

# Lenus: Research Repository



## **Mothers and babies-reducing risk through audits and confidential enquiries**

Item Type	Other
Authors	Murphy, J F A
Publisher	Irish Medical Journal (IMJ)
Journal	Irish Medical Journal (IMJ)
Download date	2026-04-11 14:45:46
Link to Item	<a href="https://hdl.handle.net/10147/239154">https://hdl.handle.net/10147/239154</a>

# Mothers and Babies-Reducing Risk through Audits and Confidential Enquiries

## Abstract:

The Confidential Enquiries into Maternal Deaths (CEMD) is being disbanded and will be incorporated into a new structure called MBRRACE-UK, Mothers and Babies-Reducing Risk through Audits and Confidential Enquiries throughout the UK. The CEMD, which has been in existence since 1952, was highly valued by clinicians. It had an unbroken 60 year history in existence. It set the bar for higher obstetric standards. It monitored the causes of maternal death and improved safety. It operated through a system of anonymised case records of obstetric deaths. A group of regional and national assessors examined the circumstances around each case. The assessors then made recommendations on the lessons to be learned. The Enquiry had widespread support among obstetricians and was an important voice in advocating better maternal care. It constantly stressed the importance of clinical vigilance. It emphasised that old messages need to be frequently repeated and that there is no room for inertia. Its strength was its ability to identify avoidable causes of maternal death in a no-blame culture. This resulted in an almost total buy-in. After preparation of the Report and before its publication all maternal death forms, relevant documents and files related to the period of the report are destroyed and all electronic data is irreversibly destroyed.

The triennium<sup>2</sup> report 2006-2008, published in March 2011, recorded an overall maternal mortality rate of 11.39 per 100,000. It identified substandard care in 70% of direct deaths and 55% of indirect deaths. Shennan and Bewley state that "some deaths are inevitable, but avoidable ones are unacceptable". The Enquiry was truly owned by the professionals who were happy to participate in the reviews of the worst clinical outcomes. The 2011 report set out a "top 10" recommendations list. These are common sense, and achievable by all units. The Report advises pre-pregnancy counselling for medical conditions such as epilepsy, diabetes, asthma, cardiac conditions and autoimmune disease. There should be a low threshold for specialist referrals and they should be prioritised. It emphasises the importance of systolic hypertension and close attention to genital tract sepsis. Concerns were expressed about the emergence of community-acquired Group A streptococcal disease. All women who died with Group A streptococcal infection had either worked with or were the mother of young children. It urges better perinatal pathology services and continued high quality local review of maternal deaths. The number of locations where pathology is undertaken should reduce and specialist pathologists taking on perinatal pathology as part of an agreed service. Ireland joined the Enquiry in Jan 2009 at the commencement of the 2009-11 triennium and its contribution will be included in the next Report. The Irish office is located at the Irish National Perinatal Epidemiology Unit in Cork.

Despite its wide reputation and influence, CEMD has increasingly been criticised by a number of groups and individuals. It is perceived as being too anecdotal. It is described as providing opinion rather than peer review. Meanwhile its supporters pointed out that it draws data from many supporters. Following a period of intense debate it was decided to incorporate the CEMD into the new structure MBRRACE-UK.

MBRRACE-UK is a collaboration of the National Perinatal Epidemiology Unit (NPEU), Oxford and several universities and charities. The lead is Jenny Kurinczuk at the NPEU. It will also incorporate TIMMS- The Infant Mortality and Morbidity Studies. TIMMS is a collaborative group of national and regional research projects. It will investigate the causes, consequences and management of morbidity and mortality of the fetus and infant. This is part of the drive for greater visibility in Neonatal care. In 2003 Neonatal networks were set up in the UK. Subsequently the Neonatal taskforce, Neonatal toolkit, NICE standards for Neonatal specialist care and the national Neonatal audit programme were established. The objective is that data should be captured once and should be of high quality. This implies consistency in data management which is the platform for quality improvement programmes. The Neonatal programmes are to be linked to a new child mortality and morbidity review programme. Its remit is a confidential in depth case reviews to help improve the care of sick children. One its first steps is to accurately determine what proportion of deaths occur in previously healthy children and what proportion occur in children with serious underlying disease. The paediatric early warning system (PEWS) is now being adopted by many units. It consists of 4 parameters-behaviour, cardiovascular, respiratory and output which are scored on a 0-3 basis. Scores of 4 or more call for action. It is a break away from the traditional chain of command system and it helps to identify sick children before their condition becomes an emergency. It is now appreciated that hospitalised children can have a prolonged compensatory stabilisation phase before an acute decompensation occurs. There is data to suggest that it can provide a forewarning greater than 11 hours, thus avoiding an acute emergency.

MBRRACE-UK faces a number of diverse challenges. It must retain the confidence and support of frontline clinicians. It mustn't become removed from individual high risk events and the medical feedback that they provide. The "on the ground" experiences of those closely involved in the actual emergencies have been invaluable in the formulation of all the previous reports. It will have to examine a number of emerging threats. One in every 100 births leads to a stillbirth or neonatal death. Over 100 women die annually during pregnancy. There has been a shift in the pattern of maternal death. Concerns include poor mental health, cardiac disease and sepsis. Other issues are deaths after assisted reproduction and elective caesarean section from breech presentation. Management of appendicitis is another worry.

It is to be hoped that the new system will build on the outgoing Confidential Enquiry which has served mothers and their babies so well for such a long time.

JFA Murphy  
Editor

1. Shennan A, Bewley S. What has happened to the UK confidential enquiry into maternal deaths. *BMJ* 2012;344:7
2. Saving mothers lives. *BJOG* 2011;118: Suppl 1
3. Akre M, Finkelstein M, Ericson M, Liu M, Vanderbilt L, Billman G. Sensitivity of the paediatric early warning system score to identify patient deterioration. *Pediatr* 2010;125:763-9.

Comments: