Midwives Alliance of West Virginia
Incident Review Procedures

Certain birth outcomes are considered reportable incidents by MAWV. All reportable incidents require automatic review according to one of the following options:

Incident Review Option 1:

Review the incident with 2 other midwives within 30 days of the incident. These must be 2 midwives who were not involved in the incident. The review can be done in person, via individual phone calls, conference calling, videoconferencing, or any combination of these. While preliminary information can be exchanged via e-mail, the incident review itself cannot be done via e-mail.

Affiliate members who choose option 1 must review the birth with at least one MAWV member, but can choose a second midwife from their own state organizations.

Incident Review Option 2:

Inform the membership within 30 days of the incident that an incident has occurred and that the incident will be reviewed at a case review session. The membership can be informed via the MAWV listserv.

The incident must be reviewed during one of the next 4 quarterly case review sessions or regional case review sessions. Incidents can be reviewed at regional meetings as long as there are at least 2 midwives present who were not directly involved in the incident.

In the event of political or legal repercussions: Inform the MAWV listserv about the incident regardless of which option is chosen for review. Details do not have to be shared on the listserv, but the midwife should let the membership know what kind of incident has occurred and which review option she has chosen. If she has already reviewed the incident with 2 other midwives, that information should be shared with the listserv. The midwife or other MAWV members may also request a peer review so that MAWV can officially review the birth and be ready to issue an official statement about it if necessary. (see peer review procedures).

Incident review documentation: Use the incident review log, located on the back side of the yearly summary report to document all reportable incidents and when they were reviewed. This log plus the yearly summary report should be sent to the treasurer by April 30th of the following year.

Reportable incidents:

- Intrapartum transfer of care
- Maternal mortality
- Maternal shock
- Uterine rupture
- Infant seizure w/in 72 hrs
- Infant mortality
- Admission to NICU
- Transfer of care within 72 hours after birth
- Maternal seizure w/in 72 hrs
- Maternal sepsis w/in 72 hrs
- Uterine inversion
- Infant sepsis w/in 72 hrs
- Apgar < 7 at 5 min