

**Perinatal and Maternal Mortality Review Committee
(PMMRC)
Minutes of meeting held Friday 5 August 2005**

Meeting held:	Miramar Links Conference and Function Centre
In Attendance:	Cynthia Farquhar (CF), Jacqueline Anderson (JA), Vicki Culling (VC), Dawn Elder (DE), Deborah Harris (DH), Elisapeta Karalus (EK), Lesley McCowan (LM), Stephanie Palmer (SP), Mollie Wilson (MW), Jane Zuccollo (JZ)
Apologies	None
Guests:	Pat Tuohy (PT)
Secretariat:	Gillian Bohm (GB), Angie Perry (AP)

Agenda Items	Summary of discussion & decisions
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Meeting Commenced	9:30 am
1. Welcome	
2. Introductions	Meeting participants introduced themselves and provided a short overview of their skills, experience and why they wanted to take part in the committee.
3. Setting up Perinatal Mortality Review – Dr Pat Tuohy	<p>PT presented to the group an overview of the history of perinatal and maternal mortality review and current knowledge of maternal and perinatal mortality in New Zealand. PT provided a number of graphical examples of data and commented that there seemed to be a significant relationship between deprivation level and stillbirth. PT also highlighted that the potential for the most improvement is in the older gestational age group.</p> <p>PT provided information on the current local and national databases collecting data relating to perinatal and maternal mortality and commented on their usefulness. The Australia and New Zealand Neonatal Network (ANZNN) database may be of limited use, as it does not contain every baby or record stillbirth/foetal deaths.</p> <p>The national New Zealand Health Information Service (NZHIS) databases are improving, although currently the recording of gravida is poor. The diagnostic coding is also improving. The best national database currently is from the Maternity and Newborn Information System (MNIS).</p>

	<p>Regionally, some DHBs use a package called Healthware. PT considered Healthware was capable of being a virtual national database. All except two tertiary hospitals currently use this package.</p> <p>PT gave a summary of the Child and Youth Mortality Review Committee's dataset and the various data sources. PT highlighted that the data was almost contemporaneous, which had enormous potential from a public health perspective.</p> <p>Discussion over maternal information and PMMRC. CF highlighted that the review of maternal deaths needed a timeframe established. Some discussion required as to whether all indirect maternal deaths should be excluded from PMMRC review (for example, should suicide be included).</p> <p>DE raised concerns over the clinical input into the NZHIS datasets and queried the input into the latest report on maternity. The Report on Maternity 2003 is currently in draft. PT will investigate obtaining a copy of the draft report for the group .</p> <p>CF raised the lack of reliable ethnicity data. GB advised that training packages and brochures had been distributed to DHBs in an effort to improve this. LM highlighted that it was inappropriate to code certain groups together, such as Chinese and Indian or all the Pacific Islands, as this masks different rates within these groups.</p>
<p>4. Committee Handbook</p>	<p>AP introduced the committee handbook and provided some commentary on each of the areas covered in the handbook.</p> <p>Action: Secretariat to confirm whether an electronic signature is acceptable on the fee claim form and whether the IR330 form needs to be completed if the committee member's organisation is claiming the fee.</p>
<p>5. Implementing the Terms of Reference</p>	<p>CF opened discussion on the terms of reference by commenting that they placed PMMRC within a quality framework.</p> <p>LM commented that there is a close link between stillbirths and near misses and that there is a missed opportunity if hypoxic-ischaemic encephalopathy (HIE) is not recorded - could this be considered by the committee in the future. JA also commented that maternal mortality near misses, although not strictly part of PMMRC's brief, would also be useful.</p> <p>DE highlighted the need to start from the beginning – to obtain good data on each death. The group discussed the different forms of data collection, such as the PSANZ form, section 88 notices, local databases and the death certificate.</p> <p>Action: Secretariat to investigate with NZHIS what changes are being made to the death certificate.</p> <p>Action: Secretariat to provide the committee with a copy of the current death certificate.</p>

	<p>The group discussed the issue of autopsy. Discussion included the possibility of PMMRC making recommendations regarding the scarcity of perinatal pathologists in NZ, the differing feelings regarding autopsy and tissue samples. It was acknowledged that education and understanding of what an autopsy means (ie: why autopsy, what occurs, the benefits for families, for clinicians etc) is important and that advice provided to families should be simple and understandable. Cultural differences were also raised, such as the importance in many cultures for a person to be buried whole.</p> <p>Education of lead maternity carers on autopsy was raised, as they cannot advise families appropriately if they do not understand the process fully themselves. Development of a training package for lead maternity carers was suggested.</p> <p>VC had devised a set of questions for the committee that needed thought: What data do we have? What are the gaps? What will the picture be when we fill the gaps? How do we ensure that we are an effective committee? How will we know that we are effective? GB advised that the committee will be expected to develop a workplan next year and that some of these questions will be important for this.</p>
<p>6. Introduction to Quickplace</p>	<p>AP introduced the committee to the PMMRC Quickplace site, a password protected internet site set up for the Committee. Quickplace will allow the Committee to exchange information quickly and securely.</p> <p>AP advised that Quickplace is used to send agendas, meeting papers and minutes. It also has a library section and a section for documents that the committee is currently working on.</p> <p>AP demonstrated how to access, navigate and use the Quickplace site and highlighted the Secretariat are available to help with any queries about using Quickplace.</p>
<p>7. Mortality Review</p>	<p>a) Gillian Bohm – Principal Advisor, Quality Improvement and Audit, Ministry of Health</p> <p>GB presented an overview of mortality review in New Zealand and the current project to develop a national framework for mortality review.</p> <p>GB advised she has begun to engage the relevant Colleges about establishing a third mortality review committee. This committee, currently named the Adult Mortality Review Committee, will cover peri-operative and unexpected medical deaths.</p> <p>GB advised the College of Surgeons wish to review all surgical deaths, therefore there is a potential for review cross-over with the Perinatal and Maternal and Child and Youth Mortality Review Committees. A mechanism to enable this will need to be agreed between the three committees.</p>

DE commented that regional mortality review co-ordinators are often undertaking this work in addition to clinical duties, therefore may not have the time required for the role. GB advised that this issue was being addressed, however the needs of each DHB differed. DHBs needed to ensure the resources were available for quality assurance activities, including mortality review.

b) Professor Barry Taylor – Chair, Child and Youth Mortality Review Committee (CYMRC)

BT presented an overview of the Child and Youth Mortality Review Committee and Service Specific Mortality Review. He explained that the national committee has a set of government and non-government advisors who attend CYMRC meetings. The advisors are from Police, Coroners, Child Youth and Family, Ministry of Education, Ministry of Health (Mental Health) and Ministry of Youth Affairs. CYMRC also has a number of 'agents', who are appointed by the Chair of CYMRC to collect information for the national committee. These agents review cases at the local level and develop recommendations that are reviewed by the national committee. Each regional group of agents has a co-ordinating agent.

Some issues have arisen, such as that agents cannot case conference. There is also some debate between government departments (who have staff participating as agents) whether a group of agents can meet to discuss cases. This issue is currently being explored and clarified.

BT advised the CYMRC have developed a brochure for bereaved families explaining the role of CYMRC. CYMRC are also developing a web based feedback form to allow families to contribute to the review process.

Action: AP to send a copy of the CYMRC information brochure to the Committee members.


BT explained the CYMRC database and the various data sources (such as Births, Deaths and Marriages, NZHIS, Police, Land Transport Safety Agency etc). The database has oversight by a data group. Local co-ordinators access the database to add information and include recommendations. The data is much more timely than any other sources.

BT commented on some issues for PMMRC to consider:

- CYMRC are interested in the first month of life also, discussion to explore options for joint review required.
- It would be advantageous to have the Perinatal/Maternal and Child and Youth Local Mortality Review Co-ordinators as the same person.
- Advisors to the CYMRC could be broadened to become advisors to the mortality review committees.

	<p>Discussion by the group over the differences between PMMRC and CYMRC. It was proposed a rapid reporting form could be developed for completion by the lead maternity carer/clinician. This would feed into a national database.</p>
<p>8. Where do we go from here?</p>	<p>CF presented her thoughts on what was possible for PMMRC, which included the development of a rapid reporting form, evaluation and piloting of the PSANZ form and establishment of local co-ordinators. CF highlighted the options for a database, including development of a new database, expansion of the CYMRC database or utilisation of other existing databases.</p> <p>On discussion, it was suggested that 'education of care providers' and 'development of an information brochure on the committee' be included on the list of what is possible.</p> <p>JA asked about maternal deaths. LM suggested starting with analysis of the last ten years of maternal death data. GB advised NZHIS could provide this information. To enable this, a query will need to be drafted of the relevant ICD codes and submitted to GB. GB will then approach NZHIS to get a costing.</p> <p>The group discussed the possibility of using the PSANZ forms as the data source. CF advised she had asked the permission of PSANZ to modify the form for New Zealand.</p> <p>CF suggested that a system to collect data could be implemented by January 2006. The group discussed this timeframe. Concerns were raised at the short timeframe and importance of consultation and buy-in raised.</p> <p>Consultation and communication discussed. It was also suggested a letter be drafted to DHB CEOs/ Funding and Planning Managers outlining what PMMRC were trying to achieve and highlighting the need to identify local co-ordinators.</p> <p>CF suggested having a national meeting for local review co-ordinators and Chairs (both obstetric and neonatal) to discuss the process.</p> <p>JA highlighted that currently midwives in the community are not actively part of hospital mortality review processes. There were however forums to engage midwives and JA could lead this.</p> <p>The group considered a mid 2006 timeframe for beginning data collection was possible, with the committee consulting with the sector and planning the meeting with local co-coordinators before this.</p> <p>Agreed: PSANZ forms to be reviewed by a group consisting of LM, DH, DE and CF. Following the review, a pilot will be undertaken by committee members' groups (DE, LM, DH, possibility of Christchurch).</p> <p>Action: Secretariat to organise a teleconference of the PSANZ review group.</p> <p>Action: Secretariat to draft PMMRC introductory letter to DHB CEOs.</p>

9. Next Meeting	Suggested dates of Friday 4 November or Friday 11 November 2005. Action: Secretariat to ascertain the date that is most suitable.
Meeting closed	4:30 pm

Minutes approved	Signature:  Date: 11 / 11 / 05
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