Recommendations
The Queensland Maternal and Perinatal Quality Council recommends that:

**Maternal mortality**

1. Mental health service providers develop processes to heighten awareness of the need to fully engage with women identified in pregnancy as being at risk of significant mental health disorders. The risk of suicidal ideation in women with new mental health symptomatology must not be ignored. [Refer to section 1.2.7]

2. When pregnant women present with common symptoms such as chest pain, palpitations, syncope and shortness of breath, there should be a low threshold for considering significant cardiovascular disease and referral for specialist opinion and investigation within a clinically appropriate time frame. [Refer to section 1.2.6]

3. Coronial autopsy is strongly recommended in the case of death of any woman who dies during pregnancy or within one year of the end of a pregnancy, other than those who die due to a clearly diagnosed terminal malignancy. [Refer to section 1.2.8]

4. In the event of sudden cardiac death, autopsy is essential and arrangements should be made for cardiac tissue to be examined by a pathologist with a specific interest in cardiac pathology where initial findings are negative. Pathologists and clinicians should be aware of the emerging role for molecular autopsy in cases of possible arrhythmic death. [Refer to section 1.2.6]

5. Legislative change to the Public Health Act, with reference to a requirement for all deaths of women during pregnancy or within one year of the end of a pregnancy being reported via the Perinatal Data Collection Unit, is necessary to improve the quality of information available for review of the causation of deaths and the possible presence of avoidable factors. [Refer to section 1.2.5]

**Perinatal mortality**

6. Every perinatal death should be subject to a comprehensive investigation that includes review by a local or regional multi-disciplinary clinical committee, leading to classification of the cause of death according to the PSANZ Classification system. These committees should consider the need for practice improvement initiatives aimed at reducing the incidence of potentially avoidable perinatal deaths. [Refer to section 1.3.3]

7. Higher rates of stillbirth and neonatal deaths for Indigenous women remain a concern. Implementation and adequate evaluation of programs to address the disparity between Indigenous and non-Indigenous perinatal mortality outcomes are required. [Refer to section 1.3.7]

8. Following review and classification of a perinatal death, a revised death certificate should be submitted, if necessary. [Refer to section 1.3.3]

9. Following a stillbirth or neonatal death, all parents should be provided the option of a high quality perinatal autopsy. Whenever possible, counselling on the option of a perinatal autopsy should be provided by a senior clinician who has developed rapport with the parents. [Refer to section 1.3.9]

10. When perinatal autopsies are requested, placental pathology and a clinical case summary must be included to ensure that the report is complete. Placental pathology should be undertaken in the case of all stillbirths and high risk newborns. [Refer to section 1.3.9]

11. There is currently an insufficient number of pathologists with expertise in perinatal autopsy, and this is an impediment to quality and reporting. Steps to rectify this are urgently required. [Refer to section 1.3.9]

12. To ensure best practice in all maternity hospitals, educational programs as exemplified by the IMPROVE (IMproving Perinatal Review and Outcomes Via Education) program developed by the Perinatal Society of Australia and New Zealand, should be undertaken as part of routine in-service education. [Refer to section 1.3.3]

**Pregnancy outcomes**

13. Maternity services consult with local and statewide Indigenous health groups to develop and implement programs, such as those described in the booklet “Successful Initiatives in Aboriginal and Torres Strait Islander Health”, with the aim of eliminating the difference between Indigenous and non-Indigenous pregnancy and newborn outcomes. [Refer to section 3.1]

14. Strategies be developed to halt the continuing rise in the incidence of elective caesarean section in both Public and Private health services, as this change in practice does not appear to be associated with significant benefit to mother or baby. [Refer to section 2.8 and 2.9]

15. Instigation of clinical policies which minimise elective intervention in pregnancy in the absence of serious fetal or maternal risk prior to 39 weeks gestation, to reverse the increasing incidence of planned birth in the gestational period 36 to 38 weeks. [Refer to section 2.4]