CQC January email chain

From: Information Access <information.access@cqc.org.uk>
Date: Tuesday, 12 January 2021 at 16:55
To:
Subject: RE: FAO [redacted] - CQC IAT 2021 0601

Dear <Researcher>

I acknowledge your email of 11 January.

We will consider your further request for information relating to your previous disclosure and will respond to this as soon as possible.

Unfortunately, we will be delayed in responding to your previous, outstanding request. This delay is due to the work required to identify, locate and extract the documents within the scope of that request, and also due to staffing and resource pressures on the CQC Information Access Team.

I apologise for this delay, which I acknowledge will take us beyond the statutory deadline. We usually respond to over 95% of FOIA requests within statutory deadlines but due to a range of factors we have been unable to maintain this level of performance during the current pandemic. I anticipate a response within the next 10 working days.

We will also conduct an Internal Review of our previous decision to withhold post-mortem reports. In accordance with our usual process, we will aim to complete and respond to this Internal Review within 20 working days. Please note that the document that you linked to in your email relates to inquest procedures in the Republic of Ireland.

Yours sincerely

<CQC>

From:
Sent: 11 January 2021 17:24
To: <CQC>
Subject: FAO [redacted] - CQC IAT 2021 0601

Dear <CQC>,

Thank you for your response to my FOI request, reference - CQC IAT 2021 0601

I have a few follow up questions, which I hope are concise enough to respond to as part of my original FOI request or, failing that, the request due on Jan 13th - as opposed to a completely new FOI request altogether.

You provided a list of abortion related complications, as in the forwarded email below.

For my research I need to know which type of abortion service is linked to each complication. For example:

Gestation greater than expected – incident notified to data collection 19/05/2020 – Midlands early medical abortion at home - (Telemedical abortion)

Secondly, you provided data on late gestations, again below. I also need to know for each case which abortion service was used. For example:

10-16 weeks – 1 - *Telemedical abortion*
16-20 weeks - 5 - 1 *Telemedical abortion, 4 standard in-clinic abortions*
20-24 weeks – 9 - 3 *Telemedical abortion, 6 standard in-clinic abortions*
>24 weeks – 4 - 4 *standard in-clinic abortions*

1. **Could you kindly send me the amended list with the requested information alongside?**

Finally, you have withheld information requested on the two maternal deaths, which you say are exempt from disclosure under section 41 of FOIA.

I hereby appeal that decision and request an internal review on the grounds that inquests and inquest reports are open to the public. There is no such thing as a private inquest in the UK and open public access to inquests is a cornerstone of accountability and transparency into the causes of death. In addition, the causes to disclose the identity of deceased persons is much more limited than that of a living person. I do not believe you have given sufficient reason to withhold this information. It is clearly important for public interest reporting that the details of death in relation to a publicly and widely available medical procedure be made known. For your background, if you persist in denying this information, I plan to escalate the complaint to the ICO. In the meantime, I would request you provide the coroners' inquest report at the very least in both cases of the maternal deaths.

Confirmation of the public nature of inquests can be found here: https://www.citizensinformation.ie/en/death/sudden_or_unexplained_death/inquests.html#:~:text=All%20inquests%20are%20conducted%20in,of%20inquests%20are%20actually%20reported.

Regards,

From: <CQC>
Date: Wednesday, 6 January 2021 at 16:19
To:
Subject: CQC IAT 2021 0601

External Sender

Dear <Researcher>

Freedom of Information Act 2000 (FOIA) Response

CQC IAT 2021 0601

I write in response to your FOIA request to the Care Quality Commission (CQC) of 4 December 2020.

That request followed on from your previous correspondence with the CQC Media Team and referred to an earlier email of 30 November 2020. By exchange of emails on 4 December, we sought and received clarification of one part of your request.

You asked for the following information:

> In the email [of 30 November 2020] CQC said: '*We are aware of a small number of serious incidents where women who have accessed early medical abortion have suffered complications.'*
>
> My corresponding FOI request is:
>
> 1. How many 'serious incidents' do you refer to?
> 2. How many of the 'serious incidents' were linked to the 'Pills in the Post' DIY abortion service introduced into law on March 30th by the Department for Health and Social Care?
> 3. What is the nature of each 'serious incident'? (e.g. Ectopic pregnancy, maternal death, live born etc.) Please respond in reference to EACH case.
> 4. When did each 'serious incident' occur?
> 5. Where (or at which hospital) did the complication occur?
>
> Secondly, you state: 'These incidents include two maternal deaths. Neither of these women had used the telemedicine abortion service or received pills by post.'
>
> 6. Again, what evidence, if any, can you provide to support that these maternal deaths did not occur after the women used the telemedicine abortion service or received pills by post? For example, what date did they take their first abortion pill?
> 7. What is the date of deaths of these two women?
> 8. Could you provide the coroners' findings?

Thirdly, you mention: 'Other incidents include ectopic pregnancy (a known complication of pregnancy) and delivery of foetuses of unexpected gestation.

Yet again, you provide scant detail on these incidents, so:

> 9. How many 'foetuses of unexpected gestation' do you refer to?
> 10. How many 'foetuses of unexpected gestation' you refer to came after the expectant mother used Pills in the Post?
> 11. What was the gestation stage of EACH foetus you refer to?

Finally, please provide:

> 12. any document (email, letter etc) held by CQC citing any concerns [of any person or organisation, including but not restricted to CQC] with any aspect of the new telemedical abortion service (that could be maternal deaths, live births, late abortions etc.)

I am now able to provide CQC's response to the first 11 of these requests.

1. How many 'serious incidents' do you refer to?

Between 1 April 2020 and 30 November 2020, CQC were notified of 31 serious incidents where women who had accessed early medical abortion had suffered complications. We were also notified of one 'near miss' that did not result in complications.

For context, there were 207,384 medical abortions in England and Wales in 2019, of which 89% were performed under 10 weeks, according to official statistics.

In normal pregnancy there can be complications such as ectopic pregnancy and spontaneous abortion – complete or incomplete – which can lead to hospital admission. According to a publication from the Royal College of Obstetricians and Gynaecologists the incidence of ectopic pregnancy in the UK is around 11 per 1000 pregnancies, with an estimated 11000 ectopic pregnancies diagnosed each year.

2. How many of the 'serious incidents' were linked to the 'Pills in the Post' DIY abortion service introduced into law on March 30th by the Department for Health and Social Care?

17 of those serious incidents notified to CQC related to early medical abortion at home.

3. What is the nature of each 'serious incident'? (e.g. Ectopic pregnancy, maternal death, live born etc.) Please respond in reference to EACH case.

4. When did each 'serious incident' occur?

5. Where (or at which hospital) did the complication occur?

Our understanding from our reading of your request is that you require these three items of data (nature, date, location) all provided in a way that is linked for each incident (as opposed to answering each question separately to provide a list of the incidents, then an unlinked list of locations, then an unlinked list of dates).

We have considered the date and location of the incident to be the place where complications were identified (e.g. symptoms began or where a foetus of greater than expected gestation was delivered). In most cases we do not know this location (presumably many were at the women's own homes, which we do not know the locations for). Where known, we have provided the region of the country, as notified to CQC.

In most of the cases, the women presented at hospital following the incident. Where we know which hospitals the women presented at, we have not included this information in our response as a) this was not the location at which the complications occurred and b) disclosure of this information into the public domain under FOIA would significantly increase the risk of individual women being identified.

In many of the cases, CQC does not hold the date of the incident / complications occurring. Where we do hold the date we have provided it. In other cases, we have provided the date of the incident notification being raised.

Providing multiple, linked details of each incident carries a risk that individual women may become identifiable. FOIA disclosures are made into the public domain and therefore CQC must consider the risks and implications arising from this data being available to the general public. Given the sensitive nature of this medical information CQC has adopted a cautious approach. In each case, the information provided is the most that we consider that we can disclose without introducing an unacceptable risk that individuals will become identifiable.

Where CQC has withheld information from the following responses, we do so in reliance upon FOIA section 40 (personal information) and section 41 (information obtained in confidence):

- Gestation greater than expected – incident notified to data collection 19/05/2020 – Midlands
- Gestation greater than expected and major haemorrhage - incident notified to data collection 19/05/2020 – Midlands
- Gestation greater than expected - incident notified to data collection 22/04/2020 – South West
- Gestation greater than expected – April 2020, incident notified to data collection 02/06/2020 – North West
- Gestation greater than expected - incident notified to data collection 02/06/2020 – Midlands
- Gestation greater than expected – incident 19/05/2020 – Midlands
- Gestation greater than expected - incident notified to data collection 19/05/2020 – Midlands
- Gestation greater than expected - incident notified to data collection 13/05/2020 – Midlands
- Maternal death – 24/03/2020 – North West – died at home

- Maternal death – 11/04/2020 – North West – died in hospital (name of hospital withheld to prevent identification of the deceased person)
- Gestation greater than expected - incident notified to data collection 19/06/2020 – South East
- Gestation greater than expected - incident notified to data collection 08/07/2020 – South East
- Gestation greater than expected - incident notified to data collection 15/07/2020 – Midlands
- Gestation greater than expected - incident notified to data collection 18/06/2020 – location unknown
- Gestation greater than expected - incident notified to data collection 02/04/2020 – North East
- Gestation greater than expected - incident notified to data collection 02/04/2020 – North East
- Gestation greater than expected - incident notified to data collection 07/04/2020 – South East
- Gestation greater than expected - incident notified to data collection 21/04/2020 – location unknown
- Gestation greater than expected - incident notified to data collection 24/04/2020 – North West
- Gestation greater than expected - incident notified to data collection 26/06/2020 – South West
- Gestation greater than expected – 04/11/20 – South East
- Ruptured ectopic - incident notified to data collection 19/05/2020 – Midlands
- Ruptured ectopic - incident notified to data collection 19/05/2020 – Midlands
- Ectopic - incident notified to data collection 13/05/2020 – Midlands
- Attended emergency department - incident notified to data collection 19/05/2020 – Midlands - name of hospital withheld to prevent identification of the data subject
- Attended emergency department (bleeding / abdominal pain) - incident notified to data collection 28/05/2020 – South West – name of hospital withheld to prevent identification of the data subject
- Attended emergency department (retained products of conception) - incident notified to data collection 09/06/2020 – South West – name of hospital withheld to prevent identification of the data subject
- Attended emergency department (retained products of conception) - incident notified to data collection 09/06/2020 – South West –name of hospital withheld to prevent identification of the data subject
- Scar Ectopic - incident notified to data collection 10/06/2020 – Midlands
- Ectopic - incident notified to data collection 29/06/2020 – North West
- Ectopic - incident notified to data collection 28/11/2020 – South West

6. **Again, what evidence, if any, can you provide to support that these maternal deaths did not occur after the women used the telemedicine**

abortion service or received pills by post? For example, what date did they take their first abortion pill?

The Secretary of State for Health and Social Care issued temporary approval for women to take both pills for early medical abortion in their own homes on 30 March 2020.

In the case of the two maternal deaths, the women both commenced their treatment before that date. The information passed to CQC about their deaths, including the coroners' post-mortem reports indicate that these women did not use early medical abortion at home services. These women attended clinics on 23 and 24 March to commence their abortions.

7. **What is the date of deaths of these two women?**

24 March 2020 and 11 April 2020

8. **Could you provide the coroners' findings?**

CQC holds copies of the coroners' post-mortem reports for both of these women, but we consider these to be information obtained in confidence and exempt from disclosure under section 41 of FOIA. Post-mortem reports are not public documents and are only usually made available to next of kin and other interested parties. CQC considers that it has a duty of confidentiality to the coroners who produced these reports and an abiding duty of confidentiality to the women.

We are withholding this information in accordance with section 41 of FOIA (information obtained in confidence).

However, I can advise you that the coroner's findings for the two deaths were sudden cardiac death in one case (noting that toxicology did not indicate an alternative cause of death) and Streptococcus sepsis in the other case.

9. **How many 'foetuses of unexpected gestation' do you refer to?**

19

10. **How many 'foetuses of unexpected gestation' you refer to came after the expectant mother used Pills in the Post?**

11 related to women who had used early medical abortion at home services.

11. What was the gestation stage of EACH foetus you refer to?

10-16 weeks – 1
16-20 weeks - 5
20-24 weeks – 9
>24 weeks – 4

Please note that gestations are approximate as last menstrual periods were estimated. The ovaries continue to regulate menstrual flow until about 13 weeks when the placenta takes over so it is possible that women can still have menstrual bleeding up to 20 weeks of pregnancy hence them thinking that they are a lesser gestation.

12. **any document (email, letter etc) held by CQC citing any concerns [of any person or organisation, including but not restricted to CQC] with any aspect of the new telemedical abortion service (that could be maternal deaths, live births, late abortions etc.)**

This part of your request has been withdrawn following CQC's advice that it would exceed the FOIA cost limit. A revised version of the request is now being handled separately with a deadline of 13 January.

Freedom of Information Act 2000 – application of exemptions

CQC has withheld a small amount of information about living persons. This information consists of the names of hospitals where women experiencing complications presented.

We consider that there is a realistic possibility that a motivated person may be able to identify these individuals if that information was disclosed into the public domain and that this would breach the rights of those data subjects. This information is withheld under section 40 of FOIA (personal information). No public interest test is required for this exemption.

CQC has also applied the exemption under section 41 (information obtained in confidence) to this information, and to information which we consider would risk identification of deceased persons, and to coroners' reports of the two deaths. No public interest test is required for this exemption.

We consider that we have an enduring duty to protect the privacy of these people, and that we have a duty of confidentiality to the providers of this information.

If you are not happy with CQC's handling of this request, or the decision to withhold some of the requested information, you can ask us to conduct an internal review by responding to this email. If you choose to do so, please be as clear as possible on your reasons for challenging our response. If you remain unhappy following internal review, you will have a right to seek an independent review from the Information Commissioner's Office (ICO). You can find more details on your rights at www.ico.org.uk

Yours sincerely

<CQC>

CQC December email chain

From: <CQC>
Date: Tuesday, 1 December 2020 at 12:01
To: <Researcher>
Subject: RE: URGENT Press Enquiry: 'Pills in the Post' service and maternal abortion deaths 2020

Dear <Researcher>

Thanks for your further email.

I think it may be helpful to explain a bit more about CQC's role in ensuring providers are complying with the requirements of the Health and Social Care Act. That legislation requires a healthcare provider to have systems and processes in place to investigate and learn from incidents and to then take any necessary steps to mitigate future risks. Where they don't, we will hold them to account and require improvements and we can use our enforcement powers if needed to make sure they improve – more info here.

CQC does not have the power to assess a specific form of treatment such as early medical abortion by post, or to investigate untoward outcomes for individual patients - unless they relate to provider level failings.

Please find below further responses to the points you have queried which I hope are helpful. These are in red text for ease of reference.

Kind regards
<CQC>

Dear <CQC>,

Thank you for your response.

The Pills in the Post service is placing women's health at risk nationally, so I stress, again, that this issue is of urgent public concern.

Therefore, your response requires corresponding transparency - which it severely lacked - and which I now request from you for a second time in reference to your latest email (Monday 30 Nov).

In your email, firstly, you say: '*We are aware of a small number of serious incidents where women who have accessed early medical abortion have suffered complications.'*

Yet, you provide scant detail on these serious incidents, so again I ask:

1. How many 'serious incidents' do you refer to? 'Small number' is far too vague.
2. How many of the 'serious incidents' were linked to the 'Pills in the Post' service?
3. What is the nature of each 'serious incident'? (e.g. Ectopic pregnancy, maternal death, live born etc.) Please respond in reference to EACH case.

4. When did each 'serious incident' occur?
5. Where (or at which hospital) did the complication occur?

Information about a small number of incidents was shared with CQC and the Royal College of Obstetricians and Gynaecology by NHS England and Improvement. As previously advised, I would suggest contacting NHS England and Improvement directly for this information. Alternatively, do feel free to contact our Information Access team to make a Freedom of Information request. They will be best placed to determine what CQC is able to share with you while maintaining our responsibility to protect patient confidentiality. Details of how to contact our information access team can be found at https://www.cqc.org.uk/about-us/our-policies/freedom-information-data-protection

Secondly, you state: 'These incidents include two maternal deaths. Neither of these women had used the telemedicine abortion service or received pills by post.'

1. Again, what evidence, if any, can you provide to support that these maternal deaths did not occur after the women used the telemedicine abortion service or received pills by post? For example, what date did they take their first abortion pill?
2. What is the date of deaths of these two women?3. Could you provide the coroners' findings?

The information provided by NHS England and Improvement show that both women had their medical abortion before the 30 March 2020.

Patient A - had the abortion on 20 March and date of death was 11 April 2020
Patient B - had the abortion on 24 March and died the same day.

Again NHS England and Improvement will be able to confirm this.

Thirdly, you mention: 'Other incidents include ectopic pregnancy (a known complication of pregnancy) and delivery of foetuses of unexpected gestation.

Yet again, you provide scant detail on these incidents, so:

1. How many 'foetuses of unexpected gestation' do you refer to?
2. How many 'foetuses of unexpected gestation' you refer to came after the expectant mother used Pills in the Post?
3. What was the gestation stage of EACH foetus you refer to?

Again, NHS England and Improvement will be able to confirm these details as the organisation that identified and shared the concerns.

You also say: 'Follow up with the three main abortion providers (MSI, BPAS and NUPAS) has prompted steps to significantly strengthen the pre medical abortion screening process.'

1. Please detail the specific steps you refer to.
2. What were the shortcomings of the previous pre medical abortion screening and their consequences - such that you needed to strengthen it in the first place?
3. You repeatedly reference your 'follow up' with abortion providers to ensure they have investigated issues with their services. What do you mean by 'follow up' in practical terms? Clearly people want to know SPECIFIC ACTIONS you have taken.

We have reviewed all of the information provided to us and followed up directly with the providers concerned. In each case we contacted the provider to understand the circumstances surrounding the incident, the process they had followed to investigate and what that investigation had found. We sought assurance of the steps they were taking to mitigate any future risks. All three providers have strengthened their screening process following the initial concerns – this has included additional steps to ensure more specific details about menstrual periods are obtained prior to any medical abortion.

Next, you say: 'The need for through and transparent investigation is essential in response to any maternal death or when unexpected complications are suffered during pregnancy.'

1. Where is the thorough and transparent investigation into the two maternal deaths I referenced? You did not provide one. Who other than the CQC would carry out such an investigation?

It is the providers responsibility to investigate when a serious incident or unexpected death takes place. In the event of an unexpected death a coroner may also have a role in investigating in order to determine the cause.

You also say: 'All services registered to provide termination of pregnancy services are subject to ongoing monitoring.'

What precisely do you mean by 'ongoing monitoring' in practical terms? HOW does the CQC monitor abortion service providers?

We have regular and frequent contact with individual services and use a range of intelligence to monitor the safety quality of care. This includes patient outcome data, information of concern, routine provider information returns and feedback from people using the service as well as information shared with us by organisations such as NHS England and Improvement.

You say the CQC will use its 'enforcement powers where necessary to protect people.'

1. Has the CQC used its enforcement powers yet in relation to abortions since March 30th and/or the Pills in the Post abortion services?

We have reviewed all of the information provided to us and followed up directly with the providers concerned. We have not identified any breach of the Health and Social Care Act regulations that has led to enforcement action.

Finally, you did not properly respond - point by point - to each of the following questions in my previous email. Please do so here.

- How many cases of problematic abortions have been referred to the CQC in total since March 30 until now?
- Of those cases how many are related to 'Pills By Post' service?
- Of those cases, how many are related to maternal deaths?
- Of those cases, how many related to foetuses aborted (or attempted abortions) over the 10-week gestation period?
- Of those cases, how many have been reported to police? And how many became police investigations? And how many are ongoing police investigations?

• Please provide further details of the range of issues woman have experienced through the 'Pills By Post' service since it began in March, to the present day.

Considering much of what I am asking here was covered in my email last Friday, my deadline for these requests is 12pm tomorrow (Tuesday) - in line with a imminent publication.

Best wishes,

<Researcher>

On 30 Nov 2020, at 11:46, Y wrote:

Hi X

Thanks for bearing with me. Please find a statement from Deputy Chief Inspector, Nigel Acheson and some additional background below. Beneath that I have included responses to each of your more specific questions.

As I mentioned in my previous email, if you haven't done so already, I would also advise contacting the RCOG as well as NHSE/I as both should be able to provide further context around the two maternal deaths which I think you will find useful.
Are you planning on running a story imminently? It would be helpful if you can give a steer on timings so I can let colleagues here know to expect it.
Many thanks
Y

Nigel Acheson, CQC's Deputy Chief Inspector of Hospitals, said: *"We are aware of a small number of serious incidents where women who have accessed early medical abortion have suffered complications. We have followed up directly with the providers concerned, and continue to work closely with NHS England and Improvement, the Department of Health and Social Care and the Royal College of Obstetricians and Gynaecologists to ensure the appropriate safeguards are in place to protect women accessing this service.*
Ends
Background

1. CQC has been notified by NHS England and Improvement of a small number of incidents where women who accessed early medical abortion have suffered complications – not all of these incidents are thought to be linked to the medical abortion or pills by post.
2. These incidents include two maternal deaths. Neither of these women had used the telemedicine abortion service or received pills by post.
3. Other incidents include ectopic pregnancy (a known complication of pregnancy) and delivery of foetuses of unexpected gestation.
4. Follow up with the three main abortion providers (MSI, BPAS and NUPAS) has prompted steps to significantly strengthen the pre medical abortion screening process.
5. All services registered to provide termination of pregnancy services are subject to ongoing monitoring and where we identify concerns or find evidence of risk, we will always follow up to ensure the safety of woman accessing those services – using our enforcement powers where necessary to protect people.

Helen Whatley MP comments in Parliament - 8 Oct 2020: Questions:

1. Is the CQC involved in the investigation? Why is it still ongoing since early this year? Which hospital dealt with her abortion? When did she die? Which service provided her with the TOP pills?
2. Could you please send me the conclusion of the investigation as soon as it becomes available?

CQC is not leading any investigation into this issue. Where concerns have been shared with us, we have followed up directly with the individual provider concerned to ensure that they have investigated, identified any learning and taken all necessary steps to ensure women using the service are not at risk.

Email dated 21 May 2020 from North West NHS Regional Chief Midwife Claire Mathews to medical staff across multiple hospitals: Questions:

1. Can you confirm - what is evident in the Claire Mathews' email - that the two aforementioned maternal deaths occurred after the women underwent 'Pills in the Post' abortions?

Neither of these maternal deaths were woman who had used the telemedicine abortion service or received pills by post. Both cases were before the telemedicine abortion service was introduced.

2. If the deaths are not related to 'Pills in the Post' abortions, then why are they referred to in an email warning specifically about that very service?
   NHS England and Improvement will need to confirm what was understood by them about both cases at the time the email was written.
3. If the deaths are not related to 'Pills in the Post' service, as the CQC has previously alleged contrary to the aforementioned email, why would the deaths be any less concerning? Rather, if these women indeed attended clinics or hospitals before undergoing the abortion, then this would have meant medical experts would have been directly involved. In which case, the results of the investigations into these deaths are equally if not more pertinent - hence the urgent need for transparent communication around these investigations.
   The need for through and transparent investigation is essential in response to any maternal death or when unexpected complications are suffered during pregnancy.

All services registered to provide termination of pregnancy services are subject to ongoing monitoring and where we identify concerns or find evidence of risk, we will always follow up to ensure the safety of woman accessing those services – using our enforcement powers where necessary to protect people.

Additional questions:

1. How many cases of problematic abortions have been referred to the CQC in total since March 30 until now?
2. Of those cases how many are related to 'Pills By Post' service?
3. Of those cases, how many are related to maternal deaths?
4. Of those cases, how many related to foetuses aborted (or attempted abortions) over the 10-week gestation period?
5. Of those cases, how many have been reported to police? And how many became police investigations? And how many are ongoing police investigations?
6. Please provide further details of the range of issues woman have experienced through the 'Pills By Post' service since it began in March, to the present day.

CQC has been notified by NHS England and Improvement of a small number of incidents where women who accessed early medical abortion have suffered complications – not all of these incidents are thought to be linked to the medical abortion or pills by post.

Where concerns have been shared with us, we have followed up directly with the individual provider concerned to ensure that they have investigated, identified any learning and taken all necessary steps to ensure women using the service are not at risk.

From: <CQC>
Sent: 27 November 2020 11:03
To: <Researcher>
Subject: RE: URGENT Press Enquiry: 'Pills in the Post' service and maternal abortion deaths 2020

Many thanks, appreciate you confirming that. I'll get back to you by then.

From: <Researcher>
Sent: 27 November 2020 11:02
To: <CQC>
Subject: Re: URGENT Press Enquiry: 'Pills in the Post' service and maternal abortion deaths 2020

Hi <CQC>,

My deadline is the morning of this Monday November 30th.

Best,
<Researcher>

From: <CQC>
Sent: 27 November 2020 10:58
To: <Researcher>
Subject: RE: URGENT Press Enquiry: 'Pills in the Post' service and maternal abortion deaths 2020

External Sender

Hi <Researcher>

Thanks for your email. I will follow up with inspection team colleagues and come back to you on your questions. When is your deadline for a response?

In the meantime, if you haven't done so already you may also find it helpful to contact the Royal College of Obstetricians and Gynaecologists as well as NHS England and Improvement.

Kind regards
<CQC>

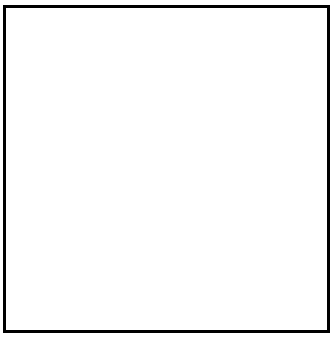
From: <Researcher>
Sent: 27 November 2020 10:11

To: <CQC>
Subject: URGENT Press Enquiry: 'Pills in the Post' service and maternal abortion deaths 2020

Dear <CQC>,

Please find below an urgent press enquiry seeking response for an upcoming article [redacted].

On October 8th Helen Whatley MP confirmed in Parliament that The Department of Health and Social Care is aware of reports of two women who died after seeking abortion treatment earlier this year. She confirmed one investigation is continuing.
See details here: https://www.theyworkforyou.com/wrans/?id=2020-09-21.92912.h&p=25800



Abortion: Coronavirus: 8 Oct 2020: Hansard Written Answers - TheyWorkForYou

To ask the Secretary of State for Health and Social Care, what recent assessment his Department has made of the effect on levels of maternal death during early medical abortion of the temporary approval of home use for both stages of early medical abortion decision of 30 March 2020.
www.theyworkforyou.com

Please provide comment on the completed investigation and all public document relating to it.

Please also provide details of the ongoing case Mrs Whatley refers to and all public document relating to it.

My questions relating to ongoing investigation:

1. Is the CQC involved in the investigation? Why is it still ongoing since early this year? Which hospital dealt with her abortion? When did she die? Which service provided her with the TOP pills?
2. Could you please send me the conclusion of the investigation as soon as it becomes available?

The two maternal deaths Mrs Whately MP referenced are the same two maternal deaths mentioned in an email dated 21 May 2020 from North West NHS Regional Chief Midwife Claire Mathews to medical staff across multiple hospitals (see attached).

The deaths are linked to the issue of Pills in the Post services which is referenced in the same sentence that refers to the deceased women, throughout the email and in the subject line.

The relevant part of the email reads, and I quote:

"In the North West we are aware that there have been 2 maternal deaths linked to this issue also. One case where a woman was found at home the morning after starting the process and the second where a woman presented with sepsis and died very quickly in the A&E dept. Neither of these women were known to our maternity or gynae services as far as we are aware."

The abortion law changed on 30 March 2020 under emergency coronavirus act allowing women to terminate pregnancies through the Pills in the Post service without the need to attend hospital after a 40-minute telephone call with a clinician, as you will know.

The email, from one of the NHS's most senior midwives, raises the alarm about 'escalating risks' of this very service citing three police investigations in the Midlands relating to the Pills By Post service.

Questions linked to the Regional Chief Midwife Claire Mathews' email:

1. Can you confirm - what is evident in the Claire Mathews' email - that the two aforementioned maternal deaths occurred after the women underwent 'Pills in the Post' abortions?
2. If the deaths are not related to 'Pills in the Post' abortions then why are referred to in an email warning specifically about that very service?
3. If the deaths are not related to 'Pills in the Post' service, as the CQC has previously alleged contrary to the aforementioned email, why would the deaths be any less concerning? Rather, if these women indeed attended clinics or hospitals before undergoing the abortion, then this would have meant medical experts would have been directly involved. In which case, the results of the investigations into these deaths are equally if not more pertinent - hence the urgent need for transparent communication around these investigations.

Claire Mathews' email, sent in May this year, makes clear that the CQC is aware of the 'escalating risk' of the Pills in the Post service after a meeting it held with Midlands Chief Midwife Janet Driver. The email states the CQC are aware of 13 'tragic' cases. But the email was written in May, with considerable time having since passed. An update into what the CQC is aware of at the present time is of urgent public interest. Not only is the Pills in the Post an ongoing service, but is currently under UK government consultation to become permanent after the pandemic.

Questions

1. How many cases of problematic abortions have been referred to the CQC in total since March 30 until now?
2. Of those cases how many are related to 'Pills By Post' service?
3. Of those cases, how many are related to maternal deaths?
4. Of those cases, how many related to foetuses aborted (or attempted abortions) over the 10 week gestation period?
5. Of those cases, how many have been reported to police? And how many became police investigations? And how many are ongoing police investigations?
6. Please provide further details of the range of issues woman have experienced through the 'Pills By Post' service since it began in March, to the present day.

As Claire Mathews' email makes apparent, this is an urgent issue potentially placing thousands of women at risk of severe health complications or worse, death.

Therefore, a full, transparent and rapid response from the CQC is crucial.

I look forward to your response.

Yours sincerely,

<Researcher>

West Midlands Police correspondence

From: <West Midlands Police>
Date: Monday, 30 November 2020 at 16:35
To: <Researcher>
Subject: RE: [External]: Re: Response to email 27/11/20

We're unable to comment as the investigation is ongoing.

Many thanks, <West Midlands Police>

From: <Researcher>
Sent: 30 November 2020 16:23
To: <West Midlands Police>
Subject: Re: [External]: Re: Response to email 27/11/20

Thanks <West Midlands Police>. Could you kindly update me as soon as any charges are made please?

Finally, I fully understand enquiries are ongoing. However, my reporting forms part of a national investigation into the Pills in The Post service - which enables expectant mothers to source abortion pills over the telephone without attending hospital - using providers including BPAS, Marie Stopes, and NUPAS.

I really need to know whether this woman's case is relevant to my investigation.

Could you please confirm which service the woman in the Erdington case used - the traditional hospital appointment, or the telephone service I refer to?

Kind regards,

<Researcher>

On 30 Nov 2020, at 16:10, <West Midlands Police> wrote:

Not yet <Researcher>, enquiries are ongoing.
Many thanks, <West Midlands Police>

From: <Researcher>
Sent: 30 November 2020 16:08
To: <West Midlands Police>
Subject: [External]: Re: Response to email 27/11/20

CAUTION: This email originated from outside of West Midlands Police. Do not click links or open attachments unless you are sure the content is safe.

Hi <West Midlands Police>,
Thank you for your response. Could you please confirm whether anybody in relation to the second case (Erdington) has been charged?
If so, please provide details: charge details (murder?), name, date, custody.
Kind regards,

<Researcher>

On 30 Nov 2020, at 15:59, <West Midlands Police> wrote:

External Sender

In November 2019, we investigated after a stillborn baby was delivered at a home in Walsall which experts felt may have been caused in suspicious circumstances. However, following a forensic post-mortem and full investigation, it was found that the mother sadly experienced an intrauterine foetal death. This police investigation was subsequently closed.
In April this year, we were alerted to a stillbirth in Erdington that may have been caused from medication being taken to induce a miscarriage, despite the mother knowing they were too far gone to have an abortion. Enquiries into this remain ongoing.
Anyone with concerns or who has information on any suspicious circumstances around baby deaths is encouraged to contact us via live chat at west-midlands.police.uk between 8am and midnight, or call 101 anytime.
Thanks,
<West Midlands Police>