

# PERINATAL DEATH CLINICAL AUDIT

Perinatal Society of Australia and New Zealand

Perinatal Mortality Group (PSANZ- PMG)

Australian and New Zealand Stillbirth Alliance (ANZSA)

## CHOOSE Type of Case

**STILLBIRTH** : A baby delivered without signs of life after 20 weeks of pregnancy, or if gestation is unknown a birth weight > 400 grams. The death is indicated by the fact that after birth the baby 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.

OR

**NEONATAL DEATH** : Death of a liveborn baby occurring before 28 completed days after birth.

*Please follow the instructions and answer all questions as directed. We understand that you may not know the answer to some of the questions but please provide as much detail as possible.*

*Personally identifiable information (of the mother, baby or carer) 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 WITHIN 48 HOURS OF THE STILLBIRTH OR NEONATAL DEATH IF POSSIBLE

1. How many perinatal deaths are linked to this pregnancy?
2. Mother: Surname  First name(s):   
Other name(s):
3. Mother Unit Record No:
4. Mother's date of birth:  /  /  (DD/MM/YYYY)
5. Was this birth the result of a termination of pregnancy?  
Yes  No   
*(If yes, indicate reason)*
- |                               |                          |
|-------------------------------|--------------------------|
| Fetal abnormality             | <input type="checkbox"/> |
| Maternal psychosocial reasons | <input type="checkbox"/> |
| Maternal medical condition    | <input type="checkbox"/> |
6. Date and time of birth of this baby?  
Date:  /  /  (DD/MM/YYYY)  
Time:  :  hrs (24hour Clock)
7. Calculated gestation of pregnancy at birth:  Wks  days
8. Baby's birth weight:  gm
9. Gender: Male  Female  Undetermined
10. Was baby one of a multiple birth ? Yes  No  Unknown   
If yes, what was birth order of the stillborn or deceased baby?
- |                                 |
|---------------------------------|
| <input type="checkbox"/> First  |
| <input type="checkbox"/> Second |
| <input type="checkbox"/> Other  |

**11. When did perinatal death occur?**

- Antepartum (Estimated gestational age at time of fetal death  Weeks  days)
- Intrapartum – first stage
- Intrapartum – second stage
- Intrapartum - Unknown
- Neonatal
- Unknown
- 

**Mothers details:**

**12. Usual residential address at time of this birth:**

House name/flat number

Street Number

Street name

Suburb /locality

Town/City

State

Post Code

**13. Marital status:** Single  Married  De facto  Widowed  Divorced  Separated

**14. Education:** <High school  High school completed  Tertiary completed

**15. Occupation:**

**16. Country of mother's birth:**

**17. Mothers ethnicity:**

- Aboriginal / Torres Strait Islander
- Maori / Pacific Islands
- Papua New Guinea/ Timor
- Caucasian
- Mediterranean
- Subcontinent (India, Pakistan, Bangladesh)
- Cambodian, Laos, Vietnamese, Thai
- Malay, Philippino, Indonesian
- Chinese, Korean
- Japanese
- Middle East, Nth Africa
- Africa
- Central / Sth America
- Other

If other please state:

**18. Maternal height**  cms **and weight**  kg (earliest measured in pregnancy)  
*(If not available please measure height and weight)*

**19. Maternal BMI at Booking if available:**  *or* Unknown

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**Previous pregnancy history:**

**20. Mother's total number of previous pregnancies:**   *or* Unknown

**Details (list pregnancy outcomes in order from first pregnancy)**

Date of Delivery	Place of birth	Gestation (weeks)	Pregnancy Outcome (see below for codes)	Method of delivery (see below for codes)	Birth weight	IUGR yes/no	Complications (see below for codes)
1.							
2.							
3.							
4.							
5.							
6.							
7.							

**Pregnancy Outcome** – LB = Live born SM = spontaneous miscarriage TOP = termination of pregnancy E = ectopic pregnancy SB = stillbirth END = early neonatal death (<7 days age) LND = late neonatal death (7 days – 28 days) Death >28/7= Death 28 days – 24 years U = unknown

**Method of Delivery** NVD = Normal vaginal delivery OV = Operative vaginal delivery VB = Vaginal breech CS = Caesarean Section

**Complications** - NIL = No complications HE = hyperemesis APH = Ante partum haemorrhage/Abruption CxS = cervical stitch GDM = Gestational diabetes PET = Pre-eclampsia Other = please comment in summary section

**21. Mother's medical history (before this pregnancy)**

	Yes	No	Unknown
a. Any pre-existing medical condition <i>(If no or unknown, go to question 21)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes pre pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Heart condition (congenital or acquired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine disorder (eg.hyper/hypothyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Mental health disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Venous thromboembolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Haematological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Cervical/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	If other please state: <input type="text"/>		

**All the following questions relate to the pregnancy relevant to perinatal death only.**

**Details of pregnancy which resulted in this perinatal death**

**22. Model of antenatal maternity care:**

Please select the model of mother's maternity care at time of booking and at birth?

*(Select one in each column)*

	<b>At booking</b>	<b>At birth</b>
No booked care	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Obstetric	<input type="checkbox"/>	<input type="checkbox"/>
Midwifery led care	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrician (private)	<input type="checkbox"/>	<input type="checkbox"/>
Midwife (private)	<input type="checkbox"/>	<input type="checkbox"/>
General Practitioner/Shared	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>

**23. History of infertility for > 12 months before this pregnancy:**

Yes       No       Unknown

**24. Fertility treatment or assisted conception for this pregnancy?**

Yes       No       Unknown

**25. Intended place of birth before labour:**

Home  
 Birth Centre  
 Public Hospital  
 Private Hospital  
 Other  
 Unknown

Please state name of place/unit/hospital:

**26. Actual place of birth:**

Home  
 Birth Centre  
 Public Hospital  
 Private Hospital  
 Unattended/Freebirth  
 Other

Please state name of unit/hospital:

**27. Antenatal procedures: *(Select all relevant)***

	<b>Yes</b>	
Anomaly Scan at ≤ 20 gestation	<input type="checkbox"/>	<i>(if yes)</i> Total number of scans <input type="text"/>
Chorion villus sampling	<input type="checkbox"/>	
Cervical suture	<input type="checkbox"/>	
Amniocentesis	<input type="checkbox"/>	
Doppler studies	<input type="checkbox"/>	
External cephalic version	<input type="checkbox"/>	
Fetocide	<input type="checkbox"/>	
Amnioreduction	<input type="checkbox"/>	
Laser treatment	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
If other please state:	<input style="width: 400px;" type="text"/>	
None of the above	<input type="checkbox"/>	
Unknown	<input type="checkbox"/>	

**28. Is mother currently smoking (cigarettes)?** Yes  *if yes,*   *per day*      No

*(If "no")*

Never smoked   
 Stopped before this pregnancy   
 Stopped during this pregnancy  If yes, gestation:  **wks**  
 Unknown

29. Maternal use of alcohol and other drugs: Yes  No  Unknown

(If "Yes" select all drugs used by mother during this pregnancy)

	during 1st trimester	month prior to birth
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine/P	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>
"Herbal highs"	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>
Petrol/paint/glue	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

If other please specify:

30. Family violence

Has mother suffered family violence during this pregnancy?  
 Yes  No  Not Asked  Unknown

31. Antenatal visits before fetal death/or delivery:

a. Total number of visits from antenatal record   Unknown   
 b. Gestation at first antenatal visit:   weeks Unknown

32. Obstetric conditions this pregnancy

Select 'Yes' for each condition present in this recent pregnancy?

a. Hypertension  Yes

(If "yes" indicate type of hypertension below)

- Gestational hypertension
- Pre-eclampsia
- Pre-eclampsia with chronic hypertension
- Eclampsia
- Unspecified

b. Preterm labour   
 c. Prolonged rupture of membranes

(If "yes" indicate time below)

- Preterm - rupture < 37 weeks gestation
- Term - rupture ≥ 37 weeks gestation

d. Cholestasis of pregnancy   
 e. Confirmed maternal infection

(If "yes" indicate kind of infection below)

Kind of infection:

- Pyelonephritis
- Lower urinary tract infection
- Other infection

If other please specify:

f. Trauma

(If "yes" indicate kind of trauma below)

Kind of trauma:

- Vehicular
- Violent personal injury
- Other

If other please specify:

- g. Vaginal bleeding**
- Before 20 weeks
- After 20 weeks

**h. Gestational diabetes**

**i. Other obstetric condition**

Please specify:

**j. Surgery in pregnancy**

Please state type of surgery:

- None of the above**
- Unknown**

**33. Suspected fetal growth restriction during pregnancy:** *(Select one)*

- No
- Yes and confirmed by scan
- Yes but normal growth on scan
- Yes but no scan performed
- Unknown

**34. Were maternal corticosteroids given antenatally?**

Yes  No  Unknown

*(If Yes is selected answer the below)*

Course of corticosteroids started at what gestation?  weeks  days

Was course of corticosteroids completed? Yes  No  Unknown

**35. Screening for gestational diabetes in this pregnancy:**

Mother tested for gestational diabetes

Yes  No  Unknown

*(If "yes" is answered for Question 28 answer the below)*

Gestational Diabetes confirmed

Raised Polycose but no Glucose Tolerance Test

Diet and/or medications taken

**36. Was this a multiple pregnancy?**

Yes  No  Unknown

*(If "yes please answer below)*

a. Number of fetuses/babies **alive** at 20 weeks gestation:

b. Chorionicity (if known) \_\_\_\_\_

**37. Folic acid taken in this pregnancy?**

*Please complete both*

Yes No Unknown

Folic Acid taken pre pregnancy?

Folic Acid taken first trimester?

**38. Other medications taken in this pregnancy? Yes  No**

If yes, list \_\_\_\_\_

**39. Was there consultation with an obstetrician during pregnancy?**

- Obstetrician was lead maternity carer
- Yes
- No
- Unknown

*(If "yes" answered to Question 40 please select all relevant below)*

**What were the reason(s) for the obstetrician/specialist consultation?**

- Prolonged pregnancy (>41 weeks)
- Age of mother
- Breech
- Recurrent miscarriage
- Mother's request
- Stillbirth (this pregnancy)
- Previous Stillbirth
- Size of fetus  *(If "yes")* large fetus  small fetus
- Previous intrauterine growth restriction
- Previous Caesarean section
- Multiple pregnancy
- Antepartum haemorrhage
- Diabetes
- Unstable lie
- Fetal Abnormality
- Prolonged rupture of membranes
- Cholestasis
- Surgery in pregnancy
- Significant infection
- Renal
- Cardiac
- Hypertension
- Decreased fetal movements
- Non-reassuring CTG
- Polyhydramnios/Oligohydramnios
- Other reason

If other please state:

**40. Was the mother referred to any other healthcare services (apart from midwifery & obstetrics) during pregnancy**

- Yes  No  Unknown

*(If "yes" select all relevant)*

- Medical
- Mental health
- Drug and alcohol
- Social
- Other service

If other please state:

***(NB: If perinatal death confirmed before labour, please go to question 59.)***

**Labour and Birth**

**41. Onset of labour:**

- Spontaneous  Induced  No labour  Unknown

*(If no labour, please go to question 46)*

**a) If labour induced, state methods used to induce labour**

- Drugs used, please specify: \_\_\_\_\_
- Artificial rupture of membranes (Date & Time \_\_\_\_\_)

Other, please specify: \_\_\_\_\_

**b) Reason for induction:**

- Post dates
- Pre-eclampsia
- APH
- Diabetes
- Maternal request
- Intra-uterine fetal death
- Intra uterine growth restriction
- Fetal Abnormality
- Other, please specify: \_\_\_\_\_

**42. Labour augmentation:** Yes  No  Unknown   
*(If yes, please select all that apply)*

**Method:**

- Artificial rupture of membranes (Date & Time \_\_\_\_\_)
- Oxytocin
- Other, please specify: \_\_\_\_\_

**43. Analgesia during labour** Yes  No  Unknown   
*(If "yes" answer the below, select all relevant)*

- Opiate
- Nitrous oxide
- Epidural
- Non-pharmacological – please specify \_\_\_\_\_
- Other - please state: \_\_\_\_\_

**44. Bath or pool during labour:** Did part of labour occur in bath/pool? Yes  No  Unknown

*(If "yes" please answer below)* Was the baby born in bath/pool? Yes  No  Unknown

**45. Fetal monitoring during labour** Yes  No  Unknown   
*(If "yes" please select all relevant)*

- Intermittent auscultation
- CTG on admission
- Intermittent CTG
- Continuous CTG external
- Continuous CTG - FSE
- Fetal Scalp ph
- Other
- If other please state: \_\_\_\_\_

**46. Method of birth of this baby :**

- Normal vaginal birth
- Vaginal breech birth  Spontaneous or assisted: \_\_\_\_\_
- Operative vaginal delivery  Details: \_\_\_\_\_
- Elective Caesarean *(additional questions below)*
- Emergency Caesarean *(additional questions below)*
- Unknown/not stated
- If multiple birth, state mode of birth other infants: \_\_\_\_\_

*(If "Caesarean" selected please answer the next 3 questions below)*  
**a. Were forceps/ventouse attempted before Caesarean?** Yes

No

**b. Reason for Caesarean birth:**

- No medical indication
- Previous Caesarean
- Breech presentation
- Pre-eclampsia
- APH
- Maternal request
- Intra-uterine fetal death
- Intra uterine growth restriction
- Fetal abnormality
- Fetal distress
- Cord presentation/prolapse
- Failure to progress in first stage
- Failure to progress in second stage
- Other, please specify: \_\_\_\_\_

**c. Type of anaesthetic at Caesarean (select one)**

- General
- Spinal
- Epidural
- Other
- If other please state: \_\_\_\_\_

**47. Complications in labour**

*(If "yes", select all relevant)*

Yes  No  Unknown

- APH
- Meconium liquor
- Fetal bradycardia
- Non-reassuring CTG
- Cord entanglement/ prolapse
- Shoulder dystocia
- Retained placenta
- Other
- If other please state: \_\_\_\_\_

**48. Length of labour**

- a) **First stage**   hours  minutes Unknown
- b) **Second stage**   hours  minutes Unknown

c) If mother admitted to hospital before birth, time in hospital before birth?  
  days   hours   minutes Unknown

**49. Apgar scores this baby:**

- 1 minute
- 5 minutes
- 10 minutes
- 15 minutes
- Unknown

**50. Live or still birth (Select one of the following)**

- Stillbirth
- Live birth
- Unknown if still birth or live birth

**51. Was baby resuscitated at birth?**

Yes  No  Unknown

*(If Yes select one of the below)*

Baby resuscitated and transferred to another clinical care area   
Baby unable to be resuscitated

*(If baby resuscitation took place select all relevant from below)*

**Resuscitation used at birth**

- Suction
- Oxygen
- IPPV – bag and mask
- External Cardiac massage
- Medications please state:
- Other resuscitation, please state:

**52. Cord gases at birth:**

Not taken

	Arterial			Venous		
pH	+ / -	<input type="text"/>	<input type="text"/>	+ / -	<input type="text"/>	<input type="text"/>
Base deficit		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
CO <sub>2</sub>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
Lactate		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>

**53. Baby's examination after birth (live and stillborn babies):**

Were there any external abnormalities noted on examination of the baby?

Yes  No

a) If yes, please specify (including birth trauma)

b) Degree of maceration: None  Slight  Moderate  Marked

**54. Date and time of perinatal death**

Date: / /  (DD/MM/YYYY)

Time:  :  Hrs (24hour Clock) or Unknown

**55. Was baby transferred from their place of birth prior to death?**

Yes  No  Unknown

If yes, where was the baby transferred to? *(Select one)*

- NICU/SCU\*  \*Neonatal Intensive Care Unit/Special Care Unit
- Post natal ward
- Home
- Died in transfer
- Tertiary Services
- Other

If other please state:

**56. If baby admitted to hospital area, provide details of further treatments.**

- a) Diagnoses made:
- b) Investigations/procedures:

- c) IV therapy and drugs:
- d) Mechanical ventilation details:
- e) Were active life supporting measures withdrawn? Yes  No

**f) Summary of neonatal events:**

Date	Time	Baby's age	Event

**57. Place of death if baby born alive:**

- Home
- Hospital  State area within hospital:
- Other  Please give details:

**58. If baby born alive, age at time of death**

Days  Hours  Minutes

**59. Baby physical examination after death:**

Were there any external abnormalities noted on examination of the baby?  
 Yes  No

a) If yes, please specify (including birth trauma) \_\_\_\_\_  
 \_\_\_\_\_

b) Degree of maceration: None  Slight  Moderate  Marked

**60. Placenta:**

a) Placenta weight:     gm or placenta not weighed  Unknown

b) Placental examination  
 Not examined  
 Normal  
 Some abnormalities, please state:

**61. Umbilical cord examined?**

Yes  No  Unknown

*(If "yes" please continue below)*

**a) Any problems with cord?**

Yes  No

*(Select all relevant)*

- True knot  *(if selected answer)* tight knot  loose knot
- Cord round neck  *(if selected answer)* tight around  loose around
- Cord round limbs or body  *(if selected answer)* tight around  loose around
- Torsion or spring-like cord
- Marginal/ velamentous insertion
- Abnormal cord thickness  *(if selected answer)* thin cord  thick cord
- Meconium stained
- Tear in cord
- 2 vessels

Other abnormality   
If other please state:

**62. Maternal outcome:**

- Alive and generally well  
 Alive but with serious morbidity e.g. admitted to ICU, hysterectomy or stroke.  
 Dead

*Please add further details in the summary if serious maternal morbidity or mortality occurred.*

**63. Post mortem examination:**

- Parents offered a post mortem examination? Yes  No  Unknown   
If yes did the Parents consent to a post mortem? Yes  No   
Death referred to the Coroner? Yes  No

**64. Were there any other factors which contributed to the perinatal death?**

Yes  No

If yes, please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**65. Bereavement support program commenced with family?** Yes  No

If yes, give details: \_\_\_\_\_  
\_\_\_\_\_

**66. Summary:** Please provide any information you think relevant that was not covered in the previous questions, which you consider may have contributed to the outcome. *(Please continue over page if needed)*

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**Section 1 of this form completed by:-**

**Name:-**

**Designation:-**

**Contact details: - Phone-  
Email-**

**Date:-**

**Please send (mail, email or fax) the completed form to:**

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## SECTION 2 : PERINATAL DEATH FOLLOW-UP

(COMPLETE THIS SECTION WHEN MOTHER IS DISCHARGED FROM MEDICAL CARE)

### 1. Follow-up visits for family

Obstetrician: \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

Neonatologist: \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

Midwife: \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

General Practitioner: \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

Bereavement support: \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

Other, specify \_\_\_\_\_ Yes  (Date/time: \_\_\_\_\_) No

G.P. notified of the death: Yes  Date notified: \_\_\_\_\_ No

Genetic counselling required? Yes  No

If yes, please specify \_\_\_\_\_

Further investigations required? Yes  No

If yes, please specify \_\_\_\_\_

Specific religious or cultural considerations? Yes  No

If yes, please specify \_\_\_\_\_

Other relevant information: \_\_\_\_\_

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### 2. Other investigations in progress

Coroner's case Yes  No

Please provide details: \_\_\_\_\_

Sentinel event report Yes  No

Please provide details: \_\_\_\_\_

R.C.A report Yes  No

Please provide details: \_\_\_\_\_

**Section 2 of this Form completed by:-**

Name:-

Designation:-

Contact details: - Phone-  
Email-

Date:-

**SECTION 3 : CAUSE OF DEATH AND ASSOCIATED FACTORS**  
(PLEASE COMPLETE THIS SECTION AT PERINATAL MORTALITY COMMITTEE REVIEW)

**1. Classification of cause of death**

**A) Cause of death recorded on Medical Certificate**

- i. Main disease or condition in fetus or infant: \_\_\_\_\_
- ii. Other diseases or conditions in fetus or infant: \_\_\_\_\_
- iii. Main maternal disease or condition affecting fetus or infant: \_\_\_\_\_
- iv. Other maternal diseases or conditions affecting fetus or infant: \_\_\_\_\_
- v. Other relevant circumstances \_\_\_\_\_

**B) PSANZ Perinatal Mortality Classification of Cause of Death**

(I) Perinatal Death Classification (PSANZ-PDC) Category   
Category description \_\_\_\_\_

(II) Neonatal Death Classification (PSANZ-NDC) Category   
Category classification \_\_\_\_\_

**C) PSANZ Perinatal Mortality Classification of associated conditions**

**Associated condition 1:**

(a) Perinatal Death Classification (PSANZ-PDC) Category   
Category description \_\_\_\_\_

**OR**

(b) Neonatal Death Classification (PSANZ-NDC) Category   
Category classification \_\_\_\_\_

**Associated condition 2:**

(a) Perinatal Death Classification (PSANZ-PDC) Category   
Category description \_\_\_\_\_

**OR**

(b) Neonatal Death Classification (PSANZ-NDC) Category   
Category classification \_\_\_\_\_

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**2. Termination of pregnancy**

Was the pregnancy terminated? Yes  No

If yes, termination due to:

Fetal abnormality  Maternal psychosocial reasons  Maternal medical condition

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**3. Congenital abnormality**

Was congenital abnormality present? Yes  No  Unknown

If yes, please state abnormality \_\_\_\_\_

If unknown, are results of investigations pending Yes  No

If yes, please state tests awaiting \_\_\_\_\_

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**4. Fetal or Neonatal Infection**

Did infection contribute to the death? Yes  No  Unknown

If yes, state organism \_\_\_\_\_  
culture site? \_\_\_\_\_ (date and time) \_\_\_\_\_

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**5. Post mortem Investigations and results**

(a) Autopsy conducted Yes - Full  Yes - Limited  No

If yes, state findings \_\_\_\_\_

(b) Maternal investigations

(c) State other tests and available results

**6. Factors relating to care**

Were any potentially contributing factors relating to provision of (or access to) care thought to be present?

Yes

No  If no, go to question 7.

If yes, please complete table and state if events were **antenatal, intrapartum or postnatal**:

<b>A. Factors related to the woman/her family/social situation</b>	<b>Sub-optimal factor code</b>	<b>Relevance to outcome code</b>
1.		
2.		
3.		
<b>B. Factors related to access to care</b>		
1.		
2.		
3.		
<b>C. Factors related to professional care</b>		
1.		
2.		
3.		
<b>D. Other factors:</b>		

<b>Suboptimal factors – coding</b>	<b>Relevance of sub-optimal factor to outcome - coding</b>
<b>R - Failure to recognise problem</b>	<b>I - Sub-optimal factor(s) identified but <u>unlikely</u> to have contributed to outcome (insignificant)</b>
<b>A - Failure to act appropriately</b>	<b>P- Sub-optimal factor(s) identified <u>might</u> have contributed to outcome (possible)</b>
<b>C - Communication failure</b>	<b>S - Sub-optimal factor(s) identified <u>likely</u> to have contributed to outcome (significant)</b>
<b>S - Failure to supervise</b>	<b>U - Insufficient information available (undetermined)</b>
<b>H - Inadequate human resources</b>	
<b>O - Other</b>	

**7. Recommendations for practice improvement :** Yes  No

Recommendation 1: \_\_\_\_\_  
Action required: \_\_\_\_\_  
Review date: \_\_\_\_\_

Recommendation 2: \_\_\_\_\_  
Action required: \_\_\_\_\_  
Review date: \_\_\_\_\_

Recommendation 3: \_\_\_\_\_  
Action required: \_\_\_\_\_  
Review date: \_\_\_\_\_

**8. Other recommendations (educational or research):** Yes  No

Recommendation 1: \_\_\_\_\_  
Recommendation 2: \_\_\_\_\_  
Recommendation 3: \_\_\_\_\_

**9. Administrative details**

Hospital of perinatal mortality review: \_\_\_\_\_

Date of review: \_\_\_\_\_

Review finalized? Yes  No

If yes, date finalized: \_\_\_\_\_

If no, please specify outstanding areas for review \_\_\_\_\_  
\_\_\_\_\_

**Section 3 of this form completed by:-**

**Name:-** \_\_\_\_\_

**Designation:-** \_\_\_\_\_

**Contact details: - Phone-** \_\_\_\_\_

**Email-** \_\_\_\_\_

**Date:-** \_\_\_\_\_.

**Please send (mail, email or fax) the completed form to:**