HEALTH ADMINISTRATION ACT 1982

New South Wales Maternal and Perinatal Mortality Review Committee

Terms of Reference

I, Elizabeth Koff, Secretary, Ministry of Health acting as the delegate of the Minister for Health, pursuant to section 23 of the Health Administration Act 1982 (the Act) and section 43 of the Interpretation Act 1987, do hereby:

(a) REVOKE the Order published in the NSW Government Gazette No 86 of 10 October 2014, authorising the NSW Maternal and Perinatal Mortality Review Committee (MPMRC) to conduct investigations and research in accordance with section 23 of the Act; and

(b) AUTHORISE the MPMRC to conduct investigations and research in accordance with section 23 of the Act as follows:

1. Primary Purpose

The primary purpose of the MPMRC is to subject all maternal and perinatal deaths occurring in NSW to peer review in order to:

- Classify maternal death as direct, indirect or coincidental
- Examine the circumstances leading to maternal and perinatal deaths in order to identify the cause and any factors which may have been preventable
- Identify shared learnings with the aim of improving patient safety and report back to the Health Secretary.

2. Accountability

The MPMRC reports to the Minister for Health through the Health Secretary. The Chief Executive of the Clinical Excellence Commission will report to the Health Secretary on clinical and system-wide matters impacting on the safety of maternal and perinatal services as well as issues relating to maternal and perinatal health and wellbeing.

3. Functions

i. In relation to maternal deaths occurring in New South Wales (NSW), to:
   a. Classify maternal deaths based on the World Health Organisation (WHO) classifications
   b. Examine the circumstances leading to a maternal death in order to identify risk trends or issues of safety and clinical practice which may have contributed to the death and/or any potentially preventable factors

c. Provide confidential feedback as appropriate to individual clinicians, groups of clinicians or networks who had been involved in the care of the woman and/or her baby
d. Provide advice to NSW Ministry of Health, public health organisations and licensed private health facilities on matters arising from the consideration of maternal deaths that may improve maternity care or prevent or reduce morbidity or mortality.

ii. In relation to perinatal deaths occurring in NSW, to:
   a. Review aggregate data on perinatal deaths and identify groups of perinatal deaths which, through detailed inquiry, may provide information for the development of policies designed to reduce perinatal morbidity and mortality
   b. Identify risk trends or issues of safety and clinical practice which may have contributed to these deaths and/or any potentially preventable factors
   c. Provide advice and feedback to the system with recommendations to improve maternal, neonatal and child health outcomes through annual reports and clinical alerts

iii. From time to time provide expert advice on clinical policy issues relating to pregnancy care, labour and birth, perinatal and child health care that may be brought to the Committee's attention by the NSW Ministry of Health, public health organisations, individual clinicians or relevant professional bodies.

4. Communication and reports

To assist it to undertake its functions the MPMRC will exchange information and report as follows:

I. The Chairperson via the secretariat attends to enquiries and correspondence addressed to the MPMRC
II. The MPMRC communicates with clinicians by confidential correspondence, if relevant, throughout the review process
III. The MPMRC provides the maternal and perinatal mortality data to the Ministry of Health Centre for Epidemiology and Evidence on an annual basis for public reporting
IV. The MPMRC provides annual maternal mortality data to the Australian Institute of Health and Welfare for the National Maternal Mortality Report
V. An annual report will be provided to the NSW Minister for Health via the Ministry of Health
VI. The MPMRC will provide an annual report to NSW maternity services in public health organisations relating to shared learnings with the aim of improving patient safety
VII. With other collaborative initiatives in Australia for the purpose of improving patient safety

5. Committee

The MPMRC is constituted under section 20 of the Health Administration Act 1982 and all Committee members are appointed by the Minister for Health or the delegate of the Minister.

6. Chair and Deputy

In carrying out its role, the MPMRC will be chaired by a member of the MPMRC as appointed by the Minister for Health for a term to be determined by the Minister for Health. The Chair will be deputised by a Deputy Chair identified and appointed for the three year term. The Deputy Chair will chair the committee in the absence of the Chair. The Chairperson and Deputy Chair will be senior clinicians with the requisite skills, knowledge and experience recommended by the Chief Executive of the Clinical Excellence Commission.

7. Secretariat

The Secretariat for the MPMRC will be provided by the Patient Safety Directorate, Clinical Excellence Commission.

8. Maternal Case Review Preparation

The Patient Safety Directorate will coordinate the ascertainment of cases, sourcing of relevant documents and undertake reviews for case presentations at each meeting

9. Membership

The MPMRC will comprise the following members:

- Director Patient Safety, Clinical Excellence Commission
- Patient Safety Analyst Maternal and Perinatal, Clinical Excellence Commission
- Senior Clinical Advisor Obstetrics, NSW Ministry of Health
- Senior Clinical Advisor Child and Family Health, NSW Ministry of Health
- Director Centre of Epidemiology and Biostatistics (EBU), NSW Ministry of Health
- Senior nursing/midwifery officer, NSW Ministry of Health
- Additional members who represent the following areas of knowledge and expertise may be appointed by the Health Secretary for a period not exceeding three years:
    - Obstetrics
    - General Practice
    - Perinatal Pathology
    - Aboriginal Health
    - Perinatal Mental Health
    - High Risk Pregnancy
    - Health Service Management
    - Emergency Response and transport
    - Feto-Maternal Medicine
    - Nursing and Midwifery
    - Practicing midwife
    - Paediatrics – general and neonatology
    - Clinical Governance

10. Subcommittees and Working Parties

The MPMRC is to convene and identify members for a subcommittee of the MPMRC with respect to perinatal mortality to assist in the discharge of the MPMRC's functions with respect to perinatal deaths.

The MPMRC may establish working groups as required, to undertake its functions, with appropriate representation from relevant groups, including invitees from outside the MPMRC. The MPMRC Secretariat shall ensure that each external participant in a working group enters into an appropriate confidentiality agreement.

11. Privilege under Section 23

The MPMRC is an authorised committee under the terms of section 23 of the Act and, as such, material created or obtained in connection with carrying out of the committee's functions is privileged and cannot be disclosed or released other than as set out within these Terms of Reference without approval of the Minister for Health.

12. Section 23 Committees

The exchange of information between committees established under the Act deemed necessary to enable the committees to undertake their functions is hereby authorised. These Committees include and are not limited to:

- Maternal and Perinatal Root Cause Analysis Committee
- NSW Clinical Risk Action Group
- Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)
- Collaborating Hospitals Audit of Surgical Mortality (CHASM)
- Mental Health Sentinel Event Review Committee

13. Meeting Operating Procedures

I. **Quorum**

A quorum will be fifty per cent plus one and must include the Chair or Deputy Chair

II. **Attendance**

Attendance is defined as either face to face, teleconference or video conference. It is expected that members will make a reasonable effort to attend a minimum of three meetings a year

14. Reporting

The MPMRC will report to the Health Secretary via the Chief Executive of the Clinical Excellence Commission on clinical and system-wide matters and lessons learnt for improving the safety and quality of maternal and perinatal services.

Working party/s are to report through the Chair of the Committee.

15. Review of Membership and Terms of Reference

The terms of reference, membership and objectives will be reviewed every at least every 3 years from the date of approval (unless an earlier review is warranted) to determine if the MPMRC is meeting its objectives.

Signed this 18th day of November 2019

Elizabeth Koff, **Secretary NSW Health**