



CLINICAL PRACTICE GUIDELINE

# Perinatal loss

This document should be read in conjunction with this [Disclaimer](#)

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# Perinatal loss in the third trimester: Management

(Previously FDIU Antenatal / Intrapartum)

## Aim

- To provide clinical staff with the information necessary to ensure the safe management of women experiencing perinatal death in the third trimester.
- To provide a guide in providing comprehensive care to a woman experiencing a third-trimester pregnancy loss: either fetal death in utero, termination of pregnancy or neonatal death.

## Scope

This guideline applies to women experiencing perinatal loss on the Labour and Birth Suite, Adult Special Care Unit, Obstetric Wards or other areas.

This protocol is designed for perinatal loss in the third trimester – however is appropriate for pregnancy loss that is beyond **20 weeks** gestation.

Inclusion criteria:

- Intrauterine fetal death, antenatal
- Intrauterine fetal death, intrapartum
- Medical termination of pregnancy (TOP)
- When palliative care of the neonate is expected

## Key points

All care to women experiencing perinatal loss in the third-trimester should be in line with evidence based guidelines and be woman focussed.

1. Identify the woman's room and medical record with universal symbols so that all clinical and non-clinical staff are aware e.g. tear drop sticker
2. All women and their support person should be given accurate information, both verbal and written about management planning, treatments, and follow-up
3. Compassionate and sensitive care should be provided with an emphasis on individual care planning and continuity of care giver
4. Cultural and religious sensitivity must be considered
5. Consent should be gained in line with policy and guidelines.
6. All inquiries from medical practitioners regarding a fetal anomaly should be directed to the Maternal Fetal Medicine Service.
  - For women undergoing termination of pregnancy there is a statutory requirement under the [Acts Amendment \(Abortion\) Act 1998](#), and Section 335(5) (d) Abortion notice) [Health \(Miscellaneous Provisions\) Act 1911](#) for Medical Practitioners to notify all terminations of

pregnancy to the Executive Director, Public Health in the prescribed form within 14 days of abortion being performed.

- Use **Form 1-Notification by Medical Practitioner of Induced Abortion**.

7. Documentation must be contemporaneous, correct and maintained.

## Background information

In Western Australia, according to the Births Deaths & Marriages legislation, perinatal deaths consist of stillbirths (the death of an unborn baby at 20 or more completed weeks gestation or at least 400 grams birthweight) and neonatal deaths (the death of a live born baby within 28 days of birth).

Between the triennium of 2011 and 2013, there were 100 460 babies born in Western Australia. Of those, 716 were stillbirths and 171 died within the first 28 days of birth. Giving a stillbirth rate of 7.1 per 1000 births and a neonatal death rate of 1.7 per 100 births.<sup>1</sup> However the perinatal mortality rates in babies born to Aboriginal or Torres Strait Islander mothers was much higher than that of babies born to non-indigenous mothers. The stillbirth rate for Aboriginal babies in the same period was 16.5 per 1000 births and the neonatal death rate for Aboriginal babies 5.3 per 1000 births.<sup>1</sup>

## Classification of cause of perinatal death

The most common cause of perinatal death in WA (2011-2013) was congenital abnormality, which contributed 27.5%, and this was followed by spontaneous preterm birth (24.9 per cent). The unexplained antepartum death rate was 11.6 percent, with specific perinatal conditions attributing 9.6 percent, and fetal growth restriction 8.1 percent.<sup>1</sup> Other causes included perinatal infection, hypertension, antepartum haemorrhage, maternal conditions, hypoxic peripartum death and no obstetric antecedent.

At King Edward Memorial Hospital there is a major contributor to the perinatal mortality rate being due to termination of pregnancy, in accordant with the Abortion (Amendment) Act 1998.

Link to [Perinatal and Infant Mortality Committee](#)

See PSANZ: [Clinical Practice Guideline for Care around Stillbirth and Neonatal Death](#)

## Predisposing factors for perinatal death

- Maternal Social factors
  - Low socio economic status
  - Aboriginal and Torres Strait Islander
  - Ethnicity: South Asian, African (including refugee or asylum seeker)
  - Smoking
  - Obesity
  - Maternal age > 35 years

- Nulliparity
- Substance Use
- Pre-existing Medical
  - Diabetes: Type 1 and Type 2
  - Essential Hypertension
  - Auto-immune disorders e.g. Systemic Lupus Erythromatosis
  - Other maternal eg Malaria, Sexually Transmitted Diseases
  - Mental Health disorder
- Obstetric
  - Antepartum
    - Congenital abnormality
    - Perinatal infection
    - Hypertensive disorders in pregnancy
    - Antepartum haemorrhage
    - Cholestasis of pregnancy
    - Antiphospholipid syndrome
    - Multiple pregnancy
    - Post term
    - Specific Perinatal Conditions: fetomaternal haemorrhage, uterine anomalies, autoimmune disease,
    - Fetal Growth Restriction
    - Reduced fetal movements
    - Placental dysfunction: eg abnormal maternal vascular perfusion
- Intrapartum
  - Hypoxic peripartum death with intrapartum complications
  - Previabile preterm labour and birth
- Postpartum/neonatal
  - Congenital abnormalities
  - Preterm birth
  - Hypoxic peripartum death in the neonatal period
  - Growth Restriction (FGR or SGA)
  - Neonatal Infection

## Planning & management

### Presentations:

- **Fetal death in utero (FDIU):** most likely presentation will be a woman presenting to MFAU, ANC or USS department with reduce or absent fetal movements, with no fetal heart able to be auscultated.  
**CMP:** FDIU may also occur in the community (Community Midwifery Program). If the fetal heart cannot be auscultated with a hand held Doppler in the antenatal or intrapartum period arrangements must be made for immediate transfer to the client's support hospital. See KEMH guideline Transfer from home to hospital (VMS/MGP/CMP). For CMP home births if the birth is imminent or the midwife arrives shortly after the birth:
  - Call 000 and the support midwife to attend
  - Encourage active pushing if the woman is in the second stage of labour and continue to attempt to auscultate the fetal heart as per the KEMH clinical guideline Second Stage of Labour and Birth
  - Resuscitative procedures must be attempted unless the baby is clearly a macerated stillborn identified by reddened/peeling/broken skin and skin slippage.
  - Recommend active management of third stage and ensure placenta accompanies baby to hospital.
  - Support midwife to attend the support hospital to provide added support to family and primary midwife.
- If FDIU confirmed: Notification should be made to Midwife Coordinator/ Triage Midwife, Senior Registrar and PLS CMC and a CIMS form completed.  
**CMP:** If CMP client then CMP CMS/CNM in hours or KEMH A/H Manager must be notified. If support hospital not KEMH then the support hospital procedure for FDIU should be followed.
- **Perinatal palliative care:** a specific individualised care plan will be in the medical record, notify the PLS CMC.
- **Preterm pre-viable labour and imminent birth:** Notify the LBS Coordinator and Senior Registrar, and transfer to Labour and Birth Suite,
- The PLS CMC will assist in arranging plans for booking admission and ongoing management, Monday – Friday 8-4pm. If out of hours, the Hospital Clinical Manager should be informed.

Clinical assessment should be undertaken by the lead consulting doctor. A comprehensive medical, surgical and psychosocial history must be taken, and examination conducted. Including:

- Accurate gestation assessment - this is essential to selecting optimal treatment options and regimens.

- Formal Ultrasound examination to confirm suspected fetal demise.
  - There should be a confirmatory ultrasound at KEMH. This ultrasound should be conducted by an accredited professional- credentialed sonographer, obstetrician or Senior Registrar. Additional information may be gathered during ultrasound, such as: looking for anomalies, gestation/size, and timing of fetal death (Spalding's sign).
  - Diagnosis of fetal death requires formal confirmation by ultrasound that demonstrates an absence of fetal heart activity
  - A midwife escort should be made available to support the woman whilst attending the ultrasound examination for confirmation.
- Relevant medical / surgical/ obstetric / gynaecological and psychosocial history.
- Intrauterine Fetal Death – assess to see if investigation bloods required as per [PSANZ Stillbirth investigations flowchart](#)
- Blood group and Rhesus status should be confirmed, and tested, if not known.
- Rh (D) immunoglobulin must be administered to non-sensitive Rhesus negative women within 72 hours of the termination.
- Medications should be charted on MR 810.07 – Pregnancy Loss Medication Chart
  - Mifepristone is to be charted for terminations of pregnancy – [see restricted area guidelines](#)
  - See Misoprostol Guidelines – [see restricted area guidelines](#)
  - [Oxytocin: Prophylactic and Therapeutic Administration / Infusion Regimes](#) for third stage management

### Breaking bad news<sup>2</sup>

- Break bad news in a private, quiet room.
- Do not delay breaking news once diagnosis had been made.
- Ensure a support person is present for the woman – involve both parents where appropriate.
- Use empathetic but unambiguous language (e.g. “your baby has died” or “your baby is too early to survive”).
- Allow time for questions and offer sympathy.
- Enquire about any special cultural or religious needs.
- Consider whether an interpreter is required.

### Investigations

Accurate identification of the cause of stillbirth is the cornerstone to prevention and is critically important to parents to help them to understand why their baby has died and to plan future pregnancies.

The recommended investigations following stillbirth include those that should be routine for the majority of stillbirths (core investigations) and those that should be carried out based on information revealed from core investigations, or in the presence of specific clinical scenarios (sequential or selective investigations)

Selective investigations only may include thrombophilia studies, tests for infectious diseases, Haemoglobin A1c (HbA1c), liver function and bile acid tests, and should be undertaken on the basis of the results of core investigations.

Clinicians should discuss the value of a full autopsy with parents in all cases of perinatal death. If the parents decline a full autopsy, a limited/partial autopsy should be offered. The placenta, membranes and cord should be sent fresh and unfixed for macroscopic and histological examination by a perinatal pathologist.

- Refer to PSANZ investigations flowchart<sup>3</sup> below

# Stillbirth Investigations Flowchart

## Core investigations

## Findings from core investigations

## Indicated selective investigations

### Mother

- Maternal history
- Maternal examination
- Kleihauer-Betke or flow cytometry

Personal or family history of thrombosis

APS (anticardiolipin, lupus anticoagulant, anti-B2 glycoprotein-1 antibodies)

Suspected cholestasis

Bile acids; LFTs

### Baby

- Clinical examination at birth
- Full autopsy

Non-consent for full autopsy

MRI; NIA; MIA; Clinical photographs

LGA

HbA1c

FGR or SGA

Infectious diseases (e.g. CMV); HbA1c; APS (anticardiolipin, lupus anticoagulant, anti-B2 glycoprotein-1 antibodies)

### Placenta

- Macroscopic examination
- Histopathology studies
- Cytogenetic analysis

Placental abruption or infarction

APS (anticardiolipin, lupus anticoagulant, anti-B2 glycoprotein-1 antibodies)

Infection

Further testing as directed by pathologist

APS: Antiphospholipid syndrome; CMA: Chromosomal microarray; CMV: Cytomegalovirus; FGR: Fetal growth restriction; LFTs: Liver Function Tests; LGA: Large-for gestational-age; HbA1c: Haemoglobin A1c; MIA: Minimally-invasive autopsy; MRI: Magnetic Resonance Imaging; NIA: Non-invasive autopsy; SGA: Small for gestational age

1: Flenady V, Oats J, Gardener G, Masson Vicki, McCowan Lesley, Kent A, Tudehope David, Middleton P, Donnelly N, Boyle F, Horey D, Ellwood D, Gordon A, Sinclair L, Humphrey M, Zuccollo J, Dahlstrom J, Henry S, Khong Y for the PSANZ Care around the time of stillbirth and neonatal death guidelines group. Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death. Version 3, NHMRC Centre of Research Excellence in Stillbirth. Brisbane, Australia, March 2018

PERINATAL  
SOCIETY  
of Australia &  
New Zealand  
PSANZ



SANDA  
Stillbirth And Neonatal  
Death Alliance  
a sub-committee of PSANZ

Stillbirth  
CENTRE OF RESEARCH EXCELLENCE



Flowchart used with permission

Acknowledgment - Flenady V, Oats J, Gardener G, Masson V, McCowan L, et al. for the PSANZ Care around the time of stillbirth and neonatal death guideline group. Clinical Practice Guideline for Care around Stillbirth and Neonatal Death. V3. NHMRC Centre of Research Excellence in Stillbirth. Brisbane, Australia, March 2018.



## Consider birthing options

Provide information on birth / induction options appropriate to the clinical circumstances and service capabilities.

- The options include expectant management (with a named contact), induction of labour immediately (usually for maternal health reasons), planned induction of labour or planned caesarean section (if indicated)
- Timing of birth should be made in the best interest of the parents. There is usually no clinical need to expedite birth urgently and hasty intervention may not be in the best long-term interests of the parents. If clinically appropriate, the woman may wish to go home and return for induction at a later date.
- Consider method of induction relevant to gestation and clinical circumstances.
- All women will be Identified by the use of a universal symbol (tear drop sticker): woman's room and medical record so that all clinical and non-clinical staff are aware

## Referrals (on admission)

- Refer routinely to Pastoral Care Service for bereavement support & information related to funeral arrangements,
- Refer routinely to Perinatal Loss Service for continuing care
- Refer routinely to Social Work Department for support & information on Birth Registration Forms, Centrelink Bereavement Payment of Family Tax Benefit & Maternity Allowance
- Refer to Psychological Medicine if there is a history of mental health disorder or clinically indicated. However, carers must be alert to the fact that women are at risk of prolonged psychological reactions including grief, depression, anxiety and post-traumatic stress disorder, and that their reactions may differ.

## Intrapartum care

- Care intrapartum must be in line with various guidelines, and ensure the most appropriate care is provided, including staffing considerations (experienced, or supported less experienced).
- Senior staff should be used routinely for consultation.
- Commence all women on: **MR 271 Perinatal loss > 20 weeks gestation vaginal birth clinical pathway**
- All women to have an intrapartum partogram
- Continuity of caregiver is best practice, limiting the numbers of staff involved.
- Individualised care plan should be applied
- Compassionate, empathetic and non-judgement care is reported as being a positive experience for bereaved families

- Active management of the third stage is recommended, at all gestations.
- Adequate analgesia is particularly important when requested by women with perinatal loss.
- Intrapartum clinical care for all women in labour with a pregnancy loss > 20 weeks gestations shall be as per KEMH Clinical Guidelines, Obstetrics & Midwifery: Intrapartum:
  - First Stage of Labour: Care of the Woman
  - Second Stage of Labour: Management
  - Third Stage: Active Management
  - Immediate Care of Mother in Labour and Birth Suite Following Birth.
- There are specific requirements for reporting of death of a child <1 year and stillbirth >20 weeks gestation. See section “Legalities” and Department of Health links: [Notification of terminations of pregnancy \(induced abortion\)](#) and [Notification of birth events and cases attended by midwives](#).

### **Postnatal care**

Length of stay, and place of stay, should be individualised, and be made in consultation with medical and midwifery staff, and the family.

- Experienced doctors and midwives should provide comprehensive and continuing care in the postnatal period,
- Information and results should be relayed when available.
- Advise on lactation suppression and breast comfort. See KEMH O&G guideline: Newborn Feeding: [Suppression of lactation](#).
- Discuss and advise on contraception if appropriate.
- Provide written information on available support services for parents, children & other family members
- Visiting Midwifery Service (VMS) (or similar) should be arranged upon discharge

### **Care of the baby**

- The literature about contact with the baby is not certain. Most families will want to see and hold their baby, and spend time with their baby. Offer all families the opportunity to see and hold their baby. If families choose not to, they should be regularly re-offered the opportunity, however not coerced. Respect for cultures and compassionate sensitivity is required.
- Parents appreciate it when staff treat their baby with respect, such as calling the baby by name. Mementoes should be created routinely for all perinatal deaths and offered to the family.
- Every family must make some arrangements for the body of the baby, such as burial or cremation, depending on the circumstances.

Refer to sections in this document:

- Perinatal loss - [Deceased baby: care and management](#)
- Perinatal loss - [Flexmort cuddle cot cooling system: Management](#)

and section 'Religious and cultural considerations' in KEMH clinical guideline, O&G: [Deceased Patient: Management](#)

## Post-mortem

- A post-mortem should be offered to all parents following a stillbirth.
- Information gained from an autopsy can assist in the understanding of events surrounding the death. In addition this information can assist in future pregnancy planning by enabling consideration of the recurrence risk and different management strategies.
- All autopsy examinations require written consent – **MR 236 -Consent for Post-Mortem**
- Provide written information about autopsy – **Non Coronial Post Mortem Examinations** pamphlet
- Discussion with the parents should include:
  - The value of an autopsy
  - Options of exam: full, limited or external only
  - Issues related to retained fetal tissues
  - The possibility that a cause may not be found
  - Cost to the parents of the autopsy (NIL)
  - Appearance of the baby following autopsy
  - The likely timeframe for results to become available and
  - Arrangements for communicating these results (e.g. PLS clinic, GP, Private Obstetrician)

## Documentation

All births and deaths that occur beyond 20 weeks gestation require documentation in accordance with various legislative requirements, policies, and guidelines. These include Registration of Birth, Medical Certificate of Cause of Stillbirth or Neonatal Death, Death in Hospital form, and for sentinel events a CIMS form.

- Refer to PLS Clinical Pathway MR 271 Perinatal Loss > 20 weeks Gestation Vaginal Birth Pathway – Documentation & Forms (p3). See also section in this document: [Legalities](#).

## Follow-up and subsequent pregnancy plan

Follow-up and subsequent pregnancy plan requires multidisciplinary collaboration, including local care providers.

- Postnatal follow-up should include VMS (or similar, i.e. GP, local hospital / clinic, or Community Midwife) to be arranged upon discharge for up until day 5 post-birth. Ensure GP/Obstetrician/Midwife follow-up at 2 and 6 weeks postpartum for maternal health check-up
- Ensure there is a process for explanation of results, including post-mortem. This could be through Perinatal Loss Service at PLS Clinic, Obstetric care provider (Private Obstetrician, GP), Genetic Services WA (if known to them), or other. This should occur at 6-8 weeks post birth.
- Subsequent pregnancy planning should include pre-conception review by their local care provider, and early referral, i.e. first trimester, to specialist care (if indicated).
- The subsequent pregnancy care plan should be made with due consideration of all information available in order to minimise the risk of perinatal death.

## Baptism & pastoral care

### Key points

1. Pastoral Care Services shall be advised as soon as possible of **ALL** deaths at KEMH even if a religious representative is present. It is preferable to call Pastoral Care prior to death occurring to assess any spiritual or religious needs (often not obvious) and to ensure that any presenting spiritual or religious needs are met by an appropriately representative person. They will also liaise, support and guide relatives and hospital staff about appropriate religious and cultural supports. Pastoral and spiritual care is available to all, regardless of religious affiliation or none.
2. Pastoral Care Services can be contacted during office hours (8am – 4pm Monday - Friday) on extensions 81726, 81036 or pagers 1294 or 3125. Alternatively via the switchboard (91). After hours the on-call chaplain should be contacted via the switchboard.
3. Cultural practices may vary significantly between groups even if they belong to the same religion. It is important not to make any assumptions.
4. Prior to contacting Pastoral Care, if possible, ascertain if parents have a particular religious affiliation or specific religious requirement. When a specific religious tradition is ascertained early it will enable the chaplain to respond more quickly and appropriately. If the parents have a Christian affiliation or association they should be asked if they would like their live-born baby baptised or an alternative ceremony performed, in accordance with their beliefs.
5. The parents may be offered an emergency baptism for their baby.

6. If a baby is stillborn or has died, a Naming and Blessing, including anointing, can be offered. This will be conducted by the chaplain or another appropriate person.
7. A “**Cultural and Health Care**’ information file is kept in the Hospital Clinical Manager’s Office.

### **Emergency baptism**

In an emergency, if a Chaplain or the parents’ priest or minister cannot arrive in time, any baptised person may be the Minister of Baptism.

#### **Procedure**

1. Place the equipment on a small trolley.
2. Pour or sprinkle water on the child saying (The child’s name)

“I baptise you in the name of God the Father, God the Son, God the Holy Spirit”

3. If there is uncertainty as to the name of the infant, the baptism can be properly administered without the use of a name, as long as the identity of the infant can be duly recorded.
4. Details of the baptism must be entered into the Baptismal Registry, which is located in Special Nursery 3.
  - A certificate of baptism should be completed and given to the parents. Certificates are available in the same drawer as the Baptismal Register.
  - Pastoral Services must be informed of any baptism administered as outlined above, on extension # 81726 or 81036.

## **Legalities and reporting**

### **Aim**

To ensure all required documents are accurately completed, in the event of a perinatal death.

### **Perinatal death- definition**

Perinatal death refers to the birth of a baby of 20 weeks gestation or more, which either dies before birth (stillbirth) or in the neonatal period i.e. first 28 days of life (neonatal death).

### **Terminations of pregnancy >20 weeks gestation**

Section 334(7) of the Health Act allows for an abortion if a gestation of 20 weeks has been reached but imposes additional legal requirements.

Section 334(7) of the Health Act provides as follows:

If at least 20 weeks of the woman’s pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless:

- Two medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners justifies the procedure; and
- The termination is performed in a facility approved by the Minister for the purposes of this section.
  - The approved facility for the purposes of section 334(7) of the Health Act is King Edward Memorial Hospital for Women or Broome Hospital in Western Australia.

### **Required documentation:**

- **Witness to Approval to Termination of Pregnancy (MR256).** This form must be signed by a Medical Practitioner prior to the abortion commencing, and will be filed in the Medical Record
- **Form 1. Health Act – Notification by Medical Practitioner of Abortion.** Will be completed by the Medical Practitioner conducting the Abortion, the original will be sent to the Abortions Registry at the Department of Health, and a copy filed in the Medical Record.

### **Stillbirth (no signs of life after birth)**

#### **1. Period of gestation 20-28 weeks**

- **Registration:** If the period of gestation is known to be 20 weeks or more or if the gestation is unknown the weight is 400gm or more, the birth and death must be registered with the Registrar of Births, Deaths and Marriages.
  - i. **The mother must register the birth** using the Birth Registration form
  - ii. **Perinatal Pathology, Funeral Director or person disposing of the body must register the Death using** the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201).

#### **2. Period of Gestation 28 weeks or more**

- **Registration:** The birth and death must be registered as above.
- **Baby Arrangements:** The parents must make arrangements for the baby to have a funeral (cremation or burial) arranged through an external funeral director

### **Neonatal death (signs of life, such as heart beat, after birth)**

- **Registration:** All babies born alive (regardless of gestation) who subsequently die in the neonatal period must have the birth and death registered with the Registrar of Births, Deaths and Marriages.

- The mother must register the birth using the Birth Registration form
  - A Funeral Director or person disposing of the body must register the death using the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201)

## Documentation

- Follow the Perinatal Loss > 20 weeks Gestation Vaginal Birth Clinical Pathway (MR 271) for the documentation required. Depending on the circumstances, not all documentation may be required.

## Stillbirth or neonatal death (> 20 weeks gestation)

- **Death in Hospital Form MR 001**- completed by the clinical staff in attendance. File in the medical record. (Assists in the determination of whether the death is reportable either under the *Coroners Act 1996* or under the *Health Act 1911*).
  - If reported under the Coroners Act: see Department of Health: Information Circular [IC 0008/07: Coroners Act 1996](#).
  - If reported under the Health Act: All deaths are required to be reported to the Chief Medical Officer. At KEMH that is via the 'Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201)' (see below).
  - Sentinel events are notified to Safety and Quality directly, see WNHS [Clinical Incident Management](#) Policy and [NMHS CIMS policy](#).
- **Medical Certificate of Cause of Stillbirth or Neonatal Death BDM 201** – completed by the attending Medical Officer. The completed certificate sent to Perinatal Pathology.
  - A copy of the BDM 201 (Death Certificate) must be sent to the Chief Health Officer (CHO) via email; [edphwa@health.wa.gov.au](mailto:edphwa@health.wa.gov.au) or fax 9222 2295. At KEMH, this is performed on a weekly basis by the Clinical Midwife Consultant for the Perinatal Loss Service.
- **Certificate of Medical Attendant (Cremation Form 7) (if > 28 weeks gestation)** –completed by the Medical Officer and the completed certificate is sent to Perinatal Pathology.
- **Consent for Cremation of Stillborn Baby (less than 28 weeks gestation).** Required for all stillborn babies less than 28 weeks gestation when KEMH cremation is consented to. Form is completed by Pastoral Care Services and sent to Perinatal Pathology. Pastoral Care should be routinely called to discuss options and facilitate.
- **Birth Registration**  
The Mother must complete the Birth Registration Form and send to the

Registrar of Births, Deaths and Marriages. The Midwife must note the name of the accoucheur and the time and date of birth.

- **Bereavement Payment forms.** The midwife documents those sections of the forms that are required to be completed by the attending midwife. . The form is completed by the parent(s). The completed form forwarded sent to Centrelink/Medicare.
- **Consent for Post Mortem Examination MR 236.** The clinical staff must discuss post mortem, and if consent is given, complete all relevant areas of the form and is responsible for the completion of the “ Consent by Next of Kin’ section of the form. The completed form is sent to Perinatal Pathology. Additional information is in the Perinatal Pathology Handbook and the patient information pamphlet ‘Non Coronial Post Mortem Examinations’.
- **Consent for Pathology Examination Baby less than 20 weeks Gestation’ form (MR 238)** Babies less than 20 weeks gestation require this form to be completed, if a post mortem examination is consented to. Clinical staff completes all relevant areas of the form. It is preferred that if consent for post mortem is declined, this is noted on the form and sent to Perinatal Pathology. Further information is located in the Perinatal Pathology Handbook.
- A laboratory request form is required if the placenta is being sent for examination. See Clinical Guidelines Placenta- Indications for examination by Microbiology and Histopathology

### **Presentation of newborn – Dead on arrival (DOA)**

If a woman presents to King Edward Memorial Hospital having given birth prior to presentation at KEMH and the newborn is dead on arrival, the following procedure is to be followed and documented in the maternal medical record.

- The Obstetric Registrar will examine the mother and baby and will enquire about the circumstances of the birth.
- The Obstetric Consultant for the team will be notified.
- The Neonatal Registrar will be called to examine the baby.
- Upon consideration of the circumstances, if the baby has been born with signs of life, or unknown if signs of life are present, the Coroner’s Office may be notified (in accordance with the WNHS Policy- Deaths, Reportable to the Coroner).
- The mother should be offered admission for continuing care and counselling.
- The baby may accompany the mother. Alternatively the baby may be transferred to Perinatal Pathology.



# Care and management of a deceased baby

## Key points

1. Care is always carried out in a private area.
2. If the death is to be investigated by the **Coroner** - leave all tubes in situ; curl up the catheters and tape to the baby, do not bath the baby.

## Procedure

1. Offer the parents the opportunity to participate in the care provided to their baby.
2. Attach an identity band to the ankle or an appropriate area, depending on the baby's size. The Identification band must remain on the baby at all times.
3. If appropriate and requested, bathe or wash the baby gently, especially if fetal death has occurred as skin integrity may be compromised.
4. Record the weight, length and head circumference.
5. Examine the baby and note any obvious abnormalities. Document the examination in the medical notes.
6. Complete a cot card.
7. Dress the baby and wrap in a sheet / blanket. The baby may be dressed in clothes provided by the parents or those provided by the hospital.
8. Obtain verbal consent from the parents to collect the following mementos and place in the memento booklet:
  - Photographs: **Note:** Lead photo must be a photo of the baby with Identification (ID) addressograph/ cot card for identification purposes. For Neonatal deaths use the baby's addressograph. The baby must have at least one photo showing ID band in-situ. This must be readable in the photo.
  - Foot and hand prints
  - A lock of hair
  - Baby identification band and cot card
9. Place these in the Memento booklet in the grief pack, and place the grief pack in the Memory Box
10. If the memento booklet is declined:
  - Document this in the notes
  - Place the mementos in a sealed envelope and file in the mothers medical records, noting the contents on the outside of the envelope.
  - Inform the parents that they will be kept on file in case they request them at a later date.
  - It is important that the information in the Grief Pack is provided to the family.

Consider transferring the baby to Perinatal Pathology intermittently to be cooled in the mortuary refrigerator as this will slow the rate of deterioration Alternatively utilise the Cuddle Cot Cooling System to cool the baby. See section in this document:

[Flexmort Cuddle Cot Cooling System: Management of](#)

## Transferring the baby to Perinatal Pathology

### 1. Ensure:

- Identification label / band on the baby is correct
- The baby remains dressed
- A 'Maternal' addressograph - on the outside of the baby's blanket after wrapping.

**Note:** if a neonatal death has occurred the neonate will have its own addressograph.

### 2. Baby/fetus must be wrapped and sealed in Bluey with maternal addressograph on the outside of the bluey

- Babies <20weeks and smaller babies > 20 weeks): must be placed in a plastic container with maternal addressograph on the outside (top and side).
- Plastic container must be placed in plastic bag & tied at the top
- Plastic container is then place in Blue fabric carry bag for transfer to Perinatal Pathology
- Larger Baby/Term must be wrapped and sealed in Bluey with maternal addressograph on the outside of the bluey
- The wrapped baby is then placed in the plastic mortuary bag with maternal/neonatal sticker on the outside
- the baby (within the mortuary bag) must be placed in the Blue fabric carry bag for Transfer to Perinatal Pathology

### 3. The placenta must be double bagged (plastic bags) with maternal addressograph on the outer plastic bag.

### 4. The bagged placenta must be placed in a sealed, plastic placenta container.

### 5. Do not place the placenta in saline, formalin or any other form of fixative.

### 6. Attach a maternal addressograph the container (lid and side).

### 7. Record date and time of birth on the addressograph on the lid of the container

### 8. A pathology request form should accompany the placenta, including date and time of the birth. Obstetric history (G/P), gestation at birth, and clinical history.

### 9. Page the orderly (3101) and ask for a mortuary bag to be brought to the area.

Refer to [Operational Directive from the Department of Health WA- Policy For](#)

[The Release Of Human Tissue And Explanted Medical Devices](#): Page 5- 1.2.3

Preparation for the release of human tissue.

10. Prior to transfer to Perinatal Pathology, cross **check identification with the Orderly**:

- Identification addressograph on the baby matches Identification addressograph in Perinatal Death Register.
- Paperwork included is checked i.e. Medical Certificate of Cause of Stillbirth or Neonatal Death, Cremation Form (Form 1)
- Any additional items to accompany the baby are listed and confirmed as being included with the baby on a Perinatal Pathology Parental Wishes sheet.
- Orderly and Midwife/Nurse to co-sign the Perinatal Death Register

11. The Orderly must record every transfer of a baby to and from Perinatal Pathology in the Perinatal Pathology Movement Register

12. A 'Permission to Transport a Deceased Baby' form (MR295.95) is required to release a baby to its parents' care. The parents may elect to return the baby to KEMH or to the care of a nominated funeral director.

13. The Release of a baby's body to a funeral director must be recorded in the Perinatal Pathology Mortuary Register. Refer to Perinatal Pathology Policy.

14. For babies of less than 20 weeks gestation, the parents may take the baby home for disposal after completion of the MR 355.10 form.

### Parental contact with their baby

- Parents can be offered the opportunity to spend time with their baby at any time, whilst an inpatient, and by arrangement after discharge
- The baby may stay in the woman's room whilst she is an inpatient
- Intermittent cooling in Perinatal Pathology Mortuary refrigerator will delay deterioration.
- If the baby is in Perinatal Pathology the following process shall be followed. Nursing / midwifery staff will:
  - Phone Perinatal Pathology 82730 and inform them that the parents wish to view their baby. Perinatal Pathology open hours: 07:30 – 15:50 Mon-Fri. (If after hours orderly can access the mortuary)
  - Page the on call orderly (3101) to collect the baby from Perinatal Pathology.
  - Accept the baby from the orderly and prepare the baby for contact with the parents.
  - When the parents request their baby to be returned, page the orderly to collect the baby from the nurse / midwife on the ward.

- Ensure the baby is returned to Perinatal Pathology at the end of the contact time.
- Following discharge the parents may wish to spend time with their baby in the viewing room in Perinatal Pathology. This can be arranged directly with Perinatal Pathology in normal working hours. Pastoral Care Services, Social Work Department or the PLS CMC may assist in making these arrangements. If the parents wish to view the baby on weekends or public holidays, the Hospital Clinical Manager, in coordination of Labour & Birth Suite, will need to make the arrangements. The parents may spend time with the baby in an appropriate area (e.g. Grieving Parents Lounge Labour and Birth Suite).

**Notes:**

If a neonatal death has occurred the neonate will have its own addressograph.

Refer to Department of Health WA Operational Directive [OD 0398/12: Release of Human Tissue and Explanted Medical Devices](#) (page 5-1.2.3 preparation for the release of human tissue).

## Flexmort cuddle cot cooling system

### Key points

- The Flexmort Cuddle Cot cooling system is a system used to cool a baby (who has passed away) in a cot or basket, allowing babies to remain with their families.
- To provide bereaved parents / families, the option of spending extended time with their baby, on the ward or at home.

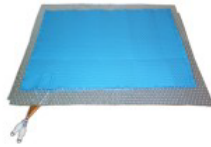


### Contents of the box

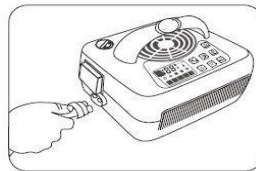
- Cooling unit, drain key and blue hose
- 2 x blue plastic cooling pads – small & large
- Bottle of Biocide
- 3 x Silver insulation foil – 1 small, 2 large

## Using the system

1. To improve the cooling efficiency, place the silver insulation under the cooling pad. Use double thickness and face the silver side upwards.



2. Place the cooling pad and insulation in the cot / basket on top of the mattress / cushions. Ensure the 2 hoses which lead from the pad are exposed and pushed through the hole of the skirt covering the wire cot.
3. Place a small bluey and thin sheet to cover the cooling pad.  
Remove the cooling unit from the blue storage box, plug into the electrical socket.
4. Plug the hose containing the large plastic connector into the cooling unit. You should here a loud click



5. Plug the cooling pad connectors into the end of the hose. Again there should be a loud 'click'.



6. Open the water filler cap and place a couple of drops of biocide into the unit. Fill the cooling unit with **distilled** water until the water level is near the top of the viewing window.

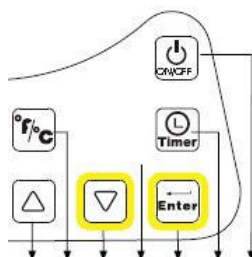


**Ensure you have completed the training prior to using the equipment.**  
**Please refer to chemical safety precautions below before handling the biocide fluid.**

7. Switch on the cooling unit by pressing the on/off button. The cooling pad will start to fill and the water level will drop. **Ensure there are no kinks in the**

**hose or pad else fluid will not circulate.** Continue to fill the unit with distilled water until the tank remains over half full (the cooling pad will now be full of water). Always keep the unit topped up during operation and an alarm will sound should the water level drop too low. **Do not disconnect the hose whilst the unit is running.**

8. Select temperature display ( $^{\circ}\text{C}$  or  $^{\circ}\text{F}$ ) by pressing the  $^{\circ}\text{C}/^{\circ}\text{F}$  button on the unit. The display will show the temperature of the water in the cooling unit. Set the required temperature to the lowest setting on the control unit (i.e.  $8^{\circ}\text{C}$ ). To do this repeatedly press down arrow key until 8 is displayed, then press "Enter". The unit will slowly begin to cool the cooling pad.



9. When the pad starts to feel cool, place the baby on the pad. **Within approximately 45 mins the display on the unit will reach between  $9-13^{\circ}\text{C}$  depending on the ambient conditions. These are normal operating temperatures & the cooling pad will feel cold.**
10. Cover the baby with blankets as this will act as insulation. For longer term use (e.g. through the night), the baby can be fully covered with blankets (including the head).
11. Always ensure at least 15cm space around the unit during cooling – to allow ventilation.

## Trouble shooting

- The unit is beeping and a blue droplet appears on the display:
  - The unit is low on water, see step 8 in 'Using the Cooling system'.
- The cooling pad is warm and not cooling:
  - Ensure there are no kinks and the unit is set at  $8^{\circ}\text{C}$ .
  - There may be trapped air in the cooling pad. To remove, leave unit running and loosen the filler cap & roll the pad towards the hose inlet/outlet to remove the air.
- The unit turns off automatically after 30/60 minutes:
  - The system has a timer which may have been activated. To ensure the timer is off, press the Timer button until "0" is displayed. Continuous cooling is recommended.

## Packing away the cuddle cot

1. Remove the baby. Switch off the unit by pressing the power button but do not

unplug until the fan stops operation.

2. Disconnect the cooling pad from the hose by pressing the release clips on the hose. Clean the pad **according to cleaning instruction below**.
3. Disconnect the hose from the unit by pressing down the plastic button on the underside of the control unit and gently pulling on the hose.
4. Drain the water from the unit by inserting the key under the water level tanks.

**(See instructions for method of disposal of fluid)** For long term storage (once finished with each baby), also drain the hose by inserting the key into the hose.

### General maintenance and power cord warning

- Dust Hazard - If dust builds up around the fan, remove the cover and wipe clean. Accumulation of dust on the fan can cause fire.
- Used cold pads should ideally be replaced every 12 months.
- Electrical Safety: Annual check of the equipment by KEMH Physical Resources (Facilities Management).

### Cleaning instructions – as advised by infection prevention and control

1. After each baby the cot covers and hospital linen require hospital grade laundering.
2. The cooling pad, inserts and tubing, silver insulation foil must be wiped down with Tuffie 5's.
3. If there is noticeable ooze on the blue cooling pad, then it should be immersed in detergent and water to ensure adequate cleaning.
4. If any breaks or tears occur on any of the products they should be replaced immediately. Report it to PLS CMC - LBS on Pager #3430 or Ext 82128.

### Chemical safety precautions for biocide

Flexmort's uses **Biocide fluid** in the cooling system to neutralise bacteria and algae which could accumulate.

However, **Biocide products are classified as dangerous** – potential acute human health hazard.

Hazard identified/Mode of entry	Precaution Wear PPE
Inhalation –vapour/mist may cause irritation to mucous membrane	Wear face mask – prevent inhalation
Skin contact – chemical can cause mild irritation	Wear gloves when handling chemical to prevent skin contact
Eye contact – splash of chemical on eyes can cause irritation, Lachrymatory effect, etc.	Wear goggles when handling chemical. To prevent splash on face & eyes–.
Ingestion – harmful if accidental swallowed, may cause nausea	Keep food substances away from the chemical to prevent accidental ingestion

**PPE: Personal Protective Equipment**

**NB:** Exposure of chemical or waste liquid: Should you have any exposure effect or spillage on your body, skin, etc. please report the incident & complete an incident form.

**NB:** Spillage on the floor, use the spill kit. Get it from the nearest location of the spillage kit

**See full Safety Data sheet for full product precautions and first aid measures – copy kept with Cuddle Cot.**

**Disposal of fluid**

**Follow safety data sheet for product handling precautions.**

1. **Wearing gloves, mask and goggles:** Drain the water from the unit by inserting the drain key under the water level tank. Also drain the hose by inserting the key into the hose.
2. Drain waste fluid into the supplied white chemical waste container labelled – **WASTE PURACHEM FRB-21.**
3. Keep the container on the ward, in the 'dirty room' for your usage. When it is full, request PCA to deliver to waste disposal area at KEMH. Suez, Waste Management will change it over from the waste area.
4. **NB: Exposure:** Should any waste liquid or the chemical accidentally spilt on your skin, please report it & complete & incident form.

**For more information: contact CMC Perinatal Loss – page # 3430 or Ext: 82128**



# Funeral arrangements for a deceased baby

## Key points

1. Pastoral Care Services are to be notified of all losses of an intact fetus or baby.
2. Discussions about the options available to parents are managed by Pastoral Care Services.
3. Parents have the option of having a memorial service in the King Edward Memorial Hospital chapel irrespective of religious affiliation or none..
4. Naming and Blessing services or acknowledgement of life rituals are conducted at a time arranged with Pastoral Care Services. These may be performed in the patient's room or the chapel.
5. Deceased babies are not to be left unattended by hospital staff in the chapel at any time.
6. Transport modules for discreet transportation are available through the Perinatal Pathology staff or orderlies.
7. All transportation of deceased babies within or from KEMH must be recorded in the appropriate transport log.
8. The option of cremation at the hospital is only available for babies who are stillborn **and** less than 28 weeks gestation. Parents are offered:
  - Individual cremations with the return of separate ashes. These arrangements are made by Pastoral Care Services with the parents in conjunction with Perinatal Pathology.
  - Communal cremation with collective interment of ashes at a monthly Interment of Ashes service. This is arranged by Pastoral Care and Perinatal Pathology.
9. Consent for Pathology (HPF 1480) shall be completed for all < 20 week losses noting whether consent for examination is given or declined.
10. Parental Consent must be obtained for cremation of a stillborn baby less than 28 weeks gestation. A MR 297 'Consent for Cremation – Baby Less than 28 Weeks Gestation' form must be completed prior to hospital cremation. This is managed by Pastoral Care Services.
11. Babies born alive who are greater than 20 weeks gestation must have funeral arrangements made through an external funeral director. This is managed by Pastoral Care Services in conjunction with the family.
12. Stillborn babies greater than 28 weeks gestation must have funeral arrangements made through an external funeral director. This is managed by Pastoral Care Services in conjunction with the family.
13. Parents may arrange their baby's funeral themselves if they wish. They should be referred to Pastoral Care Service for appropriate information and support regarding this option.

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## Related legislation and policies

### Legislation:

- [Acts Amendment \(Abortion\) Act 1998](#)
- [Births, Deaths and Marriages Registration Act 1998](#) (section 44)
- [Cemeteries Act 1986](#)
- [Coroner's Act 1996](#)
- [Health \(Miscellaneous Provisions\) Act 1911](#)
  - Part XIII Section 336 (death of a woman as a result of pregnancy or childbirth); Section 336A (certain deaths of children including stillbirth >20 weeks gestation) & 336B (death whilst under anaesthetic)
  - FDIU guideline section: Section 335 Reporting births (including living, term, premature, stillbirth or abortion) attended; (5d) Abortion notice
  - Legalities: Section 334(7)
- [Mental Health Act 2014](#)

### Department of Health WA:

- [Legal Policy Framework](#) including [Coroners Act 1996 - IC 0008/07](#)
- [Western Australian Review of Death Policy](#) (web page) & [OD 0448 / 13 WA Review of Death Policy](#)
- [IC 0195 /14 Direct Transfer of the Body of a Deceased Person into the Hands of Relatives](#)
- [OD 0462 Assessment of the Extinction of Life and the Certification of Death](#)
- [OD 0398 / 12 Policy for the Release of Human Tissue and Explanted Medical Devices](#)

## Related WNHS policies, procedures and guidelines

WNHS Policy: [Information to External Parties \(Providing\)](#) (section- Coronial investigation)

### WNHS Guidelines:

- Obstetrics & Gynaecology: [Deceased Patient: Management](#) ; [Death in Theatre](#)
- [Allied Health](#): Pastoral Care guidelines & [Hub page](#) (contact details & information)
- [Neonatology](#): End of Life Care:
  - [Post Mortem Examination and Coronial Matters](#)
  - [Last Office](#)
  - [Palliative Care, Grief and Loss](#)
  - [Viewing the Infant](#)
  - [Baptism](#)
  - [Funeral Arrangements](#)











## Useful resources

Department of Health WA (web pages):

- [Notification of anaesthetic death](#)
- [Notification of death of a woman as a result of pregnancy or childbirth](#)
- [Notification of perinatal and infant deaths](#)
- [Notification of birth events and cases attended by midwives](#)
- [Notification of terminations of pregnancy \(induced abortions\)](#)
- [From Death We Learn](#) (Summaries of coronial inquest findings)
- [Sentinel events](#)

Patient Brochure: Termination of pregnancy: Information and legal obligations for medical practitioners

[SOSU](#): Caring for Families Experiencing Perinatal Loss

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Supersedes:	<p><b>History:</b> Oct 2018 Amalgamated nine individual guidelines (five from section 'Death' in Joint Obstetrics &amp; Gynaecology; two [FDIU- Antenatal &amp; Intrapartum] from Obstetrics &amp; two [FDIU- Antenatal &amp; Intrapartum] from Community Midwifery Program (CMP) guidelines), created from August 1993 onwards into one document.</p> <p><b>Supersedes:</b></p> <ol style="list-style-type: none"> <li>1. FDIU &gt;20 Weeks Management (Antenatal) (version dated Sept 2014)</li> <li>2. FDIU &gt;20 Weeks Management (Intrapartum) (version last amended Feb 2015)</li> <li>3. Perinatal Loss: Legalities (version last endorsed Jan 2018)</li> <li>4. Perinatal Loss Funeral Arrangements for Deceased Babies (version dated April 2015)</li> <li>5. Perinatal Loss Flexmort Cuddle Cot Cooling System Management (version last amended Jan 2015)</li> <li>6. Perinatal Loss: Deceased Baby Care &amp; Management (version last endorsed Jan 2018)</li> <li>7. Perinatal Loss: Baptism &amp; Pastoral Care (version dated March 2015)</li> <li>8. CMP: Absence of Fetal Heart in the Antenatal Period (version last amended Dec 2015)</li> <li>9. CMP: Absence of Fetal Heart in the Intrapartum Period (version last amended Dec 2015)</li> </ol>		
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