



Centre for Maternal and Child Enquiries

Improving the health of mothers, babies and children

MATERNAL DEATH ENQUIRY

WHAT IS THE MATERNAL DEATH ENQUIRY?

The Maternal Death Enquiry consists of detailed case reviews on women who die during or around the time of pregnancy to determine whether the healthcare met appropriate standards and whether, according to expert clinical assessors, the death was potentially avoidable. The findings are then developed into recommendations for improving practice and the development of clinical guidelines and national policies. CMACE produces triennial reports from this work titled 'Saving Mothers' Lives' (previously 'Why Mothers Die') thus continuing the work undertaken on maternal deaths by its predecessor bodies since 1952. The aim of the enquiry is to help ensure that all pregnant and recently delivered women receive safe, high quality care delivered in appropriate settings based on their individual needs.

WHAT DOES THE MATERNAL DEATH ENQUIRY ADD?

Maternal mortality is important. It is important to the individual mother, important in relation to the health of the public and important for planning health services. Understanding mortality is central to being able to improve outcomes for pregnant women.

The maternal death enquiry aims to:

- Identify the main causes of, and trends in maternal deaths
- Determine whether the healthcare met appropriate standards
- Determine whether, according to expert clinical assessors, the death was potentially avoidable
- Develop the findings of the Enquiry into recommendations for improving clinical care, service provision, local audit, commissioning of services and the development of relevant clinical guidelines and national policies on maternal health.

WHO IS INCLUDED?

Data are collected on deaths of women during pregnancy or within 42 days of delivery or the end of the pregnancy. Deaths from suicide or cardiomyopathy up to six months after delivery are also included.

HOW ARE DATA COLLECTED?

In liaison with the healthcare provider, the Maternal Death Enquiry data collection form is completed by CMACE staff and all relevant notes associated with the case are collected. The case is then sent to a multidisciplinary regional assessment team. Their opinions on cause of death and quality of care are entered on a database. The Clinical Director of the Maternal Death Enquiry then reviews each case and allocates it to clinical experts in the appropriate specialty from a central assessment team. These central assessors, nominated by their Colleges, collectively form the Saving Mothers' Lives writing panel. The writing panel draft a triennial report containing epidemiological and case study analysis together with their top ten recommendations for practice. The next report will be published in 2010/11 and will present information on maternal deaths occurring in 2006-2008.

FURTHER INFORMATION

All the reports related to the Maternal Death Enquiry published to date are available from the publications page of the website www.cmace.org.uk.

For further information on this work please contact CMACE on [020 7486 1191](tel:02074861191).

Copies of our other reports and more information about CMACE together with contact details of our central and local offices can be found on our website or by telephoning [020 7486 1191](tel:02074861191).

