



# PERINATAL DEATH NOTIFICATION FORM 2021

## CHOOSE Type of Case (TICK)

- STILLBIRTH:** *A baby delivered without signs of life from 24 weeks' gestation and/or with a birth weight of  $\geq$  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 7<sup>th</sup> 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



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 at delivery?

Longitudinal  Oblique  Transverse

### 5.9. What was the presentation at delivery?

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  
5<sup>th</sup> 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](mailto:npec@ucc.ie)**

