|  |  |  |
| --- | --- | --- |
| National Perinatal Death Clinical Audit Tool | | |
|  |  |  |

**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*:**

*OR*

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

***Please select type*:**

*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.***

1. **How many perinatal deaths are associated with this pregnancy?**
2. **Mother: Surname**

**Given name(s):**

**Other name(s):**

**3. Mother’s Unit Record No:**

**4. Mother’s date of birth:**

**5. Usual residential address of mother at time of birth:**

Town/City/Locality

State

Post Code

**6. Date and time of baby’s birth:** Date:

Time:      hrs (24hour Clock)

**7. Date and time of baby’s death (neonatal deaths):**

Date:

Time:      hrs (24hour Clock)

**8.** **Calculated** **gestation of pregnancy at birth:**       Completed Weeks

**9. Birth weight:**      grams

**10. Gender:**

**11. Name of facility reporting:**

**12. Marital status:**

**13. Education:**

**14. Mother’s occupation:**

**15. Mother’s country of birth:**

**16. Mother’s ethnicity:**

**17. Mother’s understanding of spoken English:**

**18. Mother’s height:**      cms

**weight:**      kg (earliest measured in pregnancy)

*If not available please measure height and weight.*

**19. Maternal BMI at booking:**      *or* Unknown

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

**Yes**  **No**  **Unknown**

*If yes, what was birth order of this stillborn or deceased baby?*

First

Second

Other

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

b. Chorionicity (if known):

**21. Mother’s previous obstetric history:**

**a) total number of previous pregnancies**:       *or* Unknown

**b) details of previous pregnancies *(list in order from first pregnancy- more space page 11)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date of Birth | Place of birth | Gestation (weeks) | Pregnancy Outcome *(codes below)* | Type of birth  *(codes below)* | Birth weight | Complications  (eg. IUGR)  (*codes below*) |
| 1. |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |
| 6. |  |  |  |  |  |  |  |
| 7. |  |  |  |  |  |  |  |
| 8. |  |  |  |  |  |  |  |

**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); **NNDI** = Death 28 days – 2 years; **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; **IUGR** = intrauterine growth retardation; **GDM** = gestational diabetes mellitus; **GH** = gestational hypertension; **U** = unknown; **Other** = please comment in summary section, page 11.

**22. Mother’s medical history** (before this pregnancy)

**Yes No Unknown**

* 1. Any pre-existing medical condition

*(If no or unknown, go to question 23)*

* 1. Asthma
  2. Diabetes pre pregnancy (type 1 or 2)
  3. Epilepsy
  4. Heart condition (congenital or acquired)
  5. Hypertension
  6. Endocrine disorder (eg.hyper/hypothyroid)
  7. Inflammatory bowel disease
  8. Systemic lupus erythematosus
  9. Other autoimmune disorder
  10. Mental health disorder
  11. Renal disease
  12. Venous thromboembolism
  13. Haematological disorders
  14. Cervical/uterine surgery
  15. Urinary tract infection
  16. Uterine abnormality

**r.** Other, please state:

***All remaining questions relate only to the pregnancy*** ***associated with this perinatal death.***

**23. Fertility treatment or assisted conception in this pregnancy?**

**Yes**  **No**  **Unknown**

*If yes, method/s and dates*:

**24. Is mother a smoker? Yes**  *If yes:*       *per day* **No**

*If no:*

Never smoked

Stopped before this pregnancy

Stopped during this pregnancy  *at gestation*:       weeks

Unknown

**25. Mother’s use of alcohol and other drugs: Yes**  **No**  **Unknown**

*If yes specify drug and alcohol use during this pregnancy:*

**a) First**  **trimester :**

**b) Month prior to birth:**

**26. Antenatal check ups :**

###### a. Total number of antenatal visits recorded:      *or* Unknown

**b**. Gestation at first antenatal visit:       weeks *or* **Unknown**

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

*(Select one in each column)* **At booking At birth**

No booked care

Obstetric hospital

Maternal/Fetal Medicine

Hospital midwifery (eg birth centre)

Private obstetrician

Private midwife

General Practitioner /Shared

Unknown

|  |  |
| --- | --- |
| **28.Intended place of birth before labour:** | **29. Actual place of birth:** |
| Please state name of intended place: | Please state name of actual place: |

**30. Obstetric conditions during this pregnancy:**

*Indicate all conditions known to be present during this pregnancy*.  **Yes**

1. Hypertension

*If yes indicate type of hypertension*

Gestational hypertension

Pre-eclampsia

Pre-eclampsia with chronic hypertension

Eclampsia

Unspecified

1. Preterm labour

**c.** Prolonged rupture of membranes

*If yes indicate gestation*

Preterm - rupture < 37 weeks gestation

Term - rupture ≥ 37 weeks gestation

**d**. Cholestasis of pregnancy

1. Confirmed maternal infection

*If yes indicate kind of infection*

Pyelonephritis

Lower urinary tract infection

Other infection

If other please specify:

1. Trauma

*If yes indicate kind of trauma*

Vehicular

Fall

Violent personal injury

Other, please specify:

1. Vaginal bleeding

*If yes indicate gestation*

Before 20 weeks

After 20 weeks

1. Gestational diabetes

*If yes indicate intervention*

Oral hypoglycaemic therapy

Insulin treated

Other, please specify:

1. Other obstetric condition

*Please specify*:

**None of the above**

**Unknown**

**31. Suspected fetal growth restriction during pregnancy:**

**32. Antenatal procedures:** *(Please indicate all procedures undertaken in pregnancy* ***before*** *perinatal death)*

**Yes**

First trimester screening scan  Total number of scans=

Anomaly scan at ≤ 20 gestation

Chorion villus sampling

Cervical suture

Amniocentesis

Doppler studies

External cephalic version

Fetocide

Amnioreduction

Laser treatment

Other, please state:

None of the above

Unknown

**33.** **Please indicate if obstetric consultation occurred for these reasons:** *(All that apply)*

No obstetric consultations

Prolonged pregnancy (>41 weeks)

Poor obstetric history

Breech presentation

Mother’s request

Previous perinatal death

Size of fetus  large  *or* small

Previous caesarean section

Antepartum haemorrhage

Unstable lie

Fetal abnormality

Prolonged rupture of membranes

Decreased fetal movements

Non-reassuring CTG

Polyhydramnios/Oligohydramnios

Surgery, specify:

Other reason, specify:

**34**. **Was the mother referred to other healthcare services during pregnancy?**

**Yes**  **No**  **Unknown**

*If yes, select all applicable:*

Medical

Mental health

Drug and alcohol

Social worker

Other service

If other, specify:

35. Were maternal corticosteroids given in pregnancy?

Yes  No  Unknown

**36. Medications taken in this pregnancy? Yes**   **No**

*(Include all over the counter and traditional medicines)*

*If yes, list:*

***NB. If fetal death confirmed before labour, please go to question 42.***

**Labour and Birth:**

**37. Onset of labour**:

*(If no labour, go to question 42)*

**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:**

**38. Labour augmentation:** Yes  No  Unknown

*(If yes, please select all that apply)*

Artificial rupture of membranes (Date & Time      )

Oxytocin infusion

Other, please specify:

**39. Analgesia during labour:** Yes  No  Unknown

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

Opiate

Nitrous oxide

Epidural

Non-pharmacological – please specify

Other - please state:

**40. Water immersion during labour:**

Did part of labour occur in bath/pool? Yes  No  Unknown

*(If yes)*

Was the baby born in bath/pool?Yes  No  Unknown

**41. Fetal monitoring during labour:** Yes  No  Unknown

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

Intermittent auscultation

CTG on admission

Intermittent CTG

Continuous CTG external

Continuous CTG - FSE

Fetal scalp ph/lactate

Other, please state:

**42. Method of birth of this baby**

Vaginal non-instrumental

Forceps

Vacuum extractor

LSCS *(see below)*

Classical caesarean *(see below)*

Other, please state  *Details*:

Unknown/not stated

*If caesarean, please answer a) and b) over:*

**a) Main reason for caesarean:** *(select one):*

If Other please specify:      

**b) Anaesthetic for operative delivery:**

**43. Complications in labour:** Yes  No  Unknown

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

APH

Meconium liqour

Fetal bradycardia

Non-reassuring CTG

Cord entanglement/ prolapse

Shoulder dystocia

Failure to progress/dystocia

Other, please state:

**44. Length of labour:**

**a)** First stage     hours      minutes *or* Unknown

**b)** Second stage      hours      minutes *or* Unknown

**c)** If birth occurred in hospital, state time in hospital before birth:

      days       hours      minutes *or* Unknown

**45.** **Apgar scores:**

**46. a) Resuscitation at birth:** Yes No Unknown

*If yes answer the rest of this question:*

Baby resuscitated and transferred to another clinical area

Baby not able to be resuscitated

b) Details of resuscitation at birth: *If resuscitation commenced indicate methods:*

Suction

Oxygen

IPPV – bag and mask

External cardiac massage

Medications, specify:

Other resuscitation, specify:

State category of senior staff present:

**47. Cord gases at birth:** Yes No Unknown

**Arterial**   **Venous**

**pH**      

**Base deficit** + / -       + / -

**CO2**       

**Lactate**             

48. Baby’s examination after birth (live and stillborn babies):

a) Length       cm and Head circumference       cm

b) External abnormalities noted on examination of baby: Yes  No

*If yes, specify (including birth trauma)*

**c)** If stillborn, degree of maceration:

*NB. If fetal death confirmed before labour, go to question 53.*

**49.** **Was baby transferred from place of birth (eg via NETS) prior to death?**

Yes  No  Unknown

If yes, where was the baby transferred to?

If other please state:

50. If baby admitted to hospital, 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 significant neonatal events:

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Time | Baby’s age | Event |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**51. Place of death if baby was born alive:**

Home

Hospital  Specify location in hospital:

Other  Give details:

52. Baby examination after neonatal death:

External abnormalities noted on examination of the baby? Yes  No

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

**53. Placental examination:**

**a)** Placenta weight:     gm **or**  Unknown

**b)** Placental examination

Not examined

Normal

Abnormalities, please state:

**c)** Placenta sent to pathology**:** Yes  No  Unknown

**54. Umbilical cord notable features:** Yes  No  Unknown

*If yes,* *indicate all features noted:*

True knot  tight  loose

Cord round neck  tight  loose

Cord round limbs or body  tight  loose

Hyper-coiled appearance

Marginal/ velamentous insertion

Abnormal cord length  short  long        cms

Unusual thickness  thin  thick        cms

Meconium stained

2 vessels

Other abnormality, please state:

**55. Maternal outcome:**

*Please add further details in the summary (question 59) if serious maternal morbidity or mortality.*

56. Post mortem examination:

**a)** Parents offered a post mortem examination? YesNoUnknown

*Parental consent to full post mortem?* YesNo

*Parental consent to limited post mortem?* Yes No

*Parental consent to external examination?* Yes No

**b)** Death referred to the Coroner? Yes No

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

Yes  No

*If yes, please specify and complete section 2.*

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

**59. Summary:** Please provide any relevant information not covered in the previous questions, which you consider may have contributed to the perinatal death.

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

**Name:-**

**Designation:-**

**Contact details: - Phone-**

**Email-**      

**Date:-**

**Please mail completed original Section 1 marked ‘Confidential’ to:**

Manager, Council of Obstetric & Paediatric Mortality & Morbidity

Department of Health and Human Services

GPO Box 125

Hobart 7001 Tasmania

**SECTION 2 : CAUSE OF DEATH AND ASSOCIATED FACTORS**

***COMPLETE THIS SECTION AT PERINATAL MORTALITY COMMITTEE REVIEW***

|  |  |
| --- | --- |
| **Mother’s Surname**  ***(If multiple birth, indicate birth number of this baby)*** |  |
| **Date of perinatal death** |  |
| **Gestation** |  |
| **Facility reporting** |  |

1. **Classification of cause of death**

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

* 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:

**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

**2. Post mortem Investigations and results**

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

If yes, state limits (if applicable) and findings (or attach copy of report)

(b) Placental histopathology  **Yes**   **No**

If yes, state limits (if applicable) and findings (or attach copy of report)

(c) Maternal investigations

(d) State other tests and available results

**3. Factors relating to care**

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

**Yes**   **No**  **If no, go to question 4.**

If yes, complete table and state whether each event was **antenatal, intrapartum or postnatal**:

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

|  |  |
| --- | --- |
| **Suboptimal factors – coding** | **Relevance of sub-optimal factor to outcome - coding** |
| **R - *Failure to recognise problem***    **A - *Failure to act appropriately***    **C - *Communication failure***    **S - *Failure to supervise***    **H - *Inadequate human resources***  **O - *Other*** | **I - *Insignificant. Sub-optimal factor(s) identified but unlikely to have contributed to outcome.***  **P- *Possible. Sub-optimal factor(s) identified might have contributed to outcome.***  **S - *Significant. Sub-optimal factor(s) identified likely to have contributed to outcome***  **U - *Undetermined. Insufficient information available.*** |

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

Recommendation 1:

Action required:

Review date:

Recommendation 2:

Action required:

Review date:

Recommendation 3:

Action required:

Review date:

**5. Other recommendations (eg. education or research): Yes**  **No**

Recommendation 1:

Recommendation 2:

Recommendation 3:      

**6. Perinatal mortality review administrative details**

Location of perinatal mortality review:

Date of review:

Review finalised? Yes  No

If yes, date finalised:

If no, please specify outstanding areas for review

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

**Name:-**

**Designation:-**

**Contact details: - Phone-**

**Email-**      

**Date:-**

**Please copy Section 2 for perinatal mortality committee records and mail completed original marked ‘Confidential’ to:**

Manager, Council of Obstetric & Paediatric Mortality & Morbidity

Department of Health and Human Services

GPO Box 125

Hobart 7001 Tasmania

**SECTION 3 : PERINATAL DEATH FOLLOW-UP (*OPTIONAL*)**

***COMPLETE THIS SECTION WHEN MOTHER DISCHARGED FROM MEDICAL CARE***

***( FILE IN CASE NOTES)***

**1. Follow-up visits for family**

Obstetrician:       Yes  Date/time:

Neonatologist:       Yes  Date/time:

Midwife:       Yes  Date/time:

General Practitioner:       Yes  Date/time:

Bereavement support:       Yes  Date/time:

Other, specify:       Yes  Date/time:

G.P. notified of the perinatal death: Yes  Date notified:

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**:

**2. Other investigations proceeding:**

**Coroner’s case** Yes  No

Please provide details:

**Sentinel event report** Yes  No

Please provide details:

**Root Cause Analysis report** Yes  No

Please provide details:

**Perinatal Mortality Review Committee** Yes  No

Please provide details:

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

**Name:-**

**Designation:-**

**Contact details: - Phone-**

**Email-**      

**Date:-**