

Why Mothers Die 1997–1999

Midwifery Summary and Key Recommendations

**The Confidential Enquiries into Maternal Deaths
in the United Kingdom**

Why Mothers Die 1997–1999

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MIDWIFERY SUMMARY AND KEY RECOMMENDATIONS

Introduction

This is the first time that a separate Midwifery Summary has been produced for the Confidential Enquiries into Maternal Deaths (CEMD). It is largely based on the Midwifery Chapter (Chapter 17) contained in the full Report, and also contains an overview of the key findings. All midwives are urged to read the full Report, and the individual case vignettes contained within it, to understand the full impact of the findings and recommendations for the organisation of midwifery and obstetric care as well as for specific areas of professional practice.

This summary describes how midwives might affect, directly or indirectly, the safe outcome of pregnancy. It should be stated at the outset that, while there are areas of concern, midwives provided exemplary care for many of the women who died. However, it is important that the lessons learned from these deaths, and the recommendations drawn up as a consequence, be understood by all health professionals in order that they can continue to develop their professional practice and provide high quality care to all pregnant women.

This Report, for the first time, addresses the major issues of inequality and social exclusion. Midwives are at the forefront of planning and delivering care for these vulnerable women, who are at greater risk of death or severe morbidity. These women may speak little English, may be less articulate and are less likely to challenge the more traditional patterns of service provision, which they may see as inappropriate for their needs. Midwives should be prepared to act as their advocates, and seek their views, when planning or making the case for future, more flexible, patterns of service provision. Each woman is an individual with different social, physical and emotional needs and her pregnancy should not be viewed in isolation from the other important factors that may influence her health or that of her developing baby.

Summary of key findings

Risk factors for maternal death

As mentioned in the previous section, for the first time the Report has been able to evaluate more fully other factors that may have played a part in the woman's death. These findings are of great concern, showing that maternal mortality rates among the socially excluded including women from lower socio-economic classes, very young girls and minority ethnic groups, are higher than among the population as a whole. In summary:

- Women from the most disadvantaged groups of society are about 20 times more likely to die than those in the highest two social classes.
- Women from ethnic groups other than white are, on average, two times more likely to die than women in the white group. A large number of these women spoke little or no English.
- A disproportionate number of women from the traditional travelling community were likely to die.
- 12% of all the women whose deaths are included in this Report self-declared that they were subject to violence in the home.

- Access to care is also an issue for many of these groups of women. Twenty per cent of the women who died booked for maternity care after 24 weeks of gestation or had missed over four routine antenatal visits.
- Other factors are also associated with an increased risk of death; for example, young women under 18 years of age, increasing maternal age and increasing parity. Many women in this Enquiry were also obese. There also appeared to be over-representation of women with multiple pregnancies and those who had *in vitro* fertilisation (IVF). Although these findings should be regarded with care because the very small numbers involved mean that they cannot necessarily be proven with statistical rigour, they nevertheless provide a unique indicator of the impact that social exclusion, inequality and other issues may have on a woman's reproductive health.

Other general findings

The results show, sometimes in dramatic fashion, that the routine use of national guidelines can work. In this triennium, following the routine introduction and use of guidelines developed in part as a result of findings and recommendations from previous CEMD Reports, there have been significant decreases in deaths from pulmonary embolism and sepsis following caesarean section. In the very few cases where deaths occurred from these causes, guidelines do not appear to have been followed.

Women are still dying of potentially treatable conditions where the use of simple diagnostic guidelines may help identify conditions such as ectopic pregnancy, sepsis and pulmonary embolism. The diagnosis of many of these cases was missed in the primary care or Accident and Emergency (A&E) setting.

For the first time the number of *Indirect* deaths, from medical conditions exacerbated by pregnancy, is greater than deaths from conditions that directly arise from pregnancy. *Indirect* deaths are of no less importance than *Direct* deaths and the recommendations in this Report for *Indirect* deaths **must** be regarded with equal importance to those that have been made for *Direct* deaths in previous reports.

Deaths from mental illness

There has always been a large degree of under-ascertainment of deaths from mental illness or substance abuse by this Enquiry. Indeed, the CEMD only started to consider these deaths in detail in the last triennial Report. However, a pilot Office for National Statistics linkage study showed that the CEMD was unaware of over 40 extra deaths from suicide or deaths from violent causes, and another eight where the Coroner recorded an open verdict. In addition, 11 unreported women died from an accidental drug overdose. As it is not yet widespread practice for psychiatrists and community mental health or drug support teams to notify such deaths to this Enquiry, this degree of under-ascertainment is understandable. However, when all deaths up to one year from delivery are taken into account, the results of the study show that deaths from suicide are not only the leading cause of *Indirect* death, but also the leading cause of maternal deaths overall.

Summary of overall findings 1997–99

During this triennium 378 deaths were reported to or identified by the Enquiry, a number remarkably similar to the 376 cases reported in 1994–96.

The Enquiry includes deaths directly related to pregnancy (*Direct*), those due to pre-existing disease aggravated by pregnancy (*Indirect*), those in which the cause was unrelated to pregnancy (*Coincidental*, previously classified as *Fortuitous*) and those occurring after the internationally defined limit of six weeks after delivery but before one year from delivery (*Late* deaths).

Of the 378 deaths, 106 were classified as *Direct* and 136 as *Indirect* deaths, representing 28% and 36% of reported cases respectively. Twenty-nine (8%) were classified as *Coincidental (Fortuitous)* and 107 (28%) as *Late*. In this triennium the total number of *Direct* and *Indirect* maternal deaths reported to the Enquiry, 242, is lower than the 268 reported in the previous triennium. However, as stated before, this is the first time the number of *Indirect* deaths exceeded the number of *Direct* deaths.

In comparison with 1994–96, the first triennium in which the new system of case ascertainment was used, the overall findings for 1997–99 show:

- A small decrease in the combined overall maternal mortality rates (*Direct* and *Indirect* deaths) reported to both the Registrars General and this Enquiry. The maternal mortality rate for this triennium, derived from the CEMD data, is 11.4 deaths per 100,000 maternities.
- The *Direct* maternal mortality rate, 5.0 deaths per 100,000 maternities, is lower than in any of the other four preceding triennia for which UK data have been collected.
- The *Indirect* maternal mortality rate, 6.4 deaths per 100,000 maternities, is higher than in any of the preceding four triennia. For the first time the number of *Indirect* maternal deaths is greater than *Direct* maternal deaths.

Major causes of death

Thrombosis and thromboembolism

Thrombosis and thromboembolism remain the major *Direct* cause of maternal death, although the rate, 16.5 per million maternities, has fallen from the all-time high of 21.8 per million maternities in last Report. They account for 33% of all *Direct* maternal deaths. However, this overall death rate hides two key findings:

- The number of deaths from thromboembolism following caesarean section has fallen dramatically following the introduction and routine use of guidelines for thromboprophylaxis.
- Conversely, there has been a significant rise in the number of deaths from thromboembolism in other women, in many of whom the diagnosis was missed in either general practice or A&E departments or in women who, despite having known risk factors, were not offered appropriate thromboprophylaxis.

Hypertensive disease of pregnancy

Hypertensive disease of pregnancy remains the second leading cause of *Direct* deaths, as it was in the last triennium, although the rate has fallen to 7.1 per million maternities compared with 9.1 in the last Report. This may well again reflect the introduction of guidelines for the management of pre-eclampsia.

Sepsis

Sepsis, including deaths in early pregnancy following miscarriage and ectopic pregnancies, is the third leading cause of *Direct* deaths. Unlike other leading causes of *Direct* deaths, the rate of maternal deaths from sepsis is slowly increasing. In this triennium the rate was 8.0 per million maternities, a rise from 6.8 per million maternities in the last Report.

Deaths in early pregnancy

Although, when taken overall, deaths in early pregnancy are the second leading cause of *Direct* deaths, the deaths included in this category arise from a number of causes. The

largest number are due to ectopic pregnancy, which comprises the fourth leading cause of *Direct* deaths. The 1997–99 rate for the occurrence of ectopic pregnancy is 11.1 per 1,000 estimated pregnancies, of whom 0.4 per thousand died, compared with 11.5 per 1,000 estimated pregnancies in 1993–96 with the same rate of death; 0.4 per thousand ectopic pregnancies. As with the last Report, most of the women who died were misdiagnosed in the primary care or A&E setting.

Amniotic fluid embolism

Deaths from amniotic fluid embolism (AFE) have reduced by half compared with the last Report (a rate of 3.8 compared to 7.7 per million maternities). The reasons for this fall are not clear but some women are now surviving this previously fatal condition.

Haemorrhage

Although the fall from 5.5 to 3.3 per million maternities in the rate of death attributable directly to haemorrhage is welcome, there are a number of other cases where haemorrhage played a significant part. Concern remains that care is not always as good as it should be, even in cases where problems could have been anticipated.

Other *Direct* causes of death

There has been a slight decrease in deaths in this category, which mainly relates to uterine trauma and fatty liver. Deaths from uterine trauma have reduced to two compared with five in the last Report, while deaths from fatty liver of pregnancy have doubled to four. The combined rate of deaths in this category is 2.8 deaths per million maternities compared with 3.2 in the last Report.

Anaesthesia

There were three deaths attributed to anaesthesia, an increase on the one case in the last Report, although still only accounting for 3% of *Direct* maternal deaths.

Cardiac disease

Heart disease and thromboembolism are now the joint most common causes of maternal death reported to this Enquiry. Therefore, heart disease is still potentially dangerous in pregnancy even though disease patterns have changed. For example, rheumatic heart disease is now vanishingly rare as a cause of maternal mortality in the UK. The most common causes are cardiomyopathy, including puerperal cardiomyopathy, dissecting aneurysm of the thoracic aorta and myocardial infarction.

Women with pulmonary vascular disease have a very high risk of dying in pregnancy. Typical estimates of mortality risk are 30% per pregnancy in Eisenmenger's syndrome and 30–50% in primary and secondary pulmonary hypertension.

Substandard care

Substandard care remained very difficult to evaluate in many of the cases in this Report due to the lack of key data from some records and case notes. While it is clear that many of the cases received less than optimum care it has not always been possible to quantify these with certainty. Nevertheless, despite these limitations the assessors classified 60.4% of *Direct* deaths as having some form of substandard care. Fifty per cent of *Direct* deaths had major substandard care in which different treatment may have affected the outcome. Seventeen per cent of *Indirect* deaths and 9% of deaths from cardiac disease were associated with substandard care. By contrast, only about 10% of both *Coincidental* and *Late* deaths had substandard care, with 7% in each category being classified as major. The major concerns about the care of these cases were failings in social services support for vulnerable young girls and in lack of multidisciplinary or co-ordinated care.

The main causes of substandard care can be summarised as:

- lack of communication and team work
- failure to appreciate the severity of the illness and suboptimal treatment
- wrong diagnoses
- failure of junior staff or general practitioners to diagnose or refer the case to a senior colleague or hospital
- failure of consultants to attend, and inappropriate delegation of responsibility
- in some units, the continuing lack of a clear policy for the prevention or treatment of conditions such as pulmonary embolism, eclampsia or massive haemorrhage
- failure of the lead professionals to identify diseases or conditions that do not commonly occur in their own specialty, or to seek early advice.

Overall themes in relation to midwifery practice

Midwives provide the majority of care and are frequently the lead healthcare practitioner for pregnant and recently delivered women. With increasing emphasis on midwifery-led care, this latter role will continue to expand. Even when midwives are not the lead practitioner, they continue to see most women during their pregnancy, delivery and the postnatal period. Midwives are the professional lead for approximately 70% of births and are involved in the remaining 30%, which are usually higher risk deliveries.¹ Although many women in this Report had higher-risk pregnancies, complications or underlying medical conditions that required specialist obstetric or multidisciplinary care, midwives were also involved in their care. In most cases midwives provided the important continuity, supportive link and point of contact between the woman and a number of different health care professionals. In some cases midwives were also the healthcare professional who picked up the early signs of possible complications and referred the woman for appropriate care.

All but 21 of the 378 women whose deaths are included in the Report had had contact with the midwifery services. The 21 who had no contact died before booking or after a miscarriage or termination of pregnancy. A total of eight women had midwifery-led care and a further 42 had joint midwifery/general practitioner-led care. One hundred and ninety received 'traditional' shared care and 56, who had high-risk pregnancies, were cared for solely in the hospital setting.

From the detailed assessment four key themes emerged in relation to midwifery practice:

1. Appropriate provision and targeting of care.
2. Professional accountability and responsibility, including advocacy.
3. Risk assessment.
4. Communication.

These themes are presented here as separate areas for discussion, but they are interwoven and share many similarities and common threads.

In addition, this Report contains valuable new information for midwives and other health professionals, for example, in relation to mental illness and thromboprophylaxis. Specific

recommendations relevant to midwifery practice taken from the relevant Chapters in the main Report are given at the end of this summary.

1. Appropriate provision and targeting of care

Each woman is an individual person with different social, physical and emotional needs as well as having specific clinical factors that may affect her pregnancy. Her pregnancy should not be viewed in isolation from other important factors that may influence her health or that of her developing baby.

Midwives have a unique role in providing the majority of antenatal care and are well placed to address health inequalities and health promotion issues. *Making a Difference*² suggests that midwives should target vulnerable groups who would not traditionally use the health services. In this triennium, however, midwives appear to have missed a number of opportunities to do so. Indeed, there were many instances where women appeared to be just slotted into a rigid antenatal care programme that was inflexible and inappropriate for their specific needs.

Social exclusion

Although the United Kingdom has low maternal mortality rates compared with developing countries, social deprivation is clearly linked with an increased risk of maternal mortality or morbidity. This is demonstrated dramatically in Chapter 1 of the Report, where Table 1.16 shows that the risk of maternal death among women from the most disadvantaged groups of society is up to 20 times greater than those women in the two highest social classes.

The midwife has a vital role to play, not only in contributing to the health and wellbeing of all mothers and their babies, but also in targeting their care to those mothers most in need. Socio-economic deprivation was a prominent factor in a large number of cases considered by this Report and was associated with a tendency to delay access to, or attend regularly for midwifery care.

Five girls aged 16 years or less and a total of 13 women aged 18 years or less died in this triennium. All but one were severely socially excluded. Four of the five girls aged less than 16 years had been in the care of social services and three of these girls were homeless and living 'rough' at the time of their death. All but one of the deaths in women aged between 16 and 18 years were also characterised by social exclusion. Seven had suffered repeated episodes of domestic violence from within their own family and several of these also had suffered sexual abuse.

All women should have equal access to information and advice, regardless of their social circumstances or how articulate they are. While mothers who live in more deprived circumstances constitute a specific at-risk group it is important to adopt an individual approach to needs assessment, tailoring the care given to the specific circumstances of each mother. Examples of appropriate targeting of care in specific circumstances are discussed below. Hart *et al.*³ concluded that midwives who work with disadvantaged clients need to be able to understand a woman's social and cultural background, act as an advocate for women with medical staff and colleagues and overcome their own personal and social prejudices and practise in a reflective manner.

The booking visit presents an opportunity to undertake a complete, holistic, needs

assessment of the woman. This should include identification of factors relating to social exclusion, including problems such as learning difficulties.

Poor attenders at antenatal clinic and/or women who booked late

Twenty per cent of the total number of women who died from *Direct* and *Indirect* causes in this Enquiry either booked after 20 weeks of pregnancy or missed more than four or more antenatal visits. While it is not possible to follow up women who are unknown to the service, it was clear in many instances that non-attendance in women who had booked generated a routine appointment by post. It is not known if this was purely an administrative response or whether professionals were involved. Further, it is not clear if this decision was made based on information in the maternity records. Midwives should be aware of their professional responsibility in the protection of the interests of the mother and her baby, ensuring that they are central to the delivery of care.

Targeting care is about developing services that are effective for all women but particularly for those women who would not normally actively seek help and advice. As part of the changes in the delivery of midwifery care it is crucial that new patterns of antenatal care are developed particularly for those women who are at the greatest risk. In a very few instances this may require individual antenatal care at home.

Nearly half of the women who booked after 20 weeks of pregnancy or who were poor attenders at antenatal clinics came from ethnic minority groups. Half of these women did not speak English. In some cases midwives did go into the community to follow these women up but in others either no active follow-up was undertaken or letters were sent in English advising the woman to attend her next appointment. There were several instances of such letters not being understood by any family member.

Ethnicity

Women from ethnic groups other than white were, on average, were twice as likely to suffer a maternal death, as discussed in Chapter 1 of the Report. Care needs to be taken in interpreting these findings, however, due to the small numbers involved.

Issues to do with late booking and poor attendance in these groups of women have been discussed in the preceding section. There were also many mothers in this triennium who had little or no English. In all of these groups language difficulties and lack of knowledge of specific cultural practices may have led to a lack of understanding, which may have contributed to the midwife not being aware of critical signs and symptoms. In some cases midwives asked relatives, who themselves did not speak much English, to contact the GP because the midwife was concerned. The fact that the GP was not subsequently contacted may have been because her instructions were misunderstood or that there was little knowledge of the NHS or, indeed, possibly no-one who could make a phone call in English.

In a large number of cases professionals used family members to interpret. There were several difficult cases where children were used inappropriately to interpret intimate personal or social details of the mother and vital information was withheld. The Report makes a general recommendation about the use of interpreters. Midwives should proactively raise this issue with their Trust managers if they are concerned.

Cultural issues also affect other groups. The Report also shows that a disproportionate number of women from the traditional travelling community were likely to die.

In relation to caring for women from other cultures midwives and other health professionals should:

- develop a greater awareness of different cultural needs
- request the use of interpreters and/or link workers from within their own organisations
- be at the forefront of developing flexible services for women who are unable, for whatever reason, to regularly attend clinic based antenatal services.

All healthcare professionals should consider whether there are unrecognised but inherent racial prejudices within their own organisations, in terms of providing an equal service to all service users.

Domestic violence

Midwives are increasingly recognising the impact of domestic violence on the physical and mental wellbeing of mothers and their families. The Department of Health and the Royal College of Midwives have produced guidelines for the detection and management of domestic violence,^{4,5} as have a number of other professional organisations. Domestic violence is of such relevance to this Report that there is now a separate Chapter (Chapter 16), on this subject, which all midwives are strongly urged to read.

In this triennium 45 (12%) of the women whose deaths were investigated self-reported a history of domestic violence to a healthcare professional. Many women do not admit to being victims of domestic violence due to shame or the fear of reprisal but may do so if questioned in a sensitive manner. From the information made available to this Enquiry it appeared that no women in this Report had been routinely asked if they had suffered from violence as part of the social history taken at booking, so the figure of 12% is likely to be an underestimate of the prevalence of violence among this group of women.

Current evidence suggests that domestic violence often starts or intensifies during pregnancy. Midwives therefore need to be constantly aware of the possibility, watching for the signs and symptoms suggestive of domestic violence that are discussed in depth in Chapter 16 of the full Report.

In some of the cases discussed in Chapter 16 it is clear that the midwives provided well-planned and sympathetic care. In one case the midwife gave the woman at risk her out-of-hours telephone number. In most cases, however, while the case notes clearly gave a past history of assault or indeed stated that the woman had said that she was currently the victim of domestic violence, no action or discussions were recorded. Furthermore, in a few cases when an index of suspicion was raised, the partner was asked about his wife's bruises and the explanation he gave seems to have been accepted without asking the woman herself.

Domestic violence is a difficult issue for healthcare professionals. Many may feel that by opening up the question they may be presented with a situation that they do not know how to deal with and appear to be offering the woman more support and advice than they believe they can provide. Some midwives will also have experienced violence against themselves. For these reasons it is important that not only are health professionals, including midwives, trained to understand the importance of confronting these issues but that they are supported by a local network of agencies to whom the woman can be referred for specialised help.

All women, whether or not they admit to suffering domestic violence, should have access to information about local services, including the local Women's Aid Help Line, refuge and the

Police Community Safety Unit. Midwives should have available a 24-hour help line number that they can give to women at risk of domestic violence.

General information and the telephone numbers of local organisations offering advice and support should be made available to all women. For example, this may be printed on the hand-held record or placed in the women's toilets in the antenatal clinic.

All health professionals should make themselves aware of the importance of domestic violence in their practice. Chapter 16 of the Report contains recommendations on the identification and management of women who suffer domestic violence.

Obesity

Obesity is a risk factor for maternal morbidity and mortality from a number of conditions including thromboembolism and diabetes. Many mothers who died in this triennium were classified as obese, although, as there has been a tendency not to weigh mothers routinely in pregnancy, the precise body weights were not always available. All mothers should have their body mass index (BMI) calculated at booking as part of the full risk assessment. Further, they should be offered advice about sensible weight reduction including diet and exercise and referral to a dietician where appropriate. BMI is defined as the weight (kg) divided by the square of height (m²). An adult BMI greater than 30 would be classified as obese. Midwives should inform mothers who are obese about how to recognise early warning signs of complications. Midwives are also well placed to give advice on healthy eating, diet and exercise.

2. Professional accountability and responsibility, including advocacy

The pattern of midwifery care has undergone many changes over the past few years and these changes are set to continue with developments in government policy and national strategies, such as The NHS Plan,⁶ and with the new Nurses and Midwives Council taking over from the UKCC and the four National Boards in April 2002.

Midwives must reflect and develop their practice and play an active role in challenging the organisational structure and culture in which they work and to agree policies that reflect the recommendations in this Report. The midwife is accountable for the care she/he delivers, and should act as an advocate for the women in her care, providing a high standard of care in accordance with midwives' rules and code of practice and guidelines for professional practice.^{7,8}

One area where a good standard of care was evident was in the care of some women who had cancer in pregnancy. Some midwives excelled in their care of women who were known to be terminally ill. In one case it was documented, 'the midwives were unbelievable in the extra care and attention they devoted to this woman'. In another, community midwives visited a mother at home weekly throughout pregnancy and after, when she required care in a hospice.

Advocacy

Midwives appeared in some cases to miss the opportunity to question the decisions made by other professionals and act as an advocate for the women in their care. The Report gives examples of circumstances where midwives failed to challenge the decisions made by general practitioners or junior medical staff despite having major concerns. Also, in a few cases the midwife co-ordinating the delivery suite did not support the midwives' concerns in that she did not summon senior medical assistance.

Midwives should feel confident to challenge areas of medical practice in a proactive manner if they are concerned and should have the ability to refer women they are directly concerned about to hospital services. Midwives should also be prepared to decline taking responsibility for high-risk cases where the involvement of a consultant or senior obstetrician is essential and the reasons for this should be explained to the woman and to the obstetrician.

Inappropriate responsibility for care

A number of women who had features identifying them as high risk at the booking appointment received shared care suitable only for low-risk women.

In these cases the previous obstetric history did not appear to be part of the planning process when the care was being considered for the current pregnancy. Consultant obstetricians and midwives should be aware of the booking history prior to planning the most appropriate antenatal care. The GP booking letter is a referral mechanism and should not be relied upon to provide all the information necessary to plan antenatal care.

Three of the women receiving midwife-led antenatal care were at higher risk and should have been supervised by an obstetrician. One woman had a multiple pregnancy, another was a poorly controlled diabetic and the third, at very high risk of thromboembolism, was in a wheelchair due to an inherited disorder. Conversely, the care appeared excellent for the other cases of midwifery-led care, with appropriate transfers for specialist care.

Three further women receiving joint midwifery/GP-led care were also at higher risk and should not have been cared for in the community.

With the growing importance of midwifery-led care, it is vital that midwives undertake a full needs assessment at the booking visit in order to identify women whose past or current medical history may make them unsuitable for this type of care, and that these women be referred for more appropriate care. Similarly, midwives should be prepared to decline taking responsibility for high-risk cases where the involvement of a consultant obstetrician is essential and the reasons for this should be explained to the woman and to the obstetrician.

3. Risk Assessment

The crucial role of the midwife is to perform a continuing risk assessment of the woman at booking and then at each point of contact throughout the antenatal, intrapartum and postnatal periods. At booking, this risk assessment includes a detailed review of the woman's personal and family obstetric and medical history with particular reference to significant risk factors, such as thromboembolism and mental illness. Appropriate action should be taken when any deviations from the normal are noted.

The importance of risk assessment at each contact is illustrated by several cases of pre-eclampsia in this Report that may have gone undetected for some time. This may have been due to the woman being seen without a urine specimen being checked and emphasises the need for urinalysis at each antenatal contact after 20 weeks of pregnancy.

Midwives need to be aware of several new findings from this Enquiry when undertaking risk assessments at booking and in the antenatal period.

Major psychiatric illness

Although not apparent from the figures in this Report, a further study commissioned by the

CEMD and discussed in Chapter 1 of the full Report has found suicide to be the leading cause of maternal death. Chapter 11; Deaths from psychiatric causes, contains valuable new information and recommendations, many of which are particularly relevant to the provision of midwifery care.

Of great importance to this Enquiry is the risk of recurrence in women with a past history of a previous severe postnatal depression (PND) or puerperal psychosis, or of a non pregnancy-related condition such as bipolar illness, schizophrenia or obsessional compulsive disorder. Women with a past history of severe mental illness, be it puerperal or non-puerperal, face a risk of a recurrence of between one in two and one in three following delivery. The risk of recurrence is at its greatest in the first 30 days postpartum. Typically, these illnesses are of rapid onset, escalation of severity and of similar presentation and timing to previous puerperal episodes. This is why we repeat the recommendation made in the last Report that ‘a relatively simple procedure should be instituted in every antenatal clinic to identify women at risk of postnatal psychiatric illness and/or self harm’.

In a large percentage of cases clear psychiatric risk factors were present but were not ascertained. Staff, including midwives, often underestimated symptoms of depression or psychosis. For women with a past history of severe mental illness, clear multidisciplinary planning should take place because of the risk of recurrence. This should include referral pathways and criteria for triggering such a referral. There should be a low threshold for seeking intervention where there is a previous personal or family history of mental illness.

The midwife is well placed to identify women at greatest risk of psychiatric illness. This will involve the detection of risk factors at booking, such as a past history of psychosis or depression, whether postnatal or not. The midwife must also be vigilant in looking for signs and symptoms of psychiatric disease developing during pregnancy and the postnatal period. Half of all women who died from psychiatric illness in the postnatal period had a previous history of mental illness. Many of these women appeared to have good social support but frequently the professionals underestimated the severity of acute presentations.

It is clear that the risk assessment for many of these women was cursory, and a relevant history was noted as PND without any further enquiry. The women who died suffered from major psychiatric illnesses, not PND. The term ‘postnatal depression’ or ‘PND’ should only be used to describe a non-psychotic depressive illness of mild to moderate severity with its onset following delivery. It should not be used as a generic term to describe other mental illnesses. In this Enquiry the use of the acronym ‘PND’ to describe cases of very severe illness complicating previous childbirth may have led to the likely severity of the recurrence being underestimated and to missed opportunities for prevention.

If a woman reports a previous episode of psychiatric illness, it should not be dismissed as ‘PND’ but enquiry should be made about the severity of the illness, its clinical presentation, the treatment required and the timing of its onset. Most women who have experienced a previous serious postpartum illness will be concerned about future recurrence. Midwives, obstetricians, GPs and psychiatrists must know about the high risk of recurrence and must know that women with early-onset conditions can quickly move from appearing to be merely anxious and depressed to being psychotic and suicidal within a few days. They also need to know that being mentally well in pregnancy does not necessarily reduce the risk of recurrence after delivery. Forewarned is forearmed and, at the very least, a period of skilled monitoring and management plans for early intervention could be instituted.

In nine deaths, where the past history had been recorded in the midwifery notes, it was

referred to as ‘PND’ despite the evidence of previous severe psychiatric illness in relation to childbirth. In no case was there any evidence that the severity of the previous illness and indeed inpatient care had been ascertained. The use of the term ‘PND’ gave the impression that the illness had been less severe than it actually was and no appropriate referral to the psychiatric service or care plans had been made.

A number of cases involved women in their first pregnancy with a previous history of non-postpartum psychiatric illness. Again, the risk of a recurrence or relapse after childbirth appears not to have been recognised either by their psychiatrists or by their midwives. This led to the care being reactive rather than proactive. It seems that the professionals involved in these women’s care were taken by surprise by the rapid escalation of symptom severity following the onset of the condition.

Thromboembolism

Risk factors for thromboembolism were present in 25 of the 31 cases of maternal death discussed in Chapter 2; Thromboembolism. Thirteen women were overweight, five had had a period of bed rest, four had a family history, three had previous thromboembolism and two had undertaken long-haul flights during pregnancy. Some had multiple risk factors. In spite of this multiplicity of risk factors, many of the mothers who died appeared to be treated as low risk. Identified risk factors need to be readily available to all health professionals in the antenatal and postnatal periods. If a woman appears to be at higher risk of thromboembolism she requires referral for medical advice.

Midwives should be aware that pregnancy itself increases the risk of pulmonary embolism, which frequently presents with vague symptoms such as breathlessness. Thirteen women died from pulmonary embolism in the antenatal period. Of these, eight were in the first trimester of pregnancy. Of the seventeen postnatal deaths, ten followed a vaginal delivery.

Planning care for women at known risk of complications

Allied to the need for a risk assessment to be undertaken for all women, once a woman is known to be at higher risk of complications during pregnancy or delivery, a relevant multidisciplinary care plan should be agreed in conjunction with the woman. In several cases discussed in the Report this had not been done, or was inadequate. This led to confusion as to what protocol to follow and the unavailability of key staff when the mothers condition suddenly deteriorated. However, even when appropriate care plans had been made, in a few cases the midwives and junior doctors failed to follow the written instructions and appeared not to appreciate the seriousness of these high-risk cases. It is crucial to have well documented plans for women at identified higher risk.

4. Communication

The importance of communication between the midwives and other health professionals is a recurring theme in this Report, with poor communication being a contributory factor in many cases. In some instances communication with the woman was also poor.

Communication with other health professionals

In some cases there was evidence of good communication and multidisciplinary working even though women died. In a case discussed in Chapter 13; Cancer and other tumours, a woman was diagnosed with cancer in early pregnancy and spent much of her pregnancy in hospital. An excellent summary of the midwifery care demonstrated good planning and communication, delivering a high standard of care. Extra care given by the midwives

included liaison with other health care teams, staff and family conferences and teaching basic parenting skills to the partner.

The midwife is frequently the professional who will identify factors placing the mother at high risk when taking a booking history. It is essential that the risks identified are communicated effectively to enable the most appropriate care to be given.

Midwives working in a primary-care setting appeared to have good communication networks with secondary care and readily referred mothers to maternity hospitals directly. However, referrals to professionals working in primary care were infrequent and were generally conducted via the mother. The midwife should be more proactive where referrals to a woman's general practitioner are deemed to be necessary.

Most midwives working in the community appeared to be comfortable in referring women to the secondary-care maternity services but some did not appear to work in partnership within the primary-care setting and outside agencies. This was particularly evident in terms of communication with other members of the primary healthcare team. If a referral to a GP is thought necessary, midwives should make direct contact with a GP rather than giving the responsibility to the woman.

Knowing when to refer

In specific instances midwives appeared reluctant to refer across specialty borders to allied professionals such as community psychiatric nurses, even when there was a serious risk of mental illness. Midwives need to feel comfortable in these horizontal, interspecialty communications as well as vertical, hierarchical communication pathways. This may involve overriding the decisions of other health professionals, perhaps by direct referral to other agencies such as A&E departments or consultant-led teams. In several cases in this Enquiry a midwife correctly diagnosed and referred women to the hospital services with diagnoses that had been missed by the GP. However, in a few other cases the midwife did not appear able to override the GP when evidently there was no investigation of the woman's symptoms.

Even where the midwife is the lead practitioner, there is a need to work in partnership with other professionals, reflecting their membership of a team. The midwife should feel able to approach senior staff directly, even if this involves bypassing a less experienced doctor.

There was evidence that some midwives made appropriate referrals even though the woman died. A case discussed in Chapter 13 of the main Report describes a mother who was being cared for in a midwifery-led unit and was transferred to consultant care at twenty-four weeks with non-Hodgkin's lymphoma. The midwives caring for this woman rapidly picked up the fact that there was a problem and referred her for specialist medical opinion.

Multi-agency working

The midwife is well placed to co-ordinate partnerships with other professionals and outside agencies such as social services. There were a number of cases in the Report where closer communication between the midwifery/obstetric and social services, both antenatally and in the postnatal period, would have prevented the woman from slipping through the net and receiving little or no support for either her medical or social problems. This was particularly the case in a number of deaths from suicide, or in women who reported domestic violence.

Women with severe social problems often fail to attend for antenatal care, as do those suffering from substance abuse. A number of women who use drugs appear to default antenatal clinic attendance while attending the community drug service more regularly. Midwives should consider whether they should work in concert with social services or community drug teams and, indeed, plan future services in consultation with the women most likely to use them. In Glasgow, where drug service users have been involved in planning their services the uptake and attendance rate is high. Open access to antenatal clinics in conjunction with substance abuse services without the need for making appointments may also improve antenatal attendance.

Assisting with this Enquiry

The case reports completed by midwives for the Confidential Enquiry were frequently disappointing. Midwives often stated merely that ‘all appropriate care was given’ even though most cases had midwife involvement. If this Enquiry is to continue to improve midwifery practice, midwives must be willing to provide detailed and accurate information about the care they gave. With the introduction of new systems of reporting in the future it is hoped that midwives will provide the information that makes the recommendations made in these Reports as valuable as possible.

Conclusions

As with previous Reports, there are important lessons for all professionals involved in providing care to women and their babies. This Report should be seen as a contribution to the continuing assessment and development of the role of the midwife. The midwife is at the forefront of the delivery of care and as such is in a position to influence change. The recommendations in this Summary are intended not only for organisations to inform future policy but also to develop the practice of individual midwives.

The introduction of the consultant midwife in many Trusts in the UK will serve to enhance the professional development of the midwife. Allied to this is the role of the midwife as an advocate, crossing health and social care boundaries.

With your help, this Enquiry remains an outstanding example of professional commitment to self-audit and should continue to help improve the care provided to pregnant and recently delivered women and their wider families. Nowadays, childbirth usually brings great happiness but women and their partners rightly expect us to learn lessons when a tragedy occurs, and to apply these lessons widely and effectively.

Midwifery practice: summary of key recommendations

Apart from the specific recommendations given here, midwives should also read the recommendations contained in the main Report, or at very least the summary of key recommendations at the end of this Summary.

Antenatal care

Midwives should be at the forefront of helping to plan new models of service provision. The planning and delivery of maternity services should focus on regarding each woman as an individual person with different social, physical and emotional needs as well any specific

clinical factors that may affect her pregnancy. Her pregnancy should not be viewed in isolation from other important factors that may influence her health or that of her developing baby.

Each woman should have a flexible, individualised antenatal care plan drawn up at booking, which reflects her own circumstances and needs. This should be reviewed regularly throughout her pregnancy.

There may be many reasons why women may fail to attend clinic appointments. These women are at higher risk of maternal and fetal complications and death, and regular non-attendance should be personally and actively followed up by the midwife. If the reasons why she felt unable to seek care are ascertained through sympathetic questioning then alternative arrangements should be made that suit the particular circumstances of the woman.

Targeting care is about developing services that are effective for all women but particularly for those women who would not normally actively seek help and advice. As part of the changes in the delivery of midwifery care it is crucial that new patterns of antenatal care are developed particularly for those women who are at the greatest risk. In some instances this may require individual antenatal care at home.

Interpreters should be provided for women who do not speak English. The use of family members, including children as interpreters, should be avoided if at all possible.

Booking

At booking, a needs and risk assessment should take place to ensure that every woman has a flexible individual plan for their antenatal care, to be reviewed at each visit, which reflects their own particular requirements for antenatal care.

With the growing importance of midwifery-led care, it is vital that midwives undertake a full needs assessment at the booking visit in order to identify women whose past or current medical history may make them unsuitable for this type of care, and that these women be referred for more appropriate care. Conversely, midwives should be prepared to decline taking responsibility for high-risk cases where the involvement of a consultant obstetrician is essential and the reasons for this should be explained to the woman and to the obstetrician.

The GP booking letter is a referral mechanism and should not be relied upon to provide all the information necessary to plan antenatal care.

All mothers should have their BMI calculated at booking as part of the full risk assessment. Further, they should be offered advice about sensible weight reduction including diet and exercise and referral to a dietician where appropriate. A past history or family history of thromboembolism should be sought and if present, specialist advice should be obtained.

Midwives are uniquely placed to provide advice and support on healthy lifestyles including:

- diet and exercise
- smoking, alcohol and substance misuse
- safety in the home and workplace
- basic first aid measures, especially for women with existing conditions such as epilepsy
- the correct use of car seat belts
- guidance on the warning signs of obstetric complications such as pre-eclampsia.

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.

Enquiries about previous psychiatric history, its severity, care received and clinical presentation should be made routinely in a systematic and sensitive way at the antenatal booking clinic. Women who have a past history of serious psychiatric disorder, postpartum or non-postpartum, should be referred to a psychiatrist and a management plan should be formulated in light of the high risk of recurrence.

The term ‘postnatal depression’ or ‘PND’ should only be used to describe a nonpsychotic depressive illness of mild to moderate severity with its onset following delivery. It should not be used as a generic term to describe other mental illnesses. The term ‘postnatal depression’ or ‘PND’ in the maternity records diminishes the severity of previous illness and the high risk of recurrence and should not be used unless the illness was minor in nature. Precise details of any previous illness should be sought and recorded in line with the recommendation above.

All pregnant women should be routinely asked about domestic violence as part of their social history and should have the opportunity to discuss their pregnancy with a midwife, in privacy, without their partner present, at least once during the antenatal period.

Continuing care

All providers of maternity services should ensure that there are clear protocols and routes of referral to primary or secondary care when rapid assessment, investigation and treatment are required. This will involve close collaboration with other professionals in both primary and secondary care.

When referring woman to general practitioners, midwives should make direct contact with the general practitioner and not ask the woman or her family to do so on her behalf.

Midwives should have the ability to refer women they are directly concerned about to appropriately experienced medical staff in secondary care.

In order to increase the detection of pre-eclampsia, all mothers should have their urine tested at each antenatal contact after 20 weeks of pregnancy.

As an individual practitioner

Midwives are encouraged to reflect and develop their practice and, if necessary, be prepared to play an active role in challenging the organisational structure and culture in which they work.

Midwives and other health professionals who work with disadvantaged clients need to be able to understand a woman’s social and cultural background, act as an advocate for

women with medical staff and colleagues, overcome their own personal and social prejudices and practice in a reflective manner.

Midwives should be prepared to decline taking responsibility for high-risk cases where the involvement of a consultant obstetrician is essential and the reasons for this should be explained to the woman and to the obstetrician.

Midwives need to fully use existing systems of statutory supervision to ensure continuing professional development and actively demonstrate evidence-based care.

Continuing professional development should be accepted as the responsibility of the individual practitioner as well as an employer and knowledge and skills should be regularly updated using current research evidence.

Recommendations from other Chapters

There are a number of recommendations in other Chapters in the Report that may have specific relevance for midwives. These include:

Auditable standards for maternity care (Summary)

Each unit should identify a lead professional to develop and regularly update local multidisciplinary guidelines for the management of obstetric problems. This Report contains examples of such guidelines in a number of areas. As a minimum, guidelines should be provided for the following:

- follow-up procedures for women who regularly fail to attend for antenatal care
- the management of women who are at risk of a relapse or recurrence of a serious mental illness
- the management of and local support strategies for women who disclose domestic violence
- the management of pre-eclampsia and eclampsia
- the management of obstetric haemorrhage
- the use of thromboprophylaxis
- the use of antibiotics for caesarean section
- the identification and management of ectopic pregnancy
- the identification of and support for women with higher-risk pregnancies and who appear unsuitable for midwifery-led care.

Clinical guidelines should be prominently placed in all antenatal and postnatal wards, the delivery suite and in A&E departments, and all guidelines given to all new members of staff.

The views of women who book late or fail to attend should be sought in helping to provide more appropriate services in future. The views of all women who use the services should also be sought on a regular basis.

The implementation of the guidelines should be subject to regular audit.

Each maternal death or case of severe morbidity should be discussed at multidisciplinary meetings and the report sent to the CEMD.

Units should organise regular fire drills for cases of massive haemorrhage so that when these emergencies occur all members of staff (including the blood bank) know exactly what to do to ensure that large quantities of crossmatched blood can be delivered to the delivery suite or theatre without delay.

Thromboembolism (Chapter 2)

At booking, the BMI should be routinely calculated to identify women whose BMI is over 30 kg/m². A past history or family history of thromboembolism should be sought and, if present, specialist advice should be obtained.

Women with other risk factors for deep vein thrombosis (DVT): e.g. bed rest, pre-eclampsia, other medical disorders, should be carefully screened and consideration given to thromboprophylaxis.

All women undergoing caesarean section should receive prophylaxis against venous thromboembolism (VTE). Multiple risk factors are often present and the most effective method of prophylaxis, heparin at appropriate doses, should be used.

Wider use of thromboprophylaxis (not only after caesarean section) and better investigation of classic symptoms (particularly in high-risk women) are urgently recommended.

Midwives, general practitioners and other medical staff should pay particular attention to women in the puerperium with chest or leg symptoms after vaginal delivery in order to exclude the presence of DVT or potential pulmonary embolism.

Summary of RCOG Scientific Advisory Committee Advice on preventing thromboembolism in pregnant women travelling by air

Any gestation and up to six weeks post partum	Short-haul flight (up to four hours)	Long-haul flight (four hours or more)
No additional risk factors	Calf exercise; move around cabin; avoid dehydration; minimise alcohol and coffee consumption.	Calf exercise; move around cabin; avoid dehydration; minimise alcohol and coffee consumption; well-fitting elastic below-knee compression stockings.
Additional risk factors ^a Weight ≥ 100 kg or BMI at booking ≥ 30 Multiple pregnancy Thrombophilia Past personal or strong family history of DVT Medical disorders with increase risk of DVT	Calf exercise; move around cabin; avoid dehydration; minimise alcohol and coffee consumption; well-fitting elastic below-knee compression stockings.	Calf exercise; move around cabin; avoid dehydration; minimise alcohol and coffee consumption; well-fitting elastic below-knee compression stockings; low molecular weight heparin ^b on day of travel (pre-flight) and day after. ^c
^a Women with additional risk factors may need to seek appropriate medical advice. Some, for instance, will already be on thromboprophylactic medication. ^b Thromboprophylactic doses are 5000 units dalteparin or 40 mg enoxaparin ^c Low-dose aspirin (75 mg per day for three days before travel and on day of travel) is an acceptable alternative in those unable to take low molecular weight heparin.		

Pre-eclampsia and eclampsia (Chapter 3)

Pregnant women with a headache of sufficient severity to seek medical advice, or with new epigastric pain, should have their blood pressure measured and urine tested for protein, as a minimum.

Clear, written, management protocols for severe pre-eclampsia should guide initial and continuing treatment in hospital.

Automated blood pressure recording systems can systematically underestimate blood pressure in pre-eclampsia, to a serious degree. Blood pressure values should be compared, at the beginning of treatment, with those obtained by conventional mercury sphygmomanometers.

Magnesium sulphate is the anticonvulsant drug of choice in the treatment of eclampsia.

Women with moderate to severe pre-eclampsia require a level of clinical observation that may be incompatible with location in a single side room in hospital.

Women with multiple pregnancies are at increased risk of pre-eclampsia and their antenatal care should reflect that awareness.

Haemorrhage (Chapter 4)

The speed with which obstetric haemorrhage can become life-threatening emphasises the need for women at known high risk of haemorrhage to be delivered in a hospital with a blood bank on site and appropriate laboratory facilities including haematological advice and therapy.

Every unit should have a protocol for the management of haemorrhage and this should be reviewed and rehearsed on a regular basis. It should also be included as part of life-support training. All members of staff, including those in the blood bank, must know exactly what to do to ensure that large quantities of cross-matched blood can be delivered without delay.

Genital tract sepsis (Chapter 7)

The onset of life-threatening sepsis at any stage of pregnancy can be insidious and all doctors and midwives must be aware of the symptoms and signs and be prepared to institute immediate treatment to avoid serious consequences.

A patient with prolonged rupture of the membranes who develops a fever and/or tachycardia should be carefully assessed by senior staff.

In women with spontaneous rupture of the membranes and not in labour, vaginal assessments should be avoided or kept to a minimum and undertaken with appropriately aseptic precautions.

There is clear evidence from controlled trials showing the benefits of prophylactic antibiotics for emergency caesarean section. This Report confirms that this policy is still not universally employed.

Anaesthesia (Chapter 9)

It seems not to be widely appreciated that oxytocin (Syntocinon®; Alliance) can cause profound, fatal, hypotension, especially in the presence of cardiovascular compromise. Administration should follow the guidance in the *British National Formulary* and other

standard formularies. When given as an intravenous bolus the drug should be given slowly in a dose of not more than 5 iu.

Cardiac disease (Chapter 10)

Women with severe cardiac disease require multidisciplinary care.

In women with significant heart disease, delivery must be planned. At the very least this will involve discussion with the consultant anaesthetist(s) who will be responsible at the time.

Prepregnancy counselling about the risks of pregnancy should not alienate the woman to such an extent that she does not come for antenatal care if she does become pregnant; these women need the best care that is available throughout pregnancy.

Psychiatric causes (Chapter 11)

Protocols for the management of women at risk of relapse or recurrence of a serious mental illness after delivery should be in place in every Trust providing maternity services.

Enquiries about previous psychiatric history, its severity, care received and clinical presentation should be routinely made in a systematic and sensitive way at the booking clinic.

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 in line with the recommendations above.

Women who have a past history of serious psychiatric disorder, whether postpartum or non-postpartum, should be assessed by a psychiatrist in the antenatal period and a management plan instituted with regard to the high risk of recurrence following delivery.

Women who have suffered from serious mental illness after childbirth or at other times should be counselled about possible recurrence of that illness after further pregnancies.

Other Indirect causes (Chapter 12)

Women with epilepsy need specific specialist advice in pregnancy. The ideal treatment for pregnant women with epilepsy, which has already been instigated in some centres, is a dedicated clinic to encompass prepregnancy counselling and attended by an obstetrician, a neurologist/obstetric physician and a specialist midwife or neurological nurse.

Women with epilepsy should also be made aware of the dangers of bathing in pregnancy. They should be advised to bathe only in shallow water with someone else in the house or, alternatively, to shower.

All women should be encouraged to have HIV screening at booking.

Pregnant women appear to be particularly susceptible to infectious diseases. Those that are not improving despite standard treatment should be admitted to hospital.

The risk to the fetus from poorly treated asthma is much greater than any possible risk to the fetus from steroid drugs. Steroid therapy can and should be continued in pregnancy.

Pregnancy is not a reason for withholding plain X-ray films of the abdomen, chest X-rays, some computed tomography scans or magnetic resonance imaging from sick women.

Cancer and other tumours (Chapter 13)

Clear and relevant information must be passed from the general practitioner to the antenatal care team at booking concerning any past medical history including previous malignancies and abnormal cervical smears and any relevant family history.

A clear medical and family history needs to be taken at booking to lower the threshold for the index of suspicion in women who complain of other symptoms during pregnancy.

When any pregnant woman complains of episodes of vaginal bleeding in pregnancy, other than confirmed causes of haemorrhage, cervical cancer must be excluded by direct observation of the cervix and a cervical smear taken. This should be undertaken irrespective of her past medical history or reports of normal past cervical smears.

The importance of planned multidisciplinary care for women with cancer and other serious problems cannot be over-stressed. Obstetricians, midwives, GPs, oncologists, surgeons, Macmillan nurses and palliative care services need to be involved, in conjunction with the woman and her partner, in planning a course of antenatal care that respects the wishes of the woman and optimise the outcome for the fetus.

A summary of an excellent midwifery care plan developed for a particular woman in this Report gives a blueprint for others. Apart from providing routine care and support, the midwives' role includes:

- familiarisation visits to the special care baby unit
- support to help the woman come to terms with her condition
- liaison with other healthcare teams
- provision of information for her and her family
- providing time for rest and privacy
- ensuring the complex set of hand held notes were transferred to all the professionals involved in her care
- teaching her partner parenting skills
- being involved with the first course of post-delivery chemotherapy or treatment.

Bereavement counselling and access to representatives of religious faiths should be offered on request or when appropriate.

Domestic violence (Chapter 16)

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.

When a woman discloses violence this must be taken seriously. Women who are poor clinic attenders need active outreach services.

Local Trusts and community teams should develop guidelines to identify and provide 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 hand held maternity notes or cooperation cards.

Enquiry about violence should be routinely included when taking a social history. Obstetricians and gynaecologists should consider introducing questions about violence during the course of all consultations. In general practice and midwifery, this could be at the booking visit. There are a number of useful documents explaining how this can be achieved, through the use of sensitive questions.

When routine questioning is introduced, this must be accompanied by the development of local strategies for referral, and an educational programme for professionals, in consultation with local groups, and preferably delivered by those already working in this area.

Where the woman is unable to speak English an interpreter should be provided on at least one occasion, rather than relying on a partner, friend or family member, especially if the index of suspicion is high.

Every woman should be seen on her own at least once during the antenatal period to enable the disclosure of such information.

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