

# CESDI

## Confidential Enquiry into Stillbirths & Deaths in Infancy

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# Background

- Department of Health
- Consortium
- Regions
- Steering Group
- Expert assessors
- Local CESDI Co-ordinators

# Methodology

- Epidemiological Survey

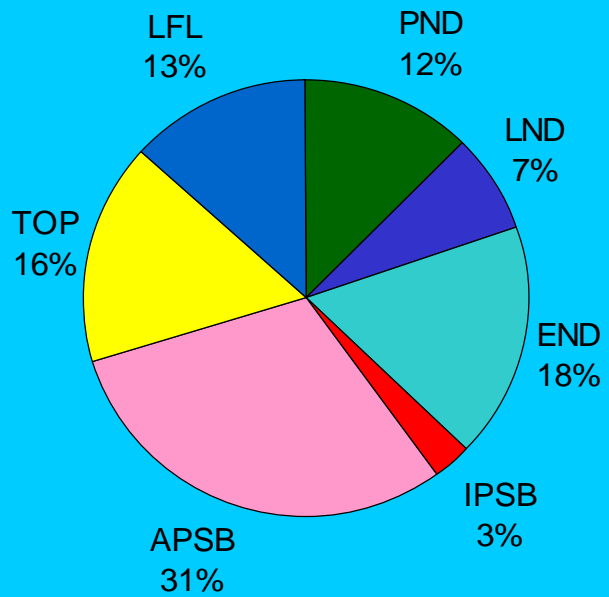
*All deaths terminations & miscarriages  
from 20 weeks to one year after birth*

- Confidential Enquiry

*Specified subgroup*

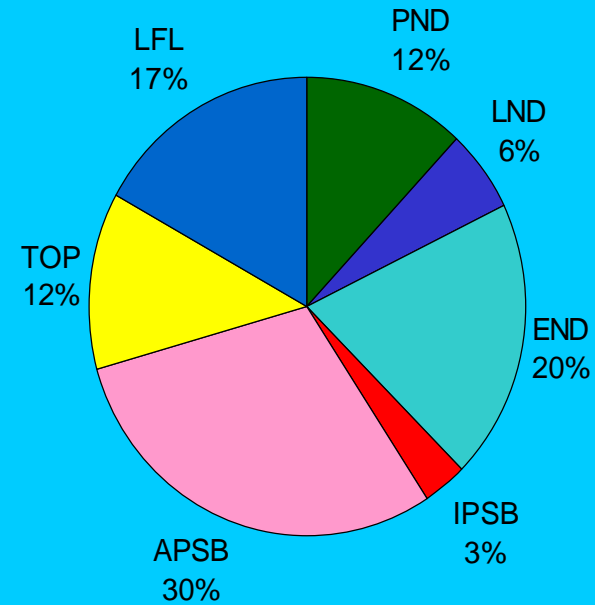
# Outcome Comparison

## Regional



1998 n = 530

## National

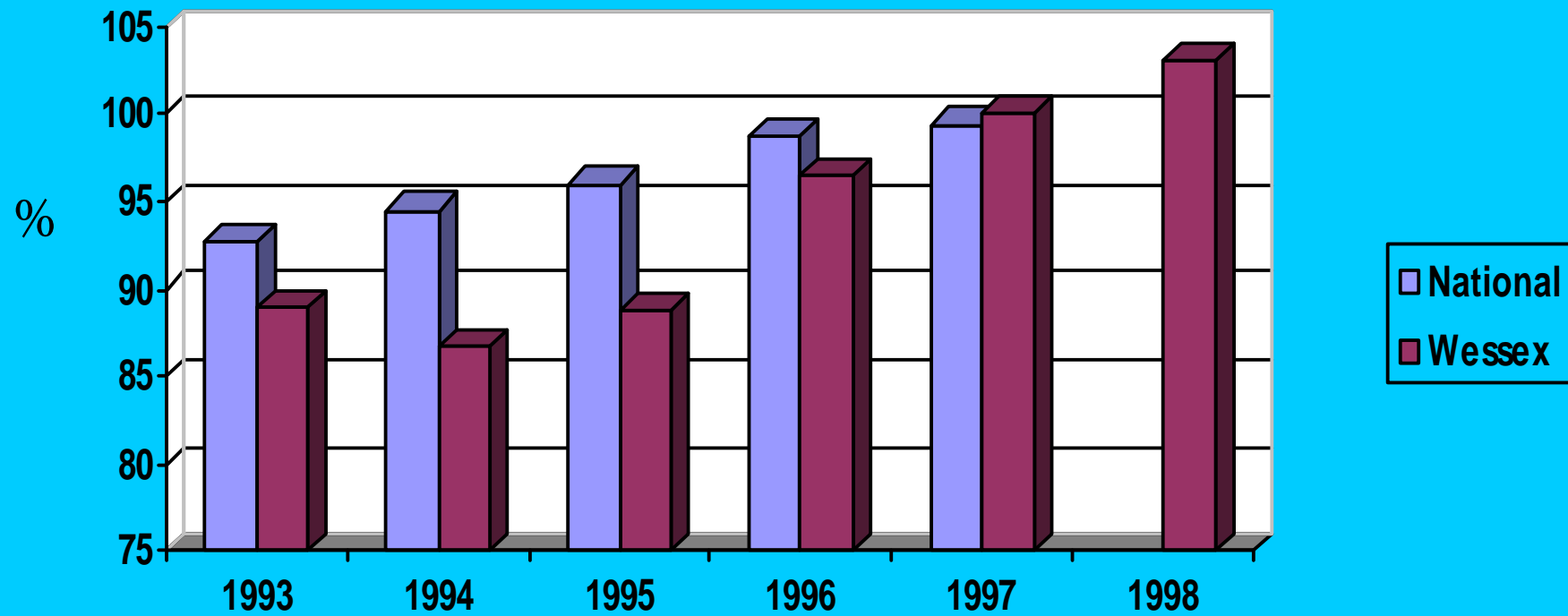


1997 n = 10 418

# Comparison of Rapid Report Form returns 1993-1997 with registration data (ONS & GRO).

Year	England, Wales and Northern Ireland										
	Stillbirths			Neonatal deaths			Postneonatal deaths			Overall Difference	
	RRF	Registration	%	RRF	Registration	%	RRF	Registration	%	N	%
<b>1997</b>	3619	3571	1.3	2706	2636	2.7	1257	1326	-5.2	44	0.6
<b>1996</b>	3688	3699	-0.3	2785	2755	1.1	1253	1372	-8.7	-100	-1.3
<b>1995</b>	3698	3747	-1.3	2714	2809	-3.4	1156	1328	-13.0	-316	-4.0
<b>1994</b>	3747	3946	-5.0	2749	2817	-2.4	1199	1376	-12.9	-444	-5.5
<b>1993</b>	3726	3966	-6.1	2755	2926	-5.8	1242	1442	-13.9	-611	-7.3

# National & Regional Ascertainment 1993 - 1998

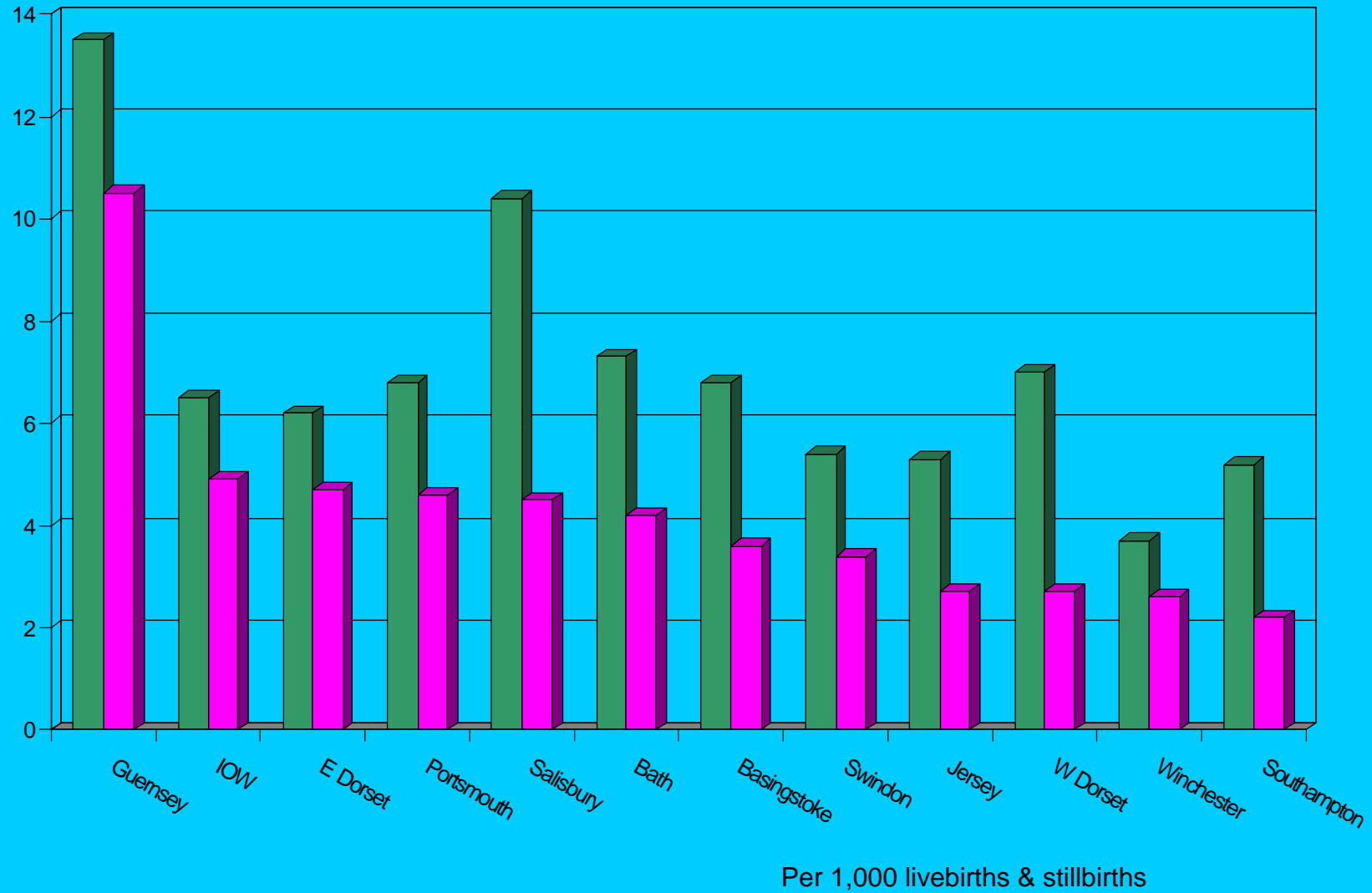


# Year on Year Quality Data?

- 100% Ascertainment
- Termination of pregnancy
- Prematurity under 24/40
- Resuscitated stillbirth
- Fetus papyracous

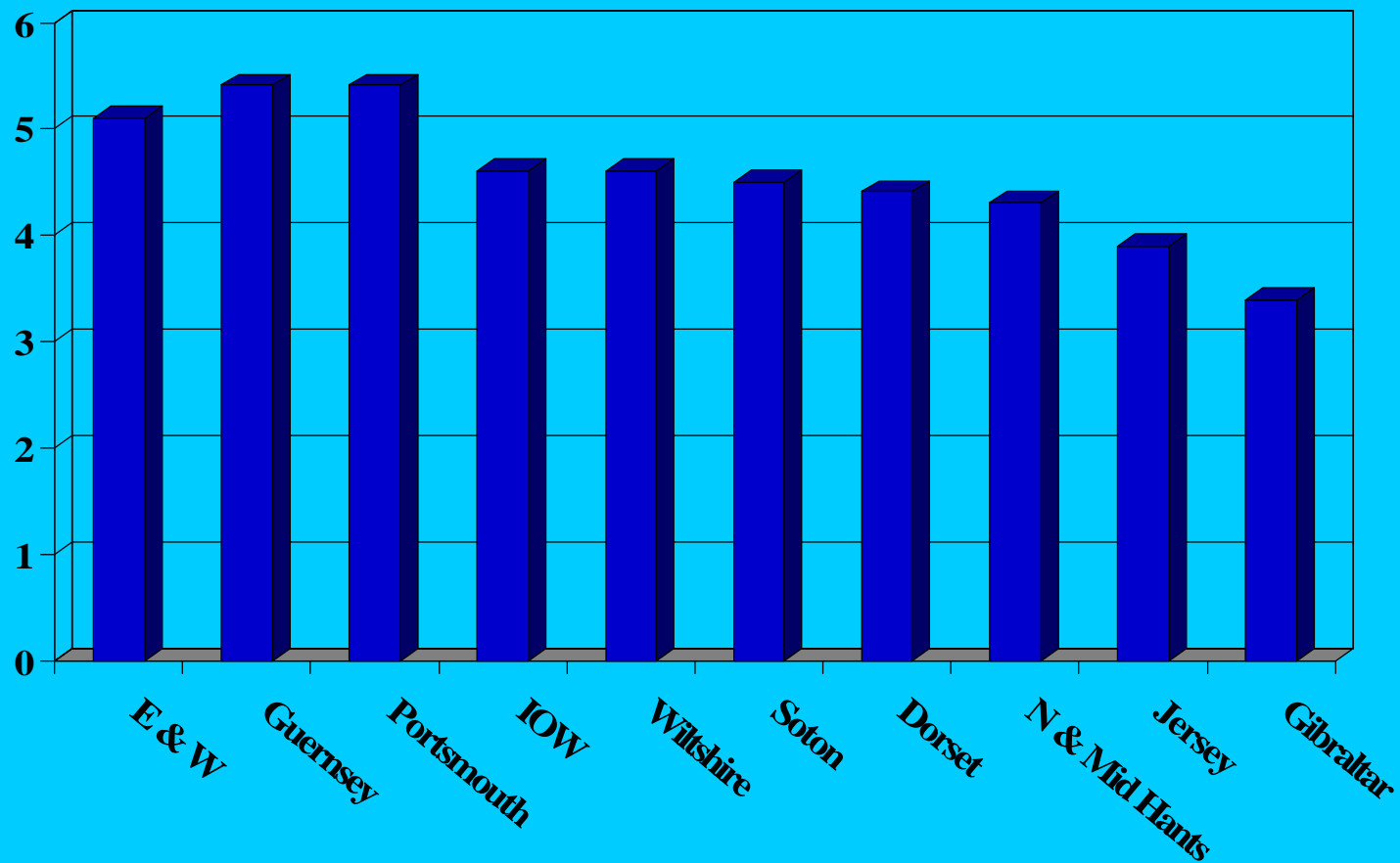
# Crude & Adjusted PMR 1998

Abnormality & gestation





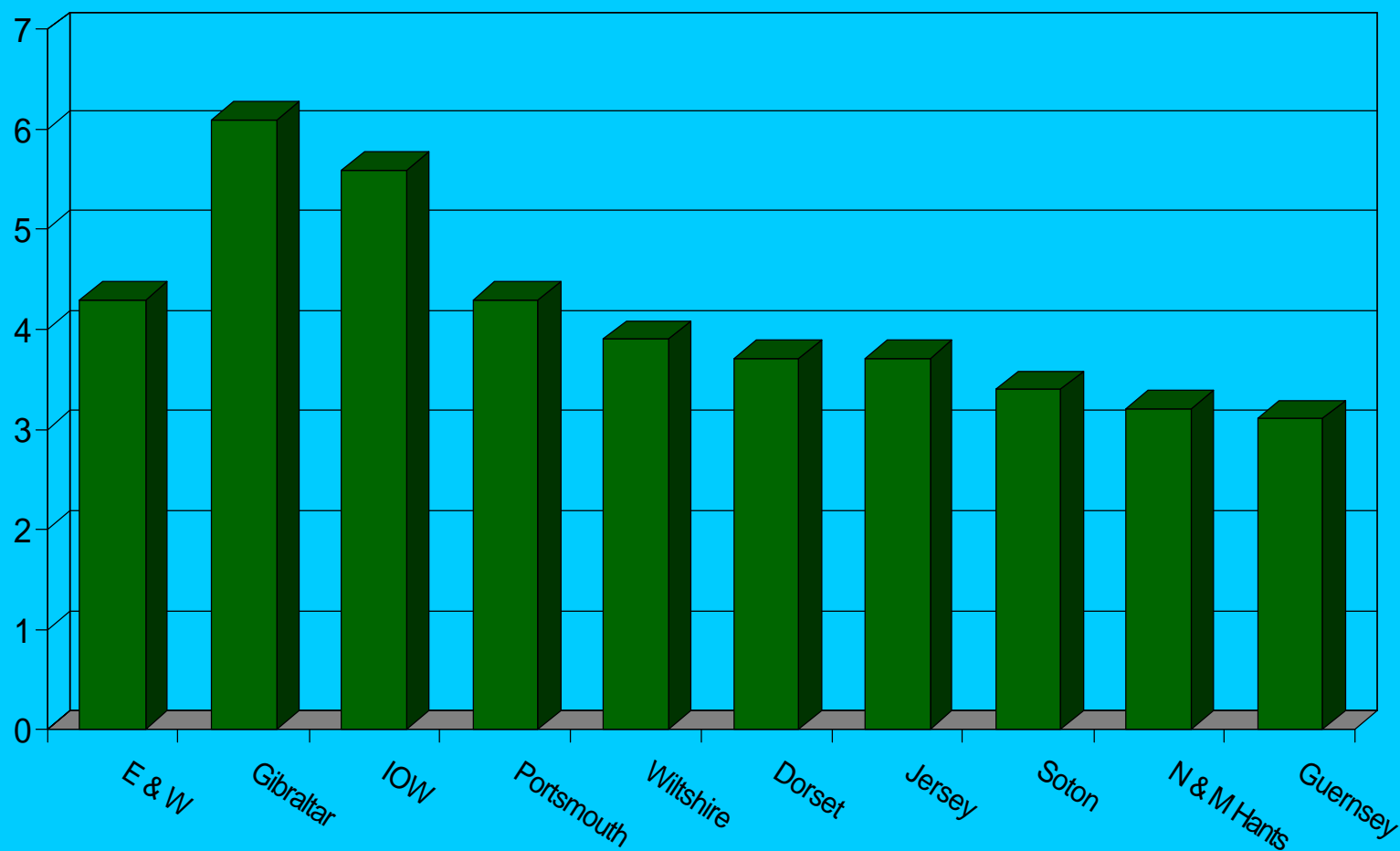
# Stillbirth Mortality by Health Authority/Island of Residence 1988 - 1997



Rate per 1,000 live & stillbirths

Gibraltar figures 1990 - 99

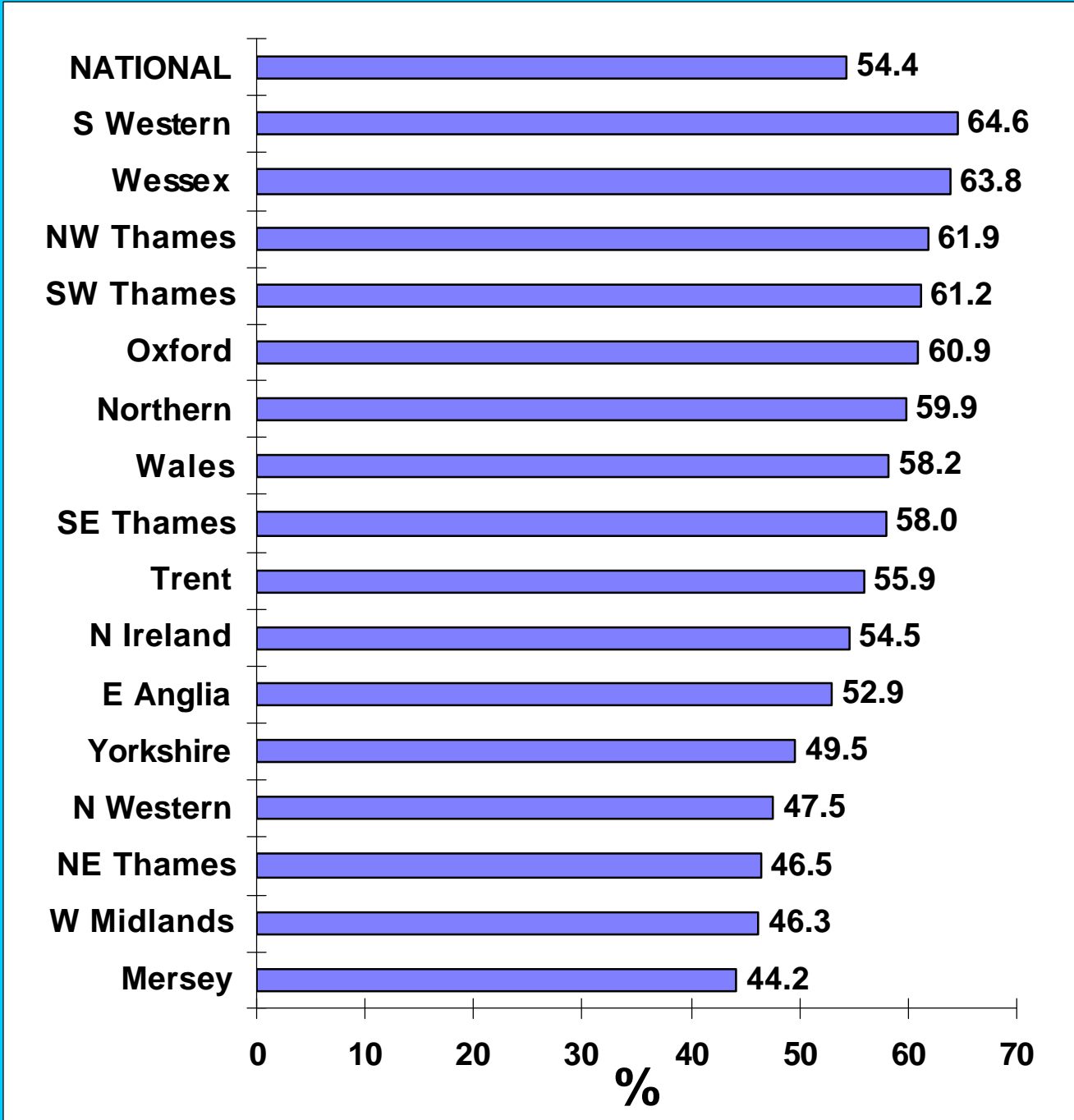
# Neonatal Mortality by Health Authority/Island of Residence 1988 - 1997



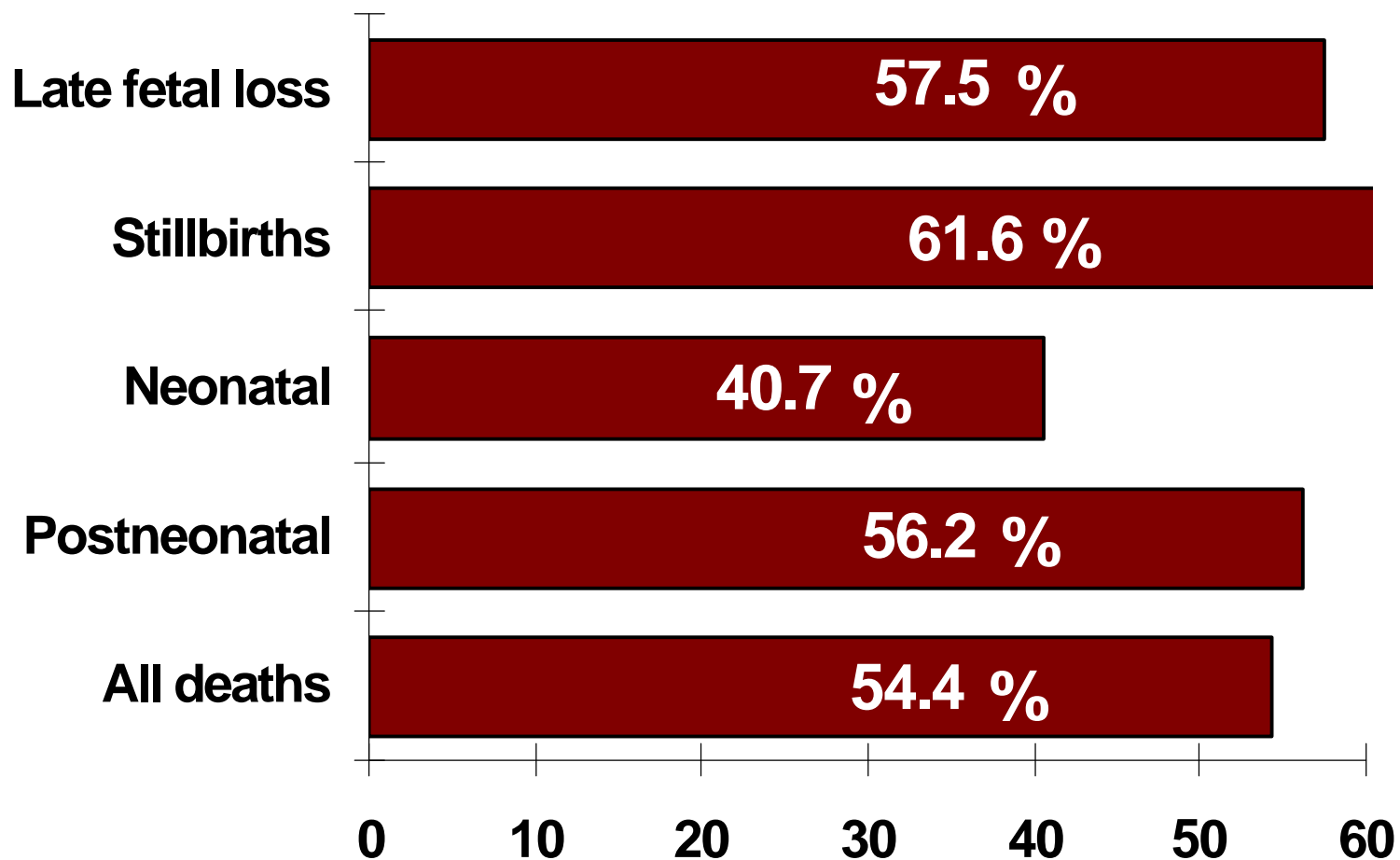
per 1,000 live births

Gibraltar figures 1990 - 99

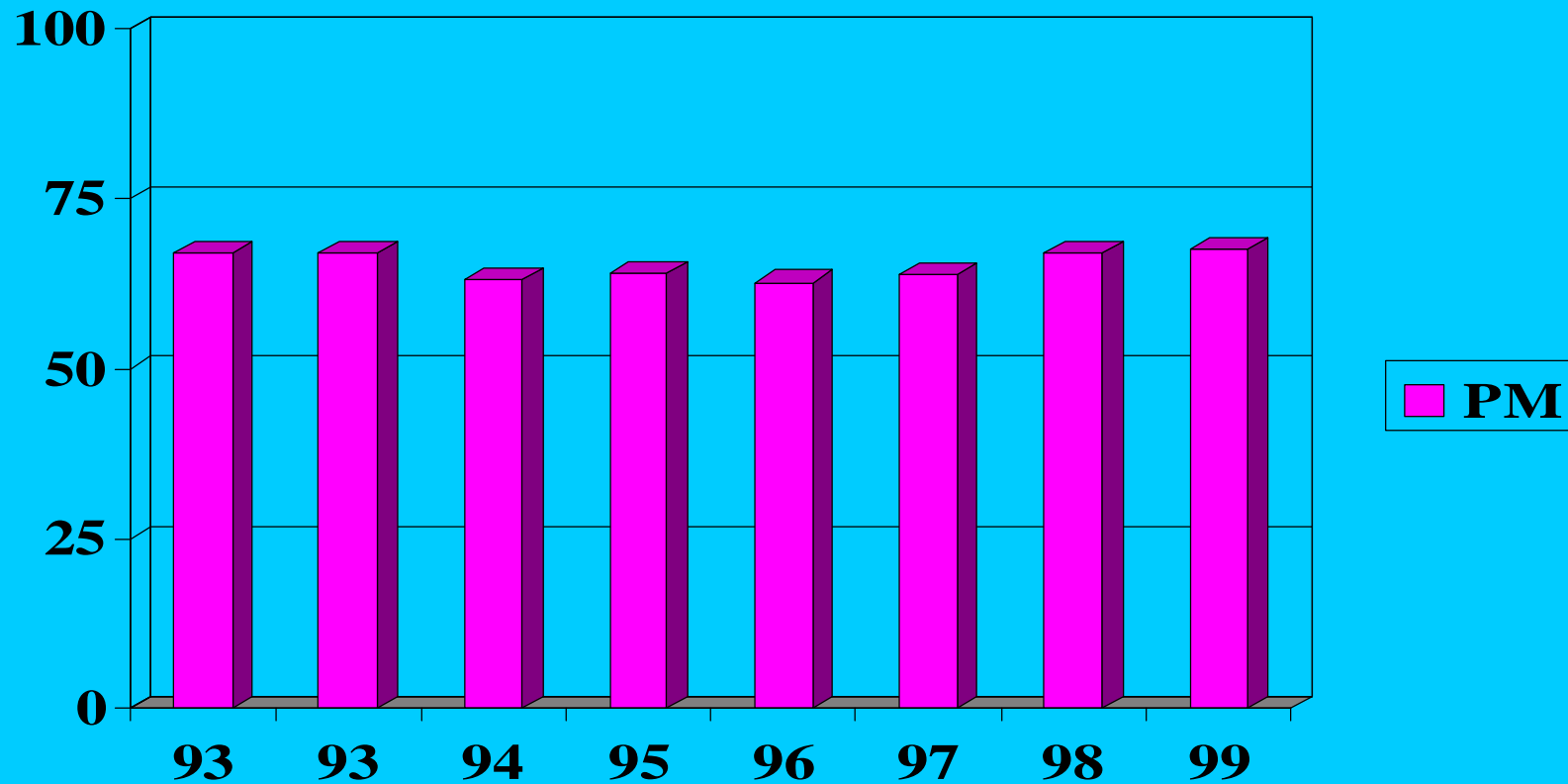
# Uptake of Postmortem 1997



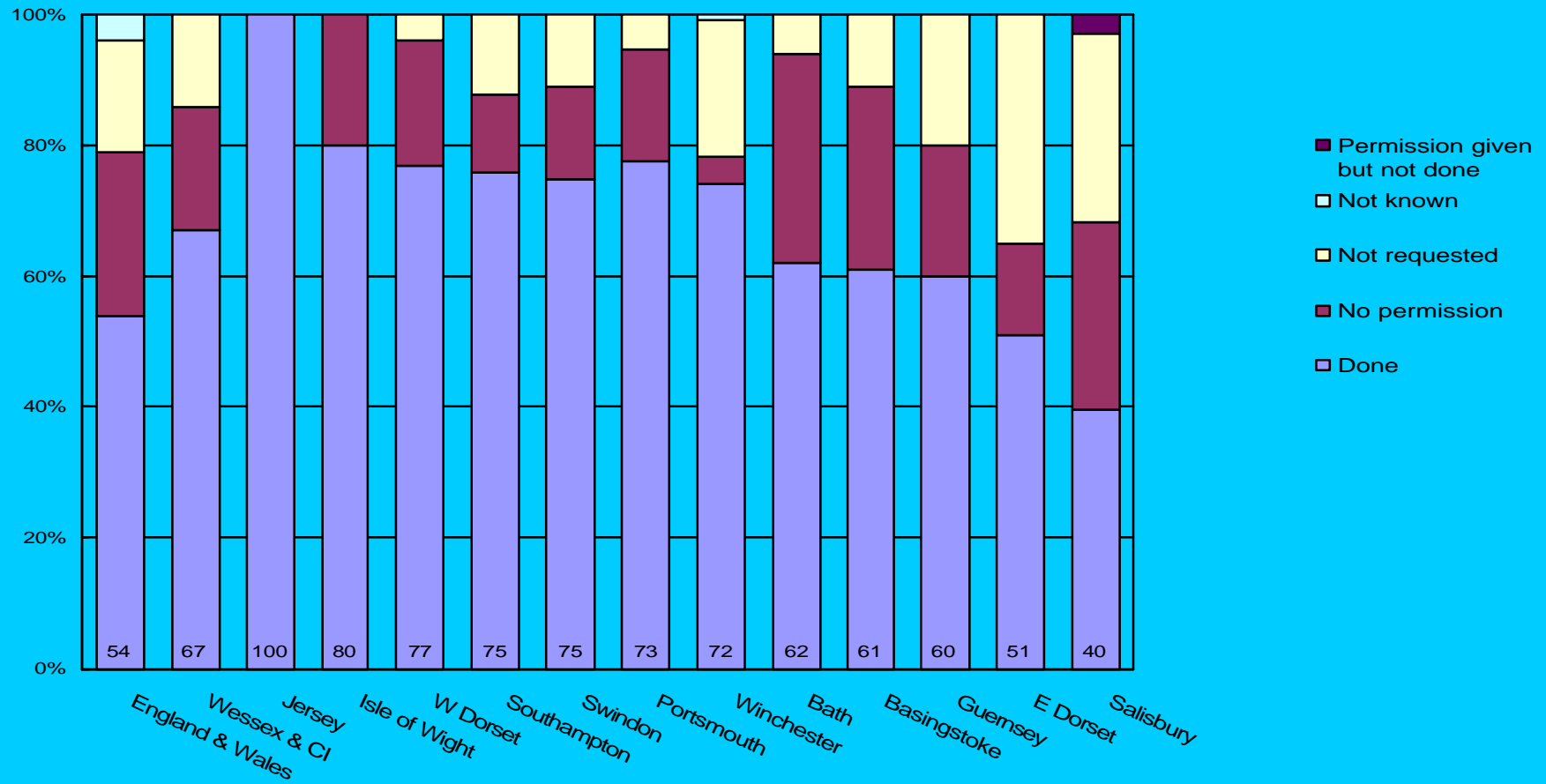
# Uptake of postmortem 1997



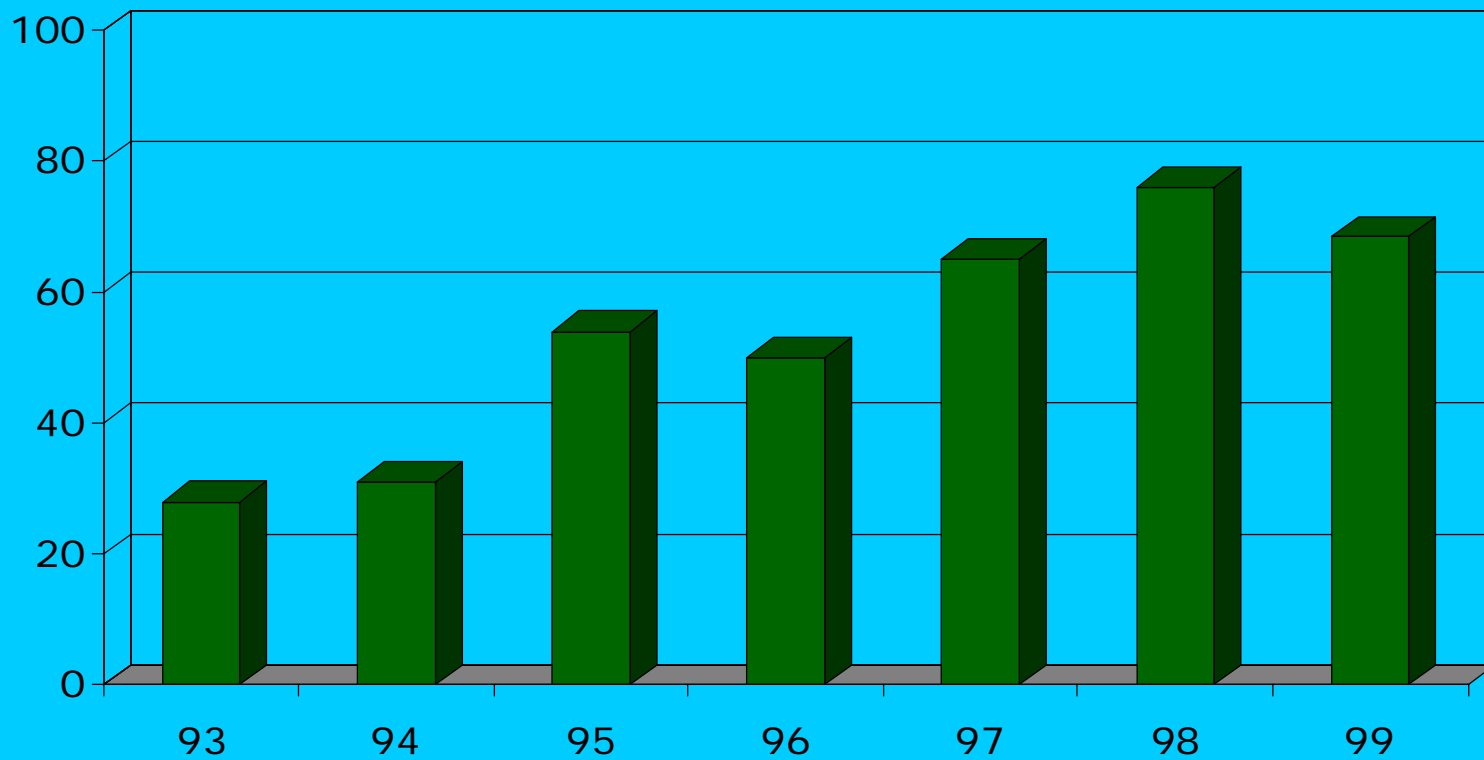
# Uptake of Postmortem Wessex



# PM Levels 1998



# % Paediatric Pathologist



# **CESDI 6th Annual Report**

**'1 in 10' enquiries**

**'4kg and over' enquiries**

**Perinatal pathology**

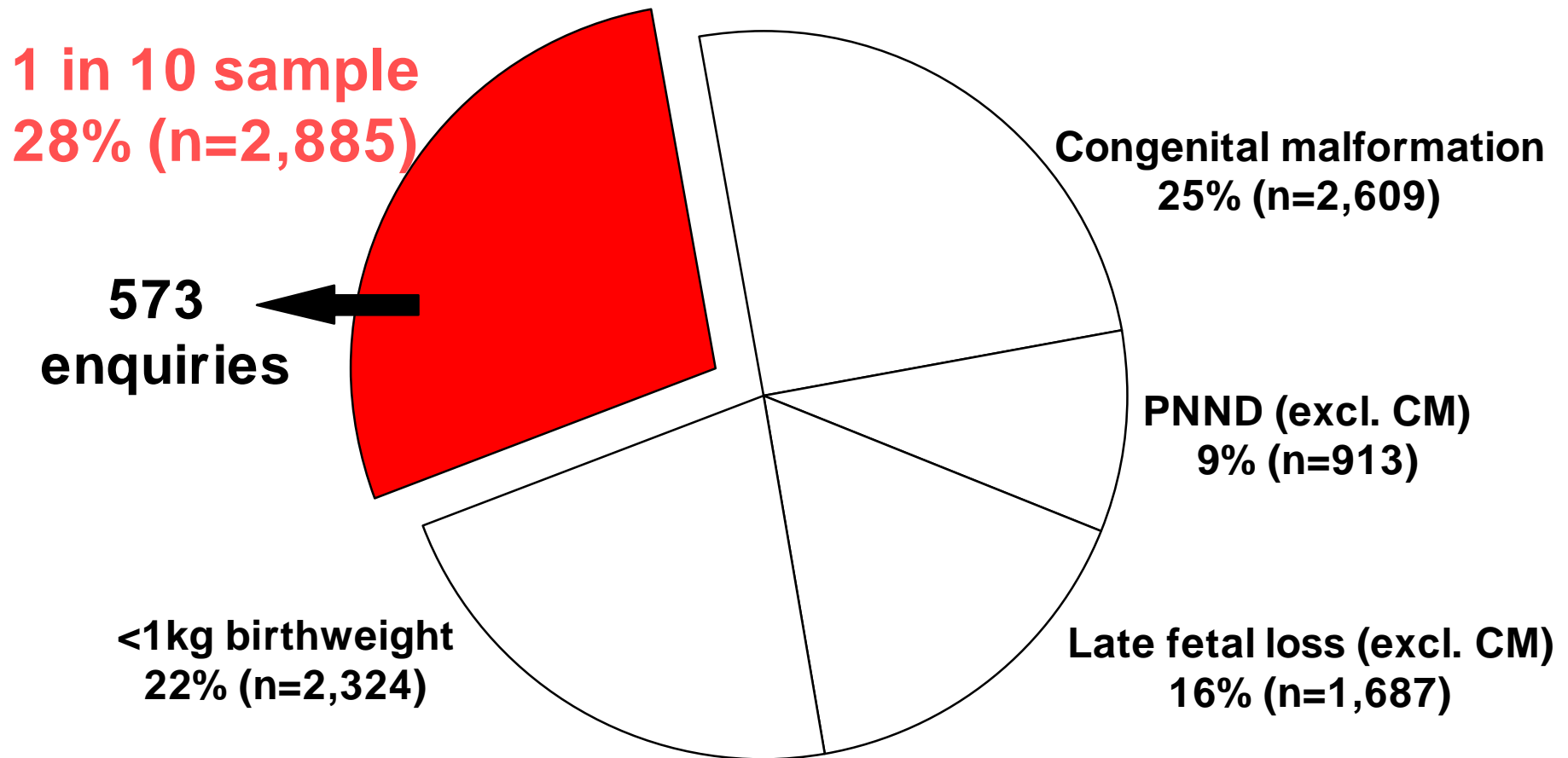
**Record keeping**

**Developing the enquiry**

**Changing practice**



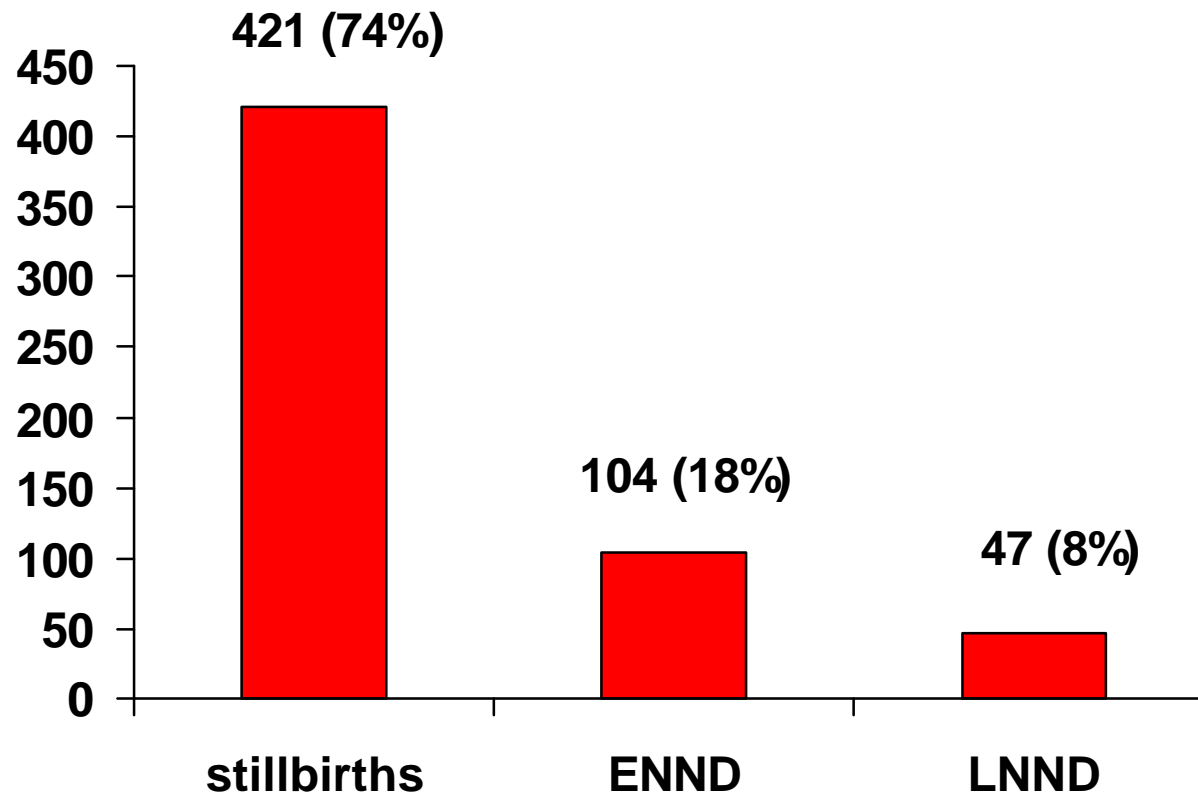
# The 1 in 10 sample in relation to all losses notified to CESDI in 1997



# The '1 in 10' enquiries

- under 28 days
- > 1kg
- > 24 weeks
- no known major congenital abnormality

# The '1 in 10' enquiries



# Risk factors

- **26% had a risk factor at booking**
- **39% had a risk factor during pregnancy**

# Cause of death - overall grade 2 / 3

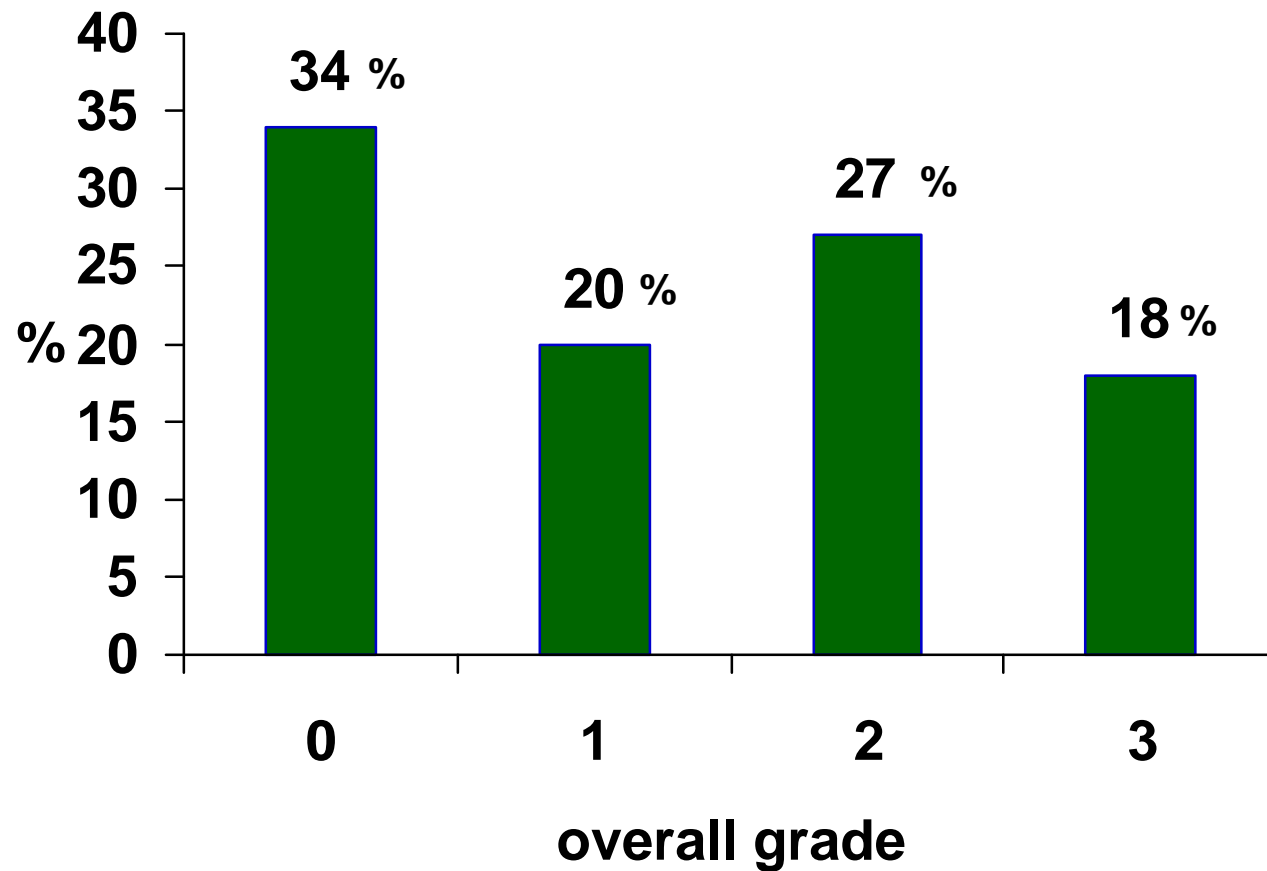
## '1 in 10'

<b>Unexplained antepartum fetal death</b>	<b>346</b>	<b>42 %</b>
<b>Antepartum haemorrhage</b>	<b>103</b>	<b>44 %</b>
<b>Intra-partum related deaths</b>	<b>86</b>	<b>73 %</b>
<b>Infection (maternal/baby)</b>	<b>34</b>	<b>56 %</b>
<b>Pre-eclampsia</b>	<b>31</b>	<b>65 %</b>
<b>Rhesus Isoimmunisation</b>	<b>4</b>	<b>100 %</b>

# Condition in pregnancy - overall grade 2/3 '1 in 10'

<b>Pre - existing diabetes</b>	<b>16</b>	<b>75 %</b>
<b>Gestational diabetes</b>	<b>18</b>	<b>61 %</b>
<b>Presentation - Breech</b>	<b>60</b>	<b>55 %</b>
- Cephalic	<b>428</b>	<b>48 %</b>
- Other	<b>9</b>	<b>67 %</b>
<b>Multiple</b>	<b>30</b>	<b>63 %</b>
<b>Singleton</b>	<b>543</b>	<b>49 %</b>
<b>Induction</b>	<b>274</b>	<b>47%</b>
<b>Spontaneous labour</b>	<b>212</b>	<b>54%</b>

# Were the stillbirths avoidable?



# The 1 in 10 enquiries Conclusions

- **Stillbirths are the single greatest group contributing to deaths reported to CESDI (35%)**
- **Most ‘unexplained’**
- **45% possibly avoidable**
- **Qualitative review of 1074 notable factors**
- **Remains a priority area to be reviewed**



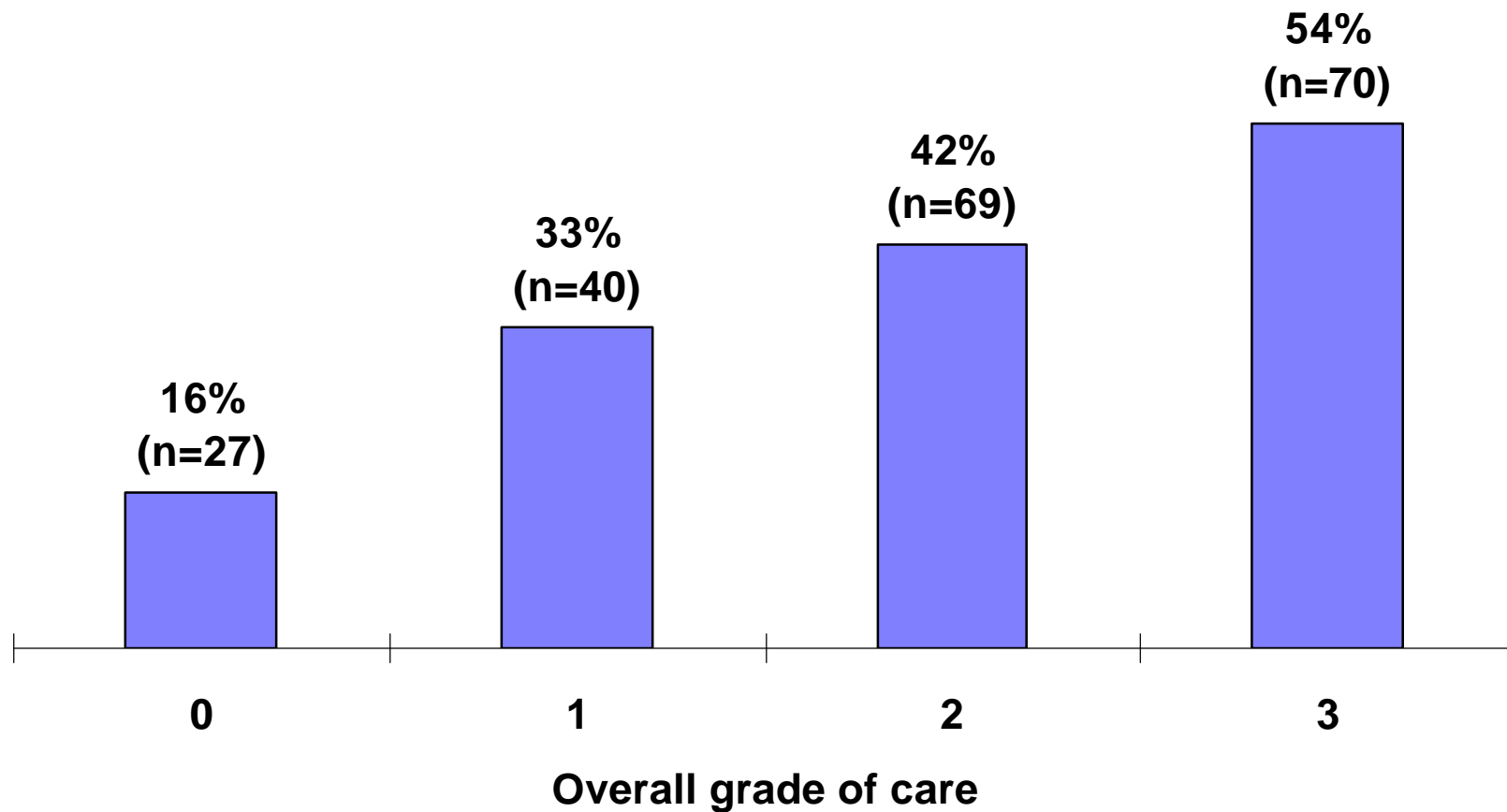
## **Record keeping**

**Was the standard of record keeping adequate in this case?**

**34% - 194/573**

**NO**

# Relationship of grade of care to poor record keeping



# Problems with record keeping

	Insufficient detail / No plan of care	Absent dates, times and signatures	Missing documentation	Errors and inaccuracies/ retrospective additions	Badly organised notes	Illegible hand-writing	Total number of problems mentioned
No. of comments where problem mentioned	97	29	27	27	16	14	210
% of all problems (n=210)	45%	14%	13%	13%	8%	7%	100%

**And there is more.....**

- **Developing the Enquiries Project 27-28**
- **Changing practice**
- **Perinatal Pathology**
- **CESDI SUDI Report**
- **Focus groups - breech, shoulder dystocia**

# Dissemination

- <http://www.cesdi.com/>
- 7th National Report July 2000
- <http://www.soton.ac.uk/~wi/cesdi/>
- 1999 Regional Interim report
- Conference
- Bi-monthly newsletter
- Local Feedback
- Access to data

# Is CESDI making an impact?

- Greater awareness
- Availability of epidemiological data
- Educational value of confidential enquiry
- Irreducible minimum?
- No quick fixes

**CESDI Conference**

**CESDI Wessex & The  
Channel Islands**

**Salisbury Postgraduate Centre**

**Friday 6th October 2000**