Deaths - Reporting of Maternal Deaths to the NSW Department of Health

Summary Requirement to report all maternal deaths to the NSW Maternal and Perinatal Committee that reviews morbidity and mortality.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Ambulance Service, Ministry of Health, Public Hospitals

Distributed to Public Health System, NSW Ambulance Service, Ministry of Health, Public Hospitals

Audience

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
Reporting of Maternal Deaths to THE NSW DEPARTMENT OF HEALTH

1. This Circular supersedes Circular 89/68.

2. A maternal death is defined as any death which occurs during pregnancy, labour or within the first year (365 days) following cessation of pregnancy. This includes deaths in the first trimester of pregnancy (for example, associated with ectopic pregnancy and following termination of pregnancy), deaths due to accidents and deaths of women who are incidentally found to be pregnant at post-mortem examination.

Previously in NSW, information on maternal deaths was collected only up to the first 42 days (6 weeks) following cessation of pregnancy. However, monitoring of maternal deaths nationally now includes 'late maternal deaths' (from 6 weeks to 12 months after cessation of pregnancy) to ensure consistency with international and World Health Organisation guidelines. Information on deaths that appear to be incidental (where the pregnancy is unlikely to have contributed to the death) is also to be consistently collected up to one year following cessation of pregnancy. For example, information on deaths due to suicide have previously been inconsistently reported.

3. Maternal deaths should be reported to the Department of Health within 72 hours of death and the following information provided:
   - Patient's name
   - Date of birth
   - Address
   - Hospital of notification
   - Hospital medical record number
   - Date of death
   - Provisional diagnosis of cause of death
Maternal deaths may be notified by mail, phone, fax or email as follows:

Mail: The Secretary, NSW Maternal and Perinatal Committee
Centre for Research and Clinical Policy
Level 7
NSW Health Department
Locked Bag 961
North Sydney NSW 2059.

Phone: (02) 9391 9212 or (02) 9391 9199
Facsimile: (02) 9391 9070
Email: MPSEC@doh.health.nsw.gov.au

4. Hospitals and clinicians should note the requirement under the Coroner's Act 1980 that unnatural deaths be reported to the Coroner. These deaths include accidents, poisonings, violence, death within 24 hours of a anaesthetic or sudden deaths the cause of which is unknown (Circular 98/2961).

5. All maternal deaths are individually reviewed by the NSW Maternal and Perinatal Committee. The NSW Maternal and Perinatal Committee is an expert committee appointed by the Minister of Health to review maternal and perinatal morbidity and mortality in the State and is privileged from subpoena under the Health Administration Act 1982 for its review of confidential medical information.

6. After notifying the Department of a maternal death, the hospital will receive a letter from the Secretary of the NSW Maternal and Perinatal Committee requesting a copy of the relevant medical and ante-natal record, post-mortem report (if applicable), medical certificate of cause of death, and any other relevant material which the hospital may wish to provide to the Committee for consideration. Hospitals should ensure that a copy of the medical certificate of cause of death is included in the medical record so that it is readily available when requested.

7. The information obtained through the statewide confidential review is used to develop policies aimed at reducing maternal and perinatal mortality in NSW.

Summary information on maternal deaths in NSW is available in the annual *NSW Mothers and Babies Report*, which is published by the NSW Department of Health and is available on the Department's web site at www.health.nsw.gov.au/public-health/epi/pubs.html.

National information on maternal deaths is available in the *Report on Maternal Deaths in Australia*, which is published triennially by the National Health and Medical Research Council (NHMRC) and is available from the NHMRC website at: www.health.gov.au/nhmrc/publications.

8. To assist with local hospital quality assurance activities, a copy of the Committee's summary of findings will be returned to the hospital.

9. This circular should be brought to the attention of all staff involved in the administration and delivery of maternity care including intensive care units and emergency wards.

Michael Reid
Director-General