



PMMRC

THE PERINATAL AND MATERNAL MORTALITY REVIEW COMMITTEE

NEWSLETTER June 2007 Issue 2

"He matenga ohorere, he wairua uiui, wairua mutunga-kore"

*"O eternal spirit -the grief of an untimely death
— we will not stop the pursuit and endeavours
to seek answers"*

(Not a literal translation)

This is the second newsletter to update clinicians on the work of the Perinatal and Maternal Mortality Review Committee (PMMRC). The PMMRC's purpose is to review New Zealand's perinatal (any infant from 20 weeks gestation or at least 400 gm if gestation not known, up until 28 complete days of life) and maternal deaths, and report to the Minister of Health on how to reduce the numbers of preventable deaths. Thank you to those of you who have supported us by collecting and submitting information.

For more information on the PMMRC go to:
<http://www.pmmrc.health.govt.nz>

Chairperson's Message

Our pilot of perinatal death data collection over the last 6 months has been very successful with data submitted on 96% of perinatal deaths. We are still identifying the gaps in the data and in some cases we hope to get more information. Once we have finished filling in these gaps we will begin the analyses. 2007 will be our first full year of collection of data related to perinatal and maternal deaths in New Zealand.

We have had some unwelcome media attention regarding maternal deaths. Whilst the release of the numbers of maternal deaths was extremely premature, it is worth stating that our methods of reporting deaths is quite different from the last Maternity

report in 2003 and therefore it is erroneous to draw comparisons with that report. In addition we are recording indirect and direct maternal deaths whereas the Maternity report in 2003 only reported on direct maternal deaths. The Maternal Mortality Working Group will be meeting in July to review the 2006 maternal deaths (see later in this newsletter).

In February we held a small Neonatal Encephalopathy workshop with several invited experts. As a result of this we have formed a Neonatal Encephalopathy Working Group to consider how we might monitor the factors leading to neonatal encephalopathy with a view to reporting to the Minister on prevention.

Thank you for your efforts in reporting perinatal deaths. We could not do this without the support of the local coordinators, Lead Maternity Carers (LMC) and clinicians in the DHBs. We hope that in the future our combined work leads to reductions in perinatal and maternal deaths in New Zealand.

Professor Cindy Farquhar



Maternal Mortality Review

The PMMRC has established a Maternal Death Working Group to review maternal deaths. This group met for the first time in October 2006. The Maternal Death Working Group will be reviewing the death of woman during pregnancy or within 42 days of termination of pregnancy/birth, (irrespective of the duration and site of the pregnancy) from any cause related to or aggravated by the pregnancy or its management. These fall into two categories

Direct maternal deaths

Those that result from conditions or complications or their management that are unique to pregnancy, occurring during the antenatal, intrapartum or postpartum period.

Indirect maternal deaths

Those that result from previously existing disease or disease that develops during pregnancy and is aggravated by the physiologic effects of pregnancy.

The PMMRC also agreed that later work for the Maternal Working Group would include reviewing maternal deaths occurring after 42 days and up to one year following the termination of pregnancy or birth. These will be known as obstetric related deaths. It is anticipated that a number of deaths during this timeframe may be attributable to mental health problems including post natal depression.

Please advise the Local Coordinator or the National Coordinator about any maternal deaths of which you are aware.

Report from Perinatal Society of Australia and New Zealand (PSANZ) Workshop 31 March 2007

In March PMMRC Members Dawn Elder, Deborah Harris, Lesley McCowan and the PMMRC National Coordinator, Vicki Masson, attended the PSANZ Perinatal Mortality Group Workshop in Melbourne, Victoria. The focus of this workshop was defining priorities for stillbirth prevention and improving clinical practice around the time of perinatal death (including bereavement care and audit.) Vicki presented the New Zealand experience of collecting information about perinatal deaths including the role of the PMMRC, its establishment and scope, what information is collected and how. The feedback from the other delegates was very positive – they were very impressed that in New Zealand all 21 District Health Boards submit information to the PMMRC. So thank you to all the LMCs and the Local Coordinators who have helped with the completion of the Rapid Reporting and Classification Forms.

Other speakers discussed causes and risk factors for stillbirths and the benefits of perinatal mortality and morbidity audits in Australia were presented. There was a

session by Emma Kirkwood, the founding member of the Stillbirth Foundation Inc – a voluntary organisation in Australia which increases public awareness of stillbirth, supports hospital bereavement services and funds and encourages research into stillbirth. Its website is: www.stillbirthfoundation.org.au

Vicki Flenady described PSANZ's Perinatal Mortality Audit Guidelines. The purpose of the guidelines is to outline a systematic approach to the investigation and audit of perinatal deaths. It is hoped that by using a systematic approach there will be better support for parents in helping them understand the cause of death and plan future pregnancies; that it will increase effectiveness of monitoring strategies aimed at reducing perinatal deaths and generally contribute to the body of knowledge about perinatal death.

Dr Lesley McCowan (PMMRC Member and Local Coordinator for Auckland DHB) was an invited speaker at the work shop and gave a plenary lecture entitled "Identification of the fetus at increased risk due to suboptimal growth". Lesley presented information on the use of customised birth weight centiles to identify small-for-gestational-age (SGA) babies in previous and current pregnancies. (*Customised growth charts maybe downloaded from the website www.gestation.net*)

Yee Khong spoke on the barriers to autopsy of stillborn babies in Australia and NZ and the importance of giving accurate information when seeking consent.

There was further discussion about autopsies, stillbirth, investigation of neonatal deaths, institutional perinatal morality audit, perinatal mortality classifications and psychological and social aspects of perinatal bereavement. There was acknowledgment of the link between fetal growth restriction and perinatal deaths and it was recommended that the Special Interest Group considered developing a guideline on SGA pregnancies

PMMRC Deputy Chair Deborah Harris

Deborah Harris was registered as a Nurse Practitioner in neonatology in 2001. She presently works in the Newborn Intensive Care Unit at Waikato Hospital. Deborah also has an honorary appointment with the University Auckland as clinical lecturer. She is actively involved in teaching nurses, midwives, registrars and specialists both within the Waikato and other centres in New Zealand.



Deborah has recently been elected to the Australian and New Zealand Perinatal Society (PSANZ) Perinatal Mortality Steering Group. The role of this group is to oversee the PSANZ Perinatal Mortality Group. Activities of the steering group include management of the PSANZ perinatal mortality classification and the [PSANZ Perinatal Mortality Audit Guideline](#) updates.

Deborah is currently working towards a PhD on neonatal hypoglycaemia. Among other research interests she is the principal investigator for an international prospective randomised control trial seeking to understand associations between infection, immunoglobulins and neonatal outcome.

Perinatal Rapid Reporting Forms

Just a reminder about the process for reporting perinatal deaths to the PMMRC. Following a perinatal death we ask that all LMCs and/or other involved clinicians enter information on the website www.pmmrc.otago.ac.nz.

Each DHB has an individual Username and Password - your Local Coordinator will be able to assist you with this or you can contact the National Coordinator. The first time you use this site you will be given a registration identification number (REG ID) You should always use the same REG ID, if you forget this please contact the National Coordinator.

Both Mother and Baby Forms need to be completed. The Guidelines for completing these are available on the website. If you start a form and do not finish it at the time you can save it and go back at a later date to complete it. The forms are saved in the INCOMPLETE section. You can access the form next time you sign into the website under your unique registration identification number (REG ID).

While we would prefer you to complete the forms on the website, paper forms are available for those who do not have access to the internet (or who only have a slow dial-up system). Please ensure you are using the November 2006 forms. These are available from your Local Coordinator or the National PMMRC Coordinator.

An information sheet is available on the website to give to family/whānau when you are completing the forms to provide information about what you are doing.

If you have any questions about data collecting following perinatal or maternal deaths please do not hesitate to contact your [Local Coordinator](#) or the National PMMRC Coordinator, [Vicki Masson](#)

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Upcoming Conferences

**Sands Stillbirth & Newborn Death
Support: Living Loving and Remembering**
September 13 – 15 2007
The Cashmere Club, Christchurch
More information: www.sands.org.nz

**International Stillbirth Alliance
3rd Annual Conference on Perinatal loss
and Improving care and prevention**
29 September -2 October 2007
Birmingham, UK
More information: www.isa2007.org