Clinical Guideline
Perinatal Loss

Policy developed by: SA Maternal & Neonatal Community of Practice
Approved SA Health Safety & Quality Strategic Governance Committee on: 19 April 2016
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Summary
Clinical practice guideline on perinatal loss

Keywords
termination of pregnancy, genetic termination of pregnancy, GTOP, autopsy, burial, cremation, fetal demise, perinatal loss, IUFD, mementos, clinical guideline

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y v7.0
Does this policy replace an existing policy? N
If so, which policies?

Applies to
All SA Health Portfolio

Staff impact
All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG119

Version control and change history

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Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient’s medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing 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,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork
The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant woman. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that Perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.
Medical Termination of Pregnancy (TOP)
Guide for Clinicians Regarding Legality

The Criminal Law Consolidation Act 1925 (the CLCA) makes procuring or assisting the termination of a pregnancy a criminal offence. However, the CLCA does recognise cases or situations where the medical termination of pregnancy is not a criminal offence, provided certain criteria are fulfilled. If these criteria are fulfilled, then a clinician involved in the medical termination of a pregnancy will not be guilty of a criminal offence.

Is the fetus/child capable of being born alive at the time of the proposed termination?

YES
In accordance with section 82A(7) of the CLCA, if a child is capable of being born alive at the time of the proposed termination.

Medical termination of pregnancy is a criminal offence, unless the following criteria are met:

i) The termination is performed in good faith;
   AND
ii) only for the purpose of preserving the life of the mother.

NO
In accordance with section 82A(1) of the CLCA if the child is not capable of being born alive at the time of the proposed termination it is not a criminal offence for a Legally Qualified Medical Practitioner (LQMP) to terminate a pregnancy if either of the following criteria (i or ii) are met:

(1) Both the medical practitioner and another LQMP are of the opinion, formed in good faith and after both have medically examined the woman, that either:
   a) the continuation of the pregnancy would involve greater risk to the life of, or injury to the physical or mental health of the woman, than if the pregnancy were terminated;
   AND the termination must be performed in a prescribed hospital and the woman has resided in South Australia for at least two months
   OR
   b) if the pregnancy were not terminated and the child was born, the child would suffer from such physical or mental abnormalities as to be seriously handicapped, AND the termination must be performed in a prescribed hospital and the woman has resided in South Australia for at least two months

(2) The LQMP is of the opinion, formed in good faith, that the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman.

NOTE 1:
“Capable of being born alive”:
A clinical assessment must be undertaken as to whether or not the fetus/child is capable of being born alive in each and every prospective termination case, and irrespective of the age of the fetus. The meaning of “capable of being born alive” requires a consideration of fetal viability. This issue has not been tested in the Australian courts.

There is an evidentiary presumption in section 92A(6) of the CLCA that 28 weeks gestation or more shall be prima facie proof of a child capable of being born alive. However, that is a presumption only and may be rebutted. Based on local, national and international data, in the absence of a significant morbidity, the boundary of fetal viability currently lies between 23 and 25 completed weeks of gestation. However currently 23 completed weeks of gestation (23 weeks 0 days) is generally considered the point of fetal viability. Please note that this time period of 23 weeks is to be used as a guide only. The length of fetal viability is only one of a number of factors that can be considered in assessing whether the fetus/child is capable of being born alive. It is necessary for clinicians to make their own evaluations based upon all available information.

NOTE 2:
In determining whether the continuation of a pregnancy would involve such risk to the physical or mental health of the woman, account may be taken of the woman’s actual or reasonably foreseeable environment.

NOTE 3:
• When referring a woman to a health unit for a termination, the referring doctor should certify the form and send it to the health unit for registration by a second doctor before the termination. The original form must be sent to the Pregnancy Outcome Unit of the South Australian Department of Health within 14 days of the termination of pregnancy. A copy of this form must be retained by the doctor who performed the termination for a period of three years commencing on the date of the termination.

• Clinicians who have any queries or concerns about the operation of section 82A of the Criminal Law Consolidation Act 1935 or of the Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 1996 should seek their own legal advice.

NOTE 4:
“Prescribed Hospital”
Listed in schedule 3 CRIMINAL LAW CONSOLIDATION (Medical termination of pregnancy) REGULATIONS 1996.
Screening and diagnosis

> Screening procedures and diagnostic tests to detect structural and fetal anomalies may be carried out in the first and second trimesters
> Specific testing for genetic disorders may be available in some clinical situations. Consultation with a Clinical Geneticist is essential as early as possible, preferably before conception
> Parental decisions about screening and diagnostic testing must be made on the basis of clear information about the nature and risks of the available interventions. Offer written information and time to consider choices

First trimester screening and diagnostic tests

> South Australian Maternal Serum Antenatal Screening (SAMSAS) Programme first trimester screen (link to pre-test information)
  > 5-10 mL clotted blood between 10+0 and 13+6 weeks
  > Ultrasound for crown-rump length and nuchal translucency from 11+0 to 13+6 weeks
> Chorionic villus sampling (between 10+0 and 13+6 weeks) for chromosome analysis or specific genetic or biochemical testing

Second trimester screening and diagnostic tests

> South Australian Maternal Serum Antenatal Screening (SAMSAS) Programme second trimester screen for trisomy 13 and 21 and neural tube defects
  > 5-10 mL clotted blood between 14+0 and 20+6 weeks, but preferably at 15 – 16 weeks)
> Amniocentesis (after 15+ weeks) for chromosome analysis or specific genetic or biochemical testing
> Morphological ultrasound (18 – 20 weeks)

Ethical considerations

> The medical practitioner counselling the pregnant woman who has a fetus with structural and / or other anomalies should explain:
  > The full nature of the fetal abnormality
  > The possibility that the abnormality will be lethal
  > The probability of impaired cognitive function
  > The known degree or likelihood of physical impairment
> Counselling from a clinical geneticist, paediatrician or paediatric surgeon may be helpful in specific cases
> Parents faced with antenatally diagnosed fetal anomalies may need additional support whether they proceed with the pregnancy or decide to request a termination of pregnancy. Parents should be offered non-medical counselling at the time that a diagnosis or suspected diagnosis is made e.g. referral to a social worker or genetic counsellor
Termination of pregnancy

> In South Australia, termination of pregnancy may be performed in a prescribed class of hospital for this purpose, where two legally qualified medical practitioners have medically examined the woman and agree:

> that the continuance of the pregnancy would pose greater risk to the life of the pregnant woman, including her physical or mental health, than if the pregnancy were terminated

> that there is a substantial risk that the child if born would suffer from such physical or mental abnormalities as to be seriously handicapped provided that the woman has not reached twenty eight weeks or more gestation

(Criminal Law Consolidation Act 1935 Section 82A)

> The green C.O.R. 19 form ‘Certificate to be completed when an abortion is performed under Section 82A of the Act’ for an extract of the ‘Criminal Law consolidation Act 1935’ (Section 82A medical termination of pregnancy) must be completed before the procedure is performed

> Refer to flow chart on Medical Termination of pregnancy - Guideline for clinicians regarding legality for further information

> The Commonwealth Government recognises all pregnancies over 20 weeks, including a stillborn child where a medical professional has certified the stillborn child was delivered. Where this certification is issued, women / families may be entitled to a bereavement payment under the Australian Government Family Assistance Scheme (Centrelink). The woman should be issued with a Centrelink Bereavement Payment Form

> All perinatal losses (including termination of pregnancy) over 20 weeks or over 400 grams require a ‘Supplementary Birth Record’ form to be completed under the Health Care Regulations, 2008 and a ‘CONFIDENTIAL REPORT ON PERINATAL DEATH’ form (‘the blue form’) to be sent to the Pregnancy Outcome Unit, SA Health

> Staff have a legally protected right to refuse to be involved in termination of pregnancy

Method of termination

Second trimester pregnancies are usually terminated by one of the following two methods:

1. Medical abortion (induction of labour) with mifepristone and the prostaglandin analogue misoprostol (see ‘Medical induction for second trimester terminations of pregnancy and miscarriages’ in the A to Z index at www.sahealth.sa.gov.au/perinatal)

   > Other prostaglandin analogues may occasionally be used and include gemprost (Cervagem®) vaginal pessaries and extra or intra amniotic prostaglandin PGF₂ alpha

2. Surgical abortion (dilatation and evacuation procedure). Prostaglandin analogues, mifepristone, laminaria tents or a cervical balloon catheter may be used for cervical priming preoperatively. In South Australia, dilatation and evacuation (D & E) is offered at the Women’s and Children’s Hospital up to 16 weeks size and at the Pregnancy Advisory Centre up to 22 weeks

Counselling

Explain the following:

> The legal definition of viability versus capacity to be born alive

> In cases where it is anticipated that signs of life may be present at the time of birth,
discussion of the risks and benefits for the mother and fetus regarding the option of feticide, should take place before the method of termination is determined

> If the woman declines the option of feticide, she should be counselled regarding the possibility of the baby being born alive and the legal and legislative reporting (Coroner’s notification) implications of this

> The woman should be advised that no resuscitation can be offered to a fetus undergoing the procedure of a termination of pregnancy

> If there are overt signs of life determined at the time of birth, regardless of gestation, an Apgar score is assigned and a time of birth and then a time of death must be recorded

> The birth is to be recorded in the hospital birth register

> Hospital notification to Births Deaths and Marriages is required

> A ‘Coroner’s notification checklist’ is completed for every birth with overt signs of life to determine those deaths reportable to the Coroner

> ONLY in cases where each/any fetus exhibits overt signs of life (i.e. respiration or heartbeat or other sign of life) at the time of birth does the birth become registrable, rather than a product of a termination of pregnancy under the Births, Deaths and Marriages Registration Act 1996. In these cases the following is issued:

> A Birth Registration Statement

> A Perinatal Death Certificate

> The mother is also eligible for a Bereavement payment

> If no overt signs of life at birth, there is no requirement to assign an Apgar score or to register the birth regardless of the gestation

Care considerations

The medical officer should consider the following in relation to the procedure of choice:

> Does the woman wish to see and hold her baby?

> Is the experience of labour important to the woman?

> Time factor involved for different methods of termination

> Is the woman aware that a D & E usually precludes viewing and handling of the fetus and may lead to some limitations with pathological examination?

> In those cases where the fetus has been diagnosed with single or multiple malformations, has the issue of further investigations such as an autopsy been discussed?

> If the woman proceeds with D & E are further investigations required? This may include amniocentesis, fetal tissue being sent for chromosome analysis and/or DNA storage. If the fetus is intact an autopsy could be requested

> Consider any specific circumstances (e.g. reduced liquor, uterine scar) that may influence choice

> The woman’s views in relation to mementos e.g. photographs, foot or hand prints, memory box as applicable

Fetal demise

> Fetal demise (whether early or late) requires confirmation from a formal ultrasound

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According to the Births, Deaths and Marriages Registration Act 1996, a still-born baby is at least 20 weeks’ gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth but does not include the product of a procedure for the termination of a pregnancy.

The birth of a still-born baby should be registered.

In the event that a fetus is spontaneously delivered with signs of respiration or heartbeat or other signs of life before 20 weeks gestation, this is classified as a birth and subsequent neonatal death and the following is required:

- A Birth Registration Statement
- A Perinatal Death Certificate
- Hospital notification to Births Deaths and Marriages is required

However, as the gestation is reliably known to be less than 20 weeks gestation, the mother is not eligible for a Bereavement payment.

Multiple pregnancy

Fetal demise of a multiple before 20 weeks gestation

If fetal demise of one multiple can be reliably known to have occurred before 20 weeks of gestation, but this fetus is not delivered until after 20 weeks of gestation, it is considered a missed miscarriage, and therefore is NOT eligible for Birth Registration or a Death Certificate. A Centrelink Bereavement Payment form is NOT issued for the demised fetus. Furthermore, the pregnancy will not continue to be regarded as a multiple pregnancy as only one fetus has reached viability and this fetus will become eligible for registration at the time of birth.

Fetal demise of a multiple after 20 weeks gestation

Each fetus, reliably known to be alive at 20 weeks gestation or more, delivering spontaneously, must be registered irrespective of its weight or whether live or stillborn at the time of birth.

- A Birth Registration Statement must be issued
- Either a Centrelink ‘Newborn Child Declaration’ form is issued OR, if stillborn the mother is eligible for a Bereavement payment

If subsequently, neonatal death of one or more of the babies occurs, the woman becomes eligible for the following:

- A Perinatal Death Certificate must be issued
- A Bereavement payment for each baby

Fetal demise gestation uncertain

However, if gestation at death is uncertain and the weight of the dead twin is 400 grams or greater, the birth of that baby must be registered and the following must be issued:

- A Birth Registration Statement
- A Perinatal Death Certificate

The mother is also eligible for a Bereavement payment.

Hospital notification to Births Deaths and Marriages is required.
Medical induction

> See ‘Medical induction for second trimester termination of pregnancy and miscarriages’ in the A to Z index at www.sahealth.sa.gov.au/perinatal
> See ‘Medical methods for induction of labour after late IUFD’ in the A to Z index at www.sahealth.sa.gov.au/perinatal

Surgical dilatation and evacuation

> Management is the same as for surgical management of miscarriage. See ‘Miscarriage’ guideline in the A to Z index at www.sahealth.sa.gov.au/perinatal

Care of the woman experiencing perinatal loss

> Explanation and support for the woman and her family should begin immediately following confirmation of fetal death or decision for medical termination
> Parents should be offered non-medical counselling at the time that a diagnosis or suspected diagnosis is made e.g. referral to a social worker or genetic counsellor
> The emotional and psychological preparation related to the timing of the induction / termination procedure after diagnosis should be discussed with the woman
> Aim for continuity of caregivers
> Provide a detailed explanation to ensure that the woman is fully informed before starting any procedure
> Obtain intravenous access and take bloods as indicated (follow link to chapter 26 Investigation of stillbirths)
  > Group and save
  > Complete blood picture
  > Coagulation profile (if at risk of coagulopathy or > 24 hours after IUFD)
> Discuss the woman and her family’s option to see, touch and hold the baby after delivery, receive mementos (discussed below), and take photographs. Parents may be unsure about seeing and holding their baby after death. It is important that staff gently explore any parental concerns and respect their choice to do what is right for them
> Offer stillbirth and neonatal death support group information (such as SANDS) and brochures to the woman and her family
> In the case of a termination of pregnancy for a fetal abnormality offer information about the Support After Fetal Diagnosis of Abnormality (SAFDA ) support group
> Arrange early anaesthetic review. If regional block required, obtain results from complete blood picture and coagulation profile before insertion
> Social work support

Care of mother and baby after delivery

Care of mother

> It is important that the wishes of the woman and her family in relation to seeing, touching and holding their baby are respected at this time
> The parents should be encouraged to name their baby and begin to develop memec

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their baby

> The gender of the baby should not be identified if any doubt exists. Indeterminate sex should be documented in the notes and pathological examination to determine gender should be requested as soon as possible. The gender can be determined within 24 hours by the South Australian Perinatal Autopsy Service at the Women’s and Children’s Hospital

> Observations as indicated and allow parents some time alone as appropriate

> If the placenta is retained, arrangements should be made for evacuation of the uterus in theatre. The urgency of performing this procedure should be determined by the amount of on-going vaginal blood loss

> As appropriate, parents may include siblings and other family members in photographs to aid the development of memories following their baby’s death

**Lactation suppression**

> Provide the opportunity for open and sensitive discussions regarding options for lactation suppression

> Prolactin is the primary hormone responsible for milk production, and in its absence, milk production ceases. Prolactin levels attain their highest levels in the third trimester and continue to increase until term. Advise the woman that milk production may commence as early as 16 weeks of gestation and is common from 18 weeks of gestation (following delivery)

> Many women may find production of milk is a reminder of the loss of their baby and will wish to initiate early suppression of lactation; however others may find that it produces positive emotions during a sad time and may wish to employ gradual suppression of lactation (particularly if perinatal loss has occurred after lactation has been established)

**Supportive measure for lactation suppression**

> Advise that breast milk production may take some time to resolve, and can range from a few days to weeks

> Encourage the woman to wear a firm bra or crop top day and night until breasts feel less full and avoid expressing or overstimulating her breasts

> Measures to alleviate uncomfortably full breasts include:

  > simple analgesia such as paracetamol

  > use of cold packs

  > gentle massage of breasts under the shower to alleviate discomfort and allow some milk to leak

  > the use of breast pads to soak up any leaking milk

> For further information see Australian Breastfeeding Association booklet ‘Lactation suppression’ at URL: www.breastfeeding.asn.au/bfinfo/lactation-suppression

**Cabergoline (Dostinex®)**

> Pharmacological suppression may be offered and is suitable from 20 weeks of gestation or may be considered earlier if lactation suppression is thought to be required

> Cabergoline (Dostinex®) is most effective if given as a single oral dose of 1 mg in the first 24 hours postpartum

> An ergot derivative, cabergoline (Dostinex®) should be given with caution in women with a history of severe cardiovascular disease, hypertension,
perinatal loss

> preeclampsia and women with a history of serious psychiatric disorder (particularly psychosis)\(^6\)

> Common side effects include dizziness, nausea, headache and hypotension\(^6\)

Care of baby

> If parents wish to see and hold their baby, ensure baby is wrapped and presented in a way that is sensitive to their individual needs

> There should be someone close at hand to remove the baby when appropriate

> Document weight and length, date and time of birth, gender and name of baby in case notes and on memento card for parents

> Medical / midwifery staff should be aware and advise women and their family as appropriate, that refrigeration (at 4˚ Celsius) of the baby is advised at least within the first 24 hours. If the woman wishes to keep her baby with her, staff should encourage regular periods of refrigeration (e.g. overnight if possible)

Blessing baby

> Women and their family may choose to have a blessing of their baby (may be arranged privately or midwifery staff can notify the hospital chaplain or other appropriate denomination if available)

Placenta

> Histological examination of the placenta provides additional information about perinatal deaths

> Where possible, all placentas of stillborn infants, early neonatal deaths and mid-trimester miscarriages / genetic terminations should be sent for examination

> The placenta should also be sent to histopathology if a chromosomal abnormality is suspected or neonatal fetal death is probable

> Twin placentas must be adequately labelled as Twin I and Twin II

> Document description and weight of placenta in case notes

Autopsy

> The placenta is sent with the fetus to the South Australian Perinatal Autopsy Service at the Women’s and Children’s Hospital (WCH mortuary)

No autopsy

> The placenta may be sent to the hospital’s histopathology department

> The placenta should be sent as soon as possible (i.e. within 12 hours) fresh, without any preservative solutions or refrigerated if there is any delay

Mementos

> All babies who have post mortem examination by the South Australian Perinatal Autopsy Service will have a memento package including:

> High quality colour digital photographs (disc with photos available on request)

> Foot and hand prints

> Name band and hair (if possible)
Individual hospitals may also create memento packages for all second trimester fetal loss, stillbirths and neonatal deaths.

Mementos may include some or all of the following:

- Identification bracelets, cards and tape measures used to measure baby (as appropriate), naming certificate, clothing, e.g. gown, bonnet, quilt, memento box.

Parents who do not wish to receive these mementos may change their minds at a later date (several weeks, months or years after their baby’s death), and wish to collect their baby’s items.

Provisions for indefinite storage of mementos should be made at individual hospitals.

**Autopsy**

Consent to autopsy is legally required for any fetus over 20 weeks, weighing over 400 grams or live born.

However, the South Australian Perinatal Autopsy Service recommends obtaining consent to autopsy or pathological examination at any gestation (tissue retention act).

The South Australian Perinatal Autopsy Service (at the Adelaide Women’s and Children’s Hospital) provides a perinatal autopsy service for all public and private hospitals in South Australia, as well as Alice Springs Hospital, Broken Hill and Mildura.

A plain language autopsy report can be requested from the South Australian Perinatal Autopsy Service (phone: 81617333) at any time. If it is anticipated that a plain language autopsy report will be required, this may be requested on the original autopsy consent form at the time of autopsy consent.

**Benefits of obtaining perinatal autopsy**

- May confirm or help determine cause of death
- May establish a diagnosis
- Important for establishing iatrogenic disease
- Important for research and teaching

The information obtained from autopsy may be useful for counselling in relation to the index pregnancy for parents as well as for siblings and future pregnancies.

A Wales review of perinatal autopsy has found that:

- 13% of clinic pathological classifications were altered
- 18% of autopsies provided a main cause of death
- 8% of autopsies provided new information

A recent retrospective study reported that autopsy added information that led to a refinement of the risk of recurrence in 27% of cases examined.

**Before obtaining consent**

The booklet ‘when a person dies: The Hospital Autopsy Process – information for family and friends’ should be given to the parents to read before any request for autopsy consent from the medical officer (link to booklet).

It is the responsibility of the medical officer to answer any queries that the woman...
partner may have related to autopsy consent before obtaining their consent for autopsy

> The autopsy request and authority form (a) MR82F should be completed by the medical officer
> The ‘autopsy request and authority form (b) MR82F’ should be completed by the senior available next of kin and signed by a witness (also interpreter if required)
> A copy of the autopsy report may be sent to the woman’s general practitioner according to the woman’s wishes (documented on form (b) MR82F)
> Parents can choose not to have an autopsy performed
> Initial information from autopsy is usually available after two weeks, but final results may not be available for some time

South Australian Perinatal Autopsy Service

> The following forms should be completed and sent to the South Australian Perinatal Autopsy Service with the fetus / baby for autopsy:
> Autopsy request and Authority forms MR82F (Parts a & b), for all non-coronial autopsy examinations (link to forms at http://www.wch.sa.gov.au/services/az/divisions/labs/sapas/index.html)
> Burial Authority and Information required by Undertaker Form
> Disposal arrangements form (for stillbirths < 20 weeks as no death certificate required)
> Confidential Report on Perinatal Death (Maternal, Perinatal and Infant mortality Committee) (may be sent directly as indicated on the form)

Transport of the fetus / baby for autopsy

> The doctor at the transferring hospital should telephone (08) 8161 6101 to inform staff at the South Australian Perinatal Autopsy Service to expect a baby
> The referring hospital should arrange transport of the baby with SA Pathology on phone number (08) 8222 3000 or via Funeral director of choice
> Transport may be by road or air as appropriate
> The baby should be refrigerated at 4˚ Celsius until transfer

Follow these guidelines for any fetus / baby being transported to the South Australian Perinatal Autopsy Service:

> The baby / bucket should be clearly labelled
> The baby should be wrapped in a shroud (sheet), then plastic
> A small fetus < 20 weeks may be transported dry in a bucket
> Transport without fixative or other fluids
> Include fresh placenta dry in sealed bag
> Use a plastic esky with ice bricks (e.g. small containers of frozen water) carefully positioned around but separate from baby (or bucket) for cold storage transport
> It is important that baby is transported dry and undistorted
> Include clinical information – obstetric history of the mother

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Culturally sensitive care

> Women often have different values, perceptions and behaviours that differ not only across cultural backgrounds but also within their own culture
> It is important for health professionals to acquire a general working knowledge of those practices that may be considered offensive in some cultures
> Health professionals should be aware that families from other cultural backgrounds may have very different belief systems and practices around death and important rituals that need to be performed
> A detailed account of various multicultural practices around death is beyond the scope of this guideline. A brief description of issues that may be relevant for Aboriginal and Muslim women is included

* Refer to section 4 of ‘SANDS – Appropriate Care for women and their partners when their baby dies’ for a detailed account of culturally sensitive care

Aboriginal women

> Aboriginal people experience very high levels of Grief and Loss in their communities, this can demand ceremonial acknowledgement. Aboriginal women should be referred to an Aboriginal Health Professional as soon as practicable
> It may be important for Aboriginal women to include their extended family who may or may not include blood relatives when grieving perinatal loss
> Utilise Aboriginal liaison services where available as support until the arrival of relatives
> It is important to understand that eye contact and questioning may be offensive to the woman
> Care for the woman at a pace suitable to her individual needs
> Ensure the woman is aware of any aboriginal services as well other available services (including funeral options) so that choices most appropriate to the woman’s cultural needs can be made

Muslim women

> Usually make own burial arrangements for stillborn baby with the funeral director.
> Ensure the woman is aware of available services at the hospital
> According to Islam, for forty days following delivery, the mother of a stillborn baby is unclean and may not touch a dead body
> The stillborn baby may be washed by a relative of the same sex
> Early discharge may be requested for early burial of the stillborn baby
> The stillborn baby should be interred (usually in a shroud) within 24 hours after death (may be without a coffin). If required, autopsy should be expedited for the parents
> These arrangements may affect the hospital’s ability to create mementos
> The funeral service is usually held in a Mosque, but may also take place in a funeral parlour or cemetery
> Cremation is not usual

Centrelink bereavement payment form

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The Commonwealth Government recognises all pregnancies over 20 weeks, including a stillborn child where a medical professional has certified the stillborn child was delivered. These women should be issued with a Centrelink Bereavement Payment form.

**Certificate of death**

Following a stillbirth, a doctor’s certificate on the form approved by the Births Deaths and Marriages Registrar, certifying the cause of fetal death should be given to:

a. The Births Deaths and Marriages Registrar
b. The funeral director or other person who will be arranging for the disposal of the human remains (Births, Deaths and Marriages Registration Act, p. 12, 1996)

**Post-mortem**

The death certificate is signed by the doctor carrying out the post-mortem

**No Post-mortem**

The death certificate should be signed by the doctor caring for the woman and her stillborn baby (any legally qualified practitioner can sign)

**Burial options**

**Greater than 20 week’s gestation**

All intrauterine fetal deaths or neonatal deaths ≥ 20 weeks receive a birth certificate and a death certificate (excluding those babies that are a result of a termination of pregnancy unless liveborn). Funeral (burial or cremation) arrangements are made privately and the woman is responsible for all costs.

- Coronial enquiry – stillborn babies do not require investigation by the coroner. Investigation is at the Coroner's discretion.
- The above funeral services apply to all babies who die in the perinatal period (i.e. from birth to 28 days after delivery) as well as second and third trimester fetal losses.
- Discuss burial or cremation options after delivery. Organise social work support in accordance with individual hospital or medical arrangements.

**Genetic termination**

It is not compulsory for a funeral (burial or cremation) if a birth is not registered. The hospital mortuary may provide a death certificate for all genetic terminations over 20 weeks gestation, for the funeral director, so a cremation can occur (legal requirement).

**Available options for the woman and her partner are:**

- A private funeral (Burial or Cremation) and the parents are responsible for all costs OR
- Surgical disposal of fetus

**NB:** Parents' grieving process is often assisted by involvement in a physical parting. Burial may be an option at any gestation.

**Less than 20 week’s gestation / genetic termination**

- The woman organises a private funeral, and is responsible for all costs OR
- Hospital arranged cremation through funeral consultants and the cremation will be with other babies (not available at all hospitals) OR
Surgical disposal of fetus
The mortuary will provide the required paperwork

**Taking baby home**

**Greater than 20 week’s gestation**

- Usually, the undertaker from the chosen funeral parlour will collect baby from the hospital before burial, however, this is not a legal requirement
- Occasionally women may wish to take their baby home in preparation for the ceremony or before transporting baby to the funeral parlour
- Arrangements for the above should be made on a case by case basis
- Parents who take their baby home and then to the funeral parlour should also take the death certificate, (including both portions for the undertaker and registrar) to hand to the undertaker with the baby
- In the above circumstances, it is important to explain to the parents:
  - Cold storage requirements for the transport and care of their baby
  - Their responsibility to take the baby to the funeral parlour within 24 hours
- It is advisable for staff caring for the woman to obtain contact details of the receiving funeral parlour and telephone the funeral parlour the following day to ensure they have received the baby
- Baby may be dressed and dry wrapped and transported home in an esky (may be foam if no plastic esky available) with ice bricks (e.g. small containers of frozen water) carefully positioned around but separate from baby for cold storage transport

**Less than 20 week’s gestation / genetic termination**

- A fetus at less than 20 weeks gestation is not considered human remains
- On request, in cases where there are no infection contraindications, women may take the remains of their baby home for burial
- In these circumstances, it is preferred that staff offer the available cremation service whereupon the ashes may then be taken home to be kept / scattered as appropriate
- If cremation has not been undertaken, the fetus should be wrapped in a waterproof shroud for transport and placed in a sealed ice box (e.g. esky containing ice bricks carefully positioned around but separate from the fetus) for cold storage
- The parents should be advised to contact their local council to ensure that burial is carried out in accordance with their local council regulations

**Discharge planning**

- Contraception advice as appropriate
- Lactation suppression advice as described under ‘lactation suppression’
- Ensure the woman is aware of the signs and symptoms of mastitis (e.g. flu-like symptoms with aches, fever, breast lumps, red, swollen, hot and painful area of the breast, and there may be red streaks extending toward the axilla13) and advise the woman to seek medical advice if symptomatic
- Follow up medical appointment after two weeks (according to individual hospital arrangements). At this appointment the woman receives a physical check and the
any investigations / autopsy in a plain language report (may take 4-6 weeks to complete). A formal report is sent to the referring general practitioner.

- Offer the woman follow-up counselling by the service provider or another appropriate agency / counsellor
- Arrange domiciliary follow up as indicated
- Medical discharge letter
- If the woman has transferred from the country, a discharge phone call and letter to the woman’s general practitioner (with the woman’s consent) should be attended by the medical officer caring for the woman

References

4. Department of Histopathology. Perinatal loss and how to access the state perinatal autopsy service. Adelaide South Australia: Women’s and Children’s Hospital; 2003
6. MIMS. Full prescribing information cabergoline. 1 Jul 2013.
10. Report on late term terminations of pregnancy. Medical Practitioners Board of Victoria, Acute Health Division, Department of Human Services; 1998
Useful websites

South Australian Perinatal Autopsy Service

South Australian Maternal Serum Antenatal Screening (SAMSAS) Program

Australian Breastfeeding Association. Lactation suppression
Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>CLCA</td>
<td>Criminal Law Consolidation Act</td>
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<tr>
<td>D &amp; E</td>
<td>Dilatation and evacuation</td>
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<td>e.g.</td>
<td>For example</td>
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<tr>
<td>g</td>
<td>Gram(s)</td>
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<tr>
<td>GTOP</td>
<td>Genetic termination of pregnancy (for fetal abnormality)</td>
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<td>IUFD</td>
<td>Intrauterine fetal death</td>
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<tr>
<td>LQMP</td>
<td>Legally Qualified Medical Practitioner</td>
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<tr>
<td>mL</td>
<td>Millilitre(s)</td>
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<tr>
<td>SAFDA</td>
<td>Support After Fetal Diagnosis of Abnormality</td>
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<td>SAMSAS</td>
<td>South Australian Maternal Serum Antenatal Screening</td>
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<td>SANDS</td>
<td>Stillbirth and neonatal death support</td>
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<td>TOP</td>
<td>Termination of pregnancy</td>
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<td>WCH</td>
<td>Women’s and Children’s Hospital</td>
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Version control and change history

**PDS reference:** OCE use only

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