DEATH

FUNERAL ARRANGEMENTS FOR DECEASED BABIES

KEY WORDS

Pastoral care, cremation, funeral, memorial, stillborn, Consent for Cremation, ashes, Perinatal Pathology

AIM

To inform staff of the memorial, funeral and cremation services available for deceased babies.

KEY POINTS

1. Pastoral Care Services are to be notified of all losses of an intact fetus or baby.
2. Discussions about the options available to parents are managed by Pastoral Care Services.
3. Parents have the option of having a memorial service in the King Edward Memorial Hospital chapel irrespective of their religious affiliations or otherwise.
4. Naming and Blessing services or acknowledgement of life rituals are conducted at a time arranged with Pastoral Care Services. These may be performed in the ward room or the chapel.
5. Babies are not to be left unattended by hospital staff in the chapel at any time
6. Transport modules for discreet transportation are available through the Perinatal Pathology staff or orderlies
7. The option of cremation at the hospital is only available for babies who are stillborn **and** less than 28 weeks gestation. Parents are offered:
    - Individual cremations with the return of separate ashes. These arrangements are made by Pastoral Care Services with the parents and in conjunction with Perinatal Pathology.
    - Communal cremation with collective interment of ashes at a monthly Interment of Ashes service. This is arranged by Pastoral Care and Perinatal Pathology.
8. Consent for Pathology (HPF 1480) shall be completed for all < 20 week losses noting whether consent for examination is given or declined.
9. Parental Consent must be obtained for cremation of a stillborn baby less than 28 weeks gestation. A MR 297 ‘Consent for Cremation – Baby Less than 28 Weeks Gestation’ form must be completed prior to hospital cremation. This is managed by Pastoral Care Services.
10. Babies born alive who are greater than 20 weeks gestation must have funeral arrangements made through an external funeral director. This is managed by Pastoral Care Services in conjunction with the family.

Government of Western Australia
Department of Health

11. Stillborn babies greater than 28 weeks gestation must have funeral arrangements made through an external funeral director. This is managed by Pastoral Care Services in conjunction with the family.
12. Parents may arrange their baby's funeral themselves if they wish.

REFERENCES (STANDARDS)	
National Standards – 12 Service Provision Legislation – Health Act 1911 Coroner's Act 1996 Cemeteries Act 1986 Related Policies – Obstetrics and Gynaecology: Death Other related documents – Nil	
RESPONSIBILITY	
Policy Sponsor	HoD Pastoral care
Initial Endorsement	August 1998
Last Reviewed	April 2015
Last Amended	
Review date	April 2018

8 DEATH

8.4 PERINATAL DEATH

Date Issued: August 1999
Date Revised: October 2012
Review Date: October 2015
Authorised by: OGCCU
Review Team: OGCCU

8.4.1 Legalities
Section A
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

8.4.1 LEGALITIES

AIM

The completion of the correct documents in the event of a perinatal death

PERINATAL DEATH – DEFINITION

Perinatal death refers to the birth of a baby of 20 weeks gestation or more, which either dies before birth (stillbirth) or in the neonatal period (neonatal death).

STILLBIRTH (NO SIGNS OF LIFE AFTER BIRTH)

1. **Period of gestation 20-28 weeks**
   - ***Registration:*** If the period of gestation is known to be 20 weeks or more, the birth and death must be registered with the Registrar of Births, Deaths and Marriages using the Birth Information Paper and the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201).
   - ***Disposal:*** The body may be cremated at King Edward Memorial Hospital (monthly collective internment of ashes, or individual cremation with return of separate ashes, parental consent required for both).
     If the parents wish, cremation or burial may be arranged by an external Funeral Director.

2. **Period of Gestation 28 weeks or more.**
   - ***Registration:*** The birth and death must be registered as above.
   - ***Disposal:*** The body must have a funeral (cremation or burial) arranged through an external funeral director

NEONATAL DEATH (HEART BEATS AFTER BIRTH)

- ***Registration:*** All babies born alive who subsequently die in the neonatal period must have the birth and death registered with the Registrar of Births, Deaths and Marriages using both the Birth Information Paper and the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201).
- ***Disposal:*** The body must have a funeral (cremation or burial) arranged through an external funeral director.

PRESENTATION OF NEWBORN – DEAD ON ARRIVAL (DOA)

If a woman presents to King Edward Memorial Hospital having given birth prior to presentation at KEMH and the newborn is DOA, the following procedure is to be followed and the details documented in the maternal medical record.

- The Obstetric Registrar will examine the mother and baby and will enquire about the circumstances of the birth.
- The Obstetric Consultant for the team will be notified.
- The Neonatal Registrar will be called to examine the baby.
- Upon consideration of the circumstances, the Coroner's Office may be notified (in accordance with WCHS policy 087)
- The mother should be offered admission for continuing care and counselling (single room).
- The baby may accompany the mother. Alternatively the baby may be transferred to Perinatal Pathology.

DOCUMENTATION

- Follow the Perinatal Death Clinical Pathway (MR 270) for the documentation required. Depending on the circumstances, not all documentation may be required.

Stillbirth or Neonatal Death (> 20 weeks gestation)

- **Death in Hospital Form MR 001**- completed by the clinical staff in attendance.(Assists in the determination of whether the death is reportable to the Coroner).
- **Medical Certificate of Cause of Stillbirth or Neonatal Death BDM 201** – the attending medical officer completes and signs the certificate. The midwife forwards the completed certificate to Perinatal Pathology.
- **Certificate of Medical Attendant Form 7 (if > 28 weeks gestation)** – the attending medical officer completes and signs the form. The midwife forwards the completed certificate to Perinatal Pathology.
- **Consent for Cremation of Stillborn Baby (less than 28 weeks gestation)**. Pastoral Care Services should routinely be called to discuss options and facilitate coordination of the chosen option ensuring the correct consent forms are completed. The midwife / nurse forwards the completed form to Perinatal Pathology.
- **Birth Information Form.** The midwife completes those sections of the form that are required to be completed by the hospital. The remainder of the form is completed by the parent(s). The completed form must be forwarded to the Registry of Births, Deaths and Marriages by the parents or using the pre paid self addressed envelope.
- **Consent for Post Mortem MR 236**.The clinical staff must discuss post mortem, and if consent is given,completes all relevant areas of the form(including the clinical history on page 3) and is responsible for the completion of the " Consent by Next of Kin' section of the form. The midwife forwards the completed certificate to Perinatal Pathology. Further information is located in the Perinatal Pathology Handbook and the pamphlet 'Patient Information on Non Coronial Post Mortem'.
- Babies less than 20 weeks gestation require a 'Consent for Pathology Examination Baby less than 20 weeks Gestation' form(MR 238) to be completed if post mortem examination is consented to. Further information is located in the Perinatal Pathology Handbook The clinical staff complete all relevant areas of the. It is preferred that if consent for post mortem is declined this is noted on the form and sent to Perinatal Pathology.
- A laboratory request form is required if the placenta is being sent for examination.

8 DEATH

Date Issued: August 1999
Date Revised: April 2012
Review Date: April 2015
Authorised by: OGCCU
Review Team: OGCCU

8.5 Care and Management of the Deceased Baby
Section A
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

8.5 CARE AND MANAGEMENT OF THE DECEASED BABY

AIM

To provide respectful care to a baby after death.

KEY POINTS

1. Care is always carried out in a private area.
2. If the death is to be investigated by the Coroner - leave all tubes in situ; curl up the catheters and tape to the baby.

PROCEDURE

1. Offer the parents the opportunity to participate in the care provided to their baby.

2. If appropriate and requested bathe or wash the baby gently especially if fetal death has occurred as skin integrity may be already compromised.

3. Record the weight, length and head circumference.

4. Examine the baby and note any obvious abnormalities. Document the examination in the medical notes.

5. Attach an identity band to the ankle or an appropriate area, depending on the baby's size.

6. Complete a cot card.

7. Dress the baby and wrap in a sheet / blanket. Avoid using a textured blanket as this may mark the skin. The baby may be dressed in clothes provided by the parents or those provided by the hospital.

8. Obtain verbal consent from the parents to collect the following mementos and place in the grief pack:
   - Photographs
   - Foot and hand prints
   - A lock of hair
   - Baby identification band and cot card

9. If the grief pack is declined:
   - document this in the notes
   - place the mementos in a sealed envelope and file in the mothers medical records, noting the contents on the outside of the envelope.

- inform the parents that they will be kept on file in case they request them at a later date.

10. Consider transferring the baby to Perinatal Pathology intermittently to be cooled in the refrigerator as this may slow the deterioration rate of skin integrity.

TRANSFERRING THE BABY TO PERINATAL PATHOLOGY.

1. Ensure there is a correct:
   - identification label / band on the baby
   - if the baby is extremely small, attaching two ID bands would be difficult. In this case, one ID band would be appropriate.
   - (maternal addressograph) on the baby's blanket after wrapping. Note: if a neonatal death has occurred the neonate will have its own addressograph.

2. Wrap baby completely in a blue plastic protector (bluey) to prevent dehydration, soiling/contamination and deterioration.

   The placenta should be sent to Perinatal Pathology in a plastic bag within a sealed, labelled plastic placenta container. Do not place the placenta in saline, formalin or any other form of fixative. Attach a maternal addressograph to the sealed plastic bag, the container and its lid. Record date and time of birth and placental weight on the container lid. A pathology request form should accompany the placenta, including details of the clinical history, maternal gravida, parity, gestation and date and time of the birth.

3. Page the orderly (3101) and ask for a mortuary bag to be brought to the area. **Babies less than 20 weeks shall be transported in a sealed, labelled white plastic container.**

Refer to Operational Directive from the Department of Health WA- POLICY FOR THE RELEASE OF HUMAN TISSUE AND EXPLANTED MEDICAL DEVICES Page 5- 1.2.3 Preparation for the release of human tissue.

4. Prior to transfer to Perinatal Pathology, **check with Orderly:**
   - Identification sticker on the baby matches Identification sticker in Perinatal Death Register.
   - any additional items to accompany the baby are listed and confirmed as being included with the baby.
   - sign the Perinatal Death Register
   - Orderly to countersign Register

5. The Hospital orderly must record every transfer of the baby to and from Perinatal Pathology in the Perinatal Pathology Movement Register

6. A 'Permission to Transport a Deceased Baby" form (MR295.95) is required to release a baby to its parents' care. The parents may elect to return the baby to KEMH or to the care of a nominated funeral director.

7. The transfer of a baby's body to a funeral director must be recorded in the Perinatal Pathology Mortuary Register.

8. For babies of less than 20 weeks gestation, the parents may take the baby home for disposal after completion of the MR 355A form.

PARENTAL CONTACT WITH THEIR BABY

- Parents shall be offered the opportunity to spend time with their baby at any time. The baby may stay in the woman's room whilst she is an inpatient.

- If the baby is in Perinatal Pathology the following process shall be followed. Nursing / midwifery staff:
    - phone Perinatal Pathology and inform them that the parents wish to view their baby.
    - page the on call orderly (3101) to collect the baby from Perinatal Pathology.
    - accept the baby from the orderly and prepare the baby for contact with the parents.
    - when the parents request their baby to be returned, page the orderly to collect the baby from the nurse / midwife on the ward.
    - ensure the baby is returned to Perinatal Pathology at the end of the contact time.

- Following discharge the parents may spend time with their baby in the viewing room in Perinatal Pathology. This is arranged through Perinatal Pathology. Pastoral Care Services, Social Work Department or the Midwife Coordinator (Perinatal Loss Service) may assist in making these arrangements. If the parents wish to view the baby on weekends or public holidays, the Hospital Clinical Manager will make the arrangements. The parents may spend time with the baby in an appropriate area (e.g. Labour and Birth Suite).

POLICY TITLE: FDIU: STILLBIRTH

Joondalup Health Campus recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant JHC employees must comply with this policy and ensure that these minimum standards are integrated into the facilities clinical systems and JHC employee's individual practice.

Key words: Purpose, Stillbirth - less than 20 weeks gestation, Policy Refers to, Expected Outcome, Equipment, Procedure / Guidelines, References, Related Policies and Procedures Guidelines, Stillbirth - greater than 20 weeks gestation, Related Forms.

PURPOSE

To provide guidelines on the appropriate management of a woman with a fetal death in utero (FDIU).

STILLBIRTH - LESS THAN 20 WEEKS GESTATION

POLICY / GUIDELINE / PROCEDURE REFERS TO

Midwife, Medical officer, Chaplaincy staff, Pathology staff

EXPECTED OUTCOME

- Grieving parents are managed appropriately with adequate support and follow-up services arranged and information given.
- Appropriate documentation is completed and tests arranged.
- Fetus is managed in the appropriate manner.

EQUIPMENT

- Equipment as required for delivery
- Pathology buckets x 2
- Pathology request slips and blood tubes
- Paperwork envelopes in stillbirth information cupboard in birth suite, appropriate to fetus' gestation.
- Bassinet and carry cot, baby clothing (provided by CWA)
- Information booklet for parents from SANDS "A Baby has died".

PROCEDURE / GUIDELINES

Paperwork required:

1. Formal Ultrasound in radiology is obtained and reviewed to confirm fetal death in utero.
2. Requirements for Post Mortem - Consent for Post Mortem Examination (MR 236) OR Laboratory Request Form or Consent for Pathology Examination - fetus of less than 20 weeks gestation (MR 238).

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

3. Requirements for Cremation - Consent for Cremation Stillborn Baby less than 28 weeks gestation (MR297).
4. General
   - Miscarriage Checklist (< 20 weeks) (HR 350-1)
   - Mortuary Record Sheet to be signed by Funeral Director collecting baby and by staff member whom baby is collected from.
   Copy kept in notes.

Pathology Department:
Blood tests from mother and placental specimens as per policy Stillbirth > 20 weeks.

Cremation:
See policy Stillbirth > 20 weeks

Post Mortem Details:
See policy Stillbirth > 20 weeks, however paperwork is as outlined above.

Care of Deceased Baby:
Wrap in blue underpad or plastic bag and place in labelled pathology bucket. Wrap in a bunny rug for viewing by parents if applicable.

Support of Grieving parents
- Limit staff involved, assign single room.
- Offer pastoral care, who will give support and assist with preparations and decision-making regarding cremation and memorial service.
- Use teardrop stickers on front of notes, patient's door, clipboard folder
- Notify other staff - clerical, cleaning, kitchen and switchboard to ensure that information released is approved by parents
- Support person to stay as required/requested, and visitor access as required by parents
- Ensure parents are debriefed by medical staff prior to discharge
- RMO to notify GP before patient discharged
- Offer home visiting service as required
- Parents to return to obstetrician's rooms 7 weeks post natal for post mortem and follow-up blood test results.
- Pain relief as ordered by medical staff may be given at **any** stage on client request.
- Commence Syntocinon infusion 30iu in 500 mL CSL after delivery of fetus.
- Clamp and cut the cord but do not attempt controlled cord traction as cord is friable and will often snap. Await spontaneous delivery of the placenta, unless actively bleeding. If so, manage as PPH. Refer to Haem: Postpartum Haemorrhage (C08.02).
- Syntometrine is given as usual, and ensure that client's bladder is empty post delivery.

Care Specific to Misoprostil Induction < 20 weeks:
- Refer to FDIU: Misoprostol - Guidelines for use of - for Miscarriage of FDIU in the Second Trimester (C06.02).

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

STILLBIRTH - GREATER THAN 20 WEEKS GESTATION

POLICY / GUIDELINE / PROCEDURE REFERS TO

Midwife, Medical Officer, Chaplaincy Staff, Pathology Staff

EXPECTED OUTCOME

- Grieving parents are managed appropriately with adequate support, follow-up services arranged and information given.
- Appropriate documentation is completed and tests arranged.
- Stillborn is managed in an appropriate manner.

EQUIPMENT

- Paperwork envelopes in stillbirth information cupboard in birth suite, appropriate to fetus' gestation.
- Bassinet/cot, baby clothing (provided by CWA)
- Pathology equipment as outlined in policy
- Equipment as required for delivery (see policy)
- Information booklet for parents from SANDS "A Baby has died".

PROCEDURE / GUIDELINES

Paperwork required:

1. Formal ultrasound in radiology is obtained and reviewed to confirm fetal death in utero.
2. To register baby:
   (All fetuses of greater than 20 weeks gestation are required by law to be registered)
   - Complete Meditech
   - Centrelink Claim for Bereavement Allowance form (SA366)
   - Birth Registration Form (BDM1)
3. Legal Documentation
   - Death in Hospital Form HR 90-0 filed in patient's notes
   - Birth Information Paper and the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM201)
   - Certificate of Medical Attendant (Form 7)
4. Requirements for Post Mortem - Consent for Post Mortem Examination (MR 236) Part F (Authority for Post Mortem Examination) must be completed by a medical officer nominated by JHC. The list of nominated medical officers is contained in the paperwork packages in birth suite.
5. Cremation (option not available at KEMH if > 28 weeks gestation, or if any signs of extra-uterine life) - Consent for Cremation of Stillborn Stillborn Baby less than 28 weeks gestation (MR297).

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

6. Fax Notification of Perinatal Death form to Executive Director of Public Health. Original to be kept in patient's notes.
7. General
   - Checklist for Stillbirth and Neonatal Death.
   - Mortuary Record Sheet to be signed by Funeral Director collecting baby, and by staff member from whom baby is collected. Copy kept in notes.
8. Pathology form for follow-up 6 week blood tests to be given to patient on discharge.

PATHOLOGY DEPARTMENT

1. Blood tests from mother - Serology; CMV, toxoplasmosis, rubella, parvovirus Group and antibody screen, thrombophilia screen, coagulation profile, TFT. Lupus anticoagulant, anticardiolipin antibody, anti -DNA antibody, C3 4, HBAIC, ANA, random BSL.
   Tubes required; 6 blue top tubes, 1 large pink top tube, 3 yellow top tubes, 3 small purple top tubes, 1 grey top tube
2. Placental specimens - See Policy Placental Specimens - Collection of (C16.40).
3. Repeat blood tests at 6 weeks post natal.

CREMATION:

KEMH offers a cremation service for all stillbirths/neonatal death up to 28 weeks gestation. Babies which show any sign of extra-uterine life (regardless of gestation), or those of greater than 28 weeks gestation, must be managed by a Funeral Director. A fee is applicable for KEMH cremations where the parents have declined a post -mortem examination.

The JHC Chaplain will assist the parents with making decisions regarding cremation and funeral arrangements. Contact Coordinator through After Hours Manager 9621/5038. Muslim parents may need to bury their baby before sunset on the day of death. The Muslim Burial Society of Perth is available to assist with these arrangements. Contacts numbers are in the White pages.

NON CORONIAL POST MORTEM EXAMINATION

Document in patient's notes when 'Non-Coronial Post Mortem Examinations Information for Parents' leaflet has been provided.

Post mortem options discussed with parents by registrar/obstetrician and outcome documented in notes.

POST- MORTEM DETAILS:

Post-Mortem examinations are able to be performed at KEMH Perinatal Pathology Department on all non-coronial stillbirths/neonatal deaths. Helpful documents pertaining to

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

this are available from birth suite, and are included in the paperwork packages. These include "Guidelines for Health Care Professionals...", “Perinatal Documentation Requirements, "What to do in the event of a perinatal death", all issued by the KEMH department of Perinatal Pathology.

Contact; KEMH Perinatal Pathology Department by phoning 9340 2730 and provide the following information - Hospital contact name and telephone number, baby's name (if given), maternal name (baby of), gestational age and completed documentation details. They will then contact the nominated registered funeral director to arrange collection and transport.

Send with baby: placenta - this must be bagged, labelled and placed in white bucket available from Pathology Department. Swabs and specimens obtained from the placenta are processed by JHC Pathology Department.

- Appropriate paperwork as outlined above, including Form 7 - Certificate of Medical Attendant and Birth Information Paper and the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM201), consent for autopsy and cremation, details of Funeral Director if known, and a contact number for the parents.

Address to: Post Mortem Coordinator
Perinatal Pathology
KEMH
Lower Ground Floor
Hensman Road, Subiaco

If Post-Mortem is refused, the following may be ordered:

1. Placental specimens as outlined above.
2. Whole placenta sent for examination.
3. Cord blood and /or CSF
4. X-ray and/or ultrasound of baby.
5. Needle biopsy of specific organs.

CARE OF DECEASED BABY:

1. Wear gloves when handling baby.
2. Affix duoband labels.
3. Record weight, length, head circumference, hand and footprints on rear of cot card, lock of hair if applicable.
4. Bathe baby gently if appropriate and dress in gown donated by the CWA and kept in the EDP office cupboard.
5. Keep baby in birth suite refrigerator until parents are prepared to release baby for autopsy. Baby should be wrapped, placed in a labelled plastic bag and laid on a towel whilst in the fridge.

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

6. Use Bassinet or cot to transport to parents room for viewing. Wrap baby in a warmed blanket prior to transport so baby does not feel so cold.

SUPPORT OF GRIEVING PARENTS

1. Issue with grief information kit available from birth suite, if greater than 28 weeks gestation, or SANDS booklet "A Baby has Died".
2. Contact pastoral care for support if appropriate.
3. Limit staff involved, assign single room.
4. Use teardrop stickers on front of notes, patients' door, clipboard folder.
5. Notify other staff - clerical, cleaning, kitchen and switchboard to ensure that information released is approved by parents.
6. Support person to stay as required / requested, and visitor access as required by parents.
7. Ensure parents are debriefed by medical staff prior to leaving hospital.
8. Services - notify patients GP, Child Health Centre and SANDS with parents consent.
9. Offer obstetric home visiting service for follow up.
10. Clinical review of the case to be carried out at next perinatal meeting. If fresh stillbirth, a case review should be planned with parent's input as to whom they would like to be present.
11. Cradle Picture offers a free service for stillbirths greater than 28 weeks gestation and are happy to be contacted at any time - phone number available from birth suite.
12. Make appointment for 7 weeks post natal with obstetrician covering delivery prior to discharge. Parents can obtain post mortem results and follow-up blood tests as applicable at this visit.
13. Ensure mother has been given Cabergoline for lactation suppression prior to discharge. (See BF: Lactation Suppression Management (C02.15)).
14. RMO to notify GP before patient discharged.

REFERENCES

1. Department of Health WA Public Health. Perinatal and Infant Deaths website. Accessed from http://www.public.health.wa.gov.au/3/503/2/perinatal_and_infant_deaths.pm 5 September 2013.
2. Perinatal Society of Australia & New Zealand. Clinical Practice Guideline for Perinatal Mortality. Second edition. Retrieved from http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=3&cad=rja&ved=0CDQQFjAC&url=http%3A%2F%2Fwww.psanz.com.au%2Fcomponent%2Fdocman%2Fdoc_download%2F54-clinical-practice-guideline-for-perinatal-mortality%3FItemid%3D131&ei=uiIoUqeVEcLklAXh7IHADg&usg=AFQjCNHZE2CjtDD8NlDC2KPnQnxvbAUyxA 5 September 2013.

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

RELATED POLICIES, PROCEDURES, GUIDELINES

- Joondalup Health Campus. BF: Lactation Suppression Management (C02.15).
- Joondalup Health Campus. Death: Certification – Documentation (C04.03).
- Joondalup Health Campus. Death: Coronial (C04.04)
- Joondalup Health Campus. Death: Non Coronial Case – Post Mortem Request (C04.06).
- Joondalup Health Campus. FDIU: Misoprostol - Guidelines for use of - for Miscarriage of FDIU in the Second Trimester (C06.02).
- Joondalup Health Campus. Haem: Postpartum Haemorrhage (C08.02).
- Joondalup Health Campus. Placental Specimens - Collection of (C16.40)
- Women and Newborn Health Service King Edward Memorial Hospital Clinical Guidelines (2009). 8.4.1 Perinatal Death - Legalities. Retrieved from http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectiona/8/a8.4.1.pdf 5 September 2013.
- Women's & Children's Health Service. (2003). Perinatal Pathology Guidelines for Health Care Professionals applicable to all perinatal deaths. 3rd Ed.
- Women and Newborn Health Service King Edward Memorial Hospital. (2007). Guidelines for health-care professionals applicable to all perinatal deaths sent to King Edward Memorial Hospital. Retrieved from http://www.kemh.health.wa.gov.au/brochures/health_professionals/wnhs0074.pdf 7 October 2013

RELATED FORMS

- Birth Information Paper and the Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM201)
- Birth Registration Form (BDM1)
- Centrelink Claim for Bereavement Allowance form (SA366)
- Certificate of Medical Attendant (Form 7)
- Consent for Cremation Stillborn Baby less than 28 weeks gestation (MR 297)
- Consent for Post Mortem Examination (MR 236).
- Checklist for Stillbirth and Neonatal Death (HR 350-2)
- Death in Hospital Form HR 90-0
- Laboratory Request Form or Consent for Pathology Examination - fetus of less than 20 weeks gestation (MR 238)
- Miscarriage Checklist (< 20 weeks) (HR 350-1)
- Notification of Perinatal Death form

Prepared/Authorised By	M Wise Clinical Nurse (JHC).	April 1999
Reviewed/Authorised By	Quality Office 0702SWJL	July 2002
Reviewed/Authorised By	M Wise Clinical Midwife.	September 2002
Reviewed/Authorised By	W Candy.	March 2004

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

POLICY TITLE: FDIU: STILLBIRTH

Reviewed/Authorised By	W Candy.	February 2005
Reviewed/Authorised By	M Wise CN.	November 2005
Reviewed/Authorised By	T Kiley CN, A Monk A/NUM, Obs & Gynaecology.	June 2006
Reviewed/Authorised By	H Godwin SDN O&G, K Glenn Maternal & Neonatal Services Manager.	July 2007
Reviewed/Authorised By	M Wise CN, K Glenn Maternal & Neonatal Services Manager, Dr V Chapple Consultant, Dr S Isdale Head of Department Obstetrics & Gynaecology, M Kruenert Patient Advocate.	April 2008
Reviewed/Authorised By	P Kiley CNS Birth Suite, K Glenn Maternal & Neonatal Services Manager, Dr S Isdale HoD Obstetrics & Gynaecology.	September 2008
Reviewed/Authorised By	P Kiley CNS Birth Suite, A Farlie Manager Maternity & Women's Health, Dr R Petersen Director Obstetrics & Gynaecology. Ratified by Guidelines & Procedure Review Committee.	January 2012
Reviewed/Authorised By	P Weston Consultant Obstetrician& Gynaecologist, H Watson CNM Public Obstetrics & Gynaecology, S Isdale HoD Obstetrics & Gynaecology. Ratified by Guideline & Procedure Review Committee	September 2013
Date Implemented		April 1999
Next Review Due		September 2016
Document Controller Contact	Quality Administration	

DOCUMENT CONTROL and HISTORY

Version 1.1	Policy implemented.	April 1999
Version 1.2	Quality Audit.	July 2002
Version 1.3	Content revised.	September 2002
Version 1.4	Content revised.	March 2004
Version 1.5	Content revised.	February 2004
Version 1.6	Content revised.	November 2005
Version 1.7	Content revised.	June 2006
Version 1.8	Content revised.	July 2007
Version 1.9	Content revised.	April 2008
Version 1.10	Content revised.	September 2008
Version 1.10.01	Previously coded JOGCC07.16(1). Content revised, purpose added.	December 2011
Version 1.11	Policy updated.	January 2012
Version 1.11.01	References, Related Policies, Procedures, Guidelines updated. Minor changes to content.	September 2013
Version 1.12	Policy updated.	September 2013

This is a confidential document for the use by Joondalup Health Campus only - not to be reproduced or otherwise used without the permission of Joondalup Health Campus.
CONTROLLED DOCUMENT

Policy

Name:	Miscarriage, Stillbirth and Neonatal Death Care of the Baby
Number:	MIC-MAT-POL-0003
Type of Policy:	Departmental
Position Responsible:	Nurse Manager, Maternity and Neonatal Services
Approved By:	Director of Nursing
Date Approved:	5th November, 2015
National Standard:	Standard 2: Partnering with Consumers Standard 5: Patient Identification and Procedure Matching Standard 6: Clinical Handover Standard 12: Provision of Care

1. Introduction

St John of God Midland Public and Private Hospital (SJGMPPH) is committed to creating a safe environment for patients and providing the highest standard of nursing and midwifery care.

Reverence for human life, from conception to death, underpins the care provided by the hospital caregivers to those suffering spontaneous abortion, stillbirth or neonatal death. In order to achieve this Midland has a multi-disciplinary approach including medical, nursing, and midwifery, social work and pastoral care services according to the individual needs of each patient.

2. Purpose

The purpose of this policy is to ensure that the fetus, irrespective of gestational age, is treated with respect and dignity and the bereaved parents are offered support during this difficult time.

3. Scope

This policy applies to all caregivers at SJGMPPH.

4. Definitions

In this policy,

Spontaneous Abortion: Refers to the expulsion of products of conception from the mother of less than 20 weeks gestation or less than 400grams in weight.

Stillbirth: Refers to the complete expulsion or extraction from the mother, of a product of conception of at least 20 weeks gestation or 400 grams birth weight, which after separation, do not show any signs of life.

Neonatal Death: Refers to the death of a live born infant (regardless of gestation) within 28 days of birth.

5. Policy

5.1 Legislation

5.1.1 Disposal of the body must be carried out according to legal requirements:

Spontaneous Abortion

According to current legislation, a fetus born at less than 20 weeks or less than 400 grams birth weight does not require to be registered as a birth and death. A funeral or service is not a legal requirement.

Recognition Certificates for early pregnancy loss before 20 weeks or less than 400 grams birth weight are now available from the West Australian Registry of Births, Deaths and Marriages for babies that are not able to be formally registered under the Births, Deaths and Marriages Registration Act (1998). A recognition certificate cannot be used for official purposes.

Stillbirth (20-28 weeks gestation)

Is required to be registered as a birth and a death. Certification of disposal of the body is required although the parents are not legally bound to have a funeral. Disposal of the body may be carried out by SJG (arranged with King Edward Memorial Hospital -KEMH) or the funeral directors according to the wishes of the parents.

Stillbirth (over 28 week's gestation)

Is required to be registered as a birth and a death. The parents are legally bound to arrange a funeral, which must be organised through a funeral director.

Neonatal Death

Is required to be registered as a birth and a death. The parents are legally bound to arrange a funeral, which must be organised through a funeral director.

5.2 Pathology testing/ disposal of remains

NB: Please refer to Pathology work flows found on intranet under Electronic Policies and Procedures for pathology testing as noted in the following points

5.2.1 Less than 12 week's gestation

- In early pregnancy loss of less than 12 weeks gestation there are usually no recognisable fetal parts, cells or tissue. In this instance the remains may be disposed of as normal clinical waste. Cremation is not required legally, however if the patient would like the products of conception cremated this can be arranged. The following options are available:

- interment of ashes at King Edward Memorial Hospital's (KEMH)Memorial Garden with the option to attend a Memorial Service at KEMH
- return of ashes to SJGMPPH to be collected by the parent/s, with the option of a Remembrance Ritual, provided by Pastoral Services.

- If pathology testing is requested by the medical practitioner SJGHC Histopathology Department will examine all products of conception and all products of conception samples. Routine histology will be performed on the sample.

5.2.2 **12–20 week's gestation**

- Written consent from one parent for pathology examination and cremation must be obtained prior to discharge from hospital (M10633) by a medical practitioner. Consent should be obtained in the pre-operative or pre-delivery period, if possible.

- The parents may make a decision regarding interment arrangements at this time or they may choose to decide at a later date (within one month) and inform Pastoral Services of their decision. If no decision is communicated to Pastoral Services within one month, Pastoral Services will continue to contact the family until a decision is made.

- Parents may choose not to have pathology examination carried out. In this instance they should be referred to the medical practitioner for further discussion.

- Cremation of fetal remains, regardless of gestation will be carried out at KEMH.

- Fetal remains less than 20 week's gestation will be transported to KEMH via the pathology department courier service. Please complete Pathology Request Form to send to SJGHC Pathology who will forward to KEMH.

- The parents should be given the following options for disposal of the remains (should identifiable fetal parts be found):

    - Cremation and interment of ashes at KEMH's Memorial Garden with the option to attend a Memorial Service at KEMH
    - Cremation and return of ashes to SJGMPPH for parent/s to collect, with the option of a Remembrance Ritual provided by Pastoral Services
    - Private burial of remains is also an option. The parents must sign a disclaimer prior to taking remains from the Hospital form M10162 – Human Tissue Disclaimer.
- If no recognisable fetal parts are found the remains sent to Pathology for testing and Cytogenetic if requested.

- Consent for pathology testing may be obtained and witnessed by the medical practitioner while the patient is in hospital.

- Consent for cremation and interment preferences may be obtained by medical practitioner, and/or Pastoral Services personnel.

5.2.3 **Stillbirth (Gestation 20-28 Weeks)**

- Cremation arranged by Pastoral Services (at KEMH) and interment of ashes at KEMH with or without a service attended or unattended by parents and family/friends.
- Cremation arranged by Pastoral Services and retention of the ashes by the parents.
- Cremation/burial by funeral directors either attended or unattended by parents. Parents must contact funeral directors to make arrangements.

5.2.4 **Stillbirth (> 28 weeks) and Neonatal Death**

- Cremation of remains over 28 week's gestation, neonatal death or burial of remains must be arranged by the parents through a funeral director. The parents are legally bound to arrange a funeral, which must be organised through a funeral director.

5.3 Documentation

5.3.1 Commence appropriate documentation as soon as possible to ensure accurate transfer of information. The Nurse, Midwife caring for the patient is responsible for ensuring completion of appropriate documentation according to current legislation.

5.3.2 Documentation to be completed:

Less than 12 weeks gestation:

- SJGHC Pathology request form for Cytogenetic (medical practitioner to complete) – this should contain brief relevant maternal history.
- If fetal parts are found at initial pathology testing – Consent for Pathology Examination/Cremation (medical practitioner to obtain).
- Early Pregnancy Loss checklist.

12 – 20 weeks gestation:

- SJGHC Pathology request form (medical practitioner to complete) this should contain brief relevant maternal history.
- Consent for Pathology Examination/Cremation (medial practitioner to obtain).
- Early Pregnancy Loss checklist.

Stillbirth Gestation (20 – 28 weeks)

- HR123 Consent for Cremation of Stillborn form. If cremation is requested this form must accompany the baby for cremation and a copy placed in

the patient's medical record. If cremation/burial by funeral directors Form 7 Certificate of Medical Attendance replaces the Consent for Cremation of Stillborn form.

- BDM201 Medical Certificate of Cause of Perinatal Death. The attending medical practitioner must complete this form in duplicate as soon as possible following delivery. (Original form to accompany the baby for cremation and a copy to be placed in the patient's medical record.)
- Consent for Post Mortem Examination. It is the responsibility of the medical practitioner to obtain parental consent for post mortem examination. The form must be signed by parents and medical practitioner.
- Nursing caregivers must confirm autopsy request by telephoning the Perinatal Pathology Department at KEMH – 9340 2730 in hours or the next available day. There is no charge to the parents for this service.
- Birth Notification Form as usual
- Birth Defects Register Form if necessary
- Bereavement Claim Form (Centrelink)

Stillbirth (> 28 weeks gestation) and Neonatal Death

- BDM201 Medical Certificate of Cause of Perinatal Death. The attending medical practitioner must complete this form in duplicate as soon as possible following delivery. (Original form to accompany the baby for cremation and a copy to be placed in the patient's medical record.)
- MR236 Consent for Post Mortem Examination. It is the responsibility of the medical practitioner to obtain parental consent for post mortem examination. The form must be signed by parents and medical practitioner.
- Form 7 Certificate of Medical Attendance (cremation only)
- Birth Notification Form
- Birth Defects Register Form if necessary
- Bereavement Claim Form (Centrelink)

5.4 Pastoral Services

5.4.1 Early referral to Pastoral Services is essential for the provision of timely and appropriate emotional care of patients who have experienced pregnancy loss. If pregnancy loss occurs after hours Pastoral Services may have to contact the patient following discharge from hospital.

5.4.2 Pastoral Service caregivers form part of the multi-disciplinary team providing care and support to patients experiencing pregnancy loss. The caregiver should inform Pastoral Services as soon as possible. The caregiver

should contact Pastoral services in hours by CIS referral and if urgent followed up by telephone to phone/paging system, out of hours requires a CIS referral. * Provide support – practical, emotional, and/or psych spiritual according to individual needs.

5.4.3 Role of Pastoral Services

- Assessment of the patient's level of grief surrounding the loss
- Provision of emotional and spiritual support as required
- Provide or facilitate access to appropriate rituals i.e. Remembrance rituals or Memorial Service at KEMH
- Provision of pregnancy loss pack for pregnancy loss <20 weeks
- Provision of bereavement support post-discharge as required
- Facilitate the collection of ashes with parent/s if ashes are returned to SJGMPH
- Naming certificate if desired by parents

6. Procedure

6.1 Notify the consultant and the care of the patient will be determined by the gestation of the pregnancy (< 20weeks gestation cared for on ward 2C, if >20 weeks gestation birth suite/2A).

6.2 The parents' wishes regarding viewing and disposing of the baby must be respected at all times, taking into consideration religious and cultural needs.

6.3 Inform Pastoral services and Social work services.

6.4 Depending on gestation follow appropriate steps:

6.4.1 Gestation < 20weeks

- Ensure that all products of conception including the placenta are kept together in the ward/theatre refrigerator, in a suitable receptacle, clearly labelled, until a decision regarding pathology tests has been made. The placenta must accompany the fetus for pathology testing. The placenta MUST NOT BE FROZEN. Formaldehyde MUST NOT BE USED unless specifically requested by the medical practitioner.

- The fetus and placenta may remain in the ward/theatre until transferred to Pathology as appropriate (according to size).

- Parents should be given the opportunity to see the fetus/baby regardless of gestation. In the case of early spontaneous abortion the fetus may be indistinguishable but explanation of size, features etc… should be given. Parents may take their own photographs.

- Wraps for dressing the fetus are located either on 2C, Pastoral Services office or Birth Suite together with memento boxes, which may be offered to the parents.

- Inform Pathology Department who will coordinate pathology or transfer to KEMH for pathology testing if required.

- The parents must be consulted prior to transfer of the fetus/baby for pathology testing, to ensure that they do not wish to see the baby again.

- All appropriate documentation according to procedure requested i.e. Consent for Pathology Examination/Cremation and SJGHC pathology request form, must accompany the fetus. The pathology form should include a brief, relevant maternal history.

- Following completion of pathology examination Pastoral Services will arrange cremation/ service if appropriate.

6.4.2 Gestation > 20 weeks

- The parents' wishes regarding viewing and disposing of the baby must be respected at all times, taking into consideration religious and cultural needs.

- Ensure that the placenta is kept in a suitable receptacle, clearly labelled, until a decision regarding pathological tests has been made. The placenta MUST accompany the fetus for pathology testing. The placenta MUST NOT BE FROZEN.

NOTE: Formaldehyde MUST NOT BE USED unless specifically requested by the doctor. If pathology testing is not to be carried out it is not necessary to keep the placenta.

- A Cold Cuddle Cot, clothes (gowns) and wraps are available in Birth Suite for use as appropriate. There are also memento boxes, which may be offered to the parent(s).

- Commence appropriate documentation as soon as possible to ensure accurate transfer of information.

- Nursing/midwifery caregivers will offer all possible support as appropriate:

    - Viewing, holding, touching baby
    - Recording of weight/length and head circumference. Also to note any obvious abnormalities and document in Medical notes.
    - Photographs and mementos of baby e.g. cot card, name band, lock of hair, foot/hand prints etc. Obtain verbal consent from the parents.
    - Apply name identification labels and cot card.
    - Bereavement package (kept in Birth Suite)
    - Information on disposal of body according to current legislation.

- Parents should be given the opportunity to see the baby regardless of gestation. Photographs may be taken at birth by the photographer and given to parents or placed in medical record. Parents may take their own photographs.

- Arrangements should be made for partner to remain as a boarder if desired.

- The parents should be allowed to be with the baby for as long as they desire. A Cold Cuddle Cot is available in the Maternity Ward. The baby should be taken to the Body Hold at the parent's request.

- Nursing/midwifery caregivers should contact either Perinatal Pathology Department at KEMH – 9340 2730 or the funeral directors chosen by the parents, to arrange transfer of the baby, according to the parents' wishes.

- The funeral directors or transport service will contact the Midwife Manager or AHNM to arrange a suitable time for collection of the baby.

- The appropriate documentation will remain in the mother's medical record until the baby is released from the fridge but must accompany the baby when transferred.

- The mother will transfer post birth to ward 2A. A room as quiet as possible should be allocated to avoid areas in close proximity to newborn babies.

- All documentation should accompany the mother, if transferred, including documentation relating to post mortem and cremation of the baby. The ward nursing/midwifery caregivers then become responsible for transfer and release of the baby from the designated Birth Suite fridge.

- The parents must be consulted prior to removal of the baby from the Body Hold, either by the transport service or funeral directors, to ensure that they do not wish to see the baby again.

- Ensure that consent has been obtained from one parent regarding post mortem examination and disposal of fetal remains as appropriate.

Note: The decision regarding disposal/interment may be made at a later date.

- Following post mortem examination the Pastoral Services Department can arrange cremation and service if appropriate.

- "Tear Drop" stickers are available in Birth Suite and Maternity Ward. These should be placed on patient's documentation, room door, bed board etc. to indicate loss of a baby.

- The Birth Suite register must be completed. Birth registration forms should be given to the parents prior to discharge.

- The social worker should be contacted if necessary.

- The appropriate child health nurse should be notified by telephone as birth information details will automatically be sent out.

- Inform HVMS and arrange follow up on discharge.

- If the death is to be investigated by the Coroner - leave all tubes in situ; curl up the catheters and tape to the baby. The Midwife manager or AHNM will contact the Coroner's Office.

Support for Caregivers

The Midwife Manager will provide support to all caregivers involved with the deceased patient and grieving family. Assistance may also be sought from Pastoral Services and Employee Assistance Program.

7. References

7.1 Department of Health, Western Australian

7.2 KEMH, Clinical guidelines, Section A, 8.4 Perinatal Death, September 2008

7.3 Perinatal pathology Department, KEMH

7.4 The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005 – 2007

7.5 Western Australian Registry of Births, Deaths and Marriages, May 2015

8. Related Documents

8.1 SJGMPPH Cold Cuddle Cot Procedure

8.2 SJGMPPH End of Life Care Policy

8.3 SJGMPPH Pathology Manual

8.4 SJGMPPH Transfer of the Deceased to the Body Hold

9. Acknowledgements

We acknowledge the following previous site endorsed work and/or contributors used to compile this policy:

9.1 SJGSH Policy MP 414 Spontaneous Abortion – Care of the Fetus/baby

9.2 SJGSH Policy MP 459 Stillbirth and Neonatal Death– Care of the Fetus/baby

10. Audit/Compliance

10.1 Compliance against this policy will be evaluated with routine incident processes.

11. Revision History

Revision No.	Position Responsible	Approving Authority	Date Approved
First Issue	Nurse Manager, Maternity and Neonatal Services	Director of Nursing*	5th November 2015

***As per "SJGMPPH Commissioning Policy and Procedure Framework"**

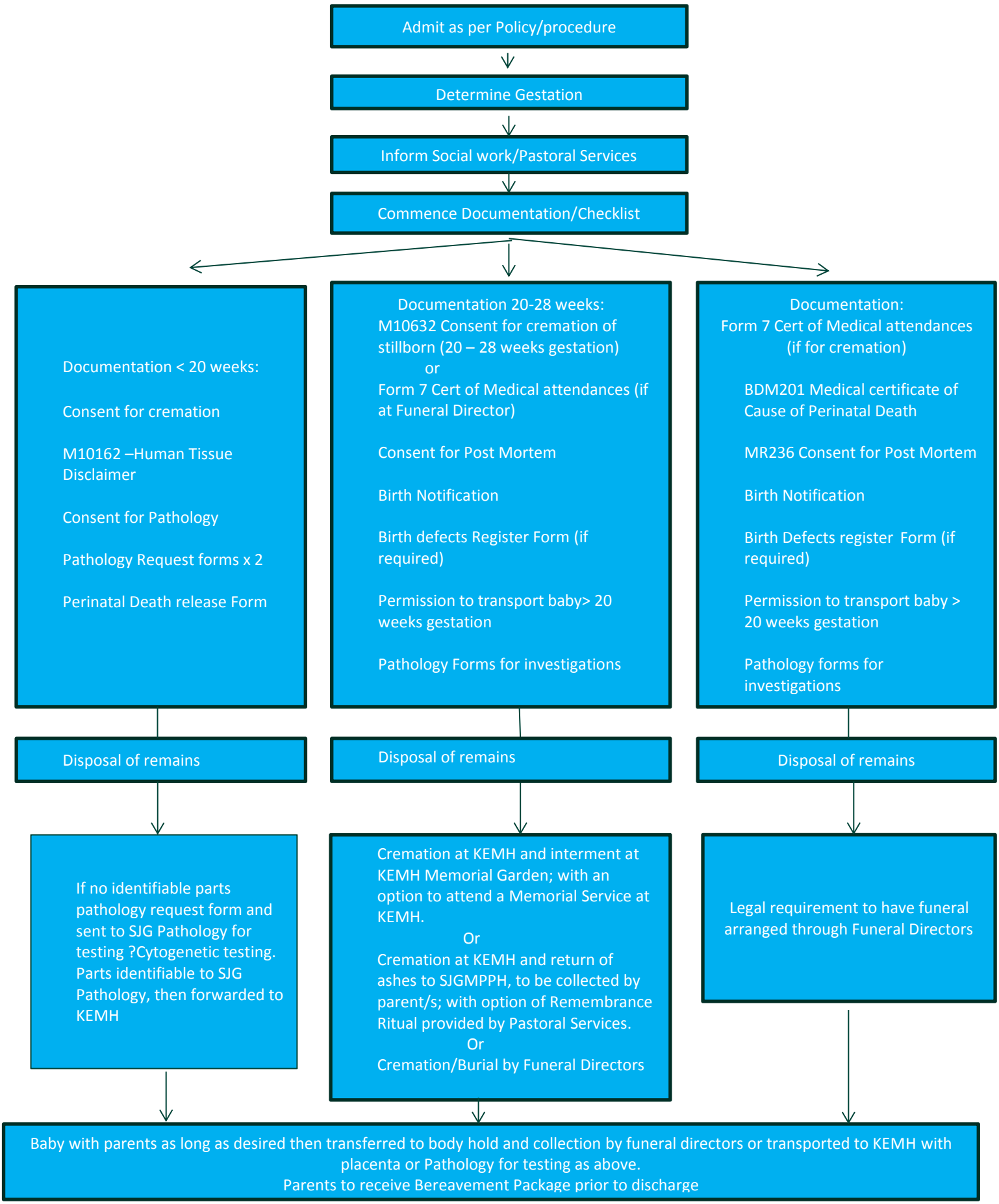
12. Next Review Date

1st August 2017

13. Disclaimer

Printed or personally saved electronic copies of this document are considered uncontrolled. Refer to the SJGHC Compass Intranet (Electronic Policies and Procedures Library) for current controlled electronic policies.

Appendix A - Miscarriage, Stillbirth and Neonatal Death Flow Chart



Perinatal Loss

Stillbirth is one of the most common adverse pregnancy outcomes. In 2006 the rate of stillbirth in Australia was 7.4/1000 births.(4) Investigation to determine the cause of death and identify contributing factors is important to assist with parental counselling and to inform future prevention strategies. (7, 8, 12, 16, 17, 19, 21)

Contents

Causes and risk factors (7, 8, 9, 15) 2
Congenital/karyotypic anomalies 2
Classification and legal identity: Refer to Appendix 3 (13, 14) 2
Diagnosis (7, 8) 2
Breaking the news: Refer to Appendix 1 (7, 8, 11) 3
Start completing PSANZ Core Investigations checklist found in the paperwork pack in the perinatal loss folder. (7) 5
Documentation: Refer to Appendix 2 5
Birth (7, 8, 10) 5
Induction of labour (7, 8, 10) 5
  Recommended dosages for different indications: (22) 5
Investigations following birth 6
Clinical examination of Baby 6
Placental Examination 7
Autopsy (7, 8, 16, 18, 20, 21) 7
  Explaining Autopsy to the Parents (7) 7
  Purpose of autopsy (7, 8, 16, 18, 20, 21) 8
  Consent for autopsy (7, 8, and 20) 8
  Preparation for autopsy 8
  Alternative Investigations when autopsy declined (7, 8, 18, 20) 9
Taking baby home (7, 8) 9
Funeral arrangements: Perinatal Loss Folder 9
Follow up (7, 8, 11, 16, 18, 20 21,) 10
  Further investigation for thrombophilia must be undertaken 8-12 weeks 10
Appendix 1: Parental Support/Funeral Directors 11
Appendix 2: Documentation 11
Appendix 3: Reporting Aid 11
Appendix 4: Photographing the baby 11
Appendix 5: Subsequent pregnancy care 11
Appendix 6: Staff Support 11
References 11

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Causes and risk factors (7, 8, 9, 15)
It is vital to try to determine the cause of stillbirth, however many cases remain unexplained (15 -18 % in WA). More than one condition may contribute to the stillbirth and conditions may be associated without directly causing the stillbirth. The proportion of stillbirths that are reported as "explained" increases when there is a systematic comprehensive approach to investigation.
The most common causes are:

Congenital/karyotypic anomalies

- Growth restriction/placental thrombosis

Medical diseases such as:

- Diabetes
- Hypertensive disease/preeclampsia
- Systemic lupus erythromatosus
- Hypothyroidism
- Renal disease
- Thrombophilias
- Cholestasis of pregnancy

Congenitally acquired infections such as:

- Group B Streptococcus and Parvovirus B19
- Other contributing factors include:

Smoking and substance use/Obesity/Multiple gestation

Classification and legal identity: Refer to Appendix 3 (13, 14)
For the purposes of birth registration of a child, the Births, Deaths and Marriages Registration Act 2003 states that "a child includes a stillborn child". It is compulsory to register the birth of a child whether born alive or stillborn. A stillborn child is defined in this legislation as a child who:

- Has shown no sign of respiration or heartbeat or other sign of life after completely leaving the child's mother; and
- Who has been gestated for 20 weeks or more; or weighs 400 g or more

It is a clinical decision as to whether there are signs of life or not

Diagnosis (7, 8)
Intrauterine fetal death requires formal confirmation by an ultrasound examination that demonstrates a lack of fetal heart activity.

- The ultrasound should be performed by experienced staff (credentialed sonographer or obstetrician)

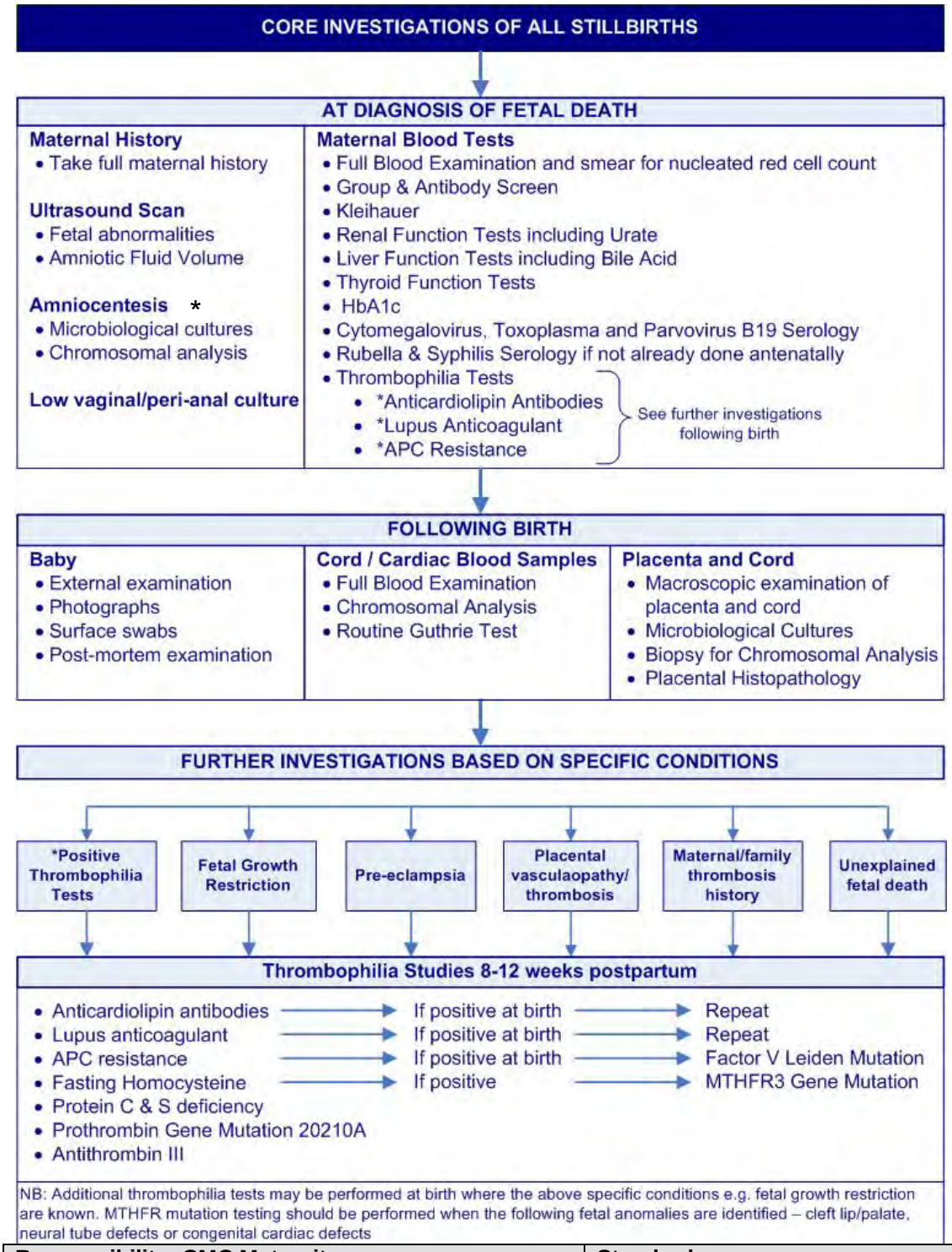
- * Amniocentesis (for karyotype and infection screen) is a useful investigation, however this is not offered at AHS.
- A midwife or doctor as escort should be made available to support the woman while attending ultrasound examination for confirmation of a suspected fetal death
- Consider the requirement for social worker support
- Promote continuity of carer for women experiencing a stillbirth

Breaking the news: Refer to Appendix 1 **(7, 8, 11)**

- Break bad news in a private, quiet room
- Ensure a support person is present for the woman
- Use empathetic but unambiguous, simple language (e.g. “your baby has died”)
- The most experienced practitioners are required for these difficult conversations
- Do not delay breaking the news once diagnosis is confirmed. This may include discussion of the option to register the birth if the baby dies before 20 weeks gestation and the birth occurs after 20 weeks gestation
- Allow as much time as needed for parents to consider care options and make decisions
- Be aware that men and women may respond and grieve differently
- Staff are encouraged to express their sorrow for what has happened. Offering sympathy is not an admission of guilt or error. Two practitioners present is helpful.
- Reassure parents that every attempt will be made to find a cause of death in a medical review
- Explain that stillbirths often remain unexplained even after a detailed review
- Avoid speculation regarding the cause of death until investigations are complete
- When appropriate, reassure the mother that the death was not due to anything she did or did not do
- Consider special circumstances (e.g. previous stillbirth or multiple pregnancy)
- Offer referral for counselling/support services (e.g. social worker, pastoral support, SIDS and KIDS WA)
- Discuss Creating memories **Appendix 1**

Core Investigations of all Stillbirths Algorithm – found in paperwork in perinatal loss folder **(7)**

* Amniocentesis (for karyotype and infection screen) is a useful investigation, however this is not offered at AHS.



Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Start completing PSANZ Core Investigations checklist found in the paperwork pack in the perinatal loss folder. (7)

CPOE perinatal loss order form available

Documentation: Refer to Appendix 2

Birth (7, 8, 10)

Provide information on birth options appropriate to the clinical circumstances and service capabilities. Vaginal birth is generally preferable to caesarean section with minimisation of maternal risk being the most important factor.

There is usually no clinical need to expedite birth urgently and hasty intervention may not be in the best long-term interests of the parents. If clinically appropriate, the woman may wish to go home and return for induction at a later date.

- Adequate analgesia is particularly important when requested by women with perinatal loss –Epidural or PCA after full discussion with the woman about both. (Refer to the Anaesthetist for PCA infusion prescription)
- Active management of the third stage is recommended (due to increased risk PPH)
- Provide information to women and their families on how the baby may appear following birth. Parent's fears are often worse than the reality: be honest and use sensitive but unambiguous language
- Support requests to normalise the birth experience (e.g. partner cutting the umbilical cord)
- Handle the baby with care, to prevent damage e.g. in case of skin slippage
- Ensure family members private waiting areas (i.e. separate from other birthing families)

Induction of labour (7, 8, 10)

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

Recommended dosages for different indications: (22)

Second Trimester	Third Trimester
Miscarriage/IUFD 14 -28 weeks	**IntraUterine Fetal Death** > 28 weeks
· **Mifepristone** 200mg orally (witnessed) – for priming	· **Mifepristone** 200mg orally (witnessed) – for priming · Followed 36 hrs later by vaginal

· Followed 36 hrs later by: **Misoprostol** 400mcg · Sub lingually 3 hourly · **OR** vaginally 4 hourly (max 5 doses) **Previous ceasarean: Half dose of Misoprostol.** In each case the dosage regimen should be discussed with the obstetric consultant and modified to the woman's particular medical circumstance.	prostaglandin (gel or pessary) · **OR** if Misoprostol is used the dose suggested is 25- 50mcg vaginally 4 hourly (Misoprostol is not generally recommended > 28 weeks for the scarred uterus and should only be used at the discretion of the Consultant on call after informed consent is given by the woman.)
	Scarred Uterus · Mifepristone alone 200mg tds for up to 3 days can be considered in the IOL of FDIU in a woman with a scarred uterus. · Once favourable an ARM can be done, followed by Oxytocin infusion as for VBAC

Investigations following birth

Continue the PSANZ **Core Investigations Checklist** (7)

Clinical examination of Baby

Complete the PSANZ **Clinical Examination of Baby Checklist** found in the paperwork pack in the perinatal loss folder. (7)

External examination of the baby	By the midwife prior to examination by a Perinatal pathologist. (7,8,18)
Surface microbiological swabs	(ear and throat) for microbiological cultures (7,8,18)
Clinical photographs.	Front, both sides and back Appendix 4 and refer to laminated pictorial instructions in the Perinatal loss folder (7,8,18)
Blood sample collection	Samples from the cord by the midwife or cardiac puncture by the pathologist for

	investigations of infection and blood group (7,8,18) Blood samples for chromosomal analysis by perinatal pathologist (7,8,18)
Baby gram at KEMH (x-ray)	(where an post-mortem is refused if facility available)(7,8,18)
Post-mortem examination	by perinatal pathologist (7,8,18)

Placental Examination

Complete the PSANZ **Accoucher Placental Examination Checklist** found in the paperwork pack in the perinatal loss folder. (7)

Placental microbiological cultures	Using sterile scissors cut just under base of cord and obtain a swab specimen from between the amnion and chorion. (7,8,18)
Placental and amnion biopsy	For chromosomal analysis (after swabbing, cut a small sample of amnion, chorion and placenta and place in normal saline in a specimen collection pot)**Not Formalin** (7,8, 18) If requested on post mortem consent, the pathologist will collect this specimen
Visual observation	Detailed macroscopic examination of the placenta and cord (7, 8, 18)

In W.A. all post mortem examinations on newborns are carried out at KEMH.
From February 2004, the transport and collection of all non-coronial perinatal deaths is co-ordinated from the Peri-natal Pathology Dept at KEMH.
Contact 9340 2730 to arrange for autopsy examinations (18) This is a Mon- Fri 07:30-16:00 service

Autopsy (7, 8, 16, 18, 20, 21)

An autopsy should be offered to all parents following a stillbirth and is the single most useful diagnostic test. It is preferable that the autopsy is performed by a perinatal pathologist, as is the case in WA. Ensure this is followed up if birth is outside of normal hours.

Explaining Autopsy to the Parents (7)

Discuss with the parents using the 'Non Coronial Post Mortem Examinations' found in the Perinatal Loss Folder. This is available in several languages

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

The PSANZ 'Explaining Autopsy'. Found in the paperwork pack in the perinatal loss folder is for your own educational use about how to discuss autopsy and what questions you may be asked. (7)

Purpose of autopsy (7, 8, 16, 18, 20, 21)

The main purposes of an autopsy are:

- Identification of an accurate cause of death
- Confirmation of antenatally diagnosed or suspected fetal pathology
- To exclude some causes of death
- Identification of disorders with implications for counselling and monitoring for future pregnancies7
- Enhancement of parents understanding of the events surrounding the death which may:
- Alleviate anxiety in a future pregnancy if a non-recurring cause is found
- Assuage guilt in mothers if an uncontrollable cause is determined
- Provide benefits to the extended family and opportunities for prenatal testing if a familial cause is evident
- To inform clinical audit of perinatal death
- For medico-legal reasons
- For research purposes (e.g. expansion of the body of knowledge)

Consent for autopsy (7, 8, and 20)

All autopsy examinations require written consent following informed discussion
MR 236 Consent for post-mortem examination is used. Clearly document the extent of the consent. (Refer to appendix 2 for all documentation required) Consent can be gained by appropriately trained clinical staff including midwives, doctors and nurses.

Preparation for autopsy

The following should accompany the baby for autopsy:

- Autopsy consent form
- Placenta (fresh not in formalin)
- Copy of AK55A with the comprehensive clinical/obstetric history including relevant previous obstetric history
- Copies of :
- The Medical Certificate of Cause of Stillbirth or Neonatal Death certificate
- All antenatal ultrasound reports
- Prenatal karyotyping results if available

Alternative Investigations when autopsy declined (7, 8, 18, 20)

A limited autopsy examination may yield useful information in situations where the parents decline full autopsy. Where parents decline a full autopsy:

- Confirm that parents understand important information may be missed

Offer parents options for:

- External examination by a perinatal/paediatric pathologist, clinical geneticist or paediatrician
- Full body X-ray (baby gram at KEMH)
- Ultrasound scan
- Clinical photographs
- Ensure request forms for pathology, histology or external examination clearly indicate the extent of consent. Ensure follow up if after hours.

Taking baby home (7, 8)

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

The requirement for a letter confirming the baby was stillborn (in case of official query e.g. during transport) Request the GP obstetrician or specialist Obstetrician to write on hospital letter head paper.

- The effect of local climate on the body (i.e. temperature and humidity) Advice about keeping the baby in a cool room and wrapped ice blocks kept on the cot mattress.
- Completion of release forms (1)
  Authorisation and 'Release of Human Tissue and Explanted Medical Device Consent Form'. WA Health MR
  http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12907
- Providing the Medical Certificate of Cause of stillbirth or Neonatal Death if care being transferred to the Funeral Director.
- Legal requirements regarding birth registration, burial/cremation
- Arrangements for return to hospital or funeral home

Funeral arrangements: Perinatal Loss Folder

It is a requirement to make arrangements for any Perinatal death, stillbirth/miscarriage or neonatal death. Options include: burial or cremation for a stillborn baby (refer to definition of stillbirth.)

- Provide information regarding options for funeral arrangements (e.g. local funeral directors, access to the baby in the funeral home)
- If in-utero fetal death less than 20 weeks, the parents have the choice of taking the body home for appropriate burial. If so, completion of release forms will be required. (1)

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Authorisation and 'Release of Human Tissue and Explanted Medical Device Consent Form'. WA Health MR http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12907
OR the body can be cremated at KEMH and the ashes scattered in the Rose garden there or collected by the family or returned to the Clinical Midwifery Consultant at Armadale hospital to be collected by the family.

- Provide information on opportunities to mourn the baby (e.g. hospital memorial services, remembrance services)

Follow up (7, 8, 11, 16, 18, 20 21,)

The woman will receive the usual visiting midwifery service at home.
An appointment is to be made with the **specialist obstetrician** involved in the care of the woman and her family at **10 weeks** postnatally. The appointment is arranged for then as the investigations will be completed and a full history can be explained.
The woman should see her GP in a few weeks for a general health check.
Refer to Appendix 4 for discussion of care in a future pregnancy.

Further investigation for thrombophilia must be undertaken 8-12 weeks after the birth where: fetal death is associated with:

- fetal growth restriction,
- preeclampsia,
- maternal thrombosis and/or there is maternal family history of thrombosis
- The stillbirth remains unexplained following the standard investigations or
- Tests for thrombophilia were positive at the time of the intrauterine fetal death (IUFD) as follows:
- Anticardiolipin antibodies; and Lupus anticoagulant repeated if positive at the time of the intrauterine fetal death or initial testing if not previously undertaken
- APC resistance if it was not undertaken at birth
- Factor V Leiden mutation if APC resistance was positive at birth
- Fasting Homocysteine and if there is a positive test for MTHFR gene mutation
- Protein C and S deficiency
- Prothrombin gene mutation 20210A

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Appendix 1: Parental Support/Funeral Directors
Appendix 2: Documentation
Appendix 3: Reporting Aid
Appendix 4: Photographing the baby
Appendix 5: Subsequent pregnancy care
Appendix 6: Staff Support
This guideline is congruent with the Perinatal Society of Australia and New Zealand (PSANZ) Clinical Practice Guideline for Perinatal Mortality (PSANZ Clinical Guideline) and clinicians are encouraged to refer to the relevant related sections.

References

Department of Health
1. Authorisation and 'Release of Human Tissue and Explanted Medical Device Consent Form'. WA Health MR
http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12907

2. Certification of death (Births, Deaths and Marriages Registration Act 1998, please see Operational
Circular 1652/03). Include Operational Directives and policy

3. Perinatal and infant deaths must be reported to the Executive Director, Public Health (Section 336 A of Health Act 1911, please see Operational Circular 1454/01).

4. Reportable deaths which require notification to the Coroner (Coroner's Act 1996, please see Information Circular 0008/07).

5. Sentinel events are to be reported to the Director, Office of Safety and Quality in Healthcare, along with reporting to AIMS. The Sentinel Event Policy is available at:
http://www.safetyandquality.health.wa.gov.au

6. Operational Directive OD 00448/13 Western Australian Review of Death Policy
http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12990. Also available at
http://www.safetyandquality.health.wa.gov.au/mortality/

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Best Practice Clinical Documents

7. Flenady V, King JF, Charles A, Gardener G, Ellwood D, Day K, et al. for the Perinatal Society of Australia and New Zealand (PSANZ) Perinatal Mortality Group, PSANZ Clinical practice guideline for perinatal mortality. April 2009; version 2.2.

8. RCOG Greentop Guideline No 55: Late Intrauterine Fetal Death and Stillbirth. October 2010 http://www.rcog.org.uk/womens-health/clinical-guidance/late-intrauterine-fetal-death-and-stillbirth-green-top-55

9. World Health Organization. Under-five mortality rate (probability of dying by age 5 per 1000 live births) 2008 [cited October 13 2010]. Available from: http://www.who.int/whosis/indicators/compendium/2008/3mr5/en/

10. ACOG practice bulletin No. 102: Management of stillbirth. Obstetrics & Gynecology. 2009; 113(3):748-761.

11. State-wide Obstetric Support Unit. Caring for families experiencing perinatal loss. West Australia Statewide Obstetric Support Unit. 2009. http://kemh.health.wa.gov.au/services/SOSU/MPLNAP.php

Others

12. Laws P, Hilder L. Australia's mothers and babies 2006. Perinatal statistics series no. 22. Cat. no. PER 46. AIHW National Perinatal Statistics Unit. 2008.

13. Chan A, King J, Flenady V. Classification of perinatal deaths: Development of the Australian and New Zealand classifications. Journal of Paediatrics and Child Health. 2004; 40(7):340-7.

14. Flenady V, Froen J, Pinar H, Torabi R, Saastad E, Guyon G, et al. An evaluation of classification systems for stillbirth. BMC Pregnancy & Childbirth. 2009; 9(24).

15. International Association of Diabetes and Pregnancy Study Groups. Recommendations on the diagnosis and classification of hyperglycemia in pregnancy. Diabetes Care. March 2010; 33:676-682.

16. Flenady V, Middleton P, Smith G C, et al. Stillbirths: the way forward in high-income countries. The Lancet's Stillbirths Series steering committee* Vol 377 May 14, 2011 http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673611600640.pdf?id=a02f57d1811fcb77:-b3a1abb:14195e3c91f:-59651381200647500

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

17. Frederik Frøen J, Cacciatore J, McClure E M, et al. Stillbirths Series steering committee* Stillbirths: why they matter. The Lancet Vol 377 April 16, 2011 http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610622325.pdf?id=a02f57d1811fcb77:-b3a1abb:14195e3c91f:-59651381200647500

18. Guidelines on autopsy practice. Scenario 9: Stillborn infant (singleton) The Royal College of pathologists June 2006 http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/G001Autopsy-Stillbirths-Jun06.pdf

19. Lawn J E, Blencowe H, Pattinson R, et al, Stillbirths: Where? When? Why? How to make the data count? The Lancet's Stillbirths Series steering committee* Vol 377 April 23, 2011 http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610621873.pdf?id=a02f57d1811fcb77:-b3a1abb:14195e3c91f:-59651381200647500

20. Measey M A, Charles C, Tursan d'Espaignet E, et al. Aetiology of Stillbirth; unexplored is not unexplained. Australian and new Zealand Journal of Public Health. 2007 Vol.31 No 5

21. Pattinson R, Kerber K, Buchmann K, et al. Stillbirths: How can health systems deliver for mothers and babies? The Lancet Vol 377 May 7, 2011 http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610623069.pdf?id=a02f57d1811fcb77:-b3a1abb:14195e3c91f:-59651381200647500

22. FIGO: Misoprostol dosage recommendation 2012

23 . Statewide Obstetric Support Unit: Perinatal Loss eLearning package http://kemh.health.wa.gov.au/services/SOSU/education.php?PHPSESSID=dbee455a7cb44ca7aeb754fc473f99f3#elearning

Appendix 1: Parental support (7.8)

Perinatal death is a significant life event and parental support is reported as being integral to recovery and integration. Parents report that health care providers behaviours that are helpful include those noted below:

- **Respect** – treat parents and baby with respect and privacy
- **Compassion** – care should be culturally sensitive and compassionate
- **Communication** – provide information, including written material
- **Time** – allow parents time to make decisions, and time with their baby
- **Continuity of carer** – promotes and enhances communication and satisfaction

Respect	Treat the deceased baby with the same respect as a live baby (e.g. handle baby with care, use name if one was given) Support parents to feel in control of the care of their baby Respect the wishes/preferences of parents when offering care Respect cultural and religious beliefs/practices/rituals
Information provision	Allow time for discussion Communicate empathetically, clearly and honestly Listen reflectively to the parents Where feasible, ensure both parents are present at discussions Provide clear explanation of the length of stay on hospital expected, and where they will be e.g. Bickley ward. Inform them they can take their baby home for a few days if they wish. Repeat important information as stress and grief may interfere with comprehension and recall of information Provide written information for frequent reference Use parent friendly language (e.g. avoid terms such as fetus, products of conception) Deliver information in a quiet private room away from other patients Consider the timing of information provision (e.g. future pregnancy information may be more appropriate after birth rather than before)
Care setting	Offer the option of private room in surgical, maternity or gynaecological units as feasible (i.e. away from other babies) Offer accommodation to the woman's support person as feasible Consider universal symbols outside room and on the health record to alert all staff to a stillbirth
Memory creation	Offer time with baby – inform parents they may hold, undress, and bath baby if desired. (Complete all swabs and tests on baby before bathing) Offer for both parents, family and siblings (if parents think it appropriate) to spend time with the baby, Provide a 'Grief pack' with brochures including information about: – memento booklet – 'SIDS and Kids' brochure – grief response brochure Parental keepsake photographs. Call 'Heartfelt". 1800 583 768

Responsibility: CMC Maternity	**Standards**
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

	Even if photographs declined, take them to keep in the medical records as parents often want to see them at a later date. Offer options to include extended family (e.g. photographs of family groups, relatives/siblings to hold baby, video conferencing if available) Offer option to take baby home if feasible Facilitate religious/cultural rituals and services Facilitate **memento** creation/gathering following parental consent (e.g. identification tags, hand and footprints, digital photographs, cot cards, hair collection) Where immediate memento creation is declined – offer storage of mementos for future access. Mementos can be stored in a sealed envelope in the woman's health record until/if parents request them
Funeral /Blessing arrangements	Discuss naming / blessing/ baptism services and other religious rituals Refer to Perinatal Pathology Handbook for additional information regarding autopsy examinations and cremation services at KEMH. Discuss funeral plans including consideration of: – cremation options – private funeral director arrangements (cremation or burial)
After care	Advise on lactation suppression and methods to manage supply Advise on contraception Advise on postnatal exercises Provide written information on available support services for parents and children Refer to below for support contacts Inform parents of expectations of grief journey Discuss options for early discharge with extended midwifery service home care where feasible Provide information on Centrelink Family Allowance Forms – Claim for Bereavement Payment of Family Tax Benefit, Maternity Allowance
Referral/Follow up	Consider the requirement for referral to relevant health care professionals and support groups prior to discharge – particularly for counselling /psychological support services (e.g. genetic counsellor, social worker, Child Health Services, pastoral care worker9) Support group contact details below Arrange follow up appointment(s) for the purposes of recurrence risk counselling17 and discussion of investigation results – first appointment within 2 months Communicate a stillbirth event to the woman's General Practitioner, Paediatrician and other relevant care providers Forward a comprehensive summary to these care providers **Cancel 'BOUNTY PACKS' 08 94175145**

Agencies providing grief support

Organisation	Contact Details
SIDS and KIDS WA	Advocate for and fund research into stillbirth and other areas of sudden and unexpected child death. Extend bereavement support and counselling to families who have experienced stillbirth or the sudden and unexpected death of a child, regardless of the cause.

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

	Web: http://www.sidsandkids.org/ Bereavement support phone: 1300 308 307 (24 hour)
SANDS (QLD) Inc. (Stillbirth and Neonatal Death Support)	Provides support, information, education and advocacy for parents and their families who have suffered the loss of a baby through miscarriage, stillbirth, neonatal death and other reproductive losses. Offers support via telephone and support group meetings Web: http://www.sandsqld.com/ SANDS WA: 1800686780 Bereavement support : Free Call 13000 SANDS (13 000 72637)
Heartfelt (formerly Australian Community of Child Photographers)	Professional photographers dedicated to providing photographic memories to families that have experienced stillbirths, premature and ill infants and children in the Neonatal Intensive Care Units of their local hospitals, as well as children with serious and terminal illnesses. All services are provided free of charge. 1800583768 Web: http://www.heartfelt.org.au/
Pregnancy and Infant Loss Australia	A support program for bereaved families who have experienced loss through miscarriage, stillbirth, genetic inducement of labour or neonatal death. Web: http://www.teddyloveclub.org.au/ Bereavement support phone 1800 824 240 No Local Contact
Lifeline	Provide telephone crisis support to anyone needing emotional support. Web: http://www.lifeline.
Angelhands Inc	www.angelhands.org.au Offers support and strength to people who are affected or bereaved by violence.
Australian Centre for Grief and Bereavement:	Freecall 1800 642 066; www.grief.org.au This service provides details of free bereavement counselling services and links to websites.
Australian Funeral Directors' Association:	Ph (08) 9355 3441; www.afda.org.au
Beyond Blue:	Freecall 1300 224 636; www.beyondblue.org.au This service assists those with depression and anxiety problems.
Compassionate Friends:	http://www.compassionatefriends.org/ An international family support organisation working to bring hope to families who have lost a child
Crisis Care 24 hour support:	Ph (08) 9223 1111 or STD Freecall 1800 199 008 or TTY (08) 9325 1232 accessed through the Telephone Interpreter Service. www.community.wa.gov.au/DFC/Resources/Helplines/Crisis_care_helpline.htm

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

DepressioNet:	www.depressionet.com.au Provides information and support to people with depression, including families and friends.
Family Helpline:	Ph (08) 9223 1100 or Freecall 1800 643 000 Free telephone counselling and information service for families with relationship difficulties.
Mensline:	Freecall 1300 789 978; www.menslineaus.org.au The service provides counselling services especially for men.
Metropolitan Cemeteries Board:	Ph (08) 9383 5200 For information about burial, cremation and services: www.mcb.wa.gov.au
Solace Association:	Freecall 1300 308 307 or Ph (08) 9359 3892 Offers support for people who have lost their partner. Services are also extended to affected children. www.solace.org.au

Multicultural Services and Resources:

Anglicare WA	Inc. including Kinway Counselling: Ph (08) 9263 2000; www.anglicarewa.org.au This service offers counselling including specialised care for Aboriginal people.
Australian Indigenous Health Infonet:	http://www.healthinfonet.ecu.edu.au/ and: http://www.healthinfonet.ecu.edu.au/states-territories-home/wa/programs-and-projects These webpages provide details and links for health programs and projects that address the health of Aboriginal people in WA.
Centrecare:	Ph (08) 9325 6644; http://www.centrecare.com.au/ This service offers counselling including specific care for migrant and Indigenous families.
Derbarl Yerrigan Health Service:	http://www.derbarlyerrigan.com.au/ This is an Aboriginal Community controlled organisation which has operated for 35 years and now has 135 staff delivering a range of health services across multiple sites in Perth.
Ishar Multicultural Women's Health Centre:	Ph (08) 9345 5335; Fax: (08) 9349 9113; 8 Sudbury Place, Mirrabooka 6061 WA; Email: info@ishar.org.au Provides many services for culturally and linguistically diverse (CALD) communities in the Perth metro

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

	area. These include a mental health counselling service, and a support and skills development program for those from a CALD community who are caring for someone with a mental illness. www.ishar.org.au
Online WA Multicultural Communities Gateway:	http://www.multicultural.online.wa.gov.au/ This website lists a large number of Community Groups and Community Service Organisations.
Yorgum Aboriginal Family Counselling Service:	Fax (08) 9228 0385 This service provides specialised counselling for Aboriginal people suffering distress.

Appendix 2: Documentation

Document	Documentation for fetus less than 20 weeks
MR 238<20	**MR 238 <20 weeks consent Pathology - Parental consent required**
MR297<20	**MR297<20 week Consent for Cremation - Parental consent required**
Bereavement	**Bereavement payment-** Not eligible
Registration	**Registration** - If LIVEBORN or stillborn > 20 weeks or ≥ 400g must be registered, otherwise not eligible for birth/death registration but will receive a 'Recognition of Life' certificate from KEMH.(If requested)
Post Mortem - Optional	**Post Mortem - Optional -** Pathology examination is offered at KEMH on the fetus less than 20 weeks – use yellow pathology form
Photos/memory box	**Photos/memory box** – Photo and hand and foot prints if possible with 'Recognition of Life' certificate from KEMH for memory box.
Cremation or funeral	**Cremation or funeral –** The baby/fetus can be taken home for appropriate disposal. Completion of Authorisation and 'Release of Human Tissue and Explanted Medical Device Consent Form'. WA Health MR is required http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12907 **Or** KEMH Cremation. Family can collect ashes or have them interred at KEMH Rose garden. Can also be sent to GP or maternity unit manager. Needs to be discussed with the family.
The Statutory	**The Statutory Law** states that gestation is assessed according to

Law	the duration of the pregnancy not intra-uterine fetal life.
Midwives Notification	**Midwives Notification Stork** – No Stork to complete for a pregnancy less than 20 weeks

Document	Documentation for fetus 20-28 weeks
BDM 100	**BDM 100** Birth registration Form – for all births greater than 20 weeks, regardless of outcome, and for live born babies less than 20 weeks gestation. Parents complete this and return the form to the Registrar Generals office. http://www.bdm.dotag.wa.gov.au/_files/BDM1_Birth_Applic_Form.pdf
FORM 7	**FORM 7** Certificate of Medical Attendant. Cremation Act 1929, for any live born baby or stillborn http://www.health.wa.gov.au/cremations/docs/cremation_form7.pdf
Post Mortem MR 236	**Post Mortem** MR 236 – If PM chosen. Placental histopathology on request (this is a critical investigation). Send the placenta (fresh) to perinatal pathology at KEMH. Not required if PM consented
BDM 201	**BDM 201** Medical Certificate of cause of Stillbirth or Neonatal Death – Completed by the attending Doctor and goes with the babe to KEMH. Perinatal Pathology returns it to the Registrar Generals office as notification of death. (for Statutory Requirements for Executive Director Public Health).
Cremation Or Outside Funeral Director	**Cremation** at KEMH is free of charge KEMH can cremate a still born up to 28 weeks gestation. To arrange this, include the **MR297** Consent for Cremation less than 28 weeks of a Stillborn. http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.6.3%20-%20HP345%20Cremation%20Consent%20less%20than%2028%20wks.pdf?PHPSESSID=63ec888e5559873ef09cd8e78f612eb9 The ashes can be for internment in Memorial Garden. Refer to dates for this to occur. Last Thursday of every month at 12:30pm. **Or** request for return of separate ashes to the woman's GP/maternity unit or collected from KEMH by woman.

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

	Or Outside Funeral Director
Midwives Notification.	**Midwives Notification**. Labour and birth summary information is reported to WA Health by Midwives as Notification of Case Attended **(NOCA)** for all births. This may be via **STORK** database where in use.
CIMS	**CIMS for is required to be completed for all babies 20 weeks gestation or signs of life**
Bereavement payment	**Bereavement payment - Claim for Bereavement Payment** form (from Family Assistance Office, ph 13 6150). If eligible for bereavement payment the parents have two choices. 1. The one off baby bonus or 2. The 12 weeks maternity leave entitlement. They are only eligible for this if they would otherwise be on paid maternity leave. http://www.humanservices.gov.au/spw/customer/forms/resources/fa008m-1307en.pdf The booklet is in the perinatal loss box file.
Photos and Memory Box	**Photos and Memory Box** – completion of grief pack booklet
Statutory Law	**Law** Post Mortem – Non coronial PM's can only be performed at the parents request NOT the Doctor's. The family can request a post mortem without a doctors signature and clinical staff can witness the parental signature following discussion.MR 236 – If PM chosen
Death in Hospital	**Death in Hospital** 'Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year shall die from any cause whatsoever, the fact shall be reported forthwith to the Executive Director, Public Health.' Operational Directive OD 0448/13 Western Australian Review of Death Policy http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12990 *How to notify: A midwife or doctor can provide all the details and fax them.* Notification may be made by email, telephone, fax or mail (contact details below). Provide the following information as soon as possible, preferably within 48 hours: 1. Patient name 2. Date of death 3. Place of death 4. Contact details of reporting practitioner 5. Medical Certificate of Cause of Stillbirth or Neonatal Death or the

	Medical Certificate of Cause of Death, if available. Contact details Email: edphwa@health.wa.gov.au Telephone: 9222 2295 Fax: 9222 2322 Mail: Executive Director Public Health Regulatory Support and Training Unit Public Health and Clinical Services Division Department of Health PO Box 8172 Perth Business Centre WA 6849 Information Circular 0133/13: Notification of Deaths, can be accessed at the Department of Health Operational Directives and Information Circulars website : http://www.health.wa.gov.au/circularsnew/
FOR CORONIAL INQUIRY	**FOR CORONIAL INQUIRY** http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.4%20-%20MR001_Death_in_hospital.pdf?PHPSESSID=ohkcmgdevlzov

Document	**Documentation for fetus >28 weeks**
BDM 100	**BDM 100** Birth registration Form – for all births greater than 20 weeks, regardless of outcome. Parents complete this and return the form to the Registrar Generals office. http://www.bdm.dotag.wa.gov.au/_files/BDM1_Birth_Applic_Form.pdf
Form 7	**Form 7** Certificate of Medical Attendant. Cremation Act 1929, for any live born baby or stillborn http://www.health.wa.gov.au/cremations/docs/cremation_form7.pdf
Claim for Bereavement Payment	**Claim for Bereavement Payment** form (from Family Assistance Office, Ph 13 6150). If eligible for bereavement payment the parents have two choices. 1. The one off baby bonus or 2. The 12 weeks maternity leave entitlement. They are only eligible for this if they would otherwise be on paid maternity leave. http://www.humanservices.gov.au/spw/customer/forms/resources/fa008m-1307en.pdf The booklet is 66 pages long. An example of the claim form is in the

	perinatal loss file.
BDM 201	**BDM 201** Medical Certificate of cause of Stillbirth or Neonatal Death – Completed by the attending Doctor and goes with the babe to KEMH. Perinatal Pathology returns it to the Registrar Generals office as notification of death. (for Statutory Requirements for Executive Director Public Health) baby > 20 weeks to be cremated.
MR 236	**MR 236** Consent for post-mortem examination. Used in conjunction with the Information for parent's pamphlet. This clearly explains all procedures and options regarding post-mortem examination. A midwife may sign as a witness. http://www.health.wa.gov.au/postmortem/docs/KEMH_PM_Consent_form_Review%20_MR236_%20231002.pdf
Pathology Form	**Pathology Form** For histopathology of placenta – KEMH will accept AHS forms.
Midwives Notification.	**Midwives Notification**. Labour and birth summary information is reported to WA Health by Midwives as Notification of Case Attended **(NOCA)** for all births. This may be via **STORK** database where in use.
CIMS	**CIMS** Form to be completed
Funeral	All perinatal deaths over 28 weeks or any neonatal deaths are managed by a Private Funeral Director of the Parents' choice.
Statutory Law	**Statutory Law** Post Mortem – Non coronial PM's can only be performed at the parents request NOT the Doctor's. MR 236 – If PM chosen
Death in Hospital	**Death in Hospital** 'Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year shall die from any cause whatsoever, the fact shall be reported forthwith to the Executive Director, Public Health.' Operational Directive OD 0448/13 Western Australian Review of Death Policy http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=_12990 *How to notify: A midwife or doctor can provide all the details and fax them.* Notification may be made by email, telephone, fax or mail (contact details below). Provide the following information as soon as possible, preferably within

	48 hours: 1. Patient name 2. Date of death 3. Place of death 4. Contact details of reporting practitioner 5. Medical Certificate of Cause of Stillbirth or Neonatal Death or the Medical Certificate of Cause of Death, if available. Contact details Email: edphwa@health.wa.gov.au Telephone: 9222 2295 Fax: 9222 2322 Mail: Executive Director Public Health Regulatory Support and Training Unit Public Health and Clinical Services Division Department of Health PO Box 8172 Perth Business Centre WA 6849 Information Circular 0133/13: Notification of Deaths, can be accessed at the Department of Health Operational Directives and Information Circulars website : http://www.health.wa.gov.au/circularsnew/
CORONIAL INQUIRY: IF NEEDED	**CORONIAL INQUIRY** http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.4%20-%20MR001_Death_in_hospital.pdf?PHPSESSID=ohkcmgdevlzov

Appendix 3: Reporting Aid (7, 13, 14)

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Gestation at birth	Weight	Definition	Register Birth with Registrar of Births deaths and marriages?	Death Certificate required?	Perinatal data collection Reporting required?
<20 weeks	< 400 g	Miscarriage or fetal death before 20 weeks	No	No	No
<20 weeks	<400g	Born alive (gasps/heart beat)	Yes	Yes	Yes
< 20 weeks	≥ 400 g	Stillbirth/	Yes	Yes	Yes
≥ 20 weeks	≥ 400 g	Stillbirth	Yes	Yes	Yes
≥ 20 weeks	< 400 g	Stillbirth	Yes	Yes	Yes
≥ 20weeks and proven fetal death in-utero at < 20 weeks (proven by ultrasound)	Any weight	Fetal death before 20 weeks	Optional*	Optional*	Yes

Notes:

*The Registrar of Births Deaths and Marriages has endorsed the optional nature of birth registration in these circumstances

A stillborn child is taken to have died "…when the child has left the mother's body "(i.e. time of death = time of birth of stillbirth). A child born without signs of life for which resuscitation is attempted and is unsuccessful remains a stillbirth and time of death equals time of birth.

A stillborn child means a child "…who has shown no sign of respiration or heartbeat or other sign of life after completely leaving the child's mother".

Appendix 4: Clinical Photographs for Pathologist (7)

Refer to laminated pictorial instructions in perinatal loss folder

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Instructions on taking clinical photographs

High quality medical photographs are preferred; however, Polaroid pictures are better than no pictures at all. Ideally digital photographs should be taken which will allow the clinician to check each photograph after it is taken. These photographs should be taken in addition to bereavement photographs.

Consent:

Parental consent is necessary prior to taking clinical photographs. Document the consent in the medical notes. Due to their clinical nature it is strongly recommended that the parents are not offered copies, but specific bereavement photographs are taken instead. These only need to be done if there is no post mortem being done.

Ensure the baby is handled with respect and sensitivity at all times.

Background:

Plain drapes (blue is the best background – other backgrounds may create glare or alter skin tone). Use of a blue theatre gown would suffice. **Scale:**

- Place a paper tape measure next to the baby (a plastic ruler will create glare)
- Ensure zero is aligned at the base of the foot or crown of the head.
- Use sticky tape to ensure the tape is straight; and
- Measure should be on the bottom of the frame or the left.

Identification:

Write the baby's UR number on the paper tape measure for identification.

Don't write any other identifying information in case the photographs are ever mislaid.

Setting:

Photographs should be taken in a private area away from the parents.

Technique:

The photographs should be taken from directly above the baby. Consequently it is best to place the baby on the floor, in order to get sufficient height above the baby.

Magnification:

Use a 50 mm lens/magnification for the whole body photographs, and maintain a consistent distance. Use a 100 mm lens/magnification (except for digital) for the facial photographs, filling the whole frame.

Baby: The baby should be naked for all the photographs.

Position:

- AP view – whole body frontal including limbs
- PA view – whole body back including limbs
- Lateral view of the body
- Lateral views of the face
- Frontal view of the face
- Photographs of any abnormalities

Responsibility: CMC Maternity	Standards
Guideline Owner: CMC Maternity Author: CM Wendy Jackson	EQuIPNational: 1.1.1, 1.5.2, 1.7.2, 1.8, 1.9.1, 1.19,4.7.1,4.14.1, 6.2 Armadale Obstetrics and Gynaecology Manual
Endorsed By: Women's Health Review Committee	
First Compiled: Sept 2013	
Last Amended:	
Review Date: Sept 2016	

Appendix 5: Subsequent pregnancy care (7, 8)

Subsequent pregnancy care	Points for consideration
Preconception or initial visit	· Detailed medical and obstetric history · Advise early booking in for hospital based care · Recommend specialist obstetric involvement in care · Discuss increased risk of other obstetric complications · Evaluation and workup of previous stillbirth · Determination of recurrence risk as 20% of stillborn babies are small for gestational age (20,21) · Advise smoking cessation · Discuss alcohol and drug use · Advise weight loss in obese women (preconception only) · Advise on Folate supplements – consider high dose folate · Consider calcium supplementation · Genetic counselling if family genetic condition exists · Test for diabetes · Thrombophilia workup if indicated · Support and reassurance (e.g. early social worker involvement)
First trimester	· Dating ultrasound · Continue folate · First trimester screen: PAPP-A, hCG and nuchal translucency · Is cervical length screening indicated? 2 weekly · Is cervical suture indicated? 13 weeks · Consider supplementation of calcium, aspirin, vitamin D · Diabetes screen · Antiphospholipid antibodies including Thrombophilia workup depending on previous pregnancy circumstances · Facilitate continuity of carer (medical and midwifery) · Support and reassurance
Second trimester	· Fetal anatomic survey at 18–20 weeks · Consider the requirement for Maternal Fetal Medicine referral if fetal fetal anomaly or high risk of recurrence · If first trimester screen not available or not done, second trimester screen: MSAFP, hCG, estriol, and inhibin-A · Uterine artery Doppler studies at 22–24 weeks · Support and reassurance
Third trimester	· Serial ultrasound to rule out fetal growth restriction, starting at 28 weeks or earlier if history of early onset Intrauterine growth restriction (IUGR) or chromosomal conditions in parents/fetus · Discuss fetal movement awareness- provide written advice such as ANZCA's pamphlet 'knowing your baby'. · Antepartum fetal surveillance (CTG) starting at 32 weeks or 1–2 weeks earlier prior to gestational age of previous stillbirth as clinically appropriate.

	· Support and reassurance
Birth	· Consider elective induction of labour at 39 weeks (or before 39 weeks if clinically appropriate)

Appendix 6
Staff support (7)

Caring for families experiencing a perinatal loss can have a considerable impact on staff. A range of
emotions are reported similar to that of patients. Informal debriefing sessions and peer support are often helpful.
WA Health staff may access professional counselling services provided through the Employee Assistance Program, currently Converge.

- Informal debriefing and peer support
- Formal debriefing
- Professional counselling for WA Health employees through 'Converge' private Employee Assistance
Program: 1800 337 068
- Other professional private counselling services
- AMA Colleague of First Contact (08) 9273 3000
- SOSU (08) 9340 1605

Perinatal Loss
(Acute) Guideline

Preamble

Consumer Participation

The Rockingham Peel Group recognises and fully supports the need for the patient and/or their primary carer to:

- know and exercise their healthcare rights;
- be engaged in their healthcare;
- have access to information about treatment options;
- participate in treatment decisions; and
- have access to information about agreed treatment plans.
  (Australian Commission on Safety and Quality in Health Care, 2012).

Scope of Practice

It is the responsibility of each health care provider to ensure all patient care and therapeutic interventions they provide are within their individual scope of practice. Refer to the RkPG Guidelines to Writing for Clinical Policy for further information about Scope of Practice.

This guideline is congruent with the Perinatal Society of Australia and New Zealand (PSANZ) Clinical Practice Guideline for Perinatal Mortality (Flenady et al., 2009). Clinicians are encouraged to refer to the relevant related sections.

Stillbirth is one of the most common adverse pregnancy outcomes. In 2006 the rate of stillbirth in Australia was 7.4/1000 births (Department of Health Western Australia, 2007). Investigation to determine the cause of death and identify contributing factors is important, to assist with parental counselling and to inform future prevention strategies (Flenady et al., 2009; Flenady et al., 2011; Frøen et al., 2011; Lawn et al., 2011; Laws & Hidler, 2008; Pattinson et al., 2011; Royal College of Obstetricians & Gyneacologists, 2014).

Causes and risk factors

It is vital to try to determine the cause of stillbirth, however, many cases remain unexplained (15 -18 % in WA). More than one condition may contribute to the stillbirth, and conditions may be associated without directly causing the stillbirth. The proportion of stillbirths that are reported as “explained”, increases when there is a systematic comprehensive approach to investigation (Flenady et al., 2009; Metzger, 2009; Royal College of Obstetricians & Gyneacologists, 2014; World Health Organization, 2014).

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

The most common causes are:

Congenital/karyotypic anomalies

- Growth restriction/placental thrombosis

Medical diseases such as:

- Diabetes
- Hypertensive disease/preeclampsia
- Systemic lupus erythromatosus
- Hypothyroidism
- Renal disease
- Thrombophilias
- Cholestasis of pregnancy.

Congenitally acquired infections such as:

- Group B Streptococcus and Parvovirus B19
- Other contributing factors include:
    * Smoking and substance use/obesity/multiple gestation.

(Flenady et al., 2009; Metzger, 2009; Royal College of Obstetricians & Gyneacologists, 2014; World Health Organization, 2014).

Classification and legal identity

- Refer to Appendix C for the reporting aid used.
- For the purposes of birth registration of a child, the Births, Deaths and Marriages Registration Act 1998 states “a child includes a stillborn child”. It is compulsory to register the birth of a child whether born alive or stillborn. A stillborn child is defined in this legislation as a child who:
    * has shown no sign of respiration or heartbeat or other sign of life after completely leaving the child’s mother; and
    * who has been gestated for 20 weeks or more; or weighs 400g or more.
- It is a clinical decision as to whether there are signs of life or not.

(Chan, King, Flenady, Haslam, & Tudehope, 2004; Flenady et al., 2009)

Diagnosis

- Intrauterine fetal death (IUFD) requires formal confirmation by an ultrasound examination that demonstrates a lack of fetal heart activity.
- The ultrasound should be performed by experienced staff (credentialed sonographer or obstetrician).
- Amniocentesis (for karyotype and infection screen) is a useful investigation.
- A midwife or doctor as escort should be made available to support the woman, while attending ultrasound examination for confirmation of a suspected fetal death.
- Consider the requirement for social worker support.
- Promote continuity of carer for women experiencing a stillbirth

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014).

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Breaking the news

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

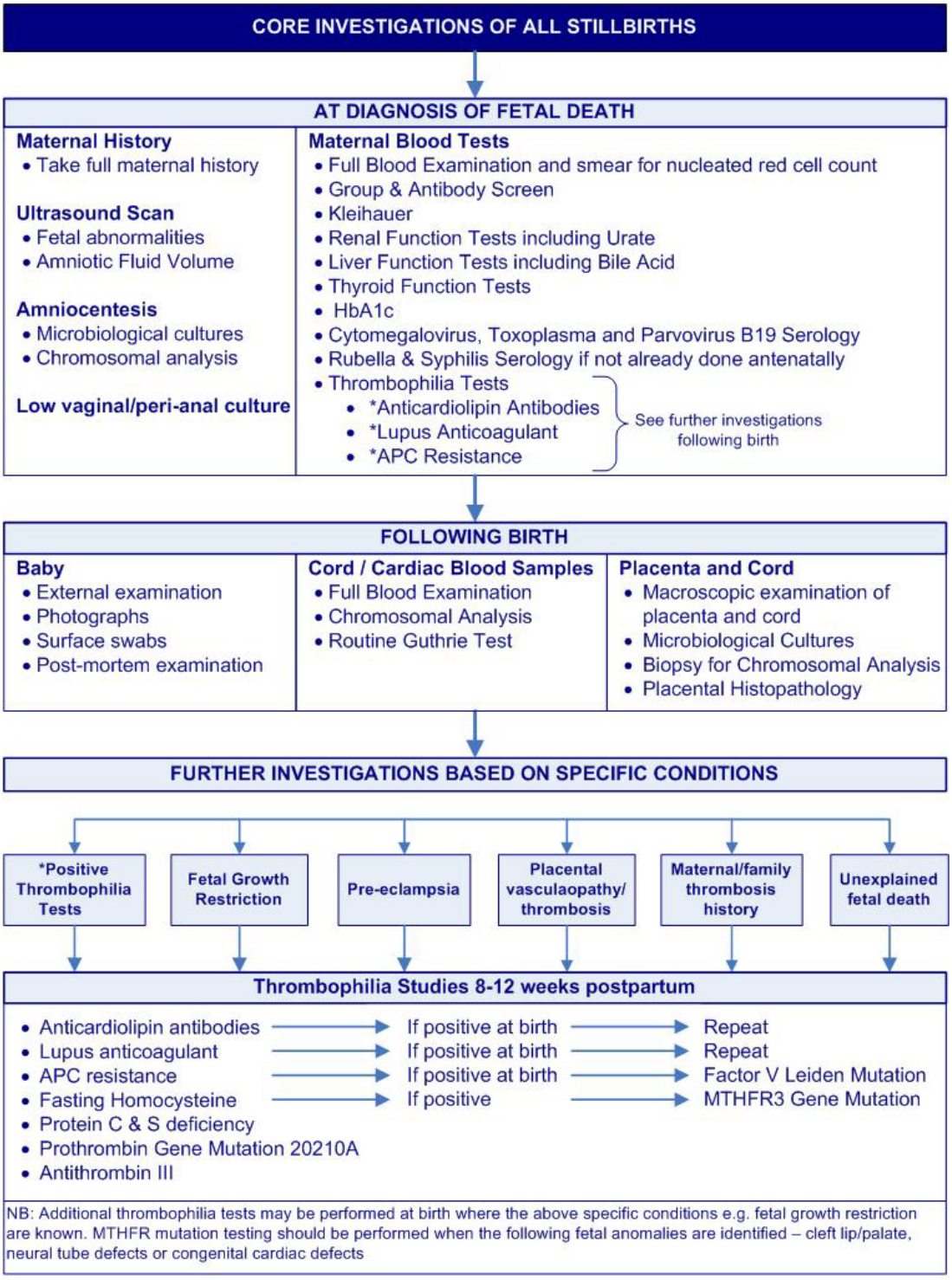
(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014; Statewide Obstetric Support Unit, 2009).

Core investigations of all stillbirths

- Refer to information and paperwork in the Maternity Unit perinatal loss folder.
- Amniocentesis (for karyotype and infection screen) is a useful investigation.
- Start completing PSANZ “Core Investigations Checklist” found in the paperwork pack in the perinatal loss folder.
- “Core investigation of all stillbirths” algorithm provides the information on investigations which must be completed with maternal consent. (see algorithm on page 4)

(Flenady et al., 2009).

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			



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

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

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Documentation

- Refer to Appendix B for all documentation requirements that must be completed by all practitioners involved in the care of the family.

Birth

- Provide information on birth options appropriate to the clinical circumstances and service capabilities. Vaginal birth is generally preferable to caesarean section with minimisation of maternal risk being the most important factor.
- There is usually no clinical need to expedite birth urgently and hasty intervention may not be in the best long-term interests of the parents. If clinically appropriate, the woman may wish to go home and return for induction at a later date. *This must be booked prior to the patient leaving.*
- Adequate analgesia is particularly important when requested by women with perinatal loss - epidural or patient controlled analgesia (PCA) after full discussion with the woman about both (refer to the anaesthetist for PCA infusion prescription).
- Active management of the third stage is recommended (due to increased risk post-partum haemorrhage (PPH).
- Provide information to women and their families on how the baby may appear following birth. Parent's fears are often worse than the reality: be honest and use sensitive but unambiguous language.
- Support requests to normalise the birth experience (e.g. partner cutting the umbilical cord).
- Handle the baby with care, to prevent damage e.g. in case of skin slippage.
- Ensure family members have access to private waiting areas (i.e. separate from other birthing families).
- Primary care giver (GPO) to be contacted by GPO on-call if unexpected stillbirth/neonatal death occurs out of hours.

(American college of Obstetricians and Gynecologists, 2009; Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014).

Induction of labour

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

(American college of Obstetricians and Gynecologists, 2009; Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014).

Recommended dosages for different indications:

Second Trimester	**Third Trimester**
Miscarriage/IUFD 14 -28 weeks	**IntraUterine Fetal Death** > 28 weeks
· **Mifepristone** 200mg orally (witnessed) – for priming. · Followed 36 hours later by: **Misoprostol** 200 - 400microg · Sub lingually 3 hourly · **OR** vaginally 4 hourly (max 5 doses). **Previous ceasarean: 200 microg of Misoprostol.** In each case the dosage regimen should be discussed with the obstetric consultant and modified to the woman's particular medical circumstance.	· **Mifepristone** 200mg orally (witnessed) – for priming. · Followed 36 hours later by vaginal prostaglandin (gel or pessary). · **OR** if Misoprostol is used the dose suggested is 25- 50microg vaginally 4 hourly (Misoprostol is not generally recommended > 28 weeks for the scarred uterus and should only be used at the discretion of the Consultant on call after informed consent is given by the woman).
	Scarred Uterus · Mifepristone alone 200mg tds for up to 3 days can be considered in the IOL of FDIU in a woman with a scarred uterus. · Once favourable an ARM can be done, followed by Oxytocin infusion as for VBAC.

(International Federation of Gynecology and Obstetrics, 2012; KEMH, 2014).

Clinical examination of baby

- Complete the PSANZ **"**Clinical Examination of Baby Checklist" found in the paperwork pack, in the perinatal loss folder (Flenady et al., 2009).

External examination of the baby	By the midwife prior to examination by a Perinatal pathologist.
Surface microbiological swabs	Ear and throat - for microbiological cultures.
Clinical photographs.	Front, both sides and back Appendix 4 and refer to laminated pictorial instructions in the Perinatal loss folder.
Blood sample collection	Samples from the cord by the midwife or cardiac puncture by the pathologist for investigations of infection and blood group Blood samples for chromosomal analysis by perinatal pathologist.
Baby gram at KEMH (x-ray)	Where a post-mortem is refused (if facility available).
Post-mortem examination	By perinatal pathologist.

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014; The Royal College of Pathologists, 2006).

Placental Examination

Complete the PSANZ **"**Accoucher Placental Examination checklist" found in the paperwork pack in the perinatal loss folder (Flenady et al., 2009).

Placental microbiological cultures	Using sterile scissors cut just under base of cord and obtain a swab specimen from between the amnion and chorion.
Placental and amnion biopsy	For chromosomal analysis (after swabbing, cut a small sample of amnion, chorion and placenta and place in normal saline in a specimen collection pot) **not** Formalin**.** If requested on post mortem consent, the pathologist will collect this specimen.
Visual observation	Detailed macroscopic examination of the placenta and cord.

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014; The Royal College of Pathologists, 2006).

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

In W.A. all non-coronial post mortem examinations on newborns are carried out at KEMH:

- From February 2004, the transport and collection is co-ordinated from the Peri-natal Pathology Department at King Edward Memorial Hospital (KEMH).
- **Contact 9340 2730 to arrange for autopsy examinations.**
- This is a Mon- Fri 07:30-16:00 service

If the death is reported to the coroner or to seek guidance about reportable death:

- Between 0700 – 0200 Monday to Sunday contact the WA Police Coronial Investigation Unit (CIU) on 08 92675700.
- Between 0200 -0700 Monday to Sunday contact the WA Police Operations Centre on 131444 (an on-call CIU officer will be notified).
- They will collect the baby for autopsy examination.

Refer to RGMR 37 "Death in Hospital" form Section 2.

Autopsy

An autopsy should be offered to all parents following a stillbirth and is the single most useful diagnostic test. It is preferable that the autopsy is performed by a perinatal pathologist, as is the case in Western Australia (WA). Ensure this is followed up if birth is outside of normal hours.
(Flenady et al., 2009; Flenady et al., 2011; Measey M et al., 2007; Pattinson et al., 2011; Royal College of Obstetricians & Gyneacologists, 2014; The Royal College of Pathologists, 2006).

Explaining Autopsy to the Parents

Discuss with the parents, using the 'Non Coronial Post Mortem Examinations' found in the perinatal loss folder. This is available in several languages.
The PSANZ 'Explaining Autopsy' information, found in the paperwork pack in the perinatal loss folder, is for your own educational use about how to discuss autopsy and what questions you may be asked (Flenady et al., 2009).

Purpose of autopsy

The main purposes of an autopsy are:

- Identification of an accurate cause of death.
- Confirmation of antenatally diagnosed or suspected fetal pathology.
- To exclude some causes of death.
- Identification of disorders with implications for counselling and monitoring for future pregnancies.
- Enhancement of parents understanding of the events surrounding the death which may:
    * Alleviate anxiety in a future pregnancy if a non-recurring cause is found.
    * Assuage guilt in mothers if an uncontrollable cause is determined.
- Provide benefits to the extended family and opportunities for prenatal testing if a familial cause is evident.
- To inform clinical audit of perinatal death.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

- For medico-legal reasons.
- For research purposes (e.g. expansion of the body of knowledge).

(Flenady et al., 2009; Flenady et al., 2011; Measey M et al., 2007; Pattinson et al., 2011; Royal College of Obstetricians & Gyneacologists, 2014; The Royal College of Pathologists, 2006).

Consent for autopsy

- All autopsy examinations require written consent following informed discussion.
- Refer to appendix B for all documentation required.
- MR 236 Consent for post-mortem examination is used.
- Clearly document the extent of the consent.
- Consent can be gained by appropriately trained clinical staff including midwives, doctors and nurses.

(Flenady et al., 2009; Measey M et al., 2007; Royal College of Obstetricians & Gyneacologists, 2014).

Preparation for autopsy

The following should accompany the baby for autopsy:

- Autopsy consent form.
- Placenta (fresh **not** in formalin).
- Copies of :
    * The medical certificate of cause of stillbirth or neonatal death certificate.
    * All antenatal ultrasound reports.
    * Prenatal karyotyping results if available.

Alternative Investigations when autopsy declined

A limited autopsy examination may yield useful information in situations where the parents decline full autopsy. Where parents decline a full autopsy:

- Confirm that parents understand important information may be missed.
- Offer parents options for:
    * External examination by a perinatal/paediatric pathologist, clinical geneticist or paediatrician.
    * Full body X-ray - baby gram at King Edward Memorial Hospital (KEMH).
    * Ultrasound scan.
    * Clinical photographs.
- Ensure request forms for pathology, histology or external examination clearly indicate the extent of consent. Ensure follow up if after hours.

(Flenady et al., 2009; Measey M et al., 2007; Royal College of Obstetricians & Gyneacologists, 2014; The Royal College of Pathologists, 2006)

Taking baby home

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

- The requirement for a letter confirming the baby was stillborn (in case of official query e.g. during transport). Request the general practitioner (GP) obstetrician or specialist obstetrician to write on hospital letter head paper.
- The effect of local climate on the body (i.e. temperature and humidity). Advise parents about keeping the baby in a cool room and wrapped ice blocks kept on the cot mattress.
- Completion of release forms - refer to the Operational Directive 0398/12 'Release of Human Tissue and Explanted Medical Devices' for consent form (DoHWA, 2012).
- Providing the Medical Certificate of Cause of stillbirth or Neonatal Death if care being transferred to the Funeral Director.
- Legal requirements regarding birth registration, burial/cremation.
- Arrangements for return to hospital or funeral home.

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014)

Funeral arrangements

- If > 28 weeks gestation or a neonatal death > 20 weeks, private funeral needs to be arranged.
- Consider referral to RGH pastoral care services for facilitation of funeral arrangements.
- It is a requirement to make arrangements for any perinatal death, stillbirth/miscarriage or neonatal death. Options include: burial or cremation for a stillborn baby (refer to definition of stillbirth).
- Provide information regarding options for funeral arrangements (e.g. local funeral directors, access to the baby in the funeral home).
- If in-utero fetal death less than 20 weeks, the parents have the choice of:
    * Taking the body home for appropriate burial. If so, completion of release forms will be required - refer to the Operational Directive 0398/12 'Release of Human Tissue and Explanted Medical Devices' for consent form (DoHWA, 2012).
    * **Or** the body can be cremated at KEMH and the ashes scattered in the rose garden there, or collected by the family or sent to the woman's GP to be collected by the family.
- Provide information on opportunities to mourn the baby (e.g. hospital memorial services, remembrance services).

Follow up

- Prior to discharge the primary midwife must check the details of the address that the woman is going home to, contact telephone numbers and next of kin details.
- **All** women delivering at RGH will receive visiting midwifery service at home regardless of place of residence. Offer referral for counselling/support services (e.g. social worker, pastoral support, SIDS and Kids WA). Clinical psychiatric referral is not required unless clinically indicated.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

- Discuss creating memories (refer to Appendix A)
- Report to the coroner if indicated on “Death in a Hospital” RGMR37.
- Provide leaflet with contact details of a primary carer (midwife) to the patient for coordination of ongoing care and follow up. This is usually the primary midwife, CNS/CNM (See appendix G).
- Midwife will make an appointment with specialist obstetrician involved in the care of the woman and her family at **10 weeks** postnatally. This is arranged to coincide with the completion of investigations and collection of results. At this appointment, a thorough explanation of results by the Obstetrician will occur.
- An appointment should be made with the woman’s booking GP or GPO for 1 week following discharge.
- Refer to Appendix D for discussion of care in a future pregnancy.
- An appointment with KEMH perinatal loss service should be offered and facilitated.
- If unable to contact the woman after discharge, escalate to CNS/CNM.

(Flenady et al., 2009; Flenady et al., 2011; Measey M et al., 2007; Pattinson et al., 2011; Royal College of Obstetricians & Gyneacologists, 2014; Statewide Obstetric Support Unit, 2009; The Royal College of Pathologists, 2006).

Further investigation for thrombophilia must be undertaken 8-12 weeks

- After the birth, where fetal death is associated with:
    - Fetal growth restriction
    - Preeclampsia
    - Maternal thrombosis and/or there is maternal family history of thrombosis.
- The stillbirth remains unexplained following the standard investigations
- Tests for thrombophilia were positive at the time of the IUFD as follows:
    - Anticardiolipin antibodies; and Lupus anticoagulant repeated if positive at the time of the IUFD or initial testing, if not previously undertaken.
    - APC resistance if it was not undertaken at birth.
    - Factor V Leiden mutation if APC resistance was positive at birth.
    - Fasting Homocysteine and if there is a positive test for MTHFR
    - Gene mutation.
    - Protein C and S deficiency.
    - Prothrombin gene mutation 20210A.

References

Australian Commission on Safety and Quality in Health Care. (2012). The National Safety and Quality Health Service Standards Safety and Quality Improvement Guide *Standard 1 Governance for Safety and Quality in Health Service Organisations* (p.4). Sydney: Australian Commission on Safety and Quality in Health Care. http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf

Australian Commission on Safety and Quality in Health Care. (2012). The National Safety and Quality Health Service Standards Safety and Quality Improvement Guide *Standard 1 Governance for Safety and Quality in Health Service Organisations* (p.4). Sydney: Australian Commission on Safety and Quality in Health Care. Retrieved 2014, from http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf

Chan, A., King, J., Flenady, V., Haslam, R., & Tudehope, D. (2004). Classification of perinatal deaths: development of the Australian and New Zealand classifications. *Journal of Paediatrics and Child Health*. (40), 340-347. Retrieved 2014, from http://www.ncbi.nlm.nih.gov/pubmed/15228558

Department of Health Western Australia. (2007). *Operational Directive* (0008/07)*: Coroners Act 1996*. Government of Western Australia. Retrieved 2014, from http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:6634P/$FILE/CoronersAct1996_00-00-00.pdf?OpenElement

Department of Health Western Australia. (2008). Extract from *Health Act* 1911 – *Section 336A*: *Certain deaths of children to be reported to Executive Director, Public Health*. Government of Western Australia, Retrieved 2014, from https://www.health.wa.gov.au/publications/documents/HealthAct1911.pdf

Department of Health Western Australia. (2012). *Operational Directive* (0398/12)*: Release of Human Tissue and Explanted Medical Devices Policy*. Perth, Western Australia: Department of Health. Retrieved 2014, from http://www.health.wa.gov.au/circularsnew/attachments/711.pdf.

Department of Health Western Australia. (2013a). *Operational Directive* (0448/13)*: Western Australian Review of Death Policy*. Perth, Western Australia: Department of Health. Retrieved 2014, from http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12990

Department of Health Western Australia. (2013b). *Operational Directive* (0133/13)*: Notification of Deaths*. Perth, Western Australia: Department of Health. Retrieved 2014, from http://www.health.wa.gov.au/circularsnew/pdfs/12938.pdf

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Department of Health. (2014). *Clinical Incident Management Policy*. Western Australia: Department of Health. Retrieved 2014, from http://www.safetyandquality.health.wa.gov.au/docs/aims/CIMS_Policy_2012.pdf.

Flenady, V., Charles, A., Gardener, G., Ellwood, D., Day, K., McGowan, L., . . . Khong, Y. (2009). Clinical Practice Guideline for Perinatal Mortality. *the Perinatal Society of Australia and New Zealand*. Retrieved 2014, from https://www.google.com.au/search?hl=en-AU&source=hp&q=psanz+clinical+practice+guideline+for+perinatal+mortality&gbv=2&oq=Clinical+practice+guideline+for+perinatal+mortality&gs_l=heirloom-hp.1.1.0i22i30l2.1422.1422.0.5000.1.1.0.0.0.0.250.250.2-1.1.0....0...1ac.1.34.heirloom-hp..0.1.250.yLHLLaHkkII

Flenady, V., Middleton, P., Smith, G., Duke, W., Erwich, J., Khong, T., . . . Frøen, F. (2011). Stillbirths: the way forward in high-income countries. *The Lancet, 377*, 1709-1717. Retrieved, 2014, from http://ac.els-cdn.com.smhslibresources.health.wa.gov.au/S0140673611600640/1-s2.0-S0140673611600640-main.pdf?_tid=c9d5497e-e48d-11e3-a305-00000aab0f01&acdnat=1401078518_458419eee80c49d0c59e5bff70187ba5

Flenady, V., J, F., Pinar, H., Torabi, R., Saastad, E., Guyon, G., . . . Gilshenan, K. (2009). An evaluation of classification systems for stillbirth. *Pregnancy and Childbirth, 9*(24). Retrieved 2014, from http://www.biomedcentral.com/content/pdf/1471-2393-9-24.pdf?bcsi_scan_c221d61a0ea4ff4c=Jfe6ggvD0kJpyth2J8swqNj0LXogAAAAAsvG4g==&bcsi_scan_filename=1471-2393-9-24.pdf

Frøen, J., Cacciatore, J., M McClure, E., Kuti, O., Jokhio, A., Islam, M., & Shiffman, J. (2011). Stillbirths: why they matter. *The Lancet, 377*, 1353-1366. Retrieved 2014, from http://ac.els-cdn.com.smhslibresources.health.wa.gov.au/S0140673610622325/1-s2.0-S0140673610622325-main.pdf?_tid=89b500c8-e48d-11e3-aa01-00000aab0f6c&acdnat=1401078410_de425394266d2ea65cf720df31a05508

International Federation of Gynecology and Obstetrics. (2012). Misoprostol Recommended Dosages. Retrieved 2014, from http://www.figo.org/files/figo-corp/Misoprostol_Recommended%20Dosages%202012.pdf

Lawn, J., Blencowe, H., Pattinson, R., Cousens, S., Kumar, R., Ibiebele, I., . . . Stanton, C. (2011). Stillbirths: Where? When? Why? How to make the data count? *The Lancet, 377*, 1448-1463. Retrieved 2014, from http://ac.els-cdn.com.smhslibresources.health.wa.gov.au/S0140673610621873/1-s2.0-S0140673610621873-main.pdf?_tid=e35aa9ea-e490-11e3-a307-00000aab0f01&acdnat=1401079849_10f64cc7694508e611aada2fc3ba5fd7

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Laws, P., & Hidler, L. (2008). Australia's mothers and babies 2006. *Australian Institute of Health and Welfare: Perinatal statistics series no. 22.* Retrieved 2014, from http://www.aihw.gov.au/publication-detail/?id=6442468191

Measey, M., Charles, A., d'Espaignet, E., Harrison, C., Deklerk, N., Douglas, C. (2007). Aetiology of stillbirth: unexplored is not unexplained. *Australian and New Zealand Journal of Public Health, 31*, 444-449. Retrieved 2014, from http://www.ncbi.nlm.nih.gov/pubmed/17931292

Metzger, B. (2009). International Association of Diabetes and Pregnancy Study Groups: Recommendations on the Diagnosis and Classification of Hyperglycemia in Pregnancy. *Diabetes Care, 33*(3), 676-682. Retrieved 2014, from http://care.diabetesjournals.org/content/33/3/676.full.pdf

Pattinson, R., Kerber, K., Buchmann, E., Friberg, I., Belizan, M., Lansky, S., . . . Lawn, E. (2011). Stillbirths: how can health systems deliver for mothers and babies? *The Lancet, 377*, 1610-1623. Retrieved 2014, from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62306-9/abstract

Parliamentary Counsel's Office of Western Australia. (1998). *Births, Deaths and Marriages Registration Act 1998*. Western Australia: Parliamentary Counsel's Office of Western Australia. Retrieved 2014, from http://www.slp.wa.gov.au/statutes/swans.nsf/(DownloadFiles)/Births+Deaths+and+Marriages+Registration+Act+1998.pdf/$file/Births+Deaths+and+Marriages+Registration+Act+1998.pdf.

Royal College of Obstetricians & Gyneacologists. (2014). Guideline 55: Late Intrauterine Fetal Death and Stillbirth. *RCOG Guidelines.* Retrieved 2014, from http://www.rcog.org.uk/womens-health/clinical-guidance/late-intrauterine-fetal-death-and-stillbirth-green-top-55

Statewide Obstetric Support Unit. (2009). Caring for families experiencing perinatal loss. Retrieved 2014, from http://kemh.health.wa.gov.au/search.htm?cx=004702629457117672014%3Agxhbtxnz_ek&cof=FORID%3A10&ie=UTF-8&q=caring+for+families+experiencing+perinatal+loss&sa=Go&siteurl=kemh.health.wa.gov.au%2Fservices%2FSOSU%2Feducation.php%3FPHPSESSID%3D537fa8dc0b0f510ed3962bf1b7735aed&ref=kemh.health.wa.gov.au%2Fservices%2FSOSU%2FMPLNAP.php&ss=12611j6789569j49

Statewide Obstetric Support Unit. (2014). Perinatal Loss e-learning package. *Education.* 2014, Retrieved 2014, from http://kemh.health.wa.gov.au/services/SOSU/education.php?PHPSESSID=dbee455a7cb44ca7aeb754fc473f99f3#elearning

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

The Royal College of Pathologists. (2006). Guidelines on Autopsy Practice. Scenario 9: Stillborn infant (singleton). *Pathology: the science behind the cure*. Retrieved 2014, from http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/G001Autopsy-Stillbirths-Jun06.pdf

World Health Organization. (2014). Under-five mortality rate (probability of dying by age 5 per 1000 live births). *Child mortality levels.* Retrieved 2014, from http://apps.who.int/gho/data/node.main.ChildMort-2?lang=en

Links

RkPG Guidelines to Writing for Clinical Policy
Operational Directive 0398/12 'Release of Human Tissue and Explanted Medical Devices'

Acknowledgement

We would like to acknowledge Wendy Jackson (Clinical Midwife) from Armadale Health Service, as author of the original document.

National Standards

R R

EQuIp National Standards

R R

RESPONSIBILITY				NATIONAL STANDARDS
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Appendix A: **Parental support**

Perinatal death is a significant life event and parental support is reported as being integral to recovery and integration. Parents report that health care providers' behaviours that are helpful include those noted below:

- Respect - treat parents and baby with respect and privacy.
- Compassion - care should be culturally sensitive and compassionate.
- Communication - provide information, including written material.
- Time - allow parents time to make decisions, and time with their baby.
- Continuity of carer - promotes and enhances communication and satisfaction.

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014)

Respect	· Treat the deceased baby with the same respect as a live baby (e.g. handle baby with care, use name if one was given). · Support parents to feel in control of the care of their baby. · Respect the wishes/preferences of parents when offering care. · Respect cultural and religious beliefs/practices/rituals.
Information provision	· Allow time for discussion. · Communicate empathetically, clearly and honestly. · Listen reflectively to the parents. · Where feasible, ensure both parents are present at discussions. · Provide clear explanation of the length of stay on hospital expected, and where they will be e.g. Maternity Ward. Inform them they can take their baby home for a few days, if they wish. · Repeat important information as stress and grief may interfere with comprehension and recall of information. · Provide written information for frequent reference. · Use parent friendly language (e.g. avoid terms such as fetus, products of conception). · Deliver information in a quiet private room away from other patients. · Consider the timing of information provision (e.g. future pregnancy information may be more appropriate after birth rather than before).
Care setting	· Offer the option of private room in surgical, maternity or gynaecological units as feasible (i.e. away from other babies). · Offer accommodation to the woman's support person as feasible. · Consider universal symbols outside room and on the health record to alert all staff to a stillbirth.
Memory creation	· Offer time with baby - inform parents they may hold, undress, and bath baby if desired (complete all swabs and tests on baby before bathing). · Offer for both parents, family and siblings (if parents think it appropriate) to spend time with the baby. · Provide a 'Grief pack' with brochures including information about: * memento booklet * 'SIDS and Kids' brochure * grief response brochure.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

	· Parental keepsake photographs. Call "Heartfelt". 1800 583 768. · Even if photographs declined, take them to keep in the medical records as parents often want to see them at a later date. · Offer options to include extended family (e.g. photographs of family groups, relatives/siblings to hold baby, video conferencing if available). · Offer option to take baby home if feasible. · Facilitate religious/cultural rituals and services. · Facilitate memento creation/gathering following parental consent (e.g. identification tags, hand and footprints, digital photographs, cot cards, hair collection). · Where immediate memento creation is declined – offer storage of mementos for future access. Mementos can be stored in a sealed envelope in the woman's health record until/if parents request them.
Funeral/ Blessing arrangements	· Discuss naming/blessing/baptism services and other religious rituals. · Refer to "Perinatal Pathology Handbook" for additional information regarding autopsy examinations and cremation services at (KEMH). · Discuss funeral plans including consideration of: * cremation options * private funeral director arrangements (cremation or burial).
After care	· Advise on lactation suppression and methods to manage supply. · Advise on contraception. · Advise on postnatal exercises. · Provide written information on available support services for parents and children (refer to below for support contacts). · Inform parents of expectations of grief journey. · Discuss options for early discharge with extended midwifery service home care where feasible. · Provide information on Centrelink Family Allowance Forms - claim for Bereavement Payment of Family Tax Benefit, Maternity Allowance.
Referral/ Follow up	· Consider the requirement for referral to relevant health care professionals and support groups prior to discharge - particularly for counselling/psychological support services (e.g. genetic counsellor, social worker, Child Health Services, pastoral care worker). See support group contact details below. Discuss with parents and make all necessary appointments prior to discharge – document on "Follow up Care" form Appendix G. Also document timeframe for follow-up phone call from primary midwife on the "Follow-up care form. · Arrange follow up appointment(s) for the purposes of recurrence risk counselling and discussion of investigation results - first appointment within 2 months. · Communicate a stillbirth event to the woman's GP, paediatrician and other relevant care providers. · Forward a comprehensive summary to these care providers. · **Cancel 'BOUNTY PACKS' 08 94175145.**

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Agencies providing grief support

Organisation	Contact Details
SIDS and KIDS WA	· Advocate for and fund research into stillbirth and other areas of sudden and unexpected child death. · Extend bereavement support and counselling to families who have experienced stillbirth or the sudden and unexpected death of a child, regardless of the cause. * Web: http://www.sidsandkids.org/ * Bereavement support phone: 1300 308 307 (24 hour)
SANDS (QLD) Inc. (Stillbirth and Neonatal Death Support)	· Provides support, information, education and advocacy for parents and their families who have suffered the loss of a baby through miscarriage, stillbirth, neonatal death and other reproductive losses. · Offers support via telephone and support group meetings. * Web: http://www.sandsqld.com/ * SANDS WA: 1800686780 * Bereavement support: Free Call 13000 SANDS (13 000 72637)
Heartfelt (formerly Australian Community of Child Photographers)	· Professional photographers dedicated to providing photographic memories to families that have experienced stillbirths, premature and ill infants and children in the Neonatal Intensive Care Units of their local hospitals, as well as children with serious and terminal illnesses. · All services are provided free of charge. * Ph: 1800583768 * Web: http://www.heartfelt.org.au/
Pregnancy and Infant Loss Australia	· A support program for bereaved families who have experienced loss through miscarriage, stillbirth, genetic inducement of labour or neonatal death. * Web: http://www.teddyloveclub.org.au/ * Bereavement support phone 1800 824 240 (no local contact)
Lifeline	· Provide telephone crisis support to anyone needing emotional support. * Web: http://www.lifeline.
Angelhands Inc	· Offers support and strength to people who are affected or bereaved by violence. * Web: www.angelhands.org.au
Australian Centre for Grief and Bereavement:	· This service provides details of free bereavement counselling services and links to websites. * Freecall 1800 642 066 * Web: www.grief.org.au
Australian Funeral Directors' Association:	* Ph (08) 9355 3441 * Web: www.afda.org.au

RESPONSIBILITY				NATIONAL STANDARDS
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Beyond Blue:	· This service assists those with depression and anxiety problems. * Freecall 1300 224 636 * Web: www.beyondblue.org.au
Compassionate Friends:	· An international family support organisation working to bring hope to families who have lost a child. Web: http://www.compassionatefriends.org/
Crisis Care 24 hour support:	· Accessed through the Telephone Interpreter Service. * Ph (08) 9223 1111 * STD Freecall 1800 199 008 * TTY (08) 9325 1232 * Web:www.community.wa.gov.au/DFC/Resources/Helplines/Crisis_care_helpline.htm
DepressioNet:	· Provides information and support to people with depression, including families and friends. * Web: www.depressionet.com.au
Family Helpline:	· Free telephone counselling and information service for families with relationship difficulties. * Ph (08) 9223 1100 * Freecall 1800 643 000
Mensline:	· The service provides counselling services especially for men. * Freecall 1300 789 978 * Web: www.menslineaus.org.au
Metropolitan Cemeteries Board:	· For information about burial, cremation and services. * Ph (08) 9383 5200 * Web: www.mcb.wa.gov.au
Solace Association:	· Offers support for people who have lost their partner. Services are also extended to affected children. * Freecall 1300 308 307 or Ph (08) 9359 3892 * Web: www.solace.org.au

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Multicultural Services and Resources

Anglicare WA	· This service offers counselling including specialised care for Aboriginal people Inc, including Kinway Counselling. * Ph (08) 9263 2000; * Web: www.anglicarewa.org.au
Australian Indigenous Health Infonet:	· These webpages provide details and links for health programs and projects that address the health of Aboriginal people in WA. * Web: http://www.healthinfonet.ecu.edu.au/ * Web: http://www.healthinfonet.ecu.edu.au/states-territories-home/wa/programs-and-projects
Centrecare:	· This service offers counselling including specific care for migrant and Indigenous families. * Ph (08) 9325 6644 * Web: http://www.centrecare.com.au/
Derbarl Yerrigan Health Service:	· This is an Aboriginal Community controlled organisation which has operated for 35 years and now has135 staff delivering a range of health services across multiple sites in Perth. * Web: http://www.derbarlyerrigan.com.au/
Ishar Multicultural Women's Health Centre:	· Provides many services for culturally and linguistically diverse (CALD) communities in the Perth metro area. These include a mental health counselling service, and a support and skills development program for those from a CALD community who are caring for someone with a mental illness. * Ph (08) 9345 5335 * Fax: (08) 9349 9113 8 * Sudbury Place, Mirrabooka 6061 WA; * Email: info@ishar.org.au * Web: www.ishar.org.au
Online WA Multicultural Communities Gateway:	· This website lists a large number of Community Groups and Community Service Organisations. * Web: http://www.multicultural.online.wa.gov.au/
Yorgum Aboriginal Family Counselling Service:	· This service provides specialised counselling for Aboriginal people suffering distress. * Fax (08) 9228 0385

Appendix B: **Documentation**

Documentation for fetus less than 20 weeks

Document	Documentation for fetus less than 20 weeks
MR 238<20	Consent Pathology - parental consent required
MR297<20	Consent for Cremation - parental consent required
Bereavement	Bereavement payment - not eligible
Registration	If LIVEBORN or stillborn > 20 weeks or ≥ 400g must be registered, otherwise not eligible for birth/death registration but will receive a 'Recognition of Life' certificate from KEMH (If requested)
Post Mortem	Optional - pathology examination is offered at KEMH on the fetus less than 20 weeks – use yellow pathology form
Photos/memory box	Photo and hand and foot prints, if possible, with 'Recognition of Life' certificate from KEMH for memory box.
Cremation or funeral	The baby/fetus can be taken home for appropriate disposal. Completion of authorisation and 'Release of Human Tissue and Explanted Medical Device Consent Form' is required http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12907 **Or** KEMH Cremation. Family can collect ashes or have them interred at KEMH Rose garden. Can also be sent to GP or maternity unit manager. Needs to be discussed with the family.
The Statutory Law	The Statutory Law states that gestation is assessed according to the duration of the pregnancy not intra-uterine fetal life.
Midwives Notification	No STORK to complete for a pregnancy less than 20 weeks

Documentation for fetus 20-28 weeks

Document	Documentation for fetus 20-28 weeks
BDM 100	Birth registration Form - for all births greater than 20 weeks, regardless of outcome, and for live born babies less than 20 weeks gestation. Parents complete this and return the form to the Registrar Generals office. http://www.bdm.dotag.wa.gov.au/_files/BDM1_Birth_Applic_Form.pdf
FORM 7	Certificate of Medical Attendant. Cremation Act 1929, for any live born baby or stillborn http://www.health.wa.gov.au/cremations/docs/cremation_form7.pdf
Post Mortem MR 236	If PM chosen. Placental histopathology on request (this is a critical investigation). Send the placenta (fresh) to perinatal pathology at KEMH. Not required if PM consented
BDM 201	Medical Certificate of cause of Stillbirth or Neonatal Death - completed by the attending doctor and goes with the babe to KEMH. Perinatal pathology returns it to the Registrar Generals office as notification of death (for Statutory Requirements for Executive Director Public Health).
Cremation Or Outside Funeral Director	Cremation at KEMH is free of charge KEMH can cremate a still born up to 28 weeks gestation. To arrange this, include the MR297 Consent for Cremation less than 28 weeks of a stillborn.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

	http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.6.3%20-%20HP345%20Cremation%20Consent%20less%20than%2028%20wks.pdf?PHPSESSID=63ec888e5559873ef09cd8e78f612eb9 The ashes can be for internment in memorial garden. Refer to dates for this to occur. Last Thursday of every month at 12:30pm. **Or** request for return of separate ashes to the woman's GP/maternity unit or collected from KEMH by woman **Or** Outside Funeral Director.
Midwives Notification.	Labour and birth summary information is reported to WA Health by midwives as notification of case attended (NOCA) for all births. This may be via STORK database, where in use.
Clinical Incident Management System	Clinical Incident form is required to be completed for all babies 20 weeks gestation or signs of life.
Bereavement payment	Claim for Bereavement Payment form (from Family Assistance Office; Ph 13 6150). If eligible for bereavement payment the parents have two choices. * The one off baby bonus or * The 12 weeks maternity leave entitlement. They are only eligible for this if they would otherwise be on paid maternity leave. http://www.humanservices.gov.au/spw/customer/forms/resources/fa008m-1307en.pdf The booklet is in the perinatal loss box file.
Photos and Memory Box	Completion of grief pack booklet.
Statutory Law	Non coronial post mortem can only be performed at the parents request, **not** the Doctor's. The family can request a post mortem without a doctors signature and clinical staff can witness the parental signature following discussion. MR 236 - if post mortem chosen.
Death in Hospital	**"**Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year shall die from any cause whatsoever, the fact shall be reported forthwith to the Executive Director, Public Health." See "Review of Death Policy" (Department of Health, 2013a) http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12990 · How to notify: A midwife or doctor can provide all the details and fax them. · Notification may be made by email, telephone, fax or mail (contact details below). · Provide the following information as soon as possible, preferably within 48 hours: * Patient name * Date of death * Place of death * Contact details of reporting practitioner * Medical Certificate of Cause of Stillbirth or Neonatal Death or the Medical Certificate of Cause of Death, if available.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

	Contact details * Email: edphwa@health.wa.gov.au * Telephone: 9222 2295 * Fax: 9222 2322 * Mail: Executive Director Public Health Regulatory Support and Training Unit Public Health and Clinical Services Division Department of Health PO Box 8172 Perth Business Centre WA 6849 Refer to the Operational Directive (0133/13): "Notification of Deaths" (DoHWA, 2013b). http://www.health.wa.gov.au/circularsnew/pdfs/12938.pdf
FOR CORONIAL INQUIRY	See form required at: http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.4%20-%20MR001_Death_in_hospital.pdf?PHPSESSID=ohkcmgdevlzov

Documentation for fetus >28 weeks

Document	Documentation for fetus >28 weeks
BDM 100	Birth registration form - for all births greater than 20 weeks, regardless of outcome. Parents complete this and return the form to the Registrar Generals office. http://www.bdm.dotag.wa.gov.au/_files/BDM1_Birth_Applic_Form.pdf
Form 7	Certificate of medical attendant. Refer to Cremation Act 1929, for any live born baby or stillborn. http://www.health.wa.gov.au/cremations/docs/cremation_form7.pdf
Claim for Bereavement Payment	Form available from Family Assistance Office; Ph: 13 6150. If eligible for bereavement payment the parents have two choices: * The one off baby bonus * The 12 weeks maternity leave entitlement. They are only eligible for this if they would otherwise be on paid maternity leave. http://www.humanservices.gov.au/spw/customer/forms/resources/fa008m-1307en.pdf The booklet is 66 pages long. An example of the claim form is in the perinatal loss file.
BDM 201	Medical certificate of cause of Stillbirth or Neonatal Death - completed by the attending doctor and goes with the baby to KEMH. Perinatal Pathology returns it to the Registrar Generals office as notification of death (for Statutory Requirements for Executive Director Public Health) baby > 20 weeks to be cremated.
MR 236	Consent for post-mortem examination. Used in conjunction with the Information for parent's pamphlet. This clearly explains all procedures and options regarding post-mortem examination. A midwife may sign as a witness.http://www.health.wa.gov.au/postmortem/docs/KEMH_PM_Consent_form_Review%20_MR236_%20231002.pdf

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Pathology Form	For histopathology of placenta – KEMH will accept RGH forms.
Midwives Notification.	Labour and birth summary information is reported to WA Health by Midwives as Notification of Case Attended (NOCA) for all births. This may be via STORK database where in use.
Clinical Incident Management System	Clinical Incident form to be completed.
Funeral	All perinatal deaths over 28 weeks or any neonatal deaths are managed by a Private Funeral Director of the Parents' choice.
Statutory Law	Non coronial post mortems can only be performed at the parents request, **not** the doctor's. MR 236 - if post mortem chosen.
Death in Hospital	**"**Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year shall die from any cause whatsoever, the fact shall be reported forthwith to the Executive Director, Public Health". See "Review of Death Policy" (Department of Health, 2013a). http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12990 · Notification may be made by email, telephone, fax or mail (contact details below). · Provide the following information as soon as possible, preferably within 48 hours: * Patient name * Date of death * Place of death * Contact details of reporting practitioner * Medical Certificate of Cause of Stillbirth or Neonatal Death or the Medical Certificate of Cause of Death, if available. Contact details * Email: edphwa@health.wa.gov.au * Telephone: 9222 2295 * Fax: 9222 2322 * Mail: Executive Director Public Health Regulatory Support and Training Unit Public Health and Clinical Services Division Department of Health PO Box 8172 Perth Business Centre WA 6849 Refer to the Operational Directive (0133/13): "Notification of Deaths" (DoHWA, 2013b). http://www.health.wa.gov.au/circularsnew/pdfs/12938.pdf
CORONIAL INQUIRY: IF NEEDED	**CORONIAL INQUIRY** http://www.kemh.health.wa.gov.au/services/SOSU/documents/MPLNAP/2.4%20-%20MR001_Death_in_hospital.pdf?PHPSESSID=ohkcmgdevlzov

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Appendix C: **Reporting Aid**

Gestation at birth	Weight	Definition	Register Birth with Registrar of Births deaths and marriages?	Death Certificate required?	Perinatal data collection Reporting required?
<20 weeks	< 400 g	Miscarriage or fetal death before 20 weeks	No	No	No
<20 weeks	<400g	Born alive (gasps/heart beat)	Yes	Yes	Yes
< 20 weeks	≥ 400 g	Stillbirth	Yes	Yes	Yes
≥ 20 weeks	≥ 400 g	Stillbirth	Yes	Yes	Yes
≥ 20 weeks	< 400 g	Stillbirth	Yes	Yes	Yes
≥ 20weeks and proven fetal death in-utero at < 20 weeks (proven by ultrasound)	Any weight	Fetal death before 20 weeks	Optional*	Optional*	Yes

(Chan, King, Flenady, Haslam, & Tudehope, 2004; Flenady, Charles, et al., 2009; Flenady, J, et al., 2009)

Notes:

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

Appendix D: **Clinical Photographs for Pathologist**

Instructions on taking clinical photographs (Flenady et al., 2009).

- Refer to laminated pictorial instructions in perinatal loss folder.
- High quality medical photographs are preferred; however, 'polaroid' pictures are better than no pictures at all.
- Ideally digital photographs should be taken which will allow the clinician to check each photograph after it is taken.
- These photographs should be taken in addition to bereavement photographs.

Consent

- Parental consent is necessary prior to taking clinical photographs.
- Document the consent in the medical notes.
- Due to their clinical nature, it is strongly recommended that the parents are not offered copies, but specific bereavement photographs are taken instead. These only need to be done if there is no post mortem being done.
- Ensure the baby is handled with respect and sensitivity at all times.

Background

- Plain drapes (blue is the best background – other backgrounds may create glare or alter skin tone). Use of a blue theatre gown would suffice.
- Scale:
    * Place a paper tape measure next to the baby (a plastic ruler will create glare).
    * Ensure zero is aligned at the base of the foot or crown of the head.
    * Use sticky tape to ensure the tape is straight.
    * Measure should be on the bottom of the frame or the left.

Identification

- Write the baby's UR number on the paper tape measure for identification.
- Don't write any other identifying information in case the photographs are ever mislaid.

Setting

- Photographs should be taken in a private area away from the parents.

Technique

- The photographs should be taken from directly above the baby. Consequently it is best to place the baby on the floor, in order to get sufficient height above the baby.

Magnification

- Use a 50 mm lens/magnification for the whole body photographs, and maintain a consistent distance. Use a 100 mm lens/magnification (except for digital) for the facial photographs, filling the whole frame.

Baby

- The baby should be naked for all the photographs.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Position

- AP view – whole body frontal including limbs.
- PA view – whole body back including limbs.
- Lateral view of the body.
- Lateral views of the face.
- Frontal view of the face.
- Photographs of any abnormalities.

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Appendix E: **Subsequent pregnancy care**

Subsequent pregnancy care	Points for consideration
Preconception or initial visit	· Detailed medical and obstetric history. · Advise early booking in for hospital based care. · Recommend specialist obstetric involvement in care. · Discuss increased risk of other obstetric complications. · Evaluation and workup of previous stillbirth. · Determination of recurrence risk as 20% of stillborn babies are small for gestational age (Measey M et al., 2007; Pattinson et al., 2011). · Advise smoking cessation. · Discuss alcohol and drug use. · Advise weight loss in obese women (preconception only). · Advise on Folate supplements - consider high dose folate. · Consider calcium supplementation. · Genetic counselling if family genetic condition exists. · Test for diabetes. · Thrombophilia workup if indicated. · Support and reassurance (e.g. early social worker involvement).
First trimester	· Dating ultrasound. · Continue folate. · First trimester screen: PAPP-A, hCG and nuchal translucency. · Is cervical length screening indicated? 2 weekly. · Is cervical suture indicated? 13 weeks. · Consider supplementation of calcium, aspirin, vitamin D. · Diabetes screen. · Antiphospholipid antibodies including thrombophilia workup depending on previous pregnancy circumstances. · Facilitate continuity of carer (medical and midwifery). · Support and reassurance.
Second trimester	· Fetal anatomic survey at 18–20 weeks. · Consider the requirement for Maternal Fetal Medicine referral if fetal anomaly or high risk of recurrence. · If first trimester screen not available or not done, second trimester screen: MSAFP, hCG, estriol, and inhibin-A. · Uterine artery Doppler studies at 22–24 weeks. · Support and reassurance.
Third trimester	· Serial ultrasound to rule out fetal growth restriction, starting at 28 weeks or earlier if history of early onset Intrauterine growth restriction (IUGR) or chromosomal conditions in parents/fetus. · Discuss fetal movement awareness- provide written advice such as ANZCA's pamphlet 'knowing your baby'. · Antepartum fetal surveillance (CTG) starting at 32 weeks or 1–2

	weeks earlier prior to gestational age of previous stillbirth as clinically appropriate. · Support and reassurance
Birth	· Consider elective induction of labour at 39 weeks (or before 39 weeks if clinically appropriate).

(Flenady et al., 2009; Royal College of Obstetricians & Gyneacologists, 2014)

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Appendix F. **Staff support**

- Caring for families experiencing a perinatal loss can have a considerable impact on staff. A range of emotions are reported similar to that of patients.
- Informal debriefing sessions and peer support are often helpful.
- WA Health staff may access professional counselling services provided through the Employee Assistance Program "Converge"
    * Informal debriefing and peer support.
    * Formal debriefing.
    * Professional counselling for WA Health employees through "Converge" private Employee Assistance Program: 1800 337 068.
- Other professional private counselling services:
    * Australian Medical Association (AMA) Colleague of First Contact (08) 9273 3000
    * Statewide Obstetric Support Unit (SOSU) (08) 9340 1605

(Flenady et al., 2009)

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Appendix G. **Follow up care form**

Agencies providing support for you and your family after you go home...

YOUR PRIMARY MIDWIFE:_____

_____ **@health.wa.gov.au**

Phone: 9599 4740
Social Worker Maternity: 9599 4000 page 159

Perinatal Pathology, King Edward Memorial Hospital
93402730 (Monday to Friday 8am til 4pm)

SIDS and KIDS WA
Web: www.sidsandkids.org
Email: perth@sidsandkids.org
Bereavement support phone: 1800 686 780 (24 hour)

SANDS (QLD) Inc. (Stillbirth and Neonatal Death Support)
Web: www.sandsqld.com
SANDS WA: 1800686780
Bereavement support: Free Call 1300 SANDS (1300 072 637)

Pregnancy and Infant Loss Australia
Web: www.teddyloveclub.org.au

Bears of Hope
Web: www.bearsofhope.org.au
Enquiries: 130011 BEAR (1300 112 327)
Email: contact@bearsofhope.org.au
Grief Support: 1300 11 HOPE (1300 114 673)
Email: Support@bearsofhope.org.au

APPOINTMENTS

GP or GPO:_____

RGH Obstetrician:_____
(Appointment will be held in the antenatal clinic area, Level 2 B block RGH)

KEMH Perinatal Loss service:_____
(Appointment information will be sent out in the post to your home)

Other:_____

_____

RESPONSIBILITY				**NATIONAL STANDARDS**
First Issued	Aug 2001	**Revisions**	Aug 2004	**National Standards (**including EQuIP National) 1.1, 1.7, 4.1, 11.5, 12.1
This version	Mar 2015	**Revision Due**	Mar 2018	
Responsibility of	Co-Directors Surgical	**Endorsed by**	DONM, DCS	
Title	*Perinatal Loss (Acute) Guideline*			

Government of Western Australia
Department of Health

FIONA STANLEY HOSPITAL

DEPARTMENTAL SERVICE PLAN

MORTUARY SERVICE

Version 1.0

Method of Development

Consultation

Stakeholders from Mortuary services from across WA Health and PathWest Laboratory Medicine WA (PathWest) were engaged to provide subject matter expertise and advice via a series of FSH clinical commissioning workshops.

A Mortuary Clinical Reference Group (CRG) was formed to review and endorse the Mortuary DSP.

Disclaimer

The content of the Mortuary Departmental Service Plan was developed by relevant stakeholders using their knowledge at the time. Information within the plan may require modification based on improvements or compromises in order to provide the service. The plan does not dictate staffing, resources or budget but indicates what is proposed to be required for the model of care described. Workforce, budgets and other requirements may impact on the final outcome of the service delivery model.

Document Control

Document History

Version #	Version Date	Description
0_1	9/11/12	Draft
0_2	11/12/12	Draft post workshop
0_3	19/12/12	Final Draft submitted to Shae Seymour (SS)
0_4	08/01/13	Draft – Project handed over to RA
0_5	18/02/2013	Final submitted to SS
0_6	07/03/2013	Updated with SS feedback. Resubmitted
0_7	15/3/2013	Feedback from SS incorporated by KM.
0_8	25/03/2013	Submitted to SS for submission to FSH Exec
0_9	14/04/2013	Feedback from Trish Morrell incorporated
0_10	15/05/2013	Template Changes by Katherine Cobb (PwC)
0_11	20/05/2013	Feedback from TM and new information from LM (PathWest) incorporated
0_12	28/05/2013	Formatting & submitted to TM
0_13	27/06/2013	Incorporated feed back from CRG
1_1		Incorporating global/operational changes/working document
1_2	03/09/2014	Changes ready for uploading to HUB
1.0	25/09/2014	Workforce section updated as per agreed process for uploading service plans to FSH Hub

Distribution List (consultation)

Name	Title
John Banfield	Coordinator of Mortuary Services, RPH
Bernie Kolay	Post-mortem Coordinator, PMH
Belinda Jennings	Midwife, Perinatal Loss Service, KEMH
Mike Middleton	Afterhours Nurse Manager, CNS, RPH
Lorella Manso	Principal Scientist, Anatomical Pathology, FSH Network
Mary Anne Townsend	Project Director - Facilities and Infrastructure, PathWest
Dugald McCallum	Head of Department, Anatomical Pathology, FSH Network
Kate Ryan	Grad Officer, FSHPT
Kylie Mulcahy	Project Manager, FSHPT
Trish Morrell	Manager Service Commissioning, FSHPT
Regan Ashley	Project Officer, FSHPT

Endorsement/Sign off

Version #	Date	Description
Mortuary Clinical Reference Group	27 June 2013	Endorsed
Manager Service Commissioning	30 June 2013	Endorsed
Executive Director – Clinical Commissioning	04 July 2013	Endorsed
Clinical Readiness Control Group (CRCG)	6 August 2013	Endorsed

FSH Executive		
Co Directors, Service 2	4 September 2014	Endorsed

Endorsed Change Register

Reason for change	Summary of change	Sections affected	Endorsed by	Date
Update consistent with changes to other DSPs	Made Bereavement, Pastoral Care and Aboriginal Liaison sections more detailed	7.1		
Linked to update of Associated Services section	Added in line to refer to Pastoral Care, Bereavement and AHLS	4.2.3		
ICT Rescope	Electronic digital medical record → digital medical record	4.2.6		
Document has been endorsed by CRCG	Document version changed to 1_1	Front page		
Specific Consultation dates not relevant	Date column removed from distribution list table	Distribution list		
Document has been endorsed by CRCG	Date of CRCG endorsement added to table	Endorsement/sign off table		
Infection Prevention and Management Service incorrectly referred to as Infection Prevention.	Change heading to Infection Prevention and Management	Infection Prevention		
Hours of operation not correct for Pastoral Care Service.	The hours of operation updated as per the endorsed Pastoral Care service plan.	7.1 Pastoral Care		
Information not relevant or appropriate	Paragraphs relating to patients on wards and ED who are not deceased have been removed.	7.3 Aboriginal Health Liaison service		
Not applicable	DRAFT watermark stamp removed from document as this is an endorsed version.	Whole document		
Issues resolved	IF.444 issue and #377 resolved	Outstanding issues register		

Contents

1 OVERVIEW AND PURPOSE 6

1.1 Interdependencies 6

1.1.1 Documents 6

1.1.2 Services 6

2 OVERVIEW OF THE MORTUARY SERVICE 7

2.1 Mortuary Service Description 7

2.2 Guiding Principles of Service Delivery 7

2.3 Service Delivery Profile 7

2.3.1 Eligibility for Service 7

2.3.2 Operational Performance 8

2.3.3 National Safety and Quality Health Service Standards (NSQHS) 8

3 FACILITY DESIGN 9

3.1 Public Area 9

3.2 Clinical Area 9

3.3 Transfer Bay 10

3.4 Relationship to Other Areas 10

4 OPERATION OF THE MORTUARY SERVICE 11

4.1 Hours of Service 11

4.1.1 After hours 11

4.2 Mortuary Service Delivery 12

4.2.1 Ingress 12

4.2.2 Egress from the Mortuary 13

4.2.3 Viewings 13

4.2.4 Non-coronial autopsies 15

4.2.5 Coronial cases 15

4.2.6 Care of Specific Patient Groups 16

5 MORTUARY WORKFORCE 21

5.1 Governance 21

5.1.1 Workforce Model 22

5.1.2 Roles and responsibilities 22

6 CLINICAL SUPPORT SERVICES 24

6.1 Pathology 24

6.2 Infection Prevention and Management 24

6.2.1 General principles 24

6.2.2 Mortuary Service principles 24

6.2.3 Quarantine 24
7 ASSOCIATED SERVICES 26
7.1 Pastoral Care 26
7.2 Bereavement Services 26
7.3 Aboriginal Hospital Liaison Service 27
7.4 Medical Illustration 27
8 EDUCATION, RESEARCH AND TRAINING 28
8.1 Education and Training 28
8.1.1 Hospital Staff 28
8.1.2 Mortuary Staff 28
8.2 Research 28
9 SAFETY, QUALITY AND RISK 29
9.1 Governance, Monitoring and Evaluation 29
9.1.1 Key Performance Indicators 29
9.1.2 Service Activity Data 29
9.2 Governance: Management 29
9.2.1 Professional Development Management 29
9.2.2 Complaints Management 30
9.2.3 Risk Management 30
10 NON-CLINICAL SUPPORT SERVICES PROVIDED BY THE FACILTIES MANAGER . 31
10.1 Internal logistics 31
10.2 Sterilisation 31
10.3 Patient transport 32
10.4 ICT 32
10.4.1 Applications 32
10.4.2 End User Devices 32
10.4.3 Communications 32
10.4.4 Specialised Equipment 33
Appendix 1: Associated Interdependent FSH Service Plans 34
Appendix 2: Mortuary Service Interdependencies 35
Appendix 3a: Safety and Quality: SMHS SQR Indicators 36
Appendix 3b: Safety and Quality: FSH Mortuary Service 36
Appendix 4a: Mortuary Processes (standard operating hours) 37
Appendix 4c: Mortuary Processes - After hours operations where storing body in cool room is prohibited (After Hours Nurse Manager – AHNM) 39
Appendix 5: Mortuary Policy and Procedures 40

1 OVERVIEW AND PURPOSE

Fiona Stanley Hospital (FSH) is a major tertiary hospital for the South Metropolitan Health Service (SMHS) and will integrate with Royal Perth Hospital, SMHS general and specialist hospitals and other health facilities to offer comprehensive health care services to the south of Perth and across the State.

The purpose of this Departmental Service Plan (DSP) is to outline the following for the Mortuary Service:

- service description, profile and service delivery model including operational performance targets
- design and physical layout of the clinical areas available to the service
- workforce model
- operational procedures and patient flows and
- non clinical support services.

This information is intended for use by hospital executive and service clinical staff to inform the development of operational processes, procedures and guidelines for the facility.

1.1 Interdependencies

1.1.1 Documents

This document should be read in conjunction with the following:

- Clinical Service Framework 2010-2020 (CSF 2010)
- Fiona Stanley Hospital Clinical Service Plan (CSP) 2012-2015
- Admission, Readmission, Discharge and Transfer Policy for WA Health Services
- Human Tissue Act 1982
- National Safety and Quality Health Service Standards
- The National Pathology Accreditation Advisory Council - Requirements for the Facilities and Operation of Mortuaries
- PathWest Quality Manual
- Memorandum of Understanding between PathWest and SMHS

For a list of the associated interdependent FSH service plans refer to Appendix 1.

1.1.2 Services

To support the delivery of the Mortuary Service at FSH, strong relationships and links must exist between FSH and a range of internal and external departments and private and non-government organisations.

For a diagram of the internal and external interdependencies for the Mortuary Service refer to Appendix 2.

2 OVERVIEW OF THE MORTUARY SERVICE

FSH provides tertiary level healthcare to the SMHS catchment area for both elective and emergency patients, as well as some state-wide services. The Mortuary at FSH provides a dignified environment for deceased patients, and enables families and friends to view the deceased in a respectful and safe manner.

2.1 Mortuary Service Description

The FSH Mortuary provides the following services:

- storage of deceased patients
- viewing of deceased patients
- release of deceased patients to funeral providers and
- hospital autopsies for FSH patients and deceased patients from other SMHS non-tertiary hospitals

The Mortuary also conducts post mortem reconstruction, dressing, preparation and casketisation services to Funeral Directors and/or family members of the deceased. Funeral Directors are charged for this service, however it is provided free of charge to families.

2.2 Guiding Principles of Service Delivery

The Mortuary provides a respectful and dignified environment based on the principles of:

- respectful handling of deceased patients which facilitates a supportive family and carer experience
- care which incorporates FSH and SMHS standards of quality and safety
- inclusive care which addresses the needs of Aboriginal patients and other culturally diverse groups and
- FSH as a State leader for adult non-coronial autopsies.

2.3 Service Delivery Profile

2.3.1 Eligibility for Service

Inclusion

FSH provides Mortuary services for the following:

- storage of deceased FSH patients including patients from the Main Hospital, Mental Health and the State Rehabilitation Centre
- storage of deceased SMHS patients that cannot be appropriate stored at the site of death and require storage
- adult non-coronial autopsies and tissue removal for research purposes

Exclusion

FSH does not provide Mortuary services for the following:

- coroner cases. These are transported to the State Mortuary at Sir Charles Gairdner Hospital (SCGH)/PathWest QEII. Refer to section *4.4.3 Coroners cases*.
- autopsies of suspected Western Australian cases of Creutzfeldt-Jakob (CJD) disease. These patients are transferred to RPH where all CJD autopsies are carried out by PathWest Neuropathology.
- cremation for deceased babies/infants. This is carried out at KEMH. Refer to section 4.2.6 – Cremation of a baby at KEMH.
- autopsies for stillborn babies or live-born babies up to 28 days old. Refer to section 4.2.6 – Babies and Infants, Coronial and non-coronial autopsies.
- autopsies for deceased patients between the ages of 28 days and 18 years old. Refer to section 4.2.6 – Children, Coronial and non-coronial autopsies

2.3.2 Operational Performance

The Mortuary Service monitors and records activity to ensure changes in service delivery and standards can be identified and appropriately addressed. The mortuary is covered by the Laboratory quality system. Yearly audits are carried out to ensure procedures and protocols are adhered to and work standards are maintained. Yearly reviews of manual documents ensure best practice procedures and protocols are in place. NATA accreditation inspections occur every 3 years.

2.3.3 National Safety and Quality Health Service Standards (NSQHS)

The Mortuary Service complies with the NSQHS and National Pathology Accreditation Advisory Council (NPAAC) accreditation standards and participate in, collect and report on Clinical (CI's) and Key Performance Indicators (KPI's) outlined in Appendix 3a and 3b of this document. The Mortuary service is required to act on these results to improve services as outlined in Section 9.

3 FACILITY DESIGN

The Mortuary is located on the Lower Ground level of the main hospital building. The design accommodates separate points of access for movement of bodies to and from the ward to the Mortuary, for visitors accessing the Mortuary and for collection by Funeral Directors.

The Mortuary has space to hold 42 bodies including 39 short-term (refrigerated) and 3 long term (frozen) storage spaces. The Mortuary also includes space for deceased bariatric patients.

The Mortuary is comprised of three functional areas:

- a public area
- a clinical area and
- a transfer bay.

3.1 Public Area

The Mortuary is designed so that members of the public do not intercept the movement of deceased patients to or from the Mortuary, and for acoustic privacy. The public area is comprised of:

- a waiting room
- one toilet (with disabled access) and
- two viewing rooms for bodies to be viewed by relatives and friends.

Public access to this area is via 'Viewing Rooms and Hyperbaric' lift off the main concourse.

3.2 Clinical Area

The clinical area of the Mortuary is accessed via a separate entrance to the public area so hospital staff do not disturb relatives. The clinical area is comprised of the following:

- a lobby area with a weighing station and write-up space with a computer workstation
- one doctors' office, including two computer workstations, storage space and a local monitor to receive audiovisual information from intercoms in the waiting room, transfer bay and viewing room
- one technicians' office, including two computer workstations and a table and chairs with a beverage bay and microwave
- a cool-room, including deep freeze drawers, with the capacity to store up to 42 bodies
- one coolroom rack and one freezer rack to accommodate bariatric patients with a maximum weight of 300kg
- a tissue preparation room
- an autopsy room with adjacent observation area and
- male and female change areas for staff.

3.3 Transfer Bay

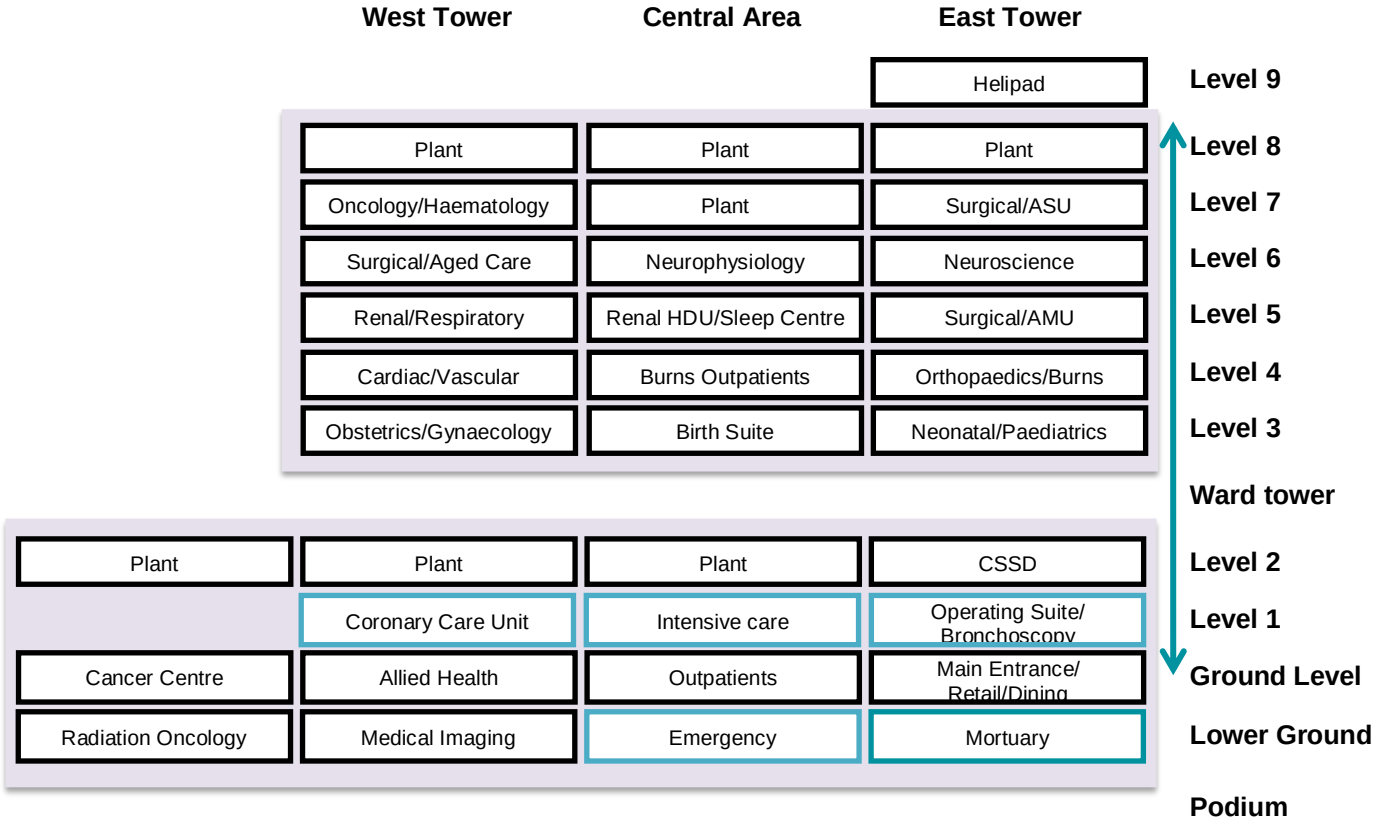
The transfer bay allows a vehicle to be brought to the facility for the safe and discrete transport of bodies. This primarily includes Funeral Directors, but also Government contractors for the collection of coronial cases, Muslim burial societies, and family or friends of the patient who collect the body for cultural reasons. The transfer bay comprises:

- discrete vehicle access via Bedbrook Row
- two covered parking bays and
- a storage area for coffins adjacent to the bays.

The transfer bay is fitted with an intercom and fixed digital camera for monitoring arrivals and departures.

3.4 Relationship to Other Areas

Figure 1: FSH Mortuary Service relationship to other areas.



The Mortuary is situated to allow:

- easy external access for the collection of bodies by Funeral Directors
- ready access to the inpatient ward towers
- ready access to the Operating Theatres
- ready access to the Emergency Department and
- ready access to the Intensive Care Unit and the Coronary Care Unit.

4 OPERATION OF THE MORTUARY SERVICE

4.1 Hours of Service

Standard hours of operation for the Mortuary Service are 0800hrs to 1600hrs, Monday to Friday. There is no after hours or on call service provided by PathWest Mortuary staff, with after hours viewings managed by the After Hours Nurse Manager.

4.1.1 After hours

The After Hours Nurse Manager is responsible for management of essential Mortuary operations outside of standard operating hours. Authorised Facilities Management staff and clinicians have access to the Mortuary area after hours.

After hours operation primarily supports:

- viewings in instances which cannot be deferred to standard operating hours (such as in the case of children, infants and babies; or for cultural reasons)
- transport of deceased babies to the mother whilst she is an inpatient and
- retrieval of tissue by DonateLife when the patient is a tissue donor, refer to section 4.4.3 Tissue Donors.

The following considerations are made for the provision of service after hours:

- the After Hours Nurse Manager is the first contact outside of standard operating hours via the Helpdesk
- the availability of the After Hours Nurse Manager is dependent on other priorities, and as such may delegate tasks to another senior nurse
- the After Hours Nurse Manager, or their delegate, is responsible for ensuring standard Mortuary processes (Refer to Standard Mortuary Procedures) are adhered to
- Pastoral Care (available 24 hours a day, seven days a week) and/or Aboriginal Liaison (available standard business hours) may be engaged to assist with the management of large groups during a viewing by calling the Helpdesk and requesting the on-call Pastoral Care staff member or the Aboriginal Liaison Service
- the movement of deceased patients to and within the mortuary, including from Cool Room to the Viewing Rooms for viewing is carried out by internal logistics porters
- the preparation of deceased patients for viewing is carried out by the Afterhours Nurse Manager or their delegate and
- the intercom at the transfer bay, and vision from the associated fixed camera, defaults to security after hours for their management.

Autopsies do not occur after hours.

Refer to *Appendix 5* for detail regarding after hours operations.

4.2 Mortuary Service Delivery

Mortuary processes for transport, storage, viewing and autopsy are detailed in *Appendix 4*.

4.2.1 Ingress

Intra-hospital transfer

Deceased patients are transported to the Mortuary when clinically and culturally appropriate and in the timeframe specified by speciality or Inpatient OSP.

If the patient does not have family or friends present at the time of death, the patient is transported to the Mortuary and this is where the viewing takes place if desired and if culturally appropriate.

The Internal Logistics service of the Facilities Management (FM) is responsible for the movement of the deceased patient from the clinical area to the Mortuary. The movement of the deceased patient is arranged by raising a request via the Helpdesk. Helpdesk allocate two porters for the movement of a deceased patient.

Prior to transport, the patient is prepared in accordance with the Deceased Patient Preparation Procedure, refer to Appendix 5.

A 'Death in Hospital Form' (indicating Coronial considerations) and a 'Transfer to Mortuary Form' (indicating personal effects and specific cultural requests) must be completed by the certifying doctor, and in the case of babies, the doctor or attending nurse/midwife respectively, prior to the patient being moved off the ward or clinical area.

When a body is delivered to the Mortuary, PathWest Mortuary staff record details of who transported the body, time of transport and from what location the patient originated in the Mortuary Register. Deceased patients then have their details entered into the Mortuary Register by PathWest staff. No deceased patient can be taken from FSH before this has occurred.

Inter-hospital transfer

Deceased patients originating from hospitals other than FSH are transported by Funeral Directors. This is coordinated by the hospital of origin with the assistance of the Coordinator of Mortuary Services and is at the expense of the site that requested the transport. The Facilities Manager can provide transport for deceased patients in exceptional circumstances where the originating site is unable to organise transport.

WA Health have contracted beds at the Hospice, St John of God Murdoch, co-located with the FSH site. On occasion, a SMHS patient may be admitted to the Hospice without funds for a funeral. When deceased, they are returned to the FSH Mortuary and not to the original referring hospital, and follow the processes outlined in 4.2.1. The cost of this transport is met by the site which utilised SJOGM contracted beds.

Mortuary reconciliation

On a daily basis Mortuary staff reconcile the number of deceased patients in the Mortuary with information on iSoft Clinical Manager (iCM). The Mortuary Register is considered the primary record of deceased patient's ingress and egress from the Mortuary.

4.2.2 Egress from the Mortuary

Bodies shall not be released from the Mortuary unless a Death Certificate, Coroner's Order, police authority, or letter from the Metropolitan Cemeteries Board is provided. Miscarried foetuses less than 20 weeks gestation are an exception to this rule, refer to 4.2.6 Babies and Infants.

Bodies are only released to authorised personnel, with a removal slip or letter of authority with the name and date of birth of the deceased. This documentation identifies them as authorised to remove the deceased patient. When a body is released to a Funeral Director or Government contractor, the receiving agent signs the Mortuary Register with the date, time, company name and any valuables which accompany the body.

In some cases it may be culturally appropriate for the family to collect the deceased patient. The family must have a:

- permit from the Metropolitan Cemeteries Board to conduct the funeral
- an appropriate vehicle, and
- a copy of the Will, which must be sighted by the Mortuary Technician.

A Death Certificate is only released with the body to the person, company or organisation licensed to conduct the funeral, as they are legally required to register the death with the Registrar, Births, Deaths and Marriages. Miscarried foetuses are an exception to this rule.

A Mortuary Technician phones the next-of-kin to advise that they need to appoint a Funeral Director when it is deemed clinically appropriate. Mortuary Technicians may be supported by FSH Bereavement Services in liaising with the deceased patient's family. In circumstances where family do not proceed with funeral arrangements, refer to section *4.2.6 – No next-of-kin or next-of-kin unable to make arrangements*.

For the release of babies and infants or children to the family, refer to sections *4.2.6 - Babies and Infants* and *Children*.

4.2.3 Viewings

During standard operating hours

The majority of deceased patients who are transported to the Mortuary are stored before being released to a Funeral Director. Whilst family and friends are encouraged to conduct viewings at a funeral home, some situations necessitate viewings being conducted at the FSH Mortuary. Refer to *Appendix 4a* for process details.

Viewings are booked by the family or next-to-kin contacting the FSH Integrated Service Centre, who transfer the call to the Mortuary. Mortuary staff then book the viewing room and advise the visitor to arrive at FSH Main Reception 10 minutes prior to the booking time.

The Mortuary Technician prepares the body thirty minutes to one hour prior to the booking time to allow the body to increase in temperature. Following this, the Mortuary Technician moves the prepared patient into the viewing room as per PathWest Standard Mortuary procedures.

When the person/s to view the deceased arrives at Main Reception, the Clerk at reception:

- phones the Mortuary to advise of the person/s arrival and
- arranges a hospital volunteer or a chaplain (if prearranged) to escort the person/s to the Mortuary if the visitor is unable to self-navigate using wayfinding.

The visitors proceed to the Viewing Rooms via the 'Viewing Rooms and Hyperbaric' lift, to the Lower Ground. The escorting staff (or visitors) use the intercom located outside the waiting room to alert the Mortuary staff of their arrival and seats the visitors in the waiting room. The visitors are then met by the Mortuary staff member who takes the visitors through to the viewing room and leaves them with the deceased patient as appropriate. Visitors are advised to use the intercom within the viewing room to contact the Mortuary staff member. All intercoms have appropriate signage detailing instructions.

Upon completion of the viewing, the Mortuary staff member escorts the visitors to the lift which takes the visitors back to Ground Level and the main concourse.

If large family groups are expected to view the deceased or the circumstances around patient's death are particularly traumatic, Pastoral Care, Social Work and/or Aboriginal Liaison should be engaged early by clinical staff on the patients ward. If prior referral is not initiated, Mortuary staff contact these services via Helpdesk.

For further information regarding these services, refer to section 7.1 Pastoral Care, 7.2 Bereavement and section 7.3 Aboriginal Liaison.

After hours

Family and friends of the patient are encouraged to arrange any viewing during business hours. However if the situation necessitates a viewing take place after hours, the After Hours Nurse Manager has oversight of this process as per section 4.1.1. The After Hours Nurse Manager or their delegate advises SIMS of the scheduled afterhour's arrival.

Unplanned viewings

If family or friends arrive at FSH to view a patient without a scheduled booking, this is accommodated wherever possible and as appropriate. During standard operating hours, visitors present to the main reception who contact the Mortuary directly to arrange viewing if appropriate. After hours, visitors use the intercom at the main hospital entrance to contact Security & Incident Management Systems (SIMS) staff who then contact the After Hours Nurse Manager via the Helpdesk to seek approval for access to the hospital and to organise a viewing if appropriate.

4.2.4 Non-coronial autopsies

Non-coronial autopsies may be requested by the treating physician or the patient's GP. The Mortuary provides a non-coronial autopsy service for sites across SMHS that do not have the appropriate facilities to perform such procedures on site. Autopsies are undertaken by the PathWest Anatomical Pathologists.

If the next-of-kin or other family member requests an autopsy, and this request is not supported by the patient's doctor, these cases are referred to the Director of Clinical Services to determine if it is suitable to refer to the Coroner.

4.2.5 Coronial cases

Under the Coroner's Act 1996, the Coroner is responsible for ensuring 'reportable deaths' are investigated. Such reportable deaths include, but are not limited to:

- a sudden or unexplained death
- death under anaesthetic or as a result of anaesthetic
- death due to injury
- death of unknown cause
- death of a person who is incarcerated, is in legal custody, is an involuntary mental health patient (as defined by the Mental Health Act 1996), or is under the care of community services
- death of a person whose identity is unknown
- death in transit to FSH and
- dead on arrival.

If there is any doubt whether the death is a Coroner's case, it should be treated as such until advised otherwise.

The Mortuary has the ultimate administrative responsibility to ensure all reportable deaths are reported to the Coroner.

If the death is deemed to be a Coroner's case, the body is collected from the Mortuary by a Government contractor for transport to the State Mortuary at SCGH/PathWest QEII. This transport is arranged by the Office of the State Coroner or WA Police. The patient's medical records must not be forwarded to the Mortuary if the death has been reported to the Coroner. The medical records of the deceased patient are retained by clerical staff on the ward. The Mortuary Primary Register is updated on discharge of the body from FSH. Refer to SMHS policy (SMAHS COC: 02 - Deaths, Reportable to the Coroner) for further details.

4.2.6 Care of Specific Patient Groups

Babies and infants

Ingress
After a stillbirth or miscarriage or the death of a baby/infant, the deceased is taken to the Mortuary when clinically appropriate. Prior to transport, deceased baby/infant preparation procedures are undertaken. Babies/infants are wrapped and placed in a protector for transport.

Viewing
Viewings of babies/infants occur as per the standard viewing process (4.4.3) with the following additional considerations:

- the family may wish to spend extended periods of time in the viewing room
- the family may wish to return and view their baby/infant numerous times
- the family may wish to touch or embrace their child and
- engaging Social Work or Pastoral Care may be appropriate via eReferral.

Transport of the baby between the Mortuary and ward
If the mother of a deceased baby is an inpatient at FSH, it may be necessary to transport the baby between the mother's ward and Mortuary numerous times. The following process is followed in these cases:

1. when the parents would like the baby returned to them, the Midwife logs this request via the Helpdesk
2. two porters collect the baby from the Mortuary (signing the baby out in the Primary and Mortuary Perinatal Register)
3. the Porters deliver the baby to the Midwife in a transfer bag
4. the Midwife accepts the baby from the porters and both sign and complete the Ward Perinatal Register and
5. the Midwife prepares the baby for contact with the parents.

When the parents are ready for the baby to be returned to the Mortuary, or when it is clinically appropriate, the following process is undertaken:

1. the parent/s return the baby to the Midwife
2. the Midwife wraps the baby in a plastic protector and returns the baby to the transfer bag
3. a request is logged via the Helpdesk and a two Porters collect the baby
4. both the Midwife and Porters sign and complete the Ward Perinatal Register and
5. the baby is transported back to the Mortuary and signed back in via the Mortuary Primary and Mortuary Perinatal Register.

The baby should be cooled intermittently in order to slow the rate of deterioration. Refrigeration for four to six hours is recommended for every four to six hours spent with the parents.

Funerals
A live birth at any gestation and stillborn babies of greater than 28 weeks gestation must have funeral arrangements made through a Funeral Director. If the gestation period is less than 28 weeks, the body may be disposed of by the hospital if unwanted by the parents. If the foetus is born alive and subsequently respiration ceases, irrespective of gestation period, it must be submitted to burial or cremation.

Taking a baby or infant home
Parents may request to take their deceased baby/infant home, such as in the case of Muslim, Maori or Jewish families. This occurs upon completion of the relevant documentation (refer to section 4.2.2 Egress from the Mortuary), and the parents retain a copy of this documentation. The baby/infant must be returned to FSH or taken to a Funeral Director by the family.

The period the deceased baby can be taken home is flexible, and at the discretion of clinical and Mortuary staff. Parents must confirm a date the baby will be returned to either the Mortuary or to a Funeral Director.

For babies born at less than 20 weeks gestation, the parents may wish to take the foetus home. This may happen with completion of the Authorisation and Release of Human Tissue and Explanted Medical Device Consent Form.

Cremation of a baby at KEMH
KEMH offer a complimentary cremation service for stillborn babies of less than 28 weeks gestation. Perinatal Pathology at KEMH is contacted and they arrange transport of the deceased baby via the Statewide Perinatal Transport System. If the family wish to have the ashes returned to them, they are returned to Pastoral Care at FSH who contact the family, or alternatively, the family may collect the ashes from KEMH directly.

Coronial and non-coronial autopsies
If the death is sudden or unexplained, this is managed as a Coronial case (refer to section *4.4.3 – Coronial Cases*). KEMH, or in some instances the State Mortuary, conduct all non-coronial autopsies for stillborn babies and live-born babies up to 28 days old. KEMH Perinatal Pathology is contacted to arrange transport of the baby.

Children

Viewing
Viewings of deceased children occur as per the standard viewing process (refer to section 4.4.3) with the following additional considerations:

- the family may wish to spend extended periods of time in the viewing room
- the family may wish to return and view their child numerous times
- the family may wish to touch or embrace their child and
- engaging Social Work or Pastoral Care may be appropriate via eReferral.

Taking a child home
Some parents request to take their deceased child home, such as in the case of Muslim, Maori or Jewish families. This occurs upon completion of the relevant documentation, parents retain a copy of this documentation (refer to section 4.2.2 Egress from the Mortuary). The child must then be returned to FSH or taken to a Funeral Director by the family.

Coronial and non-coronial autopsies
If the death is sudden or unexplained, this is managed as a Coronial case (refer to section *4.2.5 – Coronial Cases*). PMH conduct all non-coronial autopsies for child deaths and transport is arranged by calling PathWest PMH Histopathology. PMH accept patients if they are from 28 days old to 18 years old, and are less than 135cm and/or under 50kg. If the patient does not meet these criteria in height and weight, the body will be transported to the State Mortuary for the autopsy.

Custodial patients
Deaths of patients in the Department of Corrective Services (DCS) are considered to be coronial cases. Depending on the nature of the death the Coroner decides if the deceased patient is to be held in the FSH Mortuary or transported to the State Mortuary by state contractors. All case must be discharged via the mortuary for continuity of evidence.

For further information refer to the DCS DSP.

Tissue donors
DonateLife WA coordinates the collection of tissue (corneal, cardiac and musculoskeletal). A copy of the completed consent authorising removal of tissue for transplant or research must be sighted and copied into the patient's digital medical record (DMR) before granting DonateLife access to the Mortuary. The Mortuary staff or After Hours Nurse Manager is responsible for ensuring tissue collection is completed in a dignified manner, and that the patient appearance is restored to the highest standard. DonateLife staff requires access to the deceased patient's medical record before tissue removal can commence to ensure the patient is suitable for donation and the required consent has been granted. Tissue collection is conducted in the autopsy room. DonateLife supplies all required equipment and does not use Mortuary equipment other than significant fixtures such as autopsy tables. DonateLife provides all required personnel for tissue collection.

Patients who bequest their body to science
A patient may choose to bequest their body to science. If this is the case, Mortuary staff receive advice from the next-of-kin and there must be supporting documentation (such as Bequest Registration Form) in the patient's medical record.

Mortuary Technicians are responsible for contacting The University of Western Australia (UWA) Department of Anatomy. A brief medical history is given to UWA to assess patient suitability. A representative from UWA then attends the FSH Mortuary to examine the body and confirm suitability. If the body is deemed not suitable, UWA contact the next-of-kin to advise this and the next-of-kin are then responsible for appointing a Funeral Director and arranging transport to a funeral home. If the body is deemed suitable, UWA arrange for collection by a Funeral Director.

Patients who bequest their brain to science

The Mortuary maintains an internal inventory of people registered to donate their brain to science. Referrals are received from specialists, physicians, family members, organisations and support groups. Written consent for retrieval must be sought from the next-of-kin. If approval is granted by the next-of-kin, the brain is removed by Mortuary Technicians in the autopsy room and the tissue is packed before it is collected by Neuropathology, Anatomical Pathology Department (PathWest RPH) and the body is released to a funeral director. Mortuary Technicians ring the Neuropathology, Anatomical Pathology Department (PathWest RPH) to arrange collection of the brain tissue.

No next-of-kin or next-of-kin unable to make arrangements

If there is no known next-of-kin, the deceased comes under the jurisdiction of the Public Trustee. If a deceased patient remains unclaimed in the Mortuary, staff contact the Public Trustee at two weeks, four weeks and 12 weeks post death to convey this information. The deceased patient should be transferred to the freezer as soon as it is identified as being a Public Trustee case. The Public Trustee must wait a period of 12 weeks before final arrangements can be made for the body. After this time, the body of the deceased is transferred to a Funeral Director at the instruction of the Public Trustee.

If the next-of-kin is contactable, but is not able or willing to make arrangements for a Funeral Director, the Public Trustee becomes responsible for arrangements.

Aboriginal patients

Deceased Aboriginal patients may have many family members who wish to visit the body to pay their respects, so it may be necessary to make the body available in the viewing room for an extended period. FSH staff are sensitive to cultural practices, including not mentioning the name of the deceased patient.

If an Aboriginal patient in the FSH Corrective Services ward advises a clinician that they are a relative of a deceased patient in the Mortuary, the deceased patient is transferred to the State Mortuary at SCGH (or KEMH or PMH as appropriate) for cultural sensitivity.

Jewish patients

Patients of certain Jewish denominations must be accompanied by the next-of-kin (usually the eldest son) at all times. This means that this person must transit the clinical areas whilst the deceased is transported to the viewing rooms. Sensitivity must be exercised by staff in the Mortuary during this time, and the door to the Mortuary cool room and autopsy suite remain closed.

Deceased patients of Jewish faiths do not go to the cool-room. These patients go directly from the ward to the viewing room where families may remain with the body following death. The family arrange for the deceased body to be immediately collected by the appointed Funeral Director.

Muslim patients

Deceased patients of Muslim faiths do not go to the cool-room. These patients go directly from the ward to the viewing room where families may remain with the body following death.

It is cultural practice that the body is buried before sunset on the day of death, or within 24 hours of death. The family make arrangements for the body of the deceased to be promptly collected by the appropriate burial society.

Maori patients

It is Maori belief that the body cannot be left alone after death. Common custom for Maoris is to conduct vigils in a viewing room lasting up to 10 hours. If this extends beyond standard operating hours, the After Hours Nurse Manager has oversight of this process. The family are strongly encouraged to appoint a Funeral Director who can accommodate this.

Regional patients

If the patient has been transferred to FSH from a regional or rural hospital, the family may prefer to have the body returned to the locality of origin. This is coordinated, and costs covered by the Patients Assisted Travel Scheme (PATS). The patient may need to be stored in the freezer in order to retain anatomical integrity whilst arrangements are made.

5 MORTUARY WORKFORCE

Disclaimer: *The content of this section is based on the information available during the development of this service model. Following a subsequent affordability review, some FSH workforce builds have been revised, therefore the information below may no longer be current.*

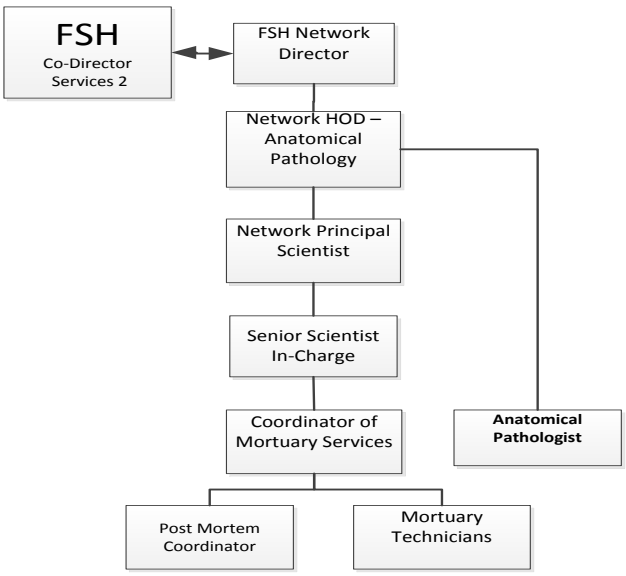
5.1 Governance

To facilitate the delivery of Mortuary services at FSH, the workforce includes:

- Network Head of Department, PathWest Anatomical Pathology
- Network Principal Scientist, PathWest Anatomical Pathology
- Senior Scientist In-Charge
- Coordinator of Mortuary Services
- Mortuary Technicians
- Anatomical Pathologists

The Network Principal Scientist reports to the Network Head of Department in Anatomical Pathology. The Network Head of Department in Anatomical Pathology reports to the PathWest FSH Network Director who reports to the PathWest Executive. The FSH Co-Director, Service 2 liaises with NMHS in regards to PathWest contract management and the FSH Network Director regarding FSH Mortuary Service delivery.

Figure 2: FSH Mortuary Service Organisational Structure



5.1.1 Workforce Model

5.1.2 Roles and responsibilities

FSH Network Head of Department, Anatomical Pathology
The Network Head of Department is responsible for:

- guiding and driving the development high level policy and strategic direction in relation to Mortuary services
- liaising with FSH senior management in regards to matters involving the Mortuary and the delivery of the service
- supervising Pathologists in the timely delivery of meaningful post-mortem reports
- deal with clinical issues and clinical instances in line with FSH and PathWest policy, operational management issues, procedures and performance.

Network Principal Scientist
The Network Principal Scientist is responsible for:

- leading the development and management of staff in the provision of Mortuary services
- reviewing, managing and directing the development and implementation of new processes and practices to enhance delivery of Mortuary services
- ensuring service delivery meets clinical governance requirements
- accountability for Quality Improvement programs that meet internal and external quality control standards and ensure accreditation of services
- accountability for the development, monitoring and control of the financial performance of the Mortuary
- reports to the Network Head of Department of Anatomical Pathology

Senior Scientist in Charge
The Senior Scientist in Charge is responsible for:

- providing expert advice to internal and external agencies on aspects relating to the Mortuary
- ensuring provision of a safe working environment in accordance with relevant Occupational Health and Safety and Equal Opportunity Legislation and
- managing, conducting and participating in approved performance management processes of staff

Anatomical Pathologist
Pathologists are responsible for:

- carrying out the non coronial case autopsies
- writing post mortem reports
- delivery of reports in a timely manner

Coordinator of Mortuary Services

The Coordinator of Mortuary Services is responsible for:

- the overall daily functionality and operations of the Mortuary Service
- liaising with appropriate persons (e.g. medical staff, medical administration, Funeral Directors) and ensuring consent in place for autopsy examination, referral of cases to the Coroner, the production of Death Certificates, Cremation Forms, coordinates process with Public Trustee for indigent deceased, donation of tissues for therapeutic purposes and notification of the deceased's General Practitioner
- admitting, recording and releasing deceased patients, ensuring the Mortuary Register and electronic records are accurately maintained
- ensuring appropriate religious and cultural requirements of the deceased are adhered to
- coordinating and provide education to all disciplines of hospital staff on cultural norms and best practice when caring for the deceased
- performing "body preparation" work on deceased patients prior to viewings and funerals in accordance with FSH Infection Prevention policies
- maintaining autopsy theatre and general mortuary area in a clean and hygienic condition including preparing and checking equipment for sterilisation and
- preparing the cadaver and Autopsy Room for post mortem.

Post Mortem Coordinator
The Post Mortem Coordinator is responsible for:

- obtaining permission for autopsy from next of kin

Mortuary Technician
The Mortuary Technician is responsible for:

- applying approved procedures and techniques to admit and release deceased patients
- preparing deceased patients for visual identification and bereavement viewings
- performing preliminary examination of patients on arrival to the Mortuary
- preparing patients in accordance with documented quality procedures as determined by type of admission (i.e. bariatric patients) and
- assist Pathologist with autopsy.

6 CLINICAL SUPPORT SERVICES

6.1 Pathology

The Mortuary service is part of the PathWest Anatomical Pathology Department and provides the mortuary services to FSH. PathWest oversees the management of and provides all pathology services to the Mortuary, including non-coronial autopsies and provide all staff and technical aspects of the service. Pathology services to the Mortuary are only provided during business hours. Outside of business hours the transfer of deceased patients, access to the Mortuary and urgent viewings are devolved to the Afterhours Nurse Manager (refer to section 4.4.3).

6.2 Infection Prevention and Management

6.2.1 General principles

The Mortuary has procedures in place, in line with hospital-wide guidelines, to ensure strict staff adherence with universal infection prevention precautions.

Hand-washing and personal protection equipment is provided to protect staff and others by minimising the risk of spreading infectious diseases. All staff must adhere to the WHO 5 moments of hand hygiene (OD042913) and the National Hand Hygiene initiative in Western Australia Healthcare Facilities. All sharps must be disposed of at the point of use into approved sharps containers and personnel that use a sharp are responsible for its safe disposal.

All Mortuary staff must adhere to the Body fluid exposure policy/procedure and any body Fluid exposures must be reported promptly to the Network Principal Scientist and Infection Prevention and Management. Body fluid spills must also be reported to Cleaning Services by raising a request via the Helpdesk for appropriate cleaning.

Clinical general and recyclable waste must be segregated into the appropriate containers.

For further information on hospital-wide infection prevention refer to the Infection Prevention and Management OSP.

6.2.2 Mortuary Service principles

Mortuary staff performing post mortems must adhere to OD 0398/12 - Release of Human Tissue and Explanted Medical Devices, when collecting tissue samples from deceased patients.

6.2.3 Quarantine

Mortuary staff must seek advice from either Infectious Diseases or Microbiology Consultants if a post mortem is to be performed on a patient with suspicion or laboratory confirmed highly transmissible infection.

Transmission based precautions are used when there is suspicion of higher infectivity tissue in patients with suspected high or low risk Creutzfeldt-Jakob disease (CJD). Autopsies on CJD patients are carried out at PathWest RPH. There is a set of instruments dedicated to patients who are suspected of carrying highly transmissible infections, other than CJD. Separate instruments are used to harvest organs and tissue for donation from these patients. These instruments have a traceability system.

7 ASSOCIATED SERVICES

7.1 Pastoral Care

The FSH Pastoral Care Service plays an important role within the FSH Mortuary Service and provides:

- support to the families of inpatients at FSH for the duration of their stay
- pastoral counselling, rituals and sacraments
- support to the FSH Mortuary team as required.

The FSH Mortuary Service refers patients via eReferral to the FSH Pastoral Care Service when patients and their families have been identified as requiring additional support during an admission. FSH Pastoral Care staff document their patient consultations in the patient's medical record.

The Pastoral Care administration is staffed during usual business hours from 0800 to 1700 hours.

The FSH Mortuary Service staff work with Chaplains to ensure that appropriate support is provided to grieving families, carers and friends of deceased patients. This may include accompanying the bereaved to the mortuary and/or arranging for extended access to the viewing rooms. An on call chaplain is available 24 hours a day, seven days a week and denomination specific ministers of religion may be contacted 24 hours a day, seven days a week. This is coordinated by the on call chaplain.

Chaplains also liaise with Mortuary Service staff to ensure that parental consent is appropriately documented prior to transfer of stillborn neonates to KEMH.

For further information refer to the Pastoral Care DSP.

7.2 Bereavement Services

The FSH Bereavement Service provides bereavement information and follow-up to families of deceased patients. This service is overseen by the Bereavement Co-ordinator.

Bereavement services can be accessed to provide support to family members or carers identified at risk of prolong distress, morbidity or psychological symptoms and in need for additional/more formal counselling. The Bereavement Service can be accessed on an as required basis via eReferral.

The FSH Bereavement Service provides counselling through FSH Social Workers, Chaplains and/or the Bereavement Co-ordinator. Alternatively, bereaved families/carers may be referred to community-based support services.

For further information on bereavement services at FSH refer to the FSH Bereavement Service SSP.

7.3 Aboriginal Hospital Liaison Service

Mortuary staff liaise with AHLS staff to manage the requirements of the family of the deceased Aboriginal patient. Extended family often wish to pay their respects which may result in large numbers of people wishing to view the deceased patient at FSH. Due to the significant distances that many families are required to travel means that the deceased may be kept in the mortuary for an extended period and require multiple viewings.

Viewing facilities are available within the Mortuary and unless family are present at the time of death, viewings are carried out in this area.

For further information on the AHL Service refer to the AHL Service DSP.

7.4 Medical Illustration

The Medical Illustration Department may complement Mortuary Services on occasion, providing clinical photography as appropriate. Refer to Medical Illustration DSP.

8 EDUCATION, RESEARCH AND TRAINING

8.1 Education and Training

8.1.1 Hospital Staff

The Mortuary Service provides education and training to hospital staff and personnel in relation to the activities and regulations around the service. This includes information on facilities, processes, patient contact (family and next of kin), legalities and coronial processes. This is completed via Mortuary tours or tutorial setups. Training is also provided to staff and personnel on completing paperwork and complying with Mortuary procedures. Common staff and personnel groups that receive such training include graduate nurses, Pastoral Care staff (assistance in dealing with death) and Internal Logistics Porters. Specialised training is also provided to Afterhours Nurse Managers and Nurse Unit Managers in relation to operation of the Mortuary after hours and procedures for the viewing, ingress and egress of deceased patients. The Mortuary Service also assists with intern doctor inductions in relation to Mortuary services.

8.1.2 Mortuary Staff

Mortuary staff receive education and training as required through PathWest education and development services in a wide variety of areas, from cultural awareness to perinatal loss and baby care.

8.2 Research

The Department of Anatomical Pathology (PathWest) assists with approved research programs and projects. Pathologists liaise with research project leads to establish clear plans to understand the requirements of Mortuary in the project.

All research projects, both internal and external, comply with Human Research Ethics Committee guidelines.

9 SAFETY, QUALITY AND RISK

The Mortuary Service has processes in place and participates in PathWest, FSH and SMHS clinical governance and patient safety, quality and risk activities. These activities align with the WA Department of Health, FSH, SMHS and PathWest Governance Frameworks

9.1 Governance, Monitoring and Evaluation

The Service evaluates and improves performance through Continuous Quality Improvement activities as outlined in PathWest Quality Manual. These activities include Key Performance Indicator monitoring and participation in safety and quality initiatives and accreditation processes.

9.1.1 Key Performance Indicators

The Mortuary Service collects and reports on the a number of Key Performance Indicators benchmarking these against identified targets or local, national and international standards where available and acting on the results to improve care and services. These KPIs are listed in Appendix 3a. The delivery of the Mortuary service is dependent on internal logistics to transport deceased patients as detailed in section 10.1.

9.1.2 Service Activity Data

The Mortuary Service collects service activity data to assists in identifying trends in activity to inform service design and improvement. Service activity data collected is reviewed annually.

Data collected includes:

- annual number of autopsies (12 months)
- average period of deceased storage
- number of non-refrigerated/frozen deceased annually
- cultural background of deceased
- age of deceased and
- weight of deceased.

9.2 Governance: Management

9.2.1 Professional Development Management

The Network Principal Scientist and Network Head of Department Anatomical Pathology ensures all staff are appropriately trained and practising within their scope of practice. Annual performance appraisals are conducted and processes are in place to address performance issues and maintain ongoing professional development.

9.2.2 Complaints Management

Reporting and management of complaints is in line with the DoH Complaints Management Policy and the PathWest Complaints Management Procedure.

Complaints and compliments are reported to the FSH Customer Service Liaison Unit which oversees the management of the complaint / compliment and all responses to the consumer.

9.2.3 Risk Management

A Departmental Risk Register is maintained for managing risks by the Network Principal Scientist. Risks that are ranked as high or extreme or which cannot be managed at the Departmental level are escalated to the PathWest Quality and Safety Officer, Head of Anatomical Pathology or if required PathWest FSH Network Director.

10 NON-CLINICAL SUPPORT SERVICES PROVIDED BY THE FACILTIES MANAGER

Non-clinical support services for the Mortuary Service are provided in accordance with the relevant service specifications for the following areas:

- access and security
- catering
- cleaning (including house-keeping)
- equipment and imprest supply (including linen supply)
- ICT/communications
- maintenance
- patient administration services (including access to medical records)
- patient transport
- sterilisation
- valuables management
- visitor management and
- waste disposal.

For further information on the non-clinical support services provided by the Facilities Manager refer to the Facilities Management Services Handbook.

Specific consideration has been given to delivery of the following non-clinical support services for Mortuary as described below.

10.1 Internal logistics

Internal logistics are carried out by Porters who transport goods and material around the hospital. Porters providing supporting Mortuary services require specialist training to; transfer deceased patients between the main hospital, State Rehabilitation Centre and Mental Health buildings and the Mortuary, prepare deceased patients for afterhours viewings, and transport deceased babies and infants to and from the wards.

The movement of deceased persons is monitored by KPI's including time of request to time of arrival at requested location. The Facilities Manager Porters must transport and discretely move the bodies of deceased persons from within the Site to the Mortuary, and where so requested, within the Mortuary. The route chosen for the transportation of deceased persons must avoid, to the greatest extent possible, public areas of the Hospital. All movements of deceased persons occurs according to the Internal Logistics Service Plan.

Porters are available to the Mortuary Service 24 hours a day, seven days a week. Mortuary staff request Porters via the Helpdesk.

10.2 Sterilisation

The sterilisation requirements of the Mortuary are carried out by the Sterilisation Service. The Mortuary has its own utensil washer for initial thermal disinfecting which is for use by Mortuary staff. After thermal disinfecting mortuary staff then place instruments in a container for collection and sterilisation by the Sterilisation Service.

Pickup and delivery of instruments is twice daily or on request.

Requests regarding sterilisation are made by raising a request via the Helpdesk.

10.3 Patient transport

The Facilities Manager's External Transport Service transport deceased patients to and from external sites and the FSH Mortuary in instances where external sites are unable to organise transport or for clinical reasons, such as transferring cCDJ patients from FSH to RPH. Requests regarding patient transport are made by raising a request via the Helpdesk.

10.4 ICT

Where possible, the Mortuary utilises paper light administrative processes. Staff utilise ICT solutions to record and store administrative data. This is not always possible, due to regulations around certain paperwork having to be in hard copy, such as Mortuary Registers and Death Certificates.

10.4.1 Applications

Core applications utilised by the Mortuary Service include:

- Clinical Incident Management System (CIMS)
- iSoft Clinical Manager
- PACs/ RIS
- Pathology Laboratory Information System (LIS; Ultra)
- EDIS/ WebPAS
- Anatomical Pathology Laboratory Information System (AP)
- Microsoft Office applications

10.4.2 End User Devices

End User Devices include:

- desktop computers with dual and single screens and fixed phones at staff bases, clinical workrooms and work spaces

10.4.3 Communications

Access to the Mortuary is controlled by Mortuary staff being alerted to the presence of non-authorised staff and public via intercoms located next to locked doors in the waiting room, transfer bay and viewing rooms. These intercoms are used to communicate a person's presence, and when friends and family of deceased patients have finished viewings and/or require Mortuary staff's assistance. The intercom diverts to the SIMS office outside of business hours, with SIMS staff answering any calls from these intercoms.

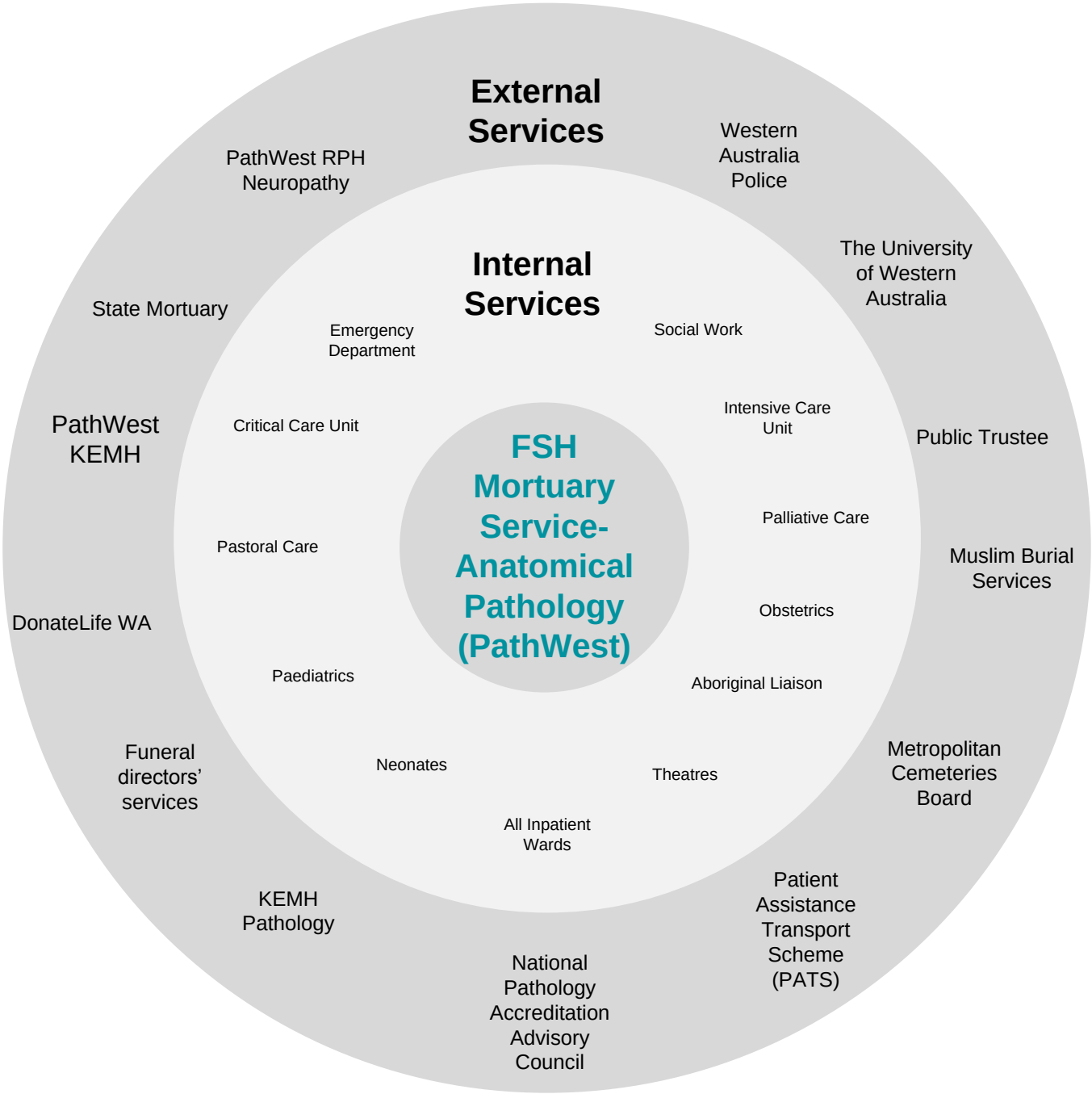
10.4.4 Specialised Equipment

The Mortuary Service does not require specialised ICT equipment.

Appendix 1: Associated Interdependent FSH Service Plans

- Palliative Care Specialty Service Plan (SSP)
- Infection Prevention and Management Operational Service Plan (OSP)
- Neonatal Departmental Service Plan (DSP)
- Paediatric Departmental Service Plan (DSP)
- Pastoral Care Departmental Service Plan (DSP)
- Bereavement Specialty Service Plan (DSP)
- Aboriginal Liaison Service Department Service Plan (DSP)
- Inpatient Operational Service Plan (OSP)
- Facilities Manager Services Handbook
- Pathology Service Plan (DSP)

Appendix 2: Mortuary Service Interdependencies



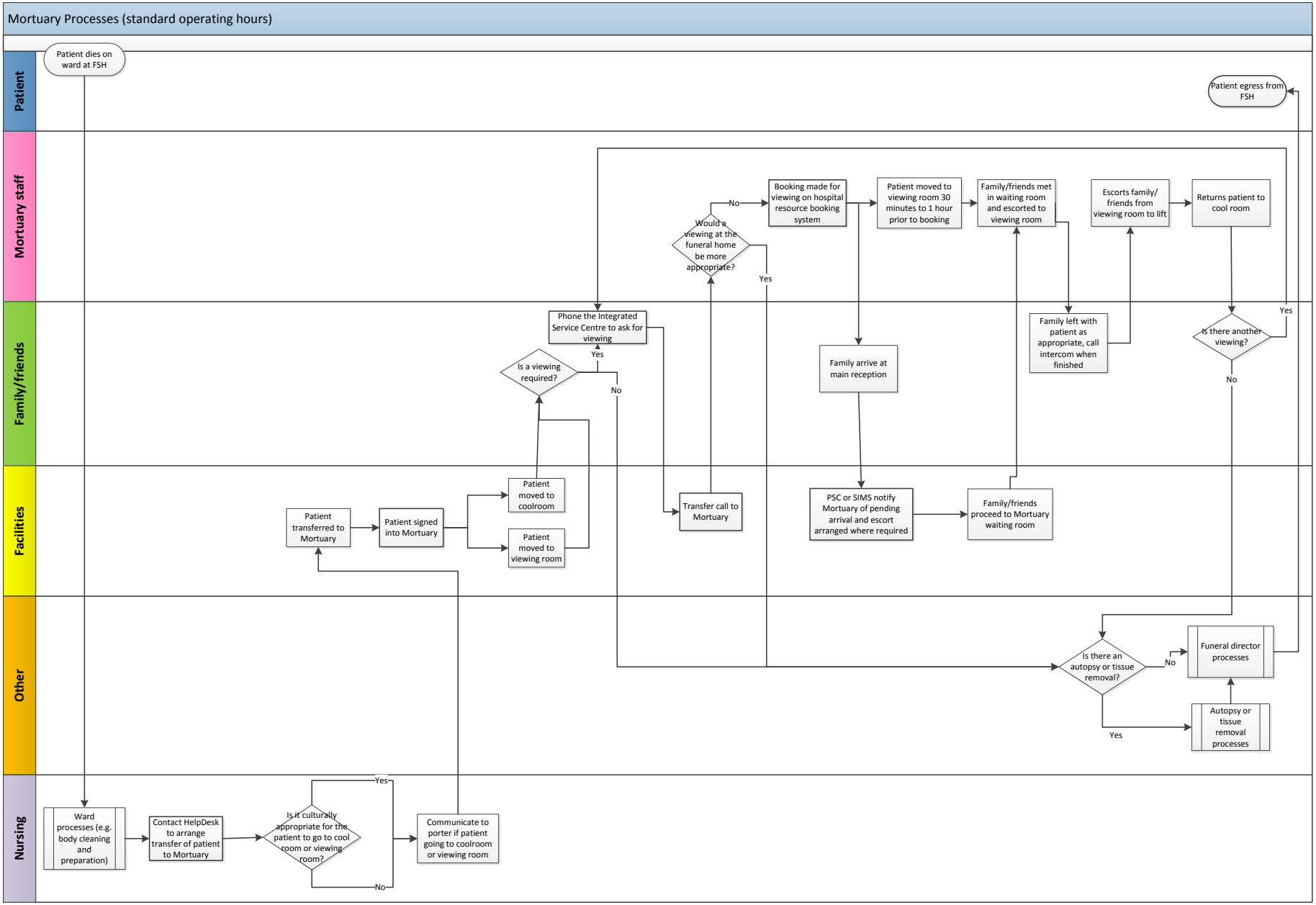
Appendix 3a: Safety and Quality: SMHS SQR Indicators

Indicator Group	Indicator Source	Indicator Title	Indicator Type Process / Outcome	KPI / Benchmark
Consumer Value	WA Complaints Management Policy	Complaints: Resolved within 30 working days (%)	Process	
Infection Control	HISWA	Rate of occupational exposure to blood and/or body fluids	Outcome	
	HHA	Hand Hygiene compliance (5 moments)	Process	

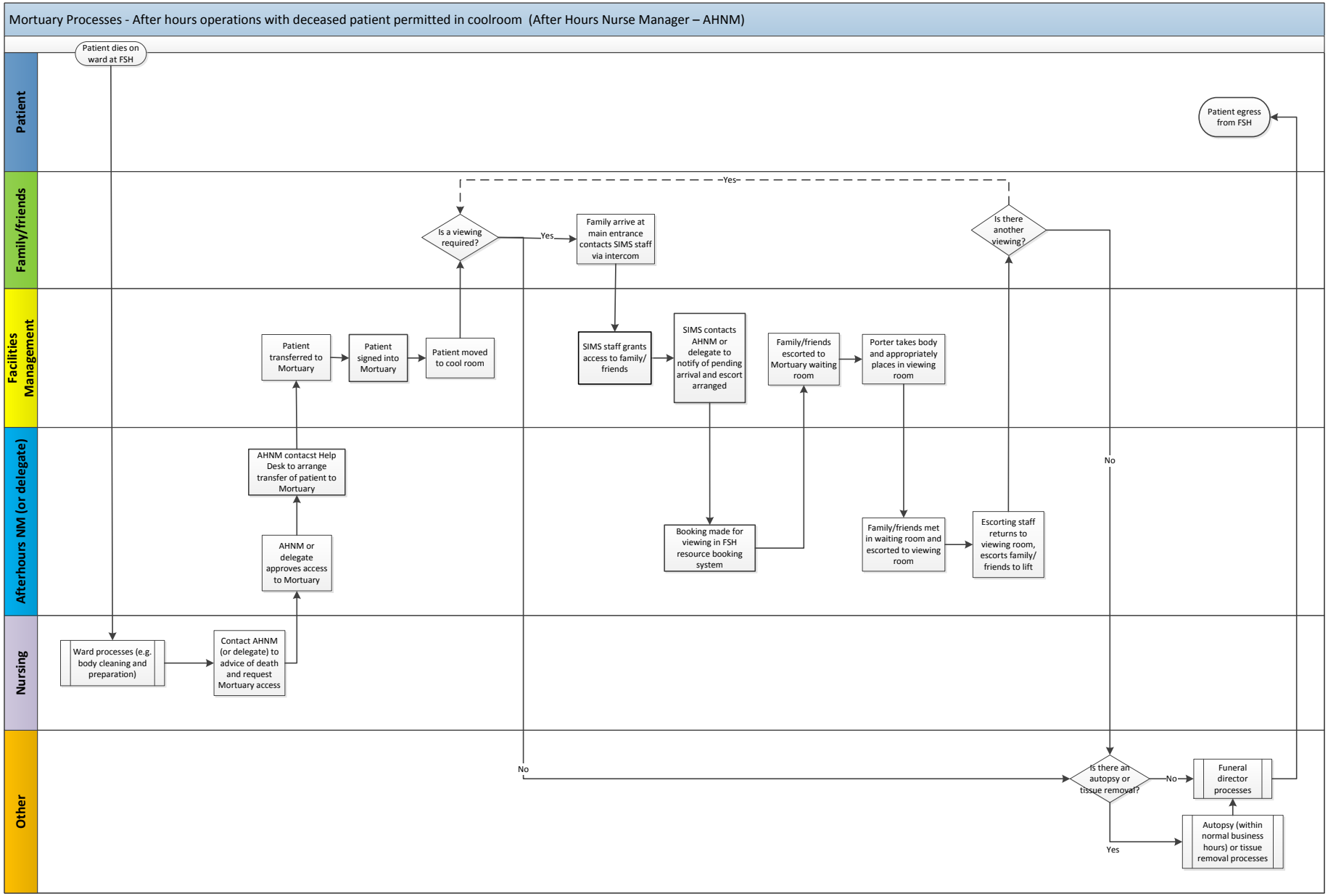
Appendix 3b: Safety and Quality: FSH Mortuary Service

Indicator Group	Indicator Source	Indicator Title	Indicator Type Process / Outcome	KPI / Benchmark	Position Responsible For KPI	Position Accountable For KPI
Dept. Process	FSH Mortuary Service	Time from death to completion of Death Certificate	Process	Baseline	Coordinator	Network Principal Scientist
		Interim autopsy report completed within 7 days of request	Process	100%		
		Final autopsy report completed within one month of request	Process	100%		

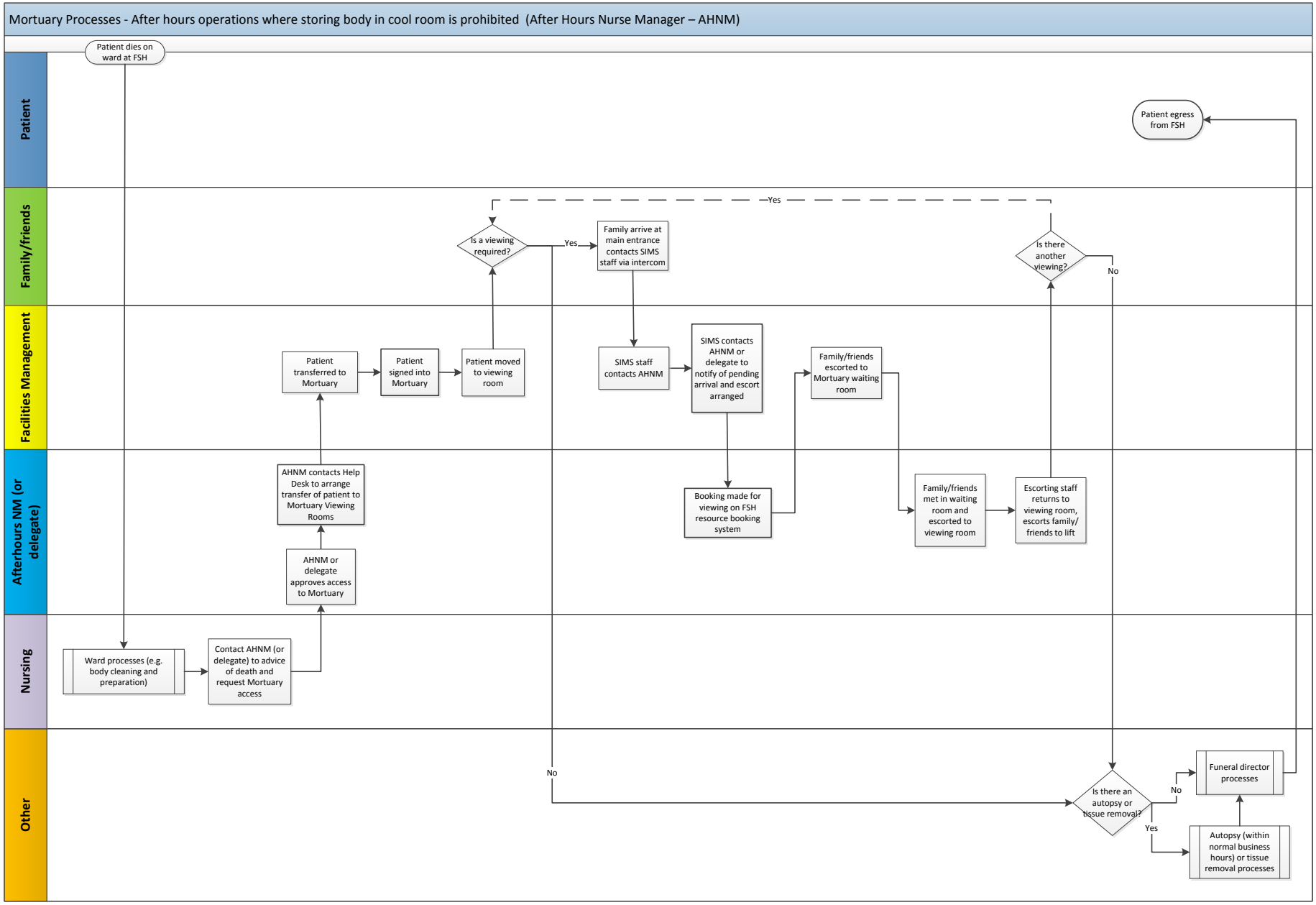
Appendix 4a: Mortuary Processes (standard operating hours)



Appendix 4b: Mortuary Processes - After hours operations with deceased patient permitted in cool room (After Hours Nurse Manager – AHNM)



Appendix 4c: Mortuary Processes - After hours operations where storing body in cool room is prohibited (After Hours Nurse Manager – AHNM)



Appendix 5: Mortuary Policy and Procedures

Existing	Procedures
Required	**Procedures**
Procedure	Afterhours access to mortuary (4.1.1)
Procedure	Standard Mortuary Processes (4.1.1)
Procedure	Transport preparation and transport process for deceased on ward (4.2.1)
Procedure	Baby /Infant Death on ward process and transport preparation (4.4.3)
Procedure	Quality procedure for preparing patients based on admission type (5.1.2)
Policy	Pneumatic Tube Policy (6.1)
Policy	Visitor Management Policy (10.10)
Procedure	Deceased Patient Preparation Procedure (4.2.1)
Policy	Post-Mortem on patients with suspicion or laboratory confirmed highly transmissible infections

Key Business Process Changes

Mortuary Service					
Business Process	**Summary of Key Changes** (Key work practice changes) (Key role, skill or capability changes) (Key ICT change other than site wide)	**Impact** (Location/department)	**Impact** (Process/activities)	**Impact** (Stakeholders/roles)	**Immediate Change Required** (Y/N)
Nil	Nil	Nil	Nil	Nil	N

This document can be made available in alternative formats on request for a person with a disability.

© Department of Health 2014