



For Office use only: PDN CODE FOR CASE 1 0

SURNAME _____

PLACE OF DEATH _____

DATE OF DELIVERY / /

Centre for Maternal and Child Enquiries
Improving the health of mothers, babies and children

PERINATAL DEATH NOTIFICATION FORM 2010

CHOOSE Type of Case (TICK)

LATE FETAL LOSS: 22-23⁺⁶ weeks' gestation.

OR

STILLBIRTH: A baby delivered without signs of life **after** 23⁺⁶ weeks of pregnancy.

If the birth occurred unattended and there was no lung aeration seen at Post Mortem (PM) and no other circumstantial evidence of life at birth, it should be assumed that the baby was stillborn.

In all cases where there is evidence that the fetus has died prior to the 24th week of pregnancy, the death **should not** be notified as a stillbirth. Where there is any doubt about the gestational age at which the fetus died, the default position would be to notify as a stillbirth.

OR

EARLY NEONATAL DEATH: Death of a live born baby occurring before 7 completed days after birth.

OR

LATE NEONATAL DEATH: Death of a live born baby occurring from the 7th day and before 28 completed days after birth.

If a baby born at <22 completed weeks is being registered as a neonatal death, please also report it to CMACE.

Brief Instructions and Guidance

1. Fill in the form using the information available in the maternity case notes and discharge summary.
2. Guidance for completing Sections 9 & 10 on Cause of Death is found on the folder enclosing this form.
3. There are no "not known" codes as all the information should be contained in the notes. ***If you do not know the answer to a question please indicate this in Section 12.***
4. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 17:45.
5. Please **DO NOT** wait for the PM details to complete and return this form.

SECTION 1. WOMAN'S DETAILS1.1 NHS number:

1.2 Surname: _____ First name: _____

1.3 Hospital number: 1.4 Usual residential address at time of delivery/birth: _____
_____1.5 Postcode: 1.6 Woman's date of birth: // or estimated age

1.7 Ethnic group:

White: British Irish Any other White background, specify _____Mixed: White & Black Caribbean White & Black African White & Asian Any other mixedAsian or Asian British: Indian Pakistani Bangladeshi Any other AsianBlack or Black British: Caribbean African Any other Black backgroundOther ethnic groups: Chinese Any other, specify _____Not stated: 1.8 Was the woman in paid employment at booking? Yes No

If yes, what is her occupation? (Transcribe exactly what is in notes) _____

1.9 Was the woman's partner in paid employment at booking? Yes No Not known

If yes, what is the partner's occupation? (Transcribe exactly what is in notes) _____

1.10 Height at booking (round up to the nearest cm): 1.11 Weight at booking (round up to the nearest kg):

If weight is unavailable, was there evidence that the woman was too heavy for hospital scales?

 Yes No1.12 Body Mass Index at booking (BMI):

1.13 Smoking status:

 Smoker Non-smokerIf non-smoker: Never Gave up prior to pregnancy Gave up in pregnancy Smoking history not known1.14 Was this woman known to abuse alcohol? Yes No1.15 Was this woman known to be a substance user? Yes No**SECTION 2. PREVIOUS PREGNANCIES**2.1 Did the woman have any previous pregnancies? If yes, complete questions 2.2-2.4 Yes No2.2 No. of completed pregnancies ≥ 24 weeks (all live & stillbirths): 2.3 No. of pregnancies <24 weeks: 2.4 Were there any previous pregnancy problems? If yes, tick all that apply below Yes No Three or more miscarriages Pre-term birth or mid trimester loss Stillbirth Neonatal death Baby with congenital anomaly Infant requiring intensive care Previous caesarean section Placenta praevia Placental abruption Pre-eclampsia (hypertension & proteinuria) Post-partum haemorrhage requiring transfusion Other, specify _____

SECTION 3. PREVIOUS MEDICAL HISTORY**3.1 Were there any pre-existing medical problems? If yes, tick all that apply below** Yes No Cardiac disease (congenital or acquired) Epilepsy Endocrine disorders e.g. hypo or hyperthyroidism Renal disease Haematological disorders e.g. sickle cell disease Psychiatric disorders Inflammatory disorders e.g. inflammatory bowel disease Drug or substance abuse Diabetes Other, specify _____**SECTION 4. THIS PREGNANCY****4.1 Final Estimated Date of Delivery (EDD):**

DD/DD/MM/YY

Use best estimate (ultrasound scan or date of last menstrual period) based on a 40 week gestation. Or the final date agreed in the notes.

4.2 Was this a multiple pregnancy at the onset of pregnancy? Yes No**4.3 Date of first booking appointment:**

DD/DD/MM/YY

 Not booked**4.4 Intended place of delivery at booking:** Undecided

Name of unit/place _____

Please specify the type of unit

 Obstetric unit Alongside midwifery unit Freestanding midwifery unit Home Other**4.5 What was the intended type of delivery care at booking?** Obstetric led care Midwifery led care**SECTION 5. DELIVERY****5.1 Onset of labour:** Spontaneous Induced Never in labour**5.2 Intended place of delivery at onset of labour:**

Name of unit/place _____

Please specify type of unit

 Obstetric unit Alongside midwifery unit Freestanding midwifery unit Home Other**5.3 What was the intended type of delivery at onset of labour?** Obstetric led care Midwifery led care Free birthing Other

Free birthing is where the woman chose to have no midwifery/obstetric involvement during labour and delivery.

5.4 Was the intended mode of delivery a planned caesarean section? Yes No**5.5 Actual place of delivery:**

Name of unit/place _____

Please specify type of unit

 Obstetric unit Alongside midwifery unit Freestanding midwifery unit Home Other**5.6 What was the type of care at delivery?** Obstetric led care Midwifery led care Unattended Free birthing Other

Free birthing is where the woman chose to have no midwifery/obstetric involvement during labour and delivery.

5.7 Date & time of delivery/birth:

Date: DD/DD/MM/YY

Time: HH:MM

5.8 What was the presentation at delivery? Vertex Breech Compound (includes transverse and shoulder presentations) Brow Face**5.9 What was the FINAL mode of delivery?** Spontaneous vaginal Ventouse Lift-out forceps Mid cavity forceps Rotational forceps Assisted breech Breech extraction Pre-labour caesarean section Caesarean section after onset of labour**CAESAREAN SECTIONS ONLY (non-Caesarean Sections go to Section 6)****5.10 What was the type of caesarean section?** Elective - At a time to suit woman or maternity team Scheduled - Needing early delivery but no maternal or fetal compromise Urgent - Maternal or fetal compromise which is not immediately life threatening Emergency - Immediate threat to life of woman or fetus

SECTION 6. ALL BABY OUTCOMES

- 6.1 Baby's surname: _____ First name: _____
- 6.2 Baby's NHS number:
- 6.3 Sex of fetus/baby: Male Female Indeterminate
- 6.4 Number of fetuses/babies this delivery: (all identifiable including papyraceous)
- 6.5 Birth order of this fetus/baby: (0=singleton)
- 6.6 If from a multiple delivery, what was the chorionicity?
 Dichorionic diamniotic Monochorionic diamniotic Monochorionic monoamniotic Trichorionic Not known
- 6.7 Birth weight (kg): .
- 6.8 Gestation at delivery: weeks + days
- 6.9 Was this a termination of pregnancy? Yes No
- 6.10 Was the death due to an intrapartum event? Yes No

INTRAPARTUM RELATED EVENTS ONLY (non-intrapartum go to section 7)

- 6.11 Was a local Hospital/Trust review of this case undertaken? Yes No
- 6.12 If no, please state why not:
- 6.13 If yes, what method was used?
 Root cause analysis Hospital/Trust review Clinical governance review
 Other, please specify _____

SECTION 7. STILLBIRTHS (if not stillbirth go to section 8)

- 7.1 At what gestation was death confirmed to have occurred? weeks + days
 If known, what date was death confirmed? / /
- 7.2 Was the baby alive at onset of care in labour?
 Yes No Never in labour Unattended Not known

SECTION 8. NEONATAL DEATHS (if not neonatal go to section 9)

- 8.1 Was spontaneous respiratory activity absent or ineffective at 5mins? Yes No
 If a baby is receiving any artificial ventilation at 5 mins assumption is absent/ineffective activity, a 0 Apgar score indicates absent activity.
- 8.2 Was the heart rate persistently <100? (i.e. heart rate never rose above 100 before death)
 Persistently <100 Rose above 100
- 8.3 Was the baby admitted to a neonatal unit? (includes SCBU and ICU) Yes No
- 8.4 Place of death: Labour ward Neonatal unit
 Name of unit/place _____
 This is where the baby actually died, e.g. 'name of unit', 'at home', 'in transit'. This includes babies who are brought to hospital, but are either declared dead on arrival or show no subsequent signs of life, despite attempted resuscitation.
- 8.5 Date & time of death: Date: / / Time: : :
- 8.6 Was the baby transferred to another unit after birth? Yes No
- 8.7 Please briefly describe the obstetric and neonatal factors contributing to and associated with the death:

SECTION 9. ASSOCIATED FACTORS & CAUSE OF DEATH - STILLBIRTH and NEONATES

9.1 Which condition, indicated in 9.2 as being present, was the MAIN condition causing or associated with the death? (NB 'non-MAIN' conditions are best described as the 'Other clinically relevant maternal or fetal conditions/factors that were associated with but not necessarily causing the death'). Please give the MAIN condition:

9.2 Please TICK ALL the maternal or fetal conditions that were present during pregnancy or were associated with the death - PLEASE REFER TO SEPARATE CAUSE OF DEATH GUIDANCE ON THE ENCLOSING FOLDER.

9.2.1 MAJOR CONGENITAL ANOMALY:

- Central nervous system Cardiovascular system Respiratory system Gastro-intestinal system
 Musculo-skeletal anomalies Multiple anomalies Chromosomal disorders Metabolic diseases
 Urinary tract Other, specify _____

9.2.2 HYPERTENSIVE DISORDERS OF PREGNANCY:

- Pregnancy induced hypertension Pre-eclampsia HELLP syndrome Eclampsia

9.2.3 ANTEPARTUM or INTRAPARTUM HAEMORRHAGE:

- Praevia Abruption Cause uncertain

9.2.4 MECHANICAL:

- Cord compression:** Prolapse cord Cord around neck Other cord entanglement or knot
Uterine rupture: Before labour During labour
Mal-presentation: Breech Face Compound
 Transverse Other, please specify _____
Shoulder dystocia:

9.2.5 MATERNAL DISORDER:

- Pre-existing hypertensive disease Diabetes Other endocrine conditions (excluding diabetes)
 Thrombophilias Obstetric cholestasis Drug misuse Uterine anomalies
 Other, please specify _____

9.2.6 INFECTION:

- Maternal infection:** Bacterial Syphilis Viral diseases
 Protozoal Other, specify _____
 Specify organism if known _____
Ascending infection: Chorioamnionitis Other, specify _____

9.2.7 SPECIFIC FETAL CONDITIONS:

- Twin-twin transfusion Feto-maternal haemorrhage Non-immune hydrops Iso-immunisation
 Other, specify _____

9.2.8 SPECIFIC PLACENTAL CONDITIONS:

- Placental infarction Massive perivillous fibrin deposition Vasa praevia Velamentous insertion
 Other, specify _____

9.2.9 INTRA-UTERINE GROWTH RESTRICTION DIAGNOSIS MADE:

What was this based on? tick all that apply

- Suspected antenatally Observed at delivery Observed at post mortem

9.2.10 ASSOCIATED OBSTETRIC FACTORS:

- Birth trauma:** Intracranial haemorrhage Birth injury to scalp Fracture, specify _____
 Other, specify _____
Intrapartum asphyxia:
Other: Polyhydramnios Oligohydramnios Premature rupture of membranes
 Spontaneous premature labour Other, specify _____

9.2.11 NO ANTECEDENT OR ASSOCIATED OBSTETRIC FACTORS: **9.2.12 UNCLASSIFIED: (Use this category as sparingly as possible)**

SECTION 10. CAUSE OF DEATH - NEONATES ONLY (Stillbirths go to Section 11)

10.1 Which condition, indicated in 10.2 as being present, was the MAIN condition causing or associated with the death? (NB 'non-MAIN' conditions are best described as the 'Other clinically relevant conditions/factors that were associated with but not necessarily causing the death'). Please give the MAIN condition:

10.2 Please TICK ALL the neonatal conditions causing and associated with the death - PLEASE REFER TO SEPARATE CAUSE OF DEATH GUIDANCE ON THE ENCLOSING FOLDER

10.2.1 MAJOR CONGENITAL ANOMALY:

- Central nervous system Cardiovascular system Respiratory system Gastro-intestinal system
 Musculo-skeletal anomalies Multiple anomalies Chromosomal disorders Metabolic disease
 Urinary tract Other, specify _____

10.2.2 PRE-VIABLE (less than 22 weeks):

10.2.3 RESPIRATORY DISORDERS:

- Severe pulmonary immaturity Surfactant deficiency lung disease Pulmonary hypoplasia Meconium aspiration syndrome
 Primary persistent pulmonary hypertension Chronic lung disease/Bronchopulmonary dysplasia (BPD)
 Other (includes pulmonary haemorrhage), specify _____

10.2.4 GASTRO-INTESTINAL DISEASE:

- Necrotising enterocolitis (NEC) Other, specify _____

10.2.5 NEUROLOGICAL DISORDER:

- Hypoxic-ischaemic encephalopathy (HIE) Intraventricular/Periventricular haemorrhage
 Other, specify _____

10.2.6 INFECTION:

- Generalised (sepsis) Pneumonia Meningitis Other, specify _____

10.2.7 INJURY/TRAUMA (postnatal):

Specify _____

10.2.8 OTHER SPECIFIC CAUSES:

- Malignancies/Tumours Specific conditions _____

10.2.9 SUDDEN UNEXPECTED DEATHS:

- Sudden Infant Death Syndrome (SIDS) Infant deaths – cause unascertained

10.2.10 UNCLASSIFIED (Use this category as sparingly as possible):

SECTION 11. POST MORTEM (Please do not wait for post mortem results before sending in this form)

11.1 Was a Post Mortem offered? Yes No

11.2 Was consent given for a Post Mortem? Yes, full Yes, limited No consent

11.2.1 If PM was limited what was consent given for?

- MRI X-Ray Other, specify _____

11.3 Was the placenta sent for histology? Yes No

11.4 Was this a Coroners' Case? Yes No

SECTION 12. ANY OTHER RELEVANT DETAILS

SECTION 13. DETAILS OF PERSON WHO COMPLETED THE FORM *(personal information is not passed to central office)*

Name: _____
Positions: _____
Addresses: _____

Tel number/email address: _____
Date of notification: / /

SECTION 14. REGIONAL OFFICE USE ONLY

Please code the causes of death that were given and the clinically derived single main cause of death
(Refer to the coding sheet)

14.1 Cause of Death: Associated Maternal & Fetal Factors and Cause of Death - STILLBIRTH & NEONATES (section 9)

14.1.1 Single Main Cause _____
14.1.2 Other Cause(s) (no more than 3): _____

14.2 Cause of Death: Associated Neonatal Factors & Cause of Death - NEONATES ONLY (section 10)

14.2.1 Single Main Cause _____
14.2.2 Other Cause(s) (no more than 3): _____

14.3 Maternal death: Yes No
14.4 Was a copy of the Post Mortem report received? Yes No
If yes, was it a limited Post Mortem? MRI scan X-Ray Other limited No
If yes, was it a Coroners' Post Mortem? Yes No
14.5 Was a copy of the placental histology report received? Yes No
14.6 Was cause of death coding completed using a Placental Histology or Post Mortem?
 Placental histology Post mortem No

