Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Safer Care Victoria

# Victoria's mothers, babies and children 2019

## Perinatal mortality

# About CCOPMM

# About CCOPMM

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) is a statutory authority appointed by the Minister for Health

Chair: Adjunct Professor Tanya Farrell

Operates under the *Public Health and Wellbeing Act 2008*

# About CCOPMM

Legislative responsibility for data collection

- Victorian Perinatal Data Collection (VPDC)
- Victorian Congenital anomalies register (VCAR)

Legislative responsibility for health surveillance

- Mortality collections and review of perinatal, child and adolescent, and maternal mortality
- Morbidity collections: severe acute maternal morbidity (SAMM)

# Undertaking case reviews

Four subcommittees report to CCOPMM:

- **Stillbirth** – Chair: Professor Susan McDonald
- **Neonatal Mortality and Morbidity** (0-27 days) – Chair: Professor Rod Hunt
- **Maternal Mortality and Morbidity** – Chair: Professor Mark Umstad
- **Child and Adolescent Mortality and Morbidity** (28 days-17 years) – Chair: Professor Paul Monagle

# Undertaking research

CCOPMM conducts research itself and also provides data for research purposes

CCOPMM identifies research priorities by:

- analysis of our reports, data and through case reviews
- collaborating with external research projects

# Why do we do what we do?

Independent oversight of all deaths and severe maternal morbidity

Highlight areas that require improvement – hospital and community

Highlight areas for further research

Inform the development of policies and guidelines

Provide advice on areas for prioritisation and investment

# Trends and comparisons: Perinatal mortality

# Perinatal mortality

- Includes fetal deaths (stillbirths) and deaths of live-born babies within the first 28 days after birth (neonatal deaths)
- Excludes terminations of pregnancy for psychosocial indications – 'adjusted' perinatal mortality:
  - provides a more accurate assessment of avoidable mortality and assists comparisons with other jurisdictions
- Detailed data for perinatal mortality can be found in the online supplementary tables

# Births in 2019

**77,779 women** gave birth in 2019

↗ **423 more** women gave birth than 2018

**78,954 babies** were born in 2019

↗ **433 more** babies born 2019 than 2018

↘ **birthrate decreased to 56.5** per 1,000 EFRP

# Perinatal deaths in 2019

**860**
**perinatal deaths** 2019
Slight increase from 848 in 2018

**688** **adjusted perinatal deaths** 2019
Slight increase from 675 in 2018

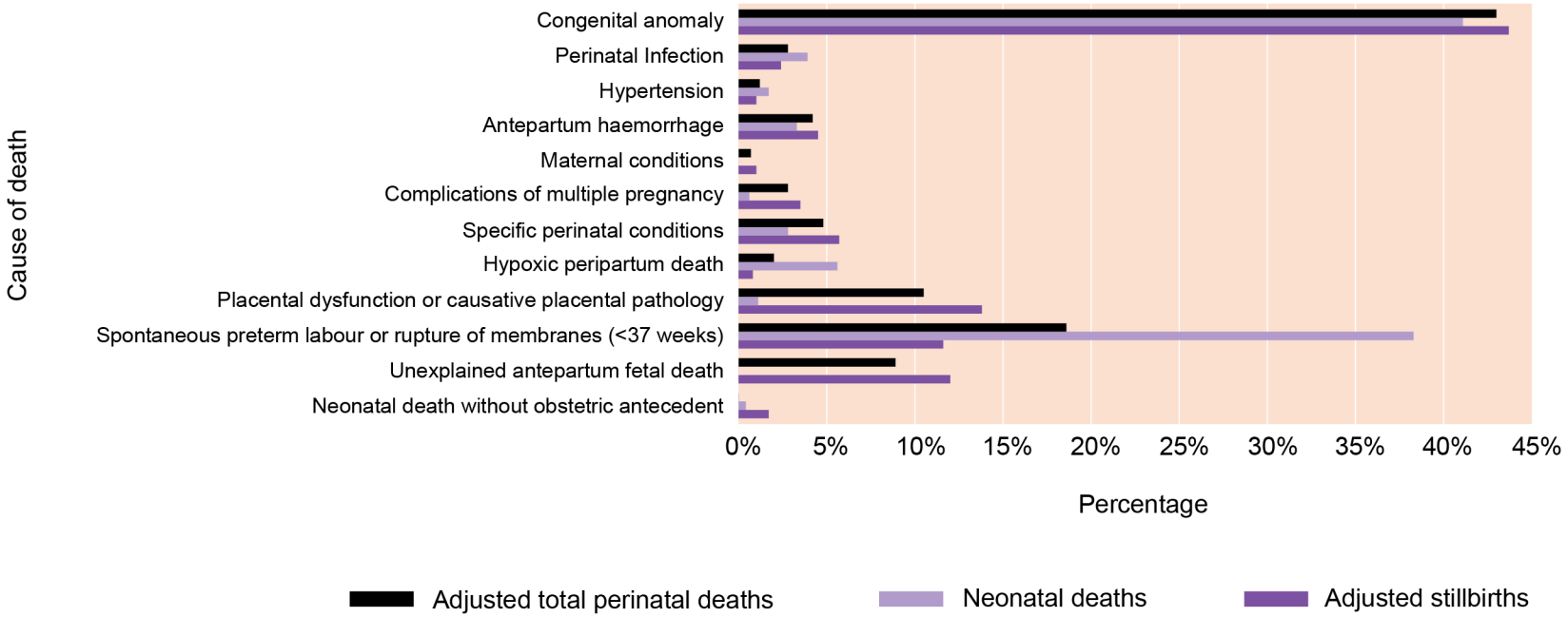
**8.7** per 1,000 births **adjusted perinatal mortality rate** 2019
Slight increase from 8.6 in 2018

**31.7%** of adjusted perinatal deaths in 2019 **underwent an autopsy**
Down from 35.5% in 2018

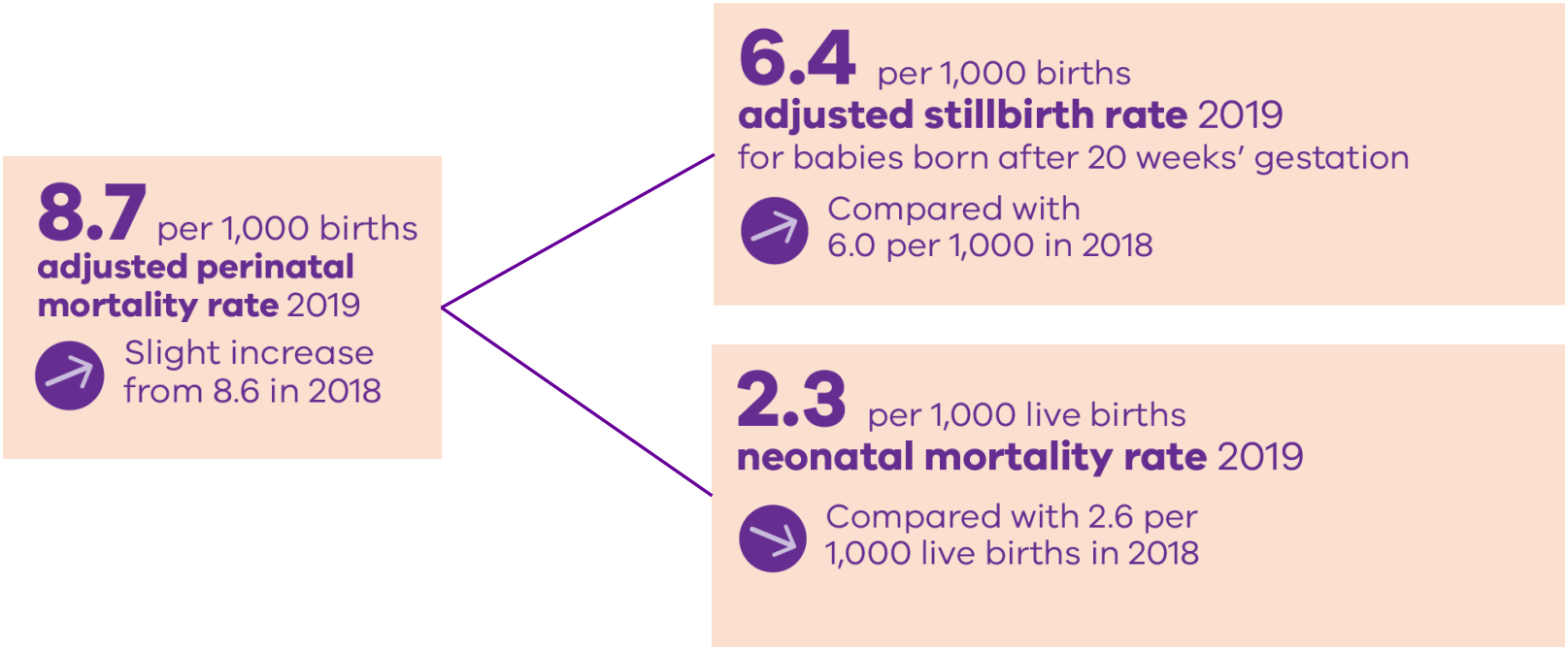
**34.4%** of stillbirths **underwent an autopsy**
Down from 39.5% in 2018

**23.9%** of neonatal deaths **underwent an autopsy**
Down from 26% in 2018

# Causes of deaths using PSANZ classifications

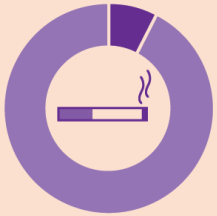


# Perinatal mortality rates in 2019



# Smoking and outcomes in 2019

**6,109 babies born**
**to women who smoked**
at any time during their pregnancy in 2019.
(7.7% of all adjusted births)



**10.5**
**adjusted PMR**
per 1,000 births

**47**
**stillbirths**

**17**
**neonatal deaths**

in women who smoked at any time during their pregnancy in 2019.

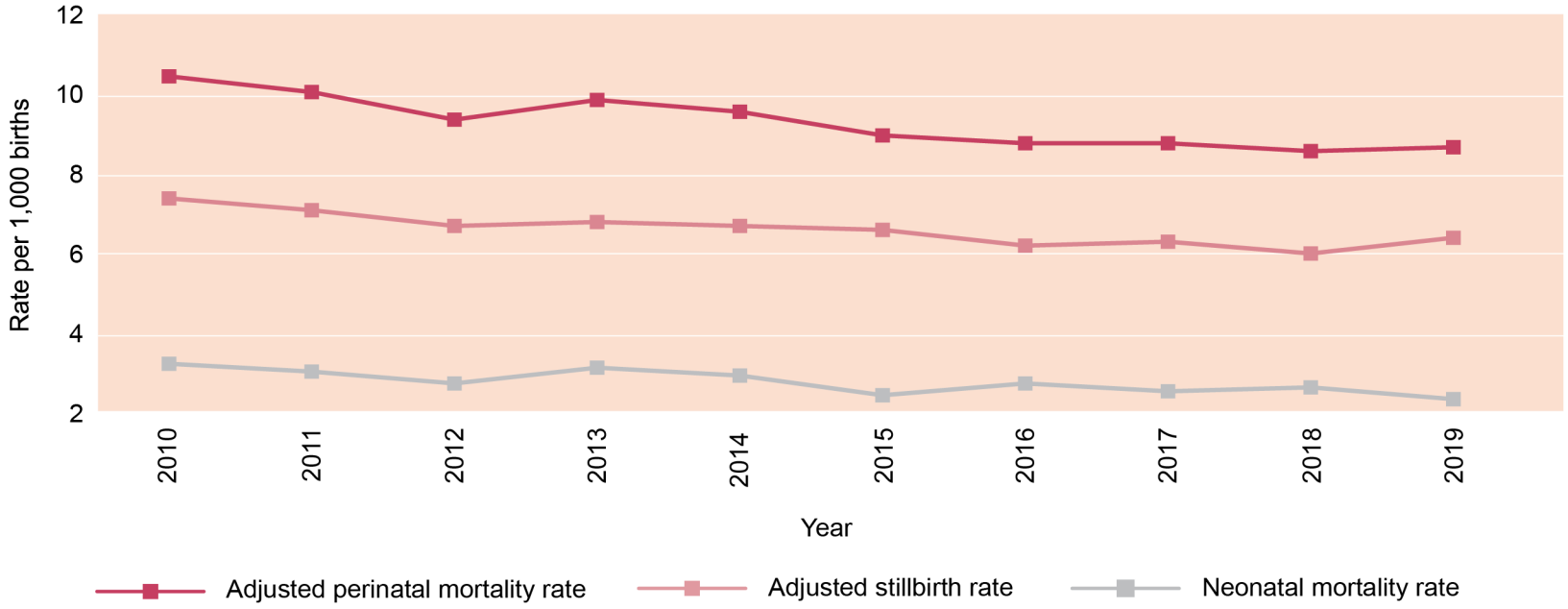
**8.6**
**adjusted PMR**
per 1,000 births

**443**
**stillbirths**

**162**
**neonatal deaths**

in women who did not smoke at any time during their pregnancy in 2019.

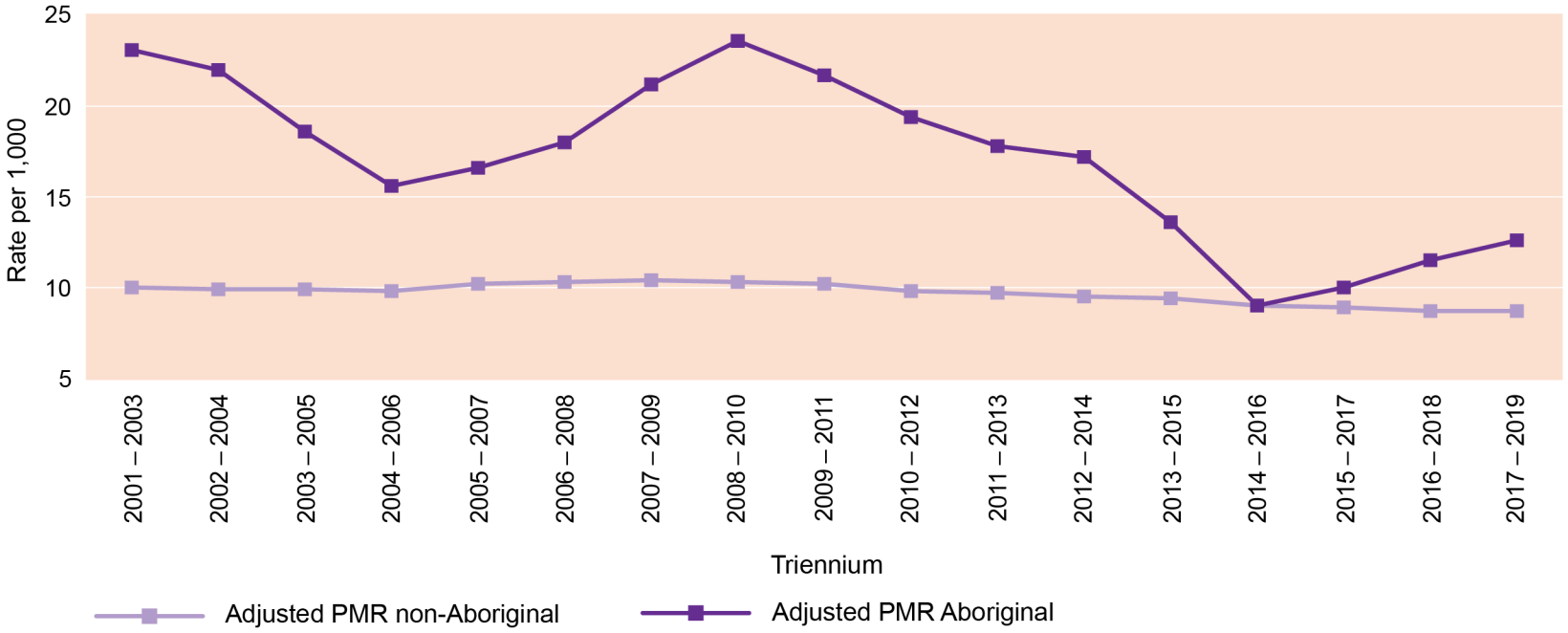
# Trends in perinatal mortality rates



# The gap: Aboriginal and Non-Aboriginal women

| | Aboriginal women | Non-Aboriginal women |
|---|---|---|
| **Perinatal Mortality Rate** (PMR) | **12.6** deaths per 1,000 births **for 2017-2019** Compared with **11.5** in 2016-2018 | **8.7** deaths per 1,000 births **for 2017-2019** Compared with **8.7** in 2016-2018 |
| **Stillbirth Mortality Rate** | **7.9** deaths per 1,000 births **for 2017-2019** Compared with **7.1** in 2016-2018 | **6.2** deaths per 1,000 births **for 2017-2019** Compared with **6.2** in 2016-2018 |
| **Neonatal Mortality Rate** | **4.7** per 1,000 live births **for 2017-2019** Compared with **4.4** in 2016-2018 | **2.5** per 1,000 live births **for 2017-2019** Compared with **2.6** in 2016-2018 |

# Perinatal mortality rate by Aboriginal status: Rolling triennia



# CCOPMM recommendations: Perinatal

## Recommendations

Maternity services must develop and regularly audit a **pathway that facilitates rapid access to an emergency operating theatre** 24/7 to prevent significant maternal or perinatal morbidity or mortality

For all Category 1 caesarean sections, services must **record the time in which the decision was made to perform the caesarean section – to enable the accurate recording of the time taken from the 'decision to deliver' to the birth** of the baby

## Recommendations

Develop and implement a **formal time out process prior to every instrumental birth and emergency caesarean section**, whether in a birth room or in the operating theatre, to improve situational awareness and decision making about whether it is the right mode of birth, in the right location, with the right instrument/s, and the right clinical team in attendance

Develop and implement a **credentialing process for medical staff practising obstetrics** at all levels of training and experience who are undertaking instrumental births and complex caesarean sections

## Recommendations

Formalise pathways for women to have **timely access to specialist clinical consultations from a named tertiary (level 6) service** for secondary and primary maternity services

**Evaluate the effectiveness of current services in meeting the specific needs of women during pregnancy and in the year following birth.** If gaps are identified, implement strategies to improve the health and wellbeing of women and families. The areas of mental health and family violence require specific focused attention

# Good practice points

Good practice points reflect the findings of CCOPMM's review of all cases of maternal, perinatal and paediatric mortality, and severe acute maternal morbidity in a reporting year

They are designed to guide local improvements in clinical performance and can relate to our **clinical care and/or the system or service we work in**

## Good practice points

Ensure **all staff** are upskilled in clinical management through PRactical Obstetric Multi-Professional Training (PROMPT) or alternative program to ensure clinicians are familiar with obstetric emergencies

Use your own **clinical scenarios** to routinely train staff

Use **rare and high-risk emergencies** in your training programs

# Good practice points

**Monitoring - Twin to Twin Transfusion Syndrome** - In addition to growth and amniotic fluid assessment every 2 weeks from 16 weeks, **include** umbilical artery and mid cerebral artery (MCA) Dopplers from 20 weeks' gestation

If there is growth discordance or amniotic fluid level discordance, **include** assessment of the ductus venosus (DV) flow

Important component of the staging for twin to twin syndrome

## Good practice point

The **judicious, or non-use, of oxytocin infusion** for augmentation of a **multiparous woman** who fails to progress in labour is recommended

# Good practice points

To prevent significant maternal or perinatal morbidity or mortality, maternity services must have clear **pathways in place** that facilitate **timely access to an emergency theatre**

**Rapid access must be available** where there is an immediate threat to life of a mother and/or baby – e.g. code green/category 1 caesarean section, management of uterine rupture, management of antepartum heamorrhage

These pathways need to be **audited** to monitor rapid access in services 24/7

## Good practice points

Clear **handover of care** must occur between health services when transferring women during pregnancy

This **must be initiated** by the service/care provider initiating the transfer

This will remove the onus on women especially when they are vulnerable or at a late gestation in pregnancy

## Good practice point

Women choosing to undergo prenatal testing with cell-free DNA testing should be offered an ultrasound at 11 to 13+6 weeks' gestation to assess early fetal structural development

## Good practice points

Strengthen your service's relationships with maternal and child health nurse (MCHN) services - to ensure there is **support for women that have complex psychosocial history and/or a history of catastrophic episodes**

Ensure effective **connection and handover** to MCHNs

# For more information

www.bettersafercare.vic.gov.au/publications/victorias-mothers-babies-and-children-2019

Refer to CCOPMM's other slide packs on:

- Mothers and babies
- Maternal mortality and morbidity
- Child and adolescent mortality
- 2019 recommendations

## Connect with us


www.bettersafercare.vic.gov.au


tanya.farrell@safercare.vic.gov.au


@safercarevic @TanyaFarrell13


Safer Care Victoria