Guidelines for public health review of congenital syphilis case

December 2023

The occurrence of a case of congenital syphilis is a sentinel event reflecting potential missed opportunities for prevention in the public health, antenatal and primary health care systems. Therefore, it is important to review each case of congenital syphilis for the purpose of health system improvement and preventing future avoidable cases.

These guidelines were prepared by the WA Syphilis Outbreak Response based on public health investigations of congenital syphilis cases conducted in and after 2019 and the feedback received from review participants.

Purpose

The purpose of the public health review is to:

- to review the clinical and public health management of a congenital syphilis case or near miss of congenital syphilis (defined as a diagnosis of infectious syphilis in a pregnant woman, who did not receive adequate treatment, and baby was not diagnosed with congenital syphilis in the neonatal period)
- identify areas for health service improvement
- identify need, if any, to update relevant clinical and public health guidelines
- raise awareness and educate health care staff about syphilis.

Activation

Upon receipt of a notification of congenital syphilis, the Director of the Communicable Disease Control Directorate (CDCD) will write to the Chief Executive (CE) of the public health unit (PHU) to request a public health review of the case.

The review is to be conducted within eight weeks of notification of a confirmed, or near miss case of congenital syphilis, to ensure that the event is still fresh in people's memories.
If the number of notifications received for one PHU exceeds one per month, the PHU may request permission from the Director of CDCD to review the cases together under one review.

Public health review participants

Public health review chairperson

This person should be familiar with the clinical guidelines, syphilis outbreak and the local context in which the case occurred. Usually this is a public health physician from the PHU that received the notification.

Public health review secretariat

This person should be appointed from the CDCD workforce.

Essential public health review participants

1. Primary health care providers involved in antenatal care of the case's mother or who provide antenatal care in the mother's usual place of residence.
2. Obstetric and infectious disease care providers involved in the mother's management.
3. Paediatric care providers involved in the case's management.
4. Other service providers involved in the management of the case or the case's mother or whom the case or the case's mother was referred to, e.g. Department of Child Protection and Family Support.

5. PHU staff involved in public health management, including contact tracing/partner notification and follow-up syphilis testing.
6. Heads of units/departments involved in any aspect of the case's, or the case's mother's, clinical or public health management.
7. WA Department of Health CDCD staff involved in state-wide disease surveillance and/or sexually transmissible infection (STI) control programs, as appropriate.
8. Clinical risk management and quality improvement staff in the health service/s responsible for the mother's antenatal care and mother's and baby's care at time of delivery.
9. If the case or case's mother is Aboriginal, from a culturally and linguistically diverse background or a member of a marginalised or disadvantaged group, appropriate health practitioners, liaison officers and representatives of appropriate community-based advocacy groups.
10. Specialist obstetric, paediatric, midwifery, public health laboratory and other relevant experts not involved in public or clinical management of the case or case's mother, as appropriate.

Optional public health review participants

Observers from other health services, as appropriate, and with agreement of the chairperson and essential participants.

Preparation of case presentation and epidemiology update

The public health review chairperson, with support from the secretariat, should:

1. Contact essential review participants in categories 1-7 above to collate a timeline and summary of the case's mother's maternity care and the clinical and public health management of the case and the case's mother care after the diagnosis of congenital syphilis was made. This will require liaison with the CE of the service providers involved.
2. Request a representative of the relevant PHU to prepare a brief update of syphilis epidemiology relevant to the case.
3. Request the secretariat to ensure that each participant has returned a signed confidentiality agreement prior to the agenda papers being sent.

Medical records

Medical records for the case and case's mother, and where appropriate the cases biological father, should be obtained and made available to review participants. The review chairperson and secretariat will need access to medical records at least five (5) working days before the review to summarise the relevant parts of the case's and the case's mother's medical records in a de-identified timeline for oral +/- visual presentation at the review. Other review participants should have access to de-identified copies of these records several days before the review.

Suggested review agenda

1	Acknowledgement of country
2	Welcome, introduce review participants and observers and outline role of participants and observers
3	Reminder regarding signing of confidentiality agreements (see attachment)
4	State purpose of the review: • to review the clinical and public health management of a congenital syphilis case • identify service gaps and areas for service improvement • identify need, if any, to update relevant clinical and public health guidelines

	• raise awareness and educate health care staff about syphilis.
5	Case presentation and epidemiology update • Summary and timeline • Update of syphilis epidemiology relevant to the case
6	Questions to be asked 1. When and at which health services did the mother receive antenatal care? 2. Was the mother offered, and did she undergo, routine syphilis testing undertaken at intervals recommended in the WA Silver book[1]? If not, was another set of guidelines used, e.g. National Pregnancy Care Guidelines[2]? 3. If the mother had symptoms or examination findings consistent with syphilis, was testing and treatment offered in accordance with the WA Silver book[1]? 4. At what gestation was the mother diagnosed with syphilis and was the time interval between diagnosis and treatment consistent with best practice guidelines? (Infectious syphilis should be treated as soon as possible and ideally within two (2) days as recommended in the Communicable Diseases Network Australia (CDNA) syphilis SoNG[3].) 5. What was the time interval between the mother being treated for syphilis and the baby's delivery? (Considered adequate if at least 30 days.) 6. Was contact tracing/partner notification undertaken in a timely manner? Were named contacts tested and treated for syphilis empirically at the time of presentation within one (1) month of being named? 7. Following the syphilis diagnosis, was the mother's ante- and post-natal care and follow-up in relation to repeat syphilis testing in accordance with the CDNA syphilis SoNG[3] and/or local guidelines? 8. Has management of the baby been in accordance with current best practice guidelines for managing congenital syphilis? (Aspects of management which should be discussed could include, but are not limited to, investigations, treatment and medical referral/transfer.) 9. Were the health service's infection control guidelines followed during management of the case? 10. What aspects of the mother and baby's syphilis-related care were managed well? 11. What aspects of the mother and baby's syphilis-related care could be improved? 12. How could this case of congenital syphilis have been prevented? (It is recommended that the review group undertake this task towards the end of the review and the chair summarises these factors in a cause and effect diagram to be included in the meeting minutes (Figure 1).[4]) 13. What actions does the Review Committee recommend at the local, state and national levels to prevent future cases of congenital syphilis? 14. What actions does the Review Committee recommend at the local, state and national levels to ensure best practice management of any future cases of congenital syphilis? 15. Any other discussion points/recommendations.
7	Conclusions and agreed action plan including documentation of who is responsible for, and the timeframe for completion of, each of the Review Committee's recommendations.

Clinical incident investigation

The Chief Health Officer (CHO) has directed that all cases of congenital syphilis are investigated as a clinical incident (in addition to the public health review) and entered as a clinical incident into the Clinical Incident Management system with a severity code relevant to the case.

Documentation and confidentiality

- Patient identified information should NOT be recorded in the minutes.
- Minutes of the review should be documented and circulated to participants for checking and correction before being finalised and sent, by the secretariat, to all participants, the CHO, the Director of CDCD, and the Chairpersons of the WA SORG for information.

Actions required after review

- The secretariat will draft the minutes and circulate to attendees for approval/input within 10 working days of the review.
- The recommendations from the review will be sent to the WASORG co-Chairs for distribution to appropriate Working Groups and relevant stakeholders.
- CDCD will meet internally within 4 weeks of the review completion to discuss the recommendations of the review and what are the next steps/action to be taken at a system manager level.
- A copy of the review minutes and recommendations will be sent (within 10 working days of finalising) to the CHO for noting and for the CHO to share with the CE of the public health unit.
- The CDCD or the PHU may write to other health service providers and non-government organisations to share the findings and recommendations of the review.
- It is expected that organisations represented at the review take the review recommendations to their CE/appropriate managers for implementation.
- CDCD will prepare a report at least every two years collating recommendations from public health reviews over the past two years.

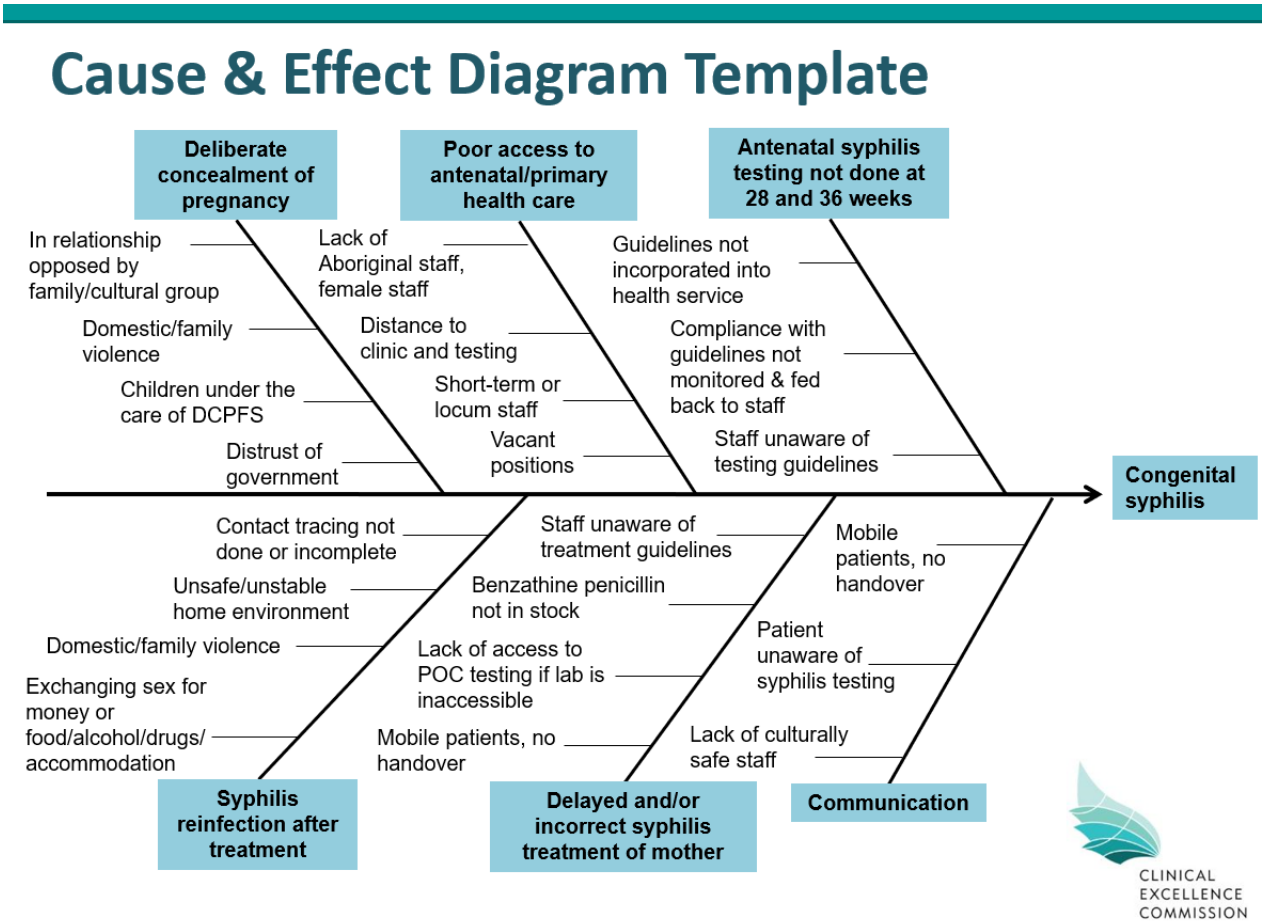

Figure 1. Example cause and effect diagram. Note this is an example only and does not include all possible factors

References

1. WA Health. Silver book: STI /BBV management guidelines. https://ww2.health.wa.gov.au/Silver-book/
2. Australian Government, Department of Health. Pregnancy Care Guidelines. https://beta.health.gov.au/resources/pregnancy-care-guidelines
3. Communicable Diseases Network Australia. National Guidelines for Public Health Units. Syphilis. https://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-syphilis.htm
4. NSW Health Clinical Excellence Commission. Cause and effect diagram. https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/cause-and-effect-diagrams
5. WA Health Severity Assessment Codes. https://ww2.health.wa.gov.au/Articles/S_T/Severity-assessment-codes