MATERNITY & NEONATAL

Queensland Maternity and Neonatal **Clinical Guideline**

Stillbirth care

Queensland Government

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These guidelines have been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach.

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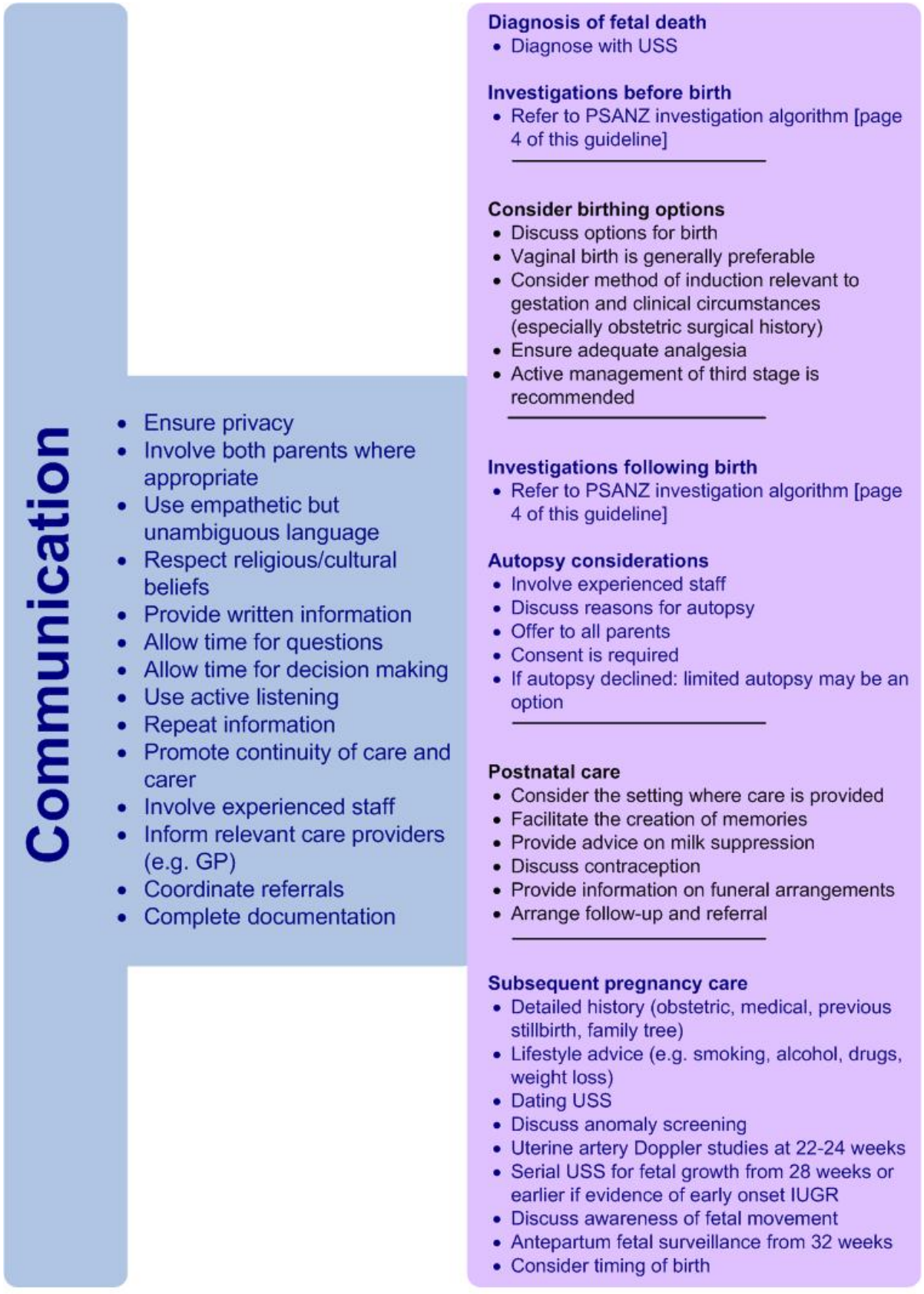
Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible to:

- Discuss care with consumers in an environment that is culturally appropriate and which enables respectful, confidential discussion. This includes the use of interpreter services where necessary
- Advise consumers of their choice and ensure informed consent is obtained
- Provide care within scope of practice, meet all legislative requirements and maintain standards of professional conduct
- Apply standard precautions and additional precautions as necessary, when delivering care
- Document all care in accordance with mandatory and local requirements

Flow Chart: Summary stillbirth care



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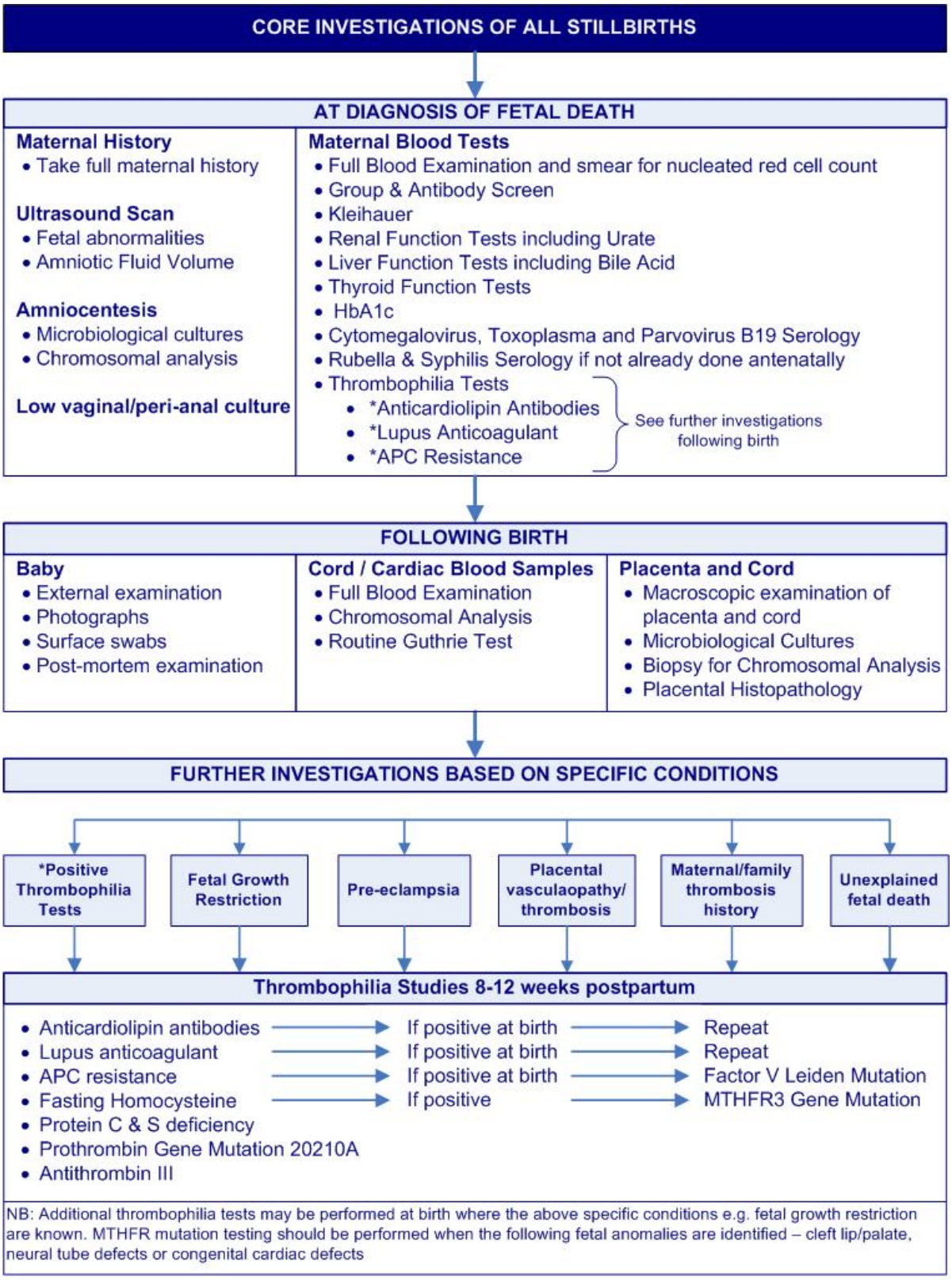
Flow Chart: PSANZ Stillbirth investigation algorithm



Source: Perinatal Society of Australia and New Zealand Perinatal Mortality Audit Guideline: Second edition, Version 2.2 April 2008 Section 5: Investigation of stillbirth: Appendix 1

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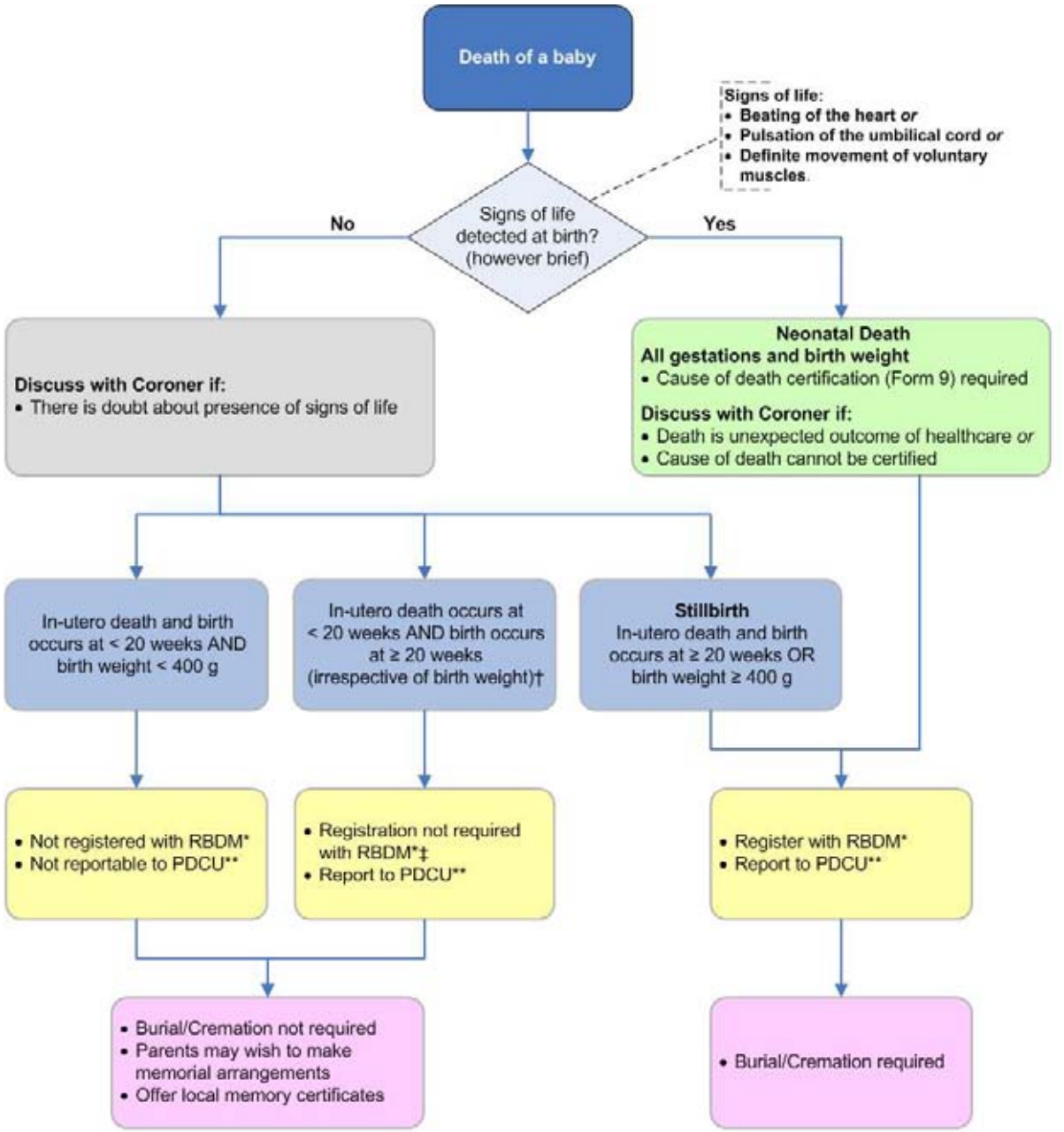
Flowchart: Perinatal death reporting



Legend
† Clinical judgement needs to be applied where it is not known whether intrauterine fetal death occurred before or after 20 weeks gestation. Delivery of acardiac twin or of a fetus papyraceous when the timing of intra-uterine demise is uncertain and extraction of a dead fetus at maternal autopsy, are situations undefined in the legislation; in the absence of a clear legal path it is optional to notify RBDM but it is a requirement to report to PDCU.
* RBDM = Registrar of Births, Deaths and Marriages. Notification is by parents using Death Registration Application (Form 8) and requires certification by a Funeral Director that a Cause of Death Certificate (Form 9) has been issued or a Coronial Autopsy has been performed
‡ Although registration with RBDM is not required, parents may choose to register the birth. Refer to Section 3.1
** PDCU = Perinatal Data Collection Unit, Queensland Health. Notification is by maternity staff using Perinatal Data Collection Form (MR63D)

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Abbreviations

APC resistance	Activated protein C resistance
ARM	Artificial rupture of membranes
CT Scan	Computed tomography scan
hCG	Human chorionic gonadotropin
IUFD	Intrauterine fetal death
IUGR	Intrauterine growth restriction
MRI	Magnetic resonance imaging
MTHFR	Methylenetetrahydrofolate reductase
MSAFP	Maternal serum alpha-fetoprotein screening
PAPP-A	Pregnancy associated plasma protein A
PDCU	Perinatal Data Collection Unit
PSANZ	Perinatal Society of Australia and New Zealand
PSANZ -PDC	Perinatal Society of Australia and New Zealand - Perinatal Death Classification
PV	Per vaginam
RBDM	Registrar of Births Deaths and Marriages

Definitions

Stillbirth	Death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birth weight. The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles.[1]
Live birth	Refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.[2]
Neonatal death	Death before the age of 28 completed days following live birth.[1]
Post-mortem examination	Examination after death. It may or may not include an autopsy.

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1 Introduction

Stillbirth is one of the most common adverse pregnancy outcomes.[3] In 2006 the rate of stillbirth in Australia was 7.4/1000 births.[4] The loss of a child and family member is a devastating experience for families and caregivers[5,6] who may continue to experience grief and loss for many years after the event. Investigation to determine the cause of death and identify contributing factors is important to assist with parental counselling[7] and to inform future prevention strategies.

This guideline is congruent with the Perinatal Society of Australia and New Zealand (PSANZ) Clinical Practice Guideline for Perinatal Mortality (PSANZ Clinical Guideline)[1] and clinicians are encouraged to refer to the relevant related sections.

1.1 Causes

The cause of stillbirth is often difficult to determine.[3,8,9] Many cases are unexplained[7,10,11], more than one condition may contribute to the stillbirth and conditions may be associated without directly causing the stillbirth.[6,10] The proportion of stillbirths that are reported as "explained" increases when there is a systematic comprehensive approach to investigation. [6]

2 Clinical standards

- A formal mechanism to review all perinatal deaths is recommended for each institution where births occur (e.g. Perinatal Mortality Review Committee)[1]
- A formal mechanism of providing feedback to clinicians (including reporting on standard of perinatal mortality investigation, documentation and communication) is recommended so that individual and hospital practices can be improved
- Consider local requirements for incident reporting where stillbirth is not anticipated at birth (e.g. PRIME CI - Queensland Health incident reporting system)
- Facilities where births occur should consider the requirement for:
    - Education of staff in stillbirth procedures and investigations
    - Training in bereavement counselling for staff involved in the care of women experiencing stillbirth
    - Access to staff skilled in open disclosure processes
    - Debriefing support services for staff involved in the care of women experiencing stillbirth (e.g. Employee Assistance Scheme)
    - Access to culturally appropriate support services for women and their families
    - Local procedures for the respectful and sensitive transfer of a stillborn baby between and within maternity services and the mortuary
    - Local procedures that support parents to take a stillborn baby home if desired
    - Local procedures to facilitate post mortem examinations if required

2.1 Legal identity

- For the purposes of reporting a birth to the Perinatal Data Collection, the Public Health Act 2005[12] defines a baby as:
    - Born alive as a "baby whose heart has beaten after delivery of the baby is completed." There is no gestational requirement specified.
    - Not born alive [i.e. stillborn] as a "baby who has shown no sign of respiration or heartbeat or other sign of life, after completely leaving the child's mother and
        - Who has been gestated for 20 weeks or more or
        - Weighs 400 grams or more"
- For the purposes of birth registration of a child, the Births, Deaths and Marriages Registration Act 2003 states that "a child includes a stillborn child". It is compulsory to register the birth of a child whether born alive or stillborn.[13] A stillborn child is defined in this legislation as a child who:
    - Has shown no sign of respiration or heartbeat or other sign of life after completely leaving the child's mother; and
    - Who has been gestated for 20 weeks or more; or weighs 400 g or more
- It is a clinical decision as to whether there are signs of life or not
- Refer to Flowchart: Perinatal death reporting and Appendix A and B for reporting aids

2.2 Documentation

- Complete the following documentation :
  - Cause of Death Certificate (Form 9)
  - Perinatal supplement to cause of death certificate (Form 9a)
  - Birth Registration application
  - Queensland Perinatal Data Collection Form
  - Centrelink Bereavement Payment form
- Collect a standardised data set for all stillbirths[1]
- Collate a comprehensive clinical summary for all stillbirths[1,3]
- Refer to the PSANZ Clinical Guideline for data sets and forms[1]

2.3 Classification

There are several classifications for perinatal death in use world wide.[6,10,15] The Queensland Statewide Maternity and Neonatal Clinical Network and the Queensland Maternal and Perinatal Quality Council both recommend the Perinatal Society of Australia and New Zealand - Perinatal Death Classification (PSANZ-PDC) be used for classification of perinatal deaths.[1]

- Review each perinatal death as soon as results of core investigations are available
- Classification should be undertaken by clinicians with knowledge of the classification system

3 Diagnosis and birth

Intrauterine fetal death requires formal confirmation by an ultrasound examination that demonstrates a lack of fetal heart activity.

- The ultrasound should be performed by experienced staff (credentialed sonographer or obstetrician)
- A midwife escort should be made available to support the woman while attending ultrasound examination for confirmation of a suspected fetal death
- Consider the requirement for social worker support
- Promote continuity of carer for women experiencing a stillbirth

3.1 Breaking the news

- Break bad news in a private, quiet room
- Ensure a support person is present for the woman
- Use empathetic but unambiguous language (e.g. “your baby has died”)
- The most experienced practitioners are required for these difficult conversations[16]
- Do not delay breaking the news once diagnosis is confirmed
- Allow time for parents to ask questions
  - This may include discussion of the option to register the birth if the baby dies before 20 weeks gestation and the birth occurs after 20 weeks gestation
- Allow as much time as needed for parents to consider care options and make decisions
- Be aware that men and women may respond and grieve differently
- Staff are encouraged to express their sorrow for what has happened. Offering sympathy is not an admission of guilt or error[16]
- Reassure parents that every attempt will be made to find a cause of death in a medical review[16]
- Explain that stillbirths often remain unexplained even after a detailed review
- Avoid speculation regarding the cause of death until investigations are complete
- When appropriate, reassure the mother that the death was not due to anything she did or did not do[16]
- Consider special circumstances (e.g. previous stillbirth or multiple pregnancy)
- Offer referral for counselling/support services (e.g. social worker)

3.2 Birth

- Provide information on birth options appropriate to the clinical circumstances and service capabilities
- Vaginal birth is generally preferable to caesarean section with minimisation of maternal risk being the most important factor
- 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
- Adequate analgesia is particularly important when requested by women with perinatal loss
- Active management of the third stage is recommended
- Provide information to women and their families on how the baby may appear following birth. Parent's fears are often worse than the reality: be honest and use sensitive but unambiguous language
- Support requests to normalise the birth experience (e.g. cutting the umbilical cord)
- Handle the baby with care in case of skin slippage
- Offer family members private waiting areas (i.e. separate from other birthing families)

3.2.1 Induction of labour

Induction of labour is often required following fetal death. There is little high level evidence regarding optimal Misoprostol regimens. Suggested methods of induction of labour are outlined in Table 1.

Table 1. Suggested methods for induction of labour following spontaneous fetal death

Gestation		
	20-28 weeks or equivalent uterine size	Greater than 28 weeks
Preinduction		Dinoprostone or Transcervical catheters (e.g. Foley's or Atad catheter)
Induction-no previous uterine surgery	Misoprostol 400 mcg PV 6 hourly x 8 doses	Oxytocin infusion Consider ARM after labour established
Induction- previous uterine surgery	Misoprostol 200 mcg PV 6 hourly x 8 doses	Transcervical catheters (May be followed by Oxytocin infusion and/or ARM at the discretion of the obstetrician)

3.3 Parental support

General considerations for parental support following stillbirth[1] are outlined in Table 2.

Table 2. Parental support considerations

Consideration	Recommendation[1]
Respect	• Treat the deceased baby with the same respect as a live baby (e.g. handle baby with care, use name if one was given[3]) • Support parents to feel in control of the care of their baby • Respect the wishes/preferences of parents when offering care • Respect cultural and religious beliefs/practices/rituals
Information provision	• Allow time for discussion • Communicate empathetically, clearly and honestly • Listen reflectively to the parents • Where feasible, ensure both parents are present at discussions • Repeat important information as stress and grief may interfere with comprehension and recall of information • Provide written information for frequent reference • Use parent friendly language (e.g. avoid terms such as fetus, products of conception[3]) • Deliver information in a quiet private room away from other patients • Consider the timing of information provision (e.g. future pregnancy information may be more appropriate after birth rather than before)
Care setting	• Offer the option of private room in surgical, maternity or gynaecological units as feasible (i.e. away from other babies) • Offer accommodation to the woman's support person as feasible • Consider universal symbols outside room and on the health record to alert all staff to a stillbirth
Memory creation	• Offer time with baby – inform parents they may hold, undress, bath baby if desired o Complete all swabs and tests on baby before bathing • Offer options to include extended family (e.g. photographs of family groups, relatives/siblings to hold baby, video conferencing if available) • Offer option to take baby home if feasible [refer to section 3.4] • Facilitate religious/cultural rituals and services • Facilitate memento creation/gathering following parental consent (e.g. identification tags, hand and footprints, digital photographs, cot cards, hair collection) • Where immediate memento creation is declined – offer storage of mementos for future access. Mementos can be stored in a sealed envelope in the woman's health record until/if parents request them
After care	• Advise on lactation suppression and methods to manage supply • Advise on contraception • Advise on postnatal exercises • Provide written information on available support services for parents and children[3] [refer to Appendix C: Support Contacts] • Inform parents of expectations of grief journey • Discuss options for early discharge with extended midwifery service home care where feasible • Provide information on Centrelink Family Allowance Forms – Claim for Bereavement Payment of Family Tax Benefit, Maternity Allowance
Referral/Follow up	• Consider the requirement for referral to relevant health care professionals and support groups prior to discharge – particularly for counselling /psychological support services (e.g. genetic counsellor, social worker, Child Health Services, pastoral care worker[9]) [refer to Appendix C: Support group contact details] • Arrange follow up appointment(s) for the purposes of recurrence risk counselling[17] and discussion of investigation results – first appointment within 2 months • Communicate a stillbirth event to the woman's General Practitioner, Paediatrician and other relevant care providers • Forward a comprehensive summary to these care providers

3.4 Taking baby home

Some parents may wish to take their baby home for periods of time. Local birthing facilities may wish to consider and discuss with parents:

- The requirement for a letter confirming the baby was stillborn (in case of official query e.g. during transport)
- Embalming of the body
- The effect of local climate on the body (i.e. temperature and humidity)
- Completion of release forms
- Providing the death certificate if return to hospital is not anticipated
- Legal requirements regarding birth registration, burial/cremation
- Arrangements for return to hospital or funeral home

3.5 Funeral arrangements

It is a requirement to arrange a burial or cremation for a stillborn baby [refer to definition of stillbirth on page 5]

- Provide information regarding options for funeral arrangements (e.g. local funeral directors, access to the baby in the funeral home)
- Where a burial/cremation is not required (in-utero fetal death less than 20 weeks) and is not otherwise desired by the parents, offer information (if appropriate to the circumstances) on what will happen to the baby's body
    - Provide information on opportunities to mourn the baby (e.g. hospital memorial services, remembrance services)

4 Investigations

There is limited high level evidence regarding the clinical investigations that should be performed following a stillbirth.[6,7] Refer to the PSANZ Clinical Guideline for data sets, forms and work instructions.[1]

Core investigations are recommended for all stillbirths at diagnosis of fetal death and following birth.[1] Further investigations for thrombophilia may be undertaken as specified at section 4.3[1] [refer to Flowchart on page 4].

4.1 At diagnosis of fetal death

The following core investigations are recommended for all women at the time of diagnosis of intrauterine fetal death[1]:

- Comprehensive maternal and family history[3,7,9,18] (including Body Mass Index)
- Ultrasound scan to detect possible fetal abnormalities and to assess amniotic fluid volume
- Amniocentesis (where available) for cytogenetic and infection investigation[3,17,18]
- Low vaginal and peri-anal swab to culture for anaerobic and aerobic organisms
- Maternal blood tests:
    - Full Blood Examination[3,9]
    - Serology for Cytomegalovirus, Toxoplasma, Parvovirus B19[3,9,18]
    - Rubella and Syphilis[3] if not already undertaken in this pregnancy
    - Blood group and antibody screen if not already undertaken in this pregnancy[9,18]
    - Kleihauer-Betke test[3,9,17,18]
    - Renal function tests including uric acid
    - Liver function tests including bile acid (fasting blood)
    - Thyroid function tests[3]
    - HbA1c (consider random glucose as well[19])
    - Anticardiolipin antibodies[3]
    - Lupus anticoagulant[3]
    - Activated protein C (APC) resistance[3]

4.2 Following birth

The following core investigations are recommended for all stillbirths following birth[1]:

- External examination of the baby[3] (by a perinatal pathologist, neonatologist or paediatrician where possible) using standard documentation
- When assessing gestational age, consider appearance, birth weight and early pregnancy ultrasound (USS)
- Clinical photographs[3,9]
- Surface swabs (ear and throat) for microbiological cultures
- Autopsy[3]
- Blood samples from the cord or cardiac puncture (where clinically feasible) for:
    - Investigation of infection
    - Chromosomal analysis[9]
    - Routine Neonatal Screening Test*
- Placental examination[3,7,9,17]
- Detailed macroscopic examination of the placenta and cord[9]
- Placental microbiological cultures**[9]
    - Placental and amnion biopsy for chromosomal analysis
    - Placental histopathology[18]

*Send a Neonatal Screening Test to the laboratory with information that the baby is deceased whether or not blood samples are able to be collected. This avoids requests for repeat tests if samples are inadequate.
**Individual pathologists may not consider microbiology on the placenta useful

4.3 Further investigations

Undertake further maternal investigations for thrombophilia 8-12 weeks after birth where[1]:

- A fetal death is associated with:
    - Fetal growth restriction
    - Preeclampsia
    - Placental vasculopathy/thrombosis
    - Maternal thrombosis and or
    - Maternal family history of thrombosis
- The stillbirth remains unexplained following core investigations[11]
- Tests for thrombophilia were positive at the time of the intrauterine fetal death or initial testing or were not previously undertaken

Consider follow up for diabetes if earlier tests suggest this as a possibility (e.g. mild impairment of fasting glucose[19])

4.3.1 Thrombophilia studies

- If positive at birth repeat:
    - Anticardiolipin antibodies[18]
    - Lupus anticoagulant[18]
- If APC resistance positive at birth then test for Factor V Leiden mutation[3,9,18]
- If Fasting Homocystine positive then test for MTHFR gene mutation[3]
- Protein C and S deficiency[3,9,18]
- Prothrombin gene mutation 20210A[3]

5 Autopsy

An autopsy should be offered to all parents following a stillbirth[1,7,9,18] and is the single most useful diagnostic test.[6] It is preferable that the autopsy is performed by a perinatal/paediatric pathologist.[6]

5.1 Purpose of autopsy

The main purposes of an autopsy are[1]:

- Identification of an accurate cause of death
- Confirmation of antenatally diagnosed or suspected fetal pathology
- To exclude of some causes of death
- Identification of disorders with implications for counselling and monitoring for future pregnancies[7]
- Enhancement of parents understanding of the events surrounding the death which may:
    - Alleviate anxiety in a future pregnancy if a non-recurring cause is found[7]
    - Assuage guilt in mothers if an uncontrollable cause is determined[7]
    - Provide benefits to the extended family and opportunities for prenatal testing if a familial cause is evident[7]
- To inform clinical audit of perinatal death[7]
- For medico-legal reasons
- For research purposes (e.g. expansion of the body of knowledge)

5.2 Consent for autopsy

- All autopsy examinations require written consent following informed discussion
- A standard approved consent form is recommended
- Clearly document the extent of the consent

5.2.1 Communications with parents

- The clinician discussing autopsy will ideally have[1]:
    - An established rapport with the parents
    - Detailed knowledge of autopsy procedures
    - Good communication skills
    - Significant clinical experience
- Consider cultural or religious beliefs relating to autopsy[3]
- Provide written information about autopsy
- Discuss with the parents:
    - The value of an autopsy[3]
    - Options for full, limited or stepwise autopsy[3]
    - Issues related to retained fetal tissues
    - The possibility that a cause may not be found
    - Requirement for and cost (if any) related to transfer of the baby to another facility
    - Cost (if any) to the parents of the autopsy
    - Appearance of the baby following autopsy
    - The likely timeframe for results to become available
    - Arrangements for communicating results (e.g. appointment following results availability)

5.3 Preparation for autopsy

The following should accompany the baby for autopsy:

- Autopsy consent form
- Placenta (fresh not in formalin)
- Comprehensive clinical/obstetric history including relevant previous obstetric history[6]
- Copies of :
    - The death certificate
    - All antenatal ultrasound reports
    - Prenatal karyotyping results if available

5.3.1 Investigations when autopsy declined

A limited autopsy examination may yield useful information in situations where the parents decline full autopsy.[3,6] Where parents decline a full autopsy[1]:

- Confirm that parents understand important information may be missed
- Offer parents options for:
    - External examination by a perinatal/paediatric pathologist, clinical geneticist or paediatrician[9,18]
    - Full body X-ray (babygram)[17]
    - Ultrasound scan
    - Magnetic resonance imaging (MRI) where available[6,7] (Computerised Tomography (CT) scan may be useful if MRI not available)
    - Clinical photographs
- Ensure request forms for pathology, histology or external examination clearly indicate the extent of consent

6 Subsequent pregnancy care

There is little evidence to inform recommendations for the management of subsequent pregnancy after stillbirth.[5] Individualise care and consider the woman's unique circumstances.[17] Suggested considerations for care are outlined in Table 3.

6.1 Recurrence counselling

The risk of recurrent unexplained stillbirth is increased depending on maternal race and characteristics of the prior stillbirth, including aetiology, gestational age and the presence of fetal growth restriction.[5] In addition, a history of stillbirth increases the risk of a range of adverse pregnancy outcomes in subsequent pregnancy.[5]

- In low risk women with unexplained stillbirth, the risk of recurrent stillbirth after 20 weeks is estimated at 7.8-10.5/1000[3]
- The risk of recurrent stillbirth after 37 weeks is very low at 1.8/1000[3]
- Women with history of live birth complicated by preterm fetal growth restriction have a stillbirth rate of 21.8/1000 in a subsequent pregnancy[3]
- Rates of recurrent fetal loss are higher in women with medical complications such as diabetes, hypertension, antiphospholipid syndrome or recurrent obstetric problems with significant recurrence risk, such as placental abruption[3]

6.2 Subsequent pregnancy care considerations

Table 3* outlines considerations for subsequent pregnancy care after stillbirth. Consider the requirement for pre-test counselling of potential outcomes.

Table 3. Subsequent pregnancy care

Timing	Good Practice Point
Preconception or initial visit	• Detailed medical and obstetric history • Advise early booking in for hospital based care • Recommend specialist obstetric involvement in care • Discuss increased risk of other obstetric complications • Evaluation and workup of previous stillbirth • Determination of recurrence risk as 20% of stillborn babies are small for gestational age[20,21] • Advise smoking cessation • Discuss alcohol and drug use • Advise weight loss in obese women (preconception only) • Advise on Folate supplements • Genetic counselling if family genetic condition exists • Test for diabetes • Thrombophilia workup if indicated • Support and reassurance (e.g. early social worker involvement)
First trimester	• Dating ultrasound • First trimester screen: PAPP-A, hCG and nuchal translucency • Diabetes screen • Antiphospholipid antibodies including Thrombophilia workup depending on previous pregnancy circumstances • Facilitate continuity of carer (medical and midwifery) • Support and reassurance
Second trimester	• Fetal anatomic survey at 18–20 weeks o Consider the requirement for Maternal Fetal Medicine referral • If first trimester screen not available or not done, second trimester screen: MSAFP, hCG, estriol, and inhibin-A • Uterine artery Doppler studies at 22–24 weeks • Support and reassurance
Third trimester	• Serial ultrasound to rule out fetal growth restriction, starting at 28 weeks or earlier if history of early onset Intrauterine growth restriction (IUGR) or chromosomal conditions in parents/fetus • Discuss fetal movement awareness • Antepartum fetal surveillance starting at 32 weeks or 1–2 weeks earlier prior to gestational age of previous stillbirth as clinically appropriate. • Support and reassurance
Birth	• Consider elective induction of labour at 39 weeks (or before 39 weeks if clinically appropriate)

*Adapted from: Reddy UM. Prediction and prevention of recurrent stillbirth. Obstetrics & Gynecology. 2007; 110(5):1151-64.

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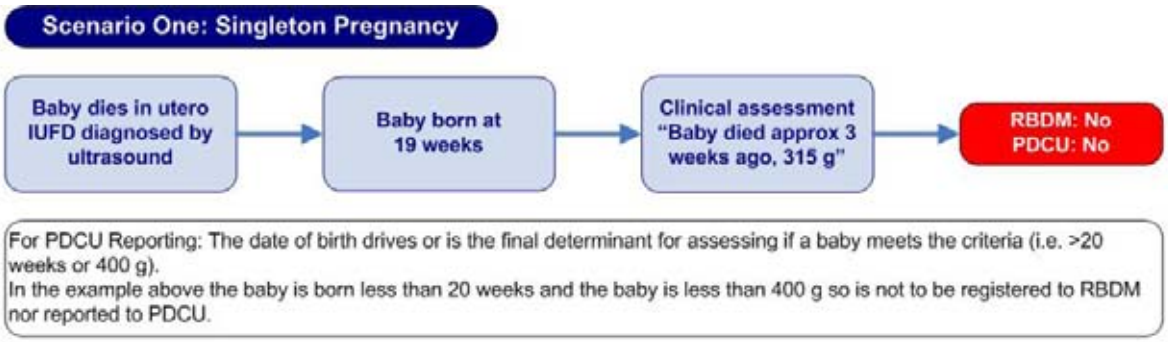
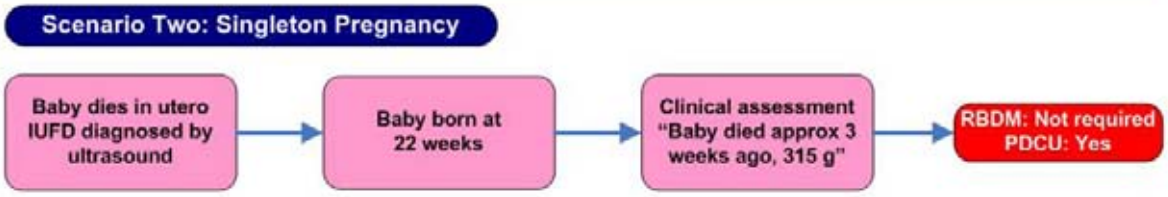
Appendix A: Scenario based reporting aid



For PDCU Reporting: The date of birth drives or is the final determinant for assessing if a baby meets the criteria (i.e. >20 weeks or 400 g).
In the example above the baby is born less than 20 weeks and the baby is less than 400 g so is not to be registered to RBDM nor reported to PDCU.

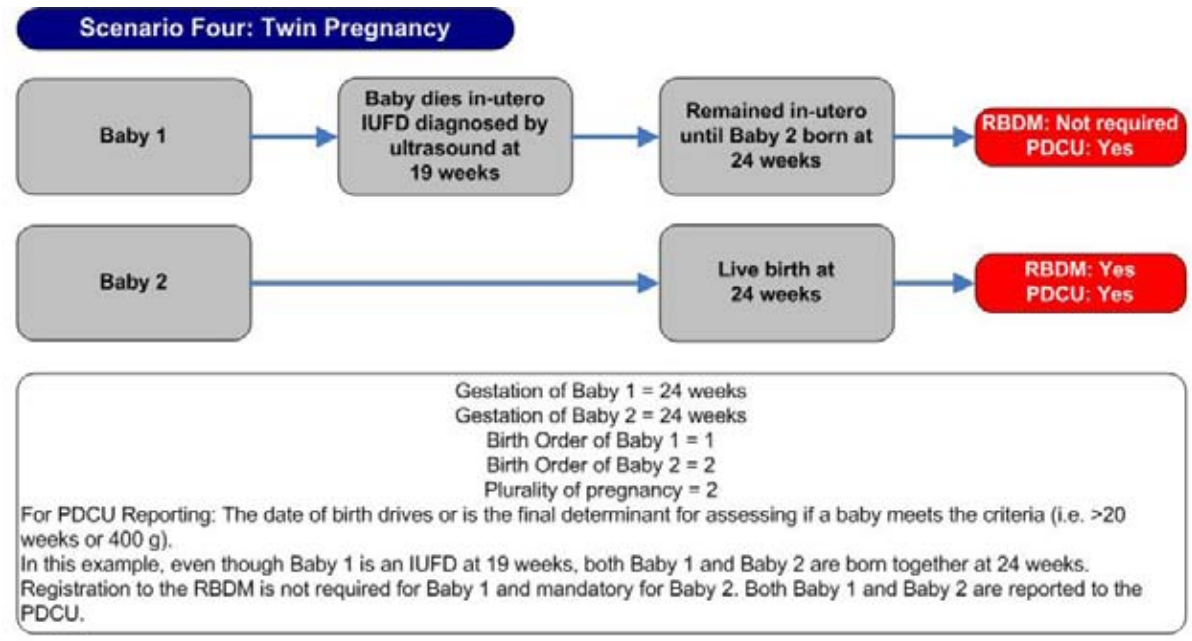


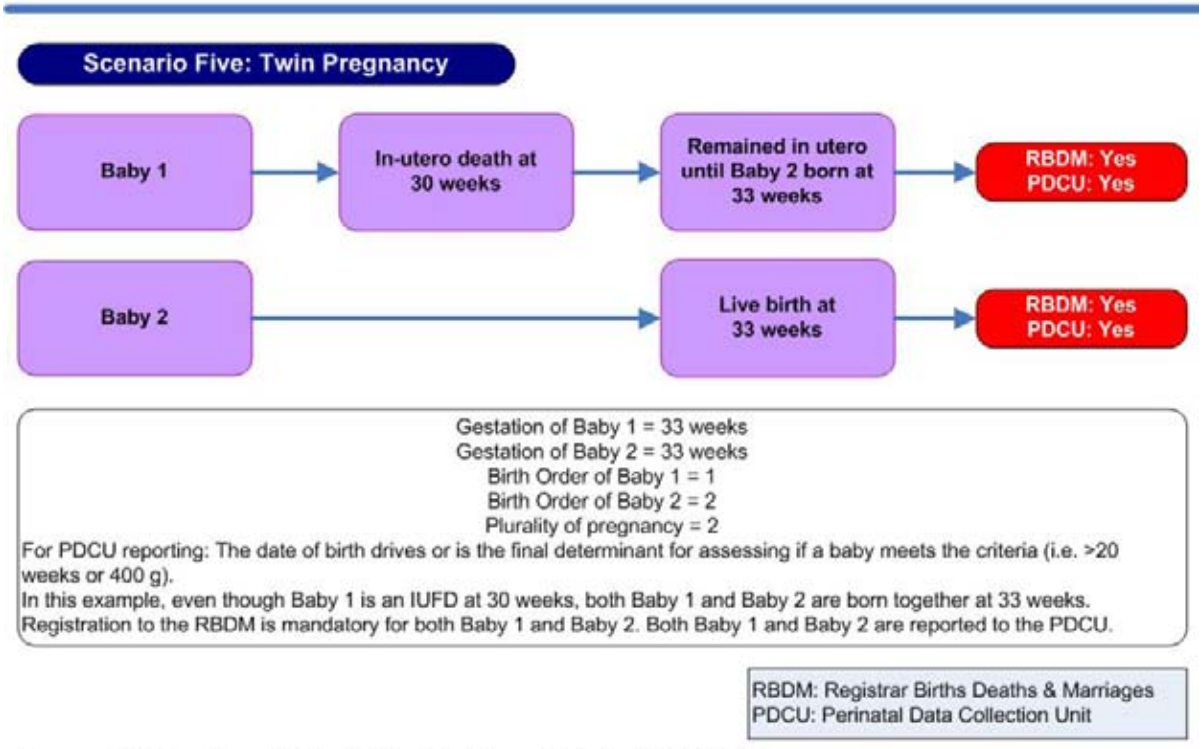
For PDCU Reporting: The date of birth drives or is the final determinant for assessing if a baby meets the criteria (i.e. >20 weeks or 400 g).
In this example the baby died at approx 19 weeks but is born at 22 weeks. The birth registration is not required with the RBDM but must be reported to PDCU.

This a singleton pregnancy
Birth Order of Baby 2 = 1
Plurality of pregnancy =1
For PDCU Reporting: The date of birth drives or is the final determinant for assessing if a baby meets the criteria (i.e. >20 weeks or 400 g).
In this example Baby 1 is born at 19 weeks with Baby 2 remaining in-utero to be born at 24 weeks. In this case Baby 1 is a miscarriage and Baby 2 then becomes a singleton birth of one baby. Baby 1 is not to be registered to RBDM nor reported to PDCU. Baby 2 is to be registered as a singleton as well as reported to PDCU as a singleton.

RBDM: Registrar Births Deaths & Marriages
PDCU: Perinatal Data Collection Unit

Queensland Maternity and Neonatal Clinical Guideline. Stillbirth care. Guideline No MN11.24-V4-R16





Queensland Maternity and Neonatal Clinical Guideline. Stillbirth care. Guideline No MN11.24-V4-R16

Appendix B: Reporting aid

Gestation at birth	Weight	Definition	Register birth with Registrar of Births, Deaths and Marriages?	Death Certificate Required?	Perinatal Data Collection reporting required?
<20 weeks	< 400 g	Miscarriage or fetal death before 20 weeks	No	No	No
< 20 weeks	≥ 400 g	Stillbirth	Yes	Yes	Yes
≥ 20 weeks	≥ 400 g	Stillbirth	Yes	Yes	Yes
≥ 20 weeks	< 400 g	Stillbirth	Yes	Yes	Yes
≥ 20weeks and proven fetal death in-utero at < 20 weeks (proven by ultrasound)	Any weight	Fetal death before 20 weeks	Optional*	Optional*	Yes

Notes:

- *The Registrar of Births Deaths and Marriages has endorsed the optional nature of birth registration in these circumstances
- A stillborn child is taken to have died "…when the child has left the mother's body " (i.e. time of death = time of birth of stillbirth). A child born without signs of life for whom resuscitation is attempted and is unsuccessful remains a stillbirth and time of death equals time of birth.
- A stillborn child means a child "…who has shown no sign of respiration or heartbeat or other sign of life after completely leaving the child's mother".

Appendix C: Support contacts

The following not for profit organisations offer support for families who have experienced a stillbirth.

Organisation	Contact Details
Small Miracles Foundation	Offers free grief counselling service for families that have experienced the loss of a baby through miscarriage, stillbirth, neonatal loss or prematurity and related issues such as infertility. Web: www.smallmiraclesfoundation.org.au Bereavement support phone: 1300 266643
SANDS (QLD) Inc. (Stillbirth and Neonatal Death Support)	Provides support, information, education and advocacy for parents and their families who have suffered the loss of a baby through miscarriage, stillbirth, neonatal death and other reproductive losses. Offers support via telephone and support group meetings Web: http://www.sandsqld.com/ Office Phone: (07) 3254 3422 Bereavement support : Free Call 13000 SANDS (13 000 72637)
SIDS and KIDS	Advocate for and fund research into stillbirth and other areas of sudden and unexpected child death. Extend bereavement support and counseling to families who have experienced stillbirth or the sudden and unexpected death of a child, regardless of the cause. Web: http://www.sidsandkids.org/ Bereavement support phone: 1300 308 307 (24 hour)
Heartfelt (formerly Australian Community of Child Photographers)	Professional photographers dedicated to providing photographic memories to families that have experienced stillbirths, premature and ill infants and children in the Neonatal Intensive Care Units of their local hospitals, as well as children with serious and terminal illnesses. All services are provided free of charge. Web: http://www.heartfelt.org.au/
Teddy Love Club	A support program for bereaved families who have experienced loss through miscarriage, stillbirth, genetic inducement of labour or neonatal death. Web: http://www.teddyloveclub.org.au/ Bereavement support phone 1800 824 240
Lifeline	Provide telephone crisis support to anyone needing emotional support. Web: http://www.lifeline.org.au/ Phone: 13 11 14
Queensland Health 13 Health	Provides health information, referral and teletriage services the public. Web: http://www.health.qld.gov.au/13health/ Phone: 13Health (13 43 25 84)

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