Introduction

The Queensland Maternal and Perinatal Quality Council (QMPQC) reconvened in 2009 after a period of inactivity. In its 2010 report, Council reviewed statewide data from 1988 to 2007 to provide a snapshot of the position for that time, providing a basis upon which to move forward.

The purpose of the Queensland Maternal and Perinatal Quality Council is to:

- Collect and analyse clinical information regarding maternal and perinatal mortality and morbidity in Queensland to identify statewide and facility-specific trends.
- Make recommendations to the Minister for Health on standards and quality indicators of maternal and perinatal clinical care to enable health providers in Queensland to improve safety and quality.
- Assist with the adoption of such standards in both Public and Private sectors.

The Council functions collaboratively with the Statewide Maternity and Neonatal Clinical Network (SMNCN) and a Private Hospitals Maternity Liaison Group (supported by Private Hospitals Association of Queensland). Terms of Reference of the Queensland Maternal and Perinatal Quality Council can be found at: http://www.health.qld.gov.au/maternity/docs/qmpqc_tor_oct10.pdf

The purpose of this report is to examine the management of pregnancies, births and newborns in Queensland, including maternal deaths and perinatal deaths and apparent risk factors for such events, and to attempt to identify areas of maternal and neonatal care where service providers might focus attention to prevent future deaths and adverse outcomes.

This report examines:

- Maternal deaths in the period 2004 to 2008
- Perinatal deaths in the decade 2000 to 2009
- Statewide maternity and neonatal data in the decade 2000 to 2009.

Issues relating to screening for and diagnosis and management of congenital anomalies are the subject of consideration by Council. Integrity and quality of data relating to congenital anomalies, and how these data relate to service provision, are difficult issues, and Council hopes to report on issues such as screening quality in subsequent years.

Equally, examination of issues relating to severe maternal morbidity is challenging due to definitional and reporting issues. Council believes that the current Australian Maternity Outcomes Surveillance System (AMOSS), which is a national program studying rare and serious conditions complicating pregnancy and childbirth, is the most effective means of such review at this time.

I wish to acknowledge the commitment of Council members, and those who support them, to improving maternal and perinatal outcomes. I trust that clinicians throughout Queensland will find this report helpful and give careful consideration to the Council’s recommendations.

Professor Michael Humphrey
Chair
Queensland Maternal and Perinatal Quality Council