

CONFIDENTIAL ENQUIRY INTO THE CAUSE OF PERINATAL DEATH: A 1978 PROPOSAL

Peter M. Dunn, MD, FRCOG, FRCP, FRCPCH
Emeritus Professor of Perinatal Medicine and
Child Health, University of Bristol,
e-mail: P.M.Dunn@bristol.ac.uk

THE BACKGROUND

In 1978, as chairman of the Bristol Paediatric Association/Royal College of Obstetricians and Gynaecologists Liaison Committee I had prepared a memorandum with the title 'Recommendations for the improvement of infant care during the perinatal period in the UK'⁽¹⁾. It was received with enthusiasm by the presidents (Fig 1 and 2) and councils of both parent bodies and then submitted by them to the House of Commons Social Services Committee (chair: Mrs. Renée Short, MP) (Fig 3) which was at that time engaged on a major study into the state of perinatal care in the UK⁽²⁾.

One of the recommendations in the memorandum was on the need for a national enquiry into the cause of perinatal death. The relevant section read as follows:

4.20 Perinatal Mortality

(v) The possibility should be explored of setting up confidential enquiries into the cause of perinatal death, along similar lines to that instituted so successfully by the RCOG with respect to maternal deaths. Because of the greater numbers involved it might be necessary initially to restrict study to non-malformed infants weighing more than 1kg at birth ... The BPA/RCOG Liaison Committee might be the appropriate body to explore this suggestion, perhaps in conjunction with the newly formed DHSS/BPA/RCOG Perinatal Epidemiology Unit.

For many years the RCOG had undertaken regular confidential enquiries into the cause of maternal deaths but no such enquiry had been instigated into the cause of perinatal death. Not only were perinatal deaths perhaps 100 times more numerous, but such enquiries would require close collaboration between obstetricians and paediatricians as well as other disciplines. In addition, there was the very sensitive matter of possible medico-legal intervention and retribution.

Early in 1978 before presenting my memorandum to the BPA/RCOG Liaison Committee, I had been to see the president of the RCOG, Sir John Dewhurst, to discuss its contents and in particular the section about possibly undertaking a confidential enquiry into perinatal deaths. He had not only given this suggestion his warm approval but had agreed that I should prepare a working paper on the subject. This I did later that



Fig 1
Professor Otto Wolff, president of the BPA 1976-79.

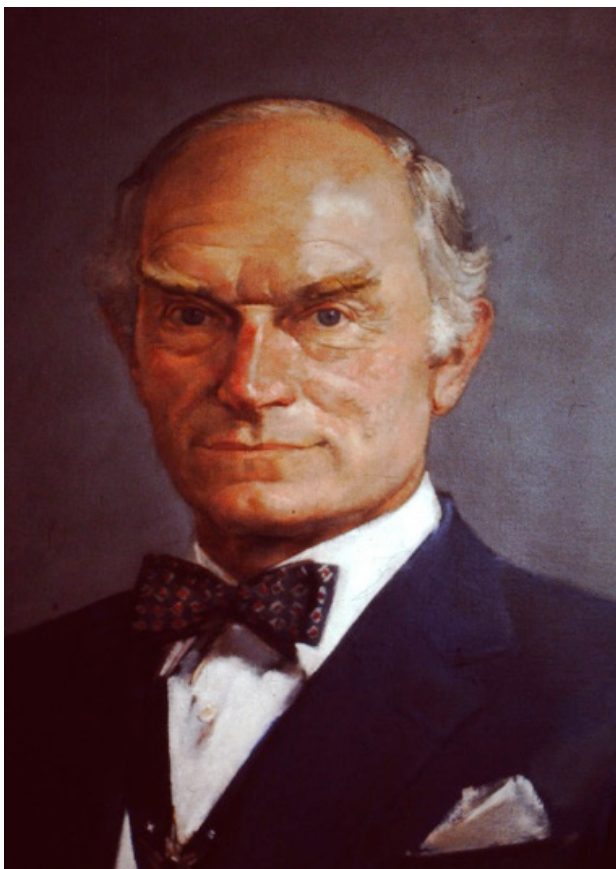


Fig 2
Sir John Dewhurst, President of the RCOG



Fig 3 Mrs. Renée Short, MP, chairman of the House of Commons Select Committee for Social Services, 1979-1987.

summer⁽³⁾ and circulated it to members of the BPA/RCOG Liaison Committee for their comments. But by this time Sir John Dewhurst had left office and Sir Anthony Alment (Fig 4) had become president.

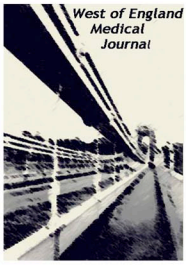


Fig 4
Sir Anthony Alment,
President of the RCOG, 1978-1981

Unfortunately, Sir Anthony was unaware that his predecessor had sanctioned in advance my paper on a possible confidential perinatal enquiry into cause of death. As a result, when one of the obstetric members of the Liaison Committee showed him a copy of my proposals, he was seriously displeased that a paediatrician should put forward suggestions on such a sensitive obstetric issue. He at once made his displeasure known to the newly appointed president of the BPA, Dr. George Komrower (Fig 5). He in turn passed this displeasure on to me in no uncertain terms. That was the last that was heard of my proposals - until the present time. I still believe they offer a rational and confidential way of investigating the cause of perinatal deaths and hence of improving the standard of obstetric and paediatric care in the perinatal period.



Fig 5
Dr. George Komrower,
President of the BPA, 1978-82.



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CONFIDENTIAL ENQUIRY INTO THE CAUSE OF PERINATAL DEATH

(Working Paper prepared by P.M. Dunn for the BPA/RCOG Liaison Committee, August 1978⁽³⁾)

AIM

To identify avoidable or treatable factors leading to perinatal death –whether medical, social, economic or organisational.

COLLECTION OF INFORMATION

This should be done at District level with local knowledge and attention to detail and should apply to all perinatal deaths in a given geographical area.

METHOD OF RECORDING DATA

Questionnaires (3 copies NCR) need to be completed locally.

PERSON(S) RESPONSIBLE FOR COMPLETING QUESTIONNAIRE

Some alternatives:

- Specially designated person.
- The clinician(s) responsible for case – obstetrician for stillbirths and obstetrician and paediatrician for neonatal deaths.
- A combination of above. This alternative has most advantages.

INFORMATION

This should include:

- Demographic information on parents.
- Past obstetric history.
- Antenatal care in present pregnancy including arrangements for delivery.
- Intrapartum and delivery events including timing (i.e. transferred).
- Neonatal events.
- Postmortem findings.
- Mother's views on management.
- Clinician's own assessment of management (this might include the midwife's view).

Control Data

Consideration should be given to the collection of similar data from a group of matched controls in which the outcome has been 'survival'. It is essential that this should be done at least in certain selected Areas.

Analysis of Data

As the main purpose of the enquiry is to improve the service, it is essential that the information should be examined locally as well as by a central and independent panel of referees.

- Local analysis at District level is already commonly practiced at the monthly perinatal mortality conferences held in most obstetric units. The clinician's conclusion on perinatal management might best be completed at this time.

- Central analysis should be undertaken by a small independent team which should include an obstetrician, a paediatrician and, in certain cases at least, a pathologist.

CONFIDENTIALITY

The identity of the patient is likely to be and indeed should be known during local analysis of perinatal data and completion of the 3-copy Perinatal Mortality Form. However, this identity need not and should not be included on the copy(s) of this form submitted for 'central' analysis. While the identity of the District (or Area) needs to be known centrally if information is to be fed back to the clinician concerned, this information need not necessarily be made available to the panel of referees.

METHODOLOGY

The 3-copy Perinatal Mortality Form should be completed at District level, preferably after post-mortem examination and discussion at the local perinatal mortality conference.

The form would include coded District, clinician(s) and patient identity numbers. Only the top copy, which should be retained by the clinician(s) would include the patient's name and hospital number.

The two under copies would be forwarded to the Regional Medical Officer who would alone hold the key to the identity of the clinician(s) and the District involved.

The Regional Medical Officer would then forward one copy of the form to the panel of referees, retaining the under copy.

After assessment the panel would return their copy and also an opinion in duplicate to the Regional MO who will retain one copy of the latter and send the other to the clinician(s) involved.

The results of regional analyses would be made available to the National Perinatal Epidemiology Unit, RCOG and BPA for further analysis and publication.

LOGISTICS

On average there will be some 800-900 perinatal deaths per year in each Region and perhaps 130 in each Area. Thus, there is a considerable workload involved even though many (perhaps half) of the deaths are fairly 'straight forward' being due to lethal malformation or extreme prematurity. If the confidential enquiry is to function satisfactorily there will be a need for funds to support at least one medical officer with perinatal and epidemiological training in each Region and also to provide secretarial support. It will also be necessary to finance the work of the panel of referees.

LEGAL ASPECTS

If the medical profession does not monitor satisfactorily the factors responsible for perinatal death the legal profession is likely to be asked to do so by individual members of the public. This has already begun to happen. It is therefore essential that no time is lost in introducing a national scheme for study of the causes of perinatal death. Yet at the same time it is vital that the findings of such an enquiry are adequately protected in some way from legal process. If this protection is not available many clinicians are likely to be reluctant to allow information respecting their patients to leave their units or practices.

PERINATAL MORBIDITY

The lessons learned from a perinatal mortality survey are likely to be applicable to the problems of prevention of perinatal morbidity. Although it may eventually be possible to extend the enquiry to cases of long term handicap arising in the perinatal period, such an extended survey will not be easy to accomplish because of medico-legal problems and because ascertainment may be delayed for many months or even years after birth, by which time research into the details of perinatal care may be difficult to gather.

REFERENCES

- British Paediatric Association/Royal College of Obstetricians and Gynaecologists: Recommendations for the Improvement of Infant Care during the Perinatal Period in the UK. BPA/RCOG Liaison Committee (Chairman, P.M. Dunn), March 1978.
- House of Commons Second Report from the Social Services Committee (Session 1979-80) Perinatal and Neonatal Mortality, Volumes 1-5. London: HMSO, 1980. The BPA/RCOG memorandum(1) may be found in Vol II, pp.166-201.
- Dunn, P.M. Confidential enquiry into the cause of perinatal death. Working Paper prepared for the BPA/RCOG Liaison Committee, August 1978.