OFFICIAL

OBSTETRICS AND GYNAECOLOGY CLINICAL PRACTICE GUIDELINE	
Perinatal loss: Unexpected (miscarriage and stillbirth)	
Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)
This document should be read in conjunction with the Disclaimer.	

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Aim

This guideline aims to assist staff to provide comprehensive care and support to parents and families experiencing an unexpected or spontaneous miscarriage or stillbirth (which may include a neonatal death).

Definitions

Miscarriage	An event that results in a pregnancy loss before 20 weeks of pregnancy.
Stillbirth	Death of a baby after 20 weeks of gestation; or of 400 g or more birthweight (if gestational age unknown from previous ultrasound).
Neonatal death	A live born baby who dies within 28 days of life

Key points of care

1. Identify the woman's room with universal symbol, tear drop sticker, so that all clinical and non-clinical staff are aware
2. All care planning should be conducted within a parent-centred decision-making process.
3. Ensure parents have clear information and time to consider all available options.
4. Provide culturally and linguistically appropriate information in a range of formats.
5. Consent should be gained in line with policy and guidelines.
6. Documentation must be contemporaneous, correct and maintained. Document care on Clinical Care Pathways and digital medical records

Pregnancy loss between 13 – 19^{+6} weeks gestation

Clinical assessment

A comprehensive medical, surgical, and psychosocial history must be taken, by the lead consulting doctor and include:

- Accurate gestation assessment - this is essential to selecting optimal care location, treatment options and regimes.
- Formal ultrasound examination to confirm suspected fetal
- Blood group and Rhesus status should be confirmed, and tested, if not known
    - Follow Rh (D) immunoglobulin guideline where applicable.
- Medications for medical management should be charted on – Medications Administered for Pregnancy Loss form (MR 810.07)

Booking an admission and care

Booking an admission

Admission from Emergency Centre <19+6 weeks – See flowchart Appendix 1

Admission management and care

Nursing and Midwifery staff to refer to the Pregnancy Loss 13-19^{+6} Weeks Gestation Clinical Pathway (MR 261.03) as a guide.

Discuss management of the placenta with patient, document consent for oxytocic administration.

Pain relief

- Discuss pain relief options as per Medications Administered for Pregnancy Loss (MR 810.07)
- Discuss other options such as: mobilisation, heat packs and water therapy (shower)

Birth of the baby

Procedure

- The woman may choose the most comfortable position in which to give birth, this may be on the bed, on the commode, or in the shower.
- After birth, place 2 x sterile cord clamps on the umbilical cord, cut the cord with sterile scissors, between the clamps.
- Record the time of birth.

Third stage management

- Refer to WNHS Obstetrics and Gynaecology Labour: Third Stage Guideline
- Administer Oxytocic following the birth of the baby, regardless of whether or not the placenta is delivered immediately.
- Medications for active management of the third stage should be charted on the “Medications Administered for Pregnancy Loss” form (MR 810.07).

- Assess the uterus for placental separation, signs include:
  - A ballotable uterus and trickle of blood.
  - **NO** attempt at cord traction should be made at gestation <20 weeks.
- If the placenta has separated:
  - Encourage a maternal position to be more upright
  - Encourage maternal effort (bearing down) to deliver the placenta.
  - Record the time the placenta was delivered.
  - Check the placenta and membranes are complete.
  - Measure and weigh blood loss and record/document.
- If there is excessive bleeding, maternal signs of deterioration, and/or a retained placenta; immediate medical management is required. Consider calling a Code Blue Medical.
- The woman should remain fasting until the placenta has been assessed as intact and vaginal loss is within normal limits.
- For Code Blue Medical and deteriorating patients, see policy: Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health)

Retained placenta

- If the placenta is not delivered within 30 minutes, or the woman is bleeding, the medical team and the Shift Co-ordinator should be notified.
  - A vaginal examination by senior medical staff may be required (to determine if a manual removal of placenta in OT is required)
- Do not apply excessive cord traction. Attempts to remove a placenta that has not separated can produce excessive bleeding.
- Refer to - WNHS Obstetrics and Gynaecology Labour (Third Stage) Clinical Practice Guideline (page 5)

Blood loss

- Refer to - WNHS Obstetrics and Gynaecology Postpartum Complications (including postpartum haemorrhage and uterine inversion) Clinical Practice Guideline
- Measure and weigh blood loss. Whilst postpartum haemorrhage (PPH) is typically >500ml, at <20 weeks a loss of 300ml is significant and should trigger a medical review.
  - **Action**: If there is continued and persistent vaginal blood loss or the loss is **300mL or above**, the medical team must be notified, transfer to theatre may be required.

Suppression of lactation

- Breast care advice should be given. Lactation may commence if the gestation was more than 14 weeks.
- Cabergoline may be charted on the MR 810.07

Care of the baby

- Always separate the baby and placenta (clamp and cut the cord).
- Label the baby with a name tag, with maternal sticker, as soon as appropriate to do so.
- Support the woman / family with their wishes to see and / or hold the baby. All babies will be kept on the ward until the woman is discharged to enable family to have access to their baby at any time.
- Offer to wash and dress the baby (this may be done with or without the family present).
- Wrap the baby in a rug/quilt and place in a basket before taking back to the room. The quilt may be taken home by the couple if they wish.
- Place the placenta in a clearly labelled clear plastic container and store this in the fridge in the Ward 6 treatment room, until transfer to Perinatal Pathology.
- Discuss memorabilia, e.g. grief pack, information, and mementos.

  Mementos such as photographs and footprints are available but require written consent. The Pastoral Care team will consent families on the NCC3.

Transferring the baby

Refer also to the Transferring the Baby to Perinatal Pathology in the ≥ 20 weeks gestation section of this Guideline.

- For babies of < 20^{+0} weeks gestation, the parents may take the baby home . Completion of the Western Australian (WA) Department of Health (Health) Patient Information Sheet and Consent Form - Authorisation and Release of a Human Fetus or Placenta is required.

  This point must also be read in conjunction with WA Health's:

  - Mandatory Policy 0129/20: Release of Human Tissue and Explanted Medical Devices Policy and
  - Guideline for the Release of a Human Fetus or Placenta (2020)
- If the parents are not taking the baby home, the baby and/or products of conception (POC) are sent to Perinatal Pathology. Fetal POC are only to be cremated and never disposed of in anatomical waste bins [RCA recommendation].

Documentation and legalities

- Ensure documentation is complete – see clinical pathway for required documents.
- **Registration of birth for babies of <20 weeks gestation is not required.**
- Parents can apply to the Registry of Births, Deaths and Marriages for a Recognition of Pregnancy Loss Certificate BDM 150 (not for official purposes) See also WA Government: Register a Birth (external website).

Discharge and follow-up plans:

- Women experiencing pregnancy loss >14 weeks gestation should be offered a phone consult follow up via the Visiting Midwifery Service (VMS). If verbal consent given staff are to complete a written VMS referral - Gynaecology form MR255.02.

- Routine follow-up should include medical review by GP or similar at 2 weeks post-birth for maternal health check-up.
- If investigations have been undertaken, including post-mortem autopsy, it is necessary to ensure there is a process for explanation of results. Discuss options. This may include GP, Private Obstetrician, Genetic Services, or via the Perinatal Loss Clinic.
- If a woman is greater than 14 weeks gestation, then an e-Referral should be completed to the Perinatal Loss Service (PLS). The PLS Midwife will triage this referral and ascertain if review in clinic is required. This clinic is booked for 6-8 weeks post birth.
- Subsequent pregnancy planning should include pre-conception review by their local care provider (GP, Private Obstetrician), and early referral, i.e. first trimester, to specialist care (if indicated). The subsequent pregnancy care plan should be made with due consideration of all information available in order to minimise the risk of perinatal death.

Pregnancy Loss ≥ 20 weeks gestation (stillbirth)

The Women and Newborn Health Service (WNHS) endorses the Care Around Stillbirth and Neonatal Death Clinical Practice Guideline (2024) developed by The Centre of Research Excellence in Stillbirth (Stillbirth CRE) and Perinatal Society of Australia and New Zealand (PSANZ), for use by WNHS staff.

This guideline is developed from leading national research, providing evidence-based recommendations for health care providers to improve service provision and promote best practice care around perinatal death. The Guideline includes 126 recommendations spanning seven major areas related to care around perinatal death:

- Approach to care
- Perinatal loss care
- Perinatal palliative care
- Care in subsequent pregnancies
- Investigations for perinatal death
- Perinatal mortality audit and classification
- Organisational recommendations

Healthcare professionals play a central role across the continuum of care from the moment of bad news, through birth and the postnatal period, and into future pregnancies.

Clinical presentation and assessment:

Intrauterine Fetal Death (IUFD)

If no fetal heart is able to be auscultated and IUFD is suspected, diagnosis must be confirmed by formal ultrasound. If this occurs in the home, arrangements must be made for immediate transfer to hospital the patient is booked to for care.

Perinatal palliative care:

- If a family has chosen a Perinatal Palliative Management Plan (MR 409.91) for their baby, a specific individualised care plan will be loaded within the DMR.
- Notify the Neonatal team and PLS CMS (in normal working hours) when patient presents to MFAU/LBS.

Preterm pre-viable labour and imminent birth

- Notify the LBS Coordinator and Senior Registrar, Neonatal team and transfer to Labour and Birth Suite.
- Consultation and care of the previable fetus must occur as soon as possible.
- Care plan for the baby should be clearly documented in the DMR.

Clinical assessment and examination

Clinical assessment should be undertaken by an Obstetric Registrar or above and include:

- Medical, social, family, and pregnancy history
- Antenatal ultrasound results
- Antenatal testing
- Parent's summary of the events surrounding the death.
- Accurate gestation assessment Formal ultrasound examination to confirm suspected fetal demise.
  - Demonstrated by absence of fetal cardiac activity. This ultrasound should be conducted by an accredited professional - credentialed sonographer, Obstetrician, or Senior Registrar. Additional information may be gathered during ultrasound, such as looking for anomalies, gestation/size, and timing of fetal death (Spalding's sign).
  - A midwife escort should be made available to support the woman whilst attending the ultrasound examination for confirmation.

Maternal investigations

- Refer to the Stillbirth CRE flowchart – Stillbirth investigations flowchart | Stillbirth CRE – Appendix 2

Breaking sad news

How news is communicated has immediate and lasting effects on experiences of care and wellbeing.

- Refer to the Stillbirth CRE resource - Breaking bad news | Stillbirth CRE eLearning

Timing of birth

- Admission will depend on patient clinical need, parents' preferences/wishes, staffing and room availability.

Induction of labour

Induction of labour (IOL) to be booked through hospital processes. See IOL bookings flowchart guide for Clinicians

Admission and care

- Nursing & Midwifery staff to refer to Perinatal Loss >20 weeks' Gestation Care Pathway MR271 (KEMH) / MR71.1 (OPH)
- Medications should be charted on 'Medication Administered for Pregnancy Loss' (MR810.07) (OPH use site-specific form). See also:
  - Refer to Misoprostol section in the WNHS Obstetrics and Gynaecology Abortion and perinatal loss medications (mifepristone and misoprostol) Clinical Practice Guideline (Restricted area guideline)
- Engage with parents to develop a detailed care plan that considers their values, preferences, wishes, concerns and any cultural protocol.

- Communicate openly with parents to ensure they have informed expectations for birth, including what their baby may look like following birth: including expectations for appearance, size and tone.

Intrapartum care:

Intrapartum care should align with all WNHS Obstetrics and Gynaecology Guidelines (health.wa.gov.au)

The full range of pharmacological and non-pharmacological pain relief options, including labour and birth in water, should be discussed with parents including advantages and disadvantages of each pain relief option.

- Labour and Birth: Third Stage Clinical Practice Guideline

In early gestations <32 weeks or if baby has been deceased for period of time, may assess umbilical cord (friable, macerated) prior to applying traction. May consider alternate strategies to deliver placenta including, emptying bladder, sitting upright/on commode, maternal effort (with no cord traction).

Postnatal care and memory making

- Support families by offering opportunities for parents (and extended family at the parent's discretion) to name their baby and spend time with them engaging in acts of caregiving and parenting. This may include bathing and dressing their baby.
- Offer families the opportunity to have mementos such as Memory Boxes / Bags, photographs, hand and footprints.
  - Perinatal Loss Photography Consent MR271.1 (KEMH)
- Discuss and provide support services and resources with parents.
- Maternal length of stay, and location of stay, should be individualised, and be made in consultation with medical and midwifery staff, and the family.
- On discharge offer:
  - VMS
  - PLS follow up

Care and management of a deceased baby

1. Offer the parents the opportunity to participate in the care provided to their baby.
2. Attach an identity band to the ankle or an appropriate area, depending on the baby's size. The Identification band must remain on the baby at all times.
3. If appropriate and requested, bathe or wash the baby gently, especially if fetal death has occurred as skin integrity may be compromised.
4. Record the weight, length, and head circumference.
5. Examine the baby and note any obvious abnormalities. Document the examination in the medical notes.
6. Complete a cot card.

7. Dress the baby and wrap in a sheet / blanket. The baby may be dressed in clothes provided by the parents or those provided by the hospital.
8. Obtain written consent, on MR271.1 Perinatal Loss Photography Consent, to collect the following photographic mementos.
    - Photographs: **Note**: Lead photo must be a photo of the baby with Identification (ID) addressograph/ cot card for identification purposes. For Neonatal deaths use the baby's addressograph. The baby must have at least one photo showing ID band in-situ. This must be readable in the photo.

    Other mementos:
    - Foot and hand prints
    - A lock of hair
    - Baby identification band and cot card
    - If the mementos are declined, document in DMR.

- Utilise the Cuddle Cot Cooling System to cool the baby, if not available consider transferring the baby to Perinatal Pathology to be placed in mortuary refrigerator.
- **OPH**: Refer to OPH PLS Checklist for OPH specifics around transferring to Holding Bay fridge and transfer to Perinatal Pathology.

Transferring the baby and placenta to Perinatal Pathology

1. Ensure:
    - Identification label / band on the baby is correct:
    - Maternal sticker for stillbirth or own addressograph for Neonatal Death
    - The baby may remain dressed or within wraps.
2. Baby wrapped and sealed in bluey with an addressograph on the outside of the bluey. Then place the baby in an appropriately sized plastic container – label container with patient stickers.
3. Transfer baby to Perinatal Pathology in the Blue fabric carry bag.
4. Placenta is double bagged (plastic bags) with maternal addressograph on the outer bag, then placed in a placenta container
5. **Do not** place the placenta in saline, formalin, or any other form of fixative.
6. Attach a maternal addressograph the container (lid and side).
7. A COMPLETED pathology request form should accompany the placenta.
8. Page the orderly (3101). All transportation of deceased babies within or from KEMH, must be recorded in the transport and mortuary logs in clinical area and Perinatal Pathology. See related WNHS Policy: Deceased Patient Management.
    - At each transfer in and out of the clinical area identification is to be checked by the Orderly and Midwife/Nurse
9. A 'Permission to Transport a Deceased Baby' form (MR295.95 KEMH / 37D (OPH)) 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 (note: babies released

to parents from Perinatal Pathology cannot be accepted back into PathWest care after release).

- Refer to WNHS OGD guideline: WNHS Obstetrics and Gynaecology Labour: Indications for Placental Examination in Pathology Clinical Practice Guideline
- Refer to - Appendix-6L_Indications-for-placental-examination-by-the-pathologist.pdf (stillbirthcre.org.au)

Postmortem / autopsy

A post-mortem examination should be recommended to all parents following an unexpected stillbirth. Information and documentation required for this service can be access from the PathWest Perinatal Pathology website at PathWest.

Reporting and documentation

All documentation requirements are listed in the:
Perinatal Loss > 20 weeks' Gestation Care Pathway (MR 271(KEMH) / 71.1 (OPH)

Document	Completed by	Location
Medical certificate of Stillbirth or Neonatal Death BDM201	Attending Medical Officer	Sent to Perinatal Pathology. Copy sent to the Chief Health Officer (CHO) via email: edphwa@health.wa.gov.au. KEMH: weekly by the PLS CMC. OPH: by case by the CMS.
Death in Hospital Form MR 001 (KEMH) / MR37B (OPH): (NOT required for Abortions)	Clinical staff in attendance (Midwife or Doctor)	File in the DMR
Certificate of Medical Attendant (Cremation Form 7)	Medical Officer.	Perinatal Pathology
Consent for Cremation and Mementos NCC FORM 3	Pastoral Care team (or Nursing / Midwifery staff if unavailable)	Perinatal Pathology. Copy to DMR & patient
Consent for Post-mortem Examination (Non-Coronial) – NCC Form 1 & NCC Form 2A (Stillbirth), NCC2B (Neonatal Death)	Senior Clinician (Medical Officer or Midwife)	Perinatal Pathology
Birth Registration	Declaration completed by the Midwife	Parent to send to BDM
Bereavement Payment Claim	Midwife declaration	Parent to complete & lodge with Centrelink

Presentation of a newborn dead-on arrival (DOA)

If a woman presents having given birth prior to presentation and the newborn is dead on arrival, the following procedure is to be followed and documented in the medical records.

- The Obstetric Registrar will examine the mother and baby and take a comprehensive, medical, and obstetric history; and circumstances of the birth.
- The Obstetric Consultant for the LBS will be notified.
- The Neonatal Registrar will be called to examine the baby.
- Upon consideration of the circumstances, if the baby has been born with signs of life, or unknown if signs of life were present, the Coroner's Office may be notified.
    - If death is to be investigated by the Coroner leave all tubes in situ.
- The mother should be offered an admission for continuing care and counselling.
- The baby may accompany the mother. Alternatively, the baby may be transferred to Perinatal Pathology.

Parental contact with their baby post discharge

- This occurs in the Perinatal pathology viewing room and is arranged directly with Perinatal Pathology on 6458 2730. Open hours are Monday - Friday 07:30 – 15:30.

Baptism, funeral, and pastoral care

- For all enquiries regarding baptism and funeral options
    - KEMH contact Pastoral Care Services.
    - OPH: Complete an eReferral.
- See related WNHS Pastoral Care guideline: Baptism and Other Life Rituals (available to WA Health staff through HealthPoint).

References and resources

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Related legislation and policies (external websites)

Legislation*:*

- *Births, Deaths and Marriages Registration Act 1998* (section 44)
- *Cemeteries Act 1986*
- *Coroner's Act 1996*
- *Health (Miscellaneous Provisions) Act 1911*
  - Part XIII Section 336 (death of a woman as a result of pregnancy or childbirth); Section 336A (certain deaths of children including stillbirth from 20^{+0} weeks gestation) and 336B (death whilst under anaesthetic)
  - FDIU guideline section: Section 335 Reporting births (including living, term, premature, stillbirth) attended
  - Legalities: Section 334(7)
- *Mental Health Act 2014*

Department of Health WA:

- Legal Policy Framework
- Review of Death Policy (web page) and MP 0098/18 Review of Death Policy and Review of Death Guideline (pdf, 471KB)

MP 0129/20 Release of Human Tissue and Explanted Medical Devices Policy (pdf, 183KB)

Related WNHS, CAHS and PathWest policies, procedures and guidelines

WNHS policies and guidelines: (available to WA Health staff through HealthPoint)

- WNHS policy: Deceased Patient Management
- Obstetrics and Gynaecology:
  - Abortion and Perinatal Loss Medications (mifepristone and misoprostol) [Restricted Area Guideline}
  - Labour and Birth: Indications for Placental Examination in Pathology
- Allied Health: Pastoral Care guidelines and Hub page (contact details and information)

CAHS Neonatology guideline: End of Life Care (available to WA Health employees through Healthpoint): Includes post mortem examination, coronial matters, last offices, palliative care, grief and loss, viewing the infant, baptism, funeral arrangements

PathWest policies and procedures (available to WA Health employees through FastTrack (external website)

Useful resources (including related forms)

Department of Health WA (external websites):

- Notification of perinatal and infant deaths
- Notification of birth events and cases attended by midwives
- From death we learn (summaries of coronial inquest findings)
- Sentinel events

WNHS Patient brochures:

- Death: Following the death of your baby (pdf 367KB) and in other languages- see 'D'
- Post mortem examinations – information for parents Having a post-mortem after the loss of your baby (health.wa.gov.au)
- Understanding What Happened to Bub – Indigenous Parent Brochure
- Pregnancy Loss: Medical management of early pregnancy loss (pdf 316KB)
- Pregnancy loss in the first 13 weeks of pregnancy (pdf 378KB)
- Pregnancy loss in the second and third trimester (pdf 404KB)
- Preparing for your Baby's Funeral Preparing-for-your-babys-funeral.pdf (health.wa.gov.au)

PathWest Perinatal Pathology website (information for families, health professionals and funeral directors)

Stillbirth Centre of Research Excellence:

- Clinical Practice Guidelines and Position Statements (external website)
- PSANZ Clinical Practice Guideline for Care around Stillbirth and Neonatal Death Section 3 - Respectful and Supportive Perinatal Bereavement Care (external website, PDF 1.59MB)

Forms:

- Death in Hospital Form (MR001 (KEMH) / MR37B (OPH))
- Pregnancy Loss 13-19+6 Weeks Gestation Clinical Pathway (MR 261.03)
- Perinatal loss > 20 weeks gestation care pathway (MR271(KEMH / 71.1(OPH))
- Permission to Transport a Deceased Baby' form (MR295.95(KEMH) / 37D(OPH))
- Perinatal Palliative Management Plan (MR 409.91)
- Medication Administered for Pregnancy Loss (MR810.07)
- Other:

- Certificate of Medical Attendant (Cremation Form 7)
- Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201)
- PathWest- Consent for Post Mortem (NCC1)
- PathWest- Perinatal Pathology: Consent for Cremation and Mementos (Miscarried or stillborn baby less than 28 weeks gestation) (NCC Form 3)
- Datix Clinical Incident Management System (CIMS)

- Under 20 weeks gestation: Department of Health WA Patient Information Sheet and Consent Form - Authorisation and Release of a Human Fetus or Placenta' (external website, PDF, 139KB)

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Endorsed by:	Clinical Governance Committee	Date:	Nov 2025
NSQHS Standards (v2) applicable:	1: Clinical Governance, 2: Partnering with Consumers, 3: Preventing and Controlling Healthcare Associated Infection, 4: Medication Safety, 5: Comprehensive Care, 6: Communicating for Safety, 8: Recognising and Responding to Acute Deterioration		
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Version history

Version number	Date	Summary
1	Oct 2018	First version. Endorsed at MSMSC 23/10/2018. **History**: Oct 2018 Amalgamated nine individual guidelines (five from section 'Death' in Joint Obstetrics & Gynaecology; two [FDIU- Antenatal & Intrapartum] from Obstetrics and two [FDIU- Antenatal and Intrapartum] from CMP guidelines), created from August 1993 onwards into one document. **In Oct 2018 these previously individual guidelines were superseded**: 1. FDIU >20 Weeks Management (Antenatal) (version dated Sept 2014)

		2. FDIU >20 Weeks Management (Intrapartum) (version last amended Feb 2015)
		3. Perinatal Loss: Legalities (version last endorsed Jan 2018)
		4. Perinatal Loss Funeral Arrangements for Deceased Babies (version dated April 2015)
		5. Perinatal Loss Flexmort Cuddle Cot Cooling System Management (version last amended Jan 2015)
		6. Perinatal Loss: Deceased Baby Care & Management (version last endorsed Jan 2018)
		7. Perinatal Loss: Baptism & Pastoral Care (version dated March 2015)
		8. CMP: Absence of Fetal Heart in the Antenatal Period (version last amended Dec 2015)
		9. CMP: Absence of Fetal Heart in the Intrapartum Period (version last amended Dec 2015)
		Changes in this version:
		• Amalgamated nine guidelines (O&G & CMP) relating to fetal death in utero and perinatal loss
		• Section perinatal loss in the third trimester (previously separated into antenatal and intrapartum guidelines for FDIU).
		  ➢ Background statistics updated for WA.
		  ➢ CMP management added.
		  ➢ Read section 'Planning & management' for updated management including formal KEMH USS requirements
		  ➢ Updated PSANZ Stillbirth Investigations Flowchart attached
		  ➢ Intrapartum care- all women require an intrapartum partogram; Added specific reporting requirements for reporting of death of a child <1 year and stillbirth >20 weeks' gestation.
		• Baptism: If baptised, a certificate of baptism should be completed and given to the parents. Certificates are available in the same drawer as the Baptismal Register. Pastoral Care must be informed of any emergency baptism.
		• Legalities- details added to clarify reporting of stillbirth. Process changed for sending copy of BDM 201 to the Chief Health Officer- is now through the Perinatal Loss Service.
		• Funeral arrangements:
		  ➢ All transportation of deceased babies within or from KEMH must be recorded in the appropriate transport log.
		If parents wish to arrange the funeral themselves, they should be referred to the Pastoral Care Service for information and support.

2	June 2021	• Legalities and reporting-
		  ➢ ~~Terminations of pregnancy resulting in a live born baby must be reported to the Coroner under the Coroners Act 1996~~ [removed in 2024]
		  ➢ Stillbirth or neonatal death- Placenta should be sent to pathology with a request form for histopathology, including all relevant clinical detail
		• Perinatal loss in the third trimester:

		➢ Link added to PSANZ for respectful and supportive bereavement care ➢ CIMS - only if concerns regarding clinical care as per CIMS policy ➢ Post-mortem examination- provide PathWest “Information for Parents” pamphlet ➢ A partogram should be commenced once in established labour or at commencement of oxytocin infusion • Baptism and cultural care- removed reference to Cultural and Health Care information file • Care and Management of the Deceased Baby- ➢ Attach the identity band to the ankle or an appropriate area, depending on the baby’s size. The Identification band must remain on the baby at all times ➢ Links to Department of Health mandatory policy on human tissue (including fetus under 20^{+0} weeks or placenta) release ➢ Removed reference to parental wishes sheet- not in use Removed Cuddle cot instructions- refer instead to instructions accompanying cot
3	Nov 2021	Changed process in chapter ‘Care and management of a deceased baby’: WNHS will no longer be providing after-hours viewings of deceased babies for discharged or external patients. These requests are now to be redirected to Perinatal Pathology (Monday- Friday during working hours).
4	Jun 2023	• Consideration for planned / booked IOL admissions for Perinatal Loss women: On arrival to LBS, women should be taken directly to their allocated room. If room not ready, families should be escorted to the dedicated PLS lounge area (next to Rm 1). Please do not make the families wait in the general waiting room on LBS. • Added link to PathWest Fast Track policies and procedures • Amendment as per Statutory Registers Branch for consistent wording when describing over 20 weeks- now ‘from 20+0 weeks’ • Consent for cremation form MR297 replaced with PathWest form NCC Form 3 OPH specific details added
5	Oct 2023	• POC not taken by the parents are sent to Perinatal Pathology for disposal and cremation. **Fetal POC are only to be cremated and never disposed of in anatomical waste bins [RCA recommendation]** • Added details for improved communication with GP after pregnancy loss- see p10 Legalities section marked as ‘under review’ due to upcoming changes to WA legislation
6	Mar 2024	**History**: Changes in WA abortion legislation led to WNHS developing new abortion guidelines and resources. Content pertaining to termination or abortion has subsequently moved out of this guideline - WNHS clinicians can refer to information on the WNHS Pregnancy Choices and Abortion Care Intranet. Content relating to perinatal loss at all gestations has been amalgamated and moved into this guideline. **This previously individual guideline has been superseded**:

		1. Mid-trimester Pregnancy Loss (dated Dec 2023) **Changes include**: • New title and guideline restructured into early pregnancy loss $\leq 19^{+6}$ weeks and stillbirth / FDIU $\geq 20^{+0}$ weeks gestation. • Funeral and baptism sections removed- refer to Pastoral care
7	Nov 2025	• Definitions for miscarriage, stillbirth and neonatal death • Reviewed and condensed content. Removal of subheadings: Fluid and nutrition, Pain management, Comfort and emotional wellbeing, Referrals, Bladder management, Commencement of treatment, and replaced with advice to follow Pregnancy Loss 13-19^{+6} weeks Gestation Clinical Care Pathway (MR261.03) • Whilst PPH is typically >500ml, at <20 weeks a loss of 300ml is significant and should trigger a medical review. • Booking IOL out of hours now refers to online calendar / e-referral • Inclusion of extensive discharge and follow-up planning content - Referral to VMS - Routine GP follow-up 2 weeks post-birth for maternal checkup - If greater than 14 weeks gestation, then an eReferral to PLS, 6-8 weeks post-delivery. • Removal of reference to ectopic and molar pregnancy not being relevant to this guideline. • Removal of Aim and Scope and Background headers in the ≥ 20 weeks gestation section to streamline content. Instead replaced with hyperlinks to the preferred source of evidence base: The WNHS endorses the Care Around Stillbirth and Neonatal Death Clinical Practice Guideline (2024) developed by the Stillbirth CRE and PSANZ, for use by WNHS staff.

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Appendix 1: Emergency Centre (EC) process: FDIU (≤19+6 weeks) medical management with mifepristone

Scope: This flowchart if for patients who present to EC and a diagnosis of FDIU and discussion with the patient regarding options has occurred.

See process below if decision has been made for Medical Management combination therapy (including Mifepristone).

Decision in EC for Medical management of FDIU

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While the woman is in EC, staff page for bed availability and booking of her admission (in 24-48 hours):

- **In hours (Mon-Fri 0700-1600)-** Contact pager #3311 (Ward 6 Manager / Consultant)
- **After hours** – Contact pager #3333 (Hospital Clinical Manager)

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Ward 6 CNM / CNC (or HCM after-hours) allocates admission date/time

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- The EC medical staff gives Mifepristone while in EC (this should be 24 -48 hours prior to admission - see Dosage and Administration Tables in Abortion and Perinatal Loss Medications CPG).
- The patient is given the details (date/time) of when to return.

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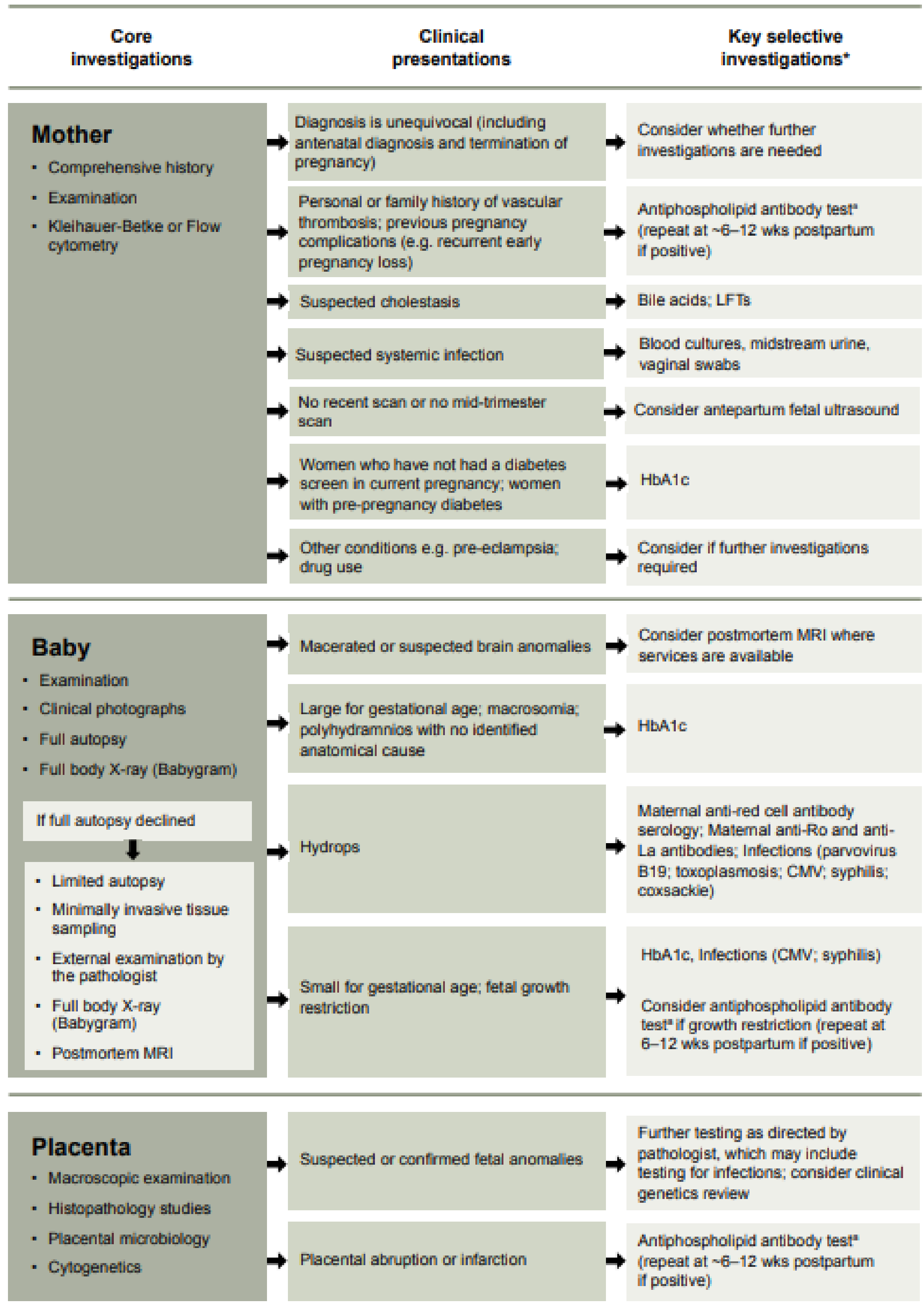
The patient returns to hospital at the pre-booked date/time (24- 48 hours after mifepristone was given in EC) for admission to the ward 6

Appendix 2: Stillbirth Investigations Flowchart

Stillbirth investigations flowchart

This flowchart provides guidance to healthcare professionals on appropriate investigations to identify the cause of stillbirth. See Appendix 6B for Neonatal death investigations flowchart.



**Antiphospholipid antibody test includes anticardiolipin, lupus anticoagulant, anti-B2 glycoprotein-1 antibodies; CMV: Cytomegalovirus; LFTs: liver function tests; HbA1c: Haemoglobin A1c; MRI: magnetic resonance imaging*

Reference: CRE Stillbirth - [Appendix-6A-Stillbirth-investigations-flowchart.pdf (stillbirthcre.org.au)]