

# Perinatal Loss

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## Note:

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

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

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

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

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

*Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.*

## Explanation of the Aboriginal artwork:

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



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

## Purpose and Scope of Perinatal Practice Guideline (PPG)

The purpose of this guideline is to provide clinicians with information to support their care of pregnant women and their families experiencing perinatal loss in the second or third trimesters, either through fetal demise or termination of pregnancy. The PPG has been updated to reflect legislative changes with the introduction of the South Australian *Termination of Pregnancy Act 2021*. It includes legal, clinical and ethical considerations for pregnant women electing late stage termination of pregnancy or experiencing intrauterine fetal death. Documentation requirements, autopsy information and options for the management of the fetus/baby following birth are also included.

Guidance for clinical management can be found at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal) in the:

- > *Termination of Pregnancy and Miscarriage in the Second Trimester PPG,*
- > *Termination of Pregnancy in the First Trimester PPG,* and
- > *Bleeding & Pain in Early Pregnancy PPG*

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## Summary of Practice Recommendations

- > Parental decisions about screening, diagnostic testing and continuation of pregnancy must be made based on clear information about the nature of the fetal anomaly and risks of the available interventions.
- > Following a decision to proceed with termination of pregnancy (TOP) in the second trimester, the TOP can be undertaken medically or surgically depending on gestation, preference and other clinical considerations.
- > Births following TOP are not registrable with Births, Deaths and Marriages, except in cases where the fetus exhibits overt signs of life at the time of birth.
- > Fetal demise known to be prior to 20 weeks gestation is not registrable (even if birth occurs after 20 weeks).
- > Intrauterine fetal death (stillbirth) from 20 weeks gestation, and live births at any gestation are registrable.
- > Explanation and support for the woman and family should begin immediately following confirmation of fetal death or decision for medical termination, including the offer of non-medical counselling.
- > Discuss the woman and family's option to see, touch and hold the baby after birth, receive mementos), and take photographs. Offer appropriate support group information and brochures.
- > Ask if there are specific cultural practices that they need to observe/be aware of in order to provide culturally appropriate care as women have different values, perceptions and behaviours that differ not only across cultural backgrounds but also within their own culture.
- > In cases of stillbirth and genetic Termination of Pregnancy, as with any major perinatal morbidity, histopathological examination of the placenta is recommended in addition to following the *Investigation of Stillbirths: SA Protocol*.
- > Autopsy is vital to exploring potential causes of death and may identify causes that have implications in counselling and monitoring for future pregnancies.

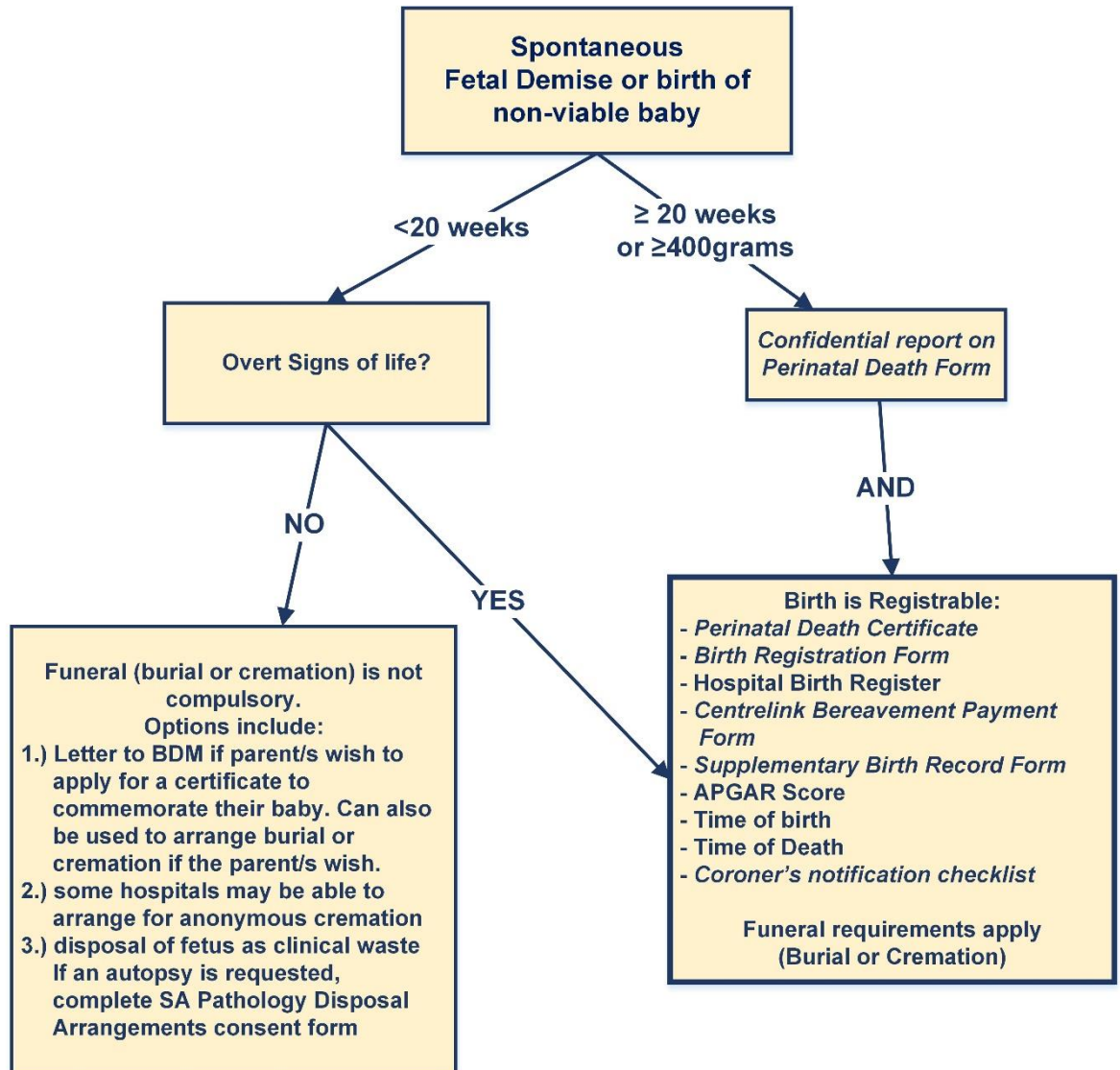
## Abbreviations

GTOP	Genetic termination of Pregnancy
IUFD	Intrauterine fetal death
LHN	Local Health Network
MTOP	Medical Termination of Pregnancy
PPG	Perinatal Practice Guideline
SA	South Australia
SAFDA	Support after fetal diagnosis of abnormality
SANDS	Stillbirth and neonatal death support
TOP	Termination of pregnancy

## Definitions

Cemetery	A place designated for the interment of human remains
Miscarriage	A fetus of less than 20 weeks that shows no signs of life following expulsion of the products of conception
Overt Signs of Life	Spontaneous respiration, heartbeat or other sign of life (tone, grimace, spontaneous movement)
Registrable	The birth of the fetus/baby meets the criteria to be registered with <i>Births, Deaths and Marriages</i> in South Australia
Stillbirth	Death before the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight <sup>1</sup>
Viability	Ability to survive outside the womb

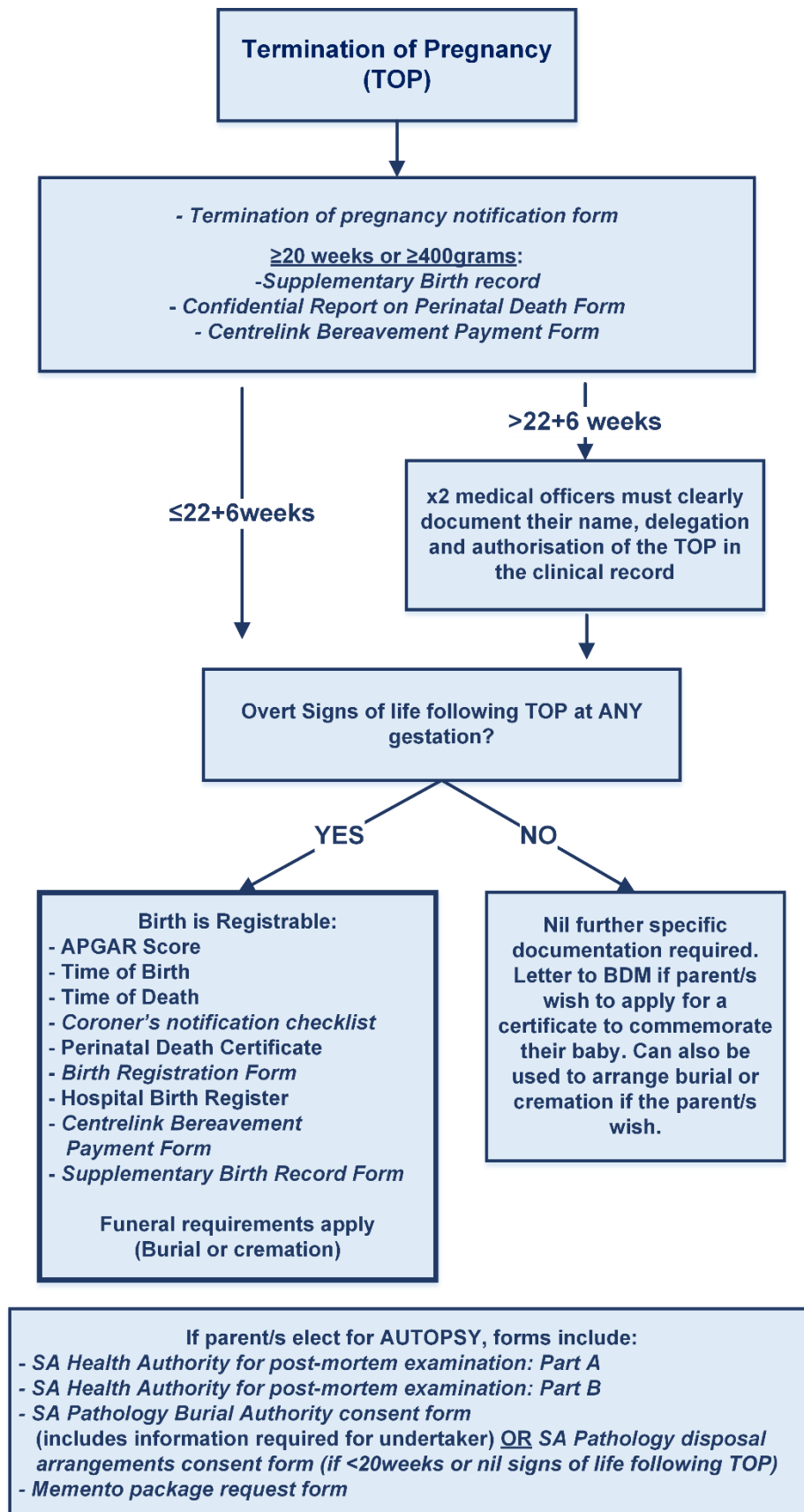
Flowchart A | Documentation guidance for Perinatal Loss (Fetal demise and birth of non-viable baby)



If parent/s elect for AUTOPSY, forms include:

- SA Health Authority for post-mortem examination: Part A
- SA Health Authority for post-mortem examination: Part B
- SA Pathology Burial Authority consent form (includes information required for undertaker)
- OR SA Pathology disposal arrangements consent form (if <20weeks or nil signs of life following MTOP)
- Memento package request form

Flowchart B | Documentation guidance for Perinatal Loss (Termination of Pregnancy)





## TERMINATION OF PREGNANCY

### Legal Considerations | Excerpt from Termination of Pregnancy Act 2021<sup>2</sup>

#### Part 2 – Termination of pregnancies

##### 5 – Terminations may be lawfully performed in South Australia

- (1) A termination may be performed on a person if –
  - a. In the case of a termination performed by a medical practitioner acting in the ordinary course of the practitioner's profession – the termination is performed on a person who is not more than 22 weeks and 6 days pregnant; or
  - b. In the case of a termination performed by any other registered health practitioner acting in the ordinary course of the practitioner's profession –
    - i. The termination is performed by administering a prescription drug or by prescribing a drug; and
    - ii. The registered health practitioner is authorised to prescribe the drug under section 18 of the Controlled Substances Act 1984
- (2) A medical practitioner may perform a termination on a person who is more than 22 weeks and 6 days pregnant if –
  - a. The medical practitioner is acting in the ordinary course of the practitioner's profession; and
  - b. The termination is performed in accordance with section 6.

##### 6 – Terminations by a medical practitioner after 22 weeks and 6 days

- (1) A medical practitioner may perform a termination on a person who is more than 22 weeks and 6 days pregnant if –
  - a. The medical practitioner considers that, in all the circumstances –
    - i. The termination is necessary to save the life of the pregnant person or save another fetus; or
    - ii. The continuance of the pregnancy would involve significant risk of injury to the physical or mental health of the pregnant person or
    - iii. There is a case, or significant risk, of serious fetal anomalies associated with the pregnancy; and
  - b. A second medical practitioner if consulted and that practitioner considers that, in all the circumstances –
    - i. The termination is necessary to save the life of the pregnant person or save another fetus; or
    - ii. The continuance of the pregnancy would involve significant risk of injury to the physical or mental health of the pregnant person or
    - iii. There is a case, or significant risk, of serious fetal anomalies associated with the pregnancy; and
  - c. The termination is performed at a prescribed hospital.
- (2) In considering whether a termination is medically appropriate, a medical practitioner must consider –
  - a. All relevant medical circumstances; and
  - b. The professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination.
- (3.) Without limiting section 13 of the Consent to Medical Treatment and Palliative Care Act 1995, a medical practitioner may, in an emergency, perform a termination on a person who is more than 22 weeks and 6 days pregnant, without complying with paragraphs (b) and (c) of the subsection (1).

##### 7 – Care of person born after termination

- (1.) This section applies if a termination results in a person being born.
- (2.) Nothing in this Act prevents the medical practitioner who performed the termination, or any other registered health practitioner present at the time the person is born, from exercising any duty to provide the person with medical care and treatment that is –
  - a. Clinically safe, and
  - b. Appropriate to the person's medical condition
- (3.) To avoid any doubt, the duty owed by a registered health practitioner to provide medical treatment to a person born as a result of a termination is no different than the duty owed to provide medical care and treatment to a person born other than as a result of termination.

##### 8 – Requirement for information about counselling

- (1.) Before performing a termination on a person, a registered health practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling.
- (2.) A registered health practitioner may, in an emergency, perform a termination on a person without complying with subsection (1).



**9 – Mandatory Considerations for medical practitioners performing terminations after 22 weeks and 6 days**

In assessing matters for the purposes of section 6(1), a medical practitioner must, when determining whether to perform a termination, have regard to the following:

- a. Whether it is essential to perform a termination of an affected fetus in a multiple pregnancy at a gestation that does not risk severe prematurity and its attendant consequences for the surviving fetus;
- b. Whether there are serious fetal abnormalities that were not identifiable, diagnosed or fully evaluated before the pregnancy reached 22 weeks and 6 days, including but not limited to abnormalities involving the brain, heart, renal and skeletal systems, or whether the fetus has been exposed to infective agents which may damage or limit the gestation and development of the fetus;
- c. Whether the patient has had difficulty accessing timely and necessary specialist services before the pregnancy reached 22 weeks and 6 days, including but not limited to patients experiencing significant socio-economic disadvantage, cultural or language barriers and those who reside in remote locations;
- d. Whether a patient has been denied agency over the decision to continue a pregnancy or not, including (but not limited to) the abuse of minors and vulnerable adults to sexual, physical violence including rape, incest and sexual slavery;
- e. Whether the abuse outlined in paragraph (d) includes circumstances in which such abuse is not apparent, or the pregnancy is not diagnosed until an advanced gestational age;
- f. Whether medical or psychiatric conditions may become apparent or deteriorate during the pregnancy to the point where they are a threat to the patient's life;
- g. Whether the patient has a deteriorating maternal medical condition, or late diagnosis of a disease requiring treatment incompatible with an ongoing pregnancy (such as malignancies).

**12 - Health Practitioner must not terminate pregnancy for sex selection**

- (1) Subject to subsection (2), a registered health practitioner must not perform a termination of pregnancy for the purposes of sex-selection
- (2) Subsection (1) does not apply to the performance of a termination if the registered health practitioner is satisfied that there is a substantial risk that the person born after the pregnancy (but for the termination) would suffer a sex-linked medical condition that would result in serious disability to that person.

## Clinical and Ethical Practice Considerations

Staff have a legally protected right to refuse to be involved in termination of pregnancy, except when it is necessary to save the life, or to prevent grave injury to the physical or mental health of a woman<sup>2</sup>.

The SA Maternal and Perinatal Mortality Committee<sup>3</sup> recommend that,

“all clinicians involved with clinical care for perinatal deaths or mortality review should attend an ‘IMPROVE’ (Improving Perinatal Mortality Review and Outcomes via Education) workshop” available at <https://learn.stillbirthcre.org.au/>

### Conscientious Objection<sup>2</sup>

If a clinician has a conscientious objection to being directly involved in the care of a pregnant woman undergoing a termination of pregnancy, they may refuse, so long as:

- > There is no immediate life-threatening risk
- > They disclose their conscientious objection and without delay, refer or provide information to the woman on how to locate or contact a health practitioner or health service who in their belief does not hold a conscientious objection to the performance of pregnancy termination.

### Late Stage Termination of Pregnancy in SA

Consistent with the Termination of Pregnancy Act 2021<sup>4</sup> (excluding an emergency situation where a termination is necessary to preserve the life of the woman), it is recommended that each Local Health Network (LHN) has a local documented procedure and process to ensure that two (2) medical practitioners are available to authorise a TOP at gestations >22+6weeks. LHN procedure for facilitating a woman's request for a later stage termination of pregnancy may include case conferencing.



## Timing of Screening, Diagnosis and Referral

Screening procedures and diagnostic tests to detect structural and fetal anomalies may be carried out in the first and second trimesters.

Specific testing for genetic disorders may be available in some clinical situations. Early consultation with a Clinical Geneticist for parent/s at increased risk is essential, preferably prior to conception.

Consideration of factors that increase a woman's risk for having a baby with chromosomal or structural anomalies should result in early specialist referral.

Perinatal care providers should be aware of current time periods for additional testing to ensure appropriate timing of initial and any subsequent screening and/or assessment.

Parental decisions about screening and diagnostic testing must be made on the basis of clear information about the nature and risks of the available interventions. Offer written information and time to consider choices.

Perinatal care providers should be aware of the current requirements for termination of pregnancy in SA to ensure timely referral and assessment, thus enabling women the option of termination of pregnancy should they choose.

Care providers can only commence TOP up to 22 weeks and 6 days gestation (22<sup>+6</sup>). TOP after this time can only be performed following agreement of two independent medical practitioners as per the Termination of Pregnancy Act 2021, and performed in a prescribed facility<sup>4</sup>. Local policy should indicate a process to support the requirements of the Act, which may include consultation with hospital ethicist to determine if the clinical decision complies with legislation. Case conferencing may be a useful tool to facilitate this and a process should be available at each site.

Consideration should be given to use of feticide in termination of pregnancy at the threshold of viability, generally this is considered from 22 weeks gestation.

## Decision making for the pregnant woman

### Prior to a decision for termination of pregnancy

In cases where the fetus has structural and/or other anomalies, the medical practitioner counselling the pregnant woman should explain:

- > The full nature of the fetal abnormality
- > The possibility that the abnormality will be lethal (if applicable)
- > The probability of impaired cognitive function (as indicated)
- > The known degree or likelihood of physical impairment
- > Time constraints for TOP in SA

Counselling from a clinical geneticist, paediatrician or paediatric surgeon may be helpful in specific cases.

Parents faced with antenatally diagnosed fetal anomalies may need additional support whether they proceed with the pregnancy or decide to request a termination of pregnancy. Parents should be offered non-medical counselling at the time a diagnosis or suspected diagnosis is made (e.g. referral to a social worker or genetic counsellor).

### Following a decision to proceed with termination of pregnancy

Pregnancies in the second trimester can be terminated medically or surgically depending on gestation, woman's preference and other clinical considerations:

1. Medical TOP (MTOP) involves inducing labour with mifepristone and misoprostol (see *Termination of Pregnancy and Miscarriage in the Second Trimester PPG*<sup>4</sup> available at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal))
2. Surgical TOP (STOP) involves a dilatation and evacuation procedure. Misoprostol, mifepristone, laminaria tents or a cervical balloon catheter may be used for cervical priming preoperatively. In SA, STOP at later gestations may be an option in some circumstances following consultation with the care provider.



The medical officer counselling the woman should discuss the following to inform their choice:

- > Whether the woman wishes to see and hold their baby and/or create mementos (see [mementos](#) section)
- > Whether the experience of labour is important to them
- > The time involved for different methods of termination
- > The possibility that a surgical procedure may preclude viewing and handling of the fetus and may lead to some limitations with pathological examination
- > The possibility that the fetus may show signs of life following a medical TOP
- > In cases where it is anticipated that signs of life may be present at the time of birth, a discussion of the risks and benefits for the mother and fetus regarding the option of feticide, should take place. If the woman declines the option of feticide, they should be counselled regarding the possibility of the baby being born alive and the legal and legislative reporting implications of this (i.e. registration of live birth and subsequent death as per the *Births, Deaths and Marriages Act 1996*<sup>5</sup>)
- > Consistent with the intention of performing a TOP, which is to end the pregnancy, resuscitation of the fetus is not appropriate. Palliative care should be offered to a person born with signs of life
- > Any specific clinical circumstances (e.g. uterine scar) that may influence choice
- > Obtain patient documented consent prior to proceeding to termination, including the associated risks of the procedure, including possibility of surgical intervention (ie. Dilatation and Curette)

In addition, the medical officer should discuss (and gain consent for) other possible investigations if indicated (e.g. amniocentesis, fetal tissue for chromosome analysis and/or DNA storage, histopathological investigation of the placenta) and [autopsy](#) (discussed in more detail later).

### Care of the person born

The Termination of Pregnancy Act 2021<sup>2</sup> refers to the duty owed by a health practitioner to the person born.

- (1.) *Nothing in this Act prevents the medical practitioner who performed the termination, or any other registered health practitioner present at the time the person is born, from exercising any duty to provide the person with medical care and treatment that is –*
  - a. *Clinically safe, and*
  - b. *Appropriate to the person's medical condition*
- (2.) *To avoid any doubt, the duty owed by a registered health practitioner to provide medical treatment to a person born as a result of a termination is no different than the duty owed to provide medical care and treatment to a person born other than as a result of termination.*

The following excerpt is taken from *Perinatal Care at the Threshold of Viability* PPG<sup>6</sup>, available at [www.sahealth.sa.gov.au/perinata](http://www.sahealth.sa.gov.au/perinata) :

- > The South Australian Consent to Medical Treatment and Palliative Care Act (1995)<sup>7</sup> indicates that medical practitioners are not required to provide life-sustaining treatment to children in the “terminal phase of a terminal illness” if that would merely prolong life in a moribund state (section 18[2]), in the absence of an express direction to the contrary.
- > There is no relevant case law in Australia relating to resuscitation of extremely premature infants. In the case of Baby D, the Australian Family Court affirmed that a decision to withdraw life-sustaining treatment could be in the interests of a newborn infant, and that parents were authorised to consent to such decisions<sup>8</sup> (Re:Baby D [No.2] [2011] FamCA 176 [27/01/2011]. Other legal cases and ethical analyses have found no legal or ethical difference between decisions to withhold life-sustaining treatment and decisions to withdraw the same treatment<sup>9</sup>.
- > Withholding resuscitation from a newborn baby where this treatment is reasonably judged to be not in the best interests of the baby is therefore consistent with existing law

Prior to the induction, the parent/s should be counselled around their wishes following the termination/birth including wishes for whether the baby is born with signs of life, and where the baby is born with no signs of life. Where there are overt signs of life at birth, the parent/s may wish to hold the baby until signs of life cease. If the parent/s do/does not wish to see or hold their baby, palliative care may be provided in a separate room by a health practitioner, ensuring comfort measures are maintained without prolonging life. Requirements for documentation are listed below, and are also outlined in flowcharts A & B.

## Documentation

### Termination of Pregnancy Notification Form

The Termination of Pregnancy Notification Form should be completed and forwarded to the South Australian Pregnancy Outcome Unit for reporting requirements outlined by the *Termination of Pregnancy Act 2021* and *Termination of Pregnancy Regulations 2022*.

The original form must be delivered or posted in a sealed envelope marked *Confidential* to the Pregnancy Outcome Unit, Wellbeing SA or via secure online portal (not email) within 28 days of the TOP. A copy of this form must be retained by the doctor who performed the TOP for a period of three (3) years commencing on the date of the termination.

### Overt signs of life

Overt signs of life are spontaneous respirations, heartbeat or other signs (ie. spontaneous movement or grimace)

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

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

Hospital notification of live birth to Births, Deaths and Marriages is required.

Individual LHNs must follow their local procedures and complete a 'Coroner's notification checklist' or equivalent check as per the *SA Health Coronial Process and the Coroners Act 2003 Policy Directive*<sup>10</sup> for every birth with overt signs of life to exclude that the death is reportable to the Coroner.

ONLY in cases where the fetus exhibits overt signs of life at the time of birth (i.e. respiration or heartbeat or other sign of life), does the birth become registrable, rather than a product of a termination of pregnancy under the *Births, Deaths and Marriages Registration Act 1996*<sup>5</sup>. In these cases the hospital issues the following paperwork:

- > A Birth Registration Statement
- > A Perinatal Death Certificate (if the parent/s elect for an autopsy, the doctor performing the autopsy will issue this)
- > Centrelink Bereavement Payment Form (for gestations  $\geq$  20 weeks)

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

### Supplementary Birth Record Form and Confidential Report on Perinatal Death Form

All perinatal losses (including termination of pregnancy) greater than or equal to 20 weeks, or at a weight of 400 grams or over require a 'Supplementary Birth Record' form to be completed under the *Health Care Regulations 2008*<sup>11</sup> and a 'CONFIDENTIAL REPORT ON PERINATAL DEATH' form to be sent to the Pregnancy Outcome Unit, Wellbeing SA.

### Centrelink Bereavement Payment Form

Births, Deaths and Marriages is a registration body regulated under South Australia law and what constitutes a registrable birth in SA is not necessarily consistent with other Australian states or territories.

Centrelink acts on behalf of the Australian Government Family Assistance Office and is under the jurisdiction of the Commonwealth Government. The Commonwealth Government recognises all pregnancies over 20 weeks, including a stillborn child or pregnancy ended via termination of pregnancy. The person should be issued with a Centrelink Bereavement Payment Form if the pregnancy reached 20 weeks gestation as families may be entitled to a bereavement payment under the Australian Government Family Assistance Scheme.

## FETAL DEMISE

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

### Fetal demise from 20 weeks gestation (Intrauterine Fetal Death/Stillbirth)

According to the *Births, Deaths and Marriages Registration Act 1996*<sup>5</sup>, a stillborn baby is at least 20 weeks gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth but does not include the product of a procedure for the termination of a pregnancy.

The birth of a stillborn baby should be registered.

A certificate of death is also required:

- > Following a stillbirth, a doctor's certificate on the form approved by the Births Deaths and Marriages Registrar, certifying the cause of fetal death should be given to:
  - a) The Births Deaths and Marriages Registrar
  - b) The funeral director or other person who will be arranging for the disposal of the human remains (Note: A copy of the death certificate should also be given to the parents to give to the undertaker if they take their baby home and then to the funeral parlour)
- > If an autopsy is undertaken, the death certificate is signed by the doctor carrying out the post-mortem
- > If an autopsy is not undertaken, the death certificate should be signed by the doctor caring for the parent and stillborn baby (any legally qualified practitioner can sign)

### Fetal demise prior to 20 weeks gestation in singleton pregnancy

In a singleton pregnancy, if a baby is known to have died prior to 20 weeks gestation but is born after 20 weeks gestation, this is considered to be a miscarriage (same rule applies as with multiple pregnancy). The date of baby's demise must be based on medical opinion, not on parent's wishes.

In these circumstances:

- > Application for a Commemorative Certificate for Early Loss of Pregnancy is available to parents upon request.
- > As the gestation is reliably known to be less than 20 weeks gestation, the mother is not eligible for a Bereavement payment

### Spontaneous birth prior to 20 weeks gestation with overt signs of life

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

- > A Birth Registration Statement
- > A Perinatal Death Certificate (If an autopsy is undertaken, the death certificate is signed by the doctor carrying out the post-mortem)
- > Hospital notification to Births Deaths and Marriages

## Multiple Pregnancy

### Fetal demise of a multiple before 20 weeks gestation

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

**Fetal demise of a multiple after 20 weeks gestation**

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

A Birth Registration Statement must be issued.

Hospital notification to Births, Deaths and Marriages is required.

Either a Centrelink 'Newborn Child Declaration' form is issued OR, if stillborn the mother is eligible for a Bereavement payment and a Centrelink Bereavement Payment Form should be issued.

If subsequently, neonatal death of one or more of the babies occurs:

- > A Perinatal Death Certificate must be issued (If an autopsy is undertaken, the death certificate is signed by the doctor carrying out the post-mortem)
- > A Bereavement payment form for the baby (or both) is issued as a replacement for the 'Newborn Child Declaration' form.

**Fetal demise gestation uncertain**

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

- > A Birth Registration Statement
- > A Perinatal Death Certificate (If an autopsy is undertaken, the death certificate is signed by the doctor carrying out the post-mortem)
- > Centrelink Bereavement Payment Form

Hospital notification to Births, Deaths and Marriages is also required.

**Medical or Surgical Management**

Women experiencing fetal demise in the second trimester have the same options as people undergoing TOP depending on gestation, their preference and other clinical considerations (see ['Following a decision to proceed with termination of pregnancy'](#) section).

**Care of the woman experiencing perinatal loss<sup>9</sup>**

Aim for continuity of caregivers.

Explanation and support for the woman and her family should begin immediately following confirmation of fetal death or decision for medical termination.

Parents should be offered non-medical counselling at the time that a diagnosis or suspected diagnosis is made e.g. referral to a social worker or genetic counsellor.

The emotional and psychological preparation related to the timing of the induction / termination procedure after diagnosis should be discussed with the woman.

Discuss the woman and her family's option to see, touch and hold the baby after birth, receive [mementos](#) (discussed below), and take photographs. Parents may be unsure about seeing and holding their baby after death. It is important that staff gently explore any parental concerns and respects their choice to do what is right for them.

It is important to consider that the perinatal loss may be revisited at any future anniversaries or during future pregnancies. Anniversary reactions and anxiety often occur around the gestational time of loss in future pregnancies and should be seen as a normal response with validation by maternity staff. Offer appropriate supports during this time.

Offer stillbirth and neonatal death support group information (such as SANDS) and brochures to the woman and her family.

In the case of a termination of pregnancy for a fetal abnormality offer information about the Support After Fetal Diagnosis of Abnormality (SAFDA) support group.

Obtain intravenous access and take bloods as indicated (see *Investigation of Stillbirths: SA Protocol*<sup>12</sup> available at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal))

- > Group and save
- > Complete blood picture
- > Coagulation profile (if at risk of coagulopathy)

Arrange early anaesthetic review. If regional anaesthesia required, obtain results from complete blood picture, and coagulation profile as indicated, following discussion with anaesthetist before insertion.

### Culturally sensitive care

Women often have different values, perceptions and behaviours that differ not only across cultural backgrounds but also within their own culture<sup>13</sup>.

Health professionals should ask if there are specific cultural practices that they need to observe/be aware of (rather than assume), in order to provide culturally appropriate care.

It is important for health professionals to acquire a general working knowledge of those practices that may be considered offensive in some cultures.

Health professionals should be aware that families from other cultural backgrounds may have very different belief systems and practices around death and important rituals that need to be performed.

A detailed account of various multicultural practices around death is beyond the scope of this guideline. A brief description of issues that may be relevant for Aboriginal and Muslim people is included:



### Aboriginal people

Aboriginal people experience very high levels of grief and loss in their communities. This can demand ceremonial acknowledgement. Aboriginal people should be referred to an Aboriginal Health Professional as soon as practicable. Where an Aboriginal Liaison Officer (ALO) is unavailable, Aboriginal Community Controlled Health Services/Organisations may be contacted to ascertain appropriate cultural advice and support with the family's consent.

It may be important for Aboriginal people to include their extended family who may or may not include blood relatives when grieving perinatal loss. It is not unreasonable for grief, loss and ceremonial processes to be managed by extended family. Please discuss, in consultation with an ALO or Aboriginal healthcare worker, where available to provide support, until the arrival of relatives.

It is important to understand that eye contact and questioning may be offensive to people.

Ensure the woman and her family are aware of any Aboriginal services as well as other available services (including funeral options) so that choices most appropriate to the woman's cultural needs can be made. This may include support to return a deceased person to country.

Consideration on the use of a deceased, Aboriginal person's name should also be discussed with the family, in addition to the collection of photographs.

### Muslim people

According to Islam, for forty days following birth, the mother of a stillborn baby is unclean and may not touch a dead body.

The stillborn baby may be washed by a relative of the same sex.

Early discharge may be requested for early burial of the stillborn baby.

The stillborn baby should be interred (usually in a shroud) within 24 hours after death (may be without a coffin). The funeral service is usually held in a Mosque, but may also take place in a funeral parlour or cemetery. The family usually make their own burial arrangements for the baby with the funeral director. Cremation is not usual.

These arrangements may affect the hospital's ability to create mementos.

If required, autopsy should be expedited for the parents.

### Care of the woman following birth

It is important that the wishes of the woman and their family in relation to seeing, touching and holding their baby are respected at this time<sup>9</sup>.

If appropriate, the parents should be encouraged to name their baby and begin to develop memories of their baby. As appropriate, parents may include siblings and other family members in photographs to aid the development of memories following their baby's death.



Observations as indicated and allow parents some time alone as appropriate

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

### Lactation suppression

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

Prolactin is the primary hormone responsible for milk production, and in its absence, milk production ceases. Advise that breast milk production may take some time to resolve, and can range from a few days to weeks<sup>14</sup>.

Many people may find that production of milk is a reminder of the loss of their baby and will wish to initiate early suppression of lactation; however others may find that it produces positive emotions during a sad time and may wish to employ gradual suppression of lactation<sup>15</sup> (particularly if perinatal loss has occurred after lactation has been established).

Measures to alleviate uncomfortably full breasts include<sup>14</sup>:

- > encourage the woman to wear a firm bra or crop top day and night until breasts feel less full and avoid expressing or overstimulating the breasts
- > simple analgesia such as paracetamol
- > use of cold packs
- > gentle massage of breasts under the shower to alleviate discomfort and allow some milk to leak
- > the use of breast pads to soak up any leaking milk

For further information see Australian Breastfeeding Association booklet 'Lactation suppression' at URL: [www.breastfeeding.asn.au/bfinfo/lactation-suppression](http://www.breastfeeding.asn.au/bfinfo/lactation-suppression)

### Cabergoline (Dostinex®)

Pharmacological suppression may be offered and is suitable from 20 weeks of gestation or may be considered earlier if lactation suppression is thought to be required<sup>15</sup>.

Cabergoline (Dostinex®) is most effective if given as a single oral dose of 1 mg in the first 24 hours postpartum<sup>16</sup>.

An ergot derivative, cabergoline (Dostinex®) should be given with caution in people with a history of severe cardiovascular disease, hypertension, preeclampsia and people with a history of serious psychiatric disorder (particularly psychosis)<sup>16</sup>.

Common side effects include dizziness, nausea, headache and hypotension<sup>16</sup>.

### Care of the baby following birth

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

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

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

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

Medical / midwifery staff should be aware and advise people and their family as appropriate, that refrigeration (at 4° Celsius) of the baby is advised at least within the first 24 hours. If they wish to keep the baby with them, staff should encourage regular periods of refrigeration (e.g. overnight if possible). Alternatively, offer use of portable devices (e.g. a 'cold-cot') to facilitate access to their baby if available.

**Blessing baby**

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

**Discharge planning**

Contraception advice as appropriate.

Lactation suppression advice as above.

Ensure the woman is aware of the signs and symptoms of mastitis (e.g. flu-like symptoms with aches, fever, breast lumps, red, swollen, hot and painful area of the breast, red streaks extending toward the axilla<sup>15</sup> and advise the woman to seek medical advice if symptomatic.

Offer follow-up counselling by the service provider or another appropriate agency / counsellor.

Arrange domiciliary follow up as indicated.

Medical discharge letter.

Follow up medical appointment according to individual hospital arrangements. At this appointment the woman should undergo a physical review and receive the results of any investigations / autopsy in a plain language report (may take 8-10 weeks to complete). A formal report is sent to the referring general practitioner.

Where possible, if the woman has transferred from the country and their general practitioner (GP) is unaware of the pregnancy outcome, the GP should be notified by telephone (with the patient's consent).

**Mementos**

Mementos can be created by individual health units and/or the SA Perinatal Autopsy Service.

All babies who have post mortem examination by the SA Perinatal Autopsy Service will have the option of a memento package including:

- > High quality colour digital photographs
- > Foot and hand prints
- > Name band
- > Hair (if possible)

Mementos created by the SA Perinatal Autopsy Service will only be undertaken if the *Memento Package Request Form* is completed and received (see [appendix](#) ).

Parents who do not wish to receive these mementos at first may still choose to have them undertaken as they may change their minds at a later date (several weeks, months or years after their baby's death), and wish to collect their baby's items. Storage of mementos as part of the SA Perinatal Autopsy Service is consistent with the SA Health *Health Record Management Policy Directive 2017*<sup>17</sup>.

Destruction of mementos, as part of the health record, should only occur once they have reached their legal period of retention in accordance with the *State Records General Disposal Schedule No. 28 - Clinical and Client Related Records*<sup>18</sup> (currently 33 years).

Families should be informed that if mementos are not collected after 33 years they will be destroyed. The discussion should be clearly documented in the medical record.

Individual hospitals may also create memento packages for second trimester fetal loss, stillbirths and neonatal deaths. Mementos may include some or all of the following: identification bracelets, cot cards, tape measures used to measure baby (as appropriate), naming certificate, memento box and clothing (e.g. gown, bonnet, quilt).

Individual LHNs/health units need their own processes for management of mementos which may include indefinite storage, but at a minimum this should be 33 years, consistent with the *State Records Disposal Schedule*<sup>18</sup>.

## Placenta

Histological examination of the placenta may provide additional clinical information<sup>9</sup>.

Where possible, all placentas of stillborn babies, early neonatal deaths and mid-trimester miscarriages / genetic terminations should be sent for examination<sup>3</sup>.

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

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

Document description and weight of placenta in case notes.

The placenta should be sent as soon as possible (i.e. within 12 hours) fresh, without any preservative solutions or refrigerated if there is any delay. See *Histopathology Management of the Placenta* PPG<sup>19</sup> available at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal)

### If consent for Autopsy

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

### If no autopsy

The placenta should be sent to the hospital's histopathology department with consent.

## Autopsy

Consent to autopsy is legally required for any fetus over 20 weeks, weighing over 400 grams or where there are overt signs of life at lesser gestations necessitating issue of a birth and then a death certificate. However, the South Australian Perinatal Autopsy Service requires that consent to autopsy or pathological examination at any gestation is obtained (see *SA Transplantation and Anatomy Act 1983*<sup>20</sup>), to ensure there is no misunderstanding and the wishes of the woman and their support person are respected.

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

A plain language autopsy report can be requested from the South Australian Perinatal Autopsy Service (phone: 8161 6315) at any time. If it is anticipated that a plain language autopsy report will be required, this may be requested on the original autopsy consent form at the time of autopsy consent.

Coronial enquiry – stillborn babies do not require investigation by the Coroner. Investigation is at the Coroner's discretion.

### Purpose of perinatal autopsy

The SA Maternal and Perinatal Mortality Committee<sup>3</sup> strongly recommend autopsy and histopathological examination of the placenta in cases of stillbirth in addition to following the *Investigation of Stillbirths: SA Protocol*<sup>12</sup> (available at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal)).

PSANZ lists the following reasons for performing an autopsy<sup>13</sup>:

- > Identify an accurate cause of death
- > Exclude some potential causes of death
- > Identify disorders that have implications for counselling and monitoring in future pregnancies
- > Provide other information related to the death, including excluding possibilities that may alleviate feelings of guilt
- > Obtain tissues for genetic tests
- > Assist grieving by helping parents' understanding of the events surrounding the death
- > Contribute to research, for example, by the recognition of new disease entities and expansion of knowledge on known diseases
- > Inform clinical audit of perinatal deaths, including deaths due to iatrogenic conditions and to confirm antenatal diagnoses or suspected fetal pathology

- > Teach pathologists and medical students
- > Avoid inaccuracies in data on causes of death for audit activities and subsequent public health policy
- > Inform medico-legal processes, for example, provide information in coronial investigations or cases of litigation

### Consent for autopsy with the SA Perinatal Autopsy Service

The booklet, *When a person dies: The Hospital Autopsy Process. Information for family and friends*<sup>21</sup> should be given to the parents to read before any request for autopsy consent from the medical officer.

It is the responsibility of the medical officer to answer any queries that the woman and her partner may have related to autopsy before obtaining their consent for autopsy<sup>13</sup>.

Parents can choose not to have an autopsy performed.

A copy of the autopsy report may be sent to the woman's general practitioner according to her wishes (documented on form (b) MR82F).

Initial information from autopsy is generally available within six (6) to eight (8) weeks.

### Forms

The following forms require completion and must be sent to the South Australian Perinatal Autopsy Service with the fetus / baby for autopsy.

- > SA Health Authority for Post Mortem Examination: Part A – Request by Medical Practitioner form should be completed by the requesting doctor
- > SA Health Authority for Post Mortem Examination: Part B – Record of Consent form should be completed by the senior available next of kin and signed by a witness (+/- interpreter if required). N.B. The witness must be independent (i.e. not the requesting doctor nor related to the deceased)
- > SA Pathology Burial Authority Consent form (includes information required by Undertaker) OR
- > SA Pathology Disposal Arrangements Consent form (for stillbirths < 20 weeks or GTOP ≥ 20 weeks with no signs of life)
- > Memento Package Request form (see [appendix](#)) if the parents want the SA Perinatal Autopsy Service to create mementos.

The *Confidential Report on Perinatal Death* may be sent directly to the Pregnancy Outcome Unit as indicated on the form.

### Transport of the fetus / baby for autopsy

The doctor at the transferring hospital should telephone (08) 8161 6101 to inform staff at the SA Perinatal Autopsy Service to expect a baby.

The referring hospital should arrange transport of the baby with SA Pathology on phone number (08) 8222 3000 or via Funeral director of choice.

Transport may be by road or air as appropriate.

The baby should be refrigerated at 4° Celsius until transfer.

### For any fetus / baby being transported to the South Australian Perinatal Autopsy Service:

- > The baby / pathology container (not the lid) should be clearly labelled
- > The baby should be wrapped in a shroud (sheet), then plastic
- > A small fetus < 20 weeks may be transported dry in a pathology container
- > Transport without fixative or other fluids
- > Include fresh placenta in sealed labelled bag
- > Use a plastic/foam insulated box (esky) with ice bricks (e.g. small containers of frozen water) carefully positioned around but separate from baby (or bucket) for cold storage transport
- > It is important that baby is transported dry and undistorted
- > Include demographic and clinical information including obstetric history of the mother

Note: A summary information booklet on the South Australian Perinatal Autopsy Service is available by contacting Anatomical Pathology at the WCH on phone number 8161 6315.

## Burial or cremation options

Discuss burial, cremation or disposal options after birth as appropriate for gestation.

Organise social work support in accordance with individual hospital or medical arrangements.

Parents' grieving process is often assisted by involvement in a physical parting, thus a funeral (burial or cremation) may be an option at any gestation. The mortuary provides required paperwork including the forms required for cremation from the South Australian Cremation Regulations, (*two certificates of death from natural causes pages 12-13, certificate of tagging and marking page 16*)

[https://www.legislation.sa.gov.au/\\_/legislation/lz/c/r/cremation%20regulations%202001/2002.06.30/2001.7.pdf](https://www.legislation.sa.gov.au/_/legislation/lz/c/r/cremation%20regulations%202001/2002.06.30/2001.7.pdf)

### Less than 20 weeks gestation (TOP or Miscarriage)

It is not compulsory for a funeral (burial or cremation) if a birth is not registered. Options therefore include:

- > The woman organises a private funeral/disposal, and is responsible for all costs. The hospital mortuary or doctor/midwife can provide an *Early Loss of Pregnancy Letter* for the funeral director so a burial or cremation can occur (see <https://www.sa.gov.au/topics/family-and-community/births-deaths-and-marriages/certificates/early-loss-of-pregnancy-certificates> for link to letter template) OR
- > The hospital arranges anonymous cremation through funeral consultants as per individual LHN arrangements (Note: The cremation may be with other fetus' and is not available at all hospitals) OR
- > Disposal of the fetus as medical / clinical waste. Note: If an autopsy is being undertaken, the completed *SA Pathology Disposal Arrangements Consent* form will need to be sent with the fetus to the SA Perinatal Autopsy Service. If there is no autopsy, consent for disposal of the fetus will need to be documented as per local LHN process which may include use of the *SA Pathology Disposal Arrangements Consent* form.

### IUFD or neonatal death from 20 weeks gestation

All intrauterine fetal deaths, stillbirth or neonatal deaths  $\geq 20$  weeks receive a birth certificate and a death certificate (excluding those babies that are a result of a termination of pregnancy unless liveborn). Any babies registered with Births, Deaths and Marriages must be interred in a place designated for human remains (ie. A cemetery funeral - burial or cremation). Arrangements are made privately and the family is responsible for all costs.

The above funeral requirements apply to all babies who die in the perinatal period (i.e. from birth to 28 days after birth) as well as  $\geq 20$  weeks gestation fetal losses.

### Termination of pregnancy from 20 weeks gestation

#### If no overt signs of life at birth and therefore not a registrable birth

Options are the same as for [Less than 20 weeks gestation \(TOP or Miscarriage\)](#), however, the hospital mortuary will need to provide a perinatal death certificate for the funeral director so a burial or cremation can occur if the woman chooses a private funeral.

#### If a live birth

Options are the same as for [IUFD or neonatal death from 20 weeks gestation](#).





## Taking baby home

### Greater than 20 weeks gestation

Usually, the undertaker from the chosen funeral parlour will collect baby from the hospital before burial, however, this is not a legal requirement.

Occasionally families may wish to take their baby home in preparation for the ceremony or before transporting baby to the funeral parlour.

Arrangements for the above should be made on a case by case basis.

Parents who take their baby home and then to the funeral parlour should also take a copy of the death certificate to hand to the undertaker with the baby. The original certificate should be forwarded to Births, Deaths and Marriages by the hospital.

In the above circumstances, it is important to explain to the parents:

- > Cold storage requirements for the transport and care of their baby. Consider use of a 'cold-cot' if available
- > It is their responsibility to take the baby to the funeral parlour within 24 hours

It is advisable for staff caring for the family to obtain contact details of the receiving funeral parlour and telephone the funeral parlour the following day to ensure they have received the baby.

The baby may be dressed, dry wrapped and transported home in an esky (may be foam if no plastic esky available) with ice bricks (e.g. small containers of frozen water) carefully positioned around but separate from baby for cold storage transport.

### Less than 20 weeks gestation / Termination of pregnancy

A fetus at less than 20 weeks gestation or a product of termination of pregnancy (without signs of life at birth) is not registrable and therefore not considered to be human remains. The fetus therefore cannot be interred in a cemetery unless an Early Loss of Pregnancy Letter (for gestations < 20 weeks) has been completed.

On request, in cases where there are no infection contraindications, families may take the remains of their baby home for burial.

In these circumstances, it is preferred that staff offer the available cremation service whereupon the ashes may then be taken home to be kept / scattered as appropriate.

If cremation has not been undertaken, the fetus should be wrapped in a waterproof shroud for transport and placed in a sealed ice box (e.g. esky containing ice bricks carefully positioned around but separate from the fetus) for cold storage.

The parents should be advised to contact their local council to ensure that burial is carried out in accordance with their local council regulations. Note: Whilst the Births, Deaths and Marriages Registration Act<sup>56</sup> define human remains as at least 20 weeks gestation, local government Acts may consider a fetus of any gestation to be human remains. This will affect individual burial options.

Cremation is recommended as there are additional considerations for burial on private property. It should be noted that if the baby is buried on private property, it becomes the property of the person who owns the house.

## Useful Websites

PSANZ and Stillbirth Centre of Research Excellence

*Clinical Practice Guideline: Care around Stillbirth and Neonatal Death*

<https://www.stillbirthcre.org.au/resources/clinical-practice-guidelines/>

PSANZ Stillbirth and Neonatal Death Alliance

<https://sanda.psanz.com.au/>

SANDS

<https://www.sands.org.au/>

South Australian Perinatal Autopsy Service

<http://www.wch.sa.gov.au/services/az/divisions/labs/sapas/index.html>

Support after Fetal Diagnosis of Abnormality (SAFDA)

<http://www.wch.sa.gov.au/services/az/divisions/labs/geneticmed/safda.html>

SA Health website information on abortions

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public%20content/sa%20health%20internet/health%20topics/health%20conditions%20prevention%20and%20treatment/abortions/abortions>

South Australian Cremation Regulations, includes forms required for cremation

*(two certificates of death from natural causes pages 12-13, certificate of tagging and marking page 16)*

[https://www.legislation.sa.gov.au/\\_legislation/lz/c/r/cremation%20regulations%202001/2002.06.30/2001.7.pdf](https://www.legislation.sa.gov.au/_legislation/lz/c/r/cremation%20regulations%202001/2002.06.30/2001.7.pdf)



## References

1. Commonwealth of Australia. Select Committee on Stillbirth Research and Education Report. Canberra: The Senate, ; 2018.
2. *Termination of Pregnancy Act*, (2021).
3. Wellbeing SA. Maternal and Perinatal Mortality in South Australia | Maternal and Perinatal Mortality Committee report Pregnancy Outcome Unit, Prevention and Population Health Branch, SA Health; 2018 [Available from: <https://das7nagdg54z0.cloudfront.net/downloads/maternal-perinatal-mortality/Maternal-and-Perinatal-Mortality-in-South-Australia-2018.pdf>].
4. SA Health. Termination of Pregnancy and miscarriage in the Second Trimester Perinatal Practice Guideline. SA Health; 2020.
5. Government of South Australia. Births, Deaths and Marriages Registration Act 1996. 1996.
6. SA Health. Perinatal Care at the Threshold of Viability Perinatal Practice Guideline. SA Health; 2019.
7. Australia S. Consent to Medical Treatment and Palliative Care Act 1995. 1995.
8. Re Baby D (No 2) [Internet]. Family Court of Australia. 2011.
9. Wilkinson D, Savulescu J. A Costly Separation Between Withdrawing and Withholding Treatment in Intensive Care. *Bioethics*. 2014;28(3):127-37.
10. SA Health. Coronial Process and the Coroners Act Policy Directive,. 2012.
11. Government of South Australia. Health Care Regulations,. 2008.
12. SA Health. Investigations of Stillbirths: SA Protocol. 2020.
13. Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death [Internet]. NHMRC Centre of Research Excellence in Stillbirth. 2018. Available from: <https://www.stillbirthcre.org.au/assets/Uploads/Section-4-PerinatalPostMortemExamination-V3-100420.pdf>
14. Australian Breastfeeding Association (ABA). Lactation suppression n.d [Available from: <https://www.breastfeeding.asn.au/bfinfo/lactation-suppression>].
15. Cole M. Lactation after perinatal, neonatal or infant loss. *Clinical lactation* 2012;3:94-100.
16. Cabergoline [Internet]. 2021. Available from: <https://www.mimsonline.com.au/Search/Search.aspx>
17. SA Health. Health Record Management Policy Directive. 2017.
18. Government of South Australia. General Disposal Schedule No. 28. Clinical and Client-Related Records of Public Health Units in South Australia Disposal Schedule. 2014.
19. SA Health. Histopathology Management of the Placenta Perinatal Practice Guideline. 2019.
20. Government of South Australia. Transplantation and Anatomy Act 1983. 1983.
21. SA Health. When a person dies: The Hospital Autopsy Process. Information for family and friends. 2017.

## Appendix: SA Perinatal Autopsy Service Memento Request Form

### MEMENTO PACKAGE REQUEST

AFIX PATIENT LABEL HERE

If requested by families, the laboratory staff at the Women's and Children's Hospital are willing to prepare Mementos. This can include any of the items listed below where possible.

It is important to note that if 'NO' is selected, a memento package will **not** be created and cannot be provided at a later time.

On completion, the package will be distributed via Women's Social Work at the Women's and Children's Hospital and where relevant the originating hospital.

A Memento Pack is requested for \_\_\_\_\_ (Baby's name)

YES  NO

If "YES" Which of the following items are requested to be included?

1. Photographs  YES  NO  
 These can be taken with the baby:  
 a) Dressed or wrapped  YES  NO  
 b) Not dressed  YES  NO

Any additional requests \_\_\_\_\_

2. Hand and foot prints  YES  NO  
 3. Lock of hair (where possible)  YES  NO  
 4. Hospital ID bracelet  YES  NO  
 5. Hospital bed card (WCH only)  YES  NO

Any additional requests \_\_\_\_\_

Name \_\_\_\_\_ Mother/Father

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone consent taken by:

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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### Write Group Lead

Marnie Aldred

### Write Group Members

Professor Jodie Dodd  
Helen Thomas  
Dr Tamara Zutlevics  
Dr Michael McEvoy  
Alison Tanner  
Carol Mawby  
Professor Gustaaf Dekker  
Dr Elizabeth Beare

### Other major contributors

Allison Rogers (previous versions)  
Judy Coffey (previous version)  
Rebecca Smith (previous version)

### SAPPG Management Group Members

Sonia Angus  
Lyn Bastian  
Dr Elizabeth Beare  
Elizabeth Bennett  
Dr Feisal Chenia  
John Coombas  
Dr Danielle Crosby  
Dr Scott Morris  
Dr Ray Farley  
Allison Waldron  
Dr Charlotte Taylor  
Catherine Leggett  
Dr Anupam Parange  
Marnie Aldred  
Prof Jodie Dodd





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23 Sep 13	V6	SA Health Safety and Quality Strategic Governance Committee	Reviewed in line with scheduled review date
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