NATIONAL PERINATAL EPIDEMIOLOGY CENTRE

For NPEC Office use only:
CASE NUMBER

PLACE OF DEATH:

PERINATAL DEATH NOTIFICATION FORM
2020

CHOOSE Type of Case *(TICK)*

☐ **STILLBIRTH:** *A baby delivered without signs of life* from 24 weeks' gestation and/or with a birth weight of ≥ 500g.

*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.

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.*

* For the purpose of reporting, a 'live born' baby is defined as any baby born with evidence of life such as breathing movements, presence of a heart beat, pulsation of the cord or definite movement of voluntary muscles.

* **If a baby born at <22 completed weeks is being registered as a neonatal death, please report same to NPEC.**

The National Perinatal Epidemiology Centre is sincerely grateful for your contribution to this audit.

Guidance for completing this form, with specific reference to Sections 11, 12 and 13 on Cause of Death, is outlined in the accompanying reference manual.

The National Perinatal Epidemiology Centre also acknowledges with thanks the Centre for Maternal and Child Enquiry (CMACE) UK for permission to modify and use its Perinatal Mortality Notification Proforma for use in the Irish context.

SECTION 1. WOMANS' DETAILS

1.1. Mother's age ☐☐

1.2. Ethnic group:

☐ White - Irish ☐ Irish Traveller

☐ Any other White background ☐ Please specify country of origin_____

☐ Asian or Asian Irish ☐ Black or Black Irish

☐ Other including mixed ethnic backgrounds: Please specify _____

☐ Not recorded

1.3. Marital status: ☐ Married ☐ Never married ☐ Separated/Divorced ☐ Widowed ☐ Unknown

1.4. Living with partner / spouse? ☐ Yes ☐ No ☐ Unknown

1.5. Woman's employment status at booking?

☐ Employed or self-employed (full or part time) ☐ Unemployed (looking for work)

☐ Student ☐ Home maker ☐ Permanently sick/disabled

☐ Other_____ ☐ Unknown

1.7. Height at booking (round up to the nearest cm): ☐☐☐

1.8. 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 ☐ No

1.9. Body Mass Index at booking (BMI): ☐☐.☐

1.10.a. Did the woman smoke at booking? ☐ Yes, specify quantity smoked per day_____

☐ No ☐ Unknown

1.10.b. Did she give up smoking during pregnancy? ☐ Yes ☐ No ☐ Unknown ☐ N/A

1.11. Is there documented history of alcohol abuse?

☐ None recorded ☐ Prior to this pregnancy ☐ During this pregnancy

1.12. Is there documented history of drug abuse or attendance at a drug rehabilitation unit?

☐ None recorded ☐ Prior to this pregnancy ☐ During this pregnancy

SECTION 2. PREVIOUS PREGNANCIES

2.1. Did the woman have any previous pregnancies? *If yes, please complete questions 2.2-2.4* ☐ Yes ☐ No

2.2. No. of completed pregnancies ≥24 weeks and or with a birth weight ≥ 500g (all live and stillbirths): ☐☐

2.3. No. of pregnancies <24 weeks and with a birth weight < 500g: ☐☐

2.4. Were there any previous pregnancy problems? *If yes, please tick all that apply below* ☐ Yes ☐ No

☐ Three or more miscarriages ☐ Pre-term birth or mid trimester loss ☐ Stillbirth, *please specify number* ☐

☐ Infant requiring intensive care ☐ Baby with congenital anomaly ☐ Neonatal death, *please specify number* ☐

☐ Previous caesarean section ☐ Placenta praevia ☐ Placental abruption

☐ Pre-eclampsia (hypertension & proteinuria) ☐ Post-partum haemorrhage requiring transfusion

☐ Other, please specify_____ ☐ Unknown

SECTION 3. PREVIOUS MEDICAL HISTORY

3.1. Were there any pre-existing medical problems? *If yes, please tick all that apply below* ☐ Yes ☐ No ☐ Unknown

☐ 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 ☐ Hypertension

☐ Diabetes ☐ Other, please specify _____

SECTION 4. THIS PREGNANCY

4.1. Final Estimated Date of Delivery (EDD): ☐☐/☐☐/☐☐ ☐ Unknown

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. Was this pregnancy a result of infertility treatment? ☐ Yes ☐ No ☐ Unknown

If yes, please specify method of fertility treatment _____

4.4 Gestation at first booking appointment: ☐☐ weeks + ☐ days ☐ Not booked ☐ Unknown

4.5 Intended place of delivery at booking: Name of unit _____

Please specify the type of unit

☐ Obstetric Unit ☐ Alongside Midwifery Unit ☐ Home ☐ Unbooked

4.6 What was the intended type of delivery care at booking?

☐ Obstetric-Led Care ☐ Midwifery-Led Care ☐ Self-Employed Community Midwife

☐ Home c/o Hospital DOMINO Scheme

4.7a Was the care of the mother transferred from another unit with the fetus in utero? ☐ Yes ☐ No

If yes please answer question 4.7 b

4.7b Gestation at time of in-utero transfer: ☐☐ weeks + ☐ days ☐ Unknown

4.8 a Did the woman undergo an anatomy scan? ☐ Yes ☐ No

If yes please answer question 4.8 b

4.8 b Gestation at time of anatomy scan: ☐☐ weeks + ☐ days

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 _____

Please specify the type of unit

☐ Obstetric Unit ☐ Alongside Midwifery Unit ☐ Home

5.3. What was the intended type of care at onset of labour?

☐ Obstetric-Led Care ☐ Midwifery-Led Care ☐ Self-Employed Community Midwife

☐ Home c/o Hospital DOMINO Scheme

5.4. Was the intended mode of delivery a planned caesarean section? ☐ Yes ☐ No

5.5. Place of delivery: Name of unit _____

Please specify the type of unit

☐ Obstetric Unit ☐ Alongside Midwifery Unit ☐ Other, please specify_____

5.6. What was the type of care at delivery?

☐ Obstetric-Led Care ☐ Midwifery -Led Care ☐ Born Before Arrival (BBA) - Unattended

☐ Self-Employed Community Midwife ☐ Home c/o Hospital DOMINO Scheme

5.7. Date and time of delivery/birth: **Date:** ☐☐/☐☐/☐☐ **Time:** ☐☐:☐☐

5.8. What was the lie of the fetus <u>at delivery</u>*?*

☐ Longitudinal ☐ Oblique ☐ Transverse

5.9. What was the presentation *<u>at delivery</u>*?

☐ Vertex ☐ Breech ☐ Compound *(includes transverse and shoulder presentations)* ☐ Brow ☐ Face

5.10. What was the mode of delivery? (Please tick all that apply)

☐ Vaginal cephalic delivery ☐ Ventouse ☐ Forceps ☐ Assisted Breech delivery

☐ Vaginal Breech delivery ☐ Pre-Labour Caesarean Section ☐ Caesarean Section After Onset of Labour

CAESAREAN SECTIONS ONLY

5.11. What was the type of *or* indication for Caesarean Section?

☐ Elective - At a time to suit woman or maternity team ☐ Urgent - Maternal or fetal compromise which is not immediately life threatening

☐ Emergency - Immediate threat to life of woman or fetus ☐ Failed instrumental delivery

SECTION 6. ALL BABY OUTCOME

6.1. Sex of fetus/baby: ☐ Male ☐ Female ☐ Indeterminate

6.2. Number of fetuses/babies in this delivery: *(all identifiable including papyraceous)* ☐

Birth order of this fetus/baby:

☐ Singleton

☐ Twin 1 ☐ Twin 2

☐ Triplet 1 ☐ Triplet 2 ☐ Triplet 3

☐ Other multiple birth pregnancy, please specify_____ Birth Order ☐

6.3. If from a multiple delivery, what was the chorionicity? *Please tick all that apply*

☐ Dichorionic diamniotic ☐ Monochorionic diamniotic ☐ Monochorionic monoamniotic ☐ Trichorionic

☐ Singleton ☐ Not known

6.4. Birth weight (kg): ☐.☐☐☐

6.5. Gestation at delivery: ☐☐ weeks + ☐ days ☐ Unknown

6.6. Was this a termination of pregnancy? ☐ Yes ☐ No

Please refer to the reference manual

6.7. Was a local hospital review of this case undertaken? ☐ Yes ☐ No

Please refer to the reference manual

SECTION 7. MATERNAL OUTCOME

7.1. Admission to HDU: ☐ Yes ☐ No

7.2. Admission to ICU: ☐ Yes ☐ No

7.3. Maternal Death: ☐ Yes ☐ No

SECTION 8. STILLBIRTH (If not a stillbirth, please go to Section 9)

8.1. At what gestation was death confirmed to have occurred? ☐☐ weeks + ☐ days

If known, what date was death confirmed? ☐☐/☐☐/☐☐

8.2. Was the baby alive at *onset of care* in labour?

☐ Yes ☐ No ☐ Never In Labour ☐ Unattended ☐ Unknown

SECTION 9. NEONATAL DEATH ONLY

9.1. Was spontaneous respiratory activity absent or ineffective at 5 minutes? ☐ Yes ☐ No

If a baby is receiving any artificial ventilation at 5 minutes, the assumption is absent/ineffective activity: a 0 Apgar score indicates absent activity.

9.2. Was the heart rate persistently <100bpm? (i.e. heart rate never rose above 100bpm before death)

☐ Persistently <100bpm ☐ Rose above 100bpm

9.3. Was the baby offered *active resuscitation in the delivery room? ☐ Yes ☐ No

(*active resuscitation includes BMV, PPV, intubation, cardiac massage)

9.4. Was the baby admitted to a neonatal unit? (Includes SCBU and ICU) ☐ Yes ☐ No

9.5a. Was the baby transferred to another unit after birth? ☐ Yes ☐ No

If yes please answer 9.5 b

9.5 b. Date and Time of Transfer to other unit after birth: Date ☐☐/☐☐/☐☐ **Time** ☐☐:☐☐

9.6. Date and Time of Death: Date ☐☐/☐☐/☐☐ **Time** ☐☐:☐☐

9.7. Place of Death*: ☐ Labour Ward ☐ Neonatal Unit ☐ Ward ☐ Theatre ☐ In Transit ☐ Paediatric Centre ☐ Home

Name of unit:_____

*This question refers to where the baby actually died, e.g. 'ICU, 'at home' or 'in transit'.
Babies are deemed to have died 'at home' if there are no signs of life documented in the home even if resuscitation is attempted.
A baby is deemed to have died 'in transit' if signs of life are documented prior to transfer but the baby was either declared dead on arrival to the hospital or showed no subsequent signs of life in the hospital, despite attempted resuscitation..

SECTION 10. POST-MORTEM INVESTIGATIONS

10.1. Was this a coroner's case? *If yes, please complete question 10.2.* ☐ Yes ☐ No

10.2. Has the post-mortem report been received from the coroner's office? ☐ Yes ☐ No

10.4. Was a post-mortem performed? ☐ Yes ☐ No

If no, please complete question 10.5.

10.5. Was a post-mortem offered? ☐ Yes ☐ No

10.6. Were any of the following procedures carried out after death?

Please tick all that apply

☐ MRI ☐ X-Ray ☐ CT ☐ External Examination ☐ Genetic testing

10.7. Was the placenta sent for histology? ☐ Yes ☐ No

SECTION 11. CAUSE OF DEATH AND ASSOCIATED FACTORS - STILLBIRTH & NEONATAL DEATH

11. Please TICK ALL the maternal or fetal conditions that were present during pregnancy or were associated with the death. ***PLEASE REFER TO THE REFERENCE MANUAL.***

11.1.1. MAJOR CONGENITAL ANOMALY:

☐ Central nervous system ☐ Cardiovascular system ☐ Respiratory system ☐ Gastro-intestinal system

☐ Musculo-skeletal anomalies ☐ Multiple anomalies ☐ Urinary tract ☐ Metabolic diseases

☐ Other major congenital anomaly, please specify _____

☐ Chromosomal disorder*, please specify _____

*** In the event of a chromosomal disorder how was the diagnosis made?**

☐ Clinically ☐ Genetic analysis * ☐ Ultrasound

**See reference manual*

11.1.1 (b) Was the diagnosis of major congenital anomaly confirmed/suspected before delivery by a Consultant Fetal Medicine Specialist? ☐ No ☐ Yes, in your unit

☐ Yes, in another unit, please specify name of unit _____

11.1.2. HYPERTENSIVE DISORDERS OF PREGNANCY:

☐ Pregnancy induced hypertension ☐ Pre-eclampsia ☐ HELLP syndrome ☐ Eclampsia

11.1.3. ANTEPARTUM or INTRAPARTUM HAEMORRHAGE:

☐ Praevia ☐ Abruption ☐ Other, please specify _____

11.1.4. 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: ☐

11.1.5. MATERNAL DISORDER:

☐ Pre-existing hypertensive disease ☐ Diabetes ☐ Other endocrine conditions (excluding diabetes)

☐ Thrombophilias ☐ Obstetric cholestasis ☐ Uterine anomalies

☐ Connective tissue disorders, please specify_____

☐ Other, please specify_____

11.1.6. INFECTION: (confirmed by microbiology/placental histology)

Maternal infection: ☐ Bacterial ☐ Syphilis ☐ Viral diseases

☐ Protozoal ☐ Group B Streptococcus

☐ Other, please specify organism _____

Ascending infection:

☐ Chorioamnionitis ☐ Other, please specify _____

11.1.7. SPECIFIC FETAL CONDITIONS:

☐ Twin-twin transfusion ☐ Feto-maternal haemorrhage ☐ Non-immune hydrops ☐ Iso-immunisation

☐ Other, please specify_____

11.1.8. SPECIFIC PLACENTAL CONDITIONS:

PLEASE NOTE THERE IS NO REQUIREMENT TO COMPLETE THIS SECTION SHOULD YOU WISH TO SUMIT AN ANONYMISED COPY OF THE PLACENTAL HISTOLOGY REPORT AS AN ATTACHMENT TO THIS FORM.

Please refer to the reference manual, page 10, for guidance on completing this section.

☐ **No abnormal histology reported**

☐ **Chorioamnionitis** → ☐ Mild ☐ Moderate ☐ Severe

☐ **Fetal vasculitis** → ☐ Arterial ☐ Venous ☐ Both

☐ **Maternal vascular malperfusion (uteroplacental insufficiency)**

Please specify pathology:

☐ Distal villous hypoplasia ☐ Placental hypoplasia

☐ Accelerated villous maturation ☐ Ischaemic villous crowding

☐ Placental infarction → Please specify approximate percentage involved _____

☐ Retroplacental haemorrhage → Please specify approximate percentage of maternal surface involved _____

☐ **Fetal vascular malperfusion:**

Please specify pathology

☐ Patchy hypoperfusion ☐ Scattered avascular villi ☐ Thrombosis in fetal circulation ☐ Fetal thrombotic vasculopathy

☐ **Cord pathology as sole finding**

Please specify pathology

☐ Hypercoiled cord ☐ Hypocoiled cord ☐ Meconium associated vascular necrosis

☐ Vasa praevia ☐ Velamentous cord ☐ Other , please specify_____

☐ **Cord pathology associated with distal disease**

please specify associated distal disease:

☐ Delayed villous maturation ☐ Thrombosis in fetal circulation

☐ **Delayed Villous maturation defect (distal villous immaturity/ delayed villous maturation)**

☐ **Villitis** → ☐ Low grade ☐ High grade ☐ With stem vessel obliteration

☐ **Other**, please specify_____

_____

11.1.9. INTRA-UTERINE GROWTH RESTRICTION DIAGNOSIS MADE: YES ☐

What was this based on? *Please tick all that apply*

☐ Suspected antenatally ☐ Observed at delivery ☐ Observed at post-mortem

11.1.10. ASSOCIATED OBSTETRIC FACTORS: *Please tick all that apply*

Birth trauma ☐ Intracranial haemorrhage ☐ Subgaleal haematoma

☐ Fracture, please specify_____

☐ Other, please specify_____

Intrapartum fetal blood sample result < 7.25 ☐ Yes ☐ No

☐ Polyhydramnios ☐ Oligohydramnios ☐ Premature rupture of membranes

☐ Prolonged rupture of membranes (> 24hours) ☐ Amniocentesis

☐ Spontaneous premature labour ☐ Other, please specify_____

11.1.11. WERE THERE ANY ANTECEDENT OR ASSOCIATED OBSTETRIC FACTORS PRESENT? YES ☐ NO ☐

11.1.12. UNCLASSIFIED: *Please use this category as sparingly as possible* ☐

SECTION 12. MAIN CAUSE OF DEATH: STILL BIRTH & NEONATAL DEATHS

12.1. Which condition, indicated in Section 11 as being present, was the MAIN condition or sentinel event causing or associated with the death. *Please refer to the post-mortem and placental histology reports.*

(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").

12.2. Sources of information used to determine cause of death?

Please tick all that apply

☐ Post Mortem ☐ Placental Histology ☐ Other, please specify_____

SECTION 13. NEONATAL DEATH ONLY: NEONATAL CONDITIONS ASSOCIATED WITH THE DEATH

13.1. Please TICK ALL the neonatal conditions causing and associated with the death.
PLEASE REFER TO THE REFERENCE MANUAL.

13.1.1. MAJOR CONGENITAL ANOMALY:

☐ Central nervous system ☐ Cardiovascular system ☐ Respiratory system ☐ Gastro-intestinal system

☐ Musculo-skeletal anomalies ☐ Multiple anomalies ☐ Urinary tract ☐ Metabolic diseases

☐ Other major malformation, please specify _____

☐ Chromosomal disorder*, please specify _____

*** In the event of a chromosomal disorder how was the diagnosis made?**

☐ Clinically ☐ Genetic analysis * ☐ Ultrasound
**See reference manual*

13.1.1 (b) Was the diagnosis of major congenital anomaly confirmed/suspected before delivery by a Consultant Fetal Medicine Specialist? ☐ No ☐ Yes, in your unit

☐ Yes, in another unit, please specify name of unit _____

13.1.2. PRE-VIABLE: (less than 22 weeks) ☐

13.1.3. RESPIRATORY DISORDERS:

☐ Severe pulmonary immaturity ☐ Surfactant deficiency lung disease ☐ Pulmonary hypoplasia ☐ Meconium aspiration syndrome

☐ Primary persistent pulm. hypertension ☐ Chronic lung disease / Bronchopulmonary dysplasia (BPD)

☐ Other (includes pulmonary haemorrhage), please specify_____

13.1.4. GASTRO-INTESTINAL DISEASE:

☐ Necrotising enterocolitis (NEC) ☐ Other, please specify _____

13.1.5. NEUROLOGICAL DISORDER:

☐ Hypoxic-ischaemic encephalopathy (HIE)

☐ *Intraventricular / Periventricular haemorrhage, please specify highest grade (0 – 4) ☐ *

☐ Hydrocephalus*, please tick all that apply:

* ☐ Congenital ☐ Acquired ☐ Communicating ☐ Obstructive ☐ Other_____

☐ Other, please specify_____

13.1.6. INFECTION:

☐ Generalised (sepsis) ☐ Pneumonia ☐ Meningitis Please specify specific organism _____

☐ Other, specify _____

13.1.7. INJURY / TRAUMA: (Postnatal) ☐

Please specify_____

13.1.8. OTHER SPECIFIC CAUSES:

☐ Malignancies / Tumours ☐ In-born errors of metabolism, please specify _____

☐ Specific conditions, please specify_____

13.1.9. SUDDEN UNEXPECTED DEATHS:

☐ Sudden Infant Death Syndrome (SIDS) ☐ Infant death – Cause unascertained

13.1.10. UNCLASSIFIED: (Use this category as sparingly as possible) ☐

13.2. Which condition, indicated in Section 13.1 as being present, was the MAIN condition causing or associated with the death. *Please refer to the post-mortem report. In the absence of a post-mortem report, please refer to the death certificate.*

(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").

13.3. Sources of information used to determine cause of death?

Please tick all that apply

☐ Post Mortem ☐ Placental Histology ☐ Other, please specify_____

SECTION 14. DETAILS OF REPORTING UNIT (Please print)

14.1. Name of reporting unit: _____

14.2. Completed by

Name: _____

Staff Grade: _____

Work address: _____

_____

Telephone Number: _____ **E-mail Address:**_____

Date of Notification: ☐☐/☐☐/☐☐

Thank you very much for taking the time to complete this form

Please return all completed forms to:

Ms Edel Manning, Project manager perinatal mortality audit,
National Perinatal Epidemiology Centre
Department of Obstetrics and Gynaecology
5th Floor
Cork University Maternity Hospital
Wilton
Cork

If you have any queries regarding the Perinatal Death Notification Form, please contact us at the National Perinatal Epidemiology Centre

Tel: (0)21 420 5042
E-mail: npec@ucc.ie