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)
      ☐ Monochorionic (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
   ☐ Post-neonatal Death
      If yes, please specify the hospital episode for neonatal/post-neonatal 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_________________________

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<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>7) Time of baby’s birth</td>
<td></td>
</tr>
<tr>
<td>8) Gender</td>
<td>☐ Male ☐ Female ☐ Unknown ☐ Intersex or indeterminate</td>
</tr>
<tr>
<td>9) Indigenous status</td>
<td>☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Not stated/unknown</td>
</tr>
<tr>
<td>10) Calculated gestation of pregnancy at birth</td>
<td></td>
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<tr>
<td>11) Birth weight (g)</td>
<td></td>
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<tr>
<td>12) Did this baby have a major congenital abnormality</td>
<td>☐ Yes ☐ No ☐ Unknown</td>
</tr>
<tr>
<td>13) Was this death unexpected</td>
<td>☐ Yes ☐ No ☐ Unknown ☐ Cannot be determined</td>
</tr>
<tr>
<td><strong>Mother’s Details</strong></td>
<td></td>
</tr>
<tr>
<td>14) Mother</td>
<td>Surname:</td>
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<tr>
<td></td>
<td>Given name(s):</td>
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<tr>
<td></td>
<td>Other(s):</td>
</tr>
<tr>
<td>15) Mother’s Unit Record No</td>
<td></td>
</tr>
<tr>
<td>16) Mother’s Date of Birth</td>
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<tr>
<td>17) Usual residential address of mother at time of birth</td>
<td>Country:</td>
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<tr>
<td></td>
<td>Town/City/Locality:</td>
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<tr>
<td></td>
<td>State:</td>
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<td>Post Code:</td>
</tr>
<tr>
<td>18) Indigenous status</td>
<td>☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Not stated/unknown</td>
</tr>
<tr>
<td>19) Mother’s understanding of spoken English</td>
<td>☐ Very well ☐ Well (help with medical terminology) ☐ Not well (help with everyday English) ☐ Not at all ☐ Unknown</td>
</tr>
</tbody>
</table>
### Previous Pregnancies

20) Number of mother’s previous pregnancies: __________  
☐ Unknown

21) Mother’s parity (Do not include current pregnancy): __________  
☐ Unknown

<table>
<thead>
<tr>
<th></th>
<th>Date of Birth</th>
<th>Place of birth (see options below)</th>
<th>Gestation (weeks)</th>
<th>Pregnancy Outcome (codes below)</th>
<th>Type of birth (codes below)</th>
<th>Birth weight (grams)</th>
<th>Complications (e.g. FGR) (codes below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</tbody>
</table>

**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); INFD = 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**

<table>
<thead>
<tr>
<th>Drug</th>
<th>First trimester</th>
<th>Month prior to birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cannabis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cocaine</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chroming/Petrol/Paint</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Methadone</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Herbal Highs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Unknown</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other: _______________________</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

28) Has the mother suffered family violence during this pregnancy?
☐ Yes  ☐ No  ☐ Not Asked  ☐ Unknown

29) Place of birth

**Please select from both columns**

<table>
<thead>
<tr>
<th>Intended place of birth before labour</th>
<th>Actual place of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital, excluding birth centre</td>
<td>☐</td>
</tr>
<tr>
<td>Birth centre, attached to hospital</td>
<td>☐</td>
</tr>
<tr>
<td>Birth centre, free standing</td>
<td>☐</td>
</tr>
<tr>
<td>Home (other)</td>
<td>☐</td>
</tr>
<tr>
<td>Home- private midwife care</td>
<td>☐</td>
</tr>
<tr>
<td>Home- public homebirth program</td>
<td>☐</td>
</tr>
<tr>
<td>In transit</td>
<td>☐</td>
</tr>
<tr>
<td>Unknown</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
</tr>
</tbody>
</table>

30) Model of antenatal maternity care

**Booking**  
Private obstetrician (specialist care)  ☐
Private midwifery care  ☐
General Practitioner obstetrician care  ☐
Shared care  ☐
Combined care  ☐
Public hospital maternity care  ☐
Public hospital high risk maternity care  ☐
Team midwifery care  ☐

**At birth**  
Private obstetrician (specialist care)  ☐
Private midwifery care  ☐
General Practitioner obstetrician care  ☐
Shared care  ☐
Combined care  ☐
Public hospital maternity care  ☐
Public hospital high risk maternity care  ☐
Team midwifery care  ☐
### 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 ____________________________________________

### 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:*

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history of thrombosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric complications during this pregnancy and obstetric consultation</td>
<td></td>
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</tr>
</tbody>
</table>

**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*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hypertension</td>
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<tr>
<td>i) If yes, please specify type of hypertension</td>
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<tr>
<td>☐ Eclampsia</td>
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<tr>
<td>☐ Preeclampsia</td>
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<tr>
<td>☐ Gestational hypertension</td>
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<tr>
<td>☐ Chronic hypertension</td>
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<tr>
<td>☐ Unknown</td>
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<tr>
<td>ii) Was there consultation with an obstetrician for hypertension</td>
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<tr>
<td>☐ Yes</td>
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<td>☐ No</td>
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<tr>
<td>☐ Already under obstetric care</td>
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<td>☐ Unknown</td>
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<tr>
<td>b) HELLP Syndrome</td>
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<tr>
<td>i) If yes, was there consultation with an obstetrician for HELLP syndrome</td>
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<td>☐ Yes</td>
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<td>☐ No</td>
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<tr>
<td>☐ Already under obstetric care</td>
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<td>☐ Unknown</td>
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<tr>
<td>c) Preterm labour</td>
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<tr>
<td>i) If yes, was there consultation with an obstetrician for preterm labour</td>
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<tr>
<td>☐ Yes</td>
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<td>☐ No</td>
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<tr>
<td>☐ Already under obstetric care</td>
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<td>☐ Unknown</td>
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<tr>
<td>d) Pre-labour rupture of membranes</td>
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<tr>
<td>i) If yes, please specify the gestation of the membrane rupture</td>
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<td>☐ Yes</td>
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<td>☐ No</td>
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<td>☐ Already under obstetric care</td>
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<td>☐ Unknown</td>
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<tr>
<td>ii) Was there consultation with an obstetrician for pre-labour rupture or membranes</td>
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<td>☐ Yes</td>
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<tr>
<td>☐ Already under obstetric care</td>
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<td>☐ Unknown</td>
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<tr>
<td>e) Obstetric cholestasis</td>
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<tr>
<td>i) If yes, was there consultation with an obstetrician for obstetric cholestasis</td>
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<td>☐ Yes</td>
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<tr>
<td>☐ No</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>☐ Already under obstetric care</td>
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<tr>
<td>☐ Unknown</td>
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</tbody>
</table>
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
<p>| | | | |</p>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>k) Breech presentation</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for breech presentation</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>l) Unstable lie</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for unstable lie</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>m) Size of fetus</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, please specify the size of the fetus</em></td>
<td>☐ Large</td>
<td>☐ Small</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>ii) <em>Was there consultation with an obstetrician for size of fetus</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>n) Decreased fetal movements</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for decreased fetal movements</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>o) Polyhydramnios</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for polyhydramnios</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>p) Oligohydramnios</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for oligohydramnios</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>q) Non-reassuring CTG</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>i) <em>If yes, was there consultation with an obstetrician for non-reassuring CTG</em></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Already under obstetric care</td>
</tr>
</tbody>
</table>
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
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:
☐ Mother’s request ☐ Previous pre-term birth ☐ Raised BMI
☐ Previous perinatal death ☐ Previous caesarean section ☐ Surgery
☐ Recurrent miscarriage ☐ Other poor obstetric history ☐ Unknown
☐ Previous intrauterine growth restriction ☐ Mother’s age >=35 years ☐ 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)
☐ Mental health ☐ Previous caesarean section ☐ Surgery
☐ Drug and alcohol ☐ Other poor obstetric history ☐ Unknown
☐ Social Worker ☐ Mother’s age >=35 years
☐ Other: ____________________________

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 ☐ Yes ☐ No ☐ Unknown

b) Morphology/anomaly ultrasound scan at 18-20 weeks’ gestation ☐ Yes ☐ No ☐ Unknown

c) Total Number of antenatal ultrasound scans (exclude those performed after fetal death) Number of ultrasounds ________ ☐ Unknown

d) Chorion villus sampling ☐ Yes ☐ No ☐ 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) ☐ Yes ☐ No ☐ Unknown

If yes, what was the dates of cervical suture: ____________________________ or ☐ Unknown

f) Amniocentesis ☐ Yes ☐ No ☐ Unknown

If yes, what were the Amniocentesis results?
What were the chromosomal microarray results?
☐ Not performed
☐ Normal
☐ Abnormal
☐ Uncertain
☐ Unknown

☐ Normal
☐ Abnormal
☐ Uncertain
☐ Unknown

What were the chromosomal microarray results?

g) Doppler studies
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

h) External cephalic version
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:

☐ ACE inhibitor
☐ Antihypertensives
☐ Magnesium sulphate
☐ Antihypertensives
☐ Glyceryl trinitrate
☐ Nifedipine
☐ Salbutamol
☐ Ritodrine
☐ Other tocolytic
☐ Steroids other than fetal lung maturation
☐ Valproate
☐ Anticonvulsant/other
☐ Infertility treatment
☐ Antiemetics
☐ Antibiotics
☐ Antidepressants
☐ Sedatives or anxiolytics
☐ Indomethacin
☐ NSAID/other
☐ Aspirin
☐ Clexane
☐ Heparin
☐ Warfarin
☐ Narcotics
☐ Non-narcotic analgesia
☐ Other Please indicate: _______________________________________

42) Was folic acid taken pre pregnancy?
☐ Yes
☐ No
☐ Unknown

43) Was folic acid taken during the first trimester
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>44) Date of admission to hospital for birth episode</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>Date:</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>Time:</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>45) Primary caregiver at onset of labour</td>
<td>☐ Obstetrician</td>
</tr>
<tr>
<td>☐ No intrapartum care provider</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
</tr>
<tr>
<td>46) Onset of labour</td>
<td>☐ Spontaneous</td>
</tr>
<tr>
<td>If induced, please provide the following information:</td>
<td></td>
</tr>
<tr>
<td>a) Date of induction of labour:</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>b) Time of induction of labour:</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>c) Specify methods used to induce labour</td>
<td>☐ Oxytocin</td>
</tr>
<tr>
<td>☐ Balloon</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
</tr>
<tr>
<td>d) Main indication for induction</td>
<td>☐ Prolonged pregnancy</td>
</tr>
<tr>
<td>☐ Body Mass Index (BMI)</td>
<td>☐ Other maternal obstetric or medical indication</td>
</tr>
<tr>
<td>☐ Administrative or geographical indication</td>
<td>☐ Maternal choice in the absence of any obstetric, medical, fetal, administrative, or geographical indication</td>
</tr>
<tr>
<td>☐ Maternal mental health indication</td>
<td>☐ Fetal compromise (includes suspected)</td>
</tr>
<tr>
<td>☐ Antepartum haemorrhage</td>
<td>☐ Maternal age</td>
</tr>
<tr>
<td>☐ Multiple pregnancy</td>
<td>☐ Previous adverse perinatal outcome</td>
</tr>
<tr>
<td>☐ Chorioamnionitis (includes suspected)</td>
<td>☐ Fetal growth restriction (includes suspected)</td>
</tr>
<tr>
<td>☐ Diabetes</td>
<td>☐ Fetal congenital anomaly</td>
</tr>
<tr>
<td>☐ Maternal age</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Unknown</td>
<td></td>
</tr>
<tr>
<td>47) Labour augmentation</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>If yes, please select method used to augment labour</td>
<td>☐ Oxytocin</td>
</tr>
<tr>
<td>☐ Unknown</td>
<td>☐ Other:</td>
</tr>
<tr>
<td>Please specify the day of ARM Date:</td>
<td></td>
</tr>
<tr>
<td>48) Analgesia during labour</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>If yes, please indicate type of analgesia administered</td>
<td>☐ Nitrous oxide</td>
</tr>
<tr>
<td>☐ Spinal</td>
<td>☐ Combined spinal/epidural</td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
</tr>
</tbody>
</table>
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 that 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

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

Baby Resuscitation at Birth
(This section is not required for terminations of pregnancy for maternal psychological reasons)
☐ Intermittent positive pressure respiration bag and mask with oxygen
☐ Oxygen therapy ☐ Suction

☐ Medications ☐ Unknown ☐ Other: __________________________
- Adrenalin
- Narcotic antagonist
- Sodium bicarbonate
- Volume expander
- Unknown
- Other:__________________

What medications?

☐ Student ☐ Midwife ☐ Paediatric resident
☐ Paediatric registrar ☐ Obstetric registrar ☐ Obstetric consultant
☐ Consultant paediatrician ☐ Neonatal 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: __________________________
- b) Base deficit- arterial: __________________________
- c) Lactate- arterial: __________________________
- d) CO2- arterial: __________________________
- e) ph- venous: __________________________
- f) Base deficit- venous: __________________________
- g) Lactate- venous: __________________________
- h) CO2- venous: __________________________

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

If yes, please specify
☐ IV therapy  ☐ Antibiotics  ☐ Nitric Oxide
☐ Inotropes  ☐ Mechanical ventilation  ☐ Phototherapy
☐ Extracorporeal membrane oxygenation  ☐ Therapeutic hypothermia  ☐ Unknown
☐ 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
☐ Home  ☐ Emergency department  ☐ NICU
☐ PICU  ☐ SCN  ☐ Paediatric ward
☐ Unknown  ☐ Other: _______________________________

Maternal Investigations after Stillbirth or Neonatal Death
(This section is not required for terminations of pregnancy for maternal psychological reasons)
ii) What was the antibody screen?
☐ Positive  ☐ Negative  ☐ Unknown

Please specific 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
   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 ☐ No ☐ 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: ________________________________
      ii) Results ☐ Positive ☐ Negative ☐ Unknown
      iii) AntiB2 glycoprotein-1antibodies ☐ Yes ☐ No ☐ Unknown
         If yes, please indicate:
         (1) Date: ________________________________
         (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

☐ Incomplete  ☐ Retroplacental clot  ☐ Gritty/Calcified
☐ Ragged membranes  ☐ Offensive odour  ☐ Vasa praevia
☐ Succenturiate lobe/bi-lobed  ☐ Circumvallate  ☐ Bipartite
☐ Unknown  ☐ Other: ____________________________

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

If yes, please specify

☐ Hyper-coiled appearance  ☐ Hypo-coiled appearance  ☐ Marginal cord insertion
☐ Velamentous cord insertion  ☐ Abnormal cord length- short  ☐ Abnormal cord length- long
☐ Unusual cord thickness- thin  ☐ Unusual cord thickness- thick  ☐ Meconium stained
☐ Two vessels in the cord  ☐ True knot- loose  ☐ True knot- tight
☐ Unknown  ☐ 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

☐ Abnormal colour- green  ☐ Malodour  ☐ Retro-membranous blood- fresh
☐ Retro-membranous blood- old  ☐ Spotty (e.g. Amnion nodosum)  ☐ Unknown
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: ____________________________________________________________

*If yes, please specify*

i) Site of other culture taken: ____________________________________________________

ii) Results of other culture taken

---

Other: ____________________________________________________________
<table>
<thead>
<tr>
<th>Pathogen</th>
<th>No pathogen</th>
<th>Uncertain</th>
<th>Unknown</th>
</tr>
</thead>
</table>

If pathogen, please specify

- Group B Streptococcus
- E coli
- Chlamydia Trachomatis
- Candida
- Pseudomonas
- Proteus
- Fusobacterium
- Hep B
- Syphilis- Treponema Pallidum
- Toxoplasma Gondii
- Varicella
- Chlamydia Psittaci
- Other:

Yes | No | Unknown

- Group A Streptococcus
- Trichomonas Vaginalis
- Ureaplasma Urealyticum
- Neisseria Gonorrhoea
- Klebsiella
- Bacteroids
- Enterobacterium
- Hep C
- Rubella
- Parvovirus
- Malaria
- Haemophilus
- Other: ____________________________

- Other Streptococcus
- Gardnnerella Vaginalis
- Mycoplasma Hominis
- Herpes
- Clostridium
- Enterococcus
- Hep A
- CMV
- Echovirus
- Unknown

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

- Confirms clinical diagnosis (no change in counselling for future pregnancies)
- Changes clinical diagnosis (diagnosis changed enough to alter counselling for future pregnancies)
- Additional information (clinical diagnosis not altered but additional clinical findings e.g. clinical diagnosis not altered)
- Additional information (clinical diagnosis not altered but additional clinical findings e.g. Additional information (clinical diagnosis not altered but additional clinical findings e.g.)
(2) If no, please specify the following

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

☐ Inexperience of staff in counselling about autopsy
☐ Lack of rapport with the parents
☐ Lack of diagnostic value in this case
☐ Staff workload
☐ Parent emotional distress
☐ Religious or cultural beliefs
☐ Time to receive results
☐ Negative perceptions in general about autopsy
☐ Multiple pregnancy feticide
☐ 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

☐ Junior medical staff
☐ Midwife
☐ Nurse
☐ Obstetric specialist
☐ Obstetric registrar
☐ GP
☐ Paediatrician
☐ 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

☐ Inexperience of staff in counselling about autopsy
☐ Lack of rapport with the parents
☐ Lack of diagnostic value in this case
☐ Staff workload
☐ Parent emotional distress
☐ Religious or cultural beliefs
☐ Time to receive results
☐ Negative perceptions in general about autopsy
☐ Multiple pregnancy feticide
☐ 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:

- ☐ Group B Streptococcus
- ☐ E coli
- ☐ Chlamydia Trachomatis
- ☐ Candida
- ☐ Pseudomonas
- ☐ Proteus
- ☐ Fusobacterium
- ☐ Hep B
- ☐ Syphilis- Treponema Pallidum
- ☐ Toxoplasma Gondii
- ☐ Varicella
- ☐ Chlamydia Psittaci
- ☐ Other:
- ☐ Other Streptococcus
- ☐ Trichomonas Vaginalis
- ☐ Ureaplasma Urealyticum
- ☐ Neisseria Gonorrhoea
- ☐ Klebsiella
- ☐ Bacteroids
- ☐ Enterobacterium
- ☐ Hep C
- ☐ Rubella
- ☐ Parvovirus
- ☐ Malaria
- ☐ Haemophilus
- ☐ E coli
- ☐ Gardnnerella Vaginalis
- ☐ Mycoplasma Hominis
- ☐ Herpes
- ☐ Clostridium
- ☐ Enterococcus
- ☐ Hep A
- ☐ HIV
- ☐ CMV
- ☐ Listeria
- ☐ Echovirus
- ☐ Unknown

If abnormal or uncertain, please describe:

75) Magnetic resonance imaging?

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

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: _________________________ x10^9 ☐ Unknown

b) Platelets: _________________________ x10^9 ☐ 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
- ☐ 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:

____________________________________________________________________________________________________

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

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.

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

<table>
<thead>
<tr>
<th>Mothers Surname: (If multiple birth, indicate birth number of this baby)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of perinatal death</td>
</tr>
<tr>
<td>Gestation</td>
</tr>
<tr>
<td>Facility reporting</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Nil</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Not Recorded</th>
<th>Unknown</th>
</tr>
</thead>
</table>

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

**Category classification**

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

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

**Category classification**

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

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

**Category classification**

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

**NB. If stillbirth, go to question 13.**

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

**Category classification**

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Nil</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Not Recorded</th>
<th>Unknown</th>
</tr>
</thead>
</table>

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

**Category classification**

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerical Code</th>
<th>Text</th>
</tr>
</thead>
</table>
b) PSANZ Neonatal Death Classification (PSANZ-NDC) – Associated condition 2

Category classification
Please insert full numerical code
Please insert full text

____________________________________________________________________________________________

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

____________________________________________________________________________________________

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)

<table>
<thead>
<tr>
<th></th>
<th>Please rate</th>
<th>Please state the specific factors and include any relevant comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Poor organisational arrangements of staff</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Inadequate education and training</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Lack of policies, protocols or guidelines</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Inadequate number of staff</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Rating</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Poor access to senior clinical staff</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Failure or delay in emergency response</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Delay in procedure (e.g. Caesarean section)</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Inadequate systems/process for sharing of clinical information between services</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Delayed access to test results or inaccurate results</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Equipment (e.g. faulty equipment, inadequate maintenance or lack of equipment)</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Building and design functionality (e.g. space, privacy, ease of access, lighting, noise, power failure, operating theatre in distant location)</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other: ____</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

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- Insufficient. 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Please rate</th>
<th>Please state the specific factors and include any relevant comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and skills of staff were lacking</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Delayed emergency response by staff</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Failure to maintain competence</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Communication between staff was inadequate</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Failure to seek help/supervision</td>
<td>________________________________</td>
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<td>----------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Failure to follow recommended best practise</td>
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<tr>
<td>Lack of recognition of complexity or seriousness of condition by care giver</td>
<td>________________________________</td>
<td></td>
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<tr>
<td>Other:</td>
<td>________________________________</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>________________________________</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Rate</th>
<th>Please state the specific factors and include any relevant comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>No antenatal care</td>
<td></td>
<td></td>
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<tr>
<td>Infrequent or late booking</td>
<td></td>
<td></td>
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<tr>
<td>Declined treatment or advice</td>
<td></td>
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<tr>
<td>Obesity impacted on delivery of optimal care (e.g. USS)</td>
<td></td>
<td></td>
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<tr>
<td>Substance use</td>
<td></td>
<td></td>
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<tr>
<td>Family violence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
☐ Lack of recognition by the woman or family of the complexity or seriousness of the condition

☐ Maternal mental illness

☐ Cultural barriers

☐ Language barriers

☐ Not eligible to access free care

☐ Environmental (e.g. isolated, long transfer, weather prevented transport)

☐ Other:

☐ Unknown

__________________________________________________________

__________________________________________________________

__________________________________________________________

Recommendations for Improvement

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

5) Please list the recommendations and the action required

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

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________________________________________________________________________________________________________

________________________________________________________________________________________________________

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: _______________________________

Please forward a copy of this completed form to:

1. CONFIDENTIAL
   Statistical Services Branch
   Qld Department of Health
   Attention: Perinatal Data Collection
   GPO Box 48
   Brisbane Qld 4001
   or via email - Perimail@health.qld.gov.au
   and

   2. QMPQC@health.qld.gov.au