

PMMRC

Perinatal and Maternal Mortality Review Committee

Guidelines for the completion of the mother and baby forms following a perinatal death

January 2009 Version 5

Introduction

What is the Perinatal and Maternal Mortality Review Committee?

The Perinatal and Maternal Mortality Review Committee (PMMRC) is a Ministerial Committee set up under the New Zealand Public Health and Disability Act 2000 (NZPHDA). The PMMRC was established by the Minister of Health in June 2005. For more information please see the PMMRC website (<http://www.PMMRC.health.nz>)

The PMMRC is responsible for reviewing:

a) Perinatal deaths

Perinatal deaths are defined as deaths occurring from 20 weeks gestation (ie: $\geq 20^0$, or a birth weight or ≥ 400 grams if gestation is unknown) to 28 completed days after birth (ie: up to midnight on the 27th day).

b) Maternal deaths

The PMMRC definition of a maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy (*delivery*), irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management. The review of maternal deaths commenced in 2006. Please advise your PMMRC Local Coordinator if a maternal death has occurred.

Why do the PMMRC want to collect this information?

The PMMRC's primary function is to review and report to the Minister on perinatal and maternal deaths in New Zealand, with a view to reducing the number of preventable deaths.

In order to do this, the PMMRC needs more in depth information than is currently collected through national data collections. The PMMRC has developed two reporting forms on perinatal deaths. One form focuses on the baby who died (if more than one baby dies a separate form will be needed for each baby), while the other focuses on the mother of the baby. Both forms will provide comprehensive information on each perinatal death in New Zealand.

After submission of the data, a National Coordinator will inform the Local Coordinator of the perinatal death. A local multidisciplinary meeting will be held and eventually all the national information will be collated into a national annual report. In the Annual Report the PMMRC will be able to make evidence based recommendations to the Minister on systemic improvements, based on the review of individual cases and aggregate information.

Confidentiality of information

The information provided in these forms is confidential. Section 5 of the New Zealand Public Health and Disability (NZPHD) Act, 2000 allows the PMMRC to request this information.

The NZPHD Act prohibits the disclosure of any personal information except in very rare and specific circumstances (Section 18 of part 2 of the NZPHDA and section 6 of schedule 5 of the NZPHDA refers, copies of which are included in Appendix A).

Publicly available information on perinatal deaths published by the PMMRC will be grouped and will be non-identifiable.

When to complete the forms

The forms should be completed for any baby death where the baby was born from 20 weeks gestation (ie: from $\geq 20^0$, or a birth weight of ≥ 400 grams if gestation is unknown), including legal abortions, and each baby born alive but dying before 28 completed days of life.

While the maternal form should be completed once, the reporting form for a perinatal death should be completed for each perinatal death that has occurred (ie: in cases of multiple births)

Who should complete the forms?

Any clinician who has the information such as the Lead Maternity Carer. It may be that one clinician is able to fill out the form on the mother and then another clinician e.g., a Neonatal Nurse, fills out the form on the baby.

How do we fill out a form on the computer?

Log on to the database www.pmmrc.otago.ac.nz

Each DHB will have a separate username and password, even if you do not work for the DHB you can use the password of the local DHB where the death occurred.

For this DHB the password is:

and the username is:

If the boxes above have not been filled out you can find out the username and password for your DHB by contacting your Local Coordinator (see list at back of this booklet), the National Coordinator, the Mortality Review Data Group or the Ministry of Health Secretariat:

National Coordinator – see appendix Data Group (Mon-Fri, 9-5) 09 373 7599 ext 84440

Ministry of Health Secretariat (Mon-Fri, 9-5) 04 470 8773

Once you log on to the site using the DHB username and DHB password. You will be asked to record your name, your professional group (e.g., nurse, midwife, doctor), your DHB and provide a means to contact you on Monday-Friday between 9am and 5pm (phone number and email) so that the Local or National PMMRC Co-coordinator can contact you if they have any questions. **You will be given a Registration ID number – please make a note of this and use it each time you log in.** If you forget your Registration ID number you can email the Mortality Data Group through the www.pmmrc.otago.ac.nz and your Registration ID will be sent to you.

How can I get a paper version of the form?

Wherever possible the data should be entered into the website but this is not possible, there are paper forms available. Local Co-coordinators will have copies of the forms or you can email pmmrc@moh.govt.nz or phone (04)470 8773 to request a form. The paper forms can be sent to:-

National Coordinator
PMMRC
Department of Obstetrics and Gynaecology
University of Auckland
Private Bag 92019
AUCKLAND 1020
Fax 09 303 5969

Can I go back to the form and add or change information or correct mistakes?

Yes the system does now allow you to do this. If you have not entered all the details and wish to return to the form later tick SAVE. **DO NOT** tick COMPLETE. Later when you enter your Registration ID the uncompleted forms will be in the INCOMPLETE FORM section.

(You may also contact the Local Coordinator or the National Coordinator and inform them of the additional information or the information you want to change.)

Can different people fill out the same form?

No, on the web one person needs to be responsible for completing the form. The DHB where the baby dies should either get the information about the mother and enter it or send the Mother Form to the Lead Maternity Carer (LMC) for them to complete. The Local or National Coordinator may contact the relevant clinicians to find out any missing information.

Will I be able to print off a copy of the form and put it in the clinical notes?

Yes. PRINT the form before you TICK SAVE or COMPLETE.

Will there be changes to the system?

Yes if there are some functions that need to be enhanced.

Evaluation of the data collection process

If you have any suggestions for improving the data collection process, or you notice anything is wrong do please contact us on pmmrc@moh.govt.nz.

Some things you need to be aware of:

- **Always start the Mother Form first.**

- **Question 1 and Question 2 on the Mother Form are compulsory.** They **must** be completed even if you have no other information on the Mother. This will then create the baby/babies forms.

- **Some of the questions are programmed to link to other questions.**

You are asked a main question and if you tick that main question then you will be able to select the list under it eg. You can see this in Q28, if you select that the mother did use medication you are then able to select from a list of commonly used medications. If you answer “no” or “unknown” you are not able to select these medications.

- **The website will “time out” after 30 minutes.**

If you are called away select SAVE, when you are able to return to the form enter your Registration ID and the uncompleted forms will be in the INCOMPLETE FORM section.

PMMRC Rapid Reporting Form for a Perinatal Death – Mother

The table below explains how to complete each section of the form. Definitions are included with the explanation for each section.

Questions	Explanation
<p>1 How many perinatal losses are linked to this pregnancy</p>	<p>This will then generate separate baby forms for each baby that died and link the mother information you are about to enter to each form.</p> <p>This is a compulsory field</p>
<p>2 Mother's NHI.</p>	<p>We understand that you may not know the answer to some of the questions that follow but this information is required to generate the Baby Form/s. the Mothers NHI is usually found on the Newborn Record</p> <p>This is a compulsory field</p>
<p>3- 5 Personal details</p>	<p>National Health Index (NHI) numbers are not yet issued to stillborn babies in every DHB. NZHIS will allocate an NHI when they receive notification of the stillbirth in the death report from Births, Deaths & Marriages, and Internal Affairs.</p> <p>Enter the personal details of the mother, please give any other names that the mother may be known under to make tracking records easier (the address is required to calculate the deprivation index).</p> <p>A "rapid number" is a rural property number.</p> <p>Postcodes will be required shortly.</p>
<p>6 Ethnicity</p> <p>(Amended from: Ministry of Health. 2004. <i>Ethnicity Data Protocols for the Health and Disability Sector</i>. Wellington: Ministry of Health. p.10)</p>	<p>Deceased</p> <p>Where the respondent is deceased, the standard question should be presented to the next of kin to provide a proxy response regarding the respondent's ethnicity.</p> <p>Newborns</p> <p>Where the respondents are newborns or children, the parent(s) should always be given the opportunity to complete the ethnicity question. Systems should not, for example, default ethnicity to that of the mother. It is also useful to collect the ethnicity of both the mother and father of the child.</p> <p>This should be as the mother identifies.</p>

<p>7 Maternal height and weight</p>	<p>a) Document the mother's height in centimetres (if height not previously measured, please measure now).</p> <p>b) Document the mother's weight in kilograms. This weight should be the earliest measured in pregnancy. If no early pregnancy weight is available, enter current weight.</p> <p>The height and weight will be used to calculate the Body Mass Index (BMI) of the mother. The maternal height and weight is essential to complete a customised birth weight for the baby.</p>
<p>8 Past obstetric history</p>	<p>Enter number of previous pregnancies. Then select Obs History</p> <p>List the details of all the mother's past pregnancies and their outcome. This includes miscarriages and terminations. If there is any further information on past pregnancies that is of relevance, include this information in the summary section at the end of the form. For example, if a previous baby had a congenital abnormality, was stillborn, or died in the neonatal period, provide further details. The place of birth is also important, as things are different from country to country. If the exact date is not known please enter the year only as a minimum.</p> <p>Abbreviations Pregnancy Outcome LB = Live born SM = spontaneous miscarriage TOP = termination of pregnancy E = ectopic pregnancy SB = stillbirth END = early neonatal death (<7 days age) LND = late neonatal death (7 days – 28 days) Death >28/7= Death 28 days – 24 years U = unknown</p> <p>Method of Delivery NVD = Normal vaginal delivery OV = Operative vaginal delivery VB = Vaginal breech CS = Caesarean Section</p> <p>Complications NIL = No complications HE = hyperemesis APH = Ante partum haemorrhage/Abruption CxS = cervical stitch PP = Placenta praevia GDM = Gestational diabetes PET = Pre eclampsia Other = please not in summary</p>

	<p><u>Miscarriage</u>: fetal loss before 20 weeks. If there was previous late miscarriage (after 12 weeks), provide details in the summary at end of the form.</p> <p><u>Termination of Pregnancy</u>: any gestation</p> <p><u>Ectopic pregnancy</u>: Pregnancy outside the uterus</p> <p><u>Molar Pregnancy</u>: diagnosis confirmed by histology.</p> <p><u>Stillbirth</u>: Intrauterine death after 20 weeks or if gestation is unknown and birth weight is greater than 400gms.</p> <p><u>Neonatal death</u>: death in first 28 days of life (i.e.: death up to midnight on the 27th day of life)</p> <ul style="list-style-type: none"> • Early Neonatal Death: a death less than 7 days of life • Late Neonatal Death: a death from 7days and up to midnight on the 27th day of life <p><u>Death over 28 days</u>: includes both –</p> <p>Post -neonatal death: death between 28 days and before the first year of life is completed and</p> <p>Child /Youth Death: death in childhood after the first year of life and up to 24 years.</p>
The following questions relate to this pregnancy only	
9 Family violence enquiry	Indicate whether the mother was asked about any violence against her by family members. If asked, indicate the response to this enquiry.
10 History of infertility	<p>Has the mother had a history of infertility for > 12 months preceding this pregnancy? ie: where <u>regular</u> intercourse has been occurring and conception has not occurred over a period > 12 months preceding this pregnancy.</p> <p>Do not include infertility which preceded other pregnancies.</p>
11 Fertility treatment	<p>What type of fertility treatment was used (if any) that resulted in this pregnancy? Note: on some occasions women will receive infertility treatment even if they have not been infertile > 12 months.</p> <p><u>Artificial insemination donor (AID)</u>: When sperm that is artificially inseminated comes from a male donor. Also known as DI (donor insemination).</p>

	<p><u>Artificial insemination husband/partner (AIH)</u>: When sperm that is artificially inseminated comes from the woman's husband or partner.</p> <p><u>Clomiphene citrate</u>: an oral medication taken for 5 days in the early part of the menstrual cycle to induce an ovulation</p> <p><u>Follicle-stimulating hormone (FSH)</u>: A hormone produced and released from the pituitary gland. In women it stimulates the production of oestrogen and follicles in the ovary ready for ovulation. In men it stimulates the production of sperm.</p> <p><u>Intra-cytoplasmic sperm injection (ICSI)</u>: When an egg is surgically removed from a woman and injected with a single sperm. If fertilisation is successful the embryo is placed into the woman's uterus. This technique is used when a male partner has a low sperm count or other sperm related problem.</p> <p><u>In vitro fertilisation (IVF)</u>: When eggs are surgically removed from a woman's ovaries and sperm is added (partner or donor) and placed in an incubator. When these develop into embryos they are placed into the woman's uterus.</p> <p><u>Surgery</u>: Women who have undergone tubal or ovarian surgery to improve their fertility eg. Release of adhesions, excision of endometriosis or ovarian cyst removal</p> <p><u>Insulin sensitising agents eg. Metformin</u>: An oral medication given daily to women who are trying to conceive or used in non insulin dependent diabetes and gestational diabetes.</p>
<p>12 Intended place of birth</p>	<p>At what location had the mother planned to give birth at booking?</p> <p><u>Home</u>: a home environment does not have to be the mother's own home.</p> <p><u>Birthing Unit</u>: stand alone birthing centre.</p> <p><u>Level 1</u>: No neonatal or caesarean section facilities</p> <p><u>Level 2</u>: Unable to provide long term ventilation for babies.</p> <p><u>Level 3</u>: Full neonatal intensive care including facilities for long term ventilation.</p> <p><u>Other</u>: e.g. car, ambulance</p>

	Please fill in the name of the location in the free text box.
13 Actual place of birth	At what location did the mother actually give birth? As for item 13.
14 Time of transfer of birth location	If the actual location is different from the intended location, indicate when transfer occurred.
15 Lead Maternity Carer (LMC)	Indicate the LMC at booking and at time of birth. <u>Hospital midwife</u> : refers to hospital based midwifery care eg, Domino or Know Your Midwives (KYM).
16 Antenatal procedures	<p>What procedures did the mother have during her pregnancy? Tick 'yes' for <u>each</u> of the procedures listed.</p> <p><u>Chorion villus sampling (CVS)</u>: prenatal diagnosis performed by placental biopsy.</p> <p><u>Cervical Suture</u>: a cervical stitch may also be called Shirodkar or McDonald suture.</p> <p><u>Amniocentesis</u>: Test for fetal chromosomes by taking a sample of amniotic fluid usually around 15-16 weeks gestation.</p> <p><u>Doppler studies</u>: Doppler studies performed during an antenatal scan, usually umbilical artery Doppler studies.</p> <p><u>External Cephalic Version</u>: process whereby an Obstetrician attempts to turn a breech baby to cephalic position.</p> <p><u>Fetocide</u>: may be used before termination so that fetus is not live born or to reduce fetal numbers in multiple pregnancy.</p> <p><u>Amnioreduction</u>: drainage of amniotic fluid for polyhydramnios. Twin to twin transfusion syndrome or foregut atresia are common indication.</p> <p><u>Laser treatment</u>: performed rarely for twin to twin transfusion syndrome.</p> <p><u>Traditional massage</u>: traditional massage of the maternal abdomen during pregnancy usually in Samoan or Tongan cultures. Usually performed by a lay person, may be quite vigorous and often not</p>

	<p>readily disclosed.</p> <p><u>Other</u>: Specify any other procedures the mother had during her pregnancy that are not listed. Include treatments like drainage of fetal pleural effusion, amnio infusion</p>
<p>17 Cigarette smoking habits</p>	<p>Indicate whether the mother is a current cigarette smoker (ie: still smoking). If so, how many cigarettes does she smoke a day?</p> <p>If the mother is a current smoker select whether smoking cessation advice had been offered and by whom.</p> <p>If the mother is a current non-smoker, select the option that best describes her past history of smoking.</p>
<p>18 Maternal use alcohol and other recreational drugs</p>	<p>Did the mother take any non-prescription drugs, methadone or consume alcohol during her pregnancy?</p> <p>If you select 'yes' you will be able to indicate whether it was used in the first trimester and also in the month before delivery. Herbal highs are also known as party pills.</p> <p>If the mother has used any of these substances, please provide details about frequency of use in the free summary box at the end of the form.</p> <p>If the mother advises use of another substance not listed, please specify in the 'other' category.</p> <p>Please describe use – amount and frequency.</p>
<p>19 Total number of antenatal visits</p> <p>Gestation at 1st antenatal visit</p>	<p>a) Indicate the total number of antenatal visits attended prior to the baby's death. You will need to complete this from the antenatal record as the mother may not know this.</p> <p>b) Indicate the gestation in weeks at the first antenatal visit.</p>
<p>20 Mother's clinical history</p>	<p>Tick 'yes', 'no' or 'unknown' for <u>each</u> of the diagnoses listed. This section includes any diagnosis in the current pregnancy.</p> <p>If the condition was diagnosed for the first time during pregnancy, please elaborate in the summary at the end of this document.</p> <p>To enter 'yes' for medical conditions (eg asthma,</p>

	<p>diabetes, epilepsy, thyroid) the condition must have been diagnosed by a doctor.</p> <p>Asthma: diagnosed by a doctor.</p> <p>Diabetes pre pregnancy: diagnosed prior to pregnancy</p> <p><u>Diabetes Type I:</u> diabetes with onset in childhood or as a young adult controlled with insulin injections. Previously known as insulin dependent diabetes mellitus (IDDM) Very occasionally this is diagnosed for the first time in pregnancy by the presence of antibodies.</p> <p><u>Diabetes Type II:</u> diabetes usually controlled with diet and tablets or sometimes insulin. Age of onset usually in adult life. Unusual to develop Type II diabetes at < 15 years unless very obese. Precedes onset of pregnancy or confirmed in women with GDM who are still diabetic when tested 6 weeks postpartum. Previously known as non insulin dependent diabetes mellitus (NIDDM).</p> <p><u>Impaired Glucose Tolerance:</u> includes</p> <p>Impaired Fasting Glucose (IFG): fasting plasma glucose 6.1-6.9 mmol/L, diagnosis made outside pregnancy.</p> <p>Impaired Glucose Tolerance: 2 hour glucose between 7.8 and 11 mmol/L diagnosis made outside pregnancy.</p> <p>Epilepsy: diagnosed by a doctor.</p> <p>Heart Condition (if you select this option you then need to select one of the following 4 options)</p> <p><u>Heart condition – Congenital:</u> diagnosis confirmed after investigation by a doctor.</p> <p><u>Heart condition – rheumatic:</u> valvular heart disease secondary to rheumatic fever.</p> <p><u>Heart condition – coronary artery disease:</u> history of angina or myocardial infarction prior to or during current pregnancy.</p> <p><u>Heart condition – other:</u> includes conditions such as cardiomyopathy.</p>
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	<p>Thyroid abnormality <i>(if you select this option you then need to select one of the following 3 options)</i></p> <p><u>Hyperthyroidism</u>: confirmed by laboratory testing either current or in the past.</p> <p><u>Hypothyroidism</u>: confirmed by laboratory testing either current or in the past.</p> <p><u>Other Thyroid</u>: eg. Large goitre, thyroid cancer or unknown.</p> <p>Inflammatory Bowel Disease: includes Crohn's and ulcerative colitis, not irritable bowel syndrome.</p> <p>Systemic lupus erythematosus: diagnosed by a doctor and meets criteria for lupus. Does not include women with positive auto-antibodies or antiphospholipid antibodies without clinical syndrome.</p> <p>Other autoimmune: includes conditions like Sjogrens syndrome, rheumatoid arthritis and mixed connective disease.</p> <p>Mental Health Disorder <i>(if you select this option you then need to select one of the following 3 options)</i></p> <p><u>Depression</u>: diagnosed and treated with antidepressants in pregnancy or prior to pregnancy.</p> <p><u>Psychotic disorders</u> such as manic depression, schizophrenia.</p> <p><u>Other mental health disorders</u> eg. Obsessive compulsive disorders.</p> <p>Renal disease: known underlying kidney problem, e.g., reflux nephropathy, glomerulonephritis, renal transplant, calculi. Specify in summary.</p> <p>Venous Thromboembolism: Deep vein thrombosis (usually confirmed by venogram or Doppler) or pulmonary embolus (usually confirmed by lung scan/CT), and treated with anticoagulation</p> <p>Blood Disorders <i>(if you select this option you then need to select one of the following 3 options)</i></p> <p><u>Anaemia</u>: Hb<100 in pregnancy or Hb<115 pre-pregnancy.</p> <p><u>Thalassaemia trait</u>: carrier for α or β thalassaemia.</p>
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	<p><u>Thrombophilia</u> includes: Antiphospholipid syndrome: lupus anticoagulant and / or anticardiolipin antibodies associated with one or more of the following: ≥ 3 first trimester miscarriages, ≥ 1 fetal death > 10 weeks gestation and/or arterial or venous thromboses.</p> <p>Hypertension (if you select this option you then need to select one of the following 2 options)</p> <p><u>Essential/Chronic</u>: BP $\geq 140/90$ mm Hg before 20 weeks or prior to pregnancy. Also includes women who were on antihypertensive treatment prior to pregnancy.</p> <p><u>Secondary hypertension</u>: is hypertension due to an underlying condition such as renal disease.</p> <p>Cervical surgery: LLETZ (most common), laser, cryotherapy, diathermy, or knife cone biopsy. If yes please provide details in summary. Don't include previous punch biopsy alone.</p> <p>Urinary tract infection: confirmed urine infection on culture.</p> <p>Uterine abnormality: for example, bicornuate, unicornuate uterus, large uterine septum.</p> <p>Uterine surgery: for example, myomectomy, and hysterotomy. Does not include caesarean section</p> <p>Other : please include anything that is not covered above</p>
<p>21 Screening for gestational diabetes in pregnancy</p>	<p>Was mother tested - Polycose or GTT – yes, no or unknown</p> <p>If yes, was gestational diabetes confirmed?</p> <p><i><u>Gestational Diabetes</u>: fasting glucose ≥ 5.5 mmol/L and/or 2 hour glucose ≥ 9.0 mmol/L on GTT. However a women maybe accepted as having GDM with a polycose ≥ 11 mmol/L</i></p> <p>Raised polycose but no GTT – a polycose of ≥ 7.8 or above should be followed by a GTT.</p>
<p>22 Multiple pregnancy</p>	<p>Select if this pregnancy is a multiple pregnancy- if yes: indicate the number of fetuses/ babies who were alive at 20 weeks gestation.</p> <p><i>(If the pregnancy started as twins and one fetus dies in early</i></p>

	<p><i>pregnancy, or between 13 and 20 weeks, detail in the summary.)</i></p> <p>If the answer above was 2 select type of twins: <u>Dichorionic Diamniotic (DCDA) twins</u>: arise from separate placentae so the membranes between them will be four layers thick and easy to see on scan. A triangular shape where the membranes of DCDA twins meet is called the lambda sign.</p> <p><u>Monochorionic Diamniotic (MCDA) twins</u>: arise from 1 placenta and have a thin dividing membrane on scan. They have no lambda sign. Chorionicity cannot be reliably diagnosed by scan after 13 weeks.</p> <p><u>Monoamniotic twins (MA)</u>: MA twins have no dividing membranes.</p>
<p>23 NHI of all fetus/babies</p>	<p>If you have selected that this was a multiple pregnancy in Q 23 indicate the NHI of all babies in this pregnancy</p>
<p>24 Occurrence of vaginal bleeding this pregnancy</p>	<p>Select Yes No or Unknown for both BEFORE 20 weeks and AFTER 20 weeks for whether bleeding occurred.</p>

<p>25 Obstetric conditions</p>	<p>Indicate what obstetric conditions were evident in this pregnancy. Tick as many as apply.</p> <p>Hypertension <i>(if you select this option you then need to select one of the following 5 options)</i></p> <p><u>Gestational hypertension</u>: Systolic BP ≥ 140mmHg and/or diastolic BP ≥ 90mmHg (Korotkoff V) on at least 2 occasions 4h apart after 20 weeks' gestation, but before the onset of labour.</p> <p><u>Preeclampsia</u>: Gestational hypertension with proteinuria ≥ 300 mg/24h or spot urine protein:creatinine ratio ≥ 30 mg/mmol creatinine or urine dipstick protein $\geq ++$ <u>or</u> any multi-system complication.</p> <p><u>Preeclampsia with chronic hypertension</u>: Increase in SBP of ≥ 30 mmHg and/or DBP of ≥ 15 mm Hg after 20 weeks' gestation (above 15wk SCOPE BP recording) in combination with new onset proteinuria ≥ 300 mg/24h or spot urine protein:creatinine ratio ≥ 30 mg/mmol creatinine or urine dipstick protein $\geq ++$ <u>or</u> any multi-system</p>
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	<p>complication.</p> <p><u>Eclampsia</u></p> <p><u>Unspecified hypertension:</u> unknown whether the hypertension was pregnancy induced or pre-existing. Includes women who are unbooked and present with hypertension late in pregnancy.</p> <p>Pre term labour: presents with regular painful uterine contractions on one or more occasions</p> <p>Prolonged Rupture of the membranes: rupture of the membranes for > 24 hours duration before birth.</p> <p>If yes select on of the following two:</p> <p><u>Preterm:</u> prolonged rupture of the membranes at < 37 weeks gestation.</p> <p><u>Term:</u> prolonged rupture of the membranes at ≥ 37 weeks gestation.</p> <p>Cholestasis of pregnancy: a condition associated with severe itch, abnormal AST and ALT liver function tests with or without raised bile salts.</p> <p>Confirmed maternal infection: maternal infection confirmed by culture or other means eg. PCR</p> <p>If selected tick all relevant options:</p> <p><u>Pyelonephritis:</u> infection of the kidney associated with renal angle tenderness and fever.</p> <p><u>Lower urinary tract infection:</u> confirmed urinary infection without fever and renal angle tenderness.</p> <p><u>Other infection:</u> eg. Septicaemia, pneumonia, confirmed parvovirus or cytomegalovirus. Please state.</p> <p>Trauma: significant maternal injury in pregnancy.</p> <p>If selected choose one of the following 3 options:</p> <p>Vehicular maternal injury sustained during a road traffic accident or similar.</p> <p>Violent personal injury including domestic violence.</p> <p>Other, eg. Trauma sustained from a fall</p> <p>Other obstetric condition: Specify any other conditions that are not listed in the summary.</p>
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	<p>Surgery in pregnancy: refers to major surgical procedures, eg. appendicectomy in pregnancy, cholecystectomy, ovarian cystectomy. If yes please state type of surgery.</p> <p>None of the above: no obstetric conditions in this pregnancy</p> <p>Unknown: unknown if there were obstetric conditions in this pregnancy</p>
<p>26 Suspected fetal growth restriction</p>	<p>Select whether there was suspected growth restriction before delivery.</p> <p><u>Yes and confirmed by scan:</u> abdominal circumference (AC) <10th % and /or AC crossing centile lines on ultrasound growth chart and/or head circumference significantly larger than abdominal circumference, and/or estimated fetal weight <10th% on customised fetal growth chart.</p> <p><u>Yes but normal growth on scan:</u> fetal growth restriction suspected clinically but growth scan suggests normal fetal growth.</p> <p><u>Yes but no scan performed:</u> suspected clinically but not followed up by growth scan.</p> <p><u>Unknown:</u> relevant clinical information not available, eg. Did not have a clinical check in the last month.</p>
<p>27 Folic Acid taken in pregnancy</p>	<p>Tick 'yes', 'no' or 'unknown' for <u>each</u> of the options Was Folic Acid taken pre pregnancy? Was Folic Acid taken first trimester?</p>
<p>28 Obstetric specialist consultation</p>	<p>Indicate whether the mother was under the care of a specialist obstetrician during her pregnancy. If yes select the reasons for this referral. <i>(For definitions, see questions 20 and 25).</i></p> <p><u>Poor Obstetric History:</u> would include women with previous pregnancies with recurrent miscarriages, previous growth restriction, preterm birth, preeclampsia or other serious pregnancy complication.</p> <p>If advice was sought from the specialist but she/he did not actually see the mother select "yes" but make a note in the summary that the mother was not seen.</p>
<p>29 Transfer of care</p>	<p>As a result of this consultation was there a change of LMC to a hospital team/private specialist?</p>

following consultation	
30 Referral to other health care services	<p>Indicate whether the mother was referred to other health care services during her pregnancy (other than to a general obstetric specialist).</p> <p><u>Medical:</u> Included Fetal Maternal Medicine, Physician, Anaesthetic and Genetic Services</p> <p><u>Social:</u> Includes Social Work and Cultural services (services designed to support women from a specific culture, eg. Māori Health Services)</p> <p>Please identify referrals to other services not covered in the summary.</p>
31 Induction	<p>Please select all medications that apply. If ARM was used for induction of labour please state time using 24 hour clock.</p> <p><u>Reason for induction</u> Please tick reason for induction labour. If other, please specify</p>
32 Augmentation	<p>Please select all that apply. If ARM was used for augmentation, please state time using 24 hour clock. If other, please specify.</p>
33 Analgesia/ anaesthetic in labour and delivery	<p><u>Opiate:</u> either intramuscular or intravenous – pethidine or morphine or fentanyl</p> <p><u>Nitrous oxide</u> given by inhalation.</p> <p><u>Epidural</u> either with opiates or local anaesthetic or both.</p> <p><u>TENS</u> transcutaneous electrical nerve stimulation.</p> <p><u>Unknown</u></p> <p><u>Other</u> e.g. acupuncture</p>
34 Bath or pool during labour	<p>Indicate whether any part of labour occurred in water.</p> <p>Indicate whether or not the birth of the baby occurred in water (both planned and unplanned water birth).</p>
35 Mode of birth	<p>Indicate the delivery method and the type within this for each baby in this pregnancy (for example, if 'breech' is selected, then you will need to select the type ie, assisted, extraction or spontaneous).</p> <p>If delivered by caesarean, indicate whether forceps or Ventouse had been attempted before proceeding to caesarean section.</p> <p>If a breech birth, indicate whether this was identified</p>

	<p>prior to birth.</p> <p><u>Breech assisted</u>: spontaneous delivery of buttocks and body with medical assistance for delivery of shoulders (Lovsett manoeuvre) and/or head (eg forceps to after coming head).</p> <p><u>Breech extraction</u>: the feet/ legs are grasped often from within the uterus or high in the vagina (usually for a 2nd twin) and the baby is delivered.</p> <p><u>Spontaneous breech</u>: the baby is delivered totally with maternal effort and no manipulation from medical attendants.</p> <p><u>Elective caesarean</u>: planned caesarean section performed prior to or at onset of labour.</p> <p><u>Emergency caesarean</u>: Caesarean performed urgently either before or in labour for maternal or fetal indications.</p> <p><u>Forceps low</u>: Head is visible distending the perineum.</p> <p><u>Forceps mid cavity</u>: head is in mid cavity (station usually about +1 and head not visible).</p> <p><u>Forceps mid cavity rotation</u>: as above for mid forceps but with either manual or forceps rotation.</p> <p><u>Ventouse low</u>: Head is visible distending the perineum.</p> <p><u>Ventouse mid cavity</u>: head is in mid cavity (station usually about +1 and head not visible).</p> <p><u>Ventouse Mid cavity rotation</u>: as above for Mid forceps but with either manual or ventouse rotation.</p> <p><u>Type of anaesthetic for Operative Delivery</u>: Select from the list.</p>
<p>36 Maternal outcome</p>	<p>Indicate the health outcome for the mother following birth.</p> <p><u>Alive and well</u>: discharged home without major complications.</p> <p><u>Alive but experienced major morbidity</u>: alive but serious complications e.g. admitted to intensive care, postpartum hysterectomy, and stroke. Please add further details in the summary.</p> <p><u>Dead</u>: If the mother has died please contact your</p>

	local coordinator or the national coordinator as additional information is required.
37 Placenta	<p>a. Enter the weight of the placenta in grams.</p> <p>b. Select if placenta not examined, normal or has some abnormalities.</p> <p>If some abnormalities selected, select</p> <p><u>Circumvallate Placenta</u>: the chorionic plate, from which the villi arise, is smaller than the basal plate. This means that when the placenta is viewed from the fetal surface the placental tissue extends beyond the membranes attached to the placental disc.</p> <p><u>Other</u>: please make comments if not covered by the above</p>
38. Umbilical cord	<p>If cord around limbs or body is tight it may be compressed and sometimes it will indent the baby's body.</p> <p><u>Marginal/Velamentous insertion</u>: where the cord inserts into the membranes not directly into the placenta.</p> <p><u>Torsion or spring like</u>: the cord is twisted up on itself like a spring.</p> <p><u>Abnormal cord thickness</u>: if selected choose one of the following 2:</p> <p><u>Thin cord</u>: very little Wharton's jelly.</p> <p><u>Thick cord</u>: a lot of Wharton's jelly around the cord vessels.</p> <p><u>Two vessel</u>: a single umbilical artery.</p> <p><u>Other abnormality</u>: please add comments</p>
39 Summary	<p>Include any further comment you wish to provide about the pregnancy. This should include comments which are not covered by the above questions (Eg: social circumstances) and other relevant information which may have contributed to the outcome. Please continue over leaf or add extra pages as necessary.</p>
If you <u>have not</u> finished completing the Mother Form	<p>If you have not finished and wish to revisit the form <u>DO NOT</u> select COMPLETE, just select SAVE. This will take you into the baby form/s. You will be able to revisit the form when you sign in again with your REGISTRATION ID through the</p>

	INCOMPLETE FORMS section of the website.
If you <u>have</u> finished completing the Mother Form	If you wish to print the form select PRINT. If you have completed the mother form select COMPLETE. You will receive confirmation that the Local Coordinator has been notified. And will then take you into the baby form/s.

PMMRC Rapid Reporting Form for a Perinatal Death - Baby

The table below explains how to complete each section of the form. Definitions are included with the explanation for each section.

Section	Explanation
1 Mothers NHI	This will come directly from the information you have completed on the Mother Form
to 5 Personal details	Enter the personal details of the mother and baby. <i>(Some DHBs do not assign an NHI number of stillborn babies and so you may not be able to complete that. It is hoped that eventually all DHBs will assign a NHI to stillborn babies)</i>
6 Baby's ethnicity	Ethnicity should be <u>identified by the parent of the baby</u> .
7 Live or stillbirth	If stillbirth selected please still complete questions 8 – 13 and question 15.
8 Termination of pregnancy	Indicate whether the birth was the result of a surgical or medical termination of pregnancy (including for fetal abnormality, social and other reasons). Reason for the termination will be covered in the classification of cause of death. Ensure 'Notification of Abortion' form (ASC Form No. 4) is completed.
9 Date and time of birth	a) Enter the date of birth (dd/mm/yyyy). b) Enter the time of birth using a 24 hour clock - you can enter times as a 4 digit number. E.g. 2230
10 Gestation at birth	Enter your best estimate of the gestational age in completed weeks and days and select how age was determined eg: last menstrual period, first trimester ultrasound. A first trimester scan should be used to date the pregnancy if the difference between a sure Last Menstrual Period (LMP) and the scan is > 7 days. If LMP is unsure and a scan has been performed, select the scan at earliest gestation. If LMP is unknown and no scan, select 'clinical examination of baby at birth.'
11 Birth Weight	Enter baby's birth weight
12 If this was a multiple pregnancy	Enter birth order of deceased baby <i>(please complete a separate form for each baby if there is more than one)</i>

	<i>deceased baby in this pregnancy)</i>
13 When did death occur?	<p>At what stage did the baby's death occur?</p> <p><u>Antepartum</u>: fetal movements stopped before onset of labour. Diagnosis made antepartum or occasionally in labour. Scan to confirm diagnosis of stillbirth may show signs which indicate that the baby has been dead for some time (eg Spalding's sign, overlapping skull bones).</p> <p><u>Intrapartum</u>: fetal heart present in labour and death diagnosed subsequently. Select whether death occurred in</p> <ul style="list-style-type: none"> • first stage of labour • second stage of labour • Intrapartum unknown – not known what stage of labour <p><u>Neonatal</u>: live birth but died before 28 days</p> <p><u>Unknown whether antepartum or intrapartum</u>: Select if fetal heart not listened to in early labour and woman presents with stillbirth in labour, and fetal movement history unclear, and ultrasound does not show features to suggest that death occurred some time ago.</p>
14 Estimated gestational age at time of fetal death	Only relevant if baby is stillborn
15 Place of death for live born babies	<p>Select the location where the baby died.</p> <p>If the death occurred in a hospital, select the hospital location where the death occurred.</p>
16 Baby Examination	Make a note of any abnormalities noted on external examination of the baby, including dysmorphic features
17 Post mortem	<p>Indicate whether or not a post mortem was offered to the parents.</p> <p>If Yes did the parents consent to a post mortem?</p> <p>Select whether the death was referred to the coroner.</p>
18 Date and time of death	<p>a) Enter the date the baby died (dd/mm/yyyy).</p> <p>b) Enter the time of birth using a 24 hour clock - you can enter times as a 4 digit number. E.g. 2230</p>
19 Appgars	Enter the scores at 1 and 5 mins if still 9 or below at 5 mins enter score for 10, 15 and 20 minutes.

<p>20 Cord gases</p>	<p>Were cord gases taken?</p> <p><i>(All boxes have 0.00 in them at start but you can put 2 numbers before the decimal point and one after as appropriate)</i></p> <p>If cord gases were taken, enter the pH, base deficit and CO₂ results in the appropriate boxes, based on whether the sample was arterial or venous.</p> <p>For base deficit, the result will either be + (base excess) or – (base deficit). Enter + or – in the box and then the numerical value.</p>
<p>21 Resuscitation</p>	<p>Indicate whether resuscitation was attempted. Or if resuscitation was not attempted (usually for extreme prematurity or lethal abnormality) However if resuscitation was not required-baby was in good condition at birth, Please describe in the summary box.</p> <p>If resuscitated, indicate whether baby was resuscitated and transferred to another clinical care area or unable to be resuscitated.</p>
<p>22 Were maternal corticosteroids given antenatally?</p>	<p>Indicate whether antenatal steroids were given, if yes at what gestation and whether the course of corticosteroids completed?</p>
<p>23 Transfer from place of birth</p>	<p>Was the baby transferred from their place of birth prior to death?</p>
<p>24 Where transferred</p>	<p>If yes, indicate where the baby was transferred to.</p>
<p>25 Why not transferred</p>	<p>If no, indicate the reason why.</p>
<p>26 Summary points</p>	<p>Include any further comment you wish to provide about the baby. This should include comments which are not covered by the above questions (Eg: social circumstances) and other relevant information which may have contributed to the outcome.</p>
<p>If you <u>have not</u> finished completing the Baby Form</p>	<p>If you have not finished and wish to revisit the Baby Form select SAVE. <u>DO NOT</u> select COMPLETE. You will be able to revisit the form when you sign in again through the INCOMPLETE FORM. <i>Please ensure that you do complete the forms at a later date.</i></p>
<p>If you <u>have</u> finished completing the Baby Form</p>	<p>If you wish to print the Baby Form select PRINT. If you have completed the Baby Form select COMPLETE. You will receive confirmation that the Local Coordinator has been notified. Or if</p>

	there has been more than one perinatal loss linked to this pregnancy into the next baby form/s.
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PMMRC Classification Form

Following completion of perinatal death investigations and review at the DHB perinatal meeting all deaths are classified using the PSANZ Perinatal Mortality Classification. The classification is completed by a multidisciplinary team which includes the PMMRC Local Coordinator.

All perinatal deaths are given a Perinatal Death Classification PDC to identify the single most important factor which led to the chain of events which resulted in the death.

Neonatal deaths in addition to the PDC are given a Neonatal Death Classification NDC to identify the single most important factor in the neonatal period which caused the death.

At this time contributory factors that may be highly specific to the death or generalised to the system(s) are identified. These factors are sub-classified into organisational and management, personnel, technology/equipment, environmental and those relating to the woman and/ or her family/whānau.)

The information provided in these forms is strictly confidential. Information published by the PMMRC will be grouped and individuals will not be identifiable.

Appendix A: Excerpts from the New Zealand Public Health and Disability Act 2000

18 Mortality review committees

- (1) The Minister may appoint 1 or more committees established under section 11 to carry out any of the following functions that the Minister specifies by notice to the committee:
- (a) to review and report to the Minister or 1 or more other specified committees on specified classes of deaths of persons, or deaths of persons of specified classes, with a view to reducing the numbers of deaths of those classes or persons, and to continuous quality improvement through the promotion of ongoing quality assurance programmes;
 - (b) to advise on any other matters related to mortality that the Minister specifies in the notice.
- (2) A committee appointed under subsection (1) must develop strategic plans and methodologies that—
- (a) are designed to reduce morbidity and mortality; and
 - (b) are relevant to the committee's functions.
- (3) A committee appointed under subsection (1) must, at least annually, provide the Minister with a report on its progress in carrying out its functions; and the Ministry of Health must include each such report in the Ministry's next annual report.
- (4) As soon as practicable after appointing a committee under subsection (1), or receiving a report or advice from such a committee, the Minister must present to the House of Representatives a copy of the appointment, report, or advice.
- (5) The provisions of Schedule 5 apply in relation to a committee appointed under subsection (1).
- (6) Every person who fails, without reasonable excuse, to comply with a requirement imposed under Schedule 5 by the chairperson of a committee appointed under subsection (1) commits an offence and is liable to a fine not exceeding \$10,000.
- (7) Every person who discloses information contrary to Schedule 5 commits an offence and is liable on summary conviction to a fine not exceeding \$10,000.
- (8) Any member of a registered occupational profession who commits an offence under subsection (6) or subsection (7) is liable to any disciplinary proceedings of that profession in respect of the offence, whether or not he or she is fined under that subsection.

Schedule 5 - Provisions Applying to Mortality Review Committees

1 Interpretation

In this schedule, unless the context otherwise requires,—

document has the same meaning as in section 2(1) of the Official Information Act 1982

judicial proceeding means a proceeding that is judicial within the meaning of section 108 of the Crimes Act 1961

ministerial authority means an authority—

- (a) given by the Minister under clause 6(1); and
- (b) in force for the time being

serious offence means an offence punishable by imprisonment for a term of 2 years or more.

Compare: 1995 No 95 s66

Chairperson may require person to give information

2 Chairperson may require person to give information

- (1) If a mortality review committee gives its chairperson, or an agent the committee appoints for the purpose, authority in writing to do so, the

chairperson or agent may, by notice in writing to any person, require the person to give the committee information in the person's possession, or under the person's control, and relevant to the performance by the committee of any of its functions.

- (2) Examples of the information the chairperson or agent may require are—
 - (a) patient records, clinical advice, and related information;
 - (b) answers to questions posed by the chairperson in the notice, and that the person is able to answer;
 - (c) information that became known solely as a result of a declared quality assurance activity, within the meaning of Part 6 of the Medical Practitioners Act 1995.
- (3) The person must take all reasonable steps to comply with the notice.

Production, Disclosure, And Recording Of Information

3 **Meaning of information**

In clauses 4 to 6, **information** means any information—

- (a) that is **personal information** within the meaning of section 2(1) of the Privacy Act 1993; and
- (b) that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

4 **Prohibitions on production, disclosure, and recording of information**

- (1) A member or executive officer or agent of a mortality review committee must not produce or disclose information to another person or in any judicial proceeding, or make any record of it, unless the production, disclosure, or record, is—
 - (a) for the purposes of carrying out the committee's functions; or
 - (b) in accordance with an exception stated in clause 5; or
 - (c) in accordance with a ministerial authority.
- (2) In any judicial proceeding, a member or executive officer or agent of a mortality review committee must not be required to produce information if under subclause (1) he or she is prohibited from doing so.

Compare: 1995 No 95 s70

5 **Exceptions to prohibitions**

Clause 4 does not prohibit—

- (a) the production, disclosure, or recording of information if the information does not identify, either expressly or by implication, any particular individual;
- (b) the disclosure of information—
 - (i) with the consent of every person who would be directly or indirectly identified by the disclosure;
 - (ii) to the Minister, or a person authorised by the Minister, for the purpose of enabling the Minister to decide whether or not to issue a ministerial authority;
 - (iii) for the purposes of the prosecution of an offence against section 18(7) (disclosure of information contrary to this Schedule).

Compare: 1995 No 95 s71

6 **Minister may authorise disclosure of information**

- (1) If the Minister is satisfied that information relates to conduct (whenever occurring) that constitutes or may constitute a serious offence, the Minister may, by notice in writing signed by the Minister, give a ministerial authority

- authorising the disclosure of the information, in the manner, and subject to any conditions, specified in the notice, for 1 or more of the following purposes:
- (a) for the purposes of the investigation and prosecution of offences:
 - (b) for the purposes of a Royal Commission, or a commission of inquiry appointed by an Order in Council made under the Commissions of Inquiry Act 1908.
- (2) However, a ministerial authority may be given for information of a non-factual nature (for example, expressions of opinion) only if that information consists only of matter contained in a report or advice prepared by the mortality review committee.
- (3) The Minister may at any time—
- (a) revoke a ministerial authority; or
 - (b) revoke, amend, or add to any condition or conditions to which a ministerial authority is subject.
- (4) A ministerial authority authorising the disclosure of information does not of itself—
- (a) require the disclosure of that information; or
 - (b) create a duty to disclose that information.

Compare: 1995 No 95 s72

7 **Supplementary procedure**

A mortality review committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

PMMRC Local DHB Co-ordinators

DHB	Local Co-ordinator	Contact Details
Northland	Yvonne Morgan Clinical Charge Midwife Chris Cullen Quality/Risk Facilitator	Yvonne.Morgan@northlanddhb.org.nz Christine.cullen@northlanddhb.org.nz
Waitemata	Dr Sue Belgrave Clinical Director of Obstetrics, Eleanor Gates Quality Midwife	Sue.Belgrave@waitematadhb.govt.nz Eleanor.gates@waitematadhb.govt.nz
Auckland	Emma Parry Obstetrician Lesley McCowan Associate Professor	l.mccowan@auckland.ac.nz;
Counties Manukau	Dr Graham Parry Dr Nerida Titchiner. Dr Sarah Wadsworth Consultant Obstetricians	gparry@middlemore.co.nz; NTitchiner@middlemore.co.nz swadsworth@middlemore.co.nz
Waikato	Dr Alastair Haslam Clinical Unit Leader Obstetrics and Gynaecology, Sarah Waymouth Obstetrician and Gynaecologist Phil Weston Paediatrician Tracey Craw Midwife	HaslamA@waikatodhb.govt.nz; waymouts@waikatodhb.govt.nz westonp@waikatodhb.govt.nz CrawT@waikatodhb.govt.nz
Bay of Plenty	Margret Norris Midwife Leader	margret.norris@bopdhb.govt.nz
Lakes	Tivanti Pilapitaya CNE SCBU, Midwife Lorraine Anderson Midwife	tivanti.pilapitiya@lakesdhb.govt.nz lorraine.anderson@lakesdhb.govt.nz
Tairāwhiti	Sandra Walsh Midwifery Educator Estelle Mulligan Midwife Gisborne Hospital	Sandra.Walsh@tdh.org.nz
Taranaki	Amanda Hinks Clinical Midwife Leader	Amanda.Hinks@tdhb.org.nz
Hawke's Bay	Dr Lynda Croft Obstetrician and Gynaecologist	lynda.croft@hawkesbaydhb.govt.nz
Whanganui	Lucy Pettit Midwife Robyn McDougal Midwife	Lucy.Pettit@wdhb.org.nz RobynM@ghw.co.nz
MidCentral	Billie Clayton Midwife Educator Ken Clarke Consultant Obstetrician	Billie.Clayton@midcentraldhb.govt.nz drkenclark@paradise.net.nz
Wairarapa	Donna Purvis Team Leader Midwifery	donna.purvis@wairarapa.dhb.org.nz
Capital and Coast	Dawn Elder Senior Lecturer, Dept of Paediatrics Dr Rose Elder Obstetrician	dawn.elder@otago.ac.nz Rose.Elder@ccdhb.org.nz
Hutt Valley	Joanne McMullan Midwife	Joanne.McMullan@huttvalleydhb.org.nz

Guidelines for completing perinatal death form

DHB	Local Co-ordinator	Contact Details
	Charlotte Smith Midwife Hutt Hospital	charlotte-smith@paradise.net.nz
Nelson Marlborough	Kevin Hill Obstetrician/Gynaecologist Lois McTaggart Clinical Midwife Leader	kevin.hill@nmhs.govt.nz lois.mctaggart@nmhs.govt.nz
West Coast	Jude Bruce Midwife Mary McGrane Midwife	jbruce@westcoastdhb.org.nz; mary.mcgrane@westcoastdhb.org.nz
Canterbury	Dianne Leishman Midwife Sonya Matthews Midwife Christchurch Women's Hospital	Dianne.leishman@CDHB.govt.nz Sonya.Matthews@cdhb.govt.nz
South Canterbury	Dr John Weir Obstetrician/Gynaecologist Dianne Keeman Clinical Leader Maternity Services (Midwife)	jweir@timhosp.co.nz DKeeman@timhosp.co.nz
Otago	Susan Fleming Medical Clinical Director Women's Health Helen Flockton Charge Midwife	Susan.fleming@healthotago.co.nz Helen.Flockton@healthotago.co.nz
Southland	Jenny Humphries Associate Director of Nursing and Midwifery, Maternal & Child	Jenny.Humphries@sdhb.govt.nz
National Coordinator	Vicki Masson	v.masson@auckland.ac.nz Ph 09 373 7599ext 84440 027 372 4833 Fax 09 303 5969