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MORTALITY REVIEW BULLETIN

September 2018

Hospital deaths

[Assessment of health care, hospital admissions, and mortality by ethnicity: population-based cohort study of health-system performance in Scotland.](#)

Katikireddi, S.V. et al.

Lancet Public Health. 2018 May;3(5):e226-e236. doi: 10.1016/S2468-2667(18)30068-9. Epub 2018 Apr 21. Ethnic minorities often experience barriers to health care. We studied six established quality indicators of health-system performance across ethnic groups in Scotland. These data suggest concerns about the access to and quality of primary care to prevent avoidable hospital admissions, especially for south Asians. Relatively high preventable and amenable deaths in white Scottish people, compared with several ethnic minority populations, were unexpected. Future studies

Neonate, infant and maternal deaths

[Analyzing the etiology behind mortality associated with antepartum, intrapartum, and post-partum cases in a tertiary care teaching hospital of West Bengal](#)

Sk M.I.K. et al

Journal of the Turkish-German Gynecological Association; Jun 2018; vol. 19 (no. 2); p. 65-71

The study was undertaken to understand the causes and circumstances of maternal deaths in West Bengal. Material and Methods: One hundred ten maternal deaths were reported during the period December 2010 through June 2012 in the Maternity Ward of Medical College and Hospitals, West Bengal. These deaths were reviewed using a facility-based Maternal Death Review protocol. The number and percentages were calculated and binary logistic regression analysis

should both corroborate and examine explanations for these patterns. Studies using several indicators simultaneously are also required internationally.

[Preventable deaths in a French regional trauma system: A six-year analysis of severe trauma mortality.](#)

Girard, E. et al.

J Visc Surg. 2018 May 25. pii: S1878-7886(18)30062-6. doi: 10.1016/j.jviscsurg.2018.05.002. [Epub ahead of print]

Analyzing mortality in a mature trauma system is useful to improve quality of care of severe trauma patients. Standardization of error reporting can be done using the classification of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The aim of our study was to describe preventable deaths in our trauma system and to classify errors according to the JCAHO taxonomy. Standardization of error reporting is the first step to improve the efficiency of trauma systems. Preventable deaths are frequently related to clinical performance in the early phase of trauma management. Universal strategies are necessary to prevent or mitigate these errors.

[Prehospital trauma death review in the State of Victoria, Australia: A study protocol](#)

Mercier E. et al

BMJ Open; Jul 2018; vol. 8 (no. 7)

Regionalised trauma systems have been shown to improve outcomes for trauma patients. However, the evaluation of these trauma systems has been oriented towards in-hospital care. Therefore, the epidemiology and care delivered to the injured patients who died in the prehospital setting remain poorly studied. This study aims to provide an overview of a methodological approach to reviewing trauma deaths in order to assess the preventability, identify areas for improvements in the system of care provided to these patients and evaluate the potential for novel interventions to improve outcomes for seriously injured trauma patients.

[Comparison of Military and Civilian Methods for Determining Potentially Preventable Deaths: A Systematic Review.](#)

Janak, J.C. et al.

JAMA Surg. 2018 Apr 1;153(4):367-375. doi: 10.1001/jamasurg.2017.6105.

Military and civilian trauma experts initiated a collaborative effort to develop an integrated learning trauma system to reduce preventable morbidity and mortality. Because the Department of Defense does not currently have recommended guidelines and

was performed. Conclusion: Our study demonstrates that maternal deaths occurred among young women, referred cases, with cesarean sections and type 1 delays. We recommend that imparting basic skills and improving awareness to the community about the danger signs of pregnancy could be an effective measure to detect maternal complications at an earlier stage.

[Eliminating Preventable Maternal Deaths in the United States: Progress Made and Next Steps.](#)

Metz TD.

Obstetrics and gynecology; Sep 2018

The crisis of a rising maternal mortality ratio in the United States continues to receive attention in both the scientific literature and the lay press. To continue to make progress in preventing these deaths, we must celebrate our successes and clearly delineate the next steps. The Centers for Disease Control and Prevention program, Building U.S. Capacity to Review and Prevent Maternal Deaths, recently published a report from nine maternal mortality review committees, which accomplishes just that. The report is a collaborative effort from maternal mortality review committees demonstrating the capacity to do three important tasks: 1) collect data in a standardized fashion across maternal mortality review committees throughout the United States, 2) assess preventability of maternal deaths by consensus from experts on multidisciplinary state committees, and 3) create recommendations based on maternal death review with far-reaching effect. Next steps involve expansion of this standardized process to maternal mortality review committees in every state and translation of those recommendations into state-specific action through the use of local resources such as state perinatal quality care collaboratives. This commentary summarizes the content of the report from nine maternal mortality review committees.

[Social autopsy for maternal and perinatal deaths in Bangladesh: A tool for community dialog and decision making](#)

Biswas A. et al

Public Health Reviews; Jul 2018; vol. 39 (no. 1)

Bangladesh has an established comprehensive death review system for tracking and reviewing maternal and perinatal deaths. This death review system, established in 2010, was initially known as the "Maternal and Perinatal Death Review (MPDR) System." One of the key interventions of the MPDR system, social autopsy (SA), is generally undertaken following a maternal or perinatal death notification. Social autopsy is managed at the community level by

standard operating procedures to perform military preventable death reviews in a consistent manner, these performance improvement processes must be developed. To compare military and civilian preventable death determination methods to understand the existing best practices for evaluating preventable death. The reliability of military and civilian preventable death studies is hindered by inconsistent definitions, incompatible criteria, and the overall heterogeneity in study methods. The complexity, inconsistency, and unpredictability of combat require unique considerations to perform a methodologically sound combat-related preventable death review. As the Department of Defense begins the process of developing recommended guidelines and standard operating procedures for performing military preventable death reviews, consideration must be given to the factors known to increase the risk of bias and poor reliability.

[Informing best practice for conducting morbidity and mortality reviews: a literature review](#)

Joseph, C.W. et al

Australian Health Review: 2018, 42 (3): 248-257

Preventable hospital mortality is a critical public health issue, particularly when mortalities are associated with events that are preventable. Mortality and morbidity reviews (MMRs) provide a rigorous, systematic, open, collaborative and transparent review process for clinicians to examine areas of improvement. The aim of the present review was to explore the evidence for best practice when conducting MMRs.

Learning disabilities

[Medical Certificates of Cause of Death for people with intellectual disabilities: A systematic literature review.](#)

Dunwoodie Stirton, F. et al.

J Appl Res Intellect Disabil. 2018 Mar 24. doi: 10.1111/jar.12448. [Epub ahead of print]

Mortality studies can help reduce health inequalities by informing public policy through a better understanding of causes of death and comorbidities. Mortality studies often rely on Medical Certificates of Cause of Death (MCCD) for data. Concerns about the accuracy and reliability of MCCD for people with intellectual disability raise questions about mortality data based on MCCD. Clear guidance is required from WHO for those completing MCCD for people with intellectual disability.

[Early death and causes of death of people with intellectual disabilities: A systematic review.](#)

O'Leary, L. et al

government field health workers. The main purpose of SA is to enable community discussion and create awareness of the preventable causes of maternal or neonatal deaths.

[An exploratory analysis of the notable activities of U.S. child death review teams.](#)

Douglas, Emily M; Ahola, Sarah B; Proulx, Morgan L

Death studies; Apr 2018; vol. 42 (no. 4); p. 239-246

Child death review teams (CDRTs) focus on the prevention of child deaths, but a comprehensive understanding of their activities is lacking. This exploratory study addressed this gap through a qualitative analysis of reported CDRT activities using the "spectrum of prevention" framework. We collected state-level CDRT reports published 2006-2015, recorded their activities (n = 193), and coded them using the "spectrum of prevention" framework. The highest percentage (64.2%) of activities was categorized under "fostering coalitions and networks." We recommend that CDRTs increase their reporting of activities so others can better understand their potential impact on preventing child deaths.

[Implementing Statewide Severe Maternal Morbidity Review: The Illinois Experience](#)

Koch, A.R. et al

Journal of Public Health Management and Practice:

JPHMP 2018, 24 (5): 458-464

Severe maternal morbidity (SMM) rates in the United States more than doubled between 1998 and 2010.

Advanced maternal age and chronic comorbidities do not completely explain the increase in SMM or how to effectively address it. The Centers for Disease Control and Prevention and American College of Obstetricians and Gynecologists have called for facility-level multidisciplinary review of SMM for potential preventability and have issued implementation guidelines.

[Maternal Mortality in the United States: A Review of Contemporary Data and Their Limitations](#)

Creanga, A.A.

Clinical Obstetrics and Gynecology 2018, 61 (2): 296-306

This article provides a review of maternal mortality data and their limitations in the United States. National maternal mortality data, which rely heavily on vital statistics, document that the risk of death from pregnancy-related causes has not declined for >25 years and that striking racial disparities persist. State-based maternal mortality reviews, functional in many states, obtain detailed information on medical and

J Appl Res Intellect Disabil. 2018 May;31(3):325-342. doi: 10.1111/jar.12417. Epub 2017 Oct 6.
Death of people with intellectual disabilities is considered to be earlier than for the general population. Improved health care, including anticipatory care such as health checks, and initiatives addressing most relevant lifestyle behaviours and health risks are indicated.

[Causes of Mortality in Older People With Intellectual Disability: Results From the HA-ID Study.](#)

Oppewal, A. et al.

Am J Intellect Dev Disabil. 2018 Jan;123(1):61-71. doi: 10.1352/1944-7558-123.1.61.

We aim to provide insight into the cause-specific mortality of older adults with intellectual disability (ID), with and without Down syndrome (DS), and compare this to the general population. Immediate and primary cause of death were collected through medical files of 1,050 older adults with ID, 5 years after the start of the Healthy Ageing and Intellectual Disabilities (HA-ID) study. During the follow-up period, 207 (19.7%) participants died, of whom 54 (26.1%) had DS. Respiratory failure was the most common immediate cause of death (43.4%), followed by dehydration/malnutrition (20.8%), and cardiovascular diseases (9.4%). In adults with DS, the most common cause was respiratory disease (73.3%), infectious and bacterial diseases (4.4%), and diseases of the digestive system (4.4%). Diseases of the respiratory system also formed the largest group of primary causes of death (32.1%; 80.4% was due to pneumonia), followed by neoplasms (17.6%), and diseases of the circulatory system (8.2%). In adults with DS, the main primary cause was also respiratory diseases (51.1%), followed by dementia (22.2%).

[The Learning Disabilities Mortality Review Annual Report 2017](#)

HQIP. 2018

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017.

[Medical Certificates of Cause of Death for people with intellectual disabilities: A systematic literature review.](#)

Dunwoodie Stirton F; Heslop P

nonmedical factors contributing to maternal deaths. Without this detailed knowledge from state-level data and without addressing recognized quality problems with vital statistics data at the national-level, we will have difficulty understanding maternal death trends and preventing future such deaths.

[Reporting Fatal Neglect in Child Death Review](#)

Scott, D.

Trauma, Violence, & Abuse First Published April 26, 2018

Child death reviews are conducted with the aim of preventing child deaths however, definitions, inclusion criteria for the review of child deaths and reporting practices vary across Child Death Review Teams (CDRTs). This article aims to identify a common context and understanding of fatal neglect reporting by reviewing definitional issues of fatal neglect and comparing reporting practice across a number of CDRTs. Providing a consistent context for identifying and reporting neglect-related deaths may improve the understanding of the impact of fatal neglect and the risk factors associated with it and therefore, improve the potential of CDRT review to inform prevention programs, policies, and procedures.

[Severe Maternal Morbidity and Maternal Mortality: What Can be Learned From Reviewing Near Miss and Adverse Events?](#)

Simpson, K.R.

MCN: The American Journal of Maternal/Child

Nursing: July/August 2018 - Volume 43 - Issue 4 - p 240

Severe maternal morbidity and maternal mortality cases require thorough review by an interdisciplinary quality committee. Lessons learned can be used to enhance care and develop strategies for prevention of these types of adverse events.

[Death audits and reviews for reducing maternal, perinatal and child mortality](#) (protocol)

Willcox M.L et al.

Cochrane Database of Systematic Reviews; Mar 2018; vol. 2018 (no. 3)

This is a protocol for a Cochrane Review (Intervention). The objectives are as follows: To assess the impact and cost-effectiveness of different types of death review in reducing maternal, perinatal and child mortality

[Sudden unexpected death in infancy/childhood multidisciplinary simulation study day experience](#)

Beasley D.; Hildebrandt T.

Archives of Disease in Childhood; Mar 2018; vol. 103

Journal of applied research in intellectual disabilities :

JARID; Sep 2018; vol. 31 (no. 5); p. 659-668

BACKGROUND: Mortality studies can help reduce health inequalities by informing public policy through a better understanding of causes of death and comorbidities. Mortality studies often rely on Medical Certificates of Cause of Death (MCCD) for data. **CONCLUSIONS:** Concerns about the accuracy and reliability of MCCD for people with intellectual disability raise questions about mortality data based on MCCD. Clear guidance is required from WHO for those completing MCCD for people with intellectual disability.

[Multimorbidity and Polypharmacy Are Independently Associated With Mortality in Older People With Intellectual Disabilities: A 5-Year Follow-Up From the HA-ID Study.](#)

Schoufour, J.D. et al.

Am J Intellect Dev Disabil. 2018 Jan;123(1):72-82. doi: 10.1352/1944-7558-123.1.72.

We studied the association between multimorbidity, polypharmacy, and mortality in 1,050 older adults (50+) with intellectual disability (ID). Multimorbidity (presence of ≥ 4 chronic health conditions) and polypharmacy (presence ≥ 5 chronic medication prescriptions) were collected at baseline.

Multimorbidity included a wide range of disorders, including hearing impairment, thyroid dysfunction, autism, and cancer. Mortality data were collected during a 5-year follow-up period. We showed for the first time that multimorbidity and polypharmacy are strong predictors for mortality in people with ID. Awareness and screening of these conditions is important to start existing treatments as soon as possible. Future research is required to develop interventions for older people with ID, aiming to reduce the incidence of polypharmacy and multimorbidity.

Sudden unexpected death in infancy/childhood (SUDI/C) is rare but a tragedy for parents. Clinicians have often very limited experience in dealing with unexpected death in childhood. We designed a multidisciplinary simulation study day to equip senior paediatric trainees with knowledge and skills required to lead child death review process and support parents. **Method** The study day combined interactive lectures from multi-agency experts including police, social services, a community paediatrician and pathologist. This was followed by simulation of resuscitation, communication with parents and police as well as a simulation of a SUDI/C meeting. Actors were used to enhance fidelity. All participants (17) were required to fill in questionnaires pre and post study day attendance. **Results** Evaluation of pre-study day questionnaires confirmed lack of experience and knowledge about SUDI/C process. Post study day feedback was overwhelmingly positive in terms of credibility and usefulness. **Conclusion** There is a lack of knowledge and experience regarding SUDI/C amongst senior paediatric trainees. Multidisciplinary simulation is a useful tool to prepare senior trainees and junior consultants to deal with SUDI/C process effectively and sensitively. **Recommendation** We are currently in the process of organising a second study day open to a variety of professionals.

[The impact of the Helping Babies Survive program on neonatal outcomes and health provider skills: a systematic review.](#)

Dol, J. et al.

JBI Database System Rev Implement Rep. 2018 Mar;16(3):701-737. doi: 10.11124/JBISIR-2017-003535.

The objective of this review was to evaluate the impact of the Helping Babies Survive program on neonatal outcomes and healthcare provider knowledge and skills. Helping Babies Survive has a significant positive impact on early neonatal outcomes, including fresh stillbirth and first-day mortality primarily through Helping Babies Breathe, but limited conclusions can be drawn about its impact on other neonatal outcomes. While Helping Babies Survive was found to improve immediate knowledge and skill acquisition, there is some evidence that one-time training may not be sufficient for sustained knowledge or the incorporation of key skills related to resuscitation into clinical practice. Continued research on the sustained knowledge and skills is needed to evaluate the long-term impact of the Helping Babies Survive program.

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