Newsletter - *December 2011*

MESSAGE FROM THE CHAIR

Welcome to the final issue for 2011! Preparations for the 2010 Annual Report continue to be progressed with difficulties currently being addressed in relation to reporting and data retrieval of 2010 stillbirths and neonatal deaths due to the implementation of the ObstetrixTas electronic perinatal database system in Tasmanian state hospitals. Subsequently, these hospitals have been encouraged to use a *National Perinatal Death Clinical Audit Tool* to collect stillbirth and neonatal death details in the future with the hope to also electronically capture this information sometime soon. The Maternal M&M S/c Report has been finalised and a brief overview has been included in this newsletter for your interest. It is hoped that the 2010 report from the Paediatric M&M Subcommittee will be finalised soon and available for circulation with the release of the next issue of COPMM's newsletter in March 2012. The current term of appointments for Council members is nearing its completion and renewal of appointments by the Health Minister will be undertaken before the end of the financial year for the new term commencing 2012-2015. The overall Council's Annual Report for 2010 is also expected to be finalised and released by the end of the financial year. Once again, I wish to sincerely thank our Manager and the COPMM Members for their continued support and significant contributions to Council and its ongoing activities.

On behalf of Council, I would also like to thank readers for their interest in and support of Council activities throughout 2011 and would like to take the opportunity to wish you a happy and safe Festive Season and the very best for the New Year.

A/Prof Peter Dargaville
Chairperson
Council of Obstetric & Paediatric Mortality & Morbidity

COUNCIL NEWS

Membership for the current 2009-2012 term in accordance with the Terms of Reference includes: A/Prof Peter Dargaville (Chair); Professor Allan Carmichael (UTas rep); A/Prof Amanda Dennis (UTas Rep), Dr James Brodribb (RANZCOG rep); Dr Geoff Shannon (RACGP rep); Ms Ros Escott (Community Rep); Ms Flo Jensen (ACMTas rep), Mr Paul Mason; Dr Michelle Williams (Tasmanian Branch of the Paediatric Health Division of the RACP rep) & Ms Gina Butler (DHHS rep).

The Council website continues to archive newsletters, Annual Reports and other relevant resource information http://www.dhhs.tas.gov.au/copmm. Please note that *RHH Clinical Practice Guidelines and Protocols* can be accessed from the intranet link included in Council's website.

Manager, Contact Details: Dr Jo Jordan; email: jo.jordan@dhhs.tas.gov.au

CLINICAL MATTERS

1. **Summary of Recommendations from 2010 Maternal M&M Annual Report-** In 2010 two maternal death cases were reported. One case represented a *non-maternal (incidental) death* due to substance abuse. The second case was an *indirect maternal death* due to suicidal hanging. Recommendations arising from the review of these cases include: (1) It is recommended that upon identification of "at risk" women appropriate education to drug misusing patients regarding drugs is provided and referral to complex care team and drug support services is undertaken as required; and, (2) It is recommended that upon identification of "at risk" women who suffer from mental health disorders, particularly those women who have shown a history of previous suicide attempts and self-harm, appropriate Psychiatric referral and counselling services, especially if there is suicidal ideation, should be made available during antenatal and postnatal periods. Suicidal risk should be assessed on a regular basis and suicidal threats should not be ignored or dismissed. A suicide contract should be established to specify under what conditions the counselor may be contacted in case the client feels like hurting herself. Self-mutilation behaviour should also be taken seriously as an issue of importance to discuss within counselling sessions.

2. **Electronic Perinatal Database (ObstetrixTas)-** Council has agreed that it is vitally important to ensure that a Statewide Coordinator for the ObstetrixTas system is implemented and the necessary resources are provided to ensure that the perinatal data collection form can be completed electronically. It is particularly noted that since the system currently does not include separate forms to report on Stillbirths or Neonatal Deaths, it has become apparent that difficulties have arisen in ensuring that details are entered by respective hospitals onto the old paper based form for stillbirths and neonatal deaths. As such, retrieval of information from hospitals for these areas is proving to be difficult particularly for those hospitals having a proportionally higher number of reported stillbirths for that year. Council agreed to write to the (Acting) Secretary of DHHS with a copy to the Chief Information Officer, Dr Belinda Quinn to highlight Council's concerns and point out that delays are expected with regard to the progression of review and classification of reported 2010 perinatal cases by members of Council's *Perinatal Mortality and Morbidity subcommittee*. Since timely reporting is a legislative requirement according to the *OPMM 1994 Act*, these delays become particularly obstructive in allowing Council to meet its legislative requirements. An *Electronic Perinatal Database Project Closure Report* has been drafted by the Project Manager and is to be ratified by the Steering Committee in the near future before forwarding to the Department's Chief Information Officer. Council's Data Management subcommittee will be meeting later in December to further discuss these issues.

3. **Congenital Abnormality Register–** The Data Management Subcommittee of Council continues to explore the issue of a more comprehensive Congenital Abnormality Register for Tasmania which it hopes to develop over the next 12 months and include in the ObstetrixTas electronic perinatal database system. Council has agreed to seek updates from the Chair of the Queensland Maternal and Perinatal Quality Council (Professor Michael Humphrey) with regards to the proposed development of a National Congenital Abnormality Register to assist in Tasmania's efforts in developing a register. Council has recently been advised that a National Congenital Abnormality Register has not as yet been progressed further at this stage.

4. **Australian & New Zealand Child Death Review & Prevention Group (ANZCDR&PG)–** The Chair of the Paediatric Mortality and Morbidity Subcommittee of Council, Dr Michelle Williams, who is currently representing Tasmania on this group will be participating in a teleconference meeting scheduled to be held sometime in February 2012 (tbc). Dr Williams will endeavour to provide updates in this space as appropriate.

5. **National Maternal Mortality Advisory Committee-** The Australian Institute of Health and Welfare have been contracted by the Department of Health and Ageing to undertake a National Maternity Data Development Project which will be conducted with the National Perinatal Epidemiology and Statistics Unit which is the collaborating unit of the AIHW. This project aims to develop a nationally consistent and confidential maternal death enquiry system and develop a national report on maternal mortality. This project will also include a national study of maternal and late maternal deaths using the data linkage of the perinatal collection(s) and National Death Index data. As part of this development, a *National Maternal Mortality Advisory Committee* has been established comprising experts in all fields. COPMM has nominated Associate Professor Amanda Dennis who currently chairs the Maternal Mortality and Morbidity Subcommittee of COPMM to formally represent it at future national committee meetings. Dr Jamie Brodribb has agreed to undertake proxy representation on this Committee as required. Dr Brodribb attended the recent teleconference Committee meeting and provided an update to Council on discussions including the establishment of a proposed uniform definition of maternal mortality in line with WHO recommendations and a nationally consistent reporting format for effective national maternal death enquiry etc.
6. **Standardisation of Perinatal Review in Tasmanian Hospitals-** Tasmania has been approached to participate in the pilot program of the ***National Perinatal Death Clinical Audit Tool (NPDCA)*** which has been advised as commencing in Tasmanian hospitals sometime in November 2011 for a 3-month period. Council has agreed to support this pilot in Tasmanian hospitals and relevant hospitals have indicated their willingness to pilot this tool as required. In the meantime, hospitals have agreed to Council's request for their relevant Perinatal M&M committees to complete details on reported 2010 stillbirth and neonatal deaths using this tool and provide perinatal summaries to Council for review and classification. Local hospital M&M committees have also been requested to provide future perinatal review summaries derived from this tool on a 6-monthly basis. It is hoped that this form will provide all hospitals with an effective opportunity to standardise the process of audit for perinatal mortality cases.
7. **Update from Smoking and Pregnancy Working Group-** The Smoking and Pregnancy Working Group is a sub group of the Tobacco Coalition established in 2006 to make recommendations on actions to reduce smoking prevalence by pregnant women in Tasmania. The group consists of representatives from Population Health, Maternity Services, Quit Tasmania, Child Health and Parenting Services, COPMM, Aboriginal Health GP South and Smoking Cessation Program. The recommendations that came from a State Wide forum in 2006 have been updated in the group's latest Work Plan. The priorities for the coming year are to:
   - Provide education and support for health professionals that work with pregnant women;
   - Support campaigns implemented by the Quit Tasmania Social Marketing Program
   - Improve access to cessation services;
   - Monitor Smoking during pregnancy prevalence data;
   - Support improved communication and collaboration across those working in smoking and pregnancy.

   The Smoking and Pregnancy Working group is convened by Marion Hale from the Tasmanian Women's Health Program. For further information email marion.hale@dhhs.tas.gov.au
8. **Paediatric Morbidity Issues-** Further consideration and review of these issues will be undertaken by the *Paediatric Mortality and Morbidity Subcommittee* of COPMM as feasible. In particular, a recent article by Dr Roger Byard (2011) [*MJA*, 195 (6), p. 321] has been considered by the committee where it highlights increased risk of infant deaths associated with baby slings. A clear message is given alerting parents and carers to be aware of potential safety issues with the use of these devices, particularly in very young infants. Constant monitoring of infants in slings is advised

to ensure that the infant's head is facing outwards, with no covering of the face.

SUBCOMMITTEES

PAEDIATRIC Mortality & Morbidity

This subcommittee continues to meet bimonthly to review statewide paediatric deaths and progress actions as they arise. The Review and classification of 2011 cases is near completion and preparations have commenced to progress the 2010 Paediatric Mortality & Morbidity Report with a view to release with the March 2012 issue of COPMM's newsletter. The Committee has agreed to seek out guidelines for Morbidity Serious Injury Indicators from other jurisdictions and discuss morbidity issues where possible.

PERINATAL Mortality & Morbidity

Review and classification of perinatal deaths (including stillbirths and neonatal deaths) for 2010 will commence once details of cases have been received from relevant hospitals in view of limited information currently available from *ObtsterixTas* system. Hospitals have been requested to complete 2010 stillbirth details using the *National Perinatal Death Clinical Audit* tool. This tool will also be used in the future by local hospital Perinatal M&M Committees to replace pages 3 and 4 of the stillbirth and neonatal death reports on the old paper-based Perinatal Data Collection Form. The hope is to finally capture this information electronically in line with the electronic perinatal database in the near future.

MATERNAL Mortality & Morbidity

No Maternal death cases have been reported so far in 2011. Recommendations from cases reported in 2010 are detailed above. Progress of the *Australian Maternity Outcomes Surveillance System* (AMOSS Project) will continue to be tracked and its relevance to Tasmania's reporting assessed etc.

DATA MANAGEMENT

This subcommittee is scheduled to meet again in late-December 2011 or early 2012 to progress the 2010 Annual Report and discussions concerning the development of a Congenital Abnormality Register for Tasmania. A keen interest is maintained in monitoring any national developments to assist with this matter. It is hoped to finally incorporate an updated and more comprehensive Congenital Abnormality Register for Tasmania into the electronic perinatal database. Other issues related to the Electronic Perinatal Database will also be further discussed.

MEMBERSHIP CHANGES

As previously noted, membership for the 2012-2015 term and associated Ministerial appointment processes will be progressed in early 2012 in view of the current term ending in July 2012.

MEETINGS FOR 2011

Next Council Meetings:

- Thursday 23 February, 12.30-2.00pm, Videoconference Meeting Room, Level 4, 34 Davey Street
- Thursday 24 May, 12.30-2.00pm, Videoconference Meeting Room, Level 4, 34 Davey Street
- Thursday 16 August, 12.30-2.00pm, Videoconference Meeting Room, Level 4, 34 Davey Street
- Thursday 22 November, 12.30-2.00pm, Meeting Room, Level 4, 34 Davey Street

Note: Subcommittee meetings will be advised.