



**Report of the
ACT Perinatal Mortality Committee**

**Perinatal Mortality in the ACT
2006-2010**

**Health Series
Number 61**

**Epidemiology Section
Health Improvement Branch
Population Health Division**

November 2013

ACKNOWLEDGEMENTS

The report authors, A/Prof Alison Kent and Louise Freebairn, would like to acknowledge the contribution of other ACT Perinatal Mortality Committee members: Prof David Ellwood, Prof Jane Dahlstrom, RM Elizabeth Bishop, RM Diana Wing and RM Dianne Deer. We wish to farewell Prof David Ellwood who has taken up a position interstate, his valuable experience and knowledge in perinatal medicine along with his unwavering drive to provide high quality perinatal care and reduce perinatal morbidity and mortality will be greatly missed.

Thanks also to the midwives who provided information for this report by completing the ACT Perinatal Death Forms.



ISSN 1325-1090

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Produced for ACT Health by the Epidemiology Section and printed by Communications and Marketing Unit on recycled paper. Publications in the Health Series can be accessed from the ACT Health Internet Homepage by using the link to publications and ACT Health publications index.

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Suggested citation:

ACT Health (2013). Perinatal Mortality in the ACT 2006-10, ACT Government, Canberra ACT.

Publication No: 13/1381

ACT Government telephone: Canberra 13ACT1 or 132281. Homepage at <http://www.act.gov.au>

CHAIRPERSON'S REPORT

We are pleased to produce the second report from the ACT Perinatal Mortality Committee (ACT PMC), and I would like to thank the members for their ongoing participation and enthusiasm. The Committee meets two to three times per year and now reports to the ACT Health Quality and Safety Committee each year, previously the ACT Clinical Audit Committee.

The ACT PMC developed from a few enthusiastic clinicians in 2002 who recognised the importance of collecting perinatal mortality data to allow accurate reporting and comparisons of perinatal deaths within the ACT and nationally. The committee now consists of a maternal-fetal medicine specialist, pathologist, neonatologist, representative midwives from each hospital in the Territory and a representative from the Epidemiology Section, Health Improvement Branch.

The ACT PMC classifies all perinatal deaths in the ACT using the Perinatal Society of Australia and New Zealand - Perinatal Death Classification (PSANZ-PDC) and the Perinatal Society of Australia and New Zealand - Neonatal Death Classification (PSANZ-NDC) (APPENDIX C). The majority of members are active in the Perinatal Society of Australia and New Zealand (PSANZ) Perinatal Mortality Special Interest Group, which continues to refine these classifications and implement their use throughout Australia.

As the ACT is a small territory, the ACT PMC has the ability to review all perinatal deaths within the ACT and classify them according to the PSANZ classification systems. Due to the small number of deaths, a five-year report is felt to be the most appropriate timeframe to examine perinatal deaths in the Territory.

I would like to acknowledge and thank the staff of the ACT Health's Epidemiology Section for their ongoing support in producing this report and assistance in maintaining the perinatal mortality database.

Associate Professor Alison Kent
Chairperson, ACT Perinatal Mortality Committee

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACT CAC	ACT Clinical Audit Committee
ACT MPDC	ACT Maternal and Perinatal Data Collection
ACT PMC	ACT Perinatal Mortality Committee
AIHW	Australian Institute of Health and Welfare
ANU	Australian National University
ANZ	Australian and New Zealand
CI	Confidence Interval
Dept	Department
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian modification
NSW	New South Wales
PSANZ	Perinatal Society of Australia and New Zealand
PSANZ-NDC	Perinatal Society of Australia and New Zealand - Neonatal Death Classification
PSANZ-PDC	Perinatal Society of Australia and New Zealand - Perinatal Death Classification
PSANZ-PMC	Perinatal Society of Australia and New Zealand - Perinatal Mortality Classification
RM	Registered midwife
SPSS	Statistical Program for Social Scientists
TOP	Terminations of Pregnancy
WHO	World Health Organization

1. EXECUTIVE SUMMARY

During the period 2006 to 2010, there were 377 perinatal deaths, of which 250 (66.3%) were for ACT residents. The ACT resident perinatal mortality rate was 10.5 per 1,000 total births. The ACT resident fetal death rate was 7.9 per 1,000 total births and the ACT resident neonatal mortality rate 2.6 per 1,000 live births.

It is important to note that perinatal mortality rates in the ACT fluctuate from year to year due to the small number of these deaths each year. With such small numbers a single event, for example the fetal or neonatal death of triplets, can substantially elevate mortality rates.

The main cause of perinatal death was congenital abnormality (21.6%). Spontaneous preterm birth was the next most common cause accounting for 17.6% of perinatal deaths. Specific perinatal conditions accounted for 16% of perinatal deaths. Fetal growth restriction and unexplained antepartum death each accounted for 14% of perinatal deaths.

The most common cause of fetal death was congenital abnormality (20.2%). Unexplained antepartum death accounted for 18.6% of fetal deaths and specific perinatal conditions accounted for 18.1% of fetal deaths. The most common causes of neonatal death were spontaneous preterm birth (38.7%) and congenital abnormality (25.8%).

Preterm delivery (less than 37 weeks gestation) occurred in 7.0% of all births, and 76.8% of perinatal deaths. Extreme prematurity (less than 28 weeks gestation) occurred in 57.6% of perinatal deaths, but only 0.8% of all births.

Multiple births accounted for 10.8% of all perinatal deaths. The perinatal mortality rate for multiple births was 33.6 per 1,000 births in comparison to 9.7 per 1,000 singleton births. The number of perinatal deaths associated with Twin to Twin Transfusion Syndrome has reduced from 12 cases in the 2001-2005 report to a single case in this report.

Perinatal mortality and fetal death rates for women aged 40 years or more were significantly higher than the rates for women aged 20 to 39 years.

The rate of perinatal autopsy for the ACT for 2006-2010 was 53.5%. Although this rate compares favourably with other states of Australia, it continues to be lower than the 75% recommended by the Royal College of Obstetricians and Gynaecologists and the Royal College of Pathologists.

There were no significant differences between fetal death rates and perinatal mortality rates for the ACT and Australia between 2006 and 2010 for either the annual rates or for the five-year combined rates. However, statistical testing between the main causes of perinatal deaths between Australia and the ACT showed that the ACT rate for maternal conditions was significantly lower than the Australian rate and the ACT rate for specific perinatal conditions and fetal growth restriction were significantly higher than the Australian rate.

2. RECOMMENDATIONS

2.1 Congenital abnormalities

The ACT continues to maintain data on congenital abnormalities as a cause of perinatal death, and supports the development of a nation-wide register and epidemiological investigation of congenital anomalies to enable state and territory comparisons.

2.2 Unexplained antepartum death and fetal growth restriction

Unexplained antepartum death causes significant anguish to families, and the ACT should continue to encourage research into the causes of unexplained antepartum death.

Unidentified fetal growth restriction continues to be a significant factor in perinatal deaths. The rate of perinatal deaths due to fetal growth restriction was significantly higher in the ACT compared with Australia, this may be a reflection of more accurate post-event reporting. However, improved clinical education and research into reducing unidentified fetal growth restriction has the potential to reduce perinatal deaths.

2.3 Perinatal autopsy

A high perinatal autopsy rate improves the accuracy of classification of causes of perinatal deaths, as well as the information provided to parents. All parents should be offered the option of an autopsy following a perinatal death. Adequate explanations and written material should be available to assist them with this decision.

All clinical staff involved in perinatal care should be aware of the value of perinatal autopsy.

Clinical practice guidelines for perinatal autopsy and audit should be available for all perinatal clinical care providers. Access to educational material such as the IMPROVE (Improving Perinatal Mortality Review & Outcomes Via Education) course should be encouraged for all staff involved in perinatal care.

ACT Health must ensure that a high standard of perinatal autopsy is always available and should strive to achieve high autopsy rates with results being available within six to eight weeks. This enables appropriate counselling to be provided to parents and a high standard of perinatal audit conducted. An audit of the time to provide autopsy results may be useful to indicate service improvement or provision required in this area.

2.4 General recommendations

ACT Health is encouraged to provide data administration support to the ACT PMC and to incorporate collection of perinatal data electronically in order to improve data quality.

3. INTRODUCTION

This is the second report of the ACT Perinatal Mortality Committee (ACT PMC), which was established in 2002. This report reviews data on perinatal mortality in the ACT for the years 2006 to 2010.

Perinatal mortality rates are an indicator of the health status of a given population. The rate of perinatal deaths reflects the risk in the population of a fetus being stillborn or not surviving beyond 28 days of life.

3.1 Purpose of the ACT Perinatal Mortality Committee

To provide advice to ACT Health, through the ACT Health Quality and Safety Committee (previously the ACT Clinical Audit Committee), on matters that relate to perinatal mortality in the ACT each year.

3.2 Terms of reference

This committee is a sub-committee of the ACT Maternal Perinatal Information Network Committee.

The membership should consist of:

- An obstetrician with involvement in high-risk pregnancy and fetal medicine;
- A pathologist with involvement in perinatal pathology;
- A neonatologist;
- Midwifery representatives from all delivery campuses;
- Epidemiology Section representative; and
- Any other members the committee feels are appropriate.

The role of the committee is to:

- Review all perinatal deaths within the ACT;
- Classify all deaths according to the PSANZ classification system;
- Provide an annual report to ACT Health Quality and Safety Committee; and
- Provide a five-year public health report for the ACT on perinatal mortality.

3.3 Provision of data for statistical and research purposes

The ACT PMC has collected information on all perinatal deaths in the ACT from 20 weeks gestation since 2001. The Committee is able to release information from the database provided that it does not endanger the confidentiality of families.

ACT Health generally does not publish tables with less than five individuals in each category. However, due to the small number of perinatal deaths each year in the ACT, permission was sought and granted from the ACT Chief Health Officer to publish tables with small numbers in this report.

The Committee reviews all requests for information. Formal research projects must conform to the National Health and Medical Research Council Guidelines, and be approved by the ACT Human Research Ethics Committee.

3.4 Membership

Membership of the ACT Perinatal Mortality Committee

Assoc. Professor Alison Kent (Chairperson)	Dept of Neonatology, Canberra Hospital, Australian National University
Ms Louise Freebairn	Epidemiology Section, ACT Health
Professor Jane Dahlstrom	Dept of Anatomical Pathology, Canberra Hospital, Australian National University
Professor David Ellwood	Professor of Obstetrics and Gynaecology, Canberra Hospital, Australian National University
RM Dianne Deer	Clinical Nurse Consultant, Calvary John James Hospital
RM Diana Wing	Clinical Nurse Consultant, Canberra Hospital
RM Elizabeth Bishop	Clinical Nurse Consultant, Calvary Hospital Bruce

4. METHODS

4.1 Scope

There are four hospitals (two public and two private) in the ACT providing maternity services to ACT residents and residents of the surrounding regions of NSW. During 2006-10, 16.3% of babies born in the ACT were not usual residents of the ACT. Many of these babies were those of women who were referred to ACT hospitals for tertiary level maternal and neonatal care at the Canberra Hospital during high-risk pregnancies and births.

This is reflected in the percentage of perinatal deaths for babies of women who are not ACT residents. During 2006 to 2010, one third (33.7%) of perinatal deaths that occurred in the ACT were for non-ACT residents (Table 1).

Perinatal deaths for both ACT and non-ACT residents are routinely monitored and reviewed. Each hospital performs their own morbidity and mortality review of perinatal deaths. A confidential form is completed on each perinatal death in the ACT and forwarded to the ACT Perinatal Mortality Committee (ACT PMC). An annual presentation is made to ACT Health Quality and Safety Committee of perinatal deaths and recommendations are implemented as required.

Table 1: Perinatal deaths by state of residence, ACT, 2001-10

		Fetal death		Neonatal death		Perinatal death	
		No.	%	No.	%	No.	%
2001 to 2005	ACT residents	154	75.5	63	53.8	217	67.6
	Non ACT residents	50	24.5	54	46.2	104	32.4
	Total	204	100.0	117	100.0	321	100.0
2006 to 2010	ACT residents	188	72.3	62	53.0	250	66.3
	Non ACT residents	72	27.7	55	47.0	127	33.7
	Total	260	100.0	117	100.0	377	100.0

Source: ACT Perinatal Deaths Data Collection, ACT Health

Note: Annual data are presented in Table 20.

This report includes perinatal deaths for babies of ACT residents where the birth occurred in the ACT. It does not include ACT residents who gave birth outside the ACT; however this number is small each year. For example, during 2010 only 69 of the 4,969 ACT resident women who gave birth did so in other jurisdictions (1.4%).¹

Residents from other jurisdictions have been excluded to allow population based analysis.

4.2 Clinical classification

All perinatal deaths are classified according to the primary cause of death using the Perinatal Society of Australia and New Zealand - Perinatal Death Classification (PSANZ-PDC)¹ and the Perinatal Society of Australia and New Zealand - Neonatal Death Classification (PSANZ-NDC). The use of this system allows comparison of perinatal deaths across Australia, ensuring that the aetiology of perinatal deaths is considered, identification of potential preventable factors occurs, and possible areas of research in perinatal mortality are identified.

4.3 Data collection

The major source of data is the ACT Confidential Report on Perinatal Death Forms (Appendix B), which includes placental pathology and autopsy details. Data is cross-referenced with that from the ACT Maternal Perinatal Data Collection, the ACT Admitted Patient Care data collection and the ACT Australian Bureau of Statistics (ABS) deaths data when available.

All perinatal deaths occurring at The Canberra Hospital have forms completed by the Chairperson of the ACT Perinatal Mortality Committee. For perinatal deaths occurring at the other ACT hospitals, the forms are completed by the midwifery representatives or a designated person and sent to the Chairperson of the Perinatal Mortality Committee. The committee meets twice yearly to review and classify all cases.

The ACT Maternal and Perinatal Data Collection (ACT MPDC) collects information and reports on live births and fetal deaths of at least 20 weeks gestation or at least 400 grams in birthweight in the ACT. Data are collected on births that occur in hospitals, birth centres and in the community. These data are validated against the ACT Admitted Patient Care Data Collection and ABS Deaths data to ensure quality and completeness. The ACT MPDC is provided to the National Perinatal Data Collection for national reporting.

The ABS perinatal death data includes perinatal deaths registered with Birth, Deaths and Marriages in each of the states and territories in Australia. These data are reported annually by the ABS by the mother's usual state of residence. The ABS no longer publishes perinatal deaths separately for the ACT.

4.4 Statistical analysis

The analysis for this report was conducted using an SPSS 18.0 syntax file. Mortality rates and confidence intervals were calculated in Excel 2007.

Results described as statistically significant are significant at the $p < 0.05$ level and where appropriate, confidence intervals are included in the report. A confidence interval is a computed interval with a given probability (95% in this report) that the true value of a statistic, such as a rate, mean or proportion is contained within the interval. When the confidence intervals of two estimated values do not overlap, the values are statistically different.

Differences between means (averages) were assessed using t-tests. The t-test assesses whether the means of two groups are statistically different from each other. Results were evaluated at the $p < 0.05$ level.

Due to the rounding of percentages some percentage totals may not add up to 100%. However, the total is still displayed in the table as 100.

4.5 Definitions

Fetal death

Also known as stillbirth, fetal death is defined in the Registrar of Births, Deaths and Marriages Act, 1962 as:

“a child whose heart has not beaten after it has been completely expelled or extracted from its mother and who is either of not less than 20 weeks gestation or of not less than 400g by weight at birth”.

Fetal death rate

The number of fetal deaths per 1,000 total births.

Live birth

A live birth is defined in the Registration of Births, Deaths and Marriages Act, 1962 as:

“a child whose heart has beaten after it has been completely expelled or extracted from its mother”.

Neonatal death

The death of an infant within 28 days of birth.

Neonatal mortality rate

The number of deaths of live born infants under 28 days of age per 10,000 live births.

Infant death

The death of a live born infant under one year of age and includes neonatal deaths and post-neonatal deaths up to 1 year.

Infant mortality rate

The number of deaths of infants under 1 year of age per 1,000 live births.

Perinatal death

Refers to a fetal death or a neonatal death.

Perinatal mortality rate

The number of fetal and neonatal deaths per 1,000 total births.

5. PERINATAL MORTALITY RATES AND TRENDS

5.1 Perinatal mortality rates

The perinatal mortality rate for the ACT over the five-year period from 2006 to 2010 was 10.5 per 1,000 total births. This comprised a fetal death rate of 7.9 per 1,000 total births and a neonatal mortality rate of 2.6 per 1,000 live births.

The mortality rates in Table 2 include babies born with a birthweight of less than 400 grams who were born at 20 weeks gestation or more, as these are included in the Perinatal National Minimum Dataset. However, these babies have a high risk of death and during this time period none survived. When these cases are excluded, the perinatal mortality rate decreases to 7.5 per 1,000 total births (see Section 6).

Table 2: Fetal, neonatal and perinatal deaths, ACT residents, 2006-10

Birth year	Total births	Live births	Fetal deaths			Neonatal deaths			Perinatal deaths		
			No.	Rate	95% CI	No.	Rate	95% CI	No.	Rate	95% CI
2006	4,576	4,542	34	7.4	(5.0 - 10.0)	17	3.7	(2.0 - 5.5)	51	11.2	(8.1 - 14.2)
2007	4,623	4,590	33	7.1	(4.7 - 9.6)	14	3.1	(1.5 - 4.7)	47	10.2	(7.3 - 13.1)
2008	4,796	4,753	43	9.0	(6.3 - 11.6)	15	3.2	(1.6 - 4.8)	58	12.1	(9.0 - 15.2)
2009	4,895	4,863	32	6.5	(4.3 - 8.8)	4	0.8	(0.0 - 1.6)	36	7.4	(5.0 - 9.8)
2010	4,978	4,932	46	9.2	(6.6 - 11.9)	12	2.4	(1.1 - 3.8)	58	11.7	(8.7 - 14.7)
Total	23,868	23,680	188	7.9	(6.8 - 9.0)	62	2.6	(2.0 - 3.3)	250	10.5	(9.2 - 11.8)

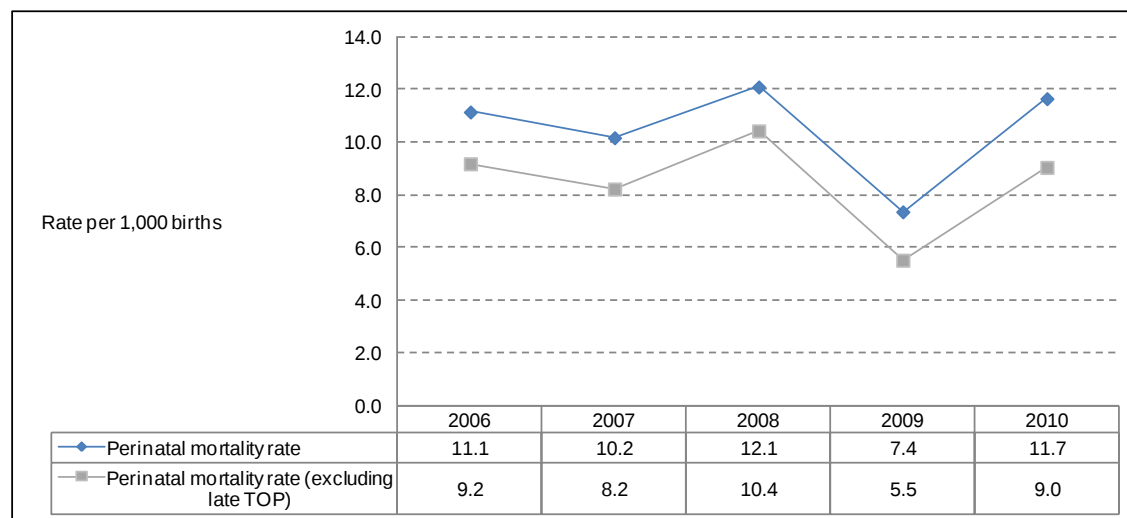
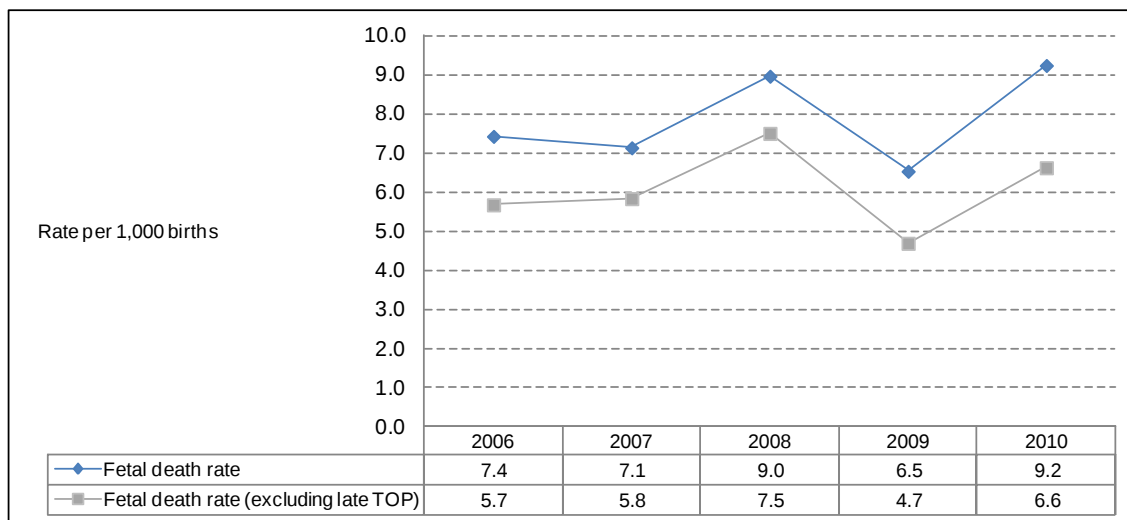
Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health

Notes: Fetal death rates and perinatal death rates are per 1,000 births. Neonatal death rates are per 1,000 live births.

Late terminations of pregnancy (terminations at 20 weeks gestation or more) for congenital abnormalities contribute to the perinatal mortality rate. There were 48 late terminations in the ACT between 2006 and 2010. The Canberra Hospital is currently the only hospital that performs late terminations for congenital abnormalities in the ACT.

When late terminations of pregnancy are removed, the perinatal death rate decreases to 8.5 per 1,000 births. Figure 1 compares the fetal, neonatal and perinatal mortality rates for ACT residents from 2006 to 2010.

Figure 1: Fetal, neonatal and perinatal mortality rates corrected for late terminations, ACT residents, 2006-10



Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health
 Note: TOP refers to Terminations of Pregnancy.

5.2 Antecedent cause of perinatal mortality

The main causes of perinatal mortality using the Perinatal Society of Australia and New Zealand - Perinatal Death Classification (PSANZ-PDC) system are presented in Table 3. The five leading causes of perinatal deaths were: congenital abnormality, spontaneous preterm birth, specific perinatal conditions, fetal growth restriction and unexplained antepartum death. These are discussed in more detail below. There were no significant differences in the rates of perinatal deaths by antecedent cause between 2001-05 and 2006-10.

Table 3: Perinatal death by antecedent cause of death, ACT, 2006-10

PSANZ-PDC	Fetal deaths			Neonatal deaths			Perinatal deaths		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Congenital abnormality	38	20.2	1.6	16	25.8	0.7	54	21.6	2.3
Perinatal infection	5	2.7	0.2	0	0.0	0.0	5	2.0	0.2
Hypertension	4	2.1	0.2	2	3.2	0.1	6	2.4	0.3
Antepartum haemorrhage	13	6.9	0.5	9	14.5	0.4	22	8.8	0.9
Maternal conditions	3	1.6	0.1	1	1.6	0.0	4	1.6	0.2
Specific perinatal conditions	34	18.1	1.4	6	9.7	0.3	40	16.0	1.7
Hypoxic peripartum deaths	3	1.6	0.1	1	1.6	0.0	4	1.6	0.2
Fetal growth restriction	33	17.6	1.4	2	3.2	0.1	35	14.0	1.5
Spontaneous preterm	20	10.6	0.8	24	38.7	1.0	44	17.6	1.8
Unexplained antepartum death	35	18.6	1.5	0	0.0	0.0	35	14.0	1.5
No obstetric antecedent	0	0.0	0.0	1	1.6	0.0	1	0.4	0.0
Total	188	100.0	7.9	62	100.0	2.6	250	100.0	10.5

Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health

Notes: Fetal death rates and perinatal death rates are per 1,000 births. Neonatal death rates are per 1,000 live births.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

Of the 54 perinatal deaths attributed to congenital abnormalities 38 were fetal deaths and 16 neonatal deaths. The most frequent congenital abnormalities were chromosomal (35.2%; 19), musculoskeletal (16.7%; 9) and central nervous system (14.8%; 8).

There were 35 unexplained antepartum deaths contributing to 14% of perinatal deaths. Fourteen (40%) of these perinatal deaths occurred at less than 28 weeks gestation, 10 (28.6%) occurred between 28 to 36 weeks gestation and 11 (31.4%) at 37 weeks or more gestation. Uteroplacental insufficiency was seen in the placental pathology of two (5.7%) of these perinatal deaths.

Spontaneous preterm birth was the third most common cause of perinatal death identified during this period, contributing to 17.6% of cases.

Of the 40 deaths attributed to specific perinatal conditions, antepartum cord complications accounted for 60% (24 deaths). Uterine abnormalities including cervical incompetence were attributed to five of the deaths. The remainder were as a consequence of fetomaternal haemorrhage, idiopathic hydrops fetalis, twin-twin transfusion syndrome and other causes.

Placental abruption and other antepartum haemorrhage were the diagnoses in the majority of antepartum haemorrhage deaths (eight and nine respectively of 22).

Perinatal infection contributed to 2.0% of perinatal deaths. Group B streptococcus and Escherichia coli accounted for the majority of infections.

5.3 Perinatal mortality by gestational age and birthweight

Two important factors determining a baby's health are birthweight and gestational age. Infants with extremely low birthweight and gestational age have a high risk of perinatal death.

Preterm births (those that are delivered at less than 37 weeks gestation) accounted for 7.0% of all births and 76.8% of perinatal deaths. Very preterm births (those that delivered at less than 28 weeks gestation) accounted for 0.8% of all births and 57.6% of all perinatal deaths.

The risk of perinatal death at term (deliveries at 37 weeks gestation or more) was 2.6 per 1,000 total births compared with 791.2 per 1,000 births for babies born at less than 28 weeks gestation. The four main causes of perinatal death for babies born at 37 weeks gestation or more were specific perinatal conditions, fetal growth restriction, unexplained antepartum death and antepartum haemorrhage.

Table 4: Perinatal deaths by cause and gestational age, ACT, 2006-10

	20 to 27 weeks		Gestational age				Total	
	No.	%	No.	%	No.	%		
PSANZ-PDC								
Congenital abnormality	42	29.2	9	18.8	3	5.2	54	21.6
Perinatal infection	1	0.7	0	0.0	4	6.9	5	2.0
Hypertension	1	0.7	5	10.4	0	0.0	6	2.4
Antepartum haemorrhage	14	9.7	3	6.3	5	8.6	22	8.8
Maternal conditions	2	1.4	0	0.0	2	3.4	4	1.6
Specific perinatal conditions	15	10.4	7	14.6	18	31.0	40	16.0
Hypoxic peripartum deaths	0	0.0	2	4.2	2	3.4	4	1.6
Fetal growth restriction	13	9.0	10	20.8	12	20.7	35	14.0
Spontaneous preterm	42	29.2	2	4.2	0	0.0	44	17.6
Unexplained antepartum death	14	9.7	10	20.8	11	19.0	35	14.0
No obstetric antecedent	0	0.0	0	0.0	1	1.7	1	0.4
Total	144	100.0	48	100.0	58	100.0	250	100.0
Rate per 1,000 births	791.2		32.1		2.6		10.5	

Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health

Notes: Due to the rounding of percentages totals may not equal 100%.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification

Low birthweight babies (those with a birthweight less than 2,500 grams) accounted for 5.9% of all births and 79.4% of all perinatal deaths. Infants with birthweight less than 1,000 grams (0.8% of all births) accounted for 61.2% of perinatal deaths.

The perinatal mortality rate for babies with a birthweight less than 1,000 grams was 826.1 per 1,000 births compared with 2.3 per 1,000 births for babies weighing over 2,500 grams.

A review of term perinatal deaths was performed between the two five-year reporting periods. The proportion of term deaths has remained consistent, 22.1% and 23.2% between 2001-05 and 2006-10 respectively. However, the causes of perinatal deaths have changed between these time periods. Perinatal deaths classified according to specific perinatal conditions have increased from 12.5% to 31.0% and fetal growth restriction from 14.6% to 20.7%. The number of unexplained antepartum deaths remained similar with 16.7% and 19.0% respectively for the two time periods. Many of the specific perinatal conditions resulting in perinatal death are not avoidable (e.g. feto-maternal haemorrhage, cord complications and hydrops fetalis), however unrecognised fetal growth restriction is a potentially avoidable event.

Table 5: Perinatal deaths by cause and birthweight, ACT, 2006-10

	Less than 1,000 grams		1,000 to 2,499 grams		Birthweight 2,500 grams or more		Total	
	No.	%	No.	%	No.	%	No.	%
PSANZ-PDC								
Congenital abnormality	44	28.9	7	15.6	3	5.9	54	21.8
Perinatal infection	1	0.7	0	0.0	4	7.8	5	2.0
Hypertension	3	2.0	3	6.7	0	0.0	6	2.4
Antepartum haemorrhage	13	8.6	3	6.7	6	11.8	22	8.9
Maternal conditions	2	1.3	0	0.0	2	3.9	4	1.6
Specific perinatal conditions	17	11.2	5	11.1	18	35.3	40	16.1
Hypoxic peripartum deaths	0	0.0	3	6.7	1	2.0	4	1.6
Fetal growth restriction	19	12.5	12	26.7	4	7.8	35	14.1
Spontaneous preterm	40	26.3	4	8.9	0	0.0	44	17.7
Unexplained antepartum death	13	8.6	8	17.8	12	23.5	33	13.3
No obstetric antecedent	0	0.0	0	0.0	1	2.0	1	0.4
Total	152	100.0	45	100.0	51	100.0	248	100.0
Rate per 1,000 births	826.1		36.6		2.3		10.4	

Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health

Notes: There were two perinatal deaths cases where birthweight was not recorded.

Due to the rounding of percentages totals may not equal 100%.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

5.4 Fetal deaths by birthweight and gestational age

There were 188 fetal deaths (fetal death in-utero or intrapartum death) between 2006 and 2010 (Table 6). The majority of fetal deaths occurred where the fetus weighed less than 2,500 grams (78.0%) and/or was less than 37 weeks gestation (74.4%). Two fetal deaths in-utero were associated with maternal hypertension.

Table 6: Fetal deaths by birthweight and gestational age, ACT, 2006-10

	No.	%
Birthweight		
Less than 1,000 grams	116	62.4
1,000 to 2,499 grams	29	15.6
2,500 grams or more	41	22.0
Total	186	100.0
Gestational age		
Less than 28 weeks gestation	105	55.9
28 to 36 weeks gestation	35	18.6
37 weeks gestation or more	48	25.5
Total	188	100.0

Source: ACT Perinatal Deaths Data Collection, ACT Health

Notes: There were two perinatal deaths cases where birthweight was not recorded. Due to the rounding of percentages totals may not equal 100%.

5.5 Neonatal mortality

Neonatal deaths were classified using the Perinatal Society of Australia and New Zealand - Neonatal Death Classification¹ (PSANZ-NDC) system. The most frequent cause of neonatal deaths was extreme prematurity (38.7%) followed by congenital abnormalities (24.2%) and neurological disorders (19.4%) (Table 7). These are discussed in more detail below.

There were 26.2 neonatal deaths per 10,000 ACT resident live births during 2006 to 2010. There were 10.1 neonatal deaths per 10,000 live births due to extreme prematurity, 6.3 per 10,000 live births due to congenital abnormalities, and 5.1 per 10,000 live births due to neurological conditions.

Table 7: Neonatal deaths by cause, ACT, 2006-10

PSANZ-NDC	No.	%	Rate
Congenital abnormality	15	24.2	6.3
Extreme prematurity	24	38.7	10.1
Cardio-respiratory disorders	6	9.7	2.5
Infection	4	6.4	1.7
Neurological	12	19.4	5.1
Gastrointestinal	0	0	0.0
Other	1	1.6	0.4
Total	62	100.0	26.2

Source: ACT Perinatal Deaths Data Collection, ACT Health

Notes: Rate is per 10,000 live births.

PSANZ-NDC refers to Perinatal Society of Australia and New Zealand - Neonatal Death Classification.

Twenty four neonatal deaths were due to extreme prematurity (these are infants less than 24 weeks gestation and less than 600 grams birthweight). Of these deaths 22 were considered pre-viable and were not resuscitated. Two infants had unsuccessful resuscitation attempts.

Of the 12 neonatal deaths attributable to neurological conditions, nine were due to hypoxic ischaemic encephalopathy and three to intraventricular or intracerebral haemorrhage.

Cardio-respiratory conditions caused 6 neonatal deaths, with the main cause identified as pulmonary hypoplasia (3 deaths; 50%). Two deaths were attributed to meconium aspiration syndrome.

Of the 15 neonatal deaths attributed to congenital abnormalities, four were classified as chromosomal abnormalities, five musculoskeletal abnormalities and three were classified under other specified congenital abnormalities.

Of the four neonatal deaths attributed to infection, three were from acquired bacterial infections and one from an unspecified organism.

There were no neonatal deaths throughout the five-year period where there was an undetermined/unknown cause of death.

Table 8: Neonatal deaths by perinatal death classification, ACT, 2006-10

PSANZ-PDC	No.	%	Rate
Congenital abnormality	16	25.8	6.8
Hypertension	2	3.2	0.8
Antepartum haemorrhage	9	14.5	3.8
Maternal conditions	1	1.6	0.4
Specific perinatal conditions	6	9.7	2.5
Hypoxic peripartum deaths	1	1.6	0.4
Fetal growth restriction	2	3.2	0.8
Spontaneous preterm	24	38.7	10.1
No obstetric antecedent	1	1.6	0.4
Total	62	100.0	26.2

Source: ACT Perinatal Deaths Data Collection, ACT Health

Notes: Rate is per 10,000 live births.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

The majority of neonatal deaths were associated with spontaneous preterm birth (38.7%), congenital anomalies (25.8%) and antepartum haemorrhage (14.5%).

5.6 Cause of neonatal mortality by gestational age and birthweight

Extreme prematurity (birth less than 28 weeks gestation) accounted for 62.9% of neonatal deaths (Table 9). Being born premature (less than 37 weeks gestation) contributed to 83.9% of neonatal deaths. The neonatal mortality rate for pre-term babies (less than 37 weeks gestation) was 33.8 per 1,000 live births and the overall neonatal mortality rate was 2.6 per 1,000 live births.

Table 9: Neonatal deaths by cause and gestational age in the ACT, 2006-10

	Gestational age							
	Less than 28 weeks		28 to 36 weeks		37 weeks or more		Total	
PSANZ-NDC	No.	%	No.	%	No.	%	No.	%
Congenital abnormality	6	15.4	7	53.8	2	20	15	24.2
Extreme prematurity	24	61.5	0	0	0	0	24	38.7
Cardio-respiratory disorders	2	5.1	2	15.4	2	20	6	9.7
Infection	3	7.7	1	7.7	0	0	4	6.4
Neurological	3	7.7	3	23.1	6	60	12	19.4
Gastrointestinal	0	0.0	0	0	0	0	0	0
Other	1	2.6	0	0	0	0	1	1.6
Total	39	100.0	13	100.0	10	100.0	62	100.0
Rate per 1,000 live births	500.0		8.9		0.5		2.6	

Source: ACT Perinatal Deaths Data Collection, ACT Health

Note: Due to the rounding of percentages totals may not equal 100%.

PSANZ-NDC refers to Perinatal Society of Australia and New Zealand - Neonatal Death Classification.

Extremely low birthweight (less than 1,000 grams) accounted for 36 (58.1%) of neonatal deaths. Fifty two neonatal deaths (83.9%) were of babies with a birthweight of less than 2,500 grams. The neonatal mortality rate for low birthweight babies (less than 2,500 grams) was 41.0 per 1,000 live births. (Table 10)

Table 10: Neonatal deaths by cause and birthweight, ACT, 2006-10

	Less than 1,000 grams		Birthweight 1,000 to 2,499 grams		2,500 grams or more		Total	
	No.	%	No.	%	No.	%	No.	%
PSANZ-NDC								
Congenital abnormality	6	16.7	8	50.0	1	10.0	15	24.2
Extreme prematurity	24	66.7	0	0.0	0	0.0	24	38.7
Cardio-respiratory disorders	1	2.8	1	6.3	4	40.0	6	9.7
Infection	2	5.6	2	12.5	0	0.0	4	6.5
Neurological	2	5.6	5	31.3	5	50.0	12	19.4
Gastrointestinal	0	0	0	0.0	0	0.0	0	0
Other	1	2.8	0	0.0	0	0.0	1	1.6
Total	36	100.0	16	100.0	10	100.0	62	100.0
Rate per 1,000 live births	521.7		13.3		0.4		2.6	

Source: ACT Perinatal Deaths Data Collection, ACT Health

Notes: Due to the rounding of percentages totals may not equal 100%.

PSANZ-NDC refers to Perinatal Society of Australia and New Zealand - Neonatal Death Classification.

5.7 Place and type of perinatal death

Perinatal deaths were also classified into the following categories: fetal death in-utero, intrapartum death, termination of pregnancy, labour ward death and neonatal intensive care death (Table 11).

Eighty nine per cent (88.8%) of perinatal deaths occurred prior to delivery or in the labour ward. Nineteen per cent (19.2%) were terminations of pregnancy for congenital abnormalities. Of the labour ward deaths 86.2% (25 of 29) were less than 28 weeks gestation. Four labour ward deaths were for babies 28 weeks gestation or above (two of these died from meconium aspiration syndrome).

Table 11: Perinatal deaths by place and type, ACT, 2001-10

	2001 - 05		2006 - 10	
	No.	%	No.	%
Fetal death in-utero	98	45.2	119	47.6
Intrapartum death	23	10.6	26	10.4
Termination of pregnancy	36	16.6	48	19.2
Labour ward death	20	9.2	29	11.6
Neonatal intensive care death	40	18.4	28	11.2
Total	217	100.0	250	100.0

Source: ACT Perinatal Deaths Data Collection, ACT Health

Note: Due to the rounding of percentages totals may not equal 100%.

Twenty eight (45.2%) neonatal deaths were for babies admitted to the Centre for Newborn Care (Table 12) with six of these deaths (21.4%) occurring within the first 24 hours of life. Nineteen (67.9%) admitted neonatal deaths occurred within the first week of life (Table 12).

Table 12: Neonatal deaths by birthweight and time, Centre for Newborn Care, The Canberra Hospital, ACT, 2006-10

	1 day or less	2-3 days	4-7 days	8-14 days	15-21 days	22-28 days	Total
Birthweight	No.	No.	No.	No.	No.	No.	No.
Less than 1,500 grams	3	1	2	2	0	3	11
1,500 to 2,499 grams	0	1	4	3	0	1	9
2,500 grams or more	3	2	3	0	0	0	8
Total	6	4	9	5	0	4	28

Source: ACT Perinatal Deaths Data Collection, ACT Health

5.8 Multiple births

During 2006-10, 3.4% of the total number of babies born in the ACT was from multiple pregnancies. There were 27 deaths involving twins and none involving triplets, contributing to 10.8% of all perinatal deaths.

The neonatal and perinatal death rates for multiple births were significantly higher than for singleton births (Table 13).

Table 13: Perinatal deaths by plurality, ACT, 2006-10

Plurality			Fetal deaths			Neonatal deaths			Perinatal deaths		
	Total births	Live births	No.	Rate	95% CI	No.	Rate	95% CI	No.	Rate	95% CI
Singleton	23,064	22,885	179	7.8	6.6 - 8.9	44	1.9	1.4 - 2.5	223	9.7	8.4 - 10.9
Twins	792	783	9	11.4	4.0 - 18.7	18	23.1	12.5 - 33.6	27	34.2	21.5 - 46.7
Triplets	12	12	0	0.0	0.0 - 0.0	0	0.0	0.0 - 0.0	0	0.0	0.0 - 0.0
Multiple births	804	795	9	11.2	3.9 - 18.5	18	22.7	12.3 - 33.1	27	33.6	21.1 - 46.0
Total	23,868	23,680	188	7.9	6.8 - 9.0	62	2.6	2.0 - 3.3	250	10.5	9.2 - 11.8

Sources: ACT Maternal and Perinatal Data Collection, ACT Health and ACT Perinatal Deaths Data Collection, ACT Health

Notes: Fetal death rates and perinatal death rates are per 1,000 births. Neonatal death rates are per 1,000 live births.

The percentage of extremely low birthweight perinatal deaths (less than 1,000 grams) was similar in singleton births (60.6%) to multiple births (66.7%).

The main causes of perinatal deaths in multiple birth babies were spontaneous preterm birth (48.1%), congenital abnormalities (11.1%) and specific perinatal conditions (11.1%) (Table 14). In comparison, the main causes of perinatal death in singleton babies were congenital abnormalities (22.9%), specific perinatal conditions (16.6%), unexplained antepartum death (15.2%), fetal growth restriction (14.8%) and spontaneous preterm birth (13.9%). The number of perinatal deaths associated with twin to twin transfusion syndrome has reduced from the 2001-05 report following feedback to perinatal care providers at morbidity and mortality meetings at each of the institutions providing antenatal care and advancements in placental laser ablation treatments for this syndrome.

Multiple birth babies were significantly more likely to die from a spontaneous preterm birth than singleton babies (RR = 4.3, Table 14).

Table 14: Perinatal deaths by cause and plurality, ACT, 2006-10

PSANZ-PDC	Singleton			Multiple			Relative	95% CI	
	No.	%	Rate	No.	%	Rate	Risk	Low	High
Congenital abnormality	51	22.9	2.2	3	11.1	3.7	0.4	0.1	1.4
Perinatal infection	5	2.2	0.2	0	0.0	0.0			
Hypertension	4	1.8	0.2	2	7.4	2.5	3.2	1.0	10.4
Antepartum haemorrhage	20	9.0	0.9	2	7.4	2.5	0.8	0.2	3.2
Maternal conditions	4	1.8	0.2	0	0.0	0.0			
Specific perinatal conditions	37	16.6	1.6	3	11.1	3.7	0.6	0.2	2.1
Hypoxic peripartum deaths	3	1.3	0.1	1	3.7	1.2	2.3	0.4	13.0
Fetal growth restriction	33	14.8	1.4	2	7.4	2.5	0.5	0.1	1.9
Spontaneous preterm	31	13.9	1.3	13	48.1	16.2	4.3*	2.2	8.6
Unexplained antepartum death	34	15.2	1.5	1	3.7	1.2	0.2	0.0	1.6
No obstetric antecedent	1	0.4	0.0	0	0.0	0.0			
Total	223	100.0	9.7	27	100.0	33.6			

Source: ACT Perinatal Deaths Data Collection, ACT Health

Note: Rates are per 1,000 births.

Due to the rounding of percentages totals may not equal 100%.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

*Statistically significant difference at p<0.05.

5.9 Maternal characteristics

Maternal age is an important risk factor for adverse perinatal outcomes. Adverse outcomes were more likely to occur in older (greater than 40 years) mothers (Table 15).

The ACT perinatal mortality rate for women aged 40 years or more was significantly higher than the mortality rate for women aged 20 to 39 years (Table 15). There was no significant relationship between maternal age and neonatal death rates.

Table 15: Perinatal deaths by maternal age, ACT, 2006-10

Maternal age	Total births		Live births		Fetal deaths			Neonatal deaths			Perinatal deaths		
					No.	Rate	95% CI	No.	Rate	95% CI	No.	Rate	95% CI
Less than 20 years	531	526	5	9.4	1.2	-	17.6	0	0.0	0.0 - 0.0	5	9.4	1.2 - 17.6
20-29 years	8,823	8,757	67	7.6	5.8	-	9.4	18	2.1	1.1 - 3.0	85	9.6	7.6 - 11.7
30-39 years	13,529	13,426	99	7.3	5.9	-	8.8	40	3.0	2.1 - 3.9	139	10.3	8.6 - 12.0
40 years or more	985	971	17	17.3	9.1	-	25.4	4	4.1	0.1 - 8.1	21	21.3	12.3 - 30.3
Total	23,868	23,680	188	7.9	6.8	-	9.0	62	2.6	2.0 - 3.3	250	10.5	9.2 - 11.8

Sources: ACT Maternal and Perinatal Data Collection, and ACT Perinatal Deaths Data Collection

Notes: Fetal death rates and perinatal death rates are per 1,000 births. Neonatal death rates are per 1,000 live births.

The average age of women who experienced a perinatal death was 31.2 years. Nine per cent (8.6%) of women had conceived with assisted reproduction technology. Thirteen per cent (12.7%) of women were documented to smoke cigarettes, 0.4% use marijuana, 0.8% use methadone and 2.8% use other illicit drugs.

There were no significant differences in perinatal death rates for women who smoked during pregnancy compared with non-smokers or for primigravida women compared with multigravida women.

5.10 Aboriginal and Torres Strait Islander perinatal mortality

In the years 2006-10 there were eight perinatal deaths for babies born to Aboriginal and Torres Strait Islander women. There is no evidence of a higher rate of perinatal deaths for babies of Aboriginal and Torres Strait Islander women compared with other women in the ACT.

5.11 Perinatal autopsy

The perinatal autopsy rate for the ACT from 2006-10 for ACT and NSW resident babies born in the ACT was 53.5% (Table 16). Perinatal autopsy was declined for 40.8% of babies and an autopsy was not requested for 2.2% of babies. The reduction in the number of autopsies 'not requested' from the 2001-05 report is an important improvement; however the overall rate of perinatal autopsies is still sub-optimal with a recommended rate of 75%.

In 2005, the perinatal autopsy rate for South Australia was 51%²; New South Wales was 37.7%³; Victoria was 28.6%⁴; and Queensland was 26.3%.⁵

Perinatal autopsies were performed for 57.4% of fetal deaths and 44.7% of neonatal deaths. Perinatal autopsy was declined for almost half (49.1%) of neonatal deaths compared with 37.1% of fetal deaths (Table 16).

Table 16: Perinatal autopsy by type of perinatal death, ACT, 2006-10

Perinatal autopsy	Fetal death		Neonatal death		Total	
	No	%	No	%	No	%
Performed	147	57.4	51	44.7	198	53.5
Declined	95	37.1	56	49.1	151	40.8
Not requested	3	1.2	5	4.4	8	2.2
Not stated	11	4.3	2	1.8	13	3.5
Total	256	100.0	114	100.0	370	100.0

Source: ACT Perinatal Deaths Data Collection, ACT Health, ACT and NSW residents

Note: Due to the rounding of percentages totals may not equal 100%.

Includes babies born in the ACT to ACT and non-ACT resident women.

Perinatal autopsy was performed most frequently for perinatal infections (100%), deaths with no obstetric antecedent (100%), fetal growth restriction (72.1%) and unexplained antepartum death (65.9%).

Placental pathology was available in 99.7% of cases. Chorioamnionitis was found in 27.0% of cases, funisitis in 16.2% and villitis in 6.1%.

Table 17: Perinatal autopsy by cause and type of death, ACT, 2006-10

PSANZ-PDC	Fetal deaths		Neonatal deaths		Perinatal deaths	
	No.	%	No.	%	No.	%
Congenital abnormality	37	56.1	18	66.7	55	59.1
Perinatal infection	7	100.0	0	0.0	7	100.0
Hypertension	2	40.0	3	60.0	5	50.0
Antepartum haemorrhage	7	36.8	3	27.3	10	33.3
Maternal conditions	3	60.0	2	66.7	5	62.5
Specific perinatal conditions	26	66.7	6	46.2	32	61.5
Hypoxic peripartum deaths	1	33.3	1	50.0	2	40.0
Fetal growth restriction	29	70.7	2	100.0	31	72.1
Spontaneous preterm	6	22.2	15	30.0	21	27.3
Unexplained antepartum death	29	65.9	0	0.0	29	65.9
No obstetric antecedent	0	0.0	1	100.0	1	100.0
Total	147	57.4	51	44.7	198	53.5

Source: ACT Perinatal Deaths Data Collection, ACT Health, ACT and NSW residents

Notes: Percentages refer to the percentage of autopsies performed in each category. For example 56.1% of fetal deaths within the congenital abnormality category had an autopsy.

PSANZ-PDC refers to Perinatal Society of Australia and New Zealand - Perinatal Death Classification.

Includes babies born in the ACT to ACT and non-ACT residents.

6. COMPARISON WITH NATIONAL DATA

6.1 Perinatal mortality rates

Perinatal mortality rates in the ACT fluctuate due to the small number of deaths each year. Between 2006-10, the ACT perinatal mortality rate ranged from 7.4 to 12.1 per 1,000 births whereas the Australian rate ranged from 9.3 to 10.3 (Figure 2).

Figure 2: Perinatal mortality rates, ACT residents and Australia, 2006-10



Sources: ACT Maternal and Perinatal Data Collection, ACT Health, ACT Perinatal Deaths Data Collection, ACT Health and Australia's Mothers and Babies, AIHW, 2006-10

Note: Rates are per 1,000 births.

The annual ACT mortality rates and the five-year average rates were not significantly higher than Australian rates during 2006-10 (Table 18) for fetal, neonatal and perinatal deaths. The ACT neonatal mortality rate was significantly lower than the Australian rate in 2009.

Table 18: Fetal, neonatal and perinatal mortality rates, ACT and Australia, 2006-10

Type of deaths	Year	ACT residents			Australia		
		Rate	95% CI		Rate	95% CI	
Fetal deaths	2006	7.4	4.9	- 9.9	7.4	7.1	- 7.7
	2007	7.1	4.7	- 9.6	7.4	7.1	- 7.7
	2008	9.0	6.3	- 11.6	7.4	7.1	- 7.7
	2009	6.5	4.3	- 8.8	7.8	7.5	- 8.1
	2010	9.2	6.6	- 11.9	7.4	7.1	- 7.7
	2006-10	7.9	6.8	- 9.0	7.5	7.3	- 7.6
Neonatal deaths	2006	3.7	2.0	- 5.5	2.9	2.7	- 3.1
	2007	3.1	1.5	- 4.6	2.9	2.7	- 3.1
	2008	3.2	1.6	- 4.8	2.8	2.6	- 3.0
	2009	0.8	0.0	- 1.6	3.0	2.7	- 3.2
	2010	2.4	1.1	- 3.8	2.9	2.6	- 3.1
	2006-10	2.6	2.0	- 3.3	2.9	2.8	- 3.0
Perinatal deaths	2006	11.1	8.1	- 14.2	10.3	9.9	- 10.7
	2007	10.2	7.3	- 13.1	10.3	9.9	- 10.6
	2008	12.1	9.0	- 15.2	10.2	9.8	- 10.5
	2009	7.4	5.0	- 9.7	9.8	9.4	- 10.2
	2010	11.7	8.7	- 14.6	9.3	8.9	- 9.6
	2006-10	10.5	9.2	- 11.8	10.0	9.8	- 10.2

Sources: ACT Maternal and Perinatal Data Collection, ACT Health, ACT Perinatal Deaths Data Collection, ACT Health and Australia's Mothers and Babies, AIHW, 2006 - 2010

Notes: Fetal death rates and perinatal death rates are per 1,000 births. Neonatal death rates are per 1,000 live births. Australian figures include: 2006 Vic, WA, SA, Tas and ACT; 2007 Vic, WA, SA and Tas; 2008 Vic, WA, SA, and Tas; 2009 WA, SA and Tas; and 2010 Qld, WA, SA, Tas, ACT and NT.

6.2 Antecedent causes of death

The main antecedent causes of perinatal death for both the ACT and Australia were congenital anomalies, spontaneous preterm births and unexplained antepartum deaths (Table 19).

The perinatal death rates for most antecedent causes did not differ significantly between the ACT and Australia. However, the ACT rate for maternal conditions was significantly lower than the Australian rate and the ACT rate for specific perinatal conditions and fetal growth restriction was significantly higher than the Australian rate, however, this may be a reflection of more accurate post-event reporting.

Table 19: Perinatal deaths, by cause, ACT residents and Australia, 2006-10

PSANZ-PDC	ACT residents		Australia	
	No.	Rate	No.	Rate
Congenital abnormality	54	2.3	1,621	2.8
Perinatal infection	5	0.2	210	0.4
Hypertension	6	0.3	168	0.3
Antepartum haemorrhage	22	0.9	398	0.7
Maternal conditions	4	0.2	650	1.1*
Specific perinatal conditions	40	1.7	514	0.9*
Hypoxic peripartum deaths	4	0.2	168	0.3
Fetal growth restriction	35	1.5	407	0.7*
Spontaneous preterm	44	1.8	1,014	1.8
Unexplained antepartum death	35	1.5	788	1.4
No obstetric antecedent	1	0.0	70	0.1
Not stated	0	0	190	0.3

Sources: ACT Perinatal Deaths Data Collection, ACT Health, 2006 to 2010 and Australia's Mothers and Babies, 2006 to 2010

Notes: Rate is per 1,000 births. Australian figures include: 2006 Vic, WA, SA, Tas and ACT; 2007 Vic, WA, SA and Tas; 2008 Vic, WA, SA, and Tas; 2009 WA, SA and Tas; and 2010 Qld, WA, SA, Tas, ACT and NT.

*Denotes statistically significant difference at $p < 0.05$.

7. APPENDIX A - SUMMARY OF PERINATAL DEATHS

Table 20: Summary of perinatal deaths by state of residence, by year, ACT, 2001-10

		Fetal Death		Neonatal death		Perinatal death	
		No.	%	No.	%	No.	%
2001	ACT residents	29	82.9	6	33.3	35	66.0
	Non ACT residents	6	17.1	12	66.7	18	34.0
	Total	35	100.0	18	100.0	53	100.0
2002	ACT residents	25	71.4	9	37.5	34	57.6
	Non ACT residents	10	28.6	15	62.5	25	42.4
	Total	35	100.0	24	100.0	59	100.0
2003	ACT residents	39	72.2	16	57.1	55	67.1
	Non ACT residents	15	27.8	12	42.9	27	32.9
	Total	54	100.0	28	100.0	82	100.0
2004	ACT residents	25	75.8	19	70.4	44	73.3
	Non ACT residents	8	24.2	8	29.6	16	26.7
	Total	33	100.0	27	100.0	60	100.0
2005	ACT residents	36	76.6	13	65.0	49	73.1
	Non ACT residents	11	23.4	7	35.0	18	26.9
	Total	47	100.0	20	100.0	67	100.0
2006	ACT residents	34	68.0	17	58.6	51	64.6
	Non ACT residents	16	32.0	12	41.4	28	35.4
	Total	50	100.0	29	100.0	79	100.0
2007	ACT residents	33	78.6	14	58.3	47	71.2
	Non ACT residents	9	21.4	10	41.7	19	28.8
	Total	42	100.0	24	100.0	66	100.0
2008	ACT residents	43	75.4	15	60.0	58	70.7
	Non ACT residents	14	24.6	10	40.0	24	29.3
	Total	57	100.0	25	100.0	82	100.0
2009	ACT residents	32	74.4	4	28.6	36	63.2
	Non ACT residents	11	25.6	10	71.4	21	36.8
	Total	43	100.0	14	100.0	57	100.0
2010	ACT residents	46	67.6	12	48.0	58	62.4
	Non ACT residents	22	32.4	13	52.0	35	37.6
	Total	68	100.0	25	100.0	93	100.0
Total	ACT residents	342	73.7	125	53.4	467	66.9
	Non ACT residents	122	26.3	109	46.6	231	33.1
	Total	464	100.0	234	100.0	698	100.0

Sources: ACT Maternal and Perinatal Data Collection, and ACT Perinatal Deaths Data Collection, ACT Health
Note: State of residence refers to maternal state of residence.

Mother's Sticky Label

Return completed form to:

Infant's Sticky Label

Copy sent to Dr Alison Kent	Yes / No
Copy placed in patient notes	Yes / No

Date information collected/...../.....

Information collected by

29

Procedures and Operations Number of ultrasounds _____ 0 None 1 Cardiocography 2 Chorionic villus sampling 3 Amniocentesis < 20 weeks 4 Amniocentesis > 20 weeks 5 X-Ray/CT scan 6 MRI 7 Cervical suture No Yes Assisted conception 0.....1 1 Hyperovulation 2 IVF/GIFT 3 Other (specify) 4 Not stated Responsibility for Antenatal Care 1 Obstetrician 2 General practitioner 3 Midwife led clinic (with max 2 GP) 4 Hospital Antenatal clinic 5 Shared care 6 Independent midwife 7 Birth centre or CMP protocols 8 Aboriginal Health Service 9 Not stated Duration of pregnancy at first visit _____ No. of visits 1 None 2 1 to 5 3 6 to 10 4 11 to 15 5 16 to 20 6 More than 20 Baby's Place of Birth 1 The Canberra Hospital 2 TCH Birth Centre 3 Calvary Bruce Public 4 Calvary Bruce Private 5 Calvary John James 6 National Capital Private 7 Home 8 Born before arrival 0 Interstate Hospital Intended Place of birth at onset of labour 1 Hospital 2 Birth centre 4 Home Was mother transferred Antenatally? 1 No 2 Prior to labour 3 During labour Transferred from 1 Planned homebirth 2 Birth centre 3 Another ACT hospital 4 Interstate hospital Reason for transfer 1 PTL 8 Septicaemia 2 PROM 9 Fetal distress 3 Fetal anomaly 4 FDIU 5 PIH 6 APH	Drugs during pregnancy? None.....0 Alcohol 7 Nicotine/Cigarettes... 1 Heroin.....2 Methadone.....3 Cocaine..... 4 Marijuana.....5 Other (specify).....6 Onset and type of labour 1 Spontaneous 2 Induction 3 No labour Method of induction 1 Oxytocin 2 Prostaglandins 3 ARM 4 Other (specify)..... No Yes Augmented 0..... 1 Method of augmentation 1 Oxytocin 2 Prostaglandins 3 ARM 4 Other (specify)..... Reason for augmentation or induction 1 FDIU 5 Post term 2 Fetal anomaly 6 Incoordinate contractions 3 PIH 7 Other 4 APH Corticosteroids 0 Not stated 1 None 2 Less than 24 hours prior to baby's birth 3 Complete 4 More than 7 days before baby's birth <table border="0"> <tr> <th>Analgesia</th> <th>Anaesthesia</th> </tr> <tr> <td>1 None</td> <td>1 None</td> </tr> <tr> <td>2 Nitrous oxide</td> <td>2 Local to perineum</td> </tr> <tr> <td>3 IMI/IV Narcotic</td> <td>3 Pudendal</td> </tr> <tr> <td>4 Epidural</td> <td>4 Epidural</td> </tr> <tr> <td>5 Spinal</td> <td>5 Spinal</td> </tr> <tr> <td>8 Other (specify)</td> <td>6 General</td> </tr> <tr> <td>.....</td> <td>8 Other (specify)</td> </tr> </table> Presentation 1 Vertex 2 Breech 3 Face 4 Brow 8 Other (compound specify)..... Method of birth 1 Spontaneous cephalic 2 Forceps 3 Vaginal breech 4 Caesarean Section 5 Vacuum extraction 8 Other (specify)..... If Caesarean Section was there a medical or obstetric emergency? 0 No.....1 Yes Complications of labour and birth 1 None 2 Fetal distress 3 Cord prolapse 4 Obstructed labour 5 PPH 6 Retained placenta 7 Major infection 8 Uterine rupture	Analgesia	Anaesthesia	1 None	1 None	2 Nitrous oxide	2 Local to perineum	3 IMI/IV Narcotic	3 Pudendal	4 Epidural	4 Epidural	5 Spinal	5 Spinal	8 Other (specify)	6 General		8 Other (specify)
Analgesia	Anaesthesia																
1 None	1 None																
2 Nitrous oxide	2 Local to perineum																
3 IMI/IV Narcotic	3 Pudendal																
4 Epidural	4 Epidural																
5 Spinal	5 Spinal																
8 Other (specify)	6 General																
.....	8 Other (specify)																

Birth Outcome 0 Stillbirth 2 Neonatal Death Date of birth/stillbirth/...../..... Date of Neonatal Death/...../..... Age at deathday(s) hour(s) Sex 1 Male 2 Female 3 Indeterminate Plurality 1 Singleton 2 Twins 3 Triplets 8 Other Birth weight grams Head circumference cm Length cm Apgar At 1 minute _____ At 5 minutes _____ Resuscitation – Active measures 1 None 2 Suction 3 Oxygen therapy 4 IPPV – bag and mask 5 IPPV – intubation 6 External cardiac massage Resuscitation – Drug therapy 1 None 2 Narcotic antagonist 3 Sodium bicarbonate 4 Adrenaline 5 Other drugs (specify) Who performed resuscitation? 0 Not done <table border="0"> <tr> <td>1 Neonatologist</td> <td>5 Neonatal Registrar</td> </tr> <tr> <td>2 Paediatrician</td> <td>6 Paediatric Registrar</td> </tr> <tr> <td>3 Obstetrician</td> <td>7 Obstetric Registrar</td> </tr> <tr> <td>4 Neonatal Nurse</td> <td>8 Midwife</td> </tr> </table> 9 Other (specify) Admission to SCN/NICU? 1 Yes Length of stay (days) _____ 2 No PostMortem <table border="0"> <tr> <td>0 Not stated</td> <td>4 Partial</td> </tr> <tr> <td>1 Not requested</td> <td>5 Full</td> </tr> <tr> <td>2 Declined</td> <td></td> </tr> </table> Histology of placenta? 0 No 1 Yes (If histology performed include report) 2 Unknown Chorioamnionitis? 0 Unknown 1 None 2 Clinically suspected 3 Pathology proven 4 Clinically & pathologically proven	1 Neonatologist	5 Neonatal Registrar	2 Paediatrician	6 Paediatric Registrar	3 Obstetrician	7 Obstetric Registrar	4 Neonatal Nurse	8 Midwife	0 Not stated	4 Partial	1 Not requested	5 Full	2 Declined		Funisitis? 0 Unknown 1 None 2 Pathologically proven Lymphohistiocytic/chronic villitis? 0 No 1 Yes APH? 0 No 1 Yes Bleeding during pregnancy? 0 Not stated 1 None 2 Placental abruption 3 Placenta praevia 4 Vasa praevia 5 Undetermined 6 Other Was hypertension present? 0 Not stated 1 None 2 Chronic hypertension – essential 3 Chronic hypertension – renal disease 4 Pregnancy induced 5 Chronic superimposed PIH Was death an unexplained antepartum death? 0 No 1 Yes 2 Unknown Was there fetal growth restriction? 0 No 1 Yes - idiopathic 2 Yes - placental pathology 3 Yes - Other 4 Unknown Was there intrapartum asphyxia? 0 No 1 Yes 2 Unknown Was there cord complications? 0 No 1 Yes (Specify) 2 Unknown Was haematological disease present? 0 No 1 Yes - Resus incompatibility 2 Yes - Other feto-maternal blood group incompatibility 3 Yes – Haemoglobinopathy 4 Unknown
1 Neonatologist	5 Neonatal Registrar														
2 Paediatrician	6 Paediatric Registrar														
3 Obstetrician	7 Obstetric Registrar														
4 Neonatal Nurse	8 Midwife														
0 Not stated	4 Partial														
1 Not requested	5 Full														
2 Declined															

Was a major fetal anomaly present?

- 0 No
 1 Yes (Specify)

 2 Unknown

Was there fetal/infant infection?

- 0 No
 1 Yes
 2 Unknown

Infection documented

- 0 None
 1 GBS
 2 Listeria
 3 CMV
 4 Parvovirus
 5 HSV
 6 Rubella
 7 Toxoplasmosis
 8 Syphilis
 9 E. coli
 10 U histolytica
 11 Other

Other conditions present

- 0 None
 1 Twin Twin Transfusion Syndrome (TTTS)
 2 Idiopathic hydrops
 3 Feto-maternal haemorrhage
 4 Uterine abnormality
 5 Drug dependence/abuse
 6 Haemolytic disease
 7 Birth trauma
 8 Accident, poisoning or violence
 9 Cervical incompetence
 10 Other

Gestation	Weight (grams)		10 th percentile
	Male	Female	
22	400	400	
23	500	470	
24	520	540	
25	620	620	
26	720	680	
27	740	730	
28	850	760	
29	950	890	
30	1080	1045	
31	1310	1140	
32	1400	1340	
33	1640	1520	
34	1840	1760	
35	2110	2030	
36	2320	2220	
37	2550	2430	
38	2780	2660	
39	2940	2820	
40	3070	2950	
41	3180	3050	
42	3210	3080	
43	3080	2950	
44	3050	2930	

Reference: Roberts C, Lancaster P (1999)
 Australian national birthweight percentiles by
 gestational age. MJA Vol. 170: 114-118

ICD-10-AM Code _____

Relevant factors:

Antenatal:

Intrapartum:

Postpartum:

Cause of Death Classifications**Australia and New Zealand Antecedent Classification of Perinatal Mortality (PSANZ-PDC)**

- 1 Congenital abnormality
 2 Perinatal infection
 3 Hypertension
 4 Antepartum haemorrhage
 5 Maternal conditions
 6 Specific perinatal conditions
 7 Hypoxic peripartum death
 8 Fetal growth restriction
 9 Spontaneous preterm
 10 Unexplained antepartum death
 11 No obstetric antecedent

Australia and New Zealand Neonatal Death Classification (PSANZ-NDC)

- 1 Congenital abnormality
 2 Extreme prematurity
 3 Cardio-respiratory disorders
 4 Infection
 5 Neurological
 6 Gastrointestinal
 7 Other

PSANZ-PDC: _____ PSANZ-NDC: _____

Note: Full Classification done by obstetrician, neonatologist, perinatal pathologist and midwife/clinical coder using the PSANZ classification guideline 2007.

Type of Death

1. Fetal Death In-Utero
 2. Intrapartum death
 3. Termination of pregnancy
 4. Non-admitted neonatal death
 5. Admitted neonatal death

Intrapartum Monitoring

1. Manual Auscultation 4. CTG - continuous
 2. Doppler 5. CTG – scalp electrode
 3. CTG – intermittent

Avoidability

1. Unavoidable 2. Avoidable
 3. Termination
 4. Possibly avoidable – IUGR not recognised
 5. Possibly avoidable – earlier delivery
 6. Possibly avoidable – infection/NEC in prem neonate
 7. Possibly avoidable - different cervical suture
 8. Possibly avoidable – cervical surgery
 9. Possibly avoidable – monitoring in labour
 10. Possibly avoidable – transfer out of rural centre
 11. Possibly avoidable – minimal antenatal care

9. APPENDIX C - PSANZ PERINATAL MORTALITY CLASSIFICATIONS

PSANZ Perinatal Death Classification (PSANZ-PDC)

1 Congenital abnormality (including terminations for congenital abnormalities)

- 1.1 Central nervous system
- 1.2 Cardiovascular system
- 1.3 Urinary system
- 1.4 Gastrointestinal system
- 1.5 Chromosomal
- 1.6 Metabolic
- 1.7 Multiple/non chromosomal syndromes
- 1.8 Other congenital abnormality
 - 1.81 Musculoskeletal
 - 1.82 Respiratory
 - 1.83 Diaphragmatic hernia
 - 1.84 Haematological
 - 1.85 Tumours
 - 1.88 Other specified congenital abnormality
- 1.9 Unspecified congenital abnormality

2 Perinatal infection

- 2.1 Bacterial
 - 2.11 Group B Streptococcus
 - 2.12 E coli
 - 2.13 Listeria monocytogenes
 - 2.14 Spirochaetal e.g. Syphilis
 - 2.18 Other bacterial
 - 2.19 Unspecified bacterial
- 2.2 Viral
 - 2.21 Cytomegalovirus
 - 2.22 Parvovirus
 - 2.23 Herpes simplex virus
 - 2.24 Rubella virus
 - 2.28 Other viral
 - 2.29 Unspecified viral
- 2.3 Protozoal e.g. Toxoplasma
- 2.5 Fungal
- 2.8 Other specified organism
- 2.9 Other unspecified organism

3 Hypertension

- 3.1 Chronic hypertension: essential
- 3.2 Chronic hypertension: secondary, e.g. renal disease
- 3.3 Chronic hypertension: unspecified
- 3.4 Gestational hypertension
- 3.5 Pre-eclampsia
 - 3.51 With laboratory evidence of thrombophilia
- 3.6 Pre-eclampsia superimposed on chronic hypertension
 - 3.61 With laboratory evidence of thrombophilia
- 3.9 Unspecified hypertension

4 Antepartum haemorrhage (APH)

- 4.1 Placental abruption
 - 4.11 With laboratory evidence of thrombophilia
- 4.2 Placenta praevia
- 4.3 Vasa praevia
- 4.8 Other APH
- 4.9 APH of undetermined origin

5 Maternal conditions

- 5.1 Termination of pregnancy for maternal psychosocial indications
- 5.2 Diabetes / Gestational diabetes
- 5.3 Maternal injury
 - 5.31 Accidental
 - 5.32 Non-accidental
- 5.4 Maternal sepsis
- 5.5 Lupus obstetric syndrome
- 5.6 Obstetric cholestasis
- 5.8 Other specified maternal conditions

6 Specific perinatal conditions

- 6.1 Twin-twin transfusion
- 6.2 Fetomaternal haemorrhage
- 6.3 Antepartum cord complications (e.g. cord haemorrhage; true knot with evidence of occlusion)
- 6.4 Uterine abnormalities, e.g. bicornuate uterus, cervical incompetence
- 6.5 Birth trauma (typically infants of >24 weeks gestation or >600g birthweight)
- 6.6 Alloimmune disease
 - 6.61 Rhesus
 - 6.62 ABO
 - 6.63 Kell
 - 6.64 Alloimmune thrombocytopenia
 - 6.68 Other
 - 6.69 Unspecified
- 6.7 Idiopathic hydrops
- 6.8 Other specific perinatal conditions (includes iatrogenic conditions such as rupture of membranes after amniocentesis, termination of pregnancy for suspected but unconfirmed congenital abnormality).

7 Hypoxic peripartum death (typically infants of >24 weeks gestation or >600g birthweight)

- 7.1 With intrapartum complications
 - 7.11 Uterine rupture
 - 7.12 Cord prolapse
 - 7.13 Shoulder dystocia
 - 7.18 Other
- 7.2 Evidence of non-reassuring fetal status in a normally grown infant (e.g. abnormal fetal heart rate, fetal scalp pH/lactate, fetal pulse oximetry without intrapartum complications)
- 7.3 No intrapartum complications and no evidence of non-reassuring fetal status.
- 7.9 Unspecified hypoxic peripartum death

8 Fetal Growth Restriction (FGR)

- 8.1 With evidence of reduced vascular perfusion on Doppler studies and /or placental histopathology (e.g. significant infarction, acute atherosclerosis, maternal and/or fetal vascular thrombosis or maternal floor infarction)
- 8.2 With chronic villitis
- 8.3 No placental pathology
- 8.4 No examination of placenta

- 8.8 Other specified placental pathology
- 8.9 Unspecified or not known whether placenta examined
- 9 Spontaneous preterm (<37 weeks gestation)**
 - 9.1 Spontaneous preterm with intact membranes, or membrane rupture <24 hours before delivery
 - 9.11 With chorioamnionitis on placental histopathology
 - 9.12 Without chorioamnionitis on placental histopathology
 - 9.13 With clinical evidence of chorioamnionitis, no examination of placenta
 - 9.17 No clinical signs of chorioamnionitis, no examination of placenta
 - 9.19 Unspecified or not known whether placenta examined
 - 9.2 Spontaneous preterm with membrane rupture ≥24 hours before delivery
 - 9.21 With chorioamnionitis on placental histopathology
 - 9.22 Without chorioamnionitis on placental histopathology
 - 9.23 With clinical evidence of chorioamnionitis, no examination of placenta
 - 9.27 No clinical signs of chorioamnionitis, no examination of placenta
 - 9.29 Unspecified or not known whether placenta examined
 - 9.3 Spontaneous preterm with membrane rupture of unknown duration before delivery
 - 9.31 With chorioamnionitis on placental histopathology
 - 9.32 Without chorioamnionitis on placental histopathology
 - 9.33 With clinical evidence of chorioamnionitis, no examination of placenta
 - 9.37 No clinical signs of chorioamnionitis, no examination of placenta
 - 9.39 Unspecified or not known whether placenta examined
- 10 Unexplained antepartum death**
 - 10.1 With evidence of reduced vascular perfusion on Doppler studies and /or placental histopathology (e.g. significant infarction, acute atherosclerosis, maternal and/or fetal vascular thrombosis or maternal floor infarction)
 - 10.2 With chronic villitis
 - 10.3 No placental pathology
 - 10.4 No examination of placenta
 - 10.8 Other specified placental pathology
 - 10.9 Unspecified or not known whether placenta examined
- 11 No obstetric antecedent**
 - 11.1 Sudden Infant Death Syndrome (SIDS)
 - 11.11 SIDS Category IA: Classic features of SIDS present and completely documented.
 - 11.12 SIDS Category IB: Classic features of SIDS present but incompletely documented.
 - 11.13 SIDS Category II : Infant deaths that meet Category I except for one or more features.
 - 11.2 Postnatally acquired infection
 - 11.3 Accidental asphyxiation
 - 11.4 Other accident, poisoning or violence (postnatal)
 - 11.8 Other specified
 - 11.9 Unknown/Undetermined
 - 11.91 Unclassified Sudden Infant Death
 - 11.92 Other Unknown/Undetermined

PSANZ Neonatal Death Classification (PSANZ-NDC)

- 1 Congenital abnormality (including terminations for congenital abnormalities)**
 - 1.1 Central nervous system
 - 1.2 Cardiovascular system
 - 1.3 Urinary system
 - 1.4 Gastrointestinal system
 - 1.5 Chromosomal
 - 1.6 Metabolic
 - 1.7 Multiple/non chromosomal syndromes
 - 1.8 Other congenital abnormality
 - 1.81 Musculoskeletal
 - 1.82 Respiratory
 - 1.83 Diaphragmatic hernia
 - 1.84 Haematological
 - 1.85 Tumours
 - 1.88 Other specified congenital abnormality
 - 1.9 Unspecified congenital abnormality
- 2 Extreme prematurity (typically infants of ≤ 24 weeks gestation or ≤ 600 g birthweight)**
 - 2.1 Not resuscitated
 - 2.2 Unsuccessful resuscitation
 - 2.9 Unspecified or not known whether resuscitation attempted
- 3 Cardio-respiratory disorders**
 - 3.1 Hyaline membrane disease / Respiratory distress syndrome (RDS)
 - 3.2 Meconium aspiration syndrome
 - 3.3 Primary persistent pulmonary hypertension
 - 3.4 Pulmonary hypoplasia
 - 3.5 Chronic neonatal lung disease (typically, bronchopulmonary dysplasia)
 - 3.8 Other
- 4 Infection**
 - 4.1 Bacterial
 - 4.11 Congenital bacterial
 - 4.12 Acquired bacterial
 - 4.2 Viral
 - 4.21 Congenital viral
 - 4.22 Acquired viral
 - 4.3 Protozoal, e.g. Toxoplasma
 - 4.4 Spirochaetal, e.g. Syphilis
 - 4.5 Fungal
 - 4.8 Other
 - 4.9 Unspecified organism
- 5 Neurological**
 - 5.1 Hypoxic ischaemic encephalopathy / Perinatal asphyxia (typically infants of >24 weeks gestation or >600 g birthweight)
 - 5.2 Intracranial haemorrhage
 - 5.8 Other
- 6 Gastrointestinal**
 - 6.1 Necrotising enterocolitis
 - 6.8 Other

-
-
- 7 Other**
 - 7.1 Sudden Infant Death Syndrome (SIDS)
 - 7.11 SIDS Category 1A: Classic features of SIDS present and completely documented.
 - 7.12 SIDS Category 1B: Classic features of SIDS present but incompletely documented.
 - 7.13 SIDS Category II : Infant deaths that meet category 1 except for one or more features.
 - 7.2 Multisystem failure-only if unknown primary cause or trigger event
 - 7.3 Trauma
 - 7.8 Other specified
 - 7.9 Unknown/Undetermined
 - 7.91 Unclassified Sudden Infant Death
 - 7.92 Other Unknown/Undetermined

10. GLOSSARY

ABORIGINAL AND TORRES STRAIT ISLANDER IDENTIFICATION (STATUS) refers to whether or not a person is of Aboriginal and/or Torres Strait Islander descent who self identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community in which he or she lives.

ABORTION is a common term often used to mean termination of pregnancy or induced abortion.

ANOMALY is a deviation from what is regarded as normal. An example would be a congenital malformation or congenital anomaly.

ANTENATAL refers to the time period of pregnancy before birth.

ANTEPARTUM FETAL DEATH refers to a fetal death occurring before the onset of labour.⁶

BIRTH refers to the birth or delivery of a child.

BIRTH STATUS is the condition of the baby immediately after birth. The status may be a live birth or stillbirth (fetal death).

BIRTHWEIGHT is the first weight of the baby (stillborn or live born) obtained after birth. It is usually measured to the nearest five grams.

CONFIDENCE INTERVAL (95% CI) is a computed interval with a given probability (for example, 95%) that a true value of a variable such as a rate, mean or proportion, is contained between the low and high values. When the confidence intervals of two estimated values do not overlap, the values are statistically significantly different.

CONGENITAL ANOMALIES are the structural or anatomical abnormalities that are present at or existing from the time of birth, usually resulting from abnormal development in the first trimester of pregnancy. These were previously reported as birth defects, congenital anomalies or malformations.

CRUDE DEATH RATE is the number of deaths per 1,000 population (unless otherwise stipulated) in a given year (ABS definition).

FETAL DEATH refers to death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400g or more of birthweight; the death is indicated by the fact that after separation the fetus does not breathe or show any other evidence of life, such as the beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles (WHO definition).

GESTATION is the period of development of a baby from the time of conception (fertilisation of the ovum) to birth.

GESTATIONAL AGE is the duration of the pregnancy in completed weeks from the first day of the last normal menstrual period. This is estimated from clinical assessment (including estimates from ultrasound examinations) when accurate information on the last menstrual period is not available or not consistent with the clinical assessment of gestational age.

GRAVIDITY refers to a pregnancy; the state of being pregnant, and is unrelated to the outcome.

ICD-9 (or ICD-9-CM) refers to the International Classification of Diseases Ninth Revision as developed by the World Health Organisation. The CM stands for Country Modification.

ICD-10 (or ICD-10-AM) refers to the International Classification of Diseases Tenth Revision as developed by the World Health Organisation. The AM stands for Australian Modification. In the ACT and most other states in Australia, ICD-10-AM codes were introduced in July 1998 to code hospital (morbidity) inpatient data.

INTRAPARTUM FETAL DEATH refers to a fetal death occurring during labour.⁶

LIVE BIRTH refers, in this publication, to the complete expulsion or extraction from its mother of a baby of 20 completed weeks gestation or more or at least 400 grams in birthweight or who after being born breathes or shows any other evidence of life, such as a heartbeat. The WHO defines live birth differently, as the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta attached, each product of such a birth is considered live born.

MISCARRIAGE is a common term used to mean spontaneous abortion. See the definition for 'Spontaneous abortion'.

MORBIDITY is a diseased state or the ratio of sick to well in the community.⁷

MORTALITY is a fatal outcome or the relative number of deaths (death rate) in a given population at a given time.

MULTIGRAVIDA refers to a woman who has been pregnant more than once.

MULTIPARA refers to pregnant women who have had at least one previous pregnancy resulting in a live birth or stillbirth.

MULTIPLE BIRTH refers to a pregnancy resulting in more than one birth. For example twins, triplets etc.

NEONATAL DEATH is the death of a live born baby within 28 days of birth.

NEONATAL MORBIDITY refers to any condition or disease of the baby diagnosed within 28 days of birth.

PARITY refers to the total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth. The definition of parity has been changed since the last publication to align with the revised National Perinatal Data Development Committee's accepted definition.

PERINATAL refers to the period from 20 weeks gestation to within 28 days after birth.

PERINATAL DEATH refers to a stillbirth or a neonatal death.

PLURALITY refers to the number of fetuses or babies from a pregnancy. On this basis a pregnancy may be classified as single or multiple.⁸

POST NEONATAL DEATH refers to the death of a baby after 28 completed days and before 365 completed days.

PRETERM BIRTH refers to a birth before 36 completed weeks of gestation. Extremely preterm refers to births between 20 and 27 weeks gestation; moderately preterm refers to births between 28 and 31 weeks gestation; and mildly preterm refers to births between 32 and 36 weeks gestation.

PRIMIGRAVIDA refers to a woman pregnant for the first time.

PRIMIPARA refers to a pregnant woman who has had no previous pregnancy resulting in a live birth or stillbirth.

PROLONGED RUPTURE OF MEMBRANES refers to the spontaneous rupture of membranes for at least 18 hours prior to the onset of regular contractions with cervical dilation.

RESUSCITATION OF A BABY refers to active measures taken shortly after birth to assist the baby's ventilation and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

SEPARATION (from hospital) refers to when a patient is discharged from hospital, transferred to another hospital or other health care accommodation, or dies in hospital following formal admission (ABS definition).

SINGLETON BIRTH refers to a pregnancy resulting in one birth.

SPONTANEOUS ABORTION refers to the premature expulsion from the uterus of the products of conception, of the embryo, or of a nonviable fetus (a fetus of less than 400 grams birthweight or less than 20 weeks gestation). These may be classified as complete or incomplete.

STATISTICALLY SIGNIFICANT infers that it can be concluded on the basis of statistical analysis that it is highly probable.

STILLBIRTH see 'Fetal death'.

11. LIST OF PUBLICATIONS

The Epidemiology Section of ACT Health maintains and adds to an ongoing health series of publications to inform health professionals, policy developers and the community on health status in the Territory. Information contained therein will assist in the development of appropriate policy and service delivery models, the evaluation of programs, and an understanding of how the ACT compares with Australia as a whole with regard to health status.

- Number 1: ACT's Health: A report on the health status of ACT residents, Carol Gilbert, Ursula White, October 1995
- Number 2: The Epidemiology of Injury in the ACT, Carol Gilbert, Chris Gordon, February 1996
- Number 3: Cancer in the Australian Capital Territory 1983 - 1992, Norma Briscoe, April 1996
- Number 4: The Epidemiology of Asthma in the ACT, Carol Gilbert, April 1996
- Number 5: The Epidemiology of Diabetes Mellitus in the ACT, Carol Gilbert, Chris Gordon, July 1996
- Number 6: Developing a Strategic Plan for Cancer Services in the ACT, Kate Burns, June 1996
- Number 7: The First Year of The Care Continuum and Health Outcomes Project, Bruce Shadbolt, June 1996
- Number 8: The Epidemiology of Cardiovascular Disease in the ACT, C Gilbert, U White, January 1997
- Number 9: Health Related Quality of Life in the ACT: 1994 - 95, D Gannon, C Gordon, B Egloff, B Shadbolt, February 1997
- Number 10: Disability and Ageing in the ACT: An Epidemiological Review, C Gilbert, April 1997
- Number 11: Mental Health in the ACT, Ursula White, C Gilbert, May 1997
- Number 12: Aboriginal and Torres Strait Islander Health in the ACT, N Briscoe, J McConnell, M Petersen, July 1997
- Number 13: Health Indicators in the ACT: Measures of health status and health services in the ACT, C Kee (Gilbert), G Johansen, U White, J McConnell, January 1998
- Number 14: Health status of the ACT by statistical sub divisions, C Kee, G Bodilson (Johansen), April 1998
- Number 15: Results from the 1996 ACT Secondary School Students' Survey, H Phung, A Webb, N Briscoe, June 1998
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