Perinatal Services BC
An agency of the Provincial Health Services Authority

Provincial Perinatal Maternal Mortality & Morbidity Review Committee

TERMS OF REFERENCE – October 2024

1.0 PURPOSE

The Provincial Perinatal Maternal Mortality & Morbidity Review Committee (MMRC) is a multidisciplinary Committee focused on reviewing causes of maternal death and severe morbidity (also known as near miss events) in British Columbia and making recommendations to help prevent future occurrences. The Committee[1] and associated efforts are led by Perinatal Services BC (PSBC) in collaboration with regional Health Authority (HA) perinatal leads and other partners.

Maternal mortality includes deaths occurring during pregnancy and up to 365 days following the end of pregnancy. Information will be gathered from death certificates, birth certificates, health records, autopsy reports, and other pertinent sources. Records are reviewed by local HA committees, or a clinical expert from the provincial committee. De-identified case narratives are reviewed by a committee of experts from diverse disciplines.

The scope of cases for Committee review is all deaths of women with indication of pregnancy, up to 365 days following the end of pregnancy, regardless of cause (i.e., motor vehicle accidents during pregnancy, motor vehicle accidents postpartum, suicide, homicide). Deaths may be identified by a number of processes, depending on the existing infrastructure and legislation.

2.0 AUTHORITY:

2.1 The MMRC is authorized to do this review through a Lieutenant Governor of BC Order in Council dated 27 January 1998, within the province of British Columbia; reconvened in 2002 and again in 2022. This Section 51 protection is separate from Health Authority Section 51 and allows for cross health authority sharing of information.

2.2 The Committee will produce regular reports that will be made available to Health Authorities that summarize and analyze perinatal and maternal and morbidity data as provided by the Perinatal Data Registry (PDR) for the purposes of quality improvement initiatives within Health Authorities.

2.3 The Committee will produce provincial perinatal maternal mortality and morbidity reports and learning summaries on a regular basis.

2.4 The Committee is accountable to the PSBC Steering Committee and will have ongoing communication with the Provincial Medical Director to identify trends and risk factors for maternal morbidity and mortality.

2.5 Where The Committee seeks Health Authority Section 51 detail for a

[1] As defined by paragraph 51(1) of the Evidence Act.

specific case, pursuant to a completed[2] Regional Quality Review, The Committee shall request such information in writing, specifying the Enacted Authority under Evidence Act Regulation that enables sharing of protected information[3].

3.0 COMMITTEE GOALS:

3.1 To facilitate local perinatal and maternal mortality reviews being performed on a regular basis throughout the province.

3.2 Determine the annual number of maternal deaths related to pregnancy (pregnancy-related mortality ratio).

3.3 Identify trends and risk factors.

3.4 Develop actionable strategies to eliminate preventable maternal deaths

3.5 Follow up on the Committee's recommendations to determine any changes in practice and maternal mortality rates.

The review process is intended to be educational, prevention-oriented, and for quality improvement. The following steps will be taken to ensure an effective review of each case:

1. Share, question, and clarify all case information.
2. Determine whether the death was pregnancy-related, the underlying cause of death, and whether the death could have been prevented.
3. Identify contributing factors.
4. Develop recommendations to decrease, modify, or eliminate contributing factors to help prevent future deaths and improve maternal health in general.
5. Disseminate recommendations to relevant facilities, organizations, and governments.

4.0 MEMBERSHIP

The MMRC is comprised of health care and social service providers from across the province/territory, as well as other relevant experts from other disciplines. Representation includes:

- Coroner/medical examiner (with authority to have access to documents)
- Obstetrics and gynaecology
- Pathology
- Midwifery
- Maternal fetal Medicine
- Anesthesiology
- Internal Medicine
- Nursing
- Family practice

[2] This mechanism is intended to support the sharing of Quality Review information that was completed by a Health Authority, prior to, during or subsequent to The Committee's review of the case.
[3] Section 51 (1)(b.1)(i-ii)

- Indigenous and FNHA partners
- Other specialties relevant to the case (i.e., emergency services, critical care, psychiatry, mental/behavioural health, social work, etc.)

Committee members are appointed by the Provincial Medical Director, PSBC upon recommendation.

from HA perinatal leads. New MMRC members will be recruited as needed, unless a specific type of expertise is required specifically for a case review (for example, domestic violence); in this case, ad hoc members may be invited to attend for a given case.

All MMRC members will serve in a volunteer capacity and will not receive compensation for their participation in the review process. Members will be reimbursed for travel expenses approved in advance that are incurred to attend in-person meetings as per PHSA policy.

5.0 TERMS OF MEMBERSHIP

The expiration of terms for MMRC members should be staggered, with the recommended length of terms being 5 years. This provides others the opportunity to contribute and build capacity for experience related to the review process.

5.1 CONFIDENTIALITY

All MMRC members must sign the MMRC Confidentiality Statement when they join the Committee. Forms will be electronically retained and considered effective as long as the relevant case files exist. Committee members will be reminded at the start of each meeting that all information discussed in the reviews must remain confidential and may not be used for reasons other than for the maternal mortality review.

All MMRC members must abide by the Freedom of Information and Protection of Privacy Act (FOIPPA), or other similar provincial/territorial legislation, ensuring appropriate safeguards to protect the privacy of personal health information.

MMRC members will have access to the specific information and records according to the legislation of their jurisdiction. To ensure the protection of privacy and confidentiality for Committee members, individuals, families, and providers, the MMRC will adhere to the following processes:

- All MMRC meetings will be held in private.
- Members of the public or press will not be allowed at MMRC meetings. If members of the public or press show up uninvited at a meeting they will be notified that the MMRC meetings are not open to the public and will be asked to leave.
- Agendas and meeting notes will be shared via a secure online system.
- MMRC members must meet in person or by a secure virtual platform to review information.
- All case summaries reviewed will be redacted per confidentiality standards.
- An MMRC member may request to review a de-identified record for additional information pertinent to the case review. The record(s) will be de-identified by relevant Department staff.

5.2 COMMITTEE FUNCTIONS

As its main functions, the Maternal Mortality Review Committee will:

- Review all maternal death cases.
- Use all possible sources of information, including health records, pathology reports, vital statistics data, social service records, coroner/medical examiner reports, and interviews to understand the factors that influence maternal death.
- Determine whether the death was preventable.
- Establish trends, patterns, and risk factors, and develop actionable recommendations for the prevention of maternal death.
- Disseminate findings and make recommendations to policymakers, health care providers and facilities via learning summaries.
- Promote public awareness of the incidents and causes of maternal deaths, including recommendations for their reduction.
- Identify system problems that should be addressed.
- Identify strengths in the systems of care that should be supported or expanded.
- Keep the information confidential in order to protect the privacy of women who have died and their families.
- Protect information, ensuring that findings are non-discoverable.

Note: There is no legal authority to revoke licensure, take disciplinary action, or judge the qualifications of health care or social service providers.

5.3 MEETINGS

5.4 Meetings will be held at the call of the Chair(s).

5.5 Meetings will be held on a bimonthly basis in-person and/or remotely.

5.6 Chair(s) will ensure scheduling of meetings and the distribution of agenda.

5.7 A majority of Committee members (including the Chair(s)) shall constitute quorum.

5.8 Decisions are made through consensus. If consensus cannot be reached, decisions will be made through voting with a simple majority of those present.

6.0 DOCUMENTATION PROTOCOL

6.1 Documents prepared for the Committee and at the request of the Committee are protected under Section 51(1) of the Evidence Act: “an organization of health professionals” means any of the following that are designated by regulation of the Lieutenant Governor in Council: (a)an organization of health care professionals;

6.2 The maintenance of the minutes, agenda, and other documentation related to the Committee is the responsibility of the Committee Chair(s).

6.3 All action items are to be brought forward at subsequent meetings. It is the

responsibility of the Committee to keep a bring-forward list. It is the responsibility of the Chair(s) to ensure follow-up takes place for all action items.

7.0 REVIEW OF TERMS OF REFERENCE

The Terms of Reference will be reviewed annually.