

Stillbirth

Clinical Care Standard

The *Stillbirth Clinical Care Standard* aims to reduce unwarranted clinical variation in the prevention and investigation of stillbirth and reduce the number of women experiencing stillbirth, especially after 28 weeks gestation. It also aims to support best practice in bereavement care for parents following any perinatal loss, and in the care provided to women when planning for, and during, subsequent pregnancies.

1 Stillbirth risk assessment before pregnancy

A woman intending pregnancy is offered pre-conception care that supports her to identify and manage stillbirth risks and improve her chance of giving birth to a healthy live-born baby.

Many women may not actively seek pre-conception care, even for a planned pregnancy. When providing care for women of reproductive age, consider opportunities to assess intentions about pregnancy. For example, the use of a simple question such as 'Would you like to become pregnant in the next year?' can encourage pre-conception care discussions.

If a woman is intending to become pregnant, discuss the importance of pre-conception health, and provide information and support, to optimise her health in preparation for pregnancy. Discuss with the woman that, although most pregnancies result in the birth of a healthy live-born baby, some women experience unexpected or adverse outcomes, including the small risk of stillbirth.

Assess the woman's risk of adverse pregnancy outcomes by considering recommendations for pre-conception risk assessment provided in relevant clinical guidelines such as the [*Guidelines for Preventive Activities in General Practice*](#), developed by the Royal Australian College of General Practitioners.

Discuss risk factors that are best managed before conception, including:

- Pre-existing maternal conditions such as diabetes or hypertension, especially if these are poorly controlled
- Maternal smoking and the risk of passive smoking through exposure to household or environmental sources
- Maternal alcohol consumption and recreational drug use
- Maternal mental health disorders
- Maternal substance use disorders
- High maternal body mass index
- Experiencing, or being at risk of, family violence.

Also, consider specific risk factors for stillbirth, including if the woman has had a previous stillbirth, complications during a past pregnancy (such as fetal growth restriction or pre-eclampsia), or has a history of congenital anomalies or genetic conditions. Where appropriate, discuss the suitability of genetic carrier screening for the woman and her partner, and offer referral for genetic counselling, if required.

Discuss the outcomes of the risk assessment with the woman and recommendations for the management of identified risks, including lifestyle changes, in a sensitive and supportive way. Provide appropriate referrals to support clinical management and facilitate access to support services, as appropriate. This should include offering the woman and her partner a referral to Quitline to support smoking cessation, if required.

Provide information in a way that meets the woman's health literacy, language and cultural needs. Document the outcome of discussions, including how any identified risks will be monitored and managed, in the woman's healthcare record.



Cultural safety and equity

Consider social and cultural factors that may limit a woman's access to pre-conception assessment and care, and personal biases that may influence the way you communicate with women about their care.

Discuss any identified risks with women using careful and sensitive language. Offer women access to an Aboriginal and Torres Strait Islander health worker or liaison officer, or a cross-cultural health worker to support discussions about pre-conception risk, in line with the woman's needs and preferences.

2 Stillbirth risk assessment during pregnancy

A woman's risk factors for stillbirth are identified early, monitored and managed with evidence-based care throughout her pregnancy. She is offered the most appropriate available model of maternity care for her clinical, personal and cultural needs.

Assess the likelihood of risk factors* for stillbirth as early as possible in the woman's pregnancy, and at each subsequent antenatal visit.

Fetal growth restriction is a key contributor to stillbirth. Assess the risk of fetal growth restriction as early as possible, and at each subsequent antenatal visit. Provide care as described in the [*Fetal Growth Restriction \(FGR\) Care Pathway*](#).

Discuss identified risk factors with the woman, using careful and sensitive language to minimise anxiety and provide reassurance, and address any questions or concerns that she may have.

Provide information to the woman about any further investigations, monitoring or referrals that may be recommended based on the outcome of the risk assessment. Where modifiable risks are identified, provide advice to the woman about evidence-based strategies that may reduce her risk and support ongoing management.

Document any identified risks in the woman's healthcare record, including details about any agreed treatments, investigations and referrals. With the woman's permission, communicate information about potential risks and their planned management to other clinicians involved in her care.

Models of care

Provide information to the woman about available maternity care models, and discuss her preferences for care in line with her level of risk, and personal and cultural needs.

The benefits of continuity of maternity carer should be recognised. Several models of care promote continuity, including those delivered by midwives, GPs and obstetricians. Where possible, all women should be offered access to models that allow continuity of carer, and access to an appropriate service for women with known risk factors for stillbirth should be prioritised.

For women who live in rural or remote areas, consider the use of telehealth services to enable access to care, where available and appropriate to the woman's clinical needs.



Cultural safety and equity

Use sensitive and culturally safe language when discussing potential stillbirth risks and management with women.

There is an increased (population-level) risk of stillbirth among Aboriginal and Torres Strait Islander women, and women from some migrant and refugee backgrounds. The reasons for this are complex and multifaceted, but may include language barriers; a lack of familiarity with, or distrust of, healthcare services; and systemic issues, such as the impacts of colonisation, racism and a lack of cultural safety within healthcare services on the ability of women to access care in line with their needs and preferences.

* Refer to the full clinical care standard for more detail.

Offer Aboriginal and Torres Strait Islander women access to culturally safe maternity care models, in line with the woman's preferences. This may include models of care offered through ACCHOs or AMSs, or models that allow continuity of carer with the involvement of an Aboriginal and Torres Strait Islander health worker or liaison officer to support the woman's care.

Midwifery continuity of carer models have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth, including Aboriginal and Torres Strait Islander women.

For women from migrant and refugee backgrounds, facilitate access to cross-cultural health workers to support improved access to care, where appropriate and in line with the woman's preferences.

Stillbirth rates are also higher among women who live in rural and remote areas, compared with metropolitan areas. Address potential barriers to care by considering the woman's options for care, including the suitability of accessing care via telehealth services, where appropriate.

3 Stillbirth awareness and strategies to reduce risk

Early in pregnancy, a woman is informed about stillbirth as a potential outcome. Throughout the pregnancy, she is supported to adopt strategies that may reduce her risk of stillbirth, including smoking cessation, using a side going-to-sleep position from 28 weeks gestation and being aware of fetal movements.

During pregnancy, provide antenatal care in line with the principles outlined in the [Clinical Practice Guidelines: Pregnancy Care](#).

Using careful and sensitive language, inform the woman about stillbirth as a possible pregnancy outcome. Explain that, although not every stillbirth can be prevented, there are strategies that may reduce the risk of stillbirth, including late-gestation losses (that is, after 28 weeks gestation).

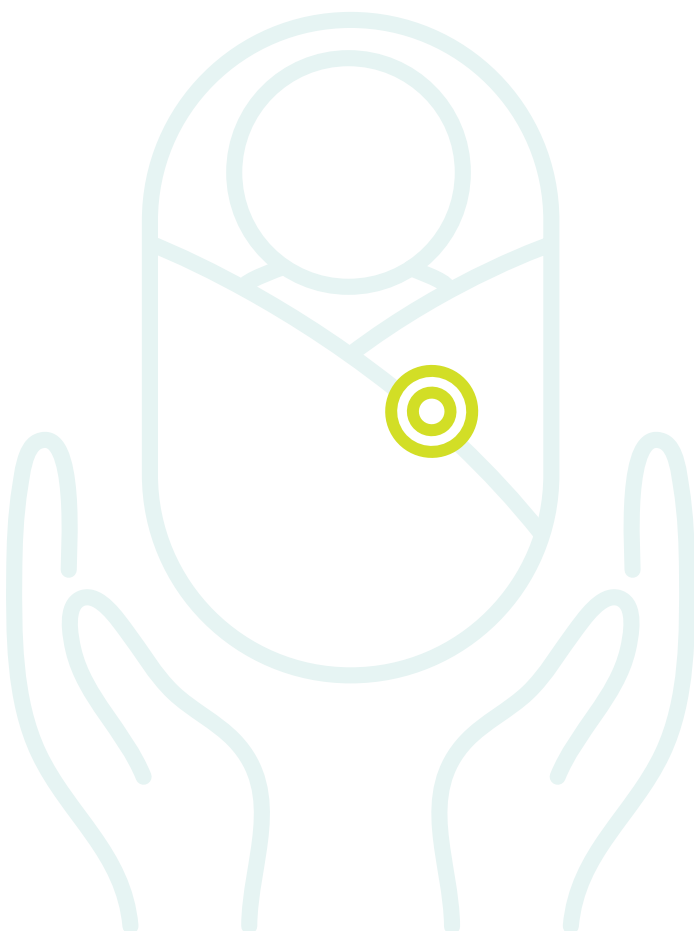
Provide verbal and written information to the woman about the strategies outlined below, and support her to adopt them, in line with her specific risks, and personal and cultural needs and preferences.

Smoking cessation

At the first antenatal visit, ask the woman about her smoking status, including her exposure to passive smoking through household or other environmental sources.

Support women who report that they smoke to stop smoking by using evidence-based approaches, such as the three-step 'Ask, Advise, Help' model, as outlined in *Supporting Smoking Cessation: A guide for health professionals*, and the [Smoking cessation care pathway](#). Offer the same advice and support to other smokers in the woman's household, whenever possible.

Explain the importance of smoking cessation and emphasise the benefits of quitting early in the pregnancy, as well as the risks of passive smoking. Discuss any concerns that the woman may have.



Provide information about available services to support the woman, her partner or household members to quit. Offer the woman and/or her partner **a referral to Quitline**. If they decline, provide smoking cessation resources and consider pharmacotherapy, such as nicotine replacement therapy, in line with the *Supporting Smoking Cessation During Pregnancy: Nicotine replacement therapy* guidelines.

Monitor the woman's smoking status at each antenatal visit, and offer access to further smoking cessation information or support services if required.

Side going-to-sleep position from 28 weeks' gestation

Provide information to the woman about the importance of going to sleep on her side from 28 weeks gestation. This should include any time the woman goes to sleep, including at night, daytime naps or returning to sleep after waking. Reassure her that it is normal to shift position when sleeping and that, if she wakes up on her back, not to be alarmed, and to settle back to sleep on her side if she is continuing her sleep.

This information should be provided to the woman by week 28 of pregnancy. The importance of going to sleep on her side should be discussed, and the woman's understanding of this information assessed, at every subsequent antenatal visit. The outcomes of these discussions should be documented in the woman's healthcare record.

Awareness of fetal movements

Between 20 and 27 weeks of pregnancy, provide the woman with verbal and written information about normal fetal movements.

Discuss the following points with the woman:

- Fetal movements are an important sign of fetal wellbeing
- Fetal movements will change as the fetus grows and develops
- Most women can detect fetal movements by 20 weeks gestation, and these movements should continue until the end of the pregnancy
- There is no set number or pattern of fetal movements – movements may differ between women, and between pregnancies
- Several factors, such as wake/sleep cycles, may affect a woman's perception of fetal movements.

Support the woman to become familiar with her fetal movements, and to understand what frequency, strength and pattern of movement is normal for her pregnancy. The use of 'kick charts' is not currently recommended as part of routine antenatal care. Encourage the woman to promptly seek advice if she has concerns about a change in her fetal movements.

At every subsequent antenatal visit, ask the woman about her fetal movements and record the information in her healthcare record. Remind the woman at each visit about the importance of fetal movement awareness, and assess and document her understanding of the information provided. Provide further information and support as required.



Cultural safety and equity

When discussing the risk of stillbirth with women and ways to reduce the risk, use careful and culturally sensitive language to minimise anxiety and provide reassurance. Where appropriate, involve an Aboriginal and Torres Strait Islander health worker or a cross-cultural health worker to support these discussions.

Offer Aboriginal and Torres Strait Islander women access to culturally appropriate smoking cessation services, in line with their needs and preferences.

4 **Ultrasound during pregnancy**

A woman is offered high-quality ultrasound during pregnancy to assess fetal growth and morphology, and identify stillbirth risks. Ultrasound performance and reporting, and communication of outcomes to the woman, are in line with current best-practice guidelines.

Early in pregnancy, discuss the importance of obstetric ultrasound with the woman. Optimally timed, high-quality ultrasound can help identify factors that may affect a woman's stillbirth risk, including the presence of a multiple pregnancy, chorionicity, the likelihood of fetal or chromosomal anomalies, and fetal growth restriction.

Discuss recommended obstetric ultrasounds with the woman, including the reasons for the ultrasounds, what they may reveal about her or her baby's health, and at what stage of pregnancy they are recommended. Provide verbal and written information

about these ultrasounds, in line with the woman's needs and preferences, and answer any questions she has. All women should be offered access to an interpreter, if required to support these discussions, and written information in their preferred language, where available.

Some women may choose to decline some, or all, recommended ultrasounds after considering the information provided, and their right to do so should be respected. Arrange for obstetric ultrasounds that the woman has agreed to, at the appropriate gestation.

Consider the woman's personal circumstances, including her financial situation, and whether she lives in a rural or remote setting and may need additional support to access recommended care.

Recommended obstetric ultrasounds that should be discussed with the woman, and their relevance to ascertaining stillbirth risk, are noted below.

Dating scan

- Primarily recommended for women who are uncertain of their conception date.
- Helps to ascertain gestational age, and the most appropriate time for other scans (for example, a nuchal translucency scan).
- Can identify the presence of a multiple pregnancy or chorionicity, which can affect stillbirth risk.

If undertaken, the dating scan is recommended between 8 weeks 0 days and 13 weeks 6 days of pregnancy.

Nuchal translucency scan

- Assesses the likelihood of aneuploidy, including trisomy 21 (responsible for Down syndrome), which may increase stillbirth risk.
- Should be offered to all women in combination with maternal plasma testing (combined first trimester screening), as this offers increased sensitivity for aneuploidy detection.
- Can ascertain gestational age, identify a multiple pregnancy, and assess chorionicity, for women who have not had a dating scan.
- Provides early anatomical assessment of the fetus, including for anomalies with high lethality (for example, anencephaly), and visualisation of structures including the placenta, amniotic fluid, cervix, uterus and adnexae.

If undertaken, the nuchal translucency scan is recommended between 12 weeks and 13 weeks 6 days of pregnancy. Maternal plasma testing is recommended between 9 weeks and 13 weeks 6 days of pregnancy.

Mid trimester fetal morphology scan

- Assesses fetal development and anatomy, and the position of the placenta.
- Can identify factors that can affect a woman's stillbirth risk, including the presence of fetal structural anomalies, placental length and placenta praevia.

The ultrasound is generally performed between 18 and 20 weeks of pregnancy, but may be offered up to 22 weeks in some circumstances. The timing of this ultrasound should ensure that, if structural anomalies are identified, women have time to consider termination within the time frames permitted in their state or territory. In some states and territories, access to termination after 20 weeks of pregnancy is highly restricted.

Screening for chromosomal anomalies

All women should be offered screening for common chromosomal anomalies such as trisomy 21. This can be undertaken through combined first trimester screening, a nuchal translucency scan alone, NIPT or second trimester maternal serum testing.

Women should be provided with information about the potential benefits, risks and costs of these options, and supported to make decisions that are in line with their needs and preferences.

Further obstetric ultrasound, including in the third trimester

Consider the need for increased obstetric ultrasound surveillance on an individual basis and according to clinical need, rather than as routine monitoring. Indications for further obstetric ultrasounds, including third trimester growth and wellbeing scans, may include:

- Clinical concerns about the risk of fetal growth restriction (for example, as outlined in the Fetal Growth Restriction (FGR) Care pathway*) or a small-for-gestational-age fetus
- Women for whom measurement of fundal height may be inaccurate (for example, high body mass index, large fibroids, polyhydramnios)

* Provide care as described in the [Fetal Growth Restriction \(FGR\) Care Pathway](#).

- A prenatal diagnosis of a genetic or structural anomaly
- Reassurance for women who have had a previous perinatal loss who request further ultrasounds for reassurance about fetal wellbeing.

Performing and reporting ultrasounds during pregnancy

Obstetric ultrasound should be performed by clinicians who have appropriate training and qualifications, and are working within their scope of practice. All referred obstetric ultrasounds, including dating, nuchal translucency and morphology scans, should be performed, interpreted and reported on by appropriately qualified clinicians, in line with the guidelines for the performance of [first](#), [second](#) and [third](#) trimester ultrasounds developed by the Australasian Society for Ultrasound in Medicine.

If a woman is being referred for an ultrasound examination, refer her to a service that meets these requirements. Consider social factors such as cost, language, remoteness of residence or distrust of mainstream health care that may be barriers to the woman accessing obstetric ultrasound, and facilitate access to an appropriate service.

If a woman has a history of stillbirth or other perinatal loss, ensure that this information is clearly communicated on any referrals for obstetric imaging. Offer all women the opportunity to have a partner or support person attend the ultrasound with them.

The woman should be advised of the results of her obstetric ultrasound. Offer all women access to an interpreter, when required, and to an Aboriginal and Torres Strait Islander health worker or cross-cultural health worker, where available and in line with the woman's preferences, to support these discussions. Note that some women may prefer to receive some, but not all, information about the findings of ultrasounds undertaken (for example, opting out of receiving information about an identified fetal anomaly if it is not life limiting), and care should be taken to respect these wishes.

A copy of the report for every ultrasound should be offered to the woman. At a minimum, key findings should be documented in her healthcare record and, with her permission, shared with other clinicians involved in her care – this includes clinicians providing care for Aboriginal and Torres Strait Islander women through ACCHOs and AMSs. If any concerns about the health or wellbeing of the fetus are identified, refer the

woman for further investigation and care, and provide information on how she can access relevant support in the interim.

Use clear and sensitive language to communicate with the woman regarding concerning or unexpected findings. Provide empathic care, in line with the recommendations in the *Parent-centred Communication in Obstetric Ultrasound Guidelines* developed by the Australasian Society for Ultrasound in Medicine.

5 Change in fetal movements

A woman who contacts her clinician or health service with concerns about a change in the frequency, strength or pattern of her baby's movements is offered timely assessment and care according to the Decreased Fetal Movement Care Pathway developed by the Centre of Research Excellence in Stillbirth and the Perinatal Society of Australia and New Zealand, or a locally approved alternative.

During pregnancy, support the woman to become familiar with her fetal movements. Let her know that she should seek clinical advice immediately if she notices any changes in the frequency, strength or pattern of fetal movements, particularly decreases in movement.

Explain that advice to attempt to stimulate the baby's movements (for example, by having something to eat or drink) is not correct. Emphasise that she should seek assistance without delay and that it is best to contact a clinician about any concerns, even if subsequent assessment confirms the baby's health and wellbeing.

Provide her with clear advice on how and where to present for further evaluation if required, including contact phone numbers. Consider options that will allow appropriate and timely assessment, especially for women in rural and remote areas who may have limited access to care. Discuss these options with the woman in advance, so that she is aware of how and when to seek assistance, if required.

When a woman presents with concerns about fetal movements, discuss her concerns and immediately assess the presence of fetal heart tones. All women should be offered access to professional interpreting services, when required, to support discussions about their assessment and care.

Note that a woman's concern about fetal movements is an important indicator, and should always be taken seriously.

Provide assessment and care according to the [Decreased Fetal Movement \(DFM\) Care Pathway](#), or a locally approved alternative. Provide or arrange urgent clinical review if fetal heart tones are difficult to determine.

If fetal heart tones are confirmed, consider further investigations to assess fetal wellbeing. These may include:

- CTG
- Taking a detailed history of fetal movements
- Using ultrasound to assess fetal growth and development
- Testing for fetomaternal haemorrhage, if indicated.

Discuss the findings of any investigations with the woman, and provide advice on further actions that may be needed. If induction of labour or caesarean section is being considered, careful consideration should be given to the potential risks and benefits of intervention. This information should be discussed with the woman to enable her to make informed decisions about timing of birth. Unless clinically indicated, birth should not be planned before 39 weeks gestation – for further information, see [Quality statement 6](#).

With the woman's permission, share the findings of these investigations with other clinicians involved in her care to ensure that any plans for ongoing care and support can be updated as appropriate.

If fetal heart tones are absent and fetal death is confirmed, communicate this to the woman promptly and sensitively, and provide appropriate care, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* and the *Parent-centred Communication in Obstetric Ultrasound Guidelines* developed by the Australasian Society for Ultrasound in Medicine.

6 Informed decision-making about timing of birth

A woman is provided with information that enables her to make informed decisions about timing of birth, in line with her individual risks and preferences. Whenever a planned birth is being considered, including when there are concerns about maternal or fetal health, the potential benefits and harms are discussed with the woman and documented appropriately.

While spontaneous onset of labour is generally preferred, a planned birth through induction or caesarean section may be considered if there are concerns about maternal or fetal health, including the risk of stillbirth.

Unless clinically indicated (that is, there is an identified increased risk to the health or wellbeing of the mother or fetus), birth should not be planned before 39 weeks gestation. A growing body of evidence supports the importance of the last few weeks leading up to 40 weeks of pregnancy for the health and developmental outcomes of babies, in the short and long term.

For some women, the risk of experiencing an adverse pregnancy outcome, such as stillbirth, may outweigh the potential adverse consequences of a planned birth before 39 weeks gestation.

The decision to have a planned birth to reduce the risk of stillbirth should be made according to the woman's individual risks and preferences. If a planned birth before 39 weeks gestation is being considered, provide verbal and written information to the woman about the possible benefits and harms for her and her baby. All women should be offered access to an interpreter, if required, to support any discussions about timing of birth.

When risk factors for stillbirth are identified early in pregnancy, discuss with the woman how these may affect decisions around timing of birth. Discuss the recommended timing of birth with the woman, and agree on a provisional timing of birth plan in line with her individual risks and preferences. Document the outcomes of the discussion in the woman's healthcare record, including any identified risk factors, how risk factors will be monitored, and the provisional timing of birth plan.

If the woman lives in a rural or remote area, consider and discuss how distance from health care may influence her needs and preferences regarding timing of birth.

Reassess every woman's stillbirth risk regularly, and again towards the end of pregnancy (at approximately 36 weeks gestation). Discuss with the woman any changes to her level of risk. If appropriate, consider the need for increased surveillance – this may include:

- Weekly antenatal visits, with careful inquiry about fetal movements
- Fetal heart rate assessment by CTG, weekly or every second week
- Serial ultrasound assessment.

If further monitoring is recommended, discuss with the woman how this may help inform decisions about timing of birth and guide revisions to the provisional birth plan.

The risk of stillbirth increases for prolonged or post-term pregnancies (that is, ≥ 42 weeks gestation), and measures to assess fetal wellbeing in the preterm period (for example, fetal biometry, blood flow, heart rate) may not be predictive of stillbirth risk. Where appropriate towards 39 to 40 weeks of pregnancy, discuss these risks with the woman, and considerations for a planned birth to reduce her risk. Provide verbal and written information to the woman about the potential benefits and risks of a planned birth in this context.

Document the outcomes of discussions in the woman's healthcare record, including changes to her level of risk, any further monitoring that is recommended, and any revisions the woman chooses to make to her provisional birth plan. Ensure that the reasons for a planned birth at any stage of pregnancy are clearly documented in the woman's healthcare record.

7 Discussing investigations for stillbirth

When a stillbirth is diagnosed, the availability, timing and anticipated value of clinical investigations, including autopsy, are discussed with the parents. The parents are supported to share their views about factors they perceive may have contributed to the stillbirth, including aspects of the woman's clinical care. This information is documented and considered alongside the agreed clinical investigations, and as part of local perinatal mortality audit or incident investigation processes.

Discuss with the parents the availability of clinical investigations to help identify factors that may have contributed to the stillbirth. Recognise that this discussion is likely to occur at an acute time of loss and emotional distress for the parents and their support people.

Decisions about the timing of this discussion should take into consideration when the stillbirth was diagnosed, and the parents' emotional and personal needs and preferences, while acknowledging the time-sensitive nature of some investigations.

The discussion should be led by a senior clinician who has established rapport with the parents, and care should be taken to ensure that information is conveyed in a clear, respectful and empathic way. Many parents value having more than one conversation about stillbirth investigations, allowing sufficient time between discussions for them to adequately consider the options offered – every effort should be made to accommodate these preferences.

Discuss with the parents and their support people:

- That investigations will only be performed with their consent
- What the investigations involve
- What information is expected from the investigations
- Where the investigations will take place and arrangements for transporting their baby if required
- How long until the results are likely to become available
- Who to contact if they have any questions or concerns
- That they can change their mind about proceeding with any investigation they have agreed to, up until the time it takes place.

Explain that the results from the investigations may help with the woman's future care, by either identifying factors that caused or contributed to the stillbirth, or ruling factors out. Advise that results of investigations may be inconclusive, and that sometimes a cause for the baby's death is not found. Some families might find it helpful to know that investigation results may help with further research about stillbirth, and potentially help reduce stillbirth rates in Australia.

Recognise the diverse beliefs and practices that may be important to women and their families after a stillbirth. Ask the parents about their personal, cultural or religious needs and preferences relating to any clinical investigations, and seek further guidance, where appropriate. Where remoteness of residence and travel distance may be a limiting factor for parents, discuss this in the context of the parents' preferences.

Provide written or electronic information to supplement and support discussions about clinical investigations, and to encourage shared decision making. Ensure that parents are given the time they need to consider and make decisions about the clinical investigations discussed with them.

Ensure that the parents and their support people are given the opportunity to share their views on factors they perceive may have contributed to the stillbirth, including any aspects of the woman's pregnancy care, and document the outcomes of this discussion. This information should complement the clinical investigations agreed to by the parents and inform discussions that occur as part of local perinatal mortality audit, and, where appropriate, incident investigation and management processes.

Care should be taken to ensure that parents are able to discuss their views in an environment that is safe, respectful and judgement-free, and that clinicians engage in these discussions sensitively to prevent any perception that the parents are to blame for the death of their baby. Advise the parents that the discussion does not need to occur immediately, and can take place at a later time when they feel ready and comfortable to share their views. Parents should also be offered the opportunity to have this discussion with another clinician, if they do not feel comfortable sharing this information with the clinicians who were directly involved in their care. Parents should also be offered to involve the support people of their choosing in these discussions.

Clinical investigations

Clinical investigations after stillbirth should be performed in line with recommendations from the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*, and the [Stillbirth Investigations Flowchart](#).

Assure the parents that their baby will always be treated with care and respect, regardless of the investigations performed. Explain to them that they will have the opportunity to see and spend time with their baby before and after investigations are completed, if they would like to do so.

The following core investigations should be recommended for all stillbirths:

- Comprehensive maternal and pregnancy history
- Kleihauer–Betke test or flow cytometry
- External examination of the baby by an appropriately trained clinician
- Clinical photographs of the baby
- Autopsy (unless a definitive cause of death has been established, for example through antenatal genetic testing)
- Full body X-ray imaging of the baby (also known as a 'babygram')
- Examination of the placenta and cord at birth by the attending clinician
- Histopathology of the umbilical cord and placenta
- Cytogenetic testing (chromosomal microarray (CMA) or karyotype if CMA is not available).

Address any questions that the parents may have about these investigations. Explain that they can choose to proceed with all, some or none of the recommended investigations, depending on their preferences.

If the parents choose not to proceed with a full autopsy, discuss other appropriate options. These may include a partial autopsy; a minimally invasive autopsy; examination of the placenta and umbilical cord alone; or other suitable investigations such as X-ray, ultrasound or MRI, where available.



Cultural safety and equity

Recognise the diverse personal, cultural and religious beliefs and practices that are important to women and their families following stillbirth, which may influence their decisions about the clinical investigations offered.

Ensure that discussions about stillbirth investigations are carried out in a sensitive and culturally safe manner that recognises these diverse perspectives, to help address parents' needs and support informed decision making. Where appropriate, offer access to an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker, and relevant spiritual or religious support people, to help facilitate these discussions.

Assumptions should not be made about the woman's preferences on the basis of her culture, religion or ethnicity – rather, discussions about stillbirth investigations should seek to identify the woman's individual perspectives, and support informed decision-making in line with her needs and preferences.

8 Reporting, documenting and communicating stillbirth investigation results

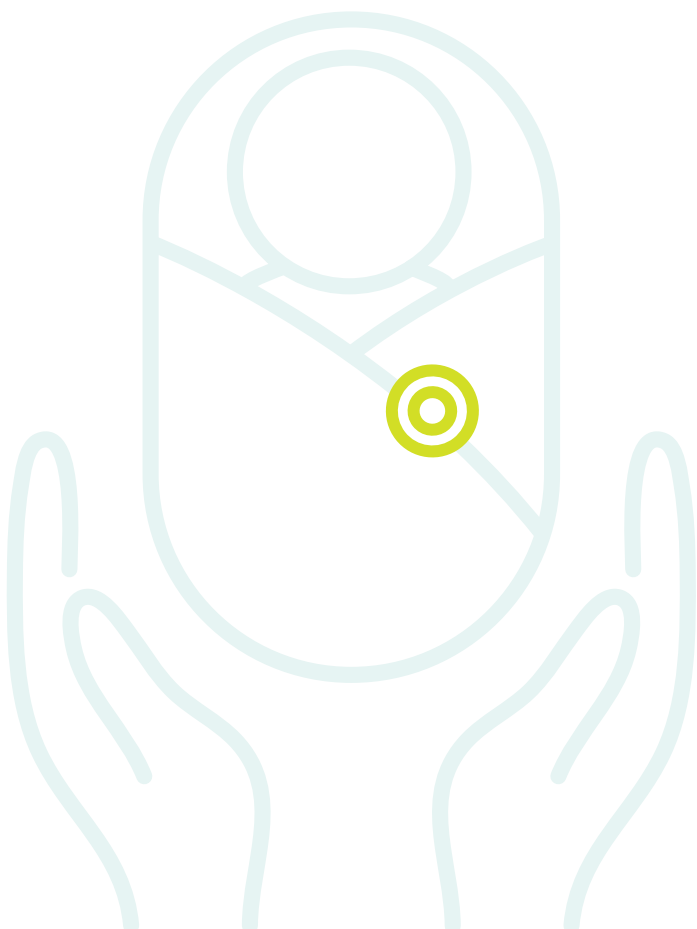
The results of stillbirth investigations are reported in a timely manner, documented appropriately and discussed with the parents, along with any information they have provided about perceived contributing factors. The stillbirth is reviewed as part of a local perinatal mortality audit process, classified according to the Perinatal Society of Australia and New Zealand classification system, and outcomes are used to inform local improvements in care.

Arrange a time with the parents to discuss clinical investigation results as soon as these are available. Inform the parents that the results of some investigations may become available before others, and that more than one meeting may be required to discuss all results. The discussion should be led by a senior clinician who has an established rapport with the family. It should consider the parents' views on factors they perceive may have contributed to the baby's death.

Care should be taken to discuss results with parents in an empathic, sensitive and culturally safe manner. The parents should be offered access to an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker and/or interpreter to support the discussion, where appropriate.

Discuss with the parents the results of any investigations undertaken, including whether any causes for the baby's death were identified and relevant recommendations for future pregnancy planning. If further consultation or investigation is needed, discuss this with the parents and arrange referrals as required. Where appropriate, this should include the option of accessing care via telehealth, especially for parents who live in rural or remote areas that may have limited access to the required clinical expertise.

Provide the parents with a copy of the results of any investigations, and a plain-language summary that outlines any recommendations for future care. Document this information, including the outcomes of the discussion with the parents, in the woman's healthcare record.



Every stillbirth should be reviewed as part of a formal perinatal mortality audit process. The PSANZ Classification System for Stillbirths and Neonatal Deaths should be used to assign a cause of death and any associated conditions for the stillbirth. As part of the audit meeting, the circumstances surrounding the stillbirth, including aspects of the woman's clinical care that may have contributed to the death and their significance, and information provided by the parents about potential contributors to the loss, should be considered to identify areas for practice improvement. These factors should be assessed using the Australian Perinatal Mortality Audit Tool or equivalent local tool. Outcomes should be documented, including recommendations for actions to address identified problems, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*.

If any aspects of the woman's clinical care were identified as potential contributors to the baby's death, engage in open disclosure with the family. This should include issuing the parents with an apology, providing them with an opportunity to share their views on what happened, and explaining to them how the incident happened and what preventive measures are being taken.

With the parents' permission, ensure that a comprehensive clinical summary, including the results of any investigations and relevant recommendations, including implications for future pregnancy planning, are shared promptly with other clinicians involved in the woman's care, including her GP and/or clinicians providing care for the woman through an ACCHO or AMS.

9 Bereavement care and support after perinatal loss

After a perinatal loss, parents and their support people are provided with compassionate, respectful and culturally safe bereavement care that recognises their specific needs and preferences, and ensures that follow-up support is available after discharge.

The death of a baby is a traumatic experience for parents, their families and support people, and the clinicians involved in their care. This is regardless of when the death occurs or the reasons for the loss.

Following diagnosis of an intrauterine fetal death or when a perinatal loss occurs, provide respectful, culturally safe and evidence-based bereavement care, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* and *Sands Australian Principles of Bereavement Care*. Parents should also be provided with bereavement care and support during pregnancy and birth when the fetus has been diagnosed with a life-limiting condition.

If a fetal death has been diagnosed in utero and the woman is not already in labour, provide information to the woman about her options for giving birth, and their potential risks and benefits – this should include a discussion about available options for pain relief during labour and birth.

Recognise the diverse beliefs and practices that may be important to women after a perinatal loss. Ask the woman about her personal, cultural, religious or spiritual needs and preferences during this time, and seek further guidance, where appropriate.

After giving birth

The following should be offered to parents who have experienced a perinatal loss:

- Verbal and written information about care that meets their health literacy, language and cultural needs
- The involvement of an interpreter, Aboriginal and Torres Strait Islander health worker or liaison officer, or cross-cultural health worker, where appropriate
- A location for care that is private, quiet, and separate from other mothers and newborn babies, if possible
- Strategies to enable members of the workforce (both clinical and non-clinical) who are interacting with the family in the hospital to recognise that the parents have experienced a perinatal loss, such as using a discreet symbol on the woman's room and in her healthcare record
- The chance for them and their family or support people to spend as much time as possible with their baby in private, and consideration of available options to facilitate taking their baby home
- Opportunities to make mementos, such as taking photos, keeping a lock of the baby's hair, or making impressions of the baby's handprints and footprints.

Support the woman to make shared decisions about the care she receives, and encourage the involvement of her partner or other support people in decision-making, if she prefers.

Physical and mental wellbeing after perinatal loss

Provide information to the woman about, and discuss ways to support, her physical recovery after giving birth, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*. This may include offering advice and support relating to lactation, vaginal bleeding, wound care and physical activity.

Discuss with the parents the potential mental health impacts of experiencing a perinatal loss. Explain that, although it is normal to feel grief and sadness after the loss, for some parents, these feelings can become worse over time, and mental health issues such as anxiety and depression may arise. Acknowledge that the experience of perinatal loss can be equally challenging for the parents' other family members (for example, grandparents, siblings) and support people. Where appropriate, discuss the availability of relevant

support services for the parents and their family, including the option of referral to clinicians with specific training in perinatal bereavement care (for example, psychologists, qualified social workers).

Support for parents after discharge

Provide the parents with the details of a contact person at the hospital, such as a bereavement care coordinator, who can be contacted should the parents require follow-up support after discharge, especially within the first 24 hours. Also provide written information about ongoing support services, including telephone, online and face-to-face services.

Offer the woman a follow-up review meeting within 12 weeks of the baby's death. Give her clear verbal and written details of the appointment time and what the meeting is expected to involve. Discuss other opportunities for ongoing support, depending on the parents' needs and preferences.

GPs and other primary care clinicians will provide health care to the woman after discharge. With the woman's agreement, promptly inform these clinicians of the baby's death so that appropriate follow-up can be arranged. Ensure that relevant information about the nature of the loss and the woman's ongoing care needs is recorded in the woman's discharge summary.

Offer and arrange for post-discharge care appropriate to the woman's needs and preferences, such as referral to:

- The GP or other primary care clinician who will provide ongoing care
- Parent support organisations and programs
- A counsellor or qualified social worker with expertise or experience in perinatal bereavement care
- A psychologist or psychiatrist, especially if the woman is assessed as having pre-existing mental health risk factors.

For parents who live in rural and remote areas, consider the use of telehealth services to enable access to appropriate clinical and psychosocial expertise following a perinatal loss, where available and in line with the parents' needs.

Support for clinicians

The death of a baby can be a devastating and difficult experience, not only for the parents and their support people, but also for the clinicians involved in their care. Your healthcare service should support you to deliver this care, by providing opportunities for bereavement care training, formal and informal debriefing, clinical supervision and access to mental health services, when required.



Cultural safety and equity

Women may have diverse belief systems and important religious or cultural rituals or practices that need to be performed after perinatal loss. Many women may prefer to involve other family members or support people when making decisions about her care during this time. It is important to always ask women about their needs and preferences during this time and not make assumptions about the care they require.

Some Aboriginal and Torres Strait Islander women will participate in a range of cultural practices and protocols associated with the passing away of a family member – this is called ‘sorry business’. During this time, it may be important for women to have the support of their extended family, who may or may not be blood relatives, as they grieve the loss of their baby. If a woman has given birth away from her community or Country, she may prioritise early discharge to return to her home so that she can access this support.

Recognise that some aspects of care offered after perinatal loss that are acceptable in one culture may be considered offensive in other cultures. This may include use of the term ‘death’, referring to the baby using his or her name, creating mementos (for example, cot cards, photographs with the baby) or making eye contact with the woman and asking her questions directly.

Offer access to an Aboriginal and Torres Strait Islander health worker or liaison officer, a cross-cultural health worker and an interpreter, if required, to facilitate discussions with women and their families after perinatal loss, and support the provision of respectful and culturally safe bereavement care. Note that some women may be more comfortable with a female interpreter – every effort should be made to accommodate such preferences.

ACCHOs and AMSs play an important role in providing Aboriginal and Torres Strait Islander women with access to relevant support after discharge, especially in rural and remote areas. If the woman’s usual care provider is based in an ACCHO or AMS, offer to contact them to advise that the woman is being discharged and discuss suitable support arrangements. Alternatively, facilitate referral to a relevant service to support ongoing care, in line with the woman’s needs and preferences.

10 Subsequent pregnancy care after perinatal loss

During a subsequent pregnancy after a perinatal loss, a woman receives antenatal care that recognises factors that may have contributed to the previous loss, and ensures that she has access to appropriate clinical expertise and psychosocial support, as required.

Women who have experienced a perinatal loss may be at increased risk of adverse outcomes during a subsequent pregnancy.

For women planning a pregnancy after a perinatal loss, provide pre-conception care as described in [Quality statement 1](#). During a subsequent pregnancy, provide sensitive and informed antenatal care, delivered by an experienced clinician or multidisciplinary team.

The benefits of continuity of carer should be considered and discussed with the parents. Studies show that, in a subsequent pregnancy following perinatal loss, access to models that offer continuity of carer allows women to develop supportive and trusting relationships with their clinicians, and may assist them to feel more involved in planning their care. Ask the parents about their preferences for care; where possible and appropriate, prioritise offering access to a suitable model that offers continuity of carer, in line with the woman’s personal and cultural needs. This should include facilitating access to culturally safe models of care for Aboriginal and Torres Strait Islander women, and enlisting the support of an Aboriginal and Torres Strait Islander health worker or liaison officer, or cross-cultural health worker, if required.

The clinician providing maternity care should work in partnership with parents to create an individualised care plan that considers the causes and circumstances of their previous loss, and their personal needs and preferences. Obtain a complete history of the previous

loss and seek access to the medical records if care was provided elsewhere and specialised advice if required. Consider any extra tests or monitoring that may be needed and discuss these with the woman. These may include:

- More frequent ultrasound, to assess fetal growth and detect complications for women with a history of stillbirth
- Aneuploidy testing for women with a history of a perinatal loss due to congenital anomaly
- Cervical length screening between 16 and 24 weeks of pregnancy for women with a history of spontaneous preterm birth, in addition to a mid trimester fetal morphology scan.

Where the cause for the previous loss is known and modifiable, start appropriate treatment to minimise the risk of recurrence. Examples include:

- Low-dose aspirin for women at risk for placental insufficiency
- Folic acid supplementation for women with a history of a perinatal loss due to neural tube defects
- Progesterone for women with a history of spontaneous preterm birth.

Parents and their support people often experience intense worry and fear, and complex emotional responses during a subsequent pregnancy. Provide care that is considerate and empathic, and let the parents and their support people know who they can contact if they have concerns. Encourage them to express their thoughts and to ask questions throughout the pregnancy. Should concerns emerge during the pregnancy, provide timely access to clinical care to allow prompt assessment and reassurance. If specialised support is needed, refer to appropriate clinical and psychosocial support services.

Where appropriate, clinicians should facilitate access to clinical and psychosocial care via telehealth, especially for parents who live in rural or remote areas and may have limited access to the care they require.

Discuss any relevant information with the parents using language that is in line with their health literacy, language, and cultural and spiritual needs. Enable access to an interpreter, Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker or other supports, in line with the parents' needs.



Cultural safety and equity

Offer Aboriginal and Torres Strait Islander women access to culturally safe maternity care models, in line with the woman's preferences. These include models of care offered through ACCHOs or AMSs, or models that offer continuity of carer with the involvement of an Aboriginal and Torres Strait Islander health worker to support the woman's care.

Models that offer continuity of carer have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth, including Aboriginal and Torres Strait Islander women.

For women from migrant and refugee backgrounds, facilitate access to cross-cultural health workers to support care, where appropriate and in line with the woman's preferences.

Questions?



Find out more about the *Stillbirth Clinical Care Standard* and other resources. Scan the QR code or use the link safetyandquality.gov.au/stillbirth-ccs.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.