PERINATAL DEATH CLINICAL AUDIT

Perinatal Society of Australia and New Zealand

Perinatal Mortality Group (PSANZ- PMG)

Australian and New Zealand Stillbirth Alliance (ANZSA)

CHOOSE Type of Case

☐ **STILLBIRTH : A baby delivered without signs of life after 20 weeks of pregnancy, or if gestation is unknown a birth weight > 400 grams. The death is indicated by the fact that after birth the baby does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.**

OR

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

Please follow the instructions and answer all questions as directed. We understand that you may not know the answer to some of the questions but please provide as much detail as possible.
Personally identifiable information (of the mother, baby or carer) collected on this form will be kept confidential. Information included in reports will be grouped and non identifiable.

Section 1: CLINICAL DATA RELEVANT TO PERINATAL DEATH

PLEASE COMPLETE WITHIN 48 HOURS OF THE STILLBIRTH OR NEONATAL DEATH IF POSSIBLE

1. **How many perinatal deaths are linked to this pregnancy?** ☐
2. **Mother: Surname** ☐ **First name(s):** ☐

   Other name(s): ☐
3. **Mother Unit Record No:** ☐
4. **Mother's date of birth:** ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
5. **Was this birth the result of a termination of pregnancy?**

   Yes ☐ **No** ☐

   (If yes, indicate reason)

   Fetal abnormality ☐
   Maternal psychosocial reasons ☐
   Maternal medical condition ☐
6. **Date and time of birth of this baby?**

   Date: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

   Time: ☐☐ . ☐☐ hrs (24hour Clock)
7. **Calculated gestation of pregnancy at birth:** ☐☐ Wks ☐ days
8. **Baby's birth weight:** ☐☐☐☐ gm
9. **Gender:** Male ☐ Female ☐ Undetermined ☐
10. **Was baby one of a multiple birth ? Yes** ☐ **No** ☐ **Unknown** ☐

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

    ☐ First
    ☐ Second
    ☐ Other

11. When did perinatal death occur?

☐ Antepartum *(Estimated gestational age at time of fetal death* ☐☐ Weeks ☐ days)

☐ Intrapartum – first stage

☐ Intrapartum – second stage

☐ Intrapartum - Unknown

☐ Neonatal

☐ Unknown

Mothers details:

12. Usual residential address at time of this birth:

House name/flat number ☐

Street Number ☐

Street name ☐

Suburb /locality ☐

Town/City ☐

State ☐

Post Code ☐

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

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

15. Occupation: ☐

16. Country of mother's birth: ☐

17. Mothers ethnicity:

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

If other please state: ☐

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

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

Previous pregnancy history:

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

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

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

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

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

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

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

	Yes	No	Unknown
a. Any pre-existing medical condition *(If no or unknown, go to question 21)*	☐	☐	☐
b. Asthma	☐	☐	☐
c. Diabetes pre pregnancy	☐	☐	☐
d. Epilepsy	☐	☐	☐
e. Heart condition (congenital or acquired)	☐	☐	☐
f. Hypertension	☐	☐	☐
g. Endocrine disorder (eg.hyper/hypothyroid)	☐	☐	☐
h. Inflammatory bowel disease	☐	☐	☐
i. Systemic lupus erythematosus	☐	☐	☐
j. Other autoimmune disorder	☐	☐	☐
k. Mental health disorder	☐	☐	☐
l. Renal disease	☐	☐	☐
m. Venous thromboembolism	☐	☐	☐
n. Haematological disorders	☐	☐	☐
o. Cervical/uterine surgery	☐	☐	☐
p. Urinary tract infection	☐	☐	☐
q. Uterine abnormality	☐	☐	☐
r. Other	If other please state: ☐		

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

Details of pregnancy which resulted in this perinatal death

22. Model of antenatal maternity care:

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

(Select one in each column)	**At booking**	**At birth**
No booked care	☐	☐
Hospital Obstetric	☐	☐
Midwifery led care	☐	☐
Obstetrician (private)	☐	☐
Midwife (private)	☐	☐
General Practitioner/Shared	☐	☐
Unknown	☐	☐

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

Yes ☐ **No** ☐ **Unknown** ☐

24. Fertility treatment or assisted conception for this pregnancy?

Yes ☐ **No** ☐ **Unknown** ☐

25. Intended place of birth before labour:

- ☐ Home
- ☐ Birth Centre
- ☐ Public Hospital
- ☐ Private Hospital
- ☐ Other
- ☐ Unknown

Please state name of place/unit/hospital: ☐

26. Actual place of birth:

- ☐ Home
- ☐ Birth Centre
- ☐ Public Hospital
- ☐ Private Hospital
- ☐ Unattended/Freebirth
- ☐ Other

Please state name of unit/hospital: ☐

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

	Yes	
Anomaly Scan at ≤ 20 gestation	☐	(*if yes*) Total number of scans ☐
Chorion villus sampling	☐	
Cervical suture	☐	
Amniocentesis	☐	
Doppler studies	☐	
External cephalic version	☐	
Fetocide	☐	
Amnioreduction	☐	
Laser treatment	☐	
Other	☐	
If other please state:	☐	
None of the above	☐	
Unknown	☐	

28. Is mother currently smoking (cigarettes)? Yes ☐ *If yes,* ☐☐ *per day* **No** ☐ *(If "no")*

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

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

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

	during 1st trimester	month prior to birth
Alcohol	☐	☐
Amphetamine/P	☐	☐
Cocaine	☐	☐
Ecstasy	☐	☐
Hallucinogens	☐	☐
"Herbal highs"	☐	☐
Marijuana	☐	☐
Opiates	☐	☐
Methadone	☐	☐
Petrol/paint/glue	☐	☐
Other	☐	☐

If other please specify: ☐

30. Family violence

Has mother suffered family violence during this pregnancy?

Yes ☐ **No** ☐ **Not Asked** ☐ **Unknown** ☐

31. Antenatal visits before fetal death/or delivery:

a. Total number of visits from antenatal record ☐☐ **Unknown** ☐

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

32. Obstetric conditions this pregnancy

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

Yes

a. Hypertension ☐

(If "yes" indicate type of hypertension below)

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

b. Preterm labour ☐

c. Prolonged rupture of membranes ☐

(If "yes" indicate time below)

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

d. Cholestasis of pregnancy ☐

e. Confirmed maternal infection ☐

(If "yes" indicate kind of infection below)

Kind of infection:

- ☐ Pyelonephritis
- ☐ Lower urinary tract infection
- ☐ Other infection

If other please specify: ☐

f. Trauma ☐

(If "yes" indicate kind of trauma below)

Kind of trauma:

- ☐ Vehicular
- ☐ Violent personal injury
- ☐ Other

If other please specify: ☐

g. Vaginal bleeding ☐

☐ Before 20 weeks
☐ After 20 weeks

h. Gestational diabetes ☐

i. Other obstetric condition ☐

Please specify: ☐

j. Surgery in pregnancy ☐

Please state type of surgery: ☐

☐ **None of the above**
☐ **Unknown**

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

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

34. Were maternal corticosteroids given antenatally?

Yes ☐ **No** ☐ **Unknown** ☐

(If Yes is selected answer the below)

Course of corticosteroids started at what gestation? ☐ **weeks** ☐ **days**
Was course of corticosteroids completed? **Yes** ☐ **No** ☐ **Unknown** ☐

35. Screening for gestational diabetes in this pregnancy:

	Yes	**No**	**Unknown**
Mother tested for gestational diabetes	☐	☐	☐
(If "yes" is answered for Question 28 answer the below)			
Gestational Diabetes confirmed	☐	☐	☐
Raised Polycose but no Glucose Tolerance Test	☐	☐	☐
Diet and/or medications taken	☐		

36. Was this a multiple pregnancy? **Yes** ☐ **No** ☐ **Unknown** ☐

(If "yes please answer below)

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

b. Chorionicity (if known) _____

37. Folic acid taken in this pregnancy?

Please complete both	**Yes**	**No**	**Unknown**
Folic Acid taken pre pregnancy?	☐	☐	☐
Folic Acid taken first trimester?	☐	☐	☐

38. Other medications taken in this pregnancy? Yes ☐ **No** ☐
If yes, list_____

39. Was there consultation with an obstetrician during pregnancy?

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

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

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

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

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

Yes ☐ **No** ☐ **Unknown** ☐

(If "yes" select all relevant)

Medical ☐
Mental health ☐
Drug and alcohol ☐
Social ☐
Other service ☐
If other please state: ☐

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

Labour and Birth

41. Onset of labour:

Spontaneous ☐ **Induced** ☐ **No labour** ☐ **Unknown** ☐

(If no labour, please go to question 46)

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

☐ Drugs used, please specify: _____
☐ Artificial rupture of membranes (Date & Time_____)

☐ Other, please specify: _____

b) Reason for induction:

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

42. Labour augmentation: Yes ☐ No ☐ Unknown ☐

(If yes, please select all that apply)

Method:

☐ Artificial rupture of membranes (Date & Time _____)
☐ Oxytocin
☐ Other, please specify: _____

43. Analgesia during labour Yes ☐ No ☐ Unknown ☐

*(If "yes" answer the below, select **all** relevant)*

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

44. Bath or pool during labour:

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

(If "yes" please answer below)

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

45. Fetal monitoring during labour Yes ☐ No ☐ Unknown ☐

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

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

46. Method of birth of this baby :

Normal vaginal birth ☐
Vaginal breech birth ☐ *Spontaneous or assisted*: ☐
Operative vaginal delivery ☐ *Details*: ☐
Elective Caesarean *(additional questions below)* ☐
Emergency Caesarean *(additional questions below)* ☐
Unknown/not stated ☐

If multiple birth, state mode of birth other infants: ☐

(If "Caesarean" selected please answer the next 3 questions below)

a. Were forceps/ventouse attempted <u>before</u> Caesarean? Yes ☐ No ☐

b. Reason for Caesarean birth:

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

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

General ☐
Spinal ☐
Epidural ☐
Other ☐
If other please state: ☐

47. Complications in labour Yes ☐ No ☐ Unknown ☐

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

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

48. Length of labour

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

c) If mother admitted to hospital before birth, time in hospital before birth?

☐☐ days ☐☐ hours ☐☐ minutes Unknown ☐

49. Apgar scores this baby:

☐ 1 minute ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes ☐ Unknown

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

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

51. Was baby resuscitated at birth? Yes ☐ No ☐ Unknown ☐

*(If Yes select **one** of the below)*

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

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

Resuscitation used at birth

☐ Suction

☐ Oxygen

☐ IPPV – bag and mask

☐ External Cardiac massage

☐ Medications please state: _____
☐ Other resuscitation, please state: _____

52. Cord gases at birth:

Not taken ☐

		Arterial		Venous
pH		☐☐.☐		☐☐.☐
Base deficit	+ / -	☐☐.☐	+ / -	☐☐.☐
CO_2		☐☐.☐		☐☐.☐
Lactate		☐☐.☐		☐☐.☐

53. Baby's examination after birth (live and stillborn babies):
Were there any external abnormalities noted on examination of the baby?
Yes ☐ No ☐

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

_____

_____

b)Degree of maceration: None ☐ Slight ☐ Moderate ☐ Marked ☐

54.Date and time of perinatal death

Date: ☐☐/☐☐/☐☐☐☐ **(DD/MM/YYYY)**

Time: ☐☐.☐☐ **Hrs (24hour Clock)** ***or* Unknown** ☐

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

Yes ☐ **No** ☐ **Unknown** ☐

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

NICU/SCU* ☐
Post natal ward ☐
Home ☐
Died in transfer ☐
Tertiary Services ☐
Other ☐

*Neonatal Intensive Care Unit/Special Care Unit

If other please state: _____

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

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

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

f) Summary of neonatal events:

Date	Time	Baby's age	Event

57. Place of death if baby born alive:

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

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

Days ☐ Hours ☐ Minutes ☐

59. Baby physical examination after death:

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

Yes ☐ No ☐

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

_____

_____

b)Degree of maceration: None ☐ Slight ☐ Moderate ☐ Marked ☐

60. Placenta:

a) Placenta weight: ☐☐☐☐ gm **or** placenta not weighed ☐ Unknown ☐

b) Placental examination

☐ Not examined
☐ Normal
☐ Some abnormalities, please state:

61. Umbilical cord examined? Yes ☐ No ☐ Unknown ☐

(If "yes" please continue below)

a) Any problems with cord? Yes ☐ No ☐

*(Select **all** relevant)*

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

Other abnormality ☐
If other please state: _____

62. Maternal outcome:

☐ Alive and generally well

☐ Alive but with serious morbidity e.g. admitted to ICU, hysterectomy or stroke.

☐ Dead

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

63. Post mortem examination:

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

64. Were there any other factors which contributed to the perinatal death? Yes ☐ No ☐

If yes, please specify _____
_____
_____

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

If yes, give details: _____
_____

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

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

Designation:-

Contact details: - Phone-
Email-
Date:-

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

SECTION 2 : PERINATAL DEATH FOLLOW-UP

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

1. Follow-up visits for family

Obstetrician: _____ Yes ☐ (Date/time:_____) No ☐

Neonatologist: _____ Yes ☐ (Date/time:_____) No ☐

Midwife: _____ Yes ☐ (Date/time:_____) No ☐

General Practitioner: _____ Yes ☐ (Date/time:_____) No ☐

Bereavement support: _____ Yes ☐ (Date/time:_____) No ☐

Other, specify_____ _____ Yes ☐ (Date/time:_____) No ☐

G.P. notified of the death: Yes ☐ Date notified:_____No ☐

Genetic counselling required? Yes ☐ No ☐
If yes, please specify _____

Further investigations required? Yes ☐ No ☐
If yes, please specify _____

Specific religious or cultural considerations? Yes ☐ No ☐
If yes, please specify _____

Other relevant information: _____
_____

2. Other investigations in progress

Coroner's case **Yes** ☐ **No** ☐
Please provide details: _____

Sentinel event report **Yes** ☐ **No** ☐
Please provide details: _____

R.C.A report **Yes** ☐ **No** ☐
Please provide details: _____

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

Designation:-

Contact details: - Phone-
Email-
Date:-

SECTION 3 : CAUSE OF DEATH AND ASSOCIATED FACTORS

(PLEASE COMPLETE THIS SECTION AT PERINATAL MORTALITY COMMITTEE REVIEW)

1. Classification of cause of death

A) Cause of death recorded on Medical Certificate

i. Main disease or condition in fetus or infant:_____

ii. Other diseases or conditions in fetus or infant:_____

iii. Main maternal disease or condition affecting fetus or infant:_____

iv. Other maternal diseases or conditions affecting fetus or infant:_____

v. Other relevant circumstances_____

B) PSANZ Perinatal Mortality Classification of Cause of Death

(I) Perinatal Death Classification (PSANZ-PDC) Category ☐

Category description_____

(II)Neonatal Death Classification (PSANZ-NDC) Category ☐

Category classification_____

C) PSANZ Perinatal Mortality Classification of associated conditions

Associated condition 1:

(a) Perinatal Death Classification (PSANZ-PDC) Category ☐

Category description_____

OR

(b) Neonatal Death Classification (PSANZ-NDC) Category ☐

Category classification_____

Associated condition 2:

(a) Perinatal Death Classification (PSANZ-PDC) Category ☐

Category description_____

OR

(b) Neonatal Death Classification (PSANZ-NDC) Category ☐

Category classification_____

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2. Termination of pregnancy

Was the pregnancy terminated? **Yes** ☐ **No** ☐

If yes, termination due to:

Fetal abnormality ☐ Maternal psychosocial reasons ☐ Maternal medical condition ☐

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3. Congenital abnormality

Was congenital abnormality present? **Yes** ☐ **No** ☐ **Unknown** ☐

If yes, please state abnormality_____

If unknown, are results of investigations pending **Yes** ☐ **No** ☐

If yes, please state tests awaiting_____

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4. Fetal or Neonatal Infection

Did infection contribute to the death? **Yes** ☐ **No** ☐ **Unknown** ☐

If yes, state organism_____

culture site?_____ (date and time)_____

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5. Post mortem Investigations and results

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

If yes, state findings _____

_____

_____
_____
_____

(b) Maternal investigations

_____
_____
_____
_____
_____

(c) State other tests and available results

_____
_____

6. Factors relating to care

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

Yes ☐ **No** ☐ **If no, go to question 7.**

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

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 - Sub-optimal factor(s) identified but <u>unlikely</u> to have contributed to outcome (insignificant)** **P- Sub-optimal factor(s) identified <u>might</u> have contributed to outcome (possible)** **S - Sub-optimal factor(s) identified <u>likely</u> to have contributed to outcome (significant)** **U - Insufficient information available (undetermined)**

7. Recommendations for practice improvement : Yes ☐ No ☐

Recommendation 1: _____
Action required: _____
Review date: _____

Recommendation 2: _____
Action required: _____
Review date: _____

Recommendation 3: _____
Action required: _____
Review date: _____

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

Recommendation 1: _____
Recommendation 2: _____
Recommendation 3: _____

9. Administrative details

Hospital of perinatal mortality review: _____
Date of review: _____
Review finalized? Yes ☐ No ☐
If yes, date finalized: _____
If no, please specify outstanding areas for review _____
_____

Section 3 of this form completed by:-

Name:- _____

Designation:- _____
Contact details: - Phone- _____
Email-_____

Date:- _____.

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