. These criteria should not only relate to the identification of women who by virtue of their medical or previous obstetric history may be at higher risk of complications but also those women with complex social needs. Particular attention should be taken in those cases where women have poor knowledge of, or difficulty in communicating, their previous obstetric or medical history. Where English is not the woman's first language independent interpreting services should be planned and used.

- Pregnant women with significant problem drug and/or alcohol use may have other social problems and their care should reflect this. They should not be managed in isolation but by maternity services that are part of a wider multi-agency network, which should include both addiction and social services.
- Women with problems with substance misuse, mental illness or known domestic violence and their babies also require close multidisciplinary follow-up in the postnatal period.
- The strengthening or development of robust and effective communication systems to increase interdisciplinary working will help to address some of the problems identified in this Report. Part of this should include ensuing all relevant information is passed between the midwife, the obstetric or other professional staff, the woman's GP and local social services, if appropriate. This will help to provide a full health and social profile on which to base the most appropriate care plan for the individual woman. Midwives should access and have direct access to the woman's GP's records for details of any previous medical, psychiatric or social history that may have a bearing on the type of care she should receive during and after her pregnancy. It is not fair on the woman to expect her to relay all such information and there are a number of cases in this Report where, should such background information have been provided, the care plan and outcome may have been different.
- All mothers should have their body mass index (BMI) calculated and recorded at booking. This should then lead to a full risk assessment and advice for women with BMI scores over 30 (the definition of obesity as described in Chapter 1). Obese women will require additional advice and information on managing their increased risks of deep vein thrombosis and pulmonary embolism, diabetes and any intercurrent cardiac or other conditions. A full family medical history taken at booking is also important for the risk management of these women. Due to the heightened maternal risk associated with obesity it is advised that very obese women with a BMI of, or greater than, 35 may be unsuitable for entirely midwifery-led antenatal care and should be recommended to give birth in a consultant unit with appropriate emergency facilities on hand should they be required.

  The risk assessment should also include an accurate weight recording so that hospital equipment (such as operating tables and overhead hoists) can be checked for their weight-bearing capacity. Where the weight capacity of the equipment does not match the woman's requirements, alternative plans must be made to hire specialist equipment for any pending admissions and/or birth.
- Midwives need adequate education and training on perinatal mental health, domestic violence, substance abuse and child protection issues both during their preregistration and continuing professional development to ensure that they have the knowledge and skills to perform the appropriate assessment in the antenatal period.
- As a contribution to improving assessment and providing support or information, all women should be routinely asked if they have previously or currently experienced domestic violence. Such systematic enquires should only be undertaken once midwives have received the appropriate training and local multidisciplinary support services are in place.

As this is a sensitive area, midwives should stress the routine nature of the question and the reasons for approaching the subject. It may be that abused women may not wish to discuss their circumstances at this stage but the midwife should demonstrate an open approach to encourage contact as the pregnancy develops, giving the woman opportunity for individual and confidential support when required. This should include opportunities for the woman to meet with the midwife without the presence of her partner and providing links with other statutory and non statutory organisations.

- Midwives should also ask all women about their consumption of alcohol, cigarettes and use of prescribed or recreational drugs. Although these have a strong correlation with social exclusion factors, it is important to note that many more affluent groups are increasingly viewing this as normal recreational behaviour.

## As an individual practitioner

*Key finding*

The midwives who contributed to this Report often acknowledged gaps in services that prevented or delayed appropriate care. This was a particular issue in the development of care plans for women with complex needs or chaotic lifestyles.

*Recommendations*

- Midwives need to be at the forefront of service design to ensure that appropriate skills, knowledge and expertise are available to meet women's changing needs. This will require midwives to examine their own role and develop new ways of working in collaboration with other staff groups and local communities to the benefit of women in their care.
- Where gaps in the skills or knowledge base of local midwives are identified, heads of midwifery will need to develop local training programmes in conjunction with other professional and educational colleagues and provide time for midwives to attend.
- Midwives, as professionals, are responsible for their continuing professional development and so should adopt a lifelong learning approach to their care provision. This will require commitment to seek new knowledge and evidence through research and audit in order to challenge existing paradigms of care.
- Midwives may need to be aware of their professional obligations and limitations as they develop services to meet the needs of the most disadvantaged groups. Where medical intervention is required but either is not available through current care systems or is against the women's wishes, the midwife should seek alternative routes to ensure provision of appropriate care. In some cases, this may require the development of more flexible antenatal care systems and access to medical services; for instance, arranging home visits by obstetricians or using family, friends or religious leaders to influence compliance with care plans. In these complex cases it is essential that the midwife has close contact with her statutory supervisor of midwives.
- Midwives should be fully conversant with statutory supervision of their care provision and use this mechanism in their everyday practice. Supervisors of midwives should be supportive of practitioners delivering care within current service pressures and receptive to their needs following tragic outcomes such as maternal deaths.

## General lessons to be learned from the findings for 2000–02 as they apply to midwifery practice

Although midwifery practice did not directly contribute to many women's deaths, there are still lessons that can be dawn from the findings. There were also a number of examples of truly outstanding midwifery care.

As midwives are often the most senior professionals having initial contact with pregnant women, it is vital that they have the skills to assess and communicate risk and support women in all aspects of the progress of their pregnancy, whether this be normal or complicated. With the additional challenges of deprivation, poverty and difficulty in accessing services, the midwife may often be the only professional who is able to build an element of trust with the woman, even when risk factors clearly indicate the need for medical intervention. In this triennial Report, this is of even greater importance owing to the increase in refugees and asylum seekers requiring the use of maternity services.

Deciding which women may be appropriate for midwifery-led care was a key factor in this Report and some women received inappropriate midwifery-led care. It is important to recognise that some women presenting with social and medical complexities are often those who do not feel able to seek or actively resist medical advice, and may rely in the midwife to act as their advocate through the services.

Pressures such as national shortages of practising midwives, the reduction in junior doctors' hours and changes in medical training will continue to challenge NHS professionals and managers alike as NHS modernisation progresses. However, with these challenges also come opportunities to review current service provision and explore what workforce and skills will be required to deliver the desired changes. Women as service users will need to be closely involved in service development to ensure their perspective of good care provision is adequately reflected in future service design.

Midwifery involvement in this Enquiry is increasing, with comments and lessons learned being documented by midwives at all stages of the process. In many instances, midwives have played a major part in the organisational review of cases as part of the Trust's risk management and clinical governance strategies. There are some exemplary records from midwives who demonstrate through their accounts the need to reflect on their practice and learn from their experiences. However, in some cases this commitment was sadly lacking with midwives contributing very little or no insight into the events leading to the woman's death.

### Overall themes

Several key themes emerged as a result of the detailed midwifery assessments of the maternal deaths which occurred during 2000–02. These themes for midwifery practice are similar to those in the last Report. However, evidence of the new challenges posed by workforce and training shortfalls is also apparent. The main themes are:

- **developing care to meet individual needs**: this means addressing inequalities, both in terms of enabling all women to access high quality maternity services as well as improving maternal and perinatal outcomes. Particularly in relation to:
  - the socially excluded, including women who live in poverty and/or areas of deprivation

  - women from minority ethnic groups
  - women who live with obesity
  - mental health concerns
  - drug and/or alcohol use
  - domestic violence
- **communication**
- **professional accountability**
- **challenges for future care delivery and improvement**.

## Developing care to meet individual needs

### *Deprivation and social exclusion*

This Report has highlighted yet again the stark differences in maternal death rates between women living in comfortable circumstances compared with those who were economically and/or socially excluded.

Many of the most vulnerable women did not access or feel able to maintain access with maternity care services. This was in some instances due to violence in the home, previous mental illness or drug or alcohol abuse but was also linked to ethnicity, particularly for recent arrivals as immigrants or refugees. However, there were some cases where women with financial stability also did not regularly attend for care as they were victims of physical abuse in the home or had problems with substance misuse.

Women with complex social needs require a comprehensive history taken at booking with GPs, midwives and social services sharing relevant information of the woman's background. As part of multidisciplinary and multi-agency working midwives will need to be aware of the range and types of service provision in their localities, how these may benefit women in their care and to be able to refer women to them as required. Some women who died attended local addiction services or local social services but there appeared to be no record of this at booking or throughout the pregnancy. Indeed, in some cases, it appeared that the midwife had little or no knowledge of other crucial factors in the woman's pregnancy including substance abuse or issues relating to child protection.

Midwives can and often are key players in addressing these wider issues as they impact on the woman's health. However, more needs to be done. Ensuring better inter-agency links and communications may require the development of new roles to meet these women's needs and to help support midwives in their professional role. The development of different care providers can also assist in the regeneration of local communities, as local people can become involved in providing support and friendship. One way in which this can be achieved, as suggested also in the National Service Framework,[1] is through the development of integrated care pathways for vulnerable women and their families. Local women and health professionals, including midwives, should help in their design.

### *Minority ethnic groups*

Women from minority ethnic groups are again over represented in this Report. There is a particular risk for those women who are new to this country and who have little or no

command of the English language. There were several cases where women who were unable to communicate their symptoms were not provided with prompt and appropriate treatment. This also applied to poor history-taking at booking where women could not communicate relevant medical or obstetric histories either through lack of interpreting services, knowledge, and understanding or perhaps fears. Regardless of the recommendations made in previous Reports, there were still some instances where family members were used as interpreters. This was a particular issue in localities where minority ethnic groups made up a small percentage of the local population or where services had not been able to respond quickly enough to a changing ethnic mix.

Cultural beliefs and practices also played a part in adverse outcomes, as demonstrated by the following vignette:

> A woman who died of a pulmonary embolism made clear her intention to rest in bed for 1 month post-delivery. Although the midwife provided her and her family with advice about the risks of deep vein thrombosis and pulmonary embolism, it would appear that the woman's traditional belief, which on investigation did not accord with those of her religious leader, proved stronger than Western medicine.

Many cultures mark the first month following childbirth as a significant time for women to recuperate after childbirth enhancing her wellbeing and that of her baby. However, in some cultures this is wrapped in mystique, religious belief and traditional practices. In reality, it is a time when the needs of mother and baby are central to family life to ensure they are free from external stresses and distractions. Several cultures believe the mother and baby should remain indoors and rest for the whole month, while some Chinese traditionalists also believe that the mother should stay in bed as much as possible to assist in straightening the back bone after carrying the baby for nine months.[9] These practices would not be seen as efficacious with current medical knowledge of the risks of deep vein thrombosis. However, although these traditional beliefs may be hard to define they should not be generalised as being linked to any one religious group or nationality as the reality may be much more to do with folklore linked to the individual family and birthplace. Therefore, midwives should make every effort to ascertain such traditions in the antenatal period and clarify the woman's intentions to rest following the birth of the baby. Where the mother and her family decline advice on the benefits of mobilisation this must be respected and prophylactic measures incorporated into the individual woman's care plan.

### *Interpreting services*

Women who spoke little or no English seemed to be at increased risk due to poor history-taking and the reliance of family and friends to communicate their needs. The following two cases act as examples of the consequences of this:

> A woman who spoke no English relied fully on her husband to interpret throughout her labour. However, when a spinal anaesthetic was required prior to a caesarean section her husband did not feel able to attend. This resulted in an extremely frightening time for the patient, the need for general anaesthesia, a failed intubation and subsequent cardiac arrest. The case, however, was fully reviewed by the Trust and an excellent report with action plan produced.

The key action points included the following:

- Reviewing the use of women's relatives as interpreters, especially where clear instructions are required in an emotionally pressured situation.
- Developing systems and protocols for accessing appropriate independent interpreters.
- Raising staff awareness and understanding of cultural issues.

Similar issues were raised with a newly arrived immigrant who spoke no English and relied upon her family to interpret. She booked very late and no medical history was disclosed. She was booked for low-risk midwifery-led care in an isolated unit. No medical examination appears to have been undertaken by either the midwife or the GP who referred her. During labour, a high systolic blood pressure and tachycardia were noted and an ECG requested. However, this was not undertaken, nor was her pulse checked in the postnatal period. She subsequently died of severe pre-existing cardiac disease.

Even if she had known of any existing cardiac problems or previous family history, she may not have wanted to disclose this information for her personal desire to become a mother to conform to her role in her wider family. She may also have had a lack of understanding of the significance of her cardiac disease in pregnancy. There are several examples of such cases in preceding Report of this Enquiry.

With hindsight, this woman would have benefited from a full medical examination and having her care and delivery managed in a consultant-led unit for ease of specialist referral and further investigations. Indeed, this should probably be the standard for all women booking with an unclear medical history. With regard to interpreters, again, an independent service with clinical and cultural understanding may have identified any risks and helped with further advice.

There were a number of other complex cases where women with pre-existing medical and psychological conditions required additional clinical and social support. In many of these the midwives were, in hindsight, able to reorganise local service provision as the helpful reflection from one midwife involved such a case included the following statement: "I realise now just how important it is to provide specialist care to vulnerable groups. Perhaps more support in the community could have been arranged to help the client with her family. This area is now a Sure Start area".

These cases highlight the need for midwives to view women in context of their lives, not just their pregnancy, and to develop services to meet these needs.

Trusts that have small minority ethnic populations may experience more difficulties in providing responsive interpreting and link worker services. This may be due to a limited number of local interpreters to recruit from or the growing diversity of languages required. All healthcare providers will need to review changes in immigration patterns and review their local needs on a regular basis to ensure availability of appropriate language skills and cultural knowledge.

*Following up women who failed to attend antenatal clinics*

The active follow-up of women who failed to attend antenatal care was an issue in a number of cases. Although most maternity services have follow up procedures for women who do not or are unable to attend antenatal appointments, these are often not robust enough or are seen to take up too much scarce midwifery time. What the findings of this Report show is that among the women who died there was a high rate of non-attendance in the socially excluded and minority ethnic groups. This may reflect the fact that these women considered the current services were unapproachable or did not reflect their perceived wishes. The reasons for this may vary but it is clear that in some areas the existing, often long-held, patterns of service provision do not meet the needs of these women and are unable to attract them to seek care in the first place or to want them to maintain contact with services. Therefore, women from all groups who find it difficult to use the current services should be fully involved in the design of services to meet their needs. This is likely to challenge some current patterns of service delivery and lead to more flexibility and ease of access to ante natal care. In addition, health information about the importance and availability of different models of antenatal care should be reviewed for appropriateness, format and accessibility.

*Advocacy*

Where services are not meeting the medical or cultural needs of women midwives should act as advocates for their clients and ensure that appropriate services are delivered, interpreting services are available and cross organisational communications are of the highest standard. The need for this appeared a number of times in several of the cases reviewed, where midwives may have made a difference to the outcome if they had voiced their obvious concerns. The following is an example:

> A pregnant woman was in obvious pain and distress but unable to communicate due to her limited understanding of English. Although the midwives were concerned and raised these with junior medical staff, her care plan remained unchanged. The midwives could see that the woman's condition deteriorating but took no further action. She died shortly afterwards.

In instances like these, where language is a real barrier, midwives should either call for appropriate and urgent interpreting services to get a clear history of symptoms and or report up to a higher level of medical authority. Midwives must feel confident and enabled to contact a consultant obstetrician or anaesthetist directly when they are concerned their professional expertise is not being heeded.

## Recommendations for midwives caring for women newly arrived in the UK and/or those who are unable to speak English

Midwives should:

- ensure that all pregnant women recently arrived in the UK have a full health screen as part of the booking process

- advise shared midwife/consultant-led care where the woman's medical history is vague or absent, or if there is any index of suspicion that she may be unwell
- err on the side of caution and investigate further or refer for a medical opinion when women cannot communicate their degree of illness or describe their pain levels
- act as advocates for women to ensure the appropriate investigations, treatment and care are delivered
- ensure that care plans reflect the cultural and traditional beliefs of the individual as far as known
- Help in assessing the needs of the local population for interpreting services and link workers
- help with the development of strategies to ensure 24-hours-a-day, 7-days-a-week access to interpreting services.

### *Obesity*

In this Report, over 35% of the women who died were obese (estimated as having a BMI of greater than 30), representing a disproportionate number of deaths associated with obesity in childbearing women. Obese women of every age died from a variety of causes of maternal death because either their physical size precluded the availability of optimum care or their obesity had clinical implications for their health.

The current epidemic of obesity is of growing concern in this country as well as many other countries in the world. As described by the Office for National Statistics in Chapter 21 Trends in reproductive epidemiology, in 2002 over one-third of all women were overweight and almost one-quarter of all women were classified as obese. This is a dramatic rise from the 16% reported in a similar survey in 1993. These figures provide an indicator of future healthcare needs, the possible clinical impact of obesity on the individual and the cost to health economies. In terms of obstetric care, it is of importance not only because of the increased risks to the pregnant woman and her baby but also the expected increase in numbers of obese pregnant women as obese teenagers reach childbearing age. This requires a review of current services and risk management strategies including the provision of appropriate health education and support. The Government is currently developing strategies to tackle obesity and unhealthy lifestyles but recognises the need for cross-government working and collaboration with many other agencies. In addition, the need to increase public responsibility for health is also being highlighted.

As obesity rates rise, it will be of even greater importance to communicate health messages regarding prepregnancy weight and healthy eating during pregnancy. Health information will therefore require review, as will service provision to support women in developing healthy lifestyles and reducing weight.

A number of the women who died and were classed as obese also had elements of social exclusion, unemployment and low income. This raises the question of the affordability of a healthy diet and the effect of psychological pressures on eating patterns. Midwives

need to provide advice and support to women in these situations and where necessary refer to dieticians.

The effect of obesity in pregnancy is well documented, with a range of risks for mother and baby.[5,6] However, in addition, there will be considerable impact on service delivery such as associated cost of complications and provision of specialist equipment, which includes beds, hoists and chairs.

Hospital and community risk assessment should be undertaken as part of the care plan for each obese woman. This will include accurate weight monitoring of the woman and ensuring beds, theatre tables, hoists, chairs, and so on, have the appropriate weight capacity. Where this is not the case, arrangement will need to be made to hire or purchase specialist equipment for subsequent admission or clinic examination. The following representative vignette illustrates many of the problems encountered in caring for 'super weight' women:

> Although a woman had several risk factors for a high-risk delivery in addition to her gross obesity, there seemed to be no preparation for her admission. Once in labour, it became apparent that she would require a caesarean section; however, the theatre table was not of the capacity to take her weight. This resulted in the operation being undertaken on two normal hospital beds placed side by side, which would have further increased the woman's risk and also the risk to staff. Although this, in itself, did not contribute to the woman's death, it is unacceptable not to have planned for and managed the situation more appropriately.

To ensure that the risks for severely overweight woman are reduced it is important midwives be involved in developing a care plan which includes a risk assessment for all stages of pregnancy, the birth and postnatal period. It is recommended that, owing to the increased health risks to mother and baby, obese women with a BMI of greater than 35 should be booked for shared care and delivered in a consultant obstetric unit.

## Obesity: midwifery recommendations

Midwives should

- ensure that all women have their height and weight measured and their BMI calculated at booking
- encourage healthy eating in pregnancy and offer referral to a dietician
- organise the availability of appropriate equipment that can take the weight of very obese women before delivery
- advise very obese women with a (BMI of 35 or more) to book for shared care with a consultant and to deliver in a consultant unit.

### Mental health

The mental health and wellbeing of women in pregnancy is pivotal to ensuring good clinical, social and other outcomes for both mother and baby and a healthy start to

family life. Modern-day stresses effect many women either through their working lives, emotional situations or through elements of social exclusion. Therefore, maternity services should focus on reducing to a minimum the stress levels of pregnant women by providing support and communicating with other specialist services if necessary.

Mental illness continues to carry considerable stigma, as does the inability to cope with the everyday stresses of modern life. However, it is important that maternity service users and their families are aware of the importance of providing an accurate medical and social history to the midwife at booking. To ensure this understanding and encourage compliance, midwives must provide clear information on why the information is important and the relevance to the woman's care and future wellbeing. It may also be appropriate to include this health information in maternity services booklets and education programmes within schools and colleges.

Of the cases reviewed in Chapter 11 Deaths related to psychiatric causes, the vast majority of women had some type of social or emotional bearing on their daily lives. Emotional influences included ongoing marriage difficulties, the recent experience of stillbirth, family bereavement or termination of pregnancy. The social aspects included unemployment, being single and unsupported, drug abuse and homelessness. Additionally, 55 women were known to have had some form of mental health problem in the past or during the current pregnancy.

Several women withheld information about their mental health history and in some cases their families colluded in this. There were also examples of the families of women who did not want to take advice from professionals about the urgent need to section the woman to a place of safety under the Mental Health Act.

The lack of identification of risk, multidisciplinary service planning and intra-agency working is one of the main areas of concern identified in this Report. Another is the lack of professional knowledge and training in the area of perinatal mental health. Further, communication between organisations and sharing of patient information was often very poor and this suggests a need for reconfiguring services to meet the needs of these, often vulnerable, women.

As in previous Reports there were several women married to men serving in the Armed Forces who appeared to be very isolated. This was especially the case when living overseas, where they may experience language difficulties and have little family support. Further, and has been reported before, in some cases there was the added issue of domestic violence. Therefore, services available to these women should be reviewed and mechanisms developed to provide appropriate support and care mechanisms.

Although there is much to be learned from the deaths of women who committed suicide, as discussed in Chapter 11, there were some excellent examples of service delivery and intra agency working. These included well-planned and coordinated care across professional groups and organisations, exemplary record keeping and report writing by midwives, reflective practice with midwives and health visitors contributing to the learning outcomes for local service provision and professional practice. It is sad to note that some midwives who provided exemplary care still blamed themselves for the woman's death, although they had done everything and more to support them. Counselling or debriefing for midwives and other health professionals in these situations should be available if required.

Midwives with a specialist interest and training in the care of vulnerable women appear to be effective in streamlining services and enhancing cross-organisational communication. This was demonstrated in some cases where specialist midwives in drug abuse provided excellent continuity and support in the care for women who died but for whom the highest standard of care had been delivered and documented.

There is a need for maternity services to review their current care pathways for women with previous mental health problems. Support may also be required for women with stressful lifestyles or life events. Service reviews should include involvement of women, their families and other major stakeholders. They should also address the effectiveness and availability of specialist mother and baby units.

Links with higher education, further education and local regeneration schemes will be required to develop training, education and manpower strategies to ensure appropriate skills and staff to deliver new service design. Some women who died had little social support or service coordination to meet their needs. Midwives, health visitors and community psychiatric nurses cannot always provide support in this way owing to workload and manpower issues. However, service redesign may result in new ways of working and the development of new support roles that will fill any existing service gap. Midwives should lead these developments within the maternity services in collaboration with psychiatric professionals to identify how future generic support workers could provide effective services across current organisational boundaries while maximising professional time and skills.

It is apparent from the cases reviewed that some professionals involved in delivering maternal health services are unaware of the significance of recognised risk factors for mental illness. The pre- and post-registration curriculum for midwives, nurses and health visitors, practice nurses and community psychiatric nurses should include these aspects. It is also important that general practitioners, obstetricians and psychiatrists have similar input into their undergraduate and postgraduate training.

## Mental health: recommendations for midwives

Midwives can help to provide general health education on mental health issues as they affect pregnant and the postpartum period for pregnant women and their families.

A systematic enquiry about previous psychiatric history, its severity, care received and clinical presentation should be routinely made at the antenatal booking visit.

The term ‘postnatal depression’ or ‘PND’ should not be used as a generic term for all types of psychiatric disorder. Details of previous illness should be sought and recorded including what, if any, treatment the woman had required, including medication, specialist help or inpatient treatment.

Women who have a past history of serious psychiatric disorder, postpartum or non-postpartum, should be assessed by a psychiatrist in the antenatal period. A management plan, regarding the high risk of recurrence following delivery, should be agreed with the woman and her maternity team and GP and placed in her handheld records.

Self-medication on wards should be underpinned with systems and controls, including the provision of secure bedside lockers for storage.

Obstetricians and midwives should be aware of the laws and issues that relate to child protection and when and to whom to refer if concerned.

## Domestic violence

A more detailed description of the issues that emerge from this Report concerning domestic violence and the recommendations arising from them are discussed in Chapter 14. In summary, 14%, 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. The 14% is undoubtedly an underestimate of the true prevalence of violence among this group of women as in none of the cases was a history of violence actively sought through routine questioning as part of the social or family history at booking.

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. Midwives are referred to the last Report and the ever-growing more up-to-date literature on this important subject.

The findings for this triennium show that:

- all of the women who were murdered had a known history of domestic violence
- nearly 50% of the women who were murdered had low-risk midwifery-led care with no liaison between health professionals or services
- all of 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 were sometimes disruptive
- 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 be a Schedule One offender
- several partners had visited the family GP expressing their concerns about the woman's low self-esteem and jealousy
- some women appeared reluctant to give their address 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.

What is of critical concern is that 70% of the women whose deaths are considered in this Report and who were in abusive relationships found it difficult to access or maintain

contact with antenatal care services. Over 85% of the women who were murdered or who were in violent relationships and died of *Direct* causes found it difficult to access care. The rates for late booking, poor or no attendance at all were also higher among women who were murdered or who died of *Direct* causes of maternal death.

## Domestic violence: key recommendations for midwives

Enquiry about violence should be routinely included when taking a social history at booking or at another opportune point in the antenatal period. Programmes for the routine enquiry about violence must not be started until all local staff have received the appropriate training and be underpinned by a local multidisciplinary support service to whom the woman can be referred if necessary.

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

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 antenatal clinic, for example in the women's toilets or printed as a routine at the bottom of handheld maternity notes or cooperation cards.

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.

### Drug and/or alcohol misuse

Thirty-one women who died this triennium were known to have problems with drug and/or alcohol use. The issues that arise from these cases are discussed in a new section, Chapter 11B, of this Report. Many have been counted as deaths from psychiatric disorders, or in Chapter 15 as *Late* deaths, but some died from other *Direct* or *Indirect* causes. Seventeen deaths were associated with drug use, seven with alcohol use and seven with drug and alcohol use. In nine cases, insufficient information was available to allow detailed examination.

The huge increase in problem drug use that has occurred nationally and internationally since the 1980s has been disproportionately large among women of childbearing

age. Consequently, there has been a large increase in numbers of pregnant drug-using women. No such change has occurred in numbers of pregnant women with problem alcohol use. There is under-identification of both groups of women in maternity services. Additionally, drug-related deaths that occur within a year of pregnancy are often not identified as such and not reported as maternal deaths.

Problem drug use is usually illegal and is socially unacceptable and therefore women may be reluctant to admit to an activity that could lead to loss of custody of their child or children. Alcohol consumption is legal and socially acceptable but levels of consumption are often underestimated by pregnant women or not recognised as problematic. A further source of underestimation is the frequent failure by healthcare professionals to take an adequate history. Nevertheless, there is increasing awareness of the need to provide specialised services for such women and specialist care is increasingly provided to varying degrees in many maternity units throughout the UK. The almost trebling of numbers in the current compared with the last triennium no doubt indicates a true increase in numbers but may also reflect better identification.

### Drug and/or alcohol related deaths: key recommendations for midwives

Staff providing antenatal care for pregnant women should ask sensitively, but routinely, about all substance use, prescribed and non prescribed, legal and illegal, including tobacco and alcohol.

Pregnant women with significant problem drug and/or alcohol use may have other social problems and their care should reflect this. They should not be managed in isolation but by maternity services that are part of a wider multi-agency network, which should include both addiction and social services.

Women with problems with substance misuse, and their babies, also require close multidisciplinary follow-up in the postnatal period.

Women with problem drug and/or alcohol use have potentially high-risk pregnancies and an obstetrician should supervise their management. However, most of their care can be usually be delivered by midwives.

Midwives require opportunities to update their knowledge and skills to identify substance misuse, assess its severity and refer women to specialist services.

## Professional accountability

### *Communication*

In a number of cases, poor communication of either patient need or between professionals resulted in poor care management and adverse clinical outcomes. On occasion, midwives were well placed to communicate this need and provide a coordinated approach to the necessary care plan but failed to do so. Midwives are well placed as clinical experts and equal members of the care team to challenge decision-making around effective care planning and apply their knowledge in the coordination of care, especially in emergency situations. An example of this is illustrated in the following case:

> A woman with placenta praevia presented with vaginal bleeding before term. She was managed conservatively for a number of days but eventually an emergency caesarean section and an urgent blood transfusion was required. However, the crossmatched blood that had been available was found to be out of date and had been removed from storage. In this case, the urgent need for crossmatched blood was predictable at some stage during pregnancy or delivery and therefore should have been a basic requirement in this woman's care plan.

In another maternal death, the local Midwifery Assessor documents her disappointment in the standard of both written and verbal communication. She states that, although the events were unpredictable, she had serious concerns about the lack of attention to detail in the woman's care. For example, there was little evidence of contemporaneous notes, timings of events were difficult to explain, delays were apparent in recognising and communicating severity of symptoms and there was a failure to take and record appropriate observations.

If maternal deaths are to be further reduced, it is vital that communication of care needs are a high priority, if lessons are to be learned from these events it is essential that clear and accurate records are produced and maintained.

## Continuing professional development

There were several instances where midwives did not appear to have the skills and knowledge required to deal with a given situation. Midwives have an individual responsibility for recognising shortfalls in their knowledge base and updating their skills as part of lifelong learning. In conjunction with this, employing authorities should facilitate the continuing professional development of midwives to enhance care delivery and clinical risk management. Statutory supervision of midwives provides a unique and independent tool to ensure safe practice and regular updating of midwives' skills. In addition, supervisors of midwives can support midwives in complex care dilemmas and in instances where poor care outcomes can be reviewed, reflected upon and lessons learned.

The future may hold many challenges for midwives, as services are redesigned and professional roles redefined. However, the most important aim must be to ensure the safest outcome of care and not the protection of professional boundaries. This point may be illustrated by the perceived shortfall of midwifery skills in postoperative care that is referred to in several cases in this Report. This was not only apparent in high-dependency or critical care situations but also more worryingly in the routine post-caesarean section care of some women. When considering preregistration and post-qualification requirements for midwives, this aspect of care must be considered of paramount importance to midwifery education and training.

## Recognising deviations from the norm

Midwives are trained as practitioners in normal pregnancy, childbirth and postnatal care. However, they work in a team with other professional groups to ensure that women receive appropriate and safe care. It is therefore important that midwives use their skills and knowledge in recognising and reporting apparent deviations from the normal. In a number of cases, midwives appeared not to recognise obvious risk factors or early

warning signs of ensuing complications, such as rise in blood pressure, tachycardia or a raised temperature. In some of these cases the appropriate medical care was delayed. Other women with known risk factors were sometimes inappropriately booking under midwifery-led care.

### Advocacy

Midwives are perfectly placed as advocates for the safe delivery of maternity care. Not only are they skilled professionals but they are also accessible, viewed by many as approachable and have an understanding of women's needs. These attributes are particularly important to those women who are socially excluded or from minority ethnic background, as they often find accessing services more intimidating. As an advocate for women, midwives should be able to assess need and provide navigation through health and social care systems. This is of particular importance for vulnerable groups such as ethnic minority groups, lone parents and low-income groups.

In some instances in this Report, midwives appeared to have missed the opportunity to question the decisions made by other professionals and advocate for the women in their care. To achieve this, midwives must have a sound knowledge base and be able and have the confidence to voice their concerns. These concerns should also be clearly documented. Where the necessary changes fail to be made, midwives should voice their concerns higher up the line. This can be in the form of a supervisor of midwives, head of midwifery services, a senior obstetrician or the medical director of the Trust. Clear reporting mechanisms in such situations should be a major part of individual and organisational risk management strategies.

### Challenges for future care delivery and improvement

Today's NHS is rapidly changing. The NHS plan sets out challenging targets for improving care and clinical outcomes but also highlights the necessity to maximise the skills and knowledge of the current workforce while recognising future manpower and skill shortages. The current shortage of healthcare professionals is well recognised. Nearly 25% of all practising midwives are aged 50 years or above.[8] Further, changes in training for junior doctors will impact on the level of skills available in clinical areas. Some of these challenges, however, can be viewed as opportunities to review custom and practice services to ensure appropriate use of skills and knowledge to meet future patient needs. There are many different initiatives now being undertaken that test new models of care and new ways of working. These initiatives require a two-pronged approach to ensure services meet individual needs of the users and to maximise the skills of an effective workforce. These include projects where the role of para-professionals are being developed, professional skills extended and local women being trained to work in their own communities as breastfeeding 'buddies'. Midwives should play an active role in the planning and design of future services for women, to ensure safe and effective practice but also to test their own paradigms of the appropriate use of their vital skills.

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