Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Safer Care Victoria

Victoria's mothers, babies and children 2019

Maternal mortality and morbidity

About CCOPMM

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The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) is a statutory authority appointed by the Minister for Health

Chair: Adjunct Professor Tanya Farrell

Operates under the *Public Health and Wellbeing Act 2008*

About CCOPMM

Legislative responsibility for data collection

- Victorian Perinatal Data Collection (VPDC)
- Victorian Congenital anomalies register (VCAR)

Legislative responsibility for health surveillance

- Mortality collections and review of perinatal, child and adolescent, and maternal mortality
- Morbidity collections: severe acute maternal morbidity (SAMM)

Undertaking case reviews

Four subcommittees report to CCOPMM:

- **Stillbirth** – Chair: Professor Susan McDonald
- **Neonatal Mortality and Morbidity** (0-27 days) – Chair: Professor Rod Hunt
- **Maternal Mortality and Morbidity** – Chair: Professor Mark Umstad
- **Child and Adolescent Mortality and Morbidity** (28 days-17 years) – Chair: Professor Paul Monagle

Undertaking research

CCOPMM conducts research itself and also provides data for research purposes

CCOPMM identifies research priorities by:

- analysis of our reports, data and through case reviews
- collaborating with external research projects

Why do we do what we do?

Independent oversight of all deaths and severe maternal morbidity

Highlight areas that require improvement – hospital and community

Highlight areas for further research

Inform the development of policies and guidelines

Provide advice on areas for prioritisation and investment

Maternal mortality and morbidity

Definition: Maternal mortality and morbidity

Include:

- All maternal deaths during pregnancy and within a year of birth
- All intensive care unit (ICU) admissions during pregnancy and up to 42 days after birth

Definition: Maternal mortality and morbidity

Maternal deaths occurring during pregnancy or within 42 days of the end of pregnancy are classified as:

- **Direct** – relating to the pregnancy or birth
- **Indirect** – relating to a pre-existing medical condition or newly diagnosed condition
- **Incidental** – unrelated to the pregnancy or birth

Maternal deaths occurring after 42 days following pregnancy and up to one year post birth are reported as **Late**

Maternal mortality ratio (MMR)

CCOPMM uses the World Health Organization's (WHO) definition to calculate the maternal mortality ratio (MMR)

This includes direct and indirect deaths that occur during pregnancy or within 42 days of the end of pregnancy

Incidental and late deaths are not included in this calculation

Definition: SAMM

Severe Acute Maternal Morbidity (SAMM) is measured as an admission to an ICU during pregnancy and up to 42 days after birth

The criteria for ICU admission may vary across hospitals, and not all maternity services in Victoria have direct access to an ICU

Trends and comparisons

Births 2019

77,779 women gave birth in 2019

423 more women gave birth than 2018

78,954 babies were born in 2019

433 more babies born 2019 than 2018

birthrate decreased to 56.5 per 1,000 EFRP

Maternal mortality: 2017 to 2019

Victorian maternal mortality ratio (MMR)

8.1 deaths per 100,000 women who gave birth during 2017-19 triennium

this is lower than 10.2 deaths per 100,000 women who gave birth during the 2016-18 triennium

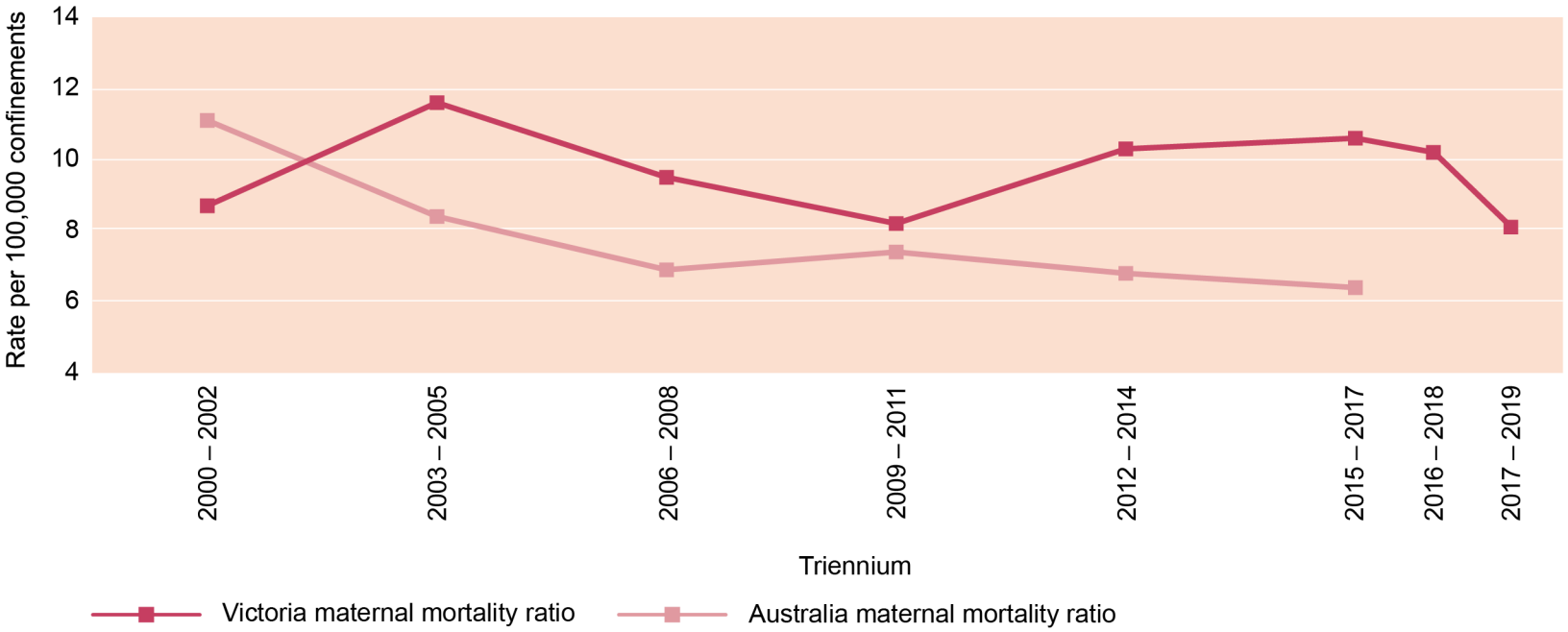
Maternal deaths per year

Suicide

was the most common cause of all maternal deaths in 2017-19

10 suicides

Maternal mortality ratios: Rolling triennia



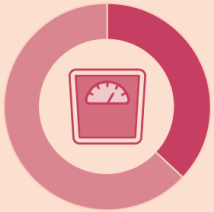
Severe Acute Maternal Morbidity (SAMM) in 2019

262
women were
admitted to an ICU with SAMM

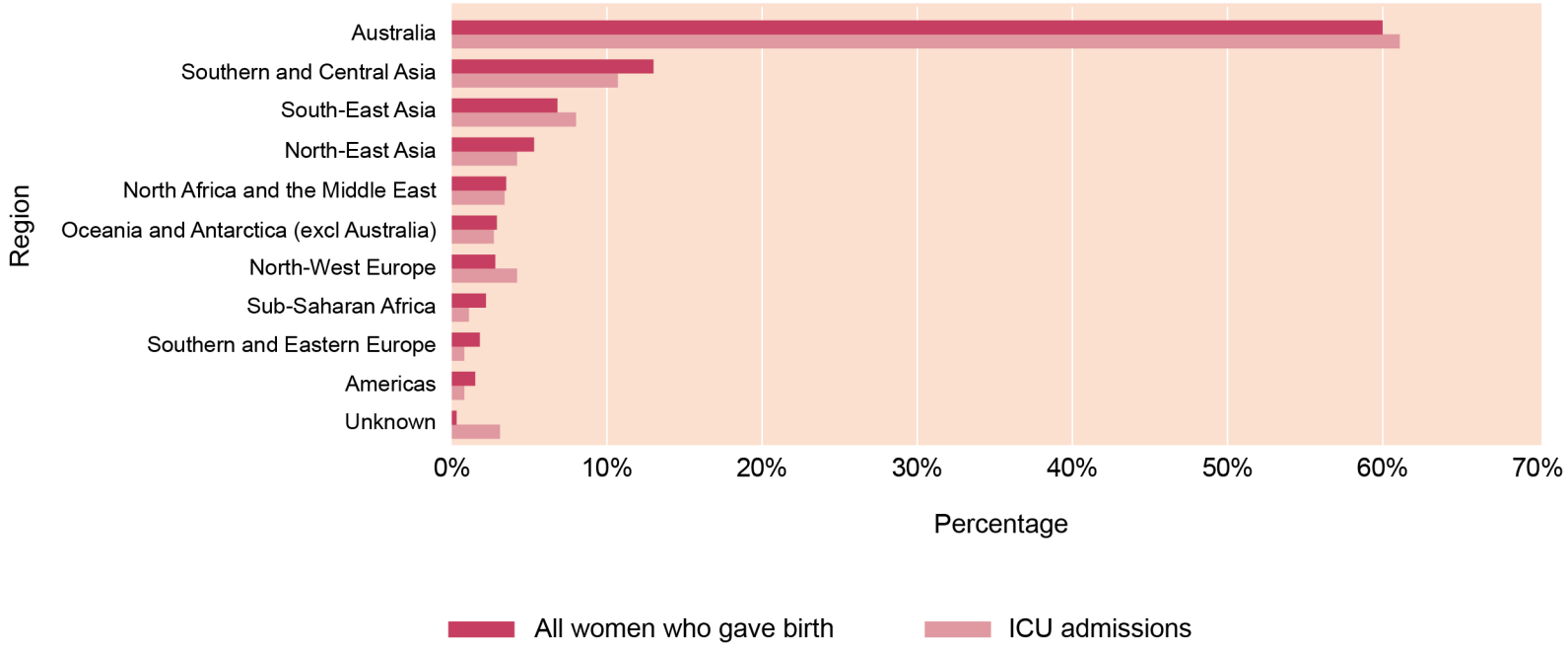
Of these 262 women
60.6% (159)
were born in Australia

Of these 262 women
0.11% (3)
were Aboriginal

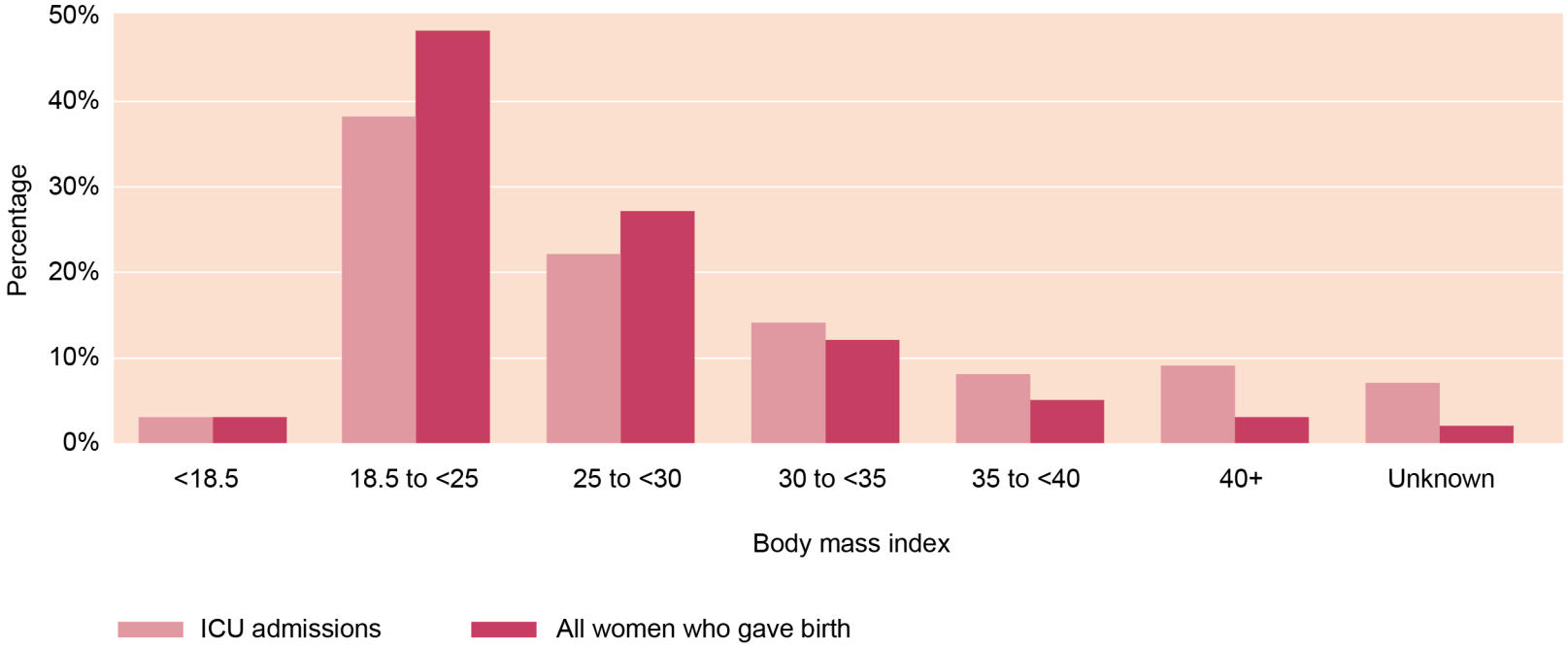
Of these 262 women
37% had a
BMI of 30 or higher



ICU admission by region of birth in 2019



ICU admission by BMI in 2019



CCOPMM recommendations: Maternal M&M

Recommendations

Develop and implement a **system-wide improvement program to prevent women experiencing postpartum haemorrhage (PPH)**

Recommendations

Evaluate the effectiveness of current services in meeting the specific needs of women during pregnancy and in the year following birth. If gaps are identified, implement strategies to improve the health and wellbeing of women and families. The areas of mental health and family violence require specific focused attention

Good practice points

Good practice points reflect the findings of CCOPMM's review of all cases of maternal, perinatal and paediatric mortality, and severe acute maternal morbidity in a reporting year

They are designed to guide local improvements in clinical performance and can relate to our **clinical care and/or the system or service we work in**

Good practice points

Ensure **all staff** are upskilled in clinical management through PRactical Obstetric Multi-Professional Training (PROMPT) or alternative program to ensure clinicians are familiar with obstetric emergencies

Use your own **clinical scenarios** to routinely train staff

Use **rare and high-risk emergencies** in your training programs

Good practice points

Strengthen your service's relationships with maternal and child health nurse (MCHN) services - to ensure there is **support for women that have complex psychosocial history and/or a history of catastrophic episodes**

Ensure effective connection and handover to MCHNs

Good practice point

Given the possibility of damage to the ureter in situations of excessive bleeding at the time of caesarean section, obstetricians should **ensure ureteric integrity** either at the time of the operation or within a reasonable time post operatively

Good practice point

The **judicious, or non-use, of oxytocin infusion** for augmentation of a **multiparous woman** who fails to progress in labour is recommended

Good practice points

To prevent significant maternal or perinatal morbidity or mortality, maternity services must have clear **pathways in place** that facilitate **timely access to an emergency theatre**

Rapid access must be available where there is an immediate threat to life of a mother and/or baby – e.g. management of uterine rupture or postpartum haemorrhage

These pathways need to be **audited** to monitor rapid access in services 24/7

Good practice points

Recommend seeking a **second opinion from a senior colleague** when **returning** acutely **unwell women to theatre**

Consider on first return to theatre and **highly recommend** on second return

Good practice points

Develop **clear guidance** around **hospital bookings for women planning a homebirth** including guidelines for transfer to hospital

Ensure **all staff**, including private midwives, have regular **training and simulation on postpartum haemorrhage** (PPH) recognition and management

For more information

www.bettersafercare.vic.gov.au/publications/victorias-mothers-babies-and-children-2019

Refer to CCOPMM's other slide packs on:

- Mothers and babies
- Perinatal mortality
- Child and adolescent mortality
- 2019 recommendations

Connect with us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