

Type of Perinatal Death

STILLBIRTH (Fetal death):

Death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight where gestation is not known. The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Please select type:

- Antepartum fetal death
- Intrapartum fetal death
- Termination of pregnancy
- Unknown

NEONATAL DEATH

Death of a liveborn infant occurring before 28 completed days after birth.

Please select type:

- Non-admitted neonatal death
- Neonatal death in hospital
- Unknown

Please follow the instructions and answer all questions as directed. You may not know the answer to some of the questions but please provide as much detail as possible. Personally identifiable information collected on this form will be kept confidential. Information included in reports will be grouped and non-identifiable.

Section 1: CLINICAL DATA RELEVANT TO PERINATAL DEATH

PLEASE COMPLETE THIS SECTION WITHIN 48 HOURS OF THE STILLBIRTH OR NEONATAL DEATH

Baby Details

1) Case Number _____

2) Was this a multiple pregnancy

- Yes No (go to Question 3) Unknown (go to Question 3)

a) Plurality of pregnancy

- Twin Triplet Quadruplet
 Quintuplet Sextuplet Unknown
 Other _____

b) Birth Order

- First Second Third
 Other (please specify) _____

c) Chorionicity

- Dichorionic Diamniotic (DCDA) Monochorionic diamniotic (MCDA) Monamniotic (MA)
 Unknown Other (please specify): _____

3) Baby Urn _____

4) Type of Death

- Undetermined
 Stillbirth (fetal death)

If yes, please specify the timing of the fetal death:

- Antepartum fetal death
 Intrapartum fetal death
 Unknown

Neonatal death

If yes, please specify the hospital episode for neonatal/post neonatal death

- Hospital other
 Hospital of birth
 Home
 Unknown

Postneonatal Death

If yes, please specify the hospital episode for neonatal/postneonatal death

- Hospital other
 Hospital of birth
 Home
 Unknown

5) Was this perinatal death a result of a termination of pregnancy

- Yes No (go to Question 6) Unknown (go to Question 6)

a) What was the reason for termination of the pregnancy?

- Congenital abnormality Medical/pregnancy condition Psychosocial reason
 Unknown

b) If medical/pregnancy conditions, what was the pregnancy or medical condition requiring termination of pregnancy?

- Fetal growth restriction Pre-eclampsia Preterm PROM
 Other: _____

6) Date of baby's birth _____

7) Time of baby's birth _____

8) Gender

- Male Female Intersex or indeterminate
 Unknown

9) Indigenous status

- Aboriginal but not Torres Strait Islander origin Torres Strait Islander but not Aboriginal origin Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin Not stated/unknown

10) Calculated gestation of pregnancy at birth _____

11) Birth weight (g) _____

12) Did this baby have a major congenital abnormality

- Yes No Unknown

13) Was this death unexpected

- Yes No Unknown
 Cannot be determined

Mother's Details

14) Mother

Surname: _____

Given name(s): _____

Other(s): _____

15) Mother's Unit Record No: _____

16) Mother's Date of Birth: _____

17) Usual residential address of mother at time of birth

Country: _____

Town/City/Locality: _____

State: _____

Post Code: _____

18) Indigenous status

- Aboriginal but not Torres Strait Islander origin Torres Strait Islander but not Aboriginal origin Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin Not stated/Unknown

19) Mother's understanding of spoken English

- Very well Well (help with medical terminology) Not well (help with everyday English)
 Not at all Unknown

Previous Pregnancies

20) Number of mother's previous pregnancies: _____

Unknown

21) Mother's parity (Do not include current pregnancy): _____

Unknown

	Date of Birth	Place of birth (see options below)	Gestation (weeks)	Pregnancy Outcome (codes below)	Type of birth (codes below)	Birth weight (grams)	Complications (e.g. FGR) (codes below)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Place of birth: Home, Birth Centre, Public Hospital, Private Hospital, Unattended / Free birth, Born before arrival (in transit), Other, Unknown.

Pregnancy Outcome: LB = live birth; SM = spontaneous miscarriage; TOP = termination of pregnancy; E = ectopic pregnancy; SB = stillbirth; NNDE = early neonatal death (<7 days age); NNDL = late neonatal death (7 days – 28 days); INFID = infant death (28 days – 1 year); U = unknown.

Type of Birth: NVB = normal vaginal birth; OVD = operative vaginal delivery; VB = vaginal breech; CS = caesarean section; U = unknown.

Complications: NIL = no complications; HE = hyperemesis; APH = ante partum haemorrhage/abruption; CxS = cervical stitch; FGR = fetal growth restriction; GDM = gestational diabetes mellitus; GH = gestational hypertension; U = unknown; Other = please comment in summary section.

Current Pregnancies

(This section is not required for terminations of pregnancy for maternal psychological reasons)

22) Mother's height: _____ cm

23) Mother's weight :

Current (around time of birth): _____ kg

At booking (antenatal visit): _____ kg

24) Artificial reproductive technology in this pregnancy?

Yes

No (*go to Question 25*)

Unknown (*go to Question 25*)

If yes, please specify fertility treatment

- Ovulation induction agents Donor insemination Embryo transfer to fallopian tubes (TEST) (ZIFT)
 Embryo transfer to uterus (GIFT) In vitro fertilisation other/unspecified Intracytoplasmic sperm injection (ICSI)
 Other _____

25) What was the mother's smoking status and history during pregnancy?

- Smoking during pregnancy Never smoked Stopped before this pregnancy
 Stopped smoking during the first 20 weeks of pregnancy Stopped smoking after the first 20 weeks of pregnancy Unknown

26) Did the mother drink alcohol during this pregnancy?

- Yes No (*go to Question 27*) Unknown (*go to question 27*)

If yes, specify the average number of standard alcoholic drinks per week

First trimester: _____ standard drinks per week or Unknown

Month prior to birth: _____ standard drinks per week or Unknown

27) Did the mother use illicit drugs during this pregnancy

- Yes No (*go to Question 28*) Unknown (*go to Question 28*)

Please specify

	<u>First trimester</u>	<u>Month prior to birth</u>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Chroming/Petrol/Paint	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>
Herbal Highs	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

28) Has the mother suffered family violence during this pregnancy

- Yes No Not Asked Unknown

29) Place of birth

Please select from both columns

	<u>Intended place of birth before labour</u>	<u>Actual place of birth</u>
Hospital, excluding birth centre	<input type="checkbox"/>	<input type="checkbox"/>
Birth centre, attached to hospital	<input type="checkbox"/>	<input type="checkbox"/>
Birth centre, free standing	<input type="checkbox"/>	<input type="checkbox"/>
Home (other)	<input type="checkbox"/>	<input type="checkbox"/>
Home- private midwife care	<input type="checkbox"/>	<input type="checkbox"/>
Home- public homebirth program	<input type="checkbox"/>	<input type="checkbox"/>
In transit	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____

30) Model of antenatal maternity care

	<u>Booking</u>	<u>At birth</u>
Private obstetrician (specialist care)	<input type="checkbox"/>	<input type="checkbox"/>
Private midwifery care	<input type="checkbox"/>	<input type="checkbox"/>
General Practitioner obstetrician care	<input type="checkbox"/>	<input type="checkbox"/>
Shared care	<input type="checkbox"/>	<input type="checkbox"/>
Combined care	<input type="checkbox"/>	<input type="checkbox"/>
Public hospital maternity care	<input type="checkbox"/>	<input type="checkbox"/>
Public hospital high risk maternity care	<input type="checkbox"/>	<input type="checkbox"/>
Team midwifery care	<input type="checkbox"/>	<input type="checkbox"/>

- Midwifery group practice caseload care
- Remote area maternity care
- Private obstetrician and privately practicing midwife joint care
- No antenatal care provider
- If other, please specify _____ _____

31) Maternal outcome

- Alive and generally well Alive but serious morbidity Died

Mothers Medical History

32) Does the mother have any pre-existing medical conditions

- Yes No (*go to Question 33*) Unknown (*go to Question 33*)

If yes, please specify:

- | | Yes | No | Unknown |
|--|--------------------------|--------------------------|--------------------------|
| a) Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Diabetes pre pregnancy (type 1 or 2) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) If yes, is the diabetes well controlled | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ii) How is the diabetes managed | | | |
| <input type="checkbox"/> Insulin | | | |
| <input type="checkbox"/> Oral hypoglycaemic | | | |
| <input type="checkbox"/> Diet and exercise | | | |
| <input type="checkbox"/> Unknown | | | |
| <input type="checkbox"/> Other (<i>please specify</i>) _____ | | | |
| c) Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Heart condition (congenital or acquired) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Thyroid abnormality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) <i>If yes, please specify</i> | | | |
| <input type="checkbox"/> Hyperthyroidism | | | |
| <input type="checkbox"/> Hypothyroidism | | | |
| <input type="checkbox"/> Unknown | | | |
| g) Inflammatory bowel disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Systemic lupus erythematosus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Other autoimmune disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Mental health disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) <i>If yes, please specify</i> | | | |
| <input type="checkbox"/> Depression | | | |
| <input type="checkbox"/> Psychotic disorder | | | |
| <input type="checkbox"/> Other (<i>please specify</i>) _____ | | | |
| k) Renal disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Venous thromboembolism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Haematological disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) <i>If yes, please specify</i> | | | |
| <input type="checkbox"/> Anaemia | | | |
| <input type="checkbox"/> Thalassaemia trait | | | |
| <input type="checkbox"/> Thrombophilia | | | |
| <input type="checkbox"/> Other (<i>please specify</i>) _____ | | | |
| n) Cervical surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| o) Uterine surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| p) Urinary tract infection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q) Uterine abnormality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r) Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Further medical conditions: _____

33) Family history of thrombosis?

Yes No Unknown

Obstetric Conditions

34) Obstetric complications during this pregnancy and obstetric consultation

Indicate all conditions known to be present during this pregnancy

a) Hypertension Yes No Unknown

i) *If yes, please specify type of hypertension*

- Eclampsia
- Preeclampsia
- Gestational hypertension
- Chronic hypertension
- Unknown

ii) *Was there consultation with an obstetrician for hypertension*

- Yes
- No
- Already under obstetric care
- Unknown

b) HELLP Syndrome Yes No Unknown

i) *If yes, was there consultation with an obstetrician for HELLP syndrome*

- Yes
- No
- Already under obstetric care
- Unknown

c) Preterm labour Yes No Unknown

i) *If yes, was there consultation with an obstetrician for preterm labour*

- Yes
- No
- Already under obstetric care
- Unknown

d) Pre-labour rupture of membranes Yes No Unknown

i) *If yes, please specify the gestation of the membrane rupture _____ or* Unknown

ii) *Was there consultation with an obstetrician for pre-labour rupture or membranes*

- Yes
- No
- Already under obstetric care
- Unknown

e) Obstetric cholestasis Yes No Unknown

i) *If yes, was there consultation with an obstetrician for obstetric cholestasis*

- Yes
- No
- Already under obstetric care
- Unknown

f) Vaginal bleeding Yes No Unknown

i) *If yes, what gestation did vaginal bleeding occur*

- Before 20 weeks
- At or after 20 weeks
- Unknown

ii) *Reasons for vaginal bleeding*

- Abruption
- Placenta praevia
- Vasa praevia
- Uterine rupture
- Cervical cause
- Unknown
- Other (please specify): _____

iii) *Was there consultation with an obstetrician for vaginal bleeding*

- Yes
- No
- Already under obstetric care
- Unknown

g) Placental praevia without haemorrhage Yes No Unknown

i) *If yes, was there consultation with an obstetrician for placental praevia without haemorrhage*

- Yes
- No
- Already under obstetric care
- Unknown

h) Gestational diabetes Yes No Unknown

i) *If yes, please indicate*

First HbA1C measure during pregnancy _____

Last HbA1C measured during pregnancy _____

ii) *How was the diabetes managed*

- Insulin
- Oral hypoglycaemic
- Diet and exercise
- Unknown
- Other (please specify): _____

iii) *Was there consultation with an obstetrician for gestational diabetes*

- Yes
- No
- Already under obstetric care
- Unknown

i) Multiple pregnancy Yes No Unknown

i) *If yes, was there consultation with an obstetrician for multiple pregnancy*

- Yes
- No
- Already under obstetric care
- Unknown

j) Prolonged pregnancy (<41 weeks) Yes No Unknown

i) *If yes, was there consultation with an obstetrician for prolonged pregnancy*

- Yes
- No
- Already under obstetric care

Unknown

k) Breech presentation Yes No Unknown

i) *If yes, was there consultation with an obstetrician for breech presentation*

- Yes
- No
- Already under obstetric care
- Unknown

l) Unstable lie Yes No Unknown

i) *If yes, was there consultation with an obstetrician for unstable lie*

- Yes
- No
- Already under obstetric care
- Unknown

m) Size of fetus Yes No Unknown

i) *If yes, please specify the size of the fetus*

- Large
- Small
- Unknown

ii) *Was there consultation with an obstetrician for size of fetus*

- Yes
- No
- Already under obstetric care
- Unknown

n) Decreased fetal movements Yes No Unknown

i) *If yes, was there consultation with an obstetrician for decreased fetal movements*

- Yes
- No
- Already under obstetric care
- Unknown

o) Polyhydramnios Yes No Unknown

i) *If yes, was there consultation with an obstetrician for polyhydramnios*

- Yes
- No
- Already under obstetric care
- Unknown

p) Oligohydramnios Yes No Unknown

i) *If yes, was there consultation with an obstetrician for oligohydramnios*

- Yes
- No
- Already under obstetric care
- Unknown

q) Non-reassuring CTG Yes No Unknown

i) *If yes, was there consultation with an obstetrician for non-reassuring CTG*

- Yes
- No
- Already under obstetric care
- Unknown

r) Fetal abnormality Yes No Unknown

i) *If yes, was there consultation with an obstetrician for fetal abnormality*

- Yes
- No
- Already under obstetric care
- Unknown

s) Other obstetric conditions Yes No Unknown

Please specify: _____

i) *If yes, was there consultation with an obstetrician for other obstetric conditions*

- Yes
- No
- Already under obstetric care
- Unknown

35) Were there any medical complications during this pregnancy

Yes No (*go to Question 36*) Unknown (*go to Question 36*)

If yes, indicate all medical complications known to be present during this pregnancy:

a) Confirmed maternal infection Yes No Unknown

i) *If yes, what type of infection*

- Pyelonephritis
- Lower urinary tract infection
- Unknown
- Other (*please specify:*) _____

ii) *Was there consultation with an obstetrician for confirmed maternal infection*

- Yes
- No
- Already under obstetric care
- Unknown

b) Trauma Yes No Unknown

i) *If yes, what type of infection*

- Vehicular
- Fall
- Violent personal injury
- Unknown
- Other (*please specify:*) _____

ii) *Was there consultation with an obstetrician for trauma*

- Yes
- No
- Already under obstetric care
- Unknown

c) Renal Yes No Unknown

i) *Was there consultation with an obstetrician for renal complications*

- Yes
- No
- Already under obstetric care
- Unknown

d) Cardiac Yes No Unknown

i) *Was there consultation with an obstetrician for cardiac complications*

- Yes
- No
- Already under obstetric care

Unknown

36) Were there other reason for obstetric consultations

Yes No (*go to Question 37*) Unknown (*go to Question 37*)

If yes, what was/were the reason(s) for the obstetric consultation? Please select all that applicable:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Mother's request | <input type="checkbox"/> Previous pre-term birth | <input type="checkbox"/> Raised BMI |
| <input type="checkbox"/> Previous perinatal death | <input type="checkbox"/> Previous caesarean section | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Recurrent miscarriage | <input type="checkbox"/> Other poor obstetric history | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Previous intrauterine growth restriction | <input type="checkbox"/> Mother's age ≥ 35 years | <input type="checkbox"/> Other: _____ |

37) Was the mother referred to another healthcare service during pregnancy

Yes No (*go to Question 38*) Unknown (*go to Question 38*)

If yes, what healthcare service was the mother referred to? Please select all that applicable:

- Medical service (please specify reason for referral to medical services)
-
- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Mental health | <input type="checkbox"/> Previous caesarean section | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Drug and alcohol | <input type="checkbox"/> Other poor obstetric history | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Mother's age ≥ 35 years | |
| <input type="checkbox"/> Other: _____ | | |

Antenatal Procedures

38) Antenatal visits

Yes No (*go to Question 39*) Unknown (*go to Question 39*)

If yes, please indicate:

- a) Total number of visits recorded: _____
- b) Gestation at first antenatal visit: _____ weeks _____ days or Unknown

39) Antenatal procedures

Please indicate all procedures undertaken in pregnancy excluding those after fetal death in utero

- | | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| a) First trimester screening ultrasound scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b) Morphology/anomaly ultrasound scan at 18-20 weeks' gestation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| c) Total Number of antenatal ultrasound scans (exclude those performed after fetal death) | Number of ultrasounds _____ | | <input type="checkbox"/> Unknown |
| d) Chorion villus sampling | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If yes, what were the CV results?

- Normal
 Abnormal
 Uncertain
 Unknown

What was the chromosomal microarray results?

- Not performed
 Normal
 Abnormal
 Uncertain
 Unknown

- | | | | |
|--|------------------------------|-----------------------------|----------------------------------|
| e) Cervical suture (vaginal or transabdominal) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| <i>If yes, what was the dates of cervical suture: _____ or</i> | | | <input type="checkbox"/> Unknown |
| f) Amniocentesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| <i>If yes, what were the Amniocentesis results?</i> | | | |

- Normal
- Abnormal
- Uncertain
- Unknown

What were the chromosomal microarray results?

- Not performed
- Normal
- Abnormal
- Uncertain
- Unknown

- g) Doppler studies** Yes No Unknown
- If yes, what were the studies performed?*
- Umbilical artery doppler Normal Abnormal Unknown
 - Uterine artery doppler Normal Abnormal Unknown
 - Middle-cerebral artery doppler Normal Abnormal Unknown
 - Other: _____ Normal Abnormal Unknown
 - Unknown
- h) External cephalic version** Yes No Unknown
- If yes, what was the dates this was performed: _____ or _____* Unknown
- i) Fetocide** Yes No Unknown
- j) Amnioreduction** Yes No Unknown
- k) Laser treatment** Yes No Unknown
- l) Intrauterine fetal blood transfusion** Yes No Unknown
- m) Ligation of vessels for twin to twin transfusion** Yes No Unknown
- n) Other: _____** Yes No Unknown

40) Were maternal corticosteroids given in pregnancy

- Yes No (*go to Question 41*) Unknown (*go to Question 41*)

If yes, please indicate:

- a) Course of corticosteroids started at what gestation: _____ weeks _____ days or _____** Unknown
- b) Was course of corticosteroids completed** Yes No Unknown

Mothers Medications

41) Were medications and supplements taken in this pregnancy

Please indicate all over the counter and traditional medicines taken in the pregnancy

- Yes No (*go to Question 42*) Unknown (*go to Question 42*)

If yes, please select medications:

- | | | |
|--|---|--|
| <input type="checkbox"/> ACE inhibitor | <input type="checkbox"/> Antihypertensives | <input type="checkbox"/> Magnesium sulphate |
| <input type="checkbox"/> Glyceryl trinitrate | <input type="checkbox"/> Nifedepine | <input type="checkbox"/> Salbutamol |
| <input type="checkbox"/> Ritodrine | <input type="checkbox"/> Other tocolytic | <input type="checkbox"/> Steroids other than fetal lung maturation |
| <input type="checkbox"/> Valproate | <input type="checkbox"/> Anticonvulsant/other | <input type="checkbox"/> Infertility treatment |
| <input type="checkbox"/> Antiemetics | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Sedatives or anxiolytics | <input type="checkbox"/> Indomethacin | <input type="checkbox"/> NSAID/other |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Clexane | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Warfarin | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Non-narcotic analgesia |
| <input type="checkbox"/> Other <i>Please indicate:</i> _____ | | |

42) Was folic acid taken pre pregnancy?

- Yes No Unknown

43) Was folic acid taken during the first trimester

Yes

No

Unknown

Labour and Birth

(This section is not required for terminations of pregnancy for maternal psychological reasons)

44) Date of admission to hospital for birth episode

Date: _____

Unknown

Time: _____

Unknown

45) Primary caregiver at onset of labour

Obstetrician

Midwife

General Practitioner

No intrapartum care provider

Unknown

Other: _____

46) Onset of labour

Spontaneous (*go to Question 47*)

Induced

No labour (*go to Question 50*)

Unknown (*go to Question 47*)

If induced, please provide the following information:

a) Date of induction of labour: _____

Unknown

b) Time of induction of labour: _____

Unknown

c) Specify methods used to induce labour

Oxytocin

Prostaglandins

Artificial rupture of membranes (ARM)

Balloon

Unknown

Other: _____

d) Main indication for induction

Prolonged pregnancy

Prelabour rupture of membranes

Diabetes

Hypertensive disorders

Multiple pregnancy

Chorioamnionitis (includes suspected)

Cholestasis of pregnancy

Antepartum haemorrhage

Maternal age

Body Mass Index (BMI)

Maternal mental health indication

Previous adverse perinatal outcome

Other maternal obstetric or medical indication

Fetal compromise (includes suspected)

Fetal growth restriction (includes suspected)

Fetal macrosomia (includes suspected)

Fetal death

Fetal congenital anomaly

Administrative or geographical indication

Maternal choice in the absence of any obstetric, medical, fetal, administrative, or geographical indication

Unknown

Other: _____

47) Labour augmentation

Yes

No (*go to Question 48*)

Unknown (*go to Question 48*)

If yes, please select method used to augment labour

Oxytocin

Prostaglandins

Artificial rupture of membranes (ARM)

Please specify the day of ARM

Date: _____

Unknown

Other: _____

48) Analgesia during labour

Yes

No (*go to Question 49*)

Unknown (*go to Question 49*)

If yes, please indicate type of analgesia administered

Nitrous oxide

Systemic opioids

Epidural or caudal

Spinal

Combined spinal/epidural

Unknown

Other: _____

49) Did part of labour occur in bath/pool Yes No (*go to Question 50*) Unknown (*go to Question 50*)

If yes, was the baby born in the bath/pool? Yes No Unknown

50) Was there fetal monitoring during the labour Yes No (*go to Question 51*) Unknown (*go to Question 51*)

If yes, what was the method of fetal monitoring

- Intermittent auscultation Admission cardiotocography Intermittent cardiotocography
 Continuous external cardiotocography Internal cardiotocography (scalp electrode) Fetal blood sampling
 Unknown Other: _____

51) What was the method of birth of this baby

- Vaginal- non-instrumental (*go to Question 52*)
 Vaginal- forceps (*go to Question 51a*)
 Vaginal- vacuum extraction (*go to Question 51a*)
 Vaginal- forceps and vacuum extraction (*go to Question 51a*)
 Planned caesarean- no labour (*go to Question 51b*)
 Planned caesarean- labour (*go to Question 51b*)
 Unplanned caesarean- labour (*go to Question 51b*)
 Unplanned caesarean- no labour (*go to Question 51b*)
 Unknown (*go to Question 52*)

a) Was anaesthetics administered? Yes No Unknown

If yes, please select which method

- Local anaesthetic to perineum Pudendal block Epidural or caudal block
 Spinal block General anaesthesia Combined spinal-epidural block
 Unknown Other: _____

b) What was the main indication for caesarean

- Fetal compromise Suspected fetal macrosomia Malpresentation
 Lack of progress; less than or equal to 3cm cervical dilatation Lack of progress in the first stage; greater than 3cm to less than 10cm cervical dilatation Lack of progress in the second stage
 Placenta praevia Placental abruption Vasa praevia
 Antepartum/intrapartum haemorrhage Multiple pregnancy Unsuccessful attempt at assisted delivery
 Cord prolapse Previous adverse perinatal outcome Previous caesarean section
 Previous severe perineal trauma Previous shoulder dystocia Maternal choice in the absence of any obstetric, medical, surgical, psychological indications
 Other: _____

i) Were forceps or vacuum tried first?

- Forceps Vacuum Forceps and vacuum
 No instrumental attempted before caesarean Unknown

ii) Was anaesthetics administered? Yes No Unknown

If yes, please select which method

- Local anaesthetic to perineum Pudendal block Epidural or caudal block
 Spinal block General anaesthesia Combined spinal-epidural block
 Unknown Other: _____

52) What was the birth presentation

- Vertex Breech Face
Brow Unknown Other:
-

53) Complications in labour/birth

- Yes No (*go to Question 54*) Unknown (*go to Question 54*)

If yes, please indicate relevant option

- APH Cord entanglement/prolapse Meconium stained liquor
Shoulder dystocia Fetal bradycardia Failure to progress/dystocia
Non-reassuring CTG Unknown Other:
-

54) Labour and membrane rupture duration

- a) First stage of labour duration: _____ hours _____ minutes Unknown
b) Second stage of labour duration known: _____ hours _____ minutes Unknown
c) Duration of membrane rupture prior to birth: _____ days _____ hours _____ minutes Unknown

55) Were antibiotics given in labour

- Yes No (*go to Question 56*) Unknown (*go to Question 56*)

a) If yes, what was the indication?

- Group B streptococcus Prolonged rupture of membranes Clinical chorioamnionitis
Suspected or confirmed infection Unknown Other _____

b) Date antibiotics given: _____ Unknown

Baby Resuscitation at Birth

(This section is not required for terminations of pregnancy for maternal psychological reasons)

56) Apgar scores

Please indicate a score between 1-10 with no decimals

- a) 1 min: _____ Unknown
b) 5 min: _____ Unknown
c) 10 min: _____ Unknown
d) 15 min: _____ Unknown

57) Did the baby receive any resuscitation at birth?

- Yes No (*go to Question 58*) Unknown (*go to Question 58*)

a) If yes, what was the outcome of the resuscitation?

- Baby resuscitated and stayed with mother Baby resuscitated and transferred to neonatal special or intensive care nursing Baby was no able to be resuscitated
Unknown

b) What was the method of resuscitation at birth?

- Continuous positive airway pressure with air CPAP with oxygen Endotracheal intubation and IPPR with oxygen
Endotracheal intubation and IPPR with air External cardiac massage and ventilation Intermittent positive pressure respiration bag and mask with air

- Intermittent positive pressure respiration bag and mask with oxygen
 - Medications
Which medications?
 - Adrenalin
 - Narcotic antagonist
 - Sodium bicarbonate
 - Volume expander
 - Unknown
 - Other: _____
- Oxygen therapy
 - Unknown
- Suction
 - Other: _____

c) What was the professional category of the most senior staff member at the resuscitation?

- Student
- Paediatric registrar
- Consultant paediatrician
- Midwife
- Obstetric registrar
- Neonatal consultant
- Paediatric resident
- Obstetric consultant
- Unknown

58) Were cord gases taken at birth? Yes No (*go to Question 59*) Unknown (*go to Question 59*)

If yes, please indicate:

- a) ph- arterial: _____ Unknown
- b) Base deficit- arterial: _____ Unknown
- c) Lactate- arterial: _____ Unknown
- d) CO₂- arterial: _____ Unknown
- e) ph- venous: _____ Unknown
- f) Base deficit- venous: _____ Unknown
- g) Lactate- venous: _____ Unknown
- h) CO₂- venous: _____ Unknown

Neonatal/Post Neonatal Care

59) Was the baby transferred from place of birth (e.g. via NETS) prior to death to a higher level of care? Yes No (*go to Question 60*) Unknown (*go to Question 60*)

a) If yes, what was the main reason for the transfer?

- Prematurity
If yes, please specify
- Less than 28 weeks gestation
- 28-31 weeks gestation
- 32-36 weeks
- Unknown
- Respiratory
If yes, please specify
- Hyaline membrane disease (respiratory distress syndrome)
- Meconium aspiration
- PPHN
- Pneumothorax
- Congenital adenomatoid lesion of the lung
- Tracheoesophageal fistula
- Other: _____
- Unknown
- Cardiac
If yes, please specify
- Coarctation of the aorta

- Transposition of the great arteries
- Tetralogy of Fallot
- Hypoplastic left heart
- Atrioventricular septal defect
- Other: _____
- Unknown

- Gastrointestinal
 - If yes, please specify*
 - Necrotising enterocolitis
 - Pyloric stenosis
 - Other: _____
 - Unknown

- Neurological
 - If yes, please specify*
 - HIE
 - Seizures
 - Intraventricular haemorrhage
 - Other intracranial haemorrhage
 - Neuromuscular disorder
 - Other: _____
 - Unknown

- Musculoskeletal
 - If yes, please specify*
 - Congenital diaphragmatic hernia
 - Gastroschisis
 - Omphalocele
 - Other: _____
 - Unknown

- Sepsis
 - If yes, please specify*
 - GBS
 - E. Coli
 - Other: _____
 - Unknown

- Metabolic
 - If yes, please specify*
 - Hypoglycaemia
 - Hyponatraemia
 - Other: _____
 - Unknown

- Haematology
 - If yes, please specify*
 - Rh isoimmunisation
 - ABO isoimmunisation
 - Alloimmune thrombocytopenia
 - Other: _____
 - Unknown

- Other: _____
- Unknown

b) On what date was the baby transferred: _____

Unknown

60) Neonatal Diagnosis (select all applicable)

- Prematurity
 - If yes, please specify*
 - Less than 28 weeks gestation
 - 28-31 weeks gestation
 - 32-36 weeks
 - Unknown

- Respiratory
 - If yes, please specify*
 - Hyaline membrane disease (respiratory distress syndrome)
 - Meconium aspiration
 - PPHN
 - Pneumothorax
 - Congenital adenomatoid lesion of the lung
 - Tracheoesophageal fistula
 - Other: _____
 - Unknown
- Cardiac
 - If yes, please specify*
 - Coarctation of the aorta
 - Transposition of the great arteries
 - Tetralogy of Fallot
 - Hypoplastic left heart
 - Atrioventricular septal defect
 - Other: _____
 - Unknown
- Gastrointestinal
 - If yes, please specify*
 - Necrotising enterocolitis
 - Pyloric stenosis
 - Other: _____
 - Unknown
- Neurological
 - If yes, please specify*
 - HIE
 - Seizures
 - Intraventricular haemorrhage
 - Other intracranial haemorrhage
 - Neuromuscular disorder
 - Other: _____
 - Unknown
- Musculoskeletal
 - If yes, please specify*
 - Congenital diaphragmatic hernia
 - Gastroschisis
 - Omphalocele
 - Other: _____
 - Unknown
- Sepsis
 - If yes, please specify*
 - GBS
 - E. Coli
 - Other: _____
 - Unknown
- Metabolic
 - If yes, please specify*
 - Hypoglycaemia
 - Hyponatraemia
 - Other: _____
 - Unknown
- Haematology
 - If yes, please specify*
 - Rh isoimmunisation
 - ABO isoimmunisation
 - Alloimmune thrombocytopenia

- Other: _____
 Unknown
 Other: _____
 Unknown

61) Did the baby receive any neonatal treatment Yes No (*go to Question 62*) Unknown (*go to Question 62*)

If yes, please specify

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> IV therapy | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Nitric Oxide |
| <input type="checkbox"/> Inotropes | <input type="checkbox"/> Mechanical ventilation | <input type="checkbox"/> Phototherapy |
| <input type="checkbox"/> Extracorporeal membrane oxygenation | <input type="checkbox"/> Therapeutic hypothermia | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other: _____ | | |

62) Were active life supporting measures withdrawn? Yes No (*go to Question 63*) Unknown (*go to Question 63*)

- a) If yes, on what date were the measures withdrawn: _____ Unknown
- b) At what time were the measures withdrawn: _____ Unknown

63) Please provide summary of significant neonatal events

64) Place of neonatal/post neonatal death

- | | | |
|----------------------------------|---|--|
| <input type="checkbox"/> Home | <input type="checkbox"/> Emergency department | <input type="checkbox"/> NICU |
| <input type="checkbox"/> PICU | <input type="checkbox"/> SCN | <input type="checkbox"/> Paediatric ward |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other: _____ | |

Maternal Investigations after Stillbirth or Neonatal Death

(This section is not required for terminations of pregnancy for maternal psychological reasons)

65) Maternal blood tests

a) Was a full blood count performed? Yes No Unknown

If yes, please indicate:

- i) Hb: _____ g/L Unknown
- ii) WCC: _____ x10⁹ Unknown
- iii) Platelets: _____ x10⁹ Unknown

b) Was a blood group and antibody screen performed? Yes No Unknown

i) If yes, what was the blood group?

- | | | |
|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> A positive | <input type="checkbox"/> A negative | <input type="checkbox"/> AB positive |
| <input type="checkbox"/> AB negative | <input type="checkbox"/> B positive | <input type="checkbox"/> B negative |
| <input type="checkbox"/> O positive | <input type="checkbox"/> O negative | <input type="checkbox"/> Unknown |

ii) What was the antibody screen?

Positive

Negative

Unknown

Please specify antibody:

- D RHESUS
- C (LITTLE C) RHESUS
- K- KELL
- C (BIG C) REHSUS
- E (LITTLE E) RHESUS
- E (BIG E) RHESUS
- JKA- KDD
- JKB- KDD
- FYA- DUFFY
- FYB- DUFFY
- Other: _____

Please note, Question c) is a core test for all stillbirths

c) Was testing for maternal fetal haemorrhage performed? Yes No Unknown

If yes, please indicate:

i) Date tests performed: _____ Unknown

ii) What was the results of testing for maternal fetal haemorrhage? Positive Negative Unknown

iii) Please state which test was performed to detect maternal fetal haemorrhage

Kleinhauer-Betke

Flow cytometry

Unknown

Other: _____

iv) Was the estimated fetal to maternal transfusion volume more than 1 ml? Yes No Unknown

If yes, what was the estimated volume of maternal transfusion?: _____

d) Renal function tests? Yes No Unknown

If yes, please indicate:

i) Creatinine: _____ umol/L Unknown

ii) Uric acid (Urate): _____ mmol/L Unknown

iii) Urea: _____ mmol/L Unknown

e) Liver function test Yes No Unknown

If yes, please indicate:

i) AST: _____ umol/L Unknown

ii) ALT: _____ U/L Unknown

iii) Bilirubin Total: _____ umol/L Unknown

f) HBA1c? Yes No Unknown

If yes, what was the result: _____ mmol/mol or % or Unknown

g) Thyroid function test? Yes No Unknown

If yes, please indicate:

i) TSH: _____ mU/L Unknown

ii) Free T4: _____ pmol/L Unknown

h) Bile acids? Yes No Unknown

If yes, please indicate:

i) Results: _____ umol/L Unknown

ii) Type of test Fasting Non-fasting Unknown

i) CMV Yes No Unknown

If yes, please indicate:

i) CMV-IgM result Reactive Non-reactive Unknown

ii) CMV-IgG result Reactive Non-reactive Unknown

iii) CMV avidity testing Yes No Unknown
If yes, result?: _____

j) Toxoplasma Yes No Unknown
If yes, please indicate:
 i) Toxoplasma- IgM result Reactive Non-reactive Unknown
 ii) Toxoplasma- IgG result Reactive Non-reactive Unknown
 iii) Toxoplasma avidity testing Yes No Unknown
If yes, result?: _____

k) Parvovirus B19 Yes No Unknown
If yes, please indicate:
 i) Parvovirus B19- IgM result Reactive Non-reactive Unknown
 ii) Parvovirus B19-IgG result Reactive Non-reactive Unknown
 iii) Parvovirus B19 avidity testing Yes No Unknown
If yes, result?: _____

l) Rubella
 Performed at routine antenatal screen Yes No Unknown

If yes or performed at routine antenatal screen, please indicate result:

Immune Not immune Indeterminate Unknown

m) Syphilis serology
 Performed at routine antenatal screen Yes No Unknown

If yes or performed at routine antenatal screen, please indicate result:

Positive Negative Unknown

n) Thrombophilia tests at time of birth Yes No Unknown
If yes, please indicate:
 i) Anticardiolipin antibodies Positive Negative Unknown
 ii) Lupus anticoagulant Positive Negative Unknown
 iii) APC resistance Positive Negative Unknown

If positive, Factor V Leiden?

Yes
Result?
 Positive
 Negative
 Unknown

iv) AntiB2 glycoprotein-1antibodies Positive Negative Unknown
If yes, result?: _____

66) Was Thrombophilia testing undertaken around the time of the follow-up visit Yes No (*go to Question 67*) Unknown (*go to Question 67*)

If yes, please indicate:

a) Anticardiolipin antibodies Yes No Unknown

If yes, please indicate:

i) Date : _____ Unknown

ii) Results Positive Negative Unknown

iii) AntiB2 glycoprotein-1antibodies Yes No Unknown

If yes, please indicate:

(1) Date: _____ Unknown

(2) Results Positive Negative Unknown

67) Were there any other maternal investigations performed to investigate the cause of death Yes No (go to Question 68) Unknown (go to Question 68)

a) If yes, please specify other investigations: _____

b) If yes, please specify the results: _____

External Examination of the Baby, Cord, Placenta and Membranes by Clinician
(Core tests required for all stillbirths)

68) Was an external examination of the baby performed? Yes No (go to Question 71) Unknown (go to Question 71)

If yes, please indicate:

a) Were any external abnormalities identified on external examination of the baby? Yes No Unknown

If yes, please specify: _____

b) Length: _____ cm Unknown

c) Head circumference: _____ cm Unknown

69) Was an examination of the placenta, cord and membrane performed? Yes No (go to Question 72) Unknown (go to Question 72)

If yes, please indicate:

a) Placenta weight: _____ gm Unknown

b) Cord length: _____ cm Unknown

c) Were any placental abnormalities noted on external examination Yes No Unknown

If yes, please specify

- | | | |
|--|--|---|
| <input type="checkbox"/> Incomplete | <input type="checkbox"/> Retroplacental clot | <input type="checkbox"/> Gritty/Calcified |
| <input type="checkbox"/> Ragged membranes | <input type="checkbox"/> Offensive odour | <input type="checkbox"/> Vasa praevia |
| <input type="checkbox"/> Succenturiate lobe/bi-lobed | <input type="checkbox"/> Circumvallate | <input type="checkbox"/> Bipartite |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other: _____ | |

d) Were any features apparent in the umbilical cord? Yes No Unknown

If yes, please specify

- | | | |
|---|--|---|
| <input type="checkbox"/> Hyper-coiled appearance | <input type="checkbox"/> Hypo-coiled appearance | <input type="checkbox"/> Marginal cord insertion |
| <input type="checkbox"/> Velamentous cord insertion | <input type="checkbox"/> Abnormal cord length- short | <input type="checkbox"/> Abnormal cord length- long |
| <input type="checkbox"/> Unusual cord thickness- thin | <input type="checkbox"/> Unusual cord thickness- thick | <input type="checkbox"/> Meconium stained |
| <input type="checkbox"/> Two vessels in the cord | <input type="checkbox"/> True knot- loose | <input type="checkbox"/> True knot- tight |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other: _____ | |

e) Was the cord wrapped around the neck or other structure? No Nuchal cord Unknown Other: _____

If yes to nuchal cord, how many times was the cord wrapped around the neck? _____ or Unknown

f) Were there any membrane abnormalities identified? Yes No Unknown

If yes, please specify

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal colour- green | <input type="checkbox"/> Malodour | <input type="checkbox"/> Retro-membranous blood- fresh |
| <input type="checkbox"/> Retro-membranous blood- old | <input type="checkbox"/> Spotty (e.g. Amnion nodosum) | <input type="checkbox"/> Unknown |

Other: _____

70) External examination of the baby by expert in addition to clinician at birth?

Yes

No (*go to Question 73*)

Unknown (*go to Question 73*)

If yes, please indicate

a) External examination performed by

Perinatal/Paediatric pathologist

Pathologist other

Pathologist unspecified

Clinical geneticist

Paediatrician

Neonatologist

Unknown

Other: _____

b) Were abnormalities identified

Yes

No

Unknown

If yes, please specify: _____

Placental Histopathology and Autopsy

(This section is not required for terminations of pregnancy for maternal psychological reasons)

(Core tests required for all stillbirths)

71) Placental and cord histopathology

a) Placental histopathology

Not performed

Normal

Abnormal

Uncertain

Unknown

If abnormal, please specify

Funisitis

Chorioamnionitis

Acute villitis

Placental abscesses

Infarct- single

Infarct- multiple

Massive perivillous fibrin

Histiocytic intervillitis

Maternal floor infarction

Villitis of unknown aetiology

Fetal thrombotic vasculopathy

Retroplacental haemorrhage

Chorioangioma

Metastatic tumour

Haemosiderin laden macrophages

Unknown

Other : _____

b) Placental swab for culture

Not performed

No pathogen

Pathogen

Uncertain

Unknown

If pathogen found, please specify

Group B Streptococcus

Group A Streptococcus

Other Streptococcus

E coli

Trichomonas Vaginalis

Gardnerella Vaginalis

Chlamydia Trachomatis

Ureaplasma Urealyticum

Mycoplasma Hominis

Candida

Neisseria Gonorrhoea

Herpes

Pseudomonas

Klebsiella

Clostridium

Proteus

Bacteroids

Enterococcus

Fusobacterium

Enterobacterium

Hep A

Hep B

Hep C

HIV

Syphilis- Treponema Pallidum

Rubella

CMV

Toxoplasma Gondii

Parvovirus

Listeria

Varicella

Malaria

Echovirus

Chlamydia Psittaci

Haemophilus

Unknown

Other: _____

c) Other site culture taken by pathologist

Yes

No

Unknown

If yes, please specify

i) Site of other culture taken: _____

ii) Results of other culture taken

- No pathogen
 Pathogen
 Uncertain
 Unknown

If pathogen, please specify

- | | | |
|---|---|---|
| <input type="checkbox"/> Group B Streptococcus | <input type="checkbox"/> Group A Streptococcus | <input type="checkbox"/> Other Streptococcus |
| <input type="checkbox"/> E coli | <input type="checkbox"/> Trichomonas Vaginalis | <input type="checkbox"/> Gardbnerella Vaginalis |
| <input type="checkbox"/> Chlamydia Trachomatis | <input type="checkbox"/> Ureaplasma Urealyticum | <input type="checkbox"/> Mycoplasma Hominis |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Neisseria Gonorrhoea | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Pseudomonas | <input type="checkbox"/> Klebsiella | <input type="checkbox"/> Clostridium |
| <input type="checkbox"/> Proteus | <input type="checkbox"/> Bacteroids | <input type="checkbox"/> Enterococcus |
| <input type="checkbox"/> Fusobacterium | <input type="checkbox"/> Enterobacterium | <input type="checkbox"/> Hep A |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> Hep C | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Syphilis- Treponema Pallidum | <input type="checkbox"/> Rubella | <input type="checkbox"/> CMV |
| <input type="checkbox"/> Toxoplasma Gondii | <input type="checkbox"/> Parvovirus | <input type="checkbox"/> Listeria |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Malaria | <input type="checkbox"/> Echovirus |
| <input type="checkbox"/> Chlamydia Psittaci | <input type="checkbox"/> Haemophilus | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other: _____ | | |

- d) Genetic testing** Yes No Unknown

If yes, please specify the following

i) Culture karyotype

- Not performed
 Normal
 Abnormal
 Uncertain
 Unknown

Please specify abnormal or uncertain results: _____

ii) Chromosomal microarray

- Not performed
 Normal
 Abnormal
 Uncertain
 Unknown

Please specify abnormal or uncertain results: _____

iii) Other genetic testing (please specify): _____

- Not performed
 Normal
 Abnormal
 Uncertain
 Unknown

Please specify abnormal or uncertain results: _____

72) Autopsy

a) Were parents offered the option of an autopsy examination

- Yes (*go to Question 74ai-ii*)
 No (*go to Question 74aiii-iv*)
 Unknown (*go to Question 74b*)

i) Parental consent for an autopsy examination

- Yes- full (*go to Question (1)*)
 Yes- limited (*please describe autopsy limitations*)(*go to Question (1) and (3)*):

- No (*go to Question (2) and (3)*)
 Unknown (*go to Question 74b*)

(1) *If yes-full or yes-limited, please specify the following*

1. What were the autopsy results

- No abnormality
 Abnormal
 Inconclusive
 Unknown

If abnormal or inconclusive, please describe: _____

2. What was the autopsy examination and clinical diagnosis

- | | | | | |
|--|--|---|---|----------------------------------|
| <input type="checkbox"/> Confirms clinical diagnosis (no change in counselling for future pregnancies) | <input type="checkbox"/> Changes clinical diagnosis (diagnosis changed enough to alter counselling for future pregnancies) | <input type="checkbox"/> Additional information (clinical diagnosis not altered but additional) | <input type="checkbox"/> Additional information (clinical diagnosis not altered but additional clinical findings e.g. | <input type="checkbox"/> Unknown |
|--|--|---|---|----------------------------------|

from Pm information)

clinical findings e.g. Abnormalities)

Abnormalities)

(2) If no, please specify the following

1. What was the most relevant reason why the parents did not consent to an autopsy examination

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Inexperience of staff in counselling about autopsy | <input type="checkbox"/> Lack of rapport with the parents | <input type="checkbox"/> Lack of diagnostic value in this case | <input type="checkbox"/> Staff workload | <input type="checkbox"/> Parent emotional distress |
| <input type="checkbox"/> Religious or cultural beliefs | <input type="checkbox"/> Time to receive results | <input type="checkbox"/> Negative perceptions in general about autopsy | <input type="checkbox"/> Multiple pregnancy fetocide | <input type="checkbox"/> Unknown |
- Other: _____

(3) If yes-limited or no, please provide comments on the barriers to approach and consent for autopsy in this case :

ii) Who sought consent for autopsy

- | | | | |
|---|----------------------------------|--|---|
| <input type="checkbox"/> Junior medical staff | <input type="checkbox"/> Midwife | <input type="checkbox"/> Nurse | <input type="checkbox"/> Obstetric specialist |
| <input type="checkbox"/> Obstetric registrar | <input type="checkbox"/> GP | <input type="checkbox"/> Paediatrician | <input type="checkbox"/> Unknown |
- Other: _____

If yes-limited or no, please provide comments on the barriers to approach and consent for autopsy in this case :

iii) Please indicate the most relevant reason from the clinical staff perspective why the option of an autopsy was not offered in this case

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Inexperience of staff in counselling about autopsy | <input type="checkbox"/> Lack of rapport with the parents | <input type="checkbox"/> Lack of diagnostic value in this case | <input type="checkbox"/> Staff workload | <input type="checkbox"/> Parent emotional distress |
| <input type="checkbox"/> Religious or cultural beliefs | <input type="checkbox"/> Time to receive results | <input type="checkbox"/> Negative perceptions in general about autopsy | <input type="checkbox"/> Multiple pregnancy fetocide | <input type="checkbox"/> Unknown |
- Other: _____

iv) Please provide comments on the barriers to approach and consent for autopsy in this case:

b) Was a Babygram (skeletal survey) performed?

- Not performed
 Yes- No abnormality
 Yes- Abnormal
 Yes- Inconclusive
 Unknown

If yes-abnormal or yes-inconclusive, please specify results:

Baby Pathology and Imaging

(This section is not required for terminations of pregnancy for maternal psychological reasons)

Please note, Question 73 is a core test for all stillbirths

73) What were the clinical photographs?

- Not taken Normal Abnormal Unknown

If abnormal, please specify: _____

74) Swabs of ear and throat taken for culture?

- No (*go to Question 77*) Yes, no pathogens (*go to Question 77*) Yes, pathogen isolated

- Uncertain (*go to Question 77*) Unknown (*go to Question 77*)

If yes, pathogens isolated, please specify:

- | | | |
|---|---|---|
| <input type="checkbox"/> Group B Streptococcus | <input type="checkbox"/> Group A Streptococcus | <input type="checkbox"/> Other Streptococcus |
| <input type="checkbox"/> E coli | <input type="checkbox"/> Trichomonas Vaginalis | <input type="checkbox"/> Gardbnerella Vaginalis |
| <input type="checkbox"/> Chlamydia Trachomatis | <input type="checkbox"/> Ureaplasma Urealyticum | <input type="checkbox"/> Mycoplasma Hominis |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Neisseria Gonorrhoea | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Pseudomonas | <input type="checkbox"/> Klebsiella | <input type="checkbox"/> Clostridium |
| <input type="checkbox"/> Proteus | <input type="checkbox"/> Bacteroids | <input type="checkbox"/> Enterococcus |
| <input type="checkbox"/> Fusobacterium | <input type="checkbox"/> Enterobacterium | <input type="checkbox"/> Hep A |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> Hep C | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Syphilis- Treponema Pallidum | <input type="checkbox"/> Rubella | <input type="checkbox"/> CMV |
| <input type="checkbox"/> Toxoplasma Gondii | <input type="checkbox"/> Parvovirus | <input type="checkbox"/> Listeria |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Malaria | <input type="checkbox"/> Echovirus |
| <input type="checkbox"/> Chlamydia Psittaci | <input type="checkbox"/> Haemophilus | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other: _____ | | |

75) Magnetic resonance imaging?

- Not performed (*go to Question 78*) Normal (*go to Question 78*) Abnormal
- Inconclusive Unknown (*go to Question 78*)

If abnormal or inconclusive, please specify:

76) Were cord and cardiac blood samples taken?

- Yes, cord Yes, cardiac No (*go to Question 79*) Unknown (*go to Question 79*)

If cord or cardiac blood samples were taken, was a full blood count with smear done (nucleated red count)?

- Yes No Unknown

If yes, please specify:

- a) Hb: _____ g/L Unknown
- b) WCC: _____ x10⁹ Unknown
- c) Platelets: _____ x10⁹ Unknown

77) Genetic testing of the baby- tissue or blood?

- Yes No (*go to Question 80*) Unknown (*go to Question 80*)

If yes, please specify:

a) Specimen from the baby for the genetic testing

- Cord Blood Skin
- Cartilage Unknown Other: _____

b) Type of genetic testing

- Karyotype Chromosomal microarray Unknown Other: _____

What were the results of the testing?

- Normal Abnormal Uncertain Unknown

If abnormal or uncertain, please describe: _____

78) Were any other investigations performed?

- Yes No (*go to Question 81*) Unknown (*go to Question 81*)

If yes, please specify investigations and results:

Case Documents

79) Please attach an autopsy, placental pathology and other relevant pathology results

Case Summary

80) Please provide a brief summary of key clinical events including factors which you consider may have contributed to the death. Please also provide any information you think relevant that was not covered in the previous questions, which you consider may have contributed to the outcome.

Hospital Review Details

81) Was this case referred to the coroner?

- Yes No (*go to Question 84*) Unknown (*go to Question 84*)

If yes, was this the coroner's case?

- Yes No Unknown

Please provide details: _____

82) Sentinel event report

- Yes No (*go to Question 85*) Unknown (*go to Question 85*)

If yes, please provide details: _____

83) Root cause analysis report

- Yes No (*go to Question 86*) Unknown (*go to Question 86*)

If yes, please provide details: _____

84) Date scheduled for hospital committee review: _____ Unknown

85) Responsibility for the completion of the data

a) Name: _____

b) Designation: _____

c) Date completed: _____

Section 2: MATERNITY SERVICE REPORT

COMPLETE THIS SECTION AT PERINATAL MORTALITY COMMITTEE REVIEW

Mothers Surname: <i>(If multiple birth, indicate birth number of this baby)</i>	
Date of perinatal death	
Gestation	
Facility reporting	

Death certificate details:

- 1) Main disease or condition in fetus or infant: _____

- 2) Other diseases or conditions in fetus or infant: _____

- 3) Main maternal disease or condition affecting fetus or infant: _____

- 4) Other maternal diseases or conditions affecting fetus or infant: _____

- 5) Other relevant circumstances: _____

Classification of Cause of Death

- 6) **PSANZ Perinatal Death Classification** – Primary condition. Presumed at time of death (PSANZ-PDC)

Category classification

Please insert full numerical code _____

Please insert full text _____

NB. If stillbirth, go to question 8.

- 7) **PSANZ Neonatal Death Classification** – Primary condition. Presumed at time of death (PSANZ-NDC)

Category classification

Please insert full numerical code _____

Please insert full text _____

- 8) **Level of understanding of the diagnosis at time of death** (rated by clinician completing the death certificate)

Well understood

Poorly understood

Not understood

Not recorded

Unknown

- 9) **PSANZ Perinatal Death Classification** – Primary condition. (PSANZ-PDC)

Category classification

Please insert full numerical code _____

Please insert full text _____

10) Were any associated conditions present according to PSANZ-PDC which contributed to the death?

- Nil One Two
 Three Not Recorded Unknown

a) PSANZ Perinatal Death Classification (PSANZ-PDC) – Associated condition 1

Category classification

Please insert full numerical code _____

Please insert full text _____

b) PSANZ Perinatal Death Classification (PSANZ-PDC) – Associated condition 2

Category classification

Please insert full numerical code _____

Please insert full text _____

c) PSANZ Perinatal Death Classification (PSANZ-PDC) – Associated condition 3

Category classification

Please insert full numerical code _____

Please insert full text _____

NB. If stillbirth, go to question 13.

11) PSANZ Neonatal Death Classification – Primary condition. (PSANZ-NDC)

Category classification

Please insert full numerical code _____

Please insert full text _____

12) Were any associated conditions present according to PSANZ-NDC which contributed to the death?

- Nil One Two
 Three Not Recorded Unknown

a) PSANZ Neonatal Death Classification (PSANZ-NDC) – Associated condition 1

Category classification

Please insert full numerical code _____

Please insert full text _____

b) PSANZ Neonatal Death Classification (PSANZ-NDC) – Associated condition 2

Category classification

Please insert full numerical code _____

Please insert full text _____

c) PSANZ Neonatal Death Classification (PSANZ-NDC) – Associated condition 3

Category classification

Please insert full numerical code _____

Please insert full text _____

13) Was the perinatal death referred to the coroner?

Yes

No

Unknown

14) Please list any associated conditions present according to the PSANZ-NDC which contributed to the death (following the outline in question 2 including the sub classifications)

Factors Related to Care

1) Were factors relating to organisational and/or management identified? (e.g. inadequate supervision of staff, lack of appropriate clinical management protocols, lack of communication between services)

Yes

No (*go to Question 5*)

Unknown (*go to question 5*)

If yes, please specify each question based on the following rates:

1- Insignificant. Sub-optimal factors identified but unlikely to have contributed to the outcome

2- Possible- Sub-optimal factors identified might have contributed to the outcome

3- Significant. Sub-optimal factors identified were likely to have contributed to the outcome

4- Undetermined. Insufficient information available

5- Unknown

	Please rate	Please state the specific factors and include any relevant comments
<input type="checkbox"/> Poor organisational arrangements of staff		_____ _____ _____
<input type="checkbox"/> Inadequate education and training		_____ _____ _____
<input type="checkbox"/> Lack of policies, protocols or guidelines		_____ _____ _____
<input type="checkbox"/> Inadequate number of staff		_____ _____ _____

<input type="checkbox"/> Poor access to senior clinical staff		_____ _____ _____
<input type="checkbox"/> Failure or delay in emergency response		_____ _____ _____
<input type="checkbox"/> Delay in procedure (e.g. Caesarean section)		_____ _____ _____
<input type="checkbox"/> Inadequate systems/process for sharing of clinical information between services		_____ _____ _____
<input type="checkbox"/> Delayed access to test results or inaccurate results		_____ _____ _____
<input type="checkbox"/> Equipment (e.g. faulty equipment, inadequate maintenance or lack of equipment)		_____ _____ _____
<input type="checkbox"/> Building and design functionality (e.g. space, privacy, ease of access, lighting, noise, power failure, operating theatre in distant location)		_____ _____ _____
<input type="checkbox"/> Other: _____		_____ _____ _____
<input type="checkbox"/> Unknown		

2) Were factors relating to personnel identified? (staff factors relating to professional care and service provision)

- Yes No (*go to Question 6*) Unknown (*go to question 6*)

If yes, please specify each question based on the following rates:
1- Insignificant. Sub-optimal factors identified but unlikely to have contributed to the outcome
2- Possible- Sub-optimal factors identified might have contributed to the outcome
3- Significant. Sub-optimal factors identified were likely to have contributed to the outcome
4- Undetermined. Insufficient information available
5- Unknown

	Please rate	Please state the specific factors and include any relevant comments
<input type="checkbox"/> Knowledge and skills of staff were lacking		_____ _____ _____
<input type="checkbox"/> Delayed emergency response by staff		_____ _____ _____
<input type="checkbox"/> Failure to maintain competence		_____ _____ _____
<input type="checkbox"/> Communication between staff was inadequate		_____ _____ _____

<input type="checkbox"/> Failure to seek help/supervision		_____ _____ _____
<input type="checkbox"/> Failure to follow recommended best practise		_____ _____ _____
<input type="checkbox"/> Lack of recognition of complexity or seriousness of condition by care giver		_____ _____ _____
<input type="checkbox"/> Other: _____ _____ _____		_____ _____ _____
<input type="checkbox"/> Unknown		

3) Were barriers to accessing/engaging with care identified? (e.g. no, infrequent or late booking for antenatal care, women decline treatment/advice)

- Yes No (**go to Question 7**) Unknown (**go to Question 7**)

If yes, please specify each question based on the following rates:
1- Insignificant. Sub-optimal factors identified but unlikely to have contributed to the outcome
2- Possible- Sub-optimal factors identified might have contributed to the outcome
3- Significant. Sub-optimal factors identified were likely to have contributed to the outcome
4- Undetermined. Insufficient information available

	Please rate	Please state the specific factors and include any relevant comments
<input type="checkbox"/> No antenatal care		_____ _____ _____
<input type="checkbox"/> Infrequent or late booking		_____ _____ _____
<input type="checkbox"/> Declined treatment or advice		_____ _____ _____
<input type="checkbox"/> Obesity impacted on delivery of optimal care (e.g. USS)		_____ _____ _____
<input type="checkbox"/> Substance use		_____ _____ _____
<input type="checkbox"/> Family violence		_____ _____ _____

<input type="checkbox"/> Lack of recognition by the woman or family of the complexity or seriousness of the condition		_____ _____ _____
<input type="checkbox"/> Maternal mental illness		_____ _____ _____
<input type="checkbox"/> Cultural barriers		_____ _____ _____
<input type="checkbox"/> Language barriers		_____ _____ _____
<input type="checkbox"/> Not eligible to access free care		_____ _____ _____
<input type="checkbox"/> Environmental (e.g. isolated, long transfer, weather prevented transport)		_____ _____ _____
<input type="checkbox"/> Other: _____ _____ _____		_____ _____ _____
<input type="checkbox"/> Unknown		

Recommendations for Improvement

4) How many recommendations resulted from the review meeting: _____

5) Please list the recommendations and the action required

6) Has the action/s been completed?

Yes

No

Unknown

If yes, please specify the action taken and the date the action was taken:

If no, why has this action not been completed:

Further Comment

7) Please provide any further comments on factors which you consider may have contributed to the death:

Perinatal Mortality Review Administration Details

8) Location of perinatal mortality review: _____

9) Date of review: _____

10) Have the [parents been provided with an update on results as required?

11) Has the GP and other relevant care providers been sent a case summary?

12) Responsibility for completion of data

Name: _____

Designation: _____

Date completed: _____