

Issue 4 June 2008

“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)

Chairpersons Message

2008 is the first year that the PMMRC will report on data from our system of collecting perinatal and maternal deaths in New Zealand. Our pilot for the last 6 months of 2006 has provided us with some useful information to improve perinatal health. The report will not be available until later in 2008 but in the future we hope to report earlier in the year. We were able to collect information on almost 100% of the perinatal deaths although there was a lot of incomplete data on individual babies.

The maternal deaths in 2006 have also been reviewed and a report has been sent to the Minister of Health. This report will also be part of the full annual report that will be published later in the year. As a result of this review we are planning a one day national workshop focusing on improving maternal mental health. The title of the workshop is Keeping Mothers Healthy and will be held on Wednesday 29th October 2008 in Auckland. We have invited Dr Margaret Oates, who leads the maternal mental health section of the Confidential Enquiry into Maternal and Child Health (CEMACH) in the United Kingdom. All health care professionals involved in providing care to pregnant women or new born infants are invited to take part in the meeting. It is hoped that a national strategy can be developed so that the differences in the provision of services across the country can be reduced.

The Neonatal Encephalopathy Working Group has met on several occasions. Plans are underway to modify the PMMRC rapid reporting forms. The forms will assist the group to monitor the prevalence of neonatal encephalopathy and to look for areas where improvements might be made.

I was pleased to meet with the new Associate Minister of Health, Steve Chadwick in April of this year to discuss our progress. Many of you will know that Steve was formerly a midwife and also a health manager prior to entering Parliament. This made the meeting

reasonably straightforward as Steve was well informed and very supportive about the work we are doing.

Finally, thank you for your efforts in reporting perinatal and maternal deaths. We could not do this without the support of the local coordinators, lead maternity carers and clinicians in the DHBs. We are grateful to you for your efforts and hope that in the future we will see reductions in perinatal and maternal deaths. I could not finish off this report without acknowledging the support of the secretariat at the Ministry of Health and the work of the National PMMRC coordinator, Vicki Masson. It has been wonderful to see all your efforts finally come together. Thank you.

Cindy Farquhar



Keeping Mothers Safe Maternal Mental Health Workshop PMMRC

We like to think that all women welcome being pregnant, look forward to motherhood, and are well supported at this time. There is however, a considerable amount of evidence to the contrary. Terminations are most commonly granted on the grounds of mental ill health in the mother. Domestic violence increases in pregnancy. Depression is common in pregnancy and these illnesses usually persist postnatally. Women with serious mental illnesses become pregnant and the associated risks are commonly overlooked. Mental health problems are common in women of childbearing age and can result in considerable morbidity and mortality. In addition women with mental health problems often receive less than optimal antenatal care.

For many years we have been aware of the close connection between childbirth and mental illness. In 1858 Louis Victor Marce wrote ‘Traite de la folie des

femmes enceintes' 'A treatise on madness in pregnant women' (Marce 1858) The increased incidence of serious affective disorder in the postpartum period has been documented for about 25 years. Enquiries into maternal deaths from the UK since 1997 have highlighted suicide as a leading cause of maternal death.

We know from the Confidential Enquiries into Maternal Deaths CEMD in the UK that women who kill themselves in the perinatal period generally have serious mental illness and have deteriorated rapidly. In the UK there are various recommendations for the care of pregnant women which have resulted from their findings. These include screening for psychiatric illness in a systematic and sensitive way at booking, and for those women who have a history of serious psychiatric disorder seeing a psychiatrist in pregnancy and developing a written management plan.

In New Zealand the Perinatal and Maternal Mortality Review Committee (PMMRC) has been established to review perinatal and maternal deaths and advise the Minister of Health on how to reduce the number of deaths. A Maternal Mortality Review Working Group (MMRWG), which reports to the PMMRC has been set up to review all maternal deaths and identify any areas of possible improvements in maternal care. This process has highlighted the need to look at the mental health needs of women in pregnancy. We know that some pregnant women are at risk of severe mental health problems during pregnancy and the post partum period. In particular we need to identify these women so that appropriate management plans can be developed. Women are seen by a number of health professionals, but care can be fragmented for a variety of reasons. Communication pathways are sometimes unclear, and risks not clearly identified.

The aim of this Workshop is to highlight maternal mental health (and ill health) and decide what we could be doing at a national level to improve outcomes for women and their families. We need to answer some important questions for care of pregnant women in New Zealand

What do LMCs need to know about mental illness?
How should we screen for maternal mental illness in pregnancy?

Having screened do we have adequate services to formulate and carry out management plans?
Do we need specialised maternal mental health teams?
Do we need mother/baby units where women with psychiatric illness can be admitted with their babies?

We will only recognize problems when we have some plan to deal with them, and this day is to help raise awareness of mental illness associated with the perinatal period. We are extremely fortunate to have Professor Margaret Oates as a key note speaker. Professor Oates is the Clinical Director, East Midlands Perinatal Mental Health Managed Care Network, UK and was a member of the UK Confidential Enquiry into Maternal Death.

Dr Cathy Hapgood
Psychiatrist and Member of PMMRC Maternal Mortality Review Working Group

To register or for further information on the Maternal Mental Health Workshop please go to:
www.pmmrc.health.govt.nz

PMMRC Neonatal Encephalopathy Working Group

The PMMRC role includes developing strategic plans and methodologies to reduce morbidity as well as mortality. Hypoxic ischaemic insults are a major cause of acute perinatal neurological injury in the full term infant. Regrettably, such cases continue to occur despite the many advances in obstetric and neonatal care over the last 25 years. Although it has long been considered that intra-partum events account for only a small percentage of affected infants (1, 2) more recent imaging studies have demonstrated evidence of significant and recent neurological injury in 80 % of infants presenting with neonatal encephalopathy (NE) (3). Sadly the outcome for affected infants may include mortality and long-term neurodevelopmental morbidity.

Internationally, there are a number of older population based studies looking at NE prevalence but there are no good national data from New Zealand. Thus, it is important to review national data to establish both the size of the problem in New Zealand and to explore ways of improving outcomes.

This is particularly pertinent as intervention with therapies, such as cooling, shifts from research to become a clinical reality.

The Neonatal Encephalopathy Working Group was established by PMMRC in late 2007. Representation was drawn from a wide range of health professionals involved in perinatal care as well as representatives of ACC and the Ministry of Health. The overall purpose of the group is to review New Zealand data on NE so as to improving services and outcomes for babies. Although there may be a temptation to look at quick easy ways to improve outcomes, there were no datasets readily available for New Zealand that could be considered helpful in this regard. Thus the first priority for the group will be to collect data that will form a national data set on NE.

The group has settled on a working definition for cases of interest. This is adapted from the definition of Nelson and Leviton (4)

“A clinically defined syndrome of disturbed neurological function within the first weeks of life in the term infant, manifesting by difficulty in initiating and maintaining respiration, depression of tone and reflexes, subnormal consciousness and often seizures”

This was considered sensitive enough to allow inclusion of cases where a clear hypoxic ischaemic cause was not proven. However, in order to be a little more specific and restrict encephalopathy evolving following postnatal conditions such as sepsis or congenital cardiac disease, the group decided to narrow the time frame to only those infants presenting in the first seven days after birth.

We will perform a short trial of data collection in late 2008 and to commence formal collection of New Zealand data in 2009.

Dr Malcolm Battin
Neonatologist and Chair of the PMMRC Neonatal Encephalopathy Working Group

Sands Stillbirth and Neonatal Death Support

The Sands New Zealand website is now up and running again - www.sands.org.nz

The website contains the Sands pamphlets from the support packs, which can be downloaded if you run out of packs; a national contacts list which features groups and contact people throughout the country and their contact details; New Zealand definitions and terminology for perinatal death; links to other pregnancy, baby and infant loss support organisations in New Zealand and around the world; and links to current research on stillbirth and perinatal loss. Information about Baby Loss Awareness Week events (9th – 15th October) being held around the country will be posted on the website and we hope to post stories and support literature in the near future.

Perinatal Death Study Days – many DHBs have held or are planning to hold a Perinatal Death Study Day. This is an effective way of providing information to midwives, registrars, consultants and associated health professionals in your DHB. If you would like information on what topics have been covered during previous Study Days and potential speakers, please email Vicki Culling, a PMMRC member and current Chairperson of Sands NZ. Vicki is happy to provide as much information as possible about organising a Study Day and whenever possible, is happy to attend and present. Vicki can be contacted on v.culling@paradise.net.nz or 021-776436.

Vicki Culling, Sands NZ and Member of PMMRC

Seatbelts use in pregnancy

Many women are unsure of the correct use of seatbelts in pregnancy. This puts their wellbeing and that of their unborn baby at risk. Women cite concerns about possible harm to the baby and discomfort as primary reasons for not wearing a seatbelt or wearing one incorrectly. However it has been shown that the best form of protection for the baby is to protect the mother. Receiving education from their LMC has been shown to increase compliance and correct usage of seatbelts.

The key words to remember for proper positioning of a seat belt during pregnancy are: **between** and **below**. The shoulder strap should go over the shoulder, collar bone and down across the chest – between the breasts. The lap belt should be as low as possible under the abdomen and the unborn child.

Maternity Seat Belts are also available to reposition the seatbelt to better fit a pregnant woman. Tests have shown that these devices do not affect the safe operation of the seatbelt and Land Transport NZ has confirmed that these comply with New Zealand law.

PMMRC Perinatal Rapid Reporting Forms

Following a perinatal death we ask that all LMCs and/or other involved clinicians enter information on the website www.pmmrc.otago.ac.nz. To ensure this process is as thorough and user friendly as possible we review and update the PMMRC rapid reporting forms annually. The latest changes to the forms came into effect on the 1st January 2008.

The PMMRC website is currently being upgraded to reflect these changes. The Mortality Data Group who manage this website have asked that you phone them on **03 470 3807** if you experience any problems during this upgrade.

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](#)

Contact details

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Upcoming Conferences and Workshops

Keeping Mothers Safe Maternal Mental Health Workshop PMMRC

9am – 5 pm, 29 October 2008
Waipuna Lodge, Auckland.

Baby Loss Awareness Week

(9th – 15th October)

www.sands.org.nz

Recent Publications

CEMACH Perinatal Report 2006 - Reviewing Perinatal deaths to improve outcomes before and after birth in the UK. Available at

www.cemach.org.uk

Neonatal Encephalopathy References

- 1.
- 2.
1. Baldawi N, Kurinczuk JJ, Keogh JM, Alessandri LM, O'Sullivan F, Burton PR et al Intrapartum risk factors for newborn encephalopathy: the Western Australian case-control study. *BMJ* 1998;317(7172):1554-8
2. Nelson KB. Relationship of intrapartum and delivery room events to long-term neurological outcome. *Clinics in Perinatology*. 1989;16(4):995-1007
3. Cowan F, Rutherford M, Groenendall F, Eken P, Mecuri E, Bydder GM, et al. Origin and timing of brain lesions in term infants with neonatal encephalopathy. *Lancet* 2003;361(9359):736-42.
4. Nelson KB, Leviton A. How much of neonatal encephalopathy is due to birth asphyxia? *American Journal of Diseases of Children*. 1991;145(11):1325-31