

HOW TO CARE FOR YOUR TEAM WHEN AN OBSTETRIC DRAMA OCCURRED

- 19:00 Introduction: 3 years of BMM
- 19:15 A mother dies while giving birth
- 19:30 How to manage a life-threatening complication
(in a pregnant woman / woman giving birth)
- 20:05 Debriefing and feedback for critical incidents
- 20:40 First or second victim, who cares?
- 21:15 Closing remarks



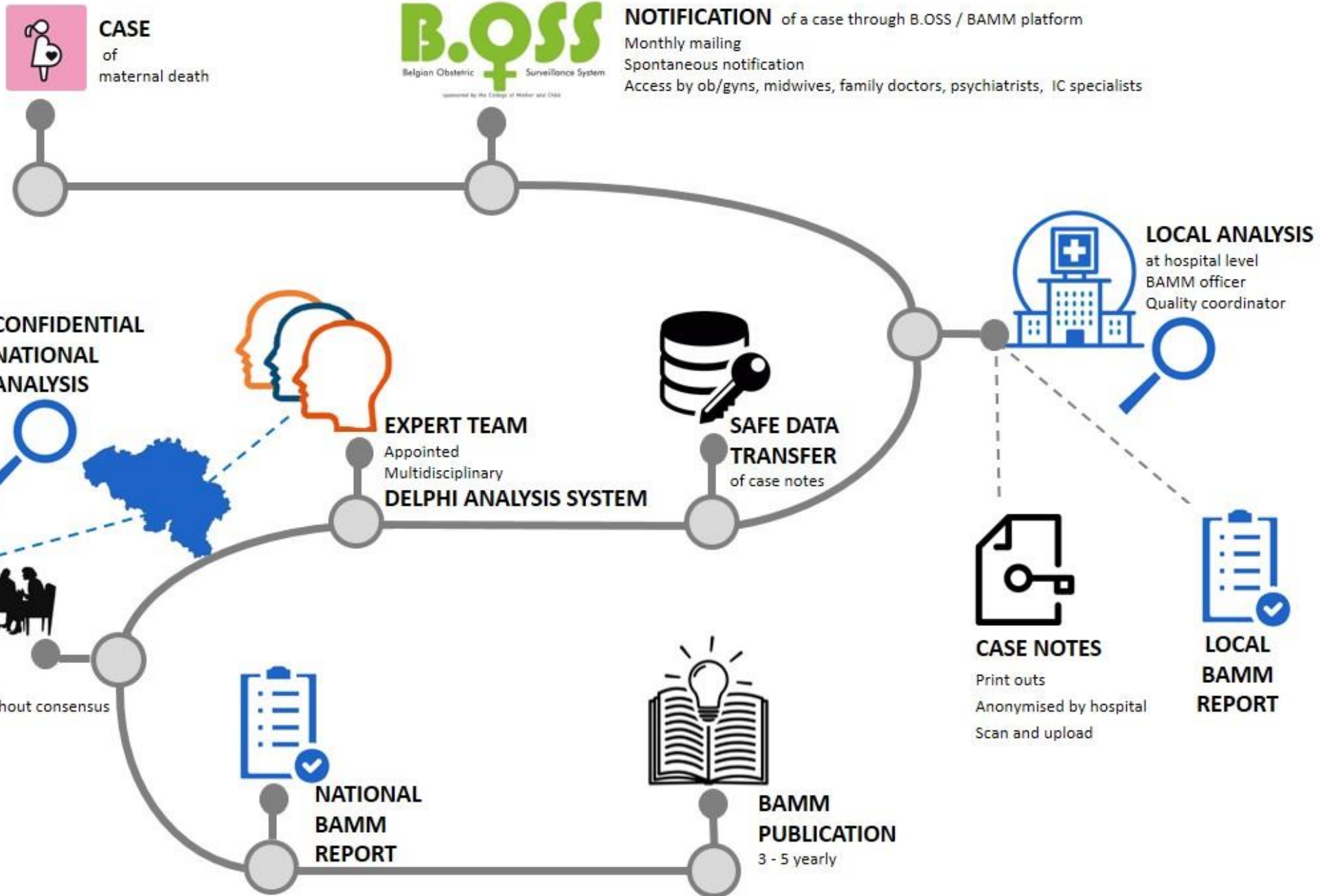
Introduction

3 years of BAMM

Dr. Griet Vandenberghe



a confidential
enhanced system
for the
registration and analysis
of maternal deaths
in Belgium
was launched in 2021





BAMMM

Belgian Analysis system for Maternal Mortality



**Health
Food Chain Safety
Environment**

Isabelle Van Der Bremt

Annemie Vlayen

Kelly Janssens



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Dr. Van Hoorick	Dr. J. De Keyser	Dr. P. Steenhaut	Dr. E. Van Obst	Dr. A. Lestrade	Dr. Y. Kacem	Dr. C. Eerdekens	Dr. B. Rombaut	Dr. N. Vanbelle
Dr. P. Cryns	Dr. C. Cayphas	Dr. K. Van Mulders	Dr. K. Vancalsteren	Dr. Waterschoot	S. Canonic	Dr. S. Dirx	Dr. V. Depauw	Dr. F. Michels
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Dr. J. Ackermans	J. Bogaerts	Dr. B. Thaler	Dr. J. Decoene	A. Boens	Dr. R. Loumaye	A. Batter	Dr. D. Mortier	Dr. M. Vandervorst
Dr. C. Gregoir	Dr. M. Bafort	Dr. K. Scharpé	E. Van Hoek	Dr. A. Laurent	S. Pochou	Dr. G. Palgen	Dr. K. Devolder	Dr. L. Claes
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Dr. P. Vanballaer	Dr. Petra Scheir	Dr. D. Van den Broecke	Dr. C. Riera	Dr. P. Baltus	Dr. A. Belliard	Dr. C. Delforge	Dr. E. Van Deynse	Dr. C. Lietaer
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Dr. A. Vercautere	Dr. F. Loumaye	Dr. J. Govaerts	Dr. M. Romain	E. Delforge	Dr. A. Corremans	Dr. Polisiou	N. Goormans	Dr. B. Moons
					Dr. D. Anton	Dr. J-F. Legrève		



GYNAECOLOGISTS

MIDWIVES

ANAESTHETISTS

PSYCHIATRISTS

CARDIOLOGISTS

INFECTIOLOGISTS

HEMATOLOGISTS

INTENSIVE CARE SPECIALISTS

EMERGENCY PHYSICIANS





BAMM TEAM

Caroline Daelemans

Julie Belhomme



Hilde Logghe

Lore Lannoo



Vincent Penesich



Karolien Benoit



Karolien Benoit



Marie Coussens

How many mothers died ?



BAMMM

Belgian Analysis system for Maternal Mortality

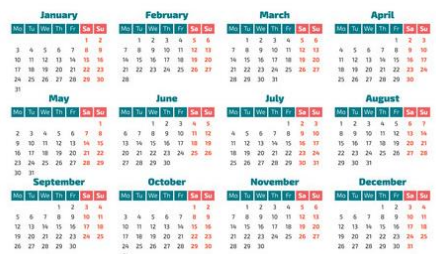
BAMMM

Belgian Analysis system for Maternal Mortality

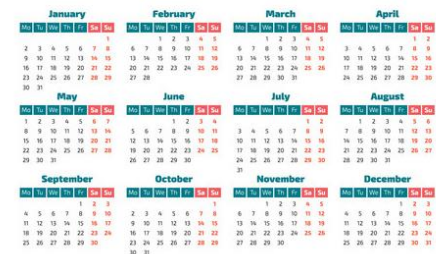
2021



2022

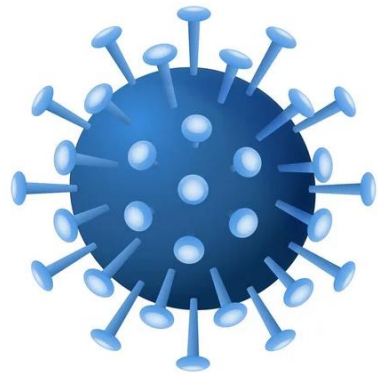


2023



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2021

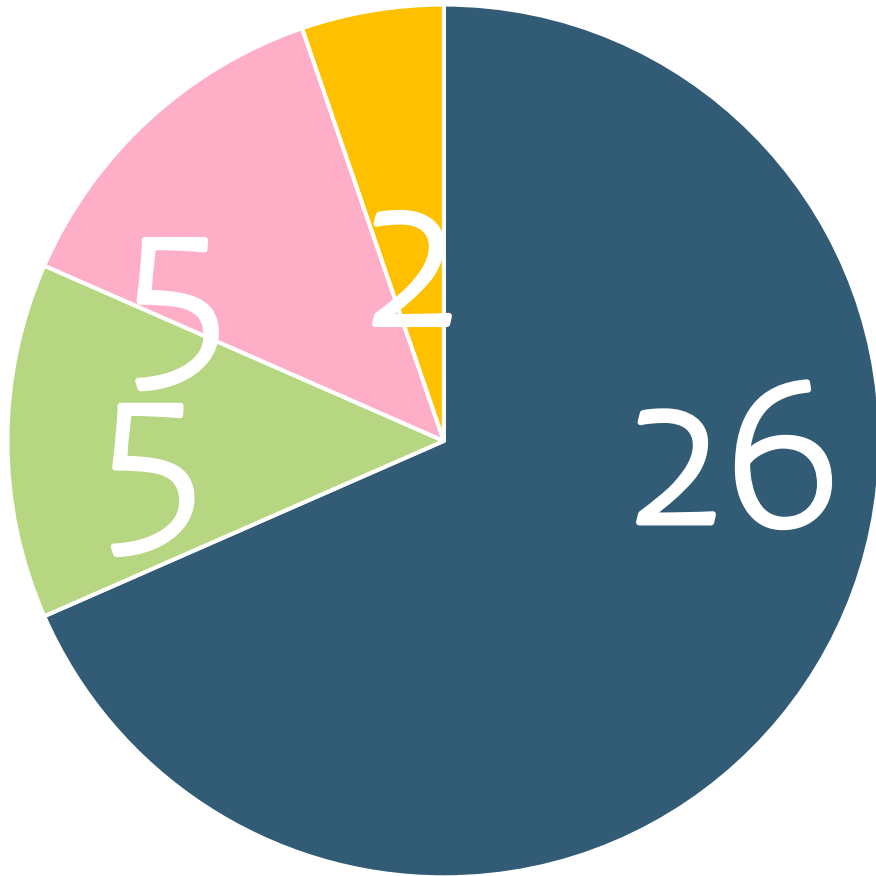


2022

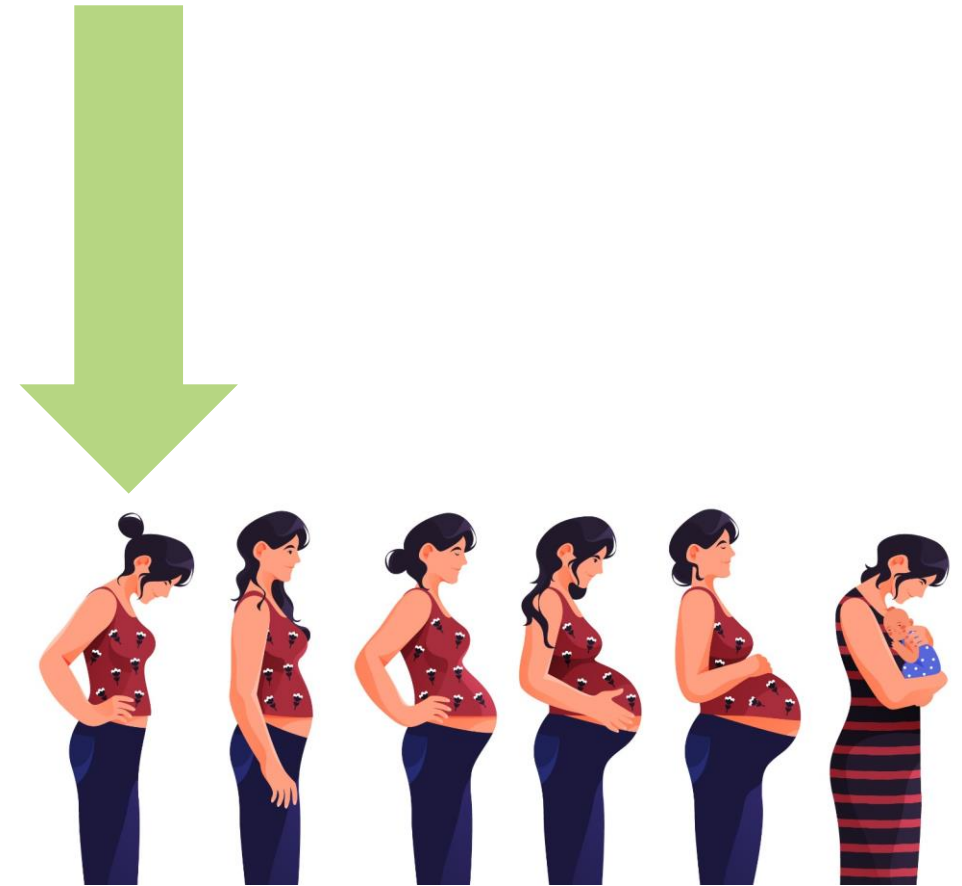
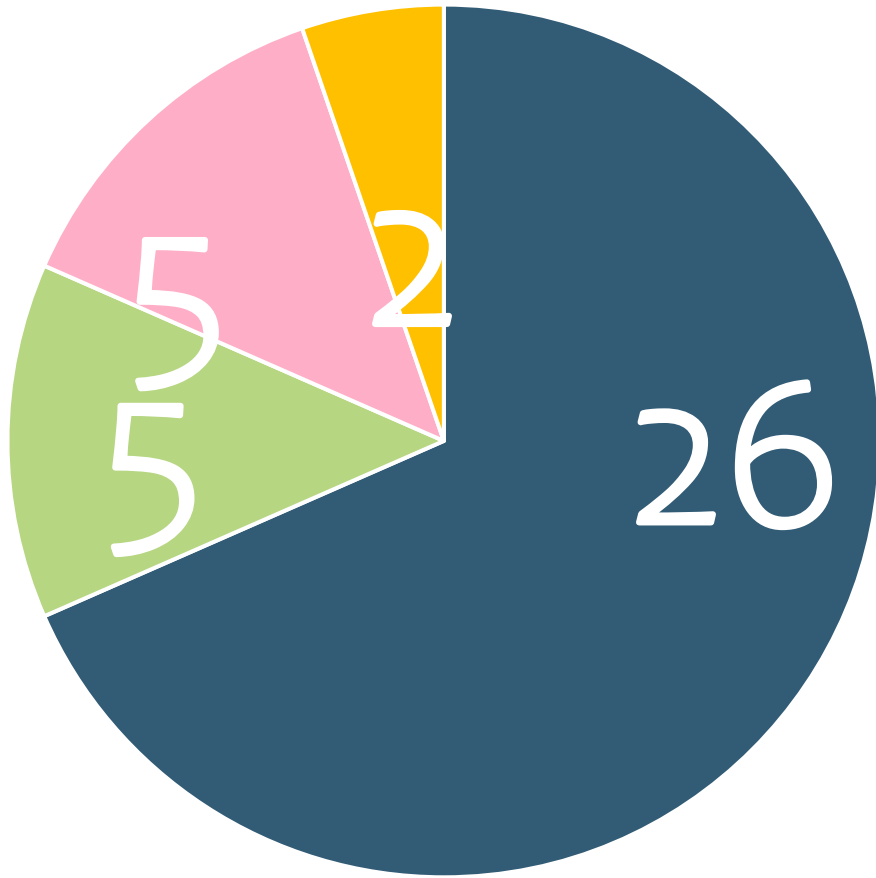


2023

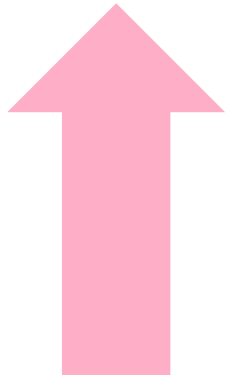
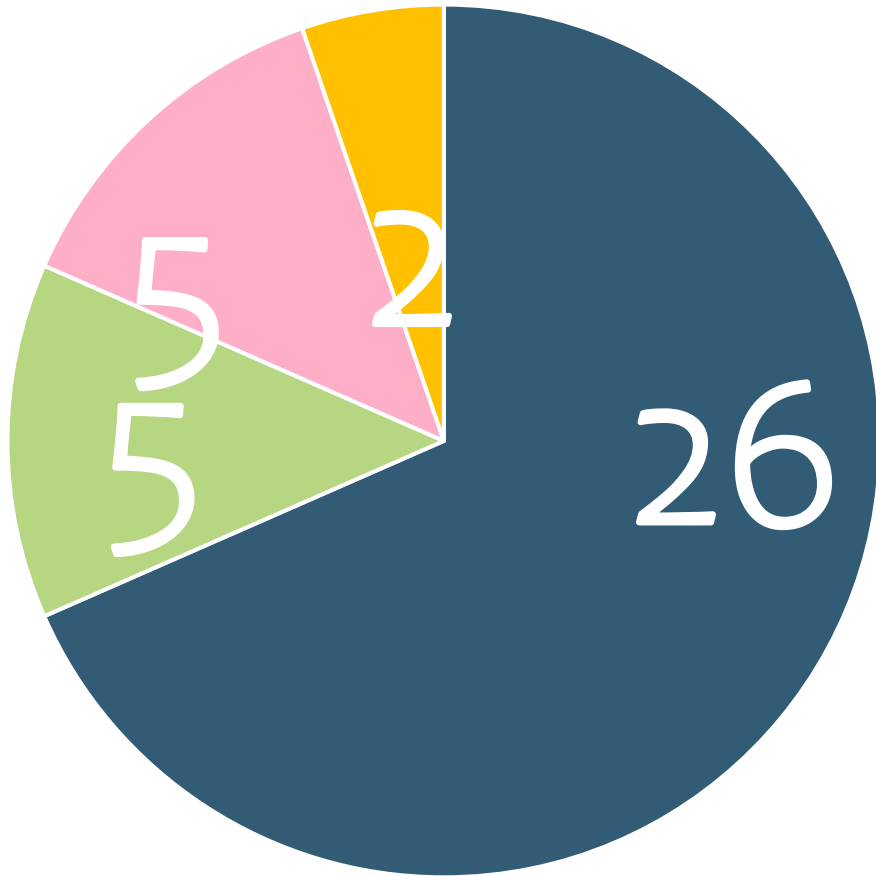




- Peripartum - 42 days
- First trimester



- Peripartum - 42 days
- First trimester



- Peripartum - 42 days
- First trimester

04 maart 2024

Zelfdoding bij jonge moeders belangrijkste oorzaak van moedersterfte

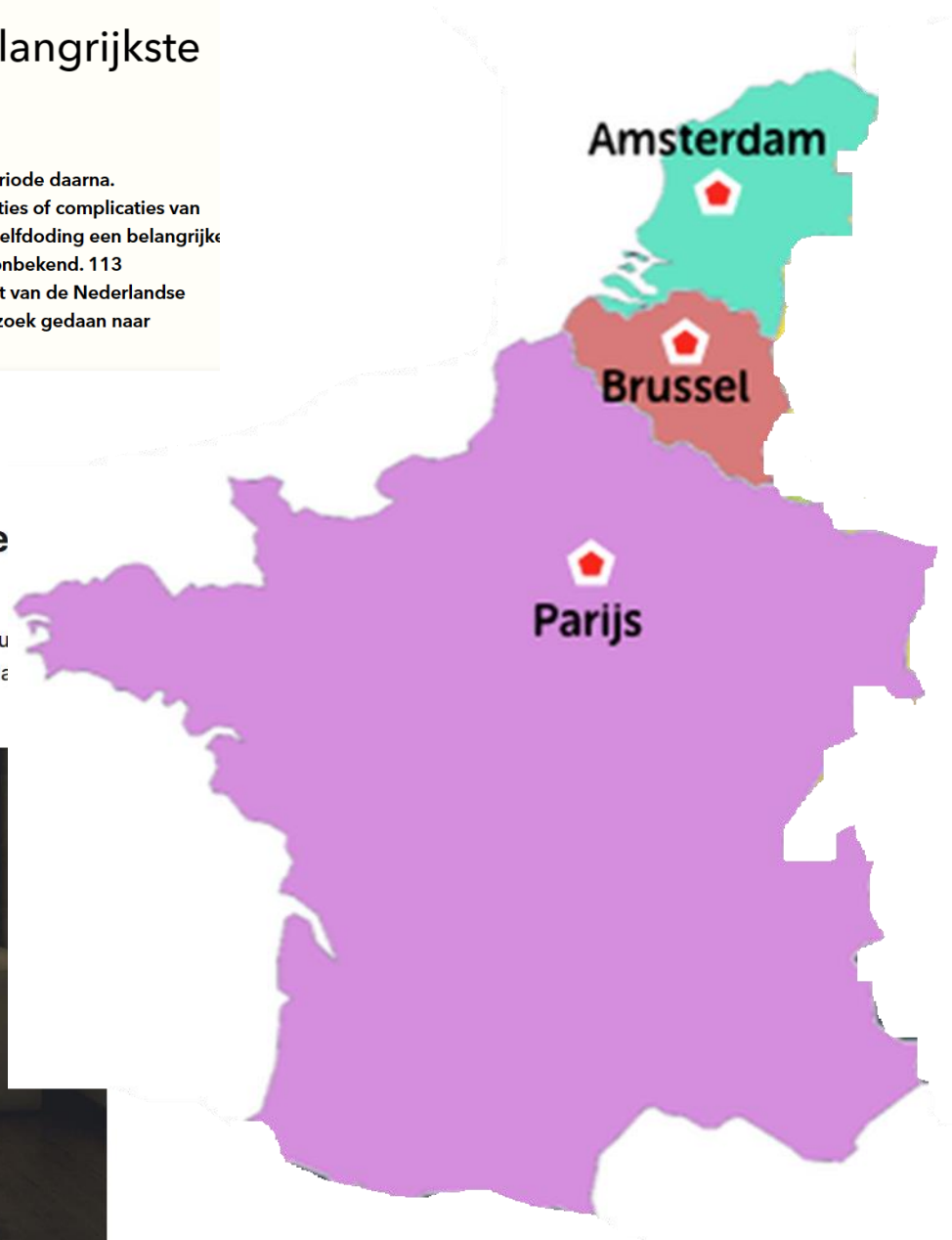
Wereldwijd sterven er vrouwen tijdens de zwangerschap of in de eerste periode daarna. Veelvoorkomende oorzaken van deze moedersterfte zijn bloedingen, infecties of complicaties van de bevalling. De afgelopen jaren werd in andere landen duidelijk dat ook zelfdoding een belangrijke oorzaak is van moedersterfte. In Nederland waren recente cijfers hierover onbekend. 113 Zelfmoordpreventie en de Auditcommissie Maternale Sterfte en Morbiditeit van de Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG) hebben recent onderzoek gedaan naar zelfdoding onder moeders in Nederland in de periode 2006 tot 2020.

Le suicide devient la première cause mortalité maternelle en France

Une étude de l'Inserm et de Santé publique France pointe que le suicide est désormais la première cause de mortalité des mères du début de la grossesse et pendant le post-partum.



En France, un décès a lieu tous les quatre jours d'une cause liée à la grossesse, à l'accouchement ou à leurs suites



RESEARCH ARTICLE | [Open Access](#) |

The contribution of suicide to maternal mortality: A nationwide population-based cohort study

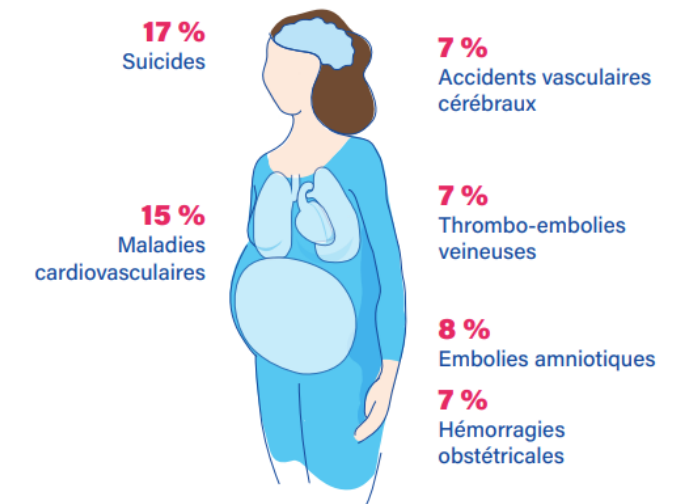
[This article relates to:](#)

Kinke M. Lommerse, Saskia Méréelle, Anna L. Rietveld, Guus Berkelmans, Thomas van den Akker, The Netherlands Audit Committee Maternal Mortality and Morbidity

First published: 12 February 2024 | <https://doi.org/10.1111/1471-0528.17784>



Principales causes des décès maternels (de la conception jusqu'à 1 an après l'accouchement)





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MZG
RHM

Triangulation of federal databases

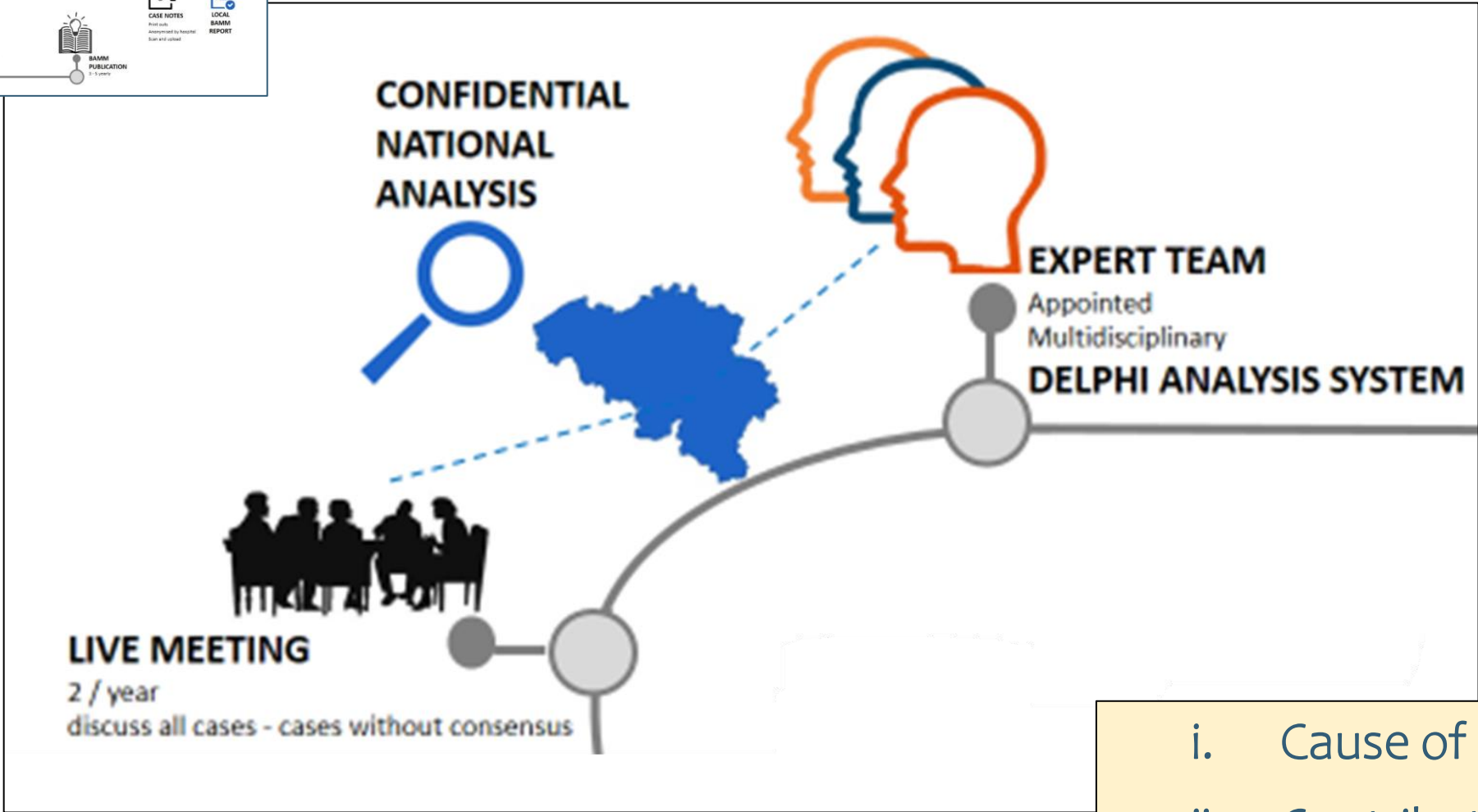
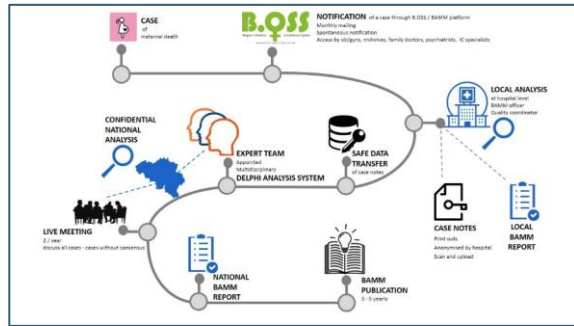
For the retrospective analysis of maternal mortality data

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Belgian Analysis system for Maternal Mortality

NO-BLAME approach

Why did these mothers die ?

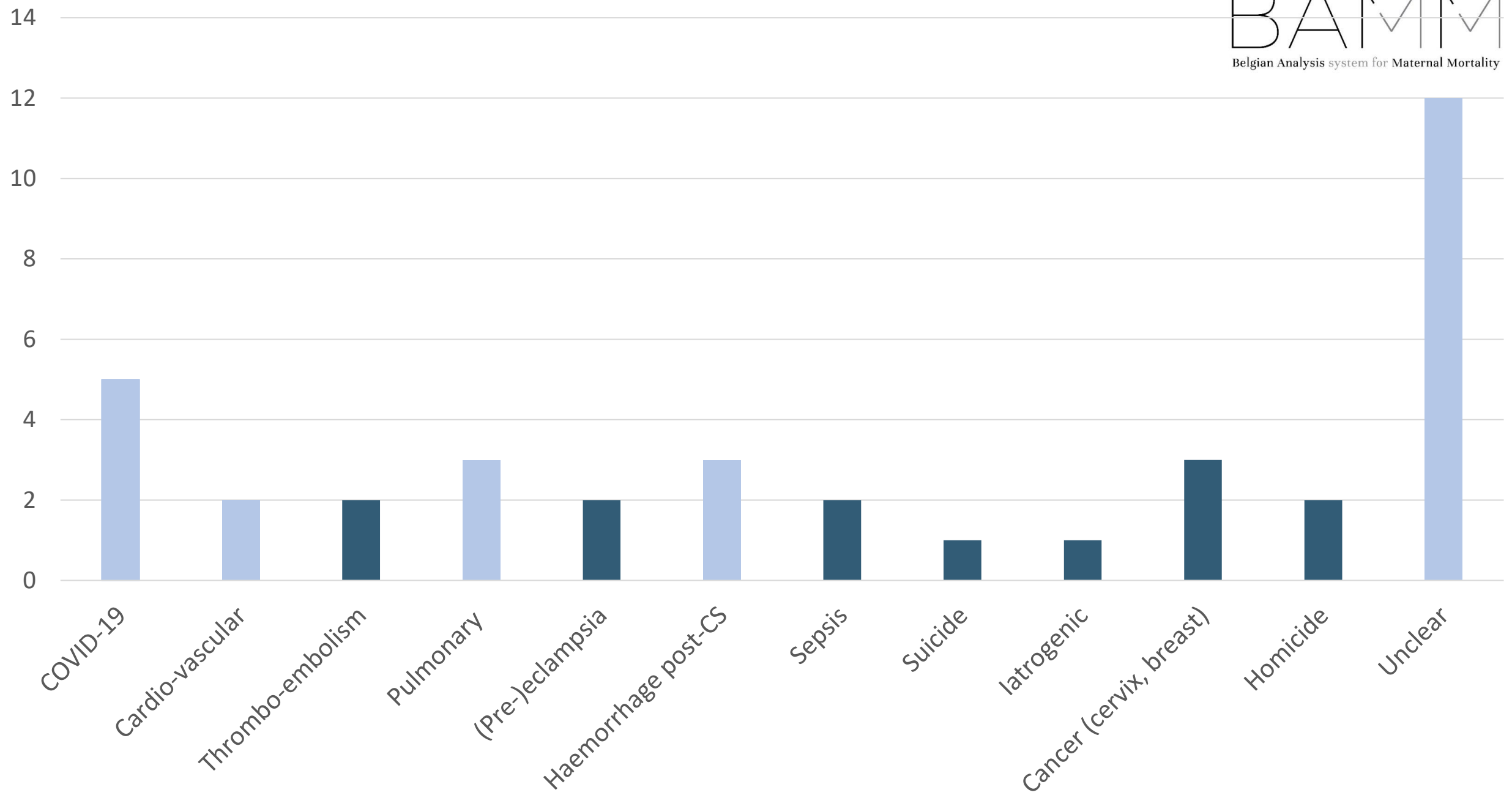


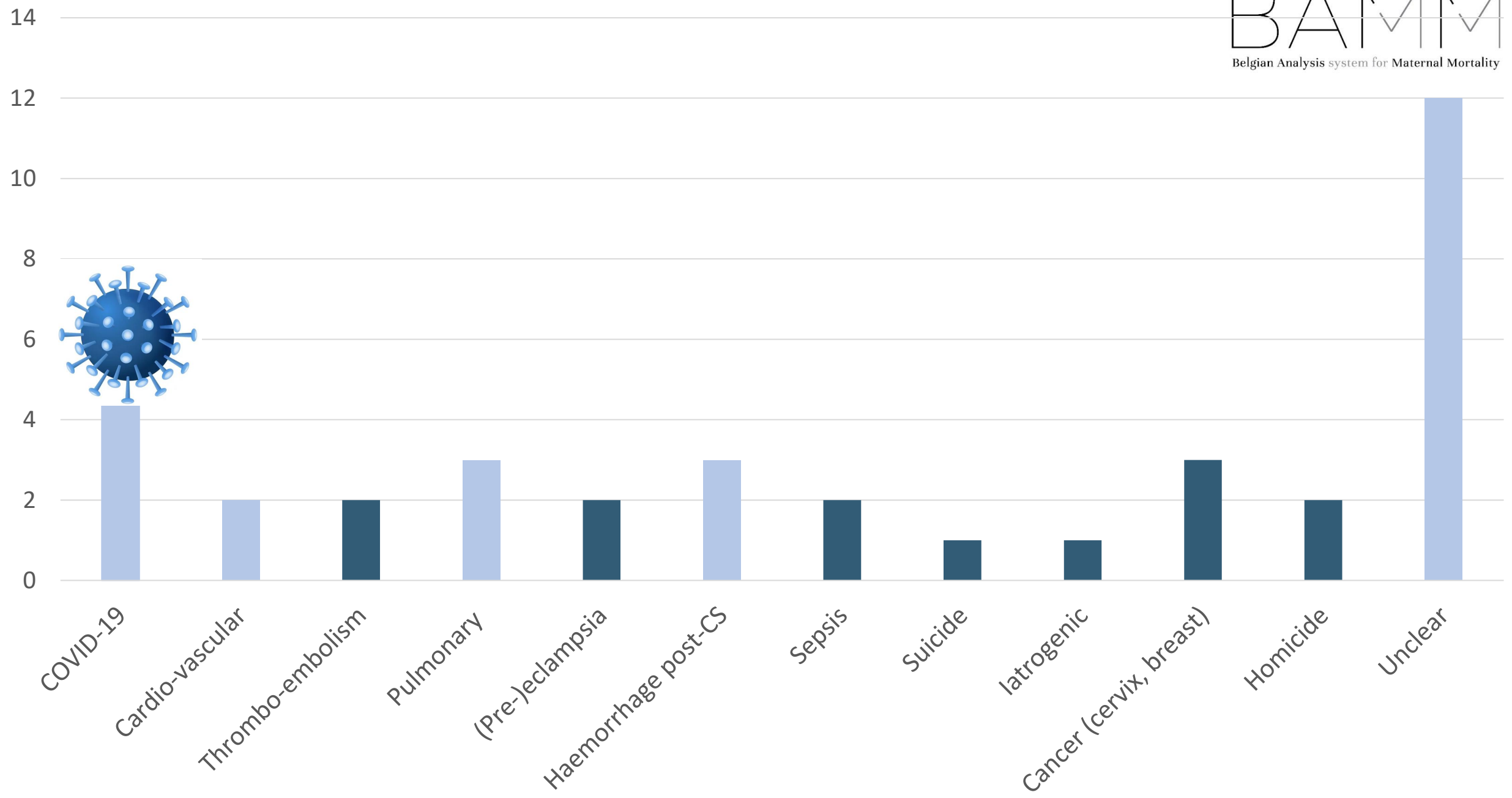
- i. Cause of death
- ii. Contributing factors
- iii. Recommendations

CURRENT STATE OF ANALYSIS OF CASES

38

Aware of	3
Local analysis in progress	9
On hold (juridical expertise)	2
Local analysis completed	2
National analysis in progress	3
National analysis completed	5
BAMM analysis complete, Feedback to be planned	10
BAMM analysis complete, Feedback given	4





What did we learn ?

Some recurring recommendations

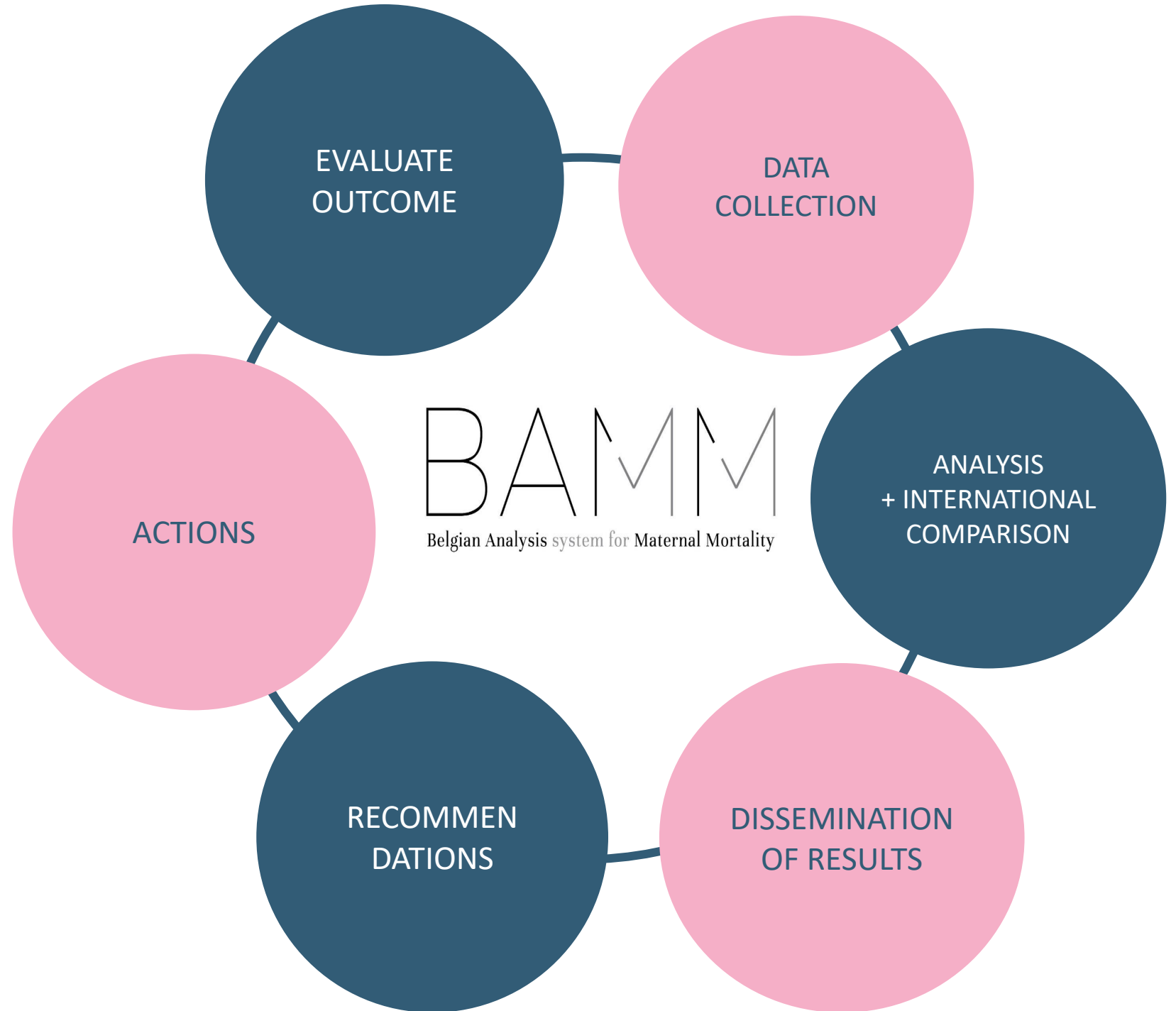
- Risk Stratification tools at intake / at admission
and organise obstetric care according to risk
- Implement Maternal Early Warning Scores
- Need for early multidisciplinary care : involve anaesthetists, IC specialists
- Need for a (national) Sepsis Awareness Campaign
- Strongly recommend autopsy in case of maternal death (make mandatory)

SEPSIS



SEPSIS
AWARENESS

ONLINE TRAINING
BASED ON BAMM
CASES



Conclusions

- BAMB is successfully launched in January 2021
- The BAMB methodology has improved with focus on LIVE expert meeting
- Strong, big multidisciplinary team of enthusiastic experts on a voluntary basis
- Need for better awareness of BAMB:
family doctors, IC specialist, emergency physicians, cardiologists, psychiatrists
- Cultural change
- Triangulation of vital databases