The CMACE Report - Unasked questions

According to its website, CMACE (Centre for Maternal and Child Enquiries) is an independent charity with a mission: "to improve the health of mothers, babies and children by carrying out confidential enquiries and other related work on a UK wide basis and widely disseminating the results." Its report on the Albany Group Practice, entitled for some obscure reason, *The London Project*, and referred to here as the Albany report or the CMACE report, has neither improved the health of mothers and babies cared for by the Albany midwives, nor have the results been widely disseminated, although copies are now available on request under the *Freedom of Information Act* from King's College Hospital.

The puzzling history of CMACE

Until last year, enquiries into maternal and perinatal mortality were managed by CEMACH (Confidential Enquiries into Maternal and Child Health). According to its website CMACE became an independent charity on July 1st, 2009. A press release on the CMACE website contains the following:

> *CEMACH has worked closely with a wide range of clinicians, including midwives, paediatricians, obstetricians and, increasingly, general practitioners in carrying out its reviews. It is committed to continuing and further strengthening these relationships once it becomes CMACE. Links with the RCOG as the legal host have been particularly strong. Although CMACE will not be part of the RCOG in the same way as CEMACH, both parties are committed to retaining close ties in the future.*
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> *Professor Arulkumaran, President of the RCOG said: "I have greatly valued the role played by CEMACH in recent years. We welcome its achievement of independence as CMACE and look forward to working in partnership with the new organisation on our shared goals."*

However, according to the Albany report, King's College Hospital commissioned CMACE to carry out this review in January 2009, six months *before* CMACE existed as an independent charity. This timetable seems somewhat odd. Whom did King's first contact to look into the Albany's cluster of cases? When did the RCOG hive off CEMACH to become an independent charity and why?

I had vaguely noticed the name change to CMACE last year and assumed it was some sort of privatisation of CEMACH, itself an amalgamation of CESDI (Confidential Enquiries into Stillbirth and Death in Infancy, started in 1992) and CEMD (Confidential Enquiries into Maternal Death, started in 1952) both with honourable histories. Last year's press release implied that CEMACH was to be *replaced* by CMACE but a look at today's website shows that CMACE has, after all, retained the name of CEMACH in its programme of confidential enquiries into maternal and child death.

I presume that CEMACH/CMACE became an independent charity so that it could be paid to take on work not normally covered by the well established confidential enquiries. The difference between CEMACH and CMACE appears to be that CMACE has an additional role, as an independent body which parties can commission to investigate particular problems. This comes under the heading of local clinical audits and confidential enquiries – but the website still talks about perinatal mortality rather than perinatal morbidity:

> *we have received requests to work with local healthcare bodies and governmental bodies to help them review their cases of perinatal and maternal deaths. In response, CMACE has started working with specific local healthcare bodies, including PCTs to set up and run confidential enquiry panels which aim to facilitate learning in cases of perinatal death. Reports remain confidential to local healthcare bodies involved.*
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> cmace.org.uk/Other-CMACE-Work/Local-Clinical-Audits-and-Confidential-Enquiries.aspx

I can only assume that the Albany report comes under this heading, although CMACE was not just reviewing perinatal death under the Albany – indeed, it singularly failed to do just that; CEMACH would have looked first at perinatal mortality and the Albany rate is half that of the local area.

Confidential Enquiries – A national treasure

Our colleagues in the USA are deeply envious of the UK's well respected enquiries into maternal death; there is no such programme in the USA where maternal death is shrouded in secrecy. Ina May Gaskin's Safe Motherhood quilt, "honors women who have died of pregnancy-related causes; the huge majority of those deaths were preventable. She contrasts the UK's excellent maternal mortality program with the US's almost nonexistent one and suggests the US follow the UK's lead." (to see the video, Google YouTube rememberthemothers.org)

It seems that CMACE is somewhat embarrassed by the response to its Albany report; the website now contains a press release about the report which perhaps would be best described as a disclaimer, it ends with: "Explanation of any actions taken beyond those recommended by the report would need to be sought from King's".

But I have concerns beyond actions taken by King's following the report; the report itself is riddled with holes. I will consider only the two most directly concerned with CEMACH and CMACE: first, the absence of any

consideration of perinatal mortality and second, CEMACH's long stated intention to consider neonatal encephalopathy in the future.

Perinatal Mortality

One could reasonably expect the authors of the CMACE report to have set it in the context of perinatal mortality in the Albany Group Practice and in the surrounding geographical area. Every CEMD, CESDI and CEMACH report I have read emphasises time and time again the links between social deprivation and mortality, but in this report we read:

"The data generated by this review confirm that the Albany Group Practice provides care for some women in the most deprived population quintiles. Despite this, the obstetrtic and medical attributes of their clientele at booking and the problems encountered in the antenatal period do not appear to be unusually challenging and as a result, similar outcome data should be anticipated for women cared for by the Albany Group Practice compared to women cared for in neighbouring midwifery practices serving King's College Hospital."

This statement goes against everything CEMACH has ever learned about social deprivation and obstetric outcome. To reiterate, the CMACE report implies that if a pregnancy reaches term with no major problems in the antenatal period, then similar outcomes can be expected to those experienced by women in neighbouring midwifery practices. If the neighbouring midwifery practice happens to serve a area with less social deprivation, this is simply not the case. The report breaks down cases by deprivation quintile – 17 out of 23 Albany cases were in the lowest quintile; only 2 out of 11 cases from neighbouring midwifery practices were in the lowest quintile (although 8 were from the fourth most deprived quintile).

The statement in the CMACE report is just plain nonsense. If nothing else, it totally discounts well researched antepartum insults to the fetus such as those caused by smoking and poor maternal diet.

CEMACH's Interest in Neonatal Encephalopathy

HIE is a diagnosis attributing some abnormal neurological behaviour at birth to oxygen starvation at or around the time of birth. HIE is thus contained within the broader diagnosis of neonatal encephalopathy which makes no assumption about causation. CEMACH has expressed an interest in neonatal encephalopathy, citing its significance in clinical negligence claims. Since the CEMACH programme is predicated on improving maternity care, it is impossible to believe that it would not include HIE in its programme to investigate neonatal encephalopathy. The purpose of obstetric care during labour is to minimise the occurrence of fetal hypoxia during labour, to deliver a healthy infant from a healthy mother.

The neonatal encephalopathy project was first mentioned in *Perinatal Mortality 2006*, published by CEMACH in April 2008 (p 76):

Intrapartum mortality and neonatal encephalopathy
We are developing a project on intrapartum mortality and neonatal encephalopathy. The intention is to carry out an organisational survey, develop consensus standards, improve knowledge of prevalence and carry out a national clinical audit of care provided in England, Wales and Northern Ireland. Consideration will be given to whether to extend the project, with partners, to include a case control study, given the potential significance of this area in terms of costs of clinical negligence.

Perinatal Mortality 2006, CEMACH, April 2008, p 76

Just before CMACE took over from CEMACH it published *Perinatal Mortality 2007* (CEMACH, June 2009) which states on page 13 that the next major CEMACH project will be a national confidential enquiry into intrapartum-related stillbirths and perinatal deaths occurring at term. In February 2009 the case control study had been embedded in the plans put forward to the NPSA. A month after learning that King's wanted it to investigate HIE cases from the Albany Group Practice, CEMACH presented a business plan to the National Patient Safety Association.

The plan is outlined on the CEMACH page of the website which states the following:

Near term Intrapartum death and neonatal encephalopathy was identified in 2007 as the next perinatal topic for CEMACH to take forward for work in 2009.

What is Neonatal encephalopathy?

Neonatal encephalopathy (NE) is a condition which is defined clinically as abnormal neurological behaviour at birth. It manifests itself "by difficulty with initiating and maintaining respiration, depression of tone and reflexes, subnormal level of consciousness, and often by seizures" (Nelson & Leviton, 1991). Perinatal brain injury (e.g. encephalopathy) led to major litigation claims for NHS Trusts costing between £ 1.5 and £ 4 million per case (DOH 2000). There are approximately a thousand cases relating to birth injury every year; it was recommended that negligent harm due to obstetric care should be reduced by 25% in 2005 (D0H 2000). Identify [sic] avoidable factors ralating [sic] to IP related mortality and morbidity is an important first step towards decreasing litigation costs in the area of maternity service provision.

CEMACHs project

The full business cae [sic] *for this project was presented to the NPSA in February 2009. The project will run from 2010-2013 and will involve:*

- *an organisational survey investigating the extent to which services are organised to prevent this occurance* [sic]
- *an audit of intrapartum care*
- *a case control study to identify avoidable factors that may be associated with intrapartum related stillbirth and neonatal death*

Why did CMACE investigate and not CEMACH?

If it had acknowledged that HIE was contained within NE, CEMACH could have used the Albany's HIE cases as a pilot study to test the effectiveness of its plans for 2010-2013. A case control study of all King's cases of HIE could have been done under the auspices of CEMACH. Simple arithmetic shows that if the Albany had 12 (42%) of King's cases, then King's had a further 15 cases (58%).

A case control study would have involved matching HIE cases using criteria such as age, parity and postcode, to cases with no adverse outcome, and looking for avoidable factors in care. True, the CEMACH project had talked of stillbirth and neonatal death, but in the paragraph above it does talk of major litigation claims, and major litigation claims result from *surviving* infants.

For some reason it must have been felt that CEMACH would not be able to investigate. It may have been because King's were anxious to include a non HIE case, a baby who suffered fits associated with hypoglycaemia as a result of well documented feeding problems. It may have been because King's wanted more say in the way the study was to be done; perhaps it wanted control over which cases were sent for review? In the event, only community midwifery cases were reviewed. We do not know whether it was a coincidence that CMACE was set up a few months after CEMACH had first been asked to enquire into the Albany HIE cases.

Confidential Enquiries – The Future

Safe in their hands?

If we wanted to believe that the confidential enquiries into maternal death and death in infancy (CEMACH) were safe in CMACE's hands, we are sadly disappointed. The charity gets around 80% of its income from the NPSA for managing the CEMACH programme. I wonder whether this contract was put out to tender before 'charity/privatisation'? I wonder what evidence the new charity gave of its ability to conduct confidential investigations, because the Albany report seems to be an object lesson in how *not* to conduct a confidential enquiry. On one email group it was said that it should be widely disseminated as a poor example of scientific investigation.

Loss of credibility

I think that the credibility of future confidential enquiries into maternal death, stillbirth and death in infancy has been severely compromised by the Albany report. Like most other members of the public, I believe that there are far too many quangos interfering with the lives of citizens, but I've always had a respect for CEMD and CESDI (although early reports did rather tend to blame the mother for not accessing antenatal care early enough, or failing to follow advice given by caregivers). Hearing Dr Gwyneth Lewis speak at the Royal Society of Medicine about the work of CEMACH, I was impressed by her passion for improving the maternity services and learning from mistakes.

To everyone involved in the childbirth movement, the NCT, AIMS, ARM, IM UK, local GPs and midwives, not to mention members of the House of Lords, the Albany model represented the possibility of a brighter future for maternity care – community based care with your own 'family midwife'. Turning around the juggernaut of NHS maternity care was always going to be a problem, but with the advent of World Class Commissioning by PCTs, it seemed there was hope that the era of the baby factory could come to an end.

Now it seems that the body charged with looking after the health of mothers and babies is looking after the interests of the baby factories themselves. This is ironic given that CEMACH has come out from being under the auspices of the RCOG, those with the most to gain from perpetuating the current model of care.

Although criticising midwifery care for the usual reasons: failure to pick up warning signs or failing to refer early enough, the report on the Albany did not exonerate King's, acknowledging:

> *some reluctance amongst the midwifery and neonatal medical and nursing teams to work in partnership when a baby is born in unexpectedly poor condition.*

There is evidence in the report itself and from the childbirth email network that transfers to hospital care did not always go smoothly, with antagonism between caregivers.

The Albany model has not resolved the age old antagonism between the medical model and the midwifery model, and no doubt there is fault on both sides. The CMACE report suggested various ways of seeking to overcome this major problem – the interface between midwifery and obstetric care. This problem is by no means unique to the Albany model but is encountered by many midwives transferring mothers into hospital, from birth centres or from home, when obstetric help is needed.

The word 'confidentiality' itself has taken on a new meaning. The confidentiality of the mothers and the other midwifery team practices has been respected, the confidentiality of those on the investigating panels has been respected, but the Albany model has been named and shamed by King's, which terminated the its contract, mentioning in the same press release concerns over safety and its commissioning of the CMACE report, while failing to mention that the report did not recommend closure.

In becoming a charity and charging a substantial fee, CMACE allowed King's to dictate the terms of reference of the supposedly independent enquiry. The Association of Radical Midwives has to question whether CMACE is fit to continue running the CEMACH programme. The confidential enquiries are too important to be left in the hands of those who may have a hidden agenda.

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