

## Newsletter - June 2011

### MESSAGE FROM THE CHAIR

I am pleased to report that preparations for the 2009 Annual Report are progressing well with a view to finalise by the end of this financial year. Final publication will be released to key stakeholders electronically and hard copies will be available upon request. The Annual Report will also be provided to members of Parliament for tabling and discussion in due course. Key clinical issues arising from the 2009 Stillbirth Report have been included in this newsletter for the Reader's interest and convenience. At its recent meeting, Council welcomed Associate Professor Amanda Dennis as second UTAS representative whose appointment has been extended until the end of the current term. Once again, I wish to sincerely thank our Manager and Members for their continued support and significant contributions to Council and its ongoing activities.



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.

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### CLINICAL MATTERS

1. **Electronic Perinatal Database (ObstetrixTas)**- A Steering Committee continues to meet to discuss identified local issues as well as common issues to ensure that this statewide system operates as effectively as possible. Council has agreed to explore available support/resources both locally and centrally to assist with the ongoing operations of the ObstetrixTas system. Moreover, Council supports the need to ensure that a *champion* be implemented in each hospital to provide a supporting role for their site and ensure that maintenance and improvement in the system is effectively achieved. Council also agreed that it was important for the DHHS to ensure that there was continued coordination and consistency within the use of the system and problems were managed effectively.



2. **Sudden Unexplained Infant Deaths**– During the review and classification of paediatric deaths in Tasmania during 2010 and 2011 it has been evident that a disturbing number of *Sudden Unexplained Deaths in Infants (SUDIs)* have been reported. It is of a particular concern that a large proportion of these SUDI cases have been found to be associated with risk factors such as co-sleeping with adults. Council urges that the message of safe sleeping practices continues to be highlighted within the community. Coroner McTaggart’s recommendations are particularly pertinent following her investigations into infant deaths in Tasmania where the Coroner believed that the DHHS should adopt a lead role in (i) developing a single set of consistent guidelines that define the appropriate strategies to be implemented by parents, carers, and health professionals for the reduction of risk factors in sudden unexpected deaths of infants; (ii) publishing the guidelines amongst the medical and nursing professions in both the public and private sector; (iii) publishing the guidelines in the wider community generally, including amongst current and future parents (eg. in antenatal classes and secondary schools); (iv) conducting a SIDS education program statewide (perhaps by employing a SIDS educator), with particular reference to any high risk sub-groups; (v) implementing a requirement that all child health nurses/community nurses receive updated training about the guidelines, and (vi) ensuring that SIDS risk assessments are conducted with parents upon the mother’s discharge from hospital, with appropriate information about the guidelines provided to them.

3. **Stillbirth Update-**

1) There were 52 stillbirths reported in 2009 where “stillbirths” refers to the expulsion of a foetus beyond 20 weeks gestation (irrespective of whether foetal death had occurred before or after 20 weeks), or > 450gms weight.

2) Three of the stillbirths were derived from pregnancies that finished prior to 20 weeks, twins weighing 84 and 96gms, and a twin weighing 100gms at 37 weeks – hydrops noted at 21 weeks.

3) The number of stillbirths occurring since 1997 are outlined below:

1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
52	37	46	45	43	49	48	37	39	42	44	61	52

4) Almost 1 in 5 stillbirths are unexplained and unfortunately, the investigations for stillbirth continue to be incomplete. Council recommends that practitioners follow the *Perinatal Society of Australia and New Zealand Recommendations (2009)* for the investigation of stillbirth.<sup>1</sup>

5) Foetal growth restriction (FGR) remains an area of considerable concern particularly since it accounts for 15% of foetal losses. All foetal deaths from FGR in 2009 occurred at >30 weeks which is comparable to previous years. These foetuses are not just mildly growth restricted but many being <3rd centile for gestation. These growth restricted babies should be identified in the course of routine antenatal care. There is clear evidence that obesity is now a major factor of concern in the community and this is reflected in the women attending for antenatal care. Extra clinical vigilance needs to be maintained in this group with early recourse to ultrasound assessment of foetal growth at any stage of pregnancy. As indicated in the 2008 Council Annual Report, the foetal survival beyond 30 weeks for normal babies delivered is almost 100%. Council encourages all maternity service providers

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<sup>1</sup> PSANZ Clinical Practice Guideline for Perinatal Mortality [http://www.PSANZ.COM.AU/files/Section\\_5\\_Version\\_2.2\\_April\\_2009.pdf](http://www.PSANZ.COM.AU/files/Section_5_Version_2.2_April_2009.pdf), accessed 31/5/2011.

to establish protocols for the detection of growth restricted fetuses from 30 weeks gestation and for timely, and appropriate, management. An aid to this process is the use of customised growth charts<sup>2</sup>, allowing growth assessment by either ultrasound or symphysis-fundus height measurements.

6) Congenital anomalies continue to account for about a quarter of foetal losses, usually as planned pregnancy termination. In the past, the contribution has been low, 1996 (5/53=9%) and 1997 (11/60=18%). The current level of 25+% reflects the increasing involvement of ultrasound scanning for foetal anomalies (now at about 20 weeks gestation) with pregnancy termination after 20 weeks. In the early years of foetal scanning this was undertaken at earlier gestations (16-18 weeks) resulting in terminations being performed before 20 weeks gestation.

7) Antepartum haemorrhages account for approximately 10% of losses, often associated with premature membrane rupture. In many instances, chorioamnionitis has supervened, often because of the conservative management of extreme prematurity of many of these pregnancies and the understandable desire to extend the period of gestation to one at which survival is likely to occur. In such situations, surveillance for and treatment of infection is of paramount importance. Antepartum haemorrhage is a significant risk marker for preterm birth and recent publications have indicated that even first trimester bleeding also carries an increased risk.

8) It has been noted for some time that surgery for cervical dysplastic disease, either cold knife conisation, laser conisation or LLETZ procedures has been linked with increased perinatal morbidity and mortality due to PROM/preterm delivery<sup>3</sup>. Therefore, close observation of such women during pregnancy for evidence of cervical incompetence after 14 weeks gestation is required when there is evidence of previous cervical surgery for cervical dysplastic disease treatment. Risks are even greater when there has been more than one such procedure performed.

9) Surprisingly, true preterm labour alone has accounted for very few stillbirths.

10) Birth trauma has been a cause of only one foetal death since 2000 (c.f. case reported in 2002).

4. **Standardisation of Perinatal Review in Tasmanian Hospitals-** All Tasmanian public and private hospitals have confirmed that their respective Mortality and Morbidity Committees will support the use of the ***Perinatal Mortality Confidential Case Summary*** as per Section 2 (of 7)-*Institutional Perinatal Mortality Audit from the Perinatal Society of Australia and New Zealand*. This comprehensive form will aim to provide all hospitals with an effective opportunity to standardise the process of audit for perinatal mortality cases. Council will be following up any concerns registered by clinicians with regards to the use of the form through the respective Chairs of each local Perinatal M&M Committee within Tasmania. COPMM has agreed to request on a 6 monthly basis that hospitals provide Council with the relevant perinatal review summaries to assist in the overall review, classification and reporting of all perinatal cases in Tasmania. It is understood that restrictions will apply to privileged information maintained by the local M&M Committees and the form will reflect this requirement.

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<sup>2</sup> Gestation Network [http://www.gestation.net/fetal\\_growth/fetal\\_growth.htm](http://www.gestation.net/fetal_growth/fetal_growth.htm) accessed 31/5/2011.

<sup>3</sup> Arbyn M, Kyrgiou M, Simoons C, Raifu AO, Koliopoulos G, Martin-Hirsch P, Prendiville W, Paraskevaidis E. (2008) Perinatal mortality and other severe adverse pregnancy outcomes associated with treatment of cervical intraepithelial neoplasia: meta-analysis. *BMJ*. Sep 18;337.



## SUBCOMMITTEES

### PAEDIATRIC Mortality & Morbidity

This subcommittee continues to meet bimonthly to review statewide paediatric deaths and progress actions as they arise. The Committee seeks to extend the appointment of the Commissioner for Children, Ms Aileen Ashford as representative on this committee beyond June 2011 subject to the current status of CDSIC. At its recent meeting, Council endorsed the extension of the Commissioner for Children representative role and would be discussing this matter further with the Commissioner for Children at a meeting to be held later in June 2011. The completed draft of 2009 Paediatric Report is currently undergoing some minor edits before being included in the 2009 Annual Report. Review and classification of 2010 cases has been completed while 2011 cases continue to be progressed.

### PERINATAL Mortality & Morbidity

Review and classification of perinatal deaths (including stillbirths and neonatal deaths) for 2009 has been completed and respective reports are being finalised for inclusion in the 2009 Annual Report. Key issues arising from the 2009 Stillbirth Report are highlighted within the Clinical Issues section of this newsletter for the Reader's information and interest.

### MATERNAL Mortality & Morbidity

With the appointment of Associate Professor Amanda Dennis having been formally extended on Council, she has been invited by Council to Chair this subcommittee. Associate Professor Dennis has accepted to undertake the role of Chair on this subcommittee and has requested that she along with members commence the review and classification of the three maternal death cases reported in 2010 as soon as possible. Recommendations will be formulated as appropriate. Progress of the *Australian Maternity Outcomes Surveillance System (AMOSS Project)* will continue to be tracked and its relevance to Tasmania's reporting's assessed etc.

### DATA MANAGEMENT

A meeting was recently held in May, 2011 to progress issues related to the 2009 Annual Report but more specifically to review the Electronic Perinatal Database (*ObstetrixTas System*). It was confirmed that all items recommended by Council had been included on the *ObstetrixTas* system except for the *Congenital Abnormality Register* that is to be developed in due course.

## MEETINGS FOR 2011

### Next Council Meetings:

- Thursday 18 August, 12.30-2.00pm, venue tbc
- Thursday 17 November, 12.30-2.00pm, venue tbc

**Note:** Subcommittee meetings will be advised.