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The Confidential Enquiry into Maternal Deaths 2015:

lessons for GPs

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INTRODUCTION

The Confidential Enquiry into Maternal Deaths began in 1952 and has led to major improvements in care for pregnant and postnatal women.

Between 2011 and 2013 there were 240 maternal deaths during or up to 6 weeks after pregnancy, giving a maternal death rate of 9 in every 100 000 women, a statistically significant decrease compared with 2009–2012.[1] Two-thirds of the deaths were due to medical and mental health comorbidities and one-third were due to obstetric causes. There has been no significant change in deaths from medical and mental health condition causes over the last 10 years. The surveillance data in this article covers 2011–2013, but cases from 2009–2013 were reviewed because the Enquiry was suspended during 2009–2010. Different conditions leading to death are covered in each report. In this article the focus will be on thromboembolic disease, mental illness, homicide, domestic violence, and late deaths (more than 6 weeks after birth).

PREVENTION OF THROMBOEMBOLIC DISEASE

Forty eight women died from pregnancy-related venous thrombosis or thromboembolism (VTE) during or up to 6 weeks after pregnancy between 2009 and 2013. One-quarter died in the first trimester of pregnancy, before usual maternity booking, although many had risk factors. GPs need to be aware of the Royal College of Obstetricians and Gynaecologists green-top guidelines;[2] if they see a woman prior to booking and consider that she is at high or medium risk, they should refer urgently for advice on thromboprophylaxis.

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

LESSONS ON MATERNAL MENTAL HEALTH

Over the 5-year period — 2009–2013, 161 women died from mental health problems: 101 died by suicide, 58 from substance misuse, and two from other causes.

Suicide

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

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

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

- recent significant change in mental state or emergence of new symptoms;

Box 1. Additional learning resources

- Three Ps in a pod: https://rcpsg.ac.uk/college/influencing-healthcare/policy/maternal-health
- Medical problems in pregnancy: http://www.e-lfh.org.uk/programmes/medical-problems-in-pregnancy/
- Perinatal mental health: http://www.e-lfh.org.uk/programmes/perinatal-mental-health/open-access-sessions/
- RCGP Perinatal Mental Health Toolkit: http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

- new thoughts or acts of violent self-harm; and
- new and persistent expressions of incompetence as a mother or estrangement from the infant.

Substance misuse

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

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

Homicide and domestic violence

A history of domestic violence was documented for only 5% of all the women who died between 2009 and 2013 during pregnancy and up to 6 weeks after birth. The National Institute for Health and Care Excellence recommends that

'Healthcare professionals need to be alert to the symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment in which they feel secure'.[3]

Almost half of these women were murdered or died from psychiatric causes. They often had multiple morbidities.

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

Late deaths

There were 553 late deaths of women between 2009 and 2013. Of these deaths 23% were due to mental illness, discussed above, and the majority of the rest were due to medical conditions. Many of the women who died between 6 weeks and 1 year after pregnancy had longstanding and multiple morbidities occurring prior to, during, and after pregnancy, and they often led socially complex lives. Only 16% of women who died late had no additional factors associated with their death and 30% had three or more additional comorbidities. Many of the factors that led to death were known about at the time of contact with maternity services. Before these women died they often had multiple contacts with other health services, including general practice. One recommendation is that repeated presentations to the GP or others should be considered a 'red flag' and warrant a thorough holistic assessment by the GP, leading to ongoing review, if appropriate.

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

CONCLUSION

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

Box 1 lists some online resources for GPs.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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