Maternal death – the role of CMACE Ireland

EDEL MANNING, CMACE IRELAND COORDINATOR

The establishment of CMACE Ireland has marked a significant step forward in supporting a culture of patient safety in Ireland and ensuring the continuous improvement of healthcare services.

Funded and endorsed by the HSE, CMACE Ireland is a stand-alone office working in partnership with CMACE UK in carrying out confidential enquiries on all maternal deaths in Ireland. The remit of CMACE Ireland does not currently include child health enquiries.

CMACE Ireland was launched as the Confidential Enquiry into Maternal and Child Health (CEMACH) Ireland in April 2009 by the Minister for Health and Children, Mary Harney.

On 1 July 2009, in partnership with CEMACH UK, the organisation changed its operational title to the Centre for Maternal and Child Enquiries (CMACE).

Objectives
• To assess the main causes of, and trends in, maternal deaths.
• To learn lessons by identifying any avoidable or sub-standard factors which may be causally related to adverse outcomes.
• To make recommendations concerning the improvement of clinical care and service provision that will save yet more mothers’ lives, and reduce the numbers who suffer severe maternal morbidity.
• To produce a triennial report.

Background
Global maternal deaths for 2005 showed that, of the estimated total of 536,000 maternal deaths, 99 per cent occurred in developing countries. Ireland was reported as having the lowest maternal mortality ratio of 1 per 100,000 live births in 2005.1

However, it is known that, in the absence of active case ascertainment, under-reporting and misclassification of maternal deaths occurs in developed countries.1-4 Maternal deaths can occur in units other than maternity units and in the community.

Although reported maternal deaths are rare in Ireland and the UK and some maternal deaths are unavoidable, there is evidence that women are still dying needlessly. Deaths can be prevented in the future only if lessons are learnt and acted upon, a process that begins with confidential enquiries into such cases.5

Confidential enquiries into maternal deaths have been carried out in the UK for over 50 years and are presently under the auspice of the Centre for Maternal and Child Enquiries (CMACE) UK. CMACE UK produces a triennial report that currently covers all cases of maternal death in England, Wales, Scotland and Northern Ireland.

The overwhelming strength of successive enquiry reports has been the impact their findings have had on improving standards of care and clinical governance in the UK maternity service and further afield.

From January 2009, Irish maternal mortality data has been included in the CMACE UK’s triennial report.
‘Ireland was reported as having the lowest (global) maternal mortality ratio of 1 per 100,000 live births in 2005.’

Definition of maternal death
‘A maternal death is a death occurring during pregnancy or within 42 days of delivery, miscarriage, termination of pregnancy or ectopic pregnancy from any cause related to, or aggravated by, the pregnancy or its management.’

This definition is currently under international discussion. There is a growing trend to collect data on maternal death up to one year after delivery, miscarriage or abortion. This is particularly the case with respect to cases of peripartum cardiomyopathy and deaths due to suicide.

Classification of maternal deaths
• Direct – deaths resulting from obstetric complications of the pregnant state.
• Indirect – deaths resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes.
• Late – deaths occurring between 42 days and one year after the abortion, miscarriage or delivery (includes direct and indirect causes).
• Coincidental – deaths from unrelated causes which happen to occur in pregnancy and the puerperium.

(Lewis G. Saving Mothers’ Lives. 2007.)

Role of health professionals

Notification
Notify CMACE Ireland in the event of a maternal death occurring during or within one year of the pregnancy. Maternal deaths can occur in units other than maternity units and in the community.

A dedicated CMACE Maternal Death Notification Form will be available in all maternity units and acute hospitals, as well as from the CMACE Ireland office/website.

Confidential enquiry
Provide the CMACE enquiry with a full and accurate account of the circumstances leading up to the maternal death with supporting records.

Learn the lessons
All health professionals in maternity units and the community should be aware of and, where applicable, implement recommendations contained within the triennial report.

Enquiry process
The enquiry process is based on a two-stage process of Irish data collection and assessment of the case followed by a central (UK) assessment to enable aggregation into a fully anonymised overall triennial report.

The confidential enquiry into maternal deaths does not preclude the necessity for a local enquiry into maternal death or critical incident review. Results of these reports should be made available to CMACE as part of the documentation for its review process.

Irish and central assessors?
The Irish and central assessors are multidisciplinary clinicians who work independently of CMACE but contribute to the Maternal Death Enquiry. Nomination is by the relevant multidisciplinary faculties.

Biographies of the Irish assessors can be accessed on the following website: http://www.ucc.ie/en/cmace

Confidentiality and the enquiry process
Confidentiality is assured in the enquiry process:
• Through a process of anonymisation of data prior to assessment of the reported case.
• CMACE Information Security Guidelines safeguard any identifiable data for the duration it is held.
• No disclosure of information to unauthorised people or agencies.
• No discoverability; before publication of the triennial report, all documentation is destroyed and all electronic data is irreversibly anonymised.
• Current data protection legislation places no bar on the disclosure of patient information concerning maternal deaths to CMACE.

Triennial reports: Saving Mothers’ Lives
• Seventh and most recent triennial report.
• Leading causes of maternal deaths.
• Top 10 recommendations and auditable standards.
• Key issues and lessons for specific health professionals.
• Executive summary for midwives.

– MMR in the UK 2003-2005 identified by death certificate data alone = 7 per 100,000 maternities
– Proactive inclusive approach of UK Confidential Enquiry 2003-2005 identified = 14 per 100,000 maternities

(Lewis G, Saving Mothers’ Lives, 2007.)
**Clinical Review**

Leading causes of direct deaths: UK rates per million maternities 2003-05

![Diagram showing leading causes of direct deaths with rates per million maternities 2003-05]

**CMACE Ireland activities to date**

- Confidential maternal death enquiries: since its inception, CMACE Ireland has been actively ascertaining cases of maternal deaths in Ireland which have become part of the enquiry process.
- Interactive workshop: a multidisciplinary interactive workshop was held in Limerick on 9 December 2009 which focused on the reporting process of the enquiry process and dissemination of recommendations with auditable standards from the most recent triennial report, Saving Mother’s Lives. It is envisaged that future workshops will be held on an annual basis.
- CMACE welcomes invites from external conference organisers who want us to make a presentation on CMACE’s work.

**Contact details**

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**References**


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