Guidelines for the completion of the Mother and Baby Forms following a Perinatal Death

2018 Version 11
Introduction

What is the Perinatal and Maternal Mortality Review Committee?

The Perinatal and Maternal Mortality Review Committee (PMMRC) is a Ministerial Committee set up under the New Zealand Public Health and Disability Act 2000 (NZPHDA). The PMMRC was established by the Minister of Health in June 2005. For more information please see the PMMRC website (http://www.PMMRC.health.nz)

The PMMRC is responsible for reviewing:

a) **Perinatal deaths**

Perinatal deaths are defined as deaths occurring from 20 weeks gestation (ie: ≥200, or a birth weight or ≥ 400 grams if gestation is unknown) to 28 completed days after birth (ie: up to midnight on the 27th day).

b) **Maternal deaths**

The PMMRC definition of a maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy (delivery), irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management. The review of maternal deaths commenced in 2006. Please advise your PMMRC Local Coordinator if a maternal death has occurred.

Why do the PMMRC want to collect this information?

The PMMRC’s primary function is to review and report to the Health Quality and Safety Commission HQSC on perinatal and maternal deaths in New Zealand, with a view to reducing the number of preventable deaths.

In order to do this, the PMMRC needs more in depth information than is currently collected through national data collections. The PMMRC has developed two reporting forms on perinatal deaths. One form focuses on the baby who died (if more than one baby dies a separate form will be needed for each baby), while the other focuses on the mother of the baby. Both forms will provide comprehensive information on each perinatal death in New Zealand.

After submission of the data, a National Coordinator will inform the Local Coordinator of the perinatal death. A local multidisciplinary meeting will be held and eventually all the national information will be collated into a national annual report. In the Annual Report the PMMRC will be able to make evidence based recommendations to the HQSC on systemic improvements, based on the review of individual cases and aggregate information.
Confidentiality of information

The information provided in these forms is confidential. Section 5 of the New Zealand Public Health and Disability (NZPHD) Act, 2000 allows the PMMRC to request this information.

The NZPHD Act prohibits the disclosure of any personal information except in very rare and specific circumstances (Section 18 of part 2 of the NZPHD Act and section 6 of schedule 5 of the NZPHD Act refers, copies of which are included in Appendix A).

Publicly available information on perinatal deaths published by the PMMRC will be grouped and will be non-identifiable.

When to complete the forms

The forms should be completed for any baby death where the baby was born from 20 weeks gestation (i.e.: from ≥20, or a birth weight of ≥400 grams if gestation is unknown), including legal abortions, and each baby born alive but dying before 28 completed days of life.

While the maternal form should be completed once, the reporting form for a perinatal death should be completed for each perinatal death that has occurred (ie: in cases of multiple births)

Who should complete the forms?
The Lead Maternity Carer is the appropriate person to complete the mother and baby forms. Other clinicians who have the information can also complete the forms.

How do we fill out a form on the computer?

1) Log in to PMMRC website www.otago.ac.nz/pmmrc

Accessing new website first time only – previous PMMRC website user
Check for migrated account: Select ‘Register’ and enter your personal details and password.

1) If registration advises ‘the email has already been taken’ then your previous account has been migrated from the old website and a random password has been assigned.

Reset your password using the ‘Forgot Password?’ link on login page and then log in.

2) If details are submitted with no error message proceed as per ‘new user’ below

Accessing new website first time only – new user

1) Register account: Select ‘Register’* and enter your personal details and password.

2) Activate account: An email will be sent to you with activation instructions.

3) ‘Register’ for the ‘Perinatal Module’ by selecting your DHB and entering the DHB ‘password’

........... DHB Password xxxxx11111
(DHB Password same as before – contact Local or National Coordinator if required)
Guidelines for completing perinatal death forms

INTRODUCTION

These accounts are individual and only the person named on the account should use it.

2. **To login** - enter your email and password.

3. **HOME PAGE** - on this page you have options for:

   - **Create Entry**
   - **All Entries**
   - **Logged in as ....... - Select to logout**

Select **Create Entry** - complete the mandatory fields (Number of babies born in this pregnancy, number of perinatal losses linked to this pregnancy and Mother’s NHI) and select **Create Entry** at bottom of page

![Mother Form](image)

**Mother Form** - select **M6047** to bring up mother form - complete all details on the form. The data will be saved after each entry. Once completed select **Proceed to the Baby Form** (at end of Mother Form) to enter data on baby.

**Baby Form** - complete all details on the form. Once complete select **Proceed to the Entry to review your forms and mark completed as appropriate** (at end of Baby Form).

![Baby Form](image)

Select **M6047** to review Mother Form and **B6275** to review Baby Form

Select **Complete** to complete each form. Once marked as COMPLETED you can no longer access these forms.

4. It is ideal to enter all the information at one time however if you are unable to do this you may access the forms through **All Entries** and selecting **M6047** to edit Mother Form and **B6275** to edit Baby Form
Contacts
PMMRC National Coordinator – v.masson@auckland.ac.nz or 09 923 4440

Otago Mortality Review Data Group - mortality.group@otago.ac.nz or (Mon-Fri, 9-5) 03 474 7007

How can I get a paper version of the form?
Wherever possible the data should be entered into the website but this is not possible, there are paper forms available. Local Coordinators will have copies of the forms or you can contact the National Coordinator.
The paper forms can be sent to:-
PMMRC National Coordinator
Department of Obstetrics and Gynaecology
University of Auckland
Private Bag 92019
AUCKLAND 1020
Fax 09 303 5969

Can I go back to the form and add or change information or correct mistakes?
Yes the system does now allow you to do this. If you have not entered all the details and wish to return to the form later DO NOT select to complete – log out of the website and when the additional information is available you may access the forms through All Entries and selecting M0000 to edit Mother Form and B0000 to edit Baby Form
(You may also contact the DHB Local Coordinator or the National Coordinator and inform them of the additional information or the information you want to change.)

Can different people fill out the same form?
No, on the web one person needs to be responsible for completing the form. The DHB where the baby dies should either get the information about the mother and enter it or send the Mother Form to the Lead Maternity Carer (LMC) for them to complete. The Local or National Coordinator may contact the relevant clinicians to find out any missing information.

Will I be able to print off a copy of the form and put it in the clinical notes?
Yes, to print R) click with mouse and select print option

Will there be changes to the system?
Yes if there are some functions that need to be enhanced.

Evaluation of the data collection process
If you have any suggestions for improving the data collection process, or you notice anything is wrong do please contact us on: mortality.group@otago.ac.nz
Some things you need to be aware of:

- **Number of babies born in this pregnancy, number of perinatal losses linked to this pregnancy and Mother's NHI** are compulsory. They must be completed even if you have no other information on the Mother. This will then create the baby/babies forms.

- **Some of the questions are programmed to link to other questions.** You are asked a main question and if you tick that main question then you will be able to select the list under it eg. You can see this in Q28; if you select **Was there consultation with an obstetrician during pregnancy?** ‘Yes’ you will be asked to complete **What was/were the reason(s) for the obstetrician consultation?** If you answer “no” or “unknown” you are not able to select these options.

- **The website will “time out” after 30 minutes.** If you are called away, when you are able to return to the form on the website select **All Entries** and the forms can be accessed by selecting **M0000** to edit Mother Form and **B0000** to edit Baby Form.
The PMMRC Rapid Reporting Form for a Perinatal Death – Mother

The table below explains how to complete each section of the form. Definitions are included with the explanation for each section.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| **Number of babies born in this pregnancy**   | This will generate additional columns for questions on the mother form as appropriate.  
This is a compulsory field |
| **How many perinatal losses are linked to this pregnancy** | This will then generate separate baby forms for each baby that died and link the mother information you are about to enter to each form.  
This is a compulsory field |
| **Mother’s NHI.**                              | We understand that you may not know the answer to some of the questions that follow but this information is required to generate the Baby Form/s. The Mothers NHI is usually found on the Newborn Record  
This is a compulsory field |
| **Personal details**                           | Enter the personal details of the mother, please give any other names that the mother may be known under to make tracking records easier (the address is required to calculate the deprivation index).  
A “rapid number” is a rural property number.  
Postcodes will be required shortly. |
| **Ethnicity**                                  | This should be as the mother identifies her ethnicity on the registration form. Select all that apply. |
| **Country of birth**                           | This should be as the mother identifies her country of birth on the registration form. |
| **Source of ethnicity information:**           | What source did you use to complete in Question 6? |
### Maternal height and weight

- **a)** Document the mother’s height in centimetres (if height not previously measured, please measure now).

- **b)** Document the mother’s weight in kilograms. This weight should be the earliest measured in pregnancy. If no early pregnancy weight is available, enter current weight.

The height and weight will be used to calculate the Body Mass Index (BMI) of the mother. The maternal height and weight is essential to complete a customised birth weight for the baby.

### Past obstetric history

Enter number of **previous** pregnancies.

**Gravidity, Parity** or **Unknown** Do not include this pregnancy in parity. Multiple births counted as one.

Then select [Add obstetric history form](#).

List the details of all the mother’s past pregnancies and their outcome. This includes miscarriages and terminations. If there is any further information on past pregnancies that is of relevance, include this information in the summary section at the end of the form. For example, if a previous baby had a congenital abnormality, was stillborn, or died in the neonatal period, provide further details. The place of birth is also important, as things are different from country to country. If the exact date is not known please enter the year only as a minimum.

**Abbreviations**

**Pregnancy Outcome**

- LB = Live born, SM = spontaneous miscarriage, TOP = termination of pregnancy, E = ectopic pregnancy, SB = stillbirth, END = early neonatal death (<7 days age), LND = late neonatal death (7 days – 27 days), CYD = Child and Youth Death (28 days – 24 years), U = unknown

**Method of Delivery**

- NVD = Normal vaginal delivery, OV = Operative vaginal delivery, VB = Vaginal breech, CS = Caesarean Section

**Complications**

- NIL = No complications, HE = hyperemesis, APH = Ante partum haemorrhage/Abruption, CxS = cervical stitch, GDM = Gestational diabetes, PET = Pre-eclampsia, Other = please comment in summary section, U = unknown

**Miscarriage**: fetal loss before 20 weeks. If there was previous late miscarriage (after 12 weeks), provide details in the summary at end of the form.
### Guidelines for completing perinatal death form for MOTHER

**Termination of Pregnancy:** any gestation

**Ectopic pregnancy:** Pregnancy outside the uterus

**Molar Pregnancy:** diagnosis confirmed by histology.

**Stillbirth:** Stillbirth is the birth of a fetus showing no signs of life at 20 weeks gestation or beyond (≥20 weeks) or weighing at least 400g if gestation is unknown

**Neonatal death:** death in first 28 days of life (i.e.: death up to midnight on the 27th day of life)
- Early Neonatal Death: a death less than 7 days of life
- Late Neonatal Death: a death from 7 days and up to midnight on the 27th day of life
- **CYD = Child and Youth Death:** includes death from 28 days and up to 24 years.

#### The following questions relate to this pregnancy only

<table>
<thead>
<tr>
<th>Family violence enquiry</th>
<th>Indicate whether the mother was asked about any violence against her by family members. If asked, indicate the response to this enquiry.</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of infertility</td>
<td>Has the mother had a history of infertility for &gt; 12 months preceding this pregnancy? i.e.: where regular intercourse has been occurring and conception has not occurred over a period &gt; 12 months preceding this pregnancy. Do not include infertility which preceded other pregnancies.</td>
</tr>
</tbody>
</table>
| Fertility treatment     | What type of fertility treatment was used (if any) that resulted in this pregnancy? Note: on some occasions women will receive infertility treatment even if they have not been infertile > 12 months.  
  - **Artificial insemination donor (AID):** When sperm that is artificially inseminated comes from a male donor. Also known as DI (donor insemination).  
  - **Artificial insemination husband/partner (AIH):** When sperm that is artificially inseminated comes from the woman's husband or partner.  
  - **Clomiphene citrate:** an oral medication taken for 5 days in the early part of the menstrual cycle to induce an ovulation  
  - **Follicle-stimulating hormone (FSH):** A hormone produced and released from the pituitary gland. In women it stimulates the production of oestrogen and follicles in the ovary ready for ovulation. In men it stimulates the production of sperm.  
  - **Intra-cytoplasmic sperm injection (ICSI):** When an egg is
surgically removed from a woman and injected with a single sperm. If fertilisation is successful the embryo is placed into the woman’s uterus. This technique is used when a male partner has a low sperm count or other sperm related problem.

**In vitro fertilisation (IVF):** When eggs are surgically removed from a woman's ovaries and sperm is added (partner or donor) and placed in an incubator. When these develop into embryos they are placed into the woman's uterus.

**Surgery:** Women who have undergone tubal or ovarian surgery to improve their fertility eg. Release of adhesions, excision of endometriosis or ovarian cyst removal

**Insulin sensitising agents eg. Metformin:** An oral medication given daily to women who are trying to conceive or used in non-insulin dependent diabetes and gestational diabetes.

**Letrozole:** An oral medication given daily to women who are trying to conceive to boost ovulation.

If ‘Yes’ fertility treatment was used, Was treatment in New Zealand? Yes    No     Unknown

If overseas, please state which country ____

<table>
<thead>
<tr>
<th>Intended place of birth</th>
<th>At what location had the mother planned to give birth at booking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home: a home environment does not have to be the mother’s own home.</td>
</tr>
<tr>
<td></td>
<td><strong>Birthing Unit:</strong> standalone birthing centre.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 1:</strong> No neonatal or caesarean section facilities</td>
</tr>
<tr>
<td></td>
<td><strong>Level 2:</strong> Unable to provide long term ventilation for babies.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 3:</strong> Full neonatal intensive care including facilities for long term ventilation.</td>
</tr>
<tr>
<td></td>
<td><strong>Other:</strong> e.g. car, ambulance</td>
</tr>
<tr>
<td></td>
<td><strong>Unknown:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Not registered:</strong> If the woman has not booked at any facility.</td>
</tr>
<tr>
<td></td>
<td>Please fill in the name of the place/unit/hospital in the free text box.</td>
</tr>
</tbody>
</table>

| Actual place of birth | At what location did the mother actually give birth? As above or ‘Fetus still in utero’ – this may apply to Maternal Deaths where the fetus is not delivered. |

| Time of transfer of birth location | If the woman was registered and the intended place of birth is different to the actual place of birth then answer this if this |
Occurred prior to or during labour.

**Lead Maternity Carer (LMC)**

Please indicate the LMC at time of first registration.

DHB Care refers to all DHB services e.g. Domino, Know Your Midwives (KYM), secondary and tertiary services.

For ‘LMC at booking’ to be different to ‘LMC at birth’ a new registration must have been completed.

**Clinical responsibility at time of birth**

Indicate the LMC/service clinically responsible for the woman’s care at time of birth.

If the service clinically responsible at the ‘time of birth’ is different to ‘LMC at booking’ please advise if this transfer of clinical responsibility occurred prior to or during labour.

**Antenatal procedures**

What procedures did the mother have during her pregnancy? Tick ‘yes’ for each of the procedures listed.

- **Scan at < 22 weeks gestation**: state how many
  - 1st trimester screening (MSS1)
  - 2nd trimester screening (MSS2)

- **Anatomy scan - state gestation weeks and days of 1st anatomy scan and 2nd anatomy scan if it was repeated.**

- **Chorionic villus sampling (CVS)**: prenatal diagnosis performed by placental biopsy.

- **Cervical Suture**: a cervical stitch may also be called Shirodkar or McDonald suture.

- **Amniocentesis**: Test for fetal chromosomes by taking a sample of amniotic fluid usually around 15-16 weeks gestation.

- **Doppler studies**: Doppler studies performed during an antenatal scan, usually umbilical artery Doppler studies.

- **External Cephalic Version**: process whereby an Obstetrician attempts to turn a breech baby to cephalic position.

- **Fetocide**: may be used before termination so that fetus is not live born or to reduce fetal numbers in multiple pregnancy.

- **Amnioreduction**: drainage of amniotic fluid for polyhydramnios. Twin to twin transfusion syndrome or foregut atresia are common indication.

- **Fetoscopic laser treatment**: performed rarely for twin to twin transfusion syndrome.

- **Traditional massage**: traditional massage of the maternal abdomen during pregnancy usually in Samoan or Tongan cultures. Usually performed by a lay person, may be quite...
### Guidelines for completing perinatal death form for MOTHER

<table>
<thead>
<tr>
<th>Vigorous and often not readily disclosed. Other: Specify any other procedures the mother had during her pregnancy that are not listed. Include treatments like drainage of fetal pleural effusion, amnio infusion</th>
</tr>
</thead>
</table>

**Smoking status at 1st registration with a LMC (Cigarettes)**

Indicate whether the mother: never smoked, if a current non-smoker select the option that best describes her past history of smoking or a current cigarette smoker (i.e.: still smoking). If so, how many cigarettes does she smoke a day?

If the mother is a current non-smoker or current smoker select whether smoking cessation advice had been offered and by whom.

**Maternal use alcohol and other recreational drugs**

Did the mother take any non-prescription drugs, methadone or consume alcohol during her pregnancy?

If you select ‘yes’ you will be able to indicate whether it was used in the first trimester and also in the month before delivery. Herbal highs are also known as party pills.

If the mother has used any of these substances, please provide details about frequency of use in the free summary box at the end of the form.

If the mother advises use of another substance not listed, please specify in the ‘other’ category.

Please describe use – amount and frequency.

**Total number of antenatal visits**

a) Indicate the total number of antenatal visits attended prior to the baby’s death. You will need to complete this from the antenatal record as the mother may not know this.

b) Indicate the gestation in weeks at the first antenatal visit with LMC.

c) Indicate the gestation in weeks at the first antenatal visit with any health provider.

**Gestation at 1st antenatal visit**

**Mother’s clinical history**

Tick ‘yes’, ‘no’ or ‘unknown’ for each of the diagnoses listed. This section includes any diagnosis in the current pregnancy.

If the condition was diagnosed for the first time during pregnancy, please elaborate in the summary at the end of this document.

To enter ‘yes’ for medical conditions (eg asthma, diabetes, epilepsy, thyroid) the condition must have been diagnosed by a doctor.

**Asthma:** diagnosed by a doctor.

**Diabetes**
Diabetes Type I: diabetes with onset in childhood or as a young adult controlled with insulin injections. Previously known as insulin dependent diabetes mellitus (IDDM). Very occasionally this is diagnosed for the first time in pregnancy by the presence of antibodies.

Diabetes Type II: diabetes usually controlled with diet and tablets or sometimes insulin. Age of onset usually in adult life. Unusual to develop Type II diabetes at < 15 years unless very obese.

Can be diagnosed by \( \text{HbA1c} \geq 50 \text{mmol/mol} \) before pregnancy or up to 20 weeks of pregnancy (or confirmed in women with GDM who are still diabetic when tested 6 weeks postpartum). Previously known as non-insulin dependent diabetes mellitus (NIDDM).

**Impaired Glucose Tolerance:** includes

- Impaired Fasting Glucose (IFG): fasting plasma glucose 6.1-6.9 mmol/L, \textit{diagnosis made outside pregnancy.}
- Impaired Glucose Tolerance: 2 hour glucose between 7.8 and 11 mmol/L, \textit{diagnosis made outside pregnancy.}
- Or \( \text{HbA1c} > 40 - 50 \text{mmol/mol} \) \textit{diagnosis made outside pregnancy.}

**Epilepsy:** diagnosed by a doctor.

**Heart Condition** (if you select this option you then need to select one of the following 4 options)

- Heart condition – Congenital: diagnosis confirmed after investigation by a doctor.
- Heart condition – rheumatic: valvular heart disease secondary to rheumatic fever.
- Heart condition – coronary artery disease: history of angina or myocardial infarction prior to or during current pregnancy.
- Heart condition – other: includes conditions such as cardiomyopathy.

**Thyroid abnormality** (if you select this option you then need to select one of the following 3 options)

- Hyperthyroidism: confirmed by laboratory testing either current or in the past.
- Hypothyroidism: confirmed by laboratory testing either current or in the past.
- Other Thyroid: eg. Large goitre, thyroid cancer or unknown.

**Inflammatory Bowel Disease:** includes Crohn's and ulcerative colitis, not irritable bowel syndrome.

**Systemic lupus erythematosus:** diagnosed by a doctor and...
meets criteria for lupus. Does not include women with positive auto-antibodies or antiphospholipid antibodies without clinical syndrome.

**Other autoimmune**: includes conditions like Sjogrens syndrome, rheumatoid arthritis and mixed connective disease.

**Mental Health Disorder** *(if you select this option you then need to select one of the following 3 options)*

- **Depression**: diagnosed and treated with antidepressants in pregnancy or prior to pregnancy.
- **Psychotic disorders** such as manic depression, schizophrenia.
- **Other mental health disorders** eg. Obsessive compulsive disorders.

**Renal disease**: known underlying kidney problem, e.g., reflux nephropathy, glomerulonephritis, renal transplant, calculi. Specify in summary.

**Venous Thromboembolism**: Deep vein thrombosis (usually confirmed by venogram or Doppler) or pulmonary embolus (usually confirmed by lung scan/CT), and treated with anticoagulation

**Blood Disorders** *(if you select this option you then need to select one of the following 3 options)*

- **Anaemia**: Hb<100 in pregnancy or Hb<115 pre-pregnancy.
- **Thalassaemia trait** carrier for α or β thalassaemia.

**Thrombophilia** includes: Antiphospholipid syndrome: lupus anticoagulant and / or anticardiolipin antibodies associated with one or more of the following: ≥3 first trimester miscarriages, ≥1 fetal death > 10 weeks gestation and/or arterial or venous thromboses.

**Hypertension** *(if you select this option you then need to select one of the following 2 options)*

- **Essential/Chronic**: BP ≥ 140/90mm Hg before 20 weeks or prior to pregnancy. Also includes women who were on antihypertensive treatment prior to pregnancy.
- **Secondary hypertension**: is hypertension due to an underlying condition such as renal disease.

**Cervical surgery**: LLETZ (most common), laser, cryotherapy, diathermy, or knife cone biopsy. If yes please provide details in summary. Don’t include previous punch biopsy alone.

**Urinary tract infection**: confirmed urine infection on culture.

**Uterine abnormality**: for example, bicornuate, unicornuate uterus, large uterine septum.
**Uterine surgery**: for example, myomectomy, and hysterotomy.

**Other**: please include anything that is not covered above

### Screening for diabetes in pregnancy

| a) Was mother tested for gestational diabetes? Yes, No, Declined, Unknown |
| b) Gestational Diabetes confirmed Yes, No, Unknown |
| c) Laboratory results and date of test |
|   i. **HbA1c at booking** |
|   ii. **HbA1c (>20 weeks)** (record highest result) |
|   iii. **Polycose** (record highest result) |
|   iv. **Glucose Tolerance Test** (record highest result) |

**Gestational Diabetes**: fasting glucose ≥ 5.5 mmol/L and/or 2 hour glucose ≥ 9.0mmol/L on GTT. However a women maybe accepted as having GDM with a polycose ≥11mmol/L

### Multiple pregnancy

Select if this pregnancy is a multiple pregnancy- if yes:

| a) Indicate the number of fetuses/ babies who were alive at first ultrasound scan. |
| b) Number total number of babies born in this delivery, including stillbirths? |
| c) If a fetal reduction occurred in this pregnancy please describe – number of fetus reduced, gestation and method. |

*(If the pregnancy started as twins and one fetus dies in early pregnancy, or between 13 and 20 weeks, detail in the summary.)*

| d) Select type of twins: |
| **Dichorionic Diamniotic (DCDA) twins**: arise from separate placentae so the membranes between them will be four layers thick and easy to see on scan. A triangular shape where the membranes of DCDA twins meet is called the lambda sign. |
| **Monochorionic Diamniotic (MCDA) twins**: arise from 1 placenta and have a thin dividing membrane on scan. They have no lambda sign. Chorionicity cannot be reliably diagnosed by scan after 13 weeks. |
| **Monoamniotic twins (MA)**: MA twins have no dividing membranes. |
| **Other multiple** – please describe chorionicity |

### NHI of all fetus/babies

If you have selected that this was a multiple pregnancy - indicate the NHI of all babies in this pregnancy
### Guidelines for completing perinatal death form for MOTHER

<table>
<thead>
<tr>
<th>Occurrence of vaginal bleeding this pregnancy</th>
<th>Select Yes No or Unknown for both BEFORE 20 weeks and AFTER 20 weeks for whether bleeding occurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric conditions</td>
<td>Indicate what obstetric conditions were evident in this pregnancy. Tick as many as apply.</td>
</tr>
<tr>
<td><strong>Hypertension</strong> (if you select this option you then need to select one of the following 5 options)</td>
<td></td>
</tr>
<tr>
<td>Gestational hypertension: Systolic BP ≥140mmHg and/or diastolic BP ≥90mmHg (Korotkoff V) on at least 2 occasions 4h apart after 20 weeks’ gestation, but before the onset of labour.</td>
<td></td>
</tr>
<tr>
<td>Preeclampsia: Gestational hypertension with proteinuria ≥ 300 mg/24h or spot urine protein: creatinine ratio ≥ 30 mg/mmol creatinine or urine dipstick protein &gt;= ++ or any multi-system complication.</td>
<td></td>
</tr>
<tr>
<td>Preeclampsia with chronic hypertension: Increase in SBP of ≥ 30 mmHg and/or DBP of ≥ 15 mm Hg after 20 weeks’ gestation (above 15wk SCOPE BP recording) in combination with new onset proteinuria ≥ 300 mg/24h or spot urine protein:creatinine ratio ≥ 30 mg/mmol creatinine or urine dipstick protein &gt;= ++ or any multi-system complication.</td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td></td>
</tr>
<tr>
<td>Chronic hypertension</td>
<td></td>
</tr>
<tr>
<td>Unspecified hypertension: unknown whether the hypertension was pregnancy induced or pre-existing. Includes women who are unbooked and present with hypertension late in pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Pre term labour: presents with regular painful uterine contractions on one or more occasions</td>
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</tr>
<tr>
<td>Prolonged Rupture of the membranes: rupture of the membranes for &gt; 24 hours duration before birth.</td>
<td></td>
</tr>
<tr>
<td>If yes select on of the following two:</td>
<td></td>
</tr>
<tr>
<td>Preterm: prolonged rupture of the membranes at &lt; 37 weeks gestation.</td>
<td></td>
</tr>
<tr>
<td>Term: prolonged rupture of the membranes at ≥ 37 weeks gestation.</td>
<td></td>
</tr>
<tr>
<td>Cholestasis of pregnancy: a condition associated with severe itch, abnormal AST and ALT liver function tests with or without raised bile salts.</td>
<td></td>
</tr>
<tr>
<td>Confirmed maternal infection: maternal infection confirmed by culture or other means eg. PCR</td>
<td></td>
</tr>
<tr>
<td>If selected tick all relevant options:</td>
<td></td>
</tr>
<tr>
<td><strong>Guidelines for completing perinatal death form for MOTHER</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **Pyelonephritis**: infection of the kidney associated with renal angle tenderness and fever.  
  **Lower urinary tract infection**: confirmed urinary infection without fever and renal angle tenderness.  
  **Other infection**: eg. Septicaemia, pneumonia, confirmed parovirus or cytomegalovirus. Please state.  
  **Trauma**: significant maternal injury in pregnancy.  
  If selected choose one of the following 3 options:  
  Vehicular maternal injury sustained during a road traffic accident or similar.  
  Violent personal injury including domestic violence. or assault  
  Other, eg. Trauma sustained from a fall  
  **Other obstetric condition**: Specify any other conditions that are not listed in the summary.  
  **Surgery in pregnancy**: refers to major surgical procedures, eg. appendicectomy in pregnancy, cholecystectomy, ovarian cystectomy. If yes please state type of surgery.  
  **Unknown**: unknown if there were obstetric conditions in this pregnancy. |
| **Suspected fetal growth restriction prior to demise** | Select whether there was suspected growth restriction **before confirmation of fetal demise**.  
  **Yes and confirmed by scan**: abdominal circumference (AC) \(<10^{th}\) \% and/or AC crossing centile lines on ultrasound growth chart and/or head circumference significantly larger than abdominal circumference, and/or estimated fetal weight \(<10^{th}\)\% on customised fetal growth chart.  
  **Yes but normal growth on scan**: fetal growth restriction suspected clinically but growth scan suggests normal fetal growth.  
  **Yes but no scan performed**: suspected clinically but not followed up by growth scan.  
  **Unknown**: relevant clinical information not available, eg. Did not have a clinical check in the last month.  
  Was a customised growth chart generated for this woman antenatally **prior to fetal demise**? |
| **Folic Acid taken in pregnancy** | Tick ‘yes’, ‘no’ or ‘unknown’ for each of the options  
  Was Folic Acid taken pre pregnancy?  
  Was Folic Acid taken first trimester? |
| **Obstetric specialist** | Indicate whether the mother was under the care of a specialist obstetrician or if there was a consultation during her |
### Consultation

pregnancy. If yes select the reasons for this referral. *(For definitions, see questions 21 and 26).*

**Poor Obstetric History:** would include women with previous pregnancies with recurrent miscarriages, previous growth restriction, preterm birth, preeclampsia or other serious pregnancy complication.

If advice was sought from the specialist but she/he did not actually see the mother select “yes” but make a note in the summary that the mother was not seen.

### Referral to other health care services

Indicate whether the mother was referred to other health care services during her pregnancy (other than to a general obstetric specialist).

**Medical:** Included Fetal Maternal Medicine, Physician, Anaesthetic and Genetic Services (non-obstetric specialists)

**Social:** Includes Social Work and Cultural services (services designed to support women from a specific culture, e.g. Māori Health Services)

Please identify referrals to other services not covered in the summary.

### Induction

Please select all medications/methods that apply.

If ARM was used for induction of labour please state date and time using 24 hour clock.

If Misoprostol was used please state dose:  mcg

**Reason for induction** Please tick reason for induction of labour other, please specify

### Augmentation

Please select all that apply.

If ARM was used for augmentation, please state date and time using 24 hour clock.

If other, please specify.

### Analgesia/anaesthetic in labour and delivery

**Opiate:** either intramuscular or intravenous – Pethidine, morphine or fentanyl

**Nitrous oxide** given by inhalation.

**Epidural** either with opiates or local anaesthetic or both.

**TENS** transcutaneous electrical nerve stimulation.

**Unknown**

**Other** e.g. acupuncture

### Bath or pool during

Indicate whether any part of labour occurred in water.
### Guidelines for completing perinatal death form for MOTHER

<table>
<thead>
<tr>
<th>labour</th>
<th>Indicate whether or not the birth of the baby occurred in water (both planned and unplanned water birth).</th>
</tr>
</thead>
</table>
| Mode of birth | Indicate the delivery method and the type within this for each baby in this pregnancy (for example, if ‘breech’ is selected, then you will need to select the type ie, assisted, extraction or spontaneous).  
If delivered by caesarean, indicate whether forceps or Ventouse had been attempted before proceeding to caesarean section.  
If a breech birth, indicate whether this was identified prior to birth.  
**Breech assisted**: spontaneous delivery of buttocks and body with medical assistance for delivery of shoulders (Lovsett manoeuvre) and/or head (eg forceps to after coming head).  
**Breech extraction**: the feet/legs are grasped often from within the uterus or high in the vagina (usually for a 2nd twin) and the baby is delivered.  
**Spontaneous breech**: the baby is delivered totally with maternal effort and no manipulation from medical attendants.  
**Forceps low**: Head is visible distending the perineum.  
**Forceps mid cavity**: head is in mid cavity (station usually about +1 and head not visible).  
**Forceps mid cavity rotation**: as above for mid forceps but with either manual or forceps rotation.  
**Ventouse low**: Head is visible distending the perineum.  
**Ventouse mid cavity**: head is in mid cavity (station usually about +1 and head not visible).  
**Ventouse Mid cavity rotation**: as above for Mid forceps but with either manual or ventouse rotation  
**Caesarean Section**: please state when this occurred  
Planned - no labour  
Planned - during labour  
Unplanned - no labour  
Unplanned - during labour  
**Type of anaesthetic for Operative Delivery**: Select from the list. |
| Maternal outcome | Indicate the health outcome for the mother following birth.  
**Alive and well**: discharged home without major complications.  
**Alive but experienced major morbidity**: alive but serious complications e.g. admitted to intensive care, postpartum |

18
hysterectomy, and stroke.

**Dead:** If the mother has died please contact your local coordinator or the national coordinator as additional information is required.

Please add further details if morbidity or mortality has occurred.

### Placenta

| a. Enter the weight of the placenta in grams. |
| b. Select if placenta not examined, normal or has some abnormalities. |

If some abnormalities selected, select **Circumvallate Placenta:** the chorionic plate, from which the villi arise, is smaller than the basal plate. This means that when the placenta is viewed from the fetal surface the placental tissue extends beyond the membranes attached to the placental disc.

**Other:** please make comments if not covered by the above

### Umbilical cord

If cord around limbs or body is tight it may be compressed and sometimes it will indent the baby’s body.

**Marginal/Velamentous insertion:** where the cord inserts into the membranes not directly into the placenta.

**Torsion or spring like:** the cord is twisted up on itself like a spring. e.g. hypercoiled

**Abnormal cord thickness:** if selected choose on of the following 2:

- **Thin cord:** very little Wharton’s jelly.
- **Thick cord:** a lot of Wharton’s jelly around the cord vessels.
- **Two vessels:** a single umbilical artery.
- **Other abnormality:** please add comments

### Summary

Include any further comment you wish to provide about the pregnancy. This should include comments which are not covered by the above questions (Eg: social circumstances) and other relevant information which may have contributed to the outcome. Please continue over leaf or add extra pages as necessary.

### Lead Maternity Carer (LMC) name and address

Please provide the name and address of the LMC if different to clinician completing the form. They will be contacted if additional information is required.

### To print

R) click with mouse and select print option
Once completed select **Proceed to the Baby Form** (at end of Mother Form) to enter data on baby.
### PMMRC Rapid Reporting Form for a Perinatal Death - Baby

The table below explains how to complete each section of the form. Definitions are included with the explanation for each section.

<table>
<thead>
<tr>
<th>Section</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby NHI</td>
<td>Please complete for all babies</td>
</tr>
<tr>
<td>Personal details</td>
<td>Enter name of the baby if known.</td>
</tr>
<tr>
<td>Baby’s ethnicity</td>
<td>Ethnicity should be identified by the parent of the baby.</td>
</tr>
<tr>
<td>Source of ethnicity information:</td>
<td>What source did you use to complete in Question 6?</td>
</tr>
<tr>
<td>Live or stillbirth</td>
<td>Questions will be ‘disabled’ dependent on which is selected - stillbirth or live birth.</td>
</tr>
<tr>
<td>Termination of pregnancy</td>
<td>Indicate whether the birth was the result of a surgical or medical termination of pregnancy (including for fetal abnormality, social and other reasons). Reason for the termination will be covered in the PSANZ classification of cause of death. Ensure 'Notification of Abortion' form (ASC Form No. 4) is completed.</td>
</tr>
<tr>
<td>Date and time of birth</td>
<td>a) Enter the date of birth (dd/mm/yyyy).</td>
</tr>
<tr>
<td></td>
<td>b) Enter the time of birth using a 24 hour clock - E.g. 22:30</td>
</tr>
<tr>
<td>Gestation at birth</td>
<td>Enter your best estimate of the gestational age in completed weeks and days and select how age was determined eg: last menstrual period, first trimester ultrasound. A first trimester scan should be used to date the pregnancy if the difference between a sure Last Menstrual Period (LMP) and the scan is &gt; 7 days. If LMP is unsure and a scan has been performed, select the scan at earliest gestation. If LMP is unknown and no scan, select ‘clinical examination of baby at birth.</td>
</tr>
<tr>
<td>Birthweight</td>
<td>Enter baby’s birthweight</td>
</tr>
<tr>
<td><strong>If this was a multiple pregnancy</strong></td>
<td>If this was a multiple pregnancy enter birth order of deceased baby <em>(please complete a separate form for each deceased baby in this pregnancy)</em></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **When did death occur?**         | At what stage did the baby’s death occur?  

**Antepartum:** fetal movements stopped before onset of labour. Diagnosis made antepartum or occasionally in labour. Scan to confirm diagnosis of stillbirth may show signs which indicate that the baby has been dead for some time (eg Spalding’s sign, overlapping skull bones).  

**Intrapartum:** fetal heart present in labour and death diagnosed subsequently.  

Select whether death occurred in  
- first stage of labour  
- second stage of labour  
- Intrapartum unknown – not known what stage of labour  

**Neonatal:** live birth but died before 28 days  

**Unknown whether antepartum or intrapartum:**  
Select if fetal heart not heard in early labour and woman presents with stillbirth in labour, and fetal movement history unclear, and ultrasound does not show features to suggest that death occurred some time ago. |
| **Estimated gestational age at time of fetal death** | Only relevant if baby is stillborn |
| **Place of death for live born babies** | Select the location where the baby died.  
If the death occurred in a hospital, select the hospital location where the death occurred. |
| **Baby Examination** | Make a note of any abnormalities noted on external examination of the baby, including dysmorphic features |
| **Post-mortem** | Indicate whether or not a post-mortem was offered to the parents.  
If yes, please select all clinicians who discussed/offered the post-mortem to the parents.  
If Yes, did the parents consent to a post-mortem?  
Select whether the death was referred to the coroner. |
### Guidelines for completing perinatal death form

| **Date and time of death** | a) Enter the date the baby died (dd/mm/yyyy).  
| | b) Enter the time of birth using a 24 hour clock - E.g. 22:30 |
| **Apgars** | Enter the scores at 1 and 5 mins if still 9 or below at 5 mins enter score for 10, 15 and 20 minutes. |
| **Cord gases** | Were cord gases taken?  
| | (All boxes have 0.00 in them at start but you can put 2 numbers before the decimal point and one after as appropriate)  
| | If cord gases were taken, enter the pH, base deficit and CO₂ results in the appropriate boxes, based on whether the sample was arterial or venous.  
| | For base deficit, the result will either be + (base excess) or – (base deficit). Enter + or – in the box and then the numerical value. |
| **Resuscitation** | Indicate whether resuscitation was attempted. Or if resuscitation was not attempted (usually for extreme prematurity or lethal abnormality) However if resuscitation was not required-baby was in good condition at birth, Please describe in the summary box.  
| | If resuscitated, indicate whether baby was resuscitated and transferred to another clinical care area or unable to be resuscitated. |
| **Were maternal corticosteroids given antenatally?** | Indicate whether antenatal steroids were given, if yes at what gestation and whether the course of corticosteroids completed. |
| **Transfer from place of birth** | Was the baby transferred from their place of birth prior to death? |
| **Where transferred** | If yes, indicate where the baby was transferred to. |
| **Why not transferred** | If no, indicate the reason why. |
| **Summary points** | Include any further comment you wish to provide about the baby. This should include comments which are not covered by the above questions and other relevant information which may have contributed to the outcome. |
| **To print** | R) click with mouse and select print option |
### Guidelines for completing perinatal death form

<table>
<thead>
<tr>
<th>Once completed</th>
<th>Select Proceed to the Entry to review your forms and mark completed as appropriate (at end of Baby Form).</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have not finished completing the Baby Form</td>
<td>Log out of website. When data is available you may access the forms through All Entries and selecting M0000 to edit Mother Form and B0000 to edit Baby Form</td>
</tr>
<tr>
<td>If you have finished completing the Forms</td>
<td>Select to complete each form. Once marked as COMPLETED you can no longer access these forms.</td>
</tr>
</tbody>
</table>

### PMMRC Classification Form

Following completion of perinatal death investigations and review at the DHB perinatal meeting all deaths are classified using the Perinatal Society of Australia and New Zealand (PSANZ) Perinatal Mortality Classification. The classification is completed by a multidisciplinary team which includes the PMMRC DHB Local Coordinator.

All perinatal deaths are given a PSANZ-PDC - Perinatal Death Classification to identify the single most important factor which led to the chain of events which resulted in the death plus a secondary PSANZ-PDC if indicated. Neonatal deaths in addition to the PSANZ-PDC are given a PSANZ-NDC Neonatal Death Classification to identify the single most important factor in the neonatal period which caused the death plus a secondary PSANZ-NDC if indicated.

At this time contributory factors are identified, these may be highly specific to the death or generalised to the system(s). These factors are sub-classified into organisational and management, personnel and those relating to barriers to accessing and engaging with care.

The information provided in these forms is strictly confidential. Information published by the PMMRC is grouped and individuals are not identifiable.
Legislation (Last updated 13/10/2016)

From 23 April 2011, mortality review committees became statutory committees under Section 59E of the amended New Zealand Public Health and Disability Act. They report to the Health Quality & Safety Commission Board. The purpose, functions, powers and scope of the committees has not changed.

Schedule 5 of the New Zealand Public Health and Disability Act outlines specific provisions applying to mortality review committees giving them the power to source any information relevant to their purpose. They are charged with strict confidentiality conditions for the collection, storage and use of the information they hold.

Excerpts from the New Zealand Public Health and Disability Act 2000 No 91 (as at 24 February 2011):

Section 59 E

HQSC may appoint Mortality Review Committees

(1) HQSC may appoint 1 or more committees to carry out any of the following functions that HQSC specifies by notice to the committee:

- (a) to review and report to HQSC on specified classes of deaths of persons, or deaths of persons of specified classes, with a view to reducing the numbers of deaths of those classes or persons, and to continuous quality improvement through the promotion of ongoing quality assurance programmes;
- (b) to advise on any other matters related to mortality that HQSC specifies in the notice.

(2) A committee appointed under subsection (1) (a mortality review committee) must develop strategic plans and methodologies that—

- (a) are designed to reduce morbidity and mortality; and
- (b) are relevant to the committee's functions.

(3) HQSC—

- (a) must, at least annually, provide the Minister with a report on the progress of mortality review committees; and
- (b) must include each such report in HQSC's next annual report.

(4) The provisions of Schedule 5 apply in relation to a mortality review committee.

(5) Every person who fails, without reasonable excuse, to comply with a requirement imposed under Schedule 5 by the chairperson of a mortality review committee commits an offence and is liable to a fine not exceeding $10,000.
(6) Every person who discloses information contrary to Schedule 5 commits an offence and is liable on summary conviction to a fine not exceeding $10,000.

(7) Any member of a registered occupational profession who commits an offence under subsection (5) or (6) is liable to any disciplinary proceedings of that profession in respect of the offence, whether or not he or she is fined under that subsection.

Section 59E: inserted, on 9 November 2010, by section 17 of the New Zealand Public Health and Disability Amendment Act 2010 (2010 No 118).

Schedule 5: Provisions applying to mortality review committees

1. Interpretation

- In this schedule, unless the context otherwise requires,—
  - document has the same meaning as in section 2(1) of the Official Information Act 1982
  - judicial proceeding means a proceeding that is judicial within the meaning of section 108 of the Crimes Act 1961
  - Ministerial authority means an authority—
    - o (a) given by the Minister under clause 6(1); and
    - o (b) in force for the time being
  - serious offence means an offence punishable by imprisonment for a term of 2 years or more.

Compare: 1995 No 95 s 66

2. Chairperson may require person to give information

- (1) If a mortality review committee gives its chairperson, or an agent the committee appoints for the purpose, authority in writing to do so, the chairperson or agent may, by notice in writing to any person, require the person to give the committee information in the person’s possession, or under the person’s control, and relevant to the performance by the committee of any of its functions.

- (2) Examples of the information the chairperson or agent may require are—
  - o (a) patient records, clinical advice, and related information:
  - o (b) answers to questions posed by the chairperson in the notice, and that the person is able to answer:
  - o (c) information that became known solely as a result of a declared quality assurance activity, within the meaning of Part 6 of the Medical Practitioners Act 1995, or a protected quality assurance activity within the meaning of section 53(1) of the Health Practitioners Competence Assurance Act 2003.

- (3) The person must take all reasonable steps to comply with the notice.

3. Meaning of information

- In clauses 4 to 6, information means any information—
  o (a) that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and
  o (b) that became known to any member or executive officer or agent of a mortality review committee only because of the committee’s functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

4. Prohibitions on production, disclosure, and recording of information

- (1) A member or executive officer or agent of a mortality review committee must not produce or disclose information to another person or in any judicial proceeding, or make any record of it, unless the production, disclosure, or record, is—
  o (a) for the purposes of carrying out the committee's functions; or
  o (b) in accordance with an exception stated in clause 5; or
  o (c) in accordance with a ministerial authority.

(2) In any judicial proceeding, a member or executive officer or agent of a mortality review committee must not be required to produce information if under subclause (1) he or she is prohibited from doing so.

Compare: 1995 No 95 s 70

5. Exceptions to prohibitions

- Clause 4 does not prohibit—
  o (a) the production, disclosure, or recording of information if the information does not identify, either expressly or by implication, any particular individual:
  o (b) the disclosure of information—
    § (i) with the consent of every person who would be directly or indirectly identified by the disclosure:
    § (ii) to the Minister, or a person authorised by the Minister, for the purpose of enabling the Minister to decide whether or not to issue a ministerial authority:
    § (iii) for the purposes of the prosecution of an offence against section 18(7) (disclosure of information contrary to this schedule).

Compare: 1995 No 95 s 71

6. Minister may authorise disclosure of information

- (1) If the Minister is satisfied that information relates to conduct (whenever occurring) that constitutes or may constitute a serious offence,
the Minister may, by notice in writing signed by the Minister, give a ministerial authority authorising the disclosure of the information, in the manner, and subject to any conditions, specified in the notice, for 1 or more of the following purposes:
- (a) for the purposes of the investigation and prosecution of offences:
- (b) for the purposes of a Royal Commission, or a commission of inquiry appointed by an Order in Council made under the Commissions of Inquiry Act 1908.

(2) However, a ministerial authority may be given for information of a non-factual nature (for example, expressions of opinion) only if that information consists only of matter contained in a report or advice prepared by the mortality review committee.

(3) The Minister may at any time—
- (a) revoke a ministerial authority; or
- (b) revoke, amend, or add to any condition or conditions to which a ministerial authority is subject.

(4) A ministerial authority authorising the disclosure of information does not of itself—
- (a) require the disclosure of that information; or
- (b) create a duty to disclose that information.

Compare: 1995 No 95 s 72

7. Supplementary procedure

- A mortality review committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.
## Guidelines for completing perinatal death form

### PMMRC Local DHB Coordinators

(26/01/2018)

<table>
<thead>
<tr>
<th>DHB</th>
<th>Local Coordinator</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Northland</strong></td>
<td>Yvonne Morgan&lt;br&gt;Clinical Charge Midwife&lt;br&gt;Dr Kristy Wolfe&lt;br&gt;Consultant Obstetrician</td>
<td>Whangarei Hospital&lt;br&gt;Private Bag 9742&lt;br&gt;Whangarei 0148</td>
</tr>
<tr>
<td><strong>Waitemata</strong></td>
<td>Dr Sue Belgrave&lt;br&gt;Obstetrician and Gynaecologist&lt;br&gt;Sharon Williams&lt;br&gt;Diane Hirst&lt;br&gt;Midwives, North Shore Hospital&lt;br&gt;Liz Snookes&lt;br&gt;Midwife, Waitakere Hospital</td>
<td>North Shore Hospital&lt;br&gt;Private Bag 93 503&lt;br&gt;Takapuna&lt;br&gt;North Shore City 0740</td>
</tr>
<tr>
<td><strong>Auckland</strong></td>
<td>Professor Lesley McCowan&lt;br&gt;Obstetrician and MFM Specialist&lt;br&gt;Debbie Greenwood&lt;br&gt;Midwife</td>
<td>Auckland City Hospital&lt;br&gt;Private Bag 92 024&lt;br&gt;Auckland Mail Centre&lt;br&gt;Auckland 1142</td>
</tr>
<tr>
<td><strong>Counties Manukau</strong></td>
<td>Dr Sarah Wadsworth&lt;br&gt;Consultant Obstetrician&lt;br&gt;Debbie Davies&lt;br&gt;Midwife</td>
<td>Middlemore Hospital&lt;br&gt;Private Bag 9311&lt;br&gt;Otahuhu&lt;br&gt;Auckland 1640</td>
</tr>
<tr>
<td><strong>Waikato</strong></td>
<td>Dr Sarah Waymouth&lt;br&gt;Dr Isobel Camano&lt;br&gt;Obstetrician and Gynaecologists&lt;br&gt;Tracey Williams&lt;br&gt;Clinical Midwife Specialist- Perinatal</td>
<td>Waikato Hospital&lt;br&gt;Pembroke Street&lt;br&gt;Private Bag 3200&lt;br&gt;Hamilton 3240</td>
</tr>
<tr>
<td><strong>Bay of Plenty</strong></td>
<td>Esther Mackay&lt;br&gt;Ann Attwood&lt;br&gt;Midwives&lt;br&gt;Dr Michael Johns&lt;br&gt;Obstetrician and Gynaecologist</td>
<td>Tauranga Hospital&lt;br&gt;Cameron Road&lt;br&gt;Private Bag 12024&lt;br&gt;Tauranga 3143</td>
</tr>
<tr>
<td><strong>Lakes</strong></td>
<td>Amanda Griffths&lt;br&gt;Midwife</td>
<td>Rotorua Hospital&lt;br&gt;Private Bag 3023&lt;br&gt;Rotorua Mail Centre&lt;br&gt;Rotorua 3046</td>
</tr>
<tr>
<td><strong>Tairawhiti</strong></td>
<td>Sheila Noakes&lt;br&gt;Midwife</td>
<td>Gisborne Hospital&lt;br&gt;Private Bag 7001&lt;br&gt;Gisborne 4010</td>
</tr>
<tr>
<td><strong>Taranaki</strong></td>
<td>Laura Scholey&lt;br&gt;Midwife&lt;br&gt;Belinda Chapman&lt;br&gt;Midwife Manager</td>
<td>Taranaki Base Hospital&lt;br&gt;P O Box 2016&lt;br&gt;New Plymouth 4310</td>
</tr>
<tr>
<td><strong>Hawke’s Bay</strong></td>
<td>Dr Lynda Croft&lt;br&gt;Obstetrician and Gynaecologist&lt;br&gt;Sara Paley&lt;br&gt;Midwifery Educator</td>
<td>Hawkes Bay Hospital&lt;br&gt;Private Bag 9014&lt;br&gt;Hastings 4120</td>
</tr>
</tbody>
</table>
### Guidelines for completing perinatal death form

<table>
<thead>
<tr>
<th>DHB</th>
<th>Local Coordinator</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wanganui</strong></td>
<td>Lucy Pettit</td>
<td>Whanganui Hospital Private Bag 3003 Wanganui 4500</td>
</tr>
<tr>
<td></td>
<td>Jo McDonnell</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midwives</td>
<td></td>
</tr>
<tr>
<td><strong>Midcentral</strong></td>
<td>Carole Collins</td>
<td>Palmerston North Hospital PO Box 2056 Palmerston North 4440</td>
</tr>
<tr>
<td></td>
<td>Midwife Educator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Steven Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obstetrician and Gynaecologist</td>
<td></td>
</tr>
<tr>
<td><strong>Wairarapa</strong></td>
<td>Michelle Thomas</td>
<td>Wairarapa Hospital PO Box 96 Masterton 5840</td>
</tr>
<tr>
<td></td>
<td>Midwife</td>
<td></td>
</tr>
<tr>
<td><strong>Capital and Coast</strong></td>
<td>Hazel Irvine</td>
<td>Wellington Hospital Private Bag 7902 Wellington South</td>
</tr>
<tr>
<td></td>
<td>Midwife and RN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rose Elder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obstetrician and Gynaecologist</td>
<td></td>
</tr>
<tr>
<td><strong>Hutt Valley</strong></td>
<td>Eleanor Martin</td>
<td>Hutt Hospital PO Box 31-907 Lower Hutt 5040</td>
</tr>
<tr>
<td></td>
<td>Christine Heiss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midwives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hutt Hospital</td>
<td></td>
</tr>
<tr>
<td><strong>Nelson Marlborough</strong></td>
<td>Lois McTaggart</td>
<td>Nelson Hospital Private Bag 18 Nelson 7042</td>
</tr>
<tr>
<td></td>
<td>Midwife Nelson</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Graeme Cross</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midwife Wairau</td>
<td></td>
</tr>
<tr>
<td><strong>West Coast</strong></td>
<td>Denise Stacey</td>
<td>Grey Base Hospital PO Box 387 Greymouth 7840</td>
</tr>
<tr>
<td></td>
<td>Midwife</td>
<td></td>
</tr>
<tr>
<td><strong>Canterbury</strong></td>
<td>Dianne Leishman</td>
<td>Christchurch Women's Hospital Private Bag 4711 Christchurch</td>
</tr>
<tr>
<td></td>
<td>Sonya Matthews</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midwives</td>
<td></td>
</tr>
<tr>
<td><strong>South Canterbury</strong></td>
<td>Teresa Back</td>
<td>Timaru Hospital Private Bag 911 Timaru 7940</td>
</tr>
<tr>
<td></td>
<td>Midwife</td>
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<td>Sheridan Massey</td>
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<td><strong>Southland</strong></td>
<td>Jenny Humphries</td>
<td>Southland Hospital PO Box 828 Invercargill 9840</td>
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