Policy Directive

Reporting of Maternal Deaths to the NSW Clinical Excellence Commission

Summary	The purpose of the Policy Directive is to inform NSW Health services of the reporting requirements for maternal deaths.
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Functional group	Clinical/Patient Services - Critical Care, Maternity, Mental Health Corporate Administration - Governance
Applies to	Ministry of Health, Local Health Districts, Board Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Public Health System Support Division, Cancer Institute, Community Health Centres, NSW Ambulance Service, Public Hospitals, Private Hospitals and day Procedure Centres
Distributed to	Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres
Audience	All Clinical Staff

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This Policy Directive may be varied, withdrawn or replaced at any time.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 CLINICAL EXCELLENCE COMMISSION

POLICY STATEMENT

All NSW Health Services must report all maternal deaths to the Clinical Excellence Commission (CEC) in addition to other existing reporting obligations.

SUMMARY OF POLICY REQUIREMENTS

For all maternal deaths, the Maternity Unit Manager, Nurse Unit Manager, or Patient Safety Manager is to email CEC-PatientSafety@health.nsw.gov.au, with relevant information.

The death is also to be reported by completing the Admitted Patient Death Screening Tool in the CEC Death Review Reporting System.

Unexpected deaths of women who are either pregnant (any stage) or up to 42 days (6 weeks) postpartum are a reportable incident and must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047).

Hospitals must also have effective systems and procedures in place to report deaths to the Coroner in accordance with the Coroners Act 2009; a Reportable death is defined in NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054) .

The health facility will be asked to supply the CEC with the following information via a secure file sharing system:

- a copy of the relevant medical records, including medical certificate of cause of death (if applicable)
- post-mortem report (if applicable)
- any other relevant material requested by the Maternal and Perinatal Mortality Review Committee.

REVISION HISTORY

Version	Approved by	Amendment notes
February-2021 (PD2021_006)	Chief Executive Clinical Excellence Commission	Minor edits to ensure alignment with language and definitions in National reporting of maternal deaths. Insertion of a hyperlink to the revised incident management policy PD 2020_047.
November-2020 (PD2020_043)	Chief Executive Clinical Excellence Commission	Document amended to update committee name.
October 2020 (PD2020_042	Deputy Secretary, Patient Experience and System Performance	Updated to reflect change in reporting process from the Department of Health to the Clinical Excellence Commission.
January 2005 (PD2005_219)		Review of document and reissue on Policy System – no changes to Circular.

Version	Approved by	Amendment notes
October 2001 (2001/94)	Director General	
June 1989 (89/68)	Secretary	

ATTACHMENTS

1. Reporting of Maternal Deaths to the Clinical Excellence Commission: Procedures.

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1 BACKGROUND

1.1 About maternal death

Maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, regardless of the duration or outcome of the pregnancy.

National data collection includes all maternal deaths up to and including 42 days postpartum. Late maternal deaths reporting (occurring from 43 days postpartum up to and including 365 days post-partum) is optional and is reported if the state/territory wishes to do so.

NSW monitors late maternal deaths to ensure consistency with international and World Health Organisation guidelines.

Maternal death is comparatively rare in Australia, though there is persistent inequity in maternal mortality between Aboriginal and non-Aboriginal women, with the maternal mortality rate (MMR) for Aboriginal women being three times that of non-Aboriginal women.

There are four different categories of maternal deaths:

Direct maternal deaths

Those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium) from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above

Indirect maternal deaths

Those resulting from previous existing diseases or diseases that developed during pregnancy, and which were not due to a direct obstetric cause, but were aggravated by the physiologic effects of pregnancy

Coincidental deaths

Deaths from unrelated causes that happen to occur in pregnancy or the puerperium

Late maternal death

A late maternal death is the death of a woman more than 42 days but less than one year after the end of the pregnancy.

The broad categories mean women may have contact with a variety of health services. Health professionals working with women in their first trimester of pregnancy (for example, associated with ectopic pregnancy and following termination of pregnancy) are required to report maternal death.

Maternal deaths may occur in the community (e.g. suicide) as well as outpatient departments, maternity, ward areas (e.g. oncology), emergency departments (e.g. motor vehicle accident), intensive care and high dependency units, as well as operating

theatres. As such, all health care providers are to read section 2.1 for instructions on how to report a maternal death.

A summary of information relating to maternal deaths in NSW is available in the annual NSW Mothers and Babies Report, which is published by NSW Health and is available on HealthStatsNSW. National information on maternal deaths is available in an annual report published by the Australian Institute of Health and Welfare (AIHW).

1.2 About the NSW Maternal and Perinatal Maternal Review Committee

The primary purpose of the Maternal and Perinatal Maternal Review Committee (MPMRC) is to subject all maternal and perinatal deaths occurring in NSW to peer review, in order to:

- Classify maternal death as direct, indirect or coincidental
- Examine the circumstances leading to maternal and perinatal deaths, in order to identify the cause and any factors which may have been preventable
- Identify shared learnings, with the aim of improving patient safety, and report back to the Secretary, Ministry of Health
- Provide a summary of findings to the hospital to assist with local hospital quality assurance activities.

This information is used by the NSW Maternal and Perinatal Mortality Review Committee (MPMRC) to implement system changes aimed at reducing maternal and perinatal mortality in NSW and assist local hospital quality assurance activities.

For more detailed information relating the MPMRC, the Terms of Reference is available in the Terms of Reference.

1.3 Legal and legislative framework

The NSW Maternal and Perinatal Mortality Review Committee (MPMRC) is constituted under Section 20 of the Health Administration Act 1982. It has special privilege and is authorised to conduct investigations and research in accordance with *section 23 of the Health Administration Act 1982.* The members are appointed by the Minister for Health to review maternal and perinatal morbidity and mortality in the State. All maternal deaths which are reported via the process described in this Policy are reviewed by the NSW MPMRC.

2 REPORTING PROCESSES

2.1 All maternal deaths

1. The Maternity Unit Manager, Nurse Unit Manager, or Patient Safety Manager is to send an email with the following information to CEC-PatientSafety@health.nsw.gov.au:

- Patient's name
- Date of birth (woman's)
- Hospital of notification

- Hospital medical record number
- Date of death
- Provisional diagnosis of cause of death
- Contact name and email of the Clinical Information Manager or Medical Records Department

2. For NSW Health services with access to the CEC Death Review Reporting System, the death is also to be reported by completing the Admitted Patient Death Screening Tool. The reporter must select the 'Pregnancy, labour or within 365 days of pregnancy' screening criteria. A copy of the PDF output of the completed screen must be sent to CEC-PatientSafety@health.nsw.gov.au.

3. For additional assistance or further information contact the CEC:

- Phone: CEC Maternal and Perinatal Patient Safety Analyst, 02 9269 5500.
- Email: CEC-PatientSafety@health.nsw.gov.au

2.2 Unexpected deaths

Unexpected deaths of women who are either pregnant (any stage) or up to 42 days (6 weeks) postpartum are a reportable incident and must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047). They require a preliminary risk assessment (PRA) followed by a serious adverse event review (SAER), under Part 2A of the Health Administration Act 1982.

It should be noted that this requirement does not apply in cases of palliative care.

Hospitals must have effective systems and procedures in place to report deaths to the Coroner in accordance with the *Coroners Act 200.* A Reportable death is defined in NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054) which provides NSW Health Staff with direction and guidance about deaths reportable to the NSW Coroner.

2.3 Request for Medical Records

After notifying the CEC as per 2.1, the Secretary of the MPMRC will issue a request to the health facility Medical Records Department.

The medical records department is to supply the following information via a secure file sharing system:

- a copy of the relevant medical records, including medical certificate of cause of death
- post-mortem report (if applicable)
- any other relevant material requested by the MPMRC.

3 REFERENCES

AIHW (2019). Maternal Deaths in Australia. ACT, AIHW.

World Health Organization (2011). ICD-10 International Statistical Classification of Diseases and Related Health Problems. Geneva.

4 RELATED POLICIES

Policy Number	NSW Health Policy Directive
(PD2010_054)	Coroners Cases and the Coroners Act 2009
(PD2020_047)	Incident Management
(PD2020_011)	Verification of Death and Medical Certificate of Cause of Death