

Perinatal Mortality Guideline 2

HOSPITAL PERINATAL MORTALITY REVIEW COMMITTEE: TERMS OF REFERENCE

This guideline is designed to facilitate Perinatal Mortality review at the local and/or regional levels. It outlines the recommended terms of reference for hospital perinatal mortality review committees. All hospital perinatal mortality review committees are provided protection under s.51 of the *B.C. Evidence Act*. If a facility has a very small number of perinatal deaths, it is recommended that review be done at the regional or tertiary level. Including stillbirths and neonatal deaths, there will be approximately eight cases to review per 1,000 births.

OBJECTIVES

To monitor and improve obstetrical and neonatal care provided in British Columbia by:

I REVIEW

To review perinatal mortality cases (\geq 500 grams or 20 weeks gestation to 28 days of life inclusive).

II CLASSIFY

To classify all perinatal deaths using the BCRCP Perinatal Death Classification System.

III EVALUATE

To evaluate the preventability of perinatal mortality cases.

IV RECOMMEND

To recommend methods to reduce the frequency of these events, including:

- Recognition of Risk Factors for each classification of death.
- Hospital policies and procedures review.
- Education.

V PROVIDE PERINATAL MORTALITY DATA

To provide data to the B.C. Perinatal Database Registry for compilation of a regular B.C. Perinatal Mortality Report.

MEMBERSHIP COULD INCLUDE

Obstetrician	Midwife
Pediatrician	Nurse
Family Practitioner	Health Records Administrator
Pathologist	Resident (Teaching hospitals)

ACCOUNTABILITY

- Medical / Nursing/ Professional Advisory Committees
- Hospital Administration
- Health Authority

FREQUENCY OF MEETINGS

As soon after the death as possible.