



Government of Western Australia
North Metropolitan Health Service
Women and Newborn Health Service



Caring for Families Experiencing Perinatal Loss

Statewide Obstetric Support Unit



Acknowledgements

'Caring for Families Experiencing Perinatal Loss' initially developed by the Statewide Obstetric Support Unit in collaboration with the Perinatal Loss Service of King Edward Memorial Hospital in 2009 and subsequently reviewed in 2018. These booklets are an adjunct to the 'Perinatal Pathology Guidelines' booklets, available from King Edward Memorial Hospital.

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Background

There are approximately 35,000 births each year in WA including 200 stillbirths and 60-70 neonatal deaths. The perinatal mortality rate (stillborn infants >20 weeks gestation plus neonatal deaths) is almost 8 per 1000 total births. Neonatal death rates have continued to fall steadily over time, but the stillbirth rate has remained relatively static for the past two decades.

Important risk factors for stillbirth are advanced maternal age, smoking, obesity, diabetes, primiparity, Aboriginal ethnicity and prolonged pregnancy. It is estimated that the number of stillbirths is now about ten times that of SIDS (Sudden Infant Death Syndrome) deaths in Australia. The high rate of unexplained stillbirths is likely to be a barrier to further reducing stillbirth rates. Thorough investigation into the cause of every stillbirth, including autopsy examination and placental histopathology, is therefore strongly recommended.

'Ballpark' Risks of:

- Maternal death - 1 in 10 000
- Perinatal death - 1 in 100
- Miscarriage - 1 in 6*

*Age 18-25, rising to 40% at age 40 years

Communication including Breaking Bad News

Confirmation of diagnosis ("breaking bad news") should be done in a private quiet room, allowing time for parents to ask questions, and offering sympathy. The most experienced practitioners should be available for these difficult conversations.

The confirmation of a suspected fetal death commonly occurs in the ultrasound department. Where possible it is recommended that a midwife escort be made available to support patients attending ultrasound examination for confirmation of a suspected fetal death.

Where the cause of the loss is not obvious, reassure parents that every attempt will be made to find one in a medical review. Always, when appropriate, reassure the mother that the loss was not due to anything she did or did not do. Explain that stillbirths sometimes remain unexplained, even after detailed review.

Staff are encouraged to express their sorrow for what has happened. Offering sympathy is not an admission of guilt or error WA Health Open Disclosure Policy. Do not withhold expressions of sympathy and/ or regret due to fear of medicolegal reprisal.

Best practice tips

- ▶ Respect – treat parents and baby with respect and privacy
- ▶ Compassion – care should be culturally sensitive and compassionate
- ▶ Communication – provide information, including written material
- ▶ Time – allow parents time to make decisions, and time with their baby
- ▶ Continuity of carer – promotes and enhances communication and satisfaction

Compassionate care

With the first knowledge that the baby's death has occurred disbelief and numbness is usual, and people commonly experience a surreal state. It is difficult to concentrate, understand or remember things in this period. It is a difficult time to make decisions.

Suggestions for supportive care include:

- ▶ Provide parents with information (verbal and written) and include them in decision making.
- ▶ Promote continuity of care giver for women.
- ▶ Provide care by a dedicated one-on-one midwife where possible.
- ▶ Provide information to assist parents in preparation for labour and birth and how the baby may appear.
- ▶ Allow time for parents to make important decisions, such as:
 - Options for ongoing care following diagnosis of serious fetal abnormality
 - Options for ongoing care including induction of labour following fetal death
 - Resuscitation or non-resuscitation at the margins of viability
 - Palliative approach to neonatal care including withdrawal of life support
- ▶ Ensure parents have written details of how and who to contact with any queries

Best practice tip

Please liaise with consultant obstetric staff or the Perinatal Loss Service prior to arranging the transfer of a patient. Both may be contacted via switch, phone (08) 6458 2222 or directly to the PLS mobile phone, during business hours, on 0416019020

Clinical Considerations

Where clinically appropriate, maternity (units) are encouraged to provide peri-partum care rather than transferring a patient to a regional or tertiary unit. Telephone support is available from the PLS to facilitate this. Please liaise with obstetric consultants and/or the PLS Clinical Midwife Consultant when considering patient transfer. Whilst it may be appropriate for a patient experiencing complex perinatal loss to be seen six to eight weeks postnatally at the PLS, it is frequently unnecessary to transfer the patient for labour and birth.

Please refer to general inclusion criteria for your unit with consideration of potential complications. Most low to medium risk patients with perinatal loss can be cared for locally. Benefits of caring for patients in the local hospital may include reduced stress, less disruption to families and cost savings. Telephone advice is available to support care at a local level when appropriate.

Transfer may be appropriate due to risk factors such as poor past obstetric history, preeclampsia, obesity, sepsis, coagulopathy, previous caesarean section and/or where the facility may not have a full range of services required (e.g. operating theatre as there is increased risk of retained placenta in mid trimester losses). Benefits of transfer may include accessing specialised multidisciplinary team care.

Transfer to KEMH is advised for women with fetal death in utero and:

- ▶ previous caesarean section requiring induction of labour
- ▶ two or more previous caesarean sections, for possible vaginal delivery.

Later termination of pregnancy (> 20 weeks) for severe fetal or maternal condition must, by legislation, only be performed at an approved facility following approval by a Ministerial Appointed Panel. ww2.health.wa.gov.au/Articles/A_E/Abortion-Notification-System

In certain circumstances perinatal palliative is required for example antenatal diagnosis of a fetal anomaly where the parents chose to continue with the pregnancy.

The [Perinatal Palliative Care, Model of Care](#), outlines pathways for referral and entry of the fetus/newborn and their family into a palliative care approach.

Mode and timing of induction and birth

It is important to consider the most appropriate timing and method of birth. Vaginal birth is generally preferable to caesarean section following fetal death, with minimisation of maternal risk being the most important factor. There is usually no clinical need to rush. It may be beneficial to delay induction of labour to allow the parents some time to adjust to the knowledge that their baby has died. Delaying induction of labour for more than one to two days against maternal wishes is not recommended. It is recommended that a written Perinatal Care Plan be prepared, with a copy provided for the woman and her family. This Plan should include details of how and who to contact if parents have any queries.

Current clinical guidelines related to induction of labour can be accessed in business hours by emailing the Clinical Guideline Coordinator at KEMH, O&GClinicalGuidelines@health.wa.gov.au or by phone: 6458 1817. Specific clinical advice is available by contacting the PLS Coordinator or Duty Obstetric Consultant at KEMH (24/7).

Analgesia

Provision of adequate analgesia is particularly important for women with perinatal loss. Suggested analgesia for induction of labour at less than 28 weeks includes opioids as required. Administration of Diclofenac 50mg at commencement of labour and continued 8 hourly throughout reduces analgesic requirements.

For women greater than 28 weeks gestation analgesia should be provided as per the woman's wishes including regional analgesia, in the absence of contraindications.

Management of the Third Stage

Management of the third stage should be active and include a prophylactic oxytocic. For pregnancies under 28 weeks Syntocinon 10 units should be administered, noting the increased incidence of retained placenta in mid trimester losses.

For gestations greater than 28 weeks oxytocin as per local policy should be administered.

Examination of baby and placenta

The baby should be carefully examined, weighed and measured as performed for a live birth, with a detailed description of the baby's general appearance documented. Describe any maceration in detail and check anatomy including eyes, ears, mouth, throat, chest, abdomen, genitalia, anus and limbs. This can be done with the parents and is particularly important where there is no formal autopsy performed. These findings should be documented. Clinical photographs may be an adjunct to examination in the identification of anomalies and fetal growth restriction.

The condition and weight of the placenta should be noted. The placenta should be sent for histopathology with appropriate request form, as a routine, except when parents object. The placenta may be able to be examined and returned to the parents if this is desired (with appropriate documentation and disclaimer).

Autopsy examination of the deceased baby is strongly recommended, and arranged through Perinatal Pathology at KEMH without the need to transfer the mother. The baby can be returned to the family, via the hospital or funeral director, within 1-2 days in most circumstances.

Postnatal care

Routine postnatal maternity care should be provided and include consideration of the woman's individual need for analgesia and a discussion about management of lactation, suppression with medication or local simple strategies.

Grief Management

Grief comprises many emotions including numbness, shock, denial, anger, bargaining, sadness, guilt and acceptance. People can experience some or all of these emotions at different times.

Emotions may quickly change from extreme sadness to extreme anger. People may also feel agitated and find it difficult to concentrate and to sleep. Sadness and tiredness may persist for long periods, however over time most people come to an acceptance of what has occurred and are able to recover.

A small proportion of people have prolonged and abnormal grief reactions.

The PLS team and the Department of Psychological Medicine at KEMH may be able to assist in the assessment and management of abnormal grief response, and provide information on local agencies.

Best practice tips

- ▶ Show respect for the patient and family's privacy where possible.
- ▶ Use the baby's name, where given
- ▶ Handle the baby gently, as you would a live baby
- ▶ Enquire about any special cultural needs
- ▶ Consider whether an interpreter is required
- ▶ Be patient and repeat information often
- ▶ Provide with written information

Care of the Baby

Attention to details, such as referring to a baby by name, can enhance sensitive care. Using 'teardrop' stickers on doors and files can help avoid insensitive actions, such as staff noisily entering a room where a baby has died.

Noise and privacy considerations are important issues. There is sometimes a conflict between the optimally 'safe' place to care for patients versus the quietest place which may be in a non- maternity area of the hospital. If possible involve the parents in the decision about place of care.

Contact with the baby is always offered and for many families this is usual, and gentle support should be offered for the parents to have contact with their baby, without coercion. There is some conflicting literature about positive and negative aspects surrounding contact with the baby and grief. Women should be encouraged to make their own choices. Mementos are often highly valued and may assist in validation of a baby, and in coping with grief. The literature suggests that women who have no contact, and those who have extraordinary contact with their baby, are at risk of maladaptation to grief.

A deceased baby's appearance may deteriorate, so photographs taken early, using a digital camera, are strongly encouraged. Keeping the baby cool reduces deterioration of the baby's skin integrity and general appearance. Many maternity units have a special cot with a cooling system known as cuddle cots. Keeping babies cool increases the time they are able to remain with their parents.

Parental permission should be sought prior to handling the baby and taking photographs, locks of hair and footprints. Parents may decline the offer of mementos at the time. It is recommended that staff offer to take photos and mementos and store them in the medical record in case parents wish to access them in the future. It is not uncommon for families to request mementos some years after the event.

There are cultural differences in the approaches to death. For example, Muslim families may not allow autopsy if this will delay burial. Asking open ended questions can help staff to understand and best meet these specific cultural needs.

There should be consideration of the psychosocial needs of the family. It is recommended that all parents are routinely offered referrals to pastoral care (chaplains) and social work that have valuable information specific to their discipline. Discuss whether the family would like to arrange a blessing or baptism service and how this may be arranged by Pastoral Care services.

Consider whether a referral to specialised mental health services is appropriate, e.g. a woman with pre-existing mental illness or identified risk. It is important to include questions about mental health issues when conducting history and physical examination.

Community supports for families include general practitioners, child/community/school health nurses, Aboriginal and other health workers, religious chaplains and other counselling and support agencies, such as SANDS and Red Nose. There are particular challenges in caring for Aboriginal women, migrant women and women with different religious beliefs. Social work staff at each unit have valuable knowledge about specific local providers. Table 5 provides some details of community agencies that may be of assistance.

Grief Support checklist

- ▶ Offer for parents to have contact with their baby, to:
 - see their baby
 - hold their baby
 - spend time with their baby
 - bath / dress / wrap their baby
- ▶ Provide a 'Grief Pack' with brochures including information about:
 - memento booklet to place photos, hand and footprints
 - SANDS (Stillbirth and Neonatal Death Support) and Red Nose brochure
 - grief response brochure
- ▶ Mementos
 - photographs (baby alone and with the family)
 - hand and foot prints
 - cot card
 - lock of hair
 - name bands
 - bunny rug, butterfly, teddy bear, heart or similar
 - memory box / bag
- ▶ Discuss naming / blessing/ baptism services and other religious/spiritual rituals
- ▶ Refer to Postmortem pamphlet or Perinatal Pathology Handbook for additional information regarding autopsy examinations and cremation services at KEMH.
- ▶ Pastoral Care/chaplain to discuss pastoral support, and funeral plans including :
 - cremation options
 - private funeral director arrangements (cremation or burial)

Routine referrals for grief support:

- ▶ Social Work / Pastoral Care
- ▶ SANDS and Red Nose

Consider additional referrals:

- ▶ Mental health referral for women at high risk of mental illness (e.g. women with pre-existing or past history of mental illness)
- ▶ Other external support agencies, e.g. Anglicare, Relationships Australia
- ▶ Specific cultural support groups

Refer to Table 5 for contact details of other agencies

Discharge Planning and Follow Up Care

Upon discharge provide a written postnatal care plan and liaise with the visiting midwife, family GP, child/ community health nurse and/or others (e.g. private obstetrician) as appropriate. Routine referral to the child/community health nurse is important for all women but especially for Aboriginal women, women of culturally and linguistically diverse (CALD) backgrounds and other vulnerable women. Arrange for the parents to have a follow up appointment to receive pathology and autopsy results, and receive advice about subsequent pregnancy. This may be at the PLS clinic.

For remote and rural patients, consider contacting the child health nurse to enable this. Consider the use of video-conference as a medium for follow-up of rural and remote patients. Appropriate referrals ensure that the mother is supported in the following weeks to months, and checked for signs of abnormal grief response/ depression/ anxiety.

Some couples respond to their grief by rushing into another pregnancy. Explain that there are many good reasons to wait at least 6 months before conceiving again. Grieving takes a long time and physical recovery takes months. It is also very important to note that the miscarriage rate and rate of further complications in the next pregnancy are not back to normal until 4 – 6 months have passed. Pregnancy within three months has double the normal rate of miscarriage.

Postnatal care checklist

At discharge:

- ▶ Written care plan
- ▶ Analgesia
- ▶ Consider sleeping strategies (which may include medication)
- ▶ Grief Pack with Grief Support brochure
- ▶ Mementos
- ▶ Physiotherapy booklet
- ▶ Lactation suppression
- ▶ Notify GP and child health nurse
- ▶ Advise when patient should attend their GP and preferably book the appointment
- ▶ Check any funeral plans are in place/pending
- ▶ Check paperwork, preferably completing Birth Certificate and Centrelink paperwork before discharge
- ▶ Book appointments for review at 6-8 weeks postnatal

At 6-8 weeks postnatal:

- ▶ Medical review and discussion of results
- ▶ Psychosocial review / check for abnormal grief response
- ▶ Consider additional counselling or referrals

Reporting requirements

There are a number of reporting requirements and audit activities that may be required when a perinatal death occurs. See Tables 1 and 2.

Neonatal deaths must be reported to the Coroner if the cause of death is unexpected, unknown, suspicious, due to violence, under anaesthetic or occurs whilst a baby is held in care. Stillbirths are not required to be reported to the Coroner.

Table 1: Documentation Requirements for all Perinatal Deaths

- ▶ Refer to unit specific perinatal loss clinical care pathway if available. The KEMH Perinatal Loss > 20 weeks Gestation Vaginal Birth Pathway (MR271) is a useful guide.
- ▶ For births of 20 weeks gestation and over only is the birth is reported to WA Health by Midwives as per the Notification of Case Attended (NOCA) for all births. This may be via STORK database where in use. DO NOT complete Stork or a Notification of Case Attended (NOCA) for births (either live born or stillborn) of less than 20 weeks gestation.
- ▶ ww2.health.wa.gov.au/Articles/J_M/Midwives-Notification-System
- ▶ Birth Registration forms are to be completed for stillbirths as normally done for livebirths. The form needs to be lodged with the Registry of Births, Deaths and Marriages by the parent/s.
- ▶ Claim for Bereavement Payment form (from Family Assistance Office, ph. 13 61 50) is available to eligible families.
- ▶ MR 001: Death in Hospital form (used for Coronial and Review of Death (ROD) Requirements) is used to report all institutional mortalities.
- ▶ BDM 201: Medical Certificate of Cause of Stillbirth or Neonatal Death (Statutory Requirements for Chief Health Officer) must be completed.
- ▶ Parents may wish to receive a Recognition Certificate if the loss occurred births before 20 weeks gestation (or if weeks are unknown) or where the baby weighed less than 400 grams. This must be declared by medical practitioner or midwife on the application form - BDM 150: Recognition of Early Pregnancy Loss.
- ▶ Certificate of Medical Attendant (form 7), *Cremation Act 1929*, for any liveborn baby or stillborn baby 20 weeks or greater in order weeks to be cremated external to KEMH.
- ▶ If the perinatal loss is due to a termination of pregnancy refer the *Abortions (Amendment) Act, 1998*.

Additional documentation to consider:

- ▶ Clinical Incident Reporting requirements, e.g. CIMS / SAC 1 / other reporting if relevant (see Table 4 for more information)

Additional documentation for KEMH Perinatal Pathology department:

- ▶ Consent for Cremation at KEMH (KEMH form MR 297) Only for Stillborn Baby < 28 weeks gestation
- ▶ Consent for post-mortem for baby KEMH form MR 236) >=20 weeks gestation
- ▶ Pathology Request form for autopsy and placental histopathology with appropriate history
- ▶ Consent for Pathology Examination (KEMH form MR 238) – baby < 20 weeks Gestation
- ▶ Permission to transport deceased baby (KEMH form MR295.95). For gestation >= 20 weeks

Table 2: Clinical Incidents and Their Relationship to Other Reporting Systems

(i) Statutory requirements

- ▶ Maternal deaths must be reported to the Chief Health Officer and the Coroner
- ▶ Perinatal and infant deaths must be reported to the Chief Health Officer
- ▶ Cases referred by the Chief Health Officer will be reviewed by the Perinatal and Infant Mortality Committee.
- ▶ Deaths of persons under anaesthesia must be reported to the Chief Health Officer
- ▶ Reportable deaths which require notification to the Coroner (Coroner's Act 1996, please see Information Circular 0008/07).
- ▶ Certification of death (Births, Deaths and Marriages Registration Act 1998)

(ii) Mandated requirements as per Department of Health policy

- ▶ Clinical incidents are to be reported via the Clinical Incident Monitoring System (CIMS). The Clinical Incident Management Policy for WA Health Services is available at WA Health Office of Safety and Quality: www.safetyandquality.health.wa.gov.au
- ▶ Sentinel events. Sentinel events are categorized as Severity Assessment Code 1 (SAC 1) are to be reported to the Patient Safety Surveillance Unit, pssu@health.wa.gov.au, along with reporting to CIMS.
- ▶ 'Death in Hospital' forms are required as per the Western Australian Review of Death Policy – OD0448/13. Reporting Policy (Western Australian Review of Mortality Policy and Guidelines for Reviewing Inpatient Deaths), also available at: www.safetyandquality.health.wa.gov.au
- ▶ Serious adverse events (including deaths) that result in a medico-legal claim or have the potential to result in a medico-legal claim are to be reported to the appropriate bodies.
- ▶ Any serious incident and adverse event involving a mental health patient is reported to the Chief Psychiatrist consistent with the *Mental Health Act (MHA) 2014* and the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist
- ▶ Deaths that occur while under the care of a surgeon are reported to the WA Audit of Surgical Mortality

(iii) Professional obligations

- ▶ Deaths should be reported to the hospital or health service Mortality Review Team, Clinical Governance Committee or similar.

Audit: CIMS, Sentinel Events and Review of Death (ROD) Reporting

In addition to statutory requirements, public hospitals in WA have a policy of reporting and investigating clinical incidents using the Clinical Incident Monitoring System (CIMS).

Clinical incidents are adverse events or circumstances resulting from health care which may have or did cause harm. These are classified and reviewed to improve systems. Root cause analysis is a method often used to review serious incidents, however there are other methods.

In addition to CIMS reporting, some serious incidents are classified as sentinel events (defined as rare, preventable clinical incidents that lead to, or can lead to serious patient outcomes including death). These are to be reported to the Chief Medical Advisor, as a mandatory requirement in WA using the 'Sentinel Event Notification Form'.

All deaths in WA are reviewed as per the WA Review of Death Policy (ROD).

Sources: Clinical Incident Management Policy 2015. WA Review of Death Policy 2013
www.safetyandquality.health.wa.gov.au

Investigation Including Pathology and Autopsy

The majority of tests listed for investigation of stillbirth are applicable to the investigation of neonatal deaths. Consultation with senior staff at KEMH or s recommended for additional guidance, e.g. for consideration of metabolic studies. The perinatal pathology staff are available to advise on autopsy and post-mortem issues.

Thorough investigation into the cause of death is recommended. Review the history including past medical and obstetric history, family history (e.g. genetic disorders, thrombophilia, diabetes, history of stillbirth), possible infections and substance use. Enquire as to when movements were last felt, when pain or bleeding started, and any symptoms of infection. The investigation should take into consideration the clinical picture but even where the cause of death appears obvious, a broader approach to investigation can identify additional information which may affect the management of future pregnancies. For example, a mother with a preterm birth should have investigations into suspected infection and assessment of uterine morphology.

There are several protocols for pathology investigations. The Perinatal Society of Australia and New Zealand (PSANZ) have produced guidelines which aim to standardise national practices (see Table 4). WNHS suggest the general adoption of these guidelines with investigations targeted and individualised. It is recommended to perform toxicology screening (drug and alcohol urine screen) as a routine in the investigation of unexplained stillbirth, and to perform thrombophilia tests selectively rather than on all patients.

Optimal investigation of perinatal death includes autopsy and Placental histopathology.

Fetal Karyotype testing should be considered. This may involve: diagnostic amniocentesis (where possible) for the assessment of fetal death close to term, and karyotype of tissue taken at the time of autopsy. Additional micro-array testing may be valuable depending on the circumstances e.g. term fetal death, suspected congenital anomaly

Autopsy should be encouraged, with compassionate explanation and reassurance that contact with the baby is available following autopsy. Parents should also be given information about the options for types of autopsy. Refer to the Postmortem Pamphlet and the Perinatal Pathology Handbook for additional information about arranging autopsy examination. Where parents decline full autopsy, external autopsy by a paediatric pathologist can provide useful clinical information. Some cultures, such as those with Islamic faith, do not permit full autopsy but may consent to external autopsy. Other options for assessment of the baby include a full body x-ray and Magnetic Resonance Imaging (MRI), targeted, e.g. of the baby's brain. The Pathologist may be able to speak with the family to achieve some compromise between their beliefs and the investigations available.

Communication between parents and Perinatal Pathology should be facilitated, to visit the baby post discharge, enable transfer of baby, funeral arrangements, memorial attendance, and return of ashes.

Staff are reminded of the importance of communicating clearly to the patient and providing written copies of information. Check that systems are in place for ensuring feedback of autopsy and pathology results, to parents and to relevant staff members. It is valuable for staff members to receive information about perinatal death reviews where possible. This may be facilitated by naming relevant staff members on the autopsy request form.

Nominating a dedicated midwife to manage the perinatal loss portfolio at a hospital may assist in streamlining processes

Causes of Stillbirth and Neonatal Death

The leading categories of stillbirth in WA are congenital abnormalities, ‘unexplained’ and prematurity due to spontaneous preterm delivery. The leading causes of neonatal death are prematurity, congenital abnormalities and perinatal infection.

Where stillbirths are not thoroughly investigated, a higher proportion of deaths remain unexplained. WA has one of the highest perinatal autopsy rates in Australia (around 60%), and this is reflected in a lower proportion of unexplained stillbirths.

There are considerable differences between causes of perinatal death in developed and developing countries. Table 3 shows a table produced by the Federation of International Gynaecology and Obstetrics (FIGO) for commonly reported maternal risk factors and causes for stillbirth in developing and developed countries. The Lancet Stillbirth Series (2011, www.thelancet.com/series/stillbirth) is a valuable reference and provides a range of papers and commentaries related to stillbirth

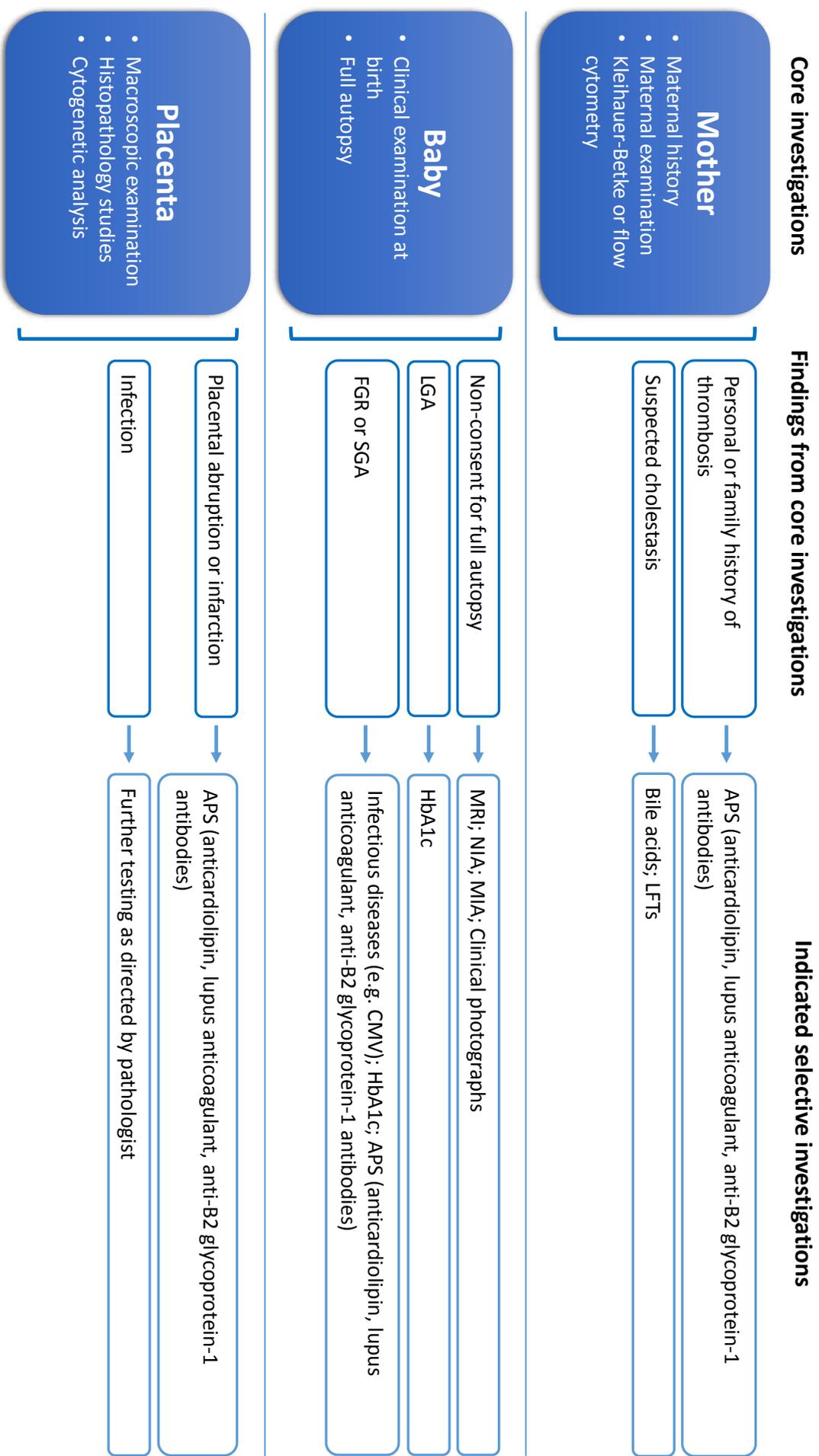
Table 3: Causes of Stillbirth in Developing and Developed Countries

Developing countries	Developed countries
<ul style="list-style-type: none"> ▶ Obstructed/prolonged labour and associated asphyxia ▶ Infection and birth injury (low availability of caesarean section) ▶ Congenitally acquired infections especially: <ul style="list-style-type: none"> ▶ Syphilis and Gram negative infections ▶ Hypertensive disease—especially poor management of preeclampsia/eclampsia ▶ Poor nutritional status ▶ Previous stillbirth ▶ Congenital anomalies <ul style="list-style-type: none"> ▶ Malaria ▶ Sickle cell disease 	<p>Congenital/karyotypic anomalies</p> <ul style="list-style-type: none"> ▶ Growth restriction/placental thrombosis <p>Medical diseases such as:</p> <ul style="list-style-type: none"> ▶ Diabetes ▶ Hypertensive disease/preeclampsia ▶ Systemic lupus erythromatosus ▶ Renal disease ▶ Thrombophilias ▶ Cholestasis of pregnancy <p>Congenitally acquired infections such as:</p> <ul style="list-style-type: none"> ▶ Group B Streptococcus and Parvovirus B19 ▶ Smoking and substance use ▶ Multiple gestation

Ref: McClure EM, Nalubama-Phiri M, Goldenberg RL. Stillbirth in Developing Countries. Intl Gynaecol Obstet 2006;94(2)82-90,

APPENDIX A

STILLBIRTH INVESTIGATION FLOWCHART



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

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Staff support

Caring for families experiencing a perinatal loss can have a considerable impact on staff. A range of emotions are reported similar to that of patients. Informal debriefing sessions and peer support are often helpful.

WA Health staff may access professional counselling services provided through the Employee Assistance Program.

Table 4: Staff Support Options

- ▶ Informal debriefing and peer support
- ▶ Formal debriefing
- ▶ Professional counselling for WA Health employees through 'Converge' private Employee Assistance Program: 1800 337 068
- ▶ Other professional private counselling services
- ▶ AMA Colleague of First Contact (08) 9273 3000
- ▶ Nurse and Midwife Support 1800667877

Table 5: Agencies Providing Grief Support

Specific Perinatal Loss Support:

Women and Newborn Health Service - Services provided through KEMH:

- ▶ The Perinatal Loss Service has been established to provide comprehensive, continuing and coordinated care for families who have experienced perinatal death and pregnancy loss at KEMH. This includes clinical care and counselling support. The PLS provides a statewide consultancy and educative service to support health care professionals who provide clinical care to women experiencing perinatal and pregnancy loss. Ph. (08) 6458 2222, page 3430
- ▶ The Perinatal Pathology Department at KEMH offers a statewide non-coronial perinatal post mortem examination service to families who have experienced the loss of a pregnancy. This includes generating mementos, in the form of photographs, handprints and footprints. A cremation service is available for stillborn babies of less than 28 weeks gestation. www.kemh.health.wa.gov.au/services/perinatal_path/index.htm Ph. (08) 6458 2730. The Perinatal Pathology Department manage the statewide Perinatal Transport system which arranges transfer of babies to and from places of birth and return.
- ▶ Pastoral Care services at KEMH provide pastoral support, grief counselling and religious ministrations (if requested). There are various brochures to assist parents dealing with grief and loss and options for decision making: www.kemh.health.wa.gov.au/services/pastoral_care/index.htm Ph. (08) 6458 1036
- ▶ The Social Work Department at KEMH provides support to women experiencing perinatal and pregnancy loss, in particular vulnerable families and patients who are experiencing complicated social situations. www.kemh.health.wa.gov.au/brochures/consumers/wnhs0259.pdf Ph. (08)6458 2777

- ▶ The Department of Psychological Medicine at KEMH provides treatment for pregnant women attending KEMH who have a psychiatric disorder in pregnancy or postnatal depression Ph. (08) 9458 1521, whilst the new Mother and Baby Unit functions as a statewide inpatient treatment centre for acute perinatal psychiatric conditions. Ph. (08) 6458 1799; Freecall: 1800 422 588 www.kemh.health.wa.gov.au/health_professionals/WA_perinatal_mental_health_unit/

WA Health publications and on-line information resources:

- ▶ Health Information Resource Service (HIRS) is situated at KEMH and provides listings of publications and videos on perinatal health and other women's and children's health topics. These can also be obtained on-line: www.kemh.health.wa.gov.au/services/hirs/index.htm or by emailing kemh_hirs@health.wa.gov.au
- ▶ The Women and Newborn Health Library has compiled a list of Community Support and Resources for Perinatal Emotional Health and Wellbeing: www.kemh.health.wa.gov.au/brochures/consumers/wnhs0282.pdf
- ▶ Other information for expectant parents about emotional wellbeing is available from the KEMH website (and may be appropriate in planning another pregnancy): www.kemh.health.wa.gov.au/health/emotional_health/help_support.htm

Red Nose:

- ▶ 24-hour-a-day bereavement support to families who suffer the sudden and unexpected death of a baby or child, regardless of cause including specialised family support groups. Contact details: 1300 308 307 www.rednosegriefandloss.com.au

SANDS:

- ▶ SANDS provides support, information and education to anyone affected by the death of a baby before, during or shortly after birth. Contact details: 1300 072 637 www.sands.org.au/

Women and New Born Health Service

King Edward Memorial Hospital
374 Bagot Road Subiaco WA 6008

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