

Appendix S1: Midwives Data Collection

NSW MIDWIVES DATA COLLECTION			
Mother Unit Record No. <input type="text"/>	Hospital <input type="text"/>	Code <input type="text"/>	
First Name <input type="text"/>	Family Name <input type="text"/>		
Address <input type="text"/>		Postcode <input type="text"/>	
Mother's birth date <input type="text"/>	day month year		
Country of birth <input type="checkbox"/> Australia <input type="checkbox"/> 36	Other <input type="checkbox"/>		
If other, specify <input type="text"/>			
Indigenous status: <input type="checkbox"/> Aboriginal <input type="checkbox"/> 1			
<input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> 2			
<input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> 3			
<input type="checkbox"/> None of the above <input type="checkbox"/> 4			
PREVIOUS PREGNANCIES			
Previous pregnancy greater than 20 weeks? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
If no, go to next section.			
If yes:			
Specify the number of previous pregnancies > 20 weeks <input type="text"/>			
Was the last birth by caesarean Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
Total number of previous caesarean sections? <input type="text"/>			
THIS PREGNANCY			
Date of LMP <input type="text"/>			
day month year			
Prenatal diagnosis (< 20 weeks gestation) <input type="checkbox"/> CVS <input type="checkbox"/>			
<input type="checkbox"/> Amniocentesis			
Antenatal care			
Duration of pregnancy at first visit (weeks) <input type="text"/>			
<input type="checkbox"/> Not booked			
Medical conditions			
<input type="checkbox"/> Diabetes mellitus			
<input type="checkbox"/> Gestational diabetes			
<input type="checkbox"/> Chronic hypertension			
<input type="checkbox"/> Pre-eclampsia			
Smoking			
Did the mother smoke at all during pregnancy? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
If yes, how many cigarettes each day on average in the second half of pregnancy?			
None <input type="checkbox"/> 1 > 10 per day <input type="checkbox"/> 2			
≤ 10 per day <input type="checkbox"/> 3 Unknown <input type="checkbox"/> 4			
LABOUR AND DELIVERY			
Onset of labour			
Spontaneous <input type="checkbox"/> 1 Induced <input type="checkbox"/> 2			
No labour <input type="checkbox"/> 3			
If labour augmented/induced (tick 1 or more):			
<input type="checkbox"/> Oxytocins <input type="checkbox"/> ARM <input type="checkbox"/>			
<input type="checkbox"/> Prostaglandins <input type="checkbox"/> Other <input type="checkbox"/>			
LABOUR AND DELIVERY			
If labour induced, main indication:			
<input type="checkbox"/> Diabetes <input type="checkbox"/> 1			
<input type="checkbox"/> Hypertensive disease <input type="checkbox"/> 2			
<input type="checkbox"/> Fetal distress <input type="checkbox"/> 3			
<input type="checkbox"/> Fetal death <input type="checkbox"/> 4			
<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> 5			
<input type="checkbox"/> Blood group isoinmunisation <input type="checkbox"/> 6			
<input type="checkbox"/> Prelabour rupture of membranes <input type="checkbox"/> 7			
<input type="checkbox"/> Prolonged pregnancy (41+ weeks) <input type="checkbox"/> 8			
<input type="checkbox"/> Suspected intrauterine growth restriction <input type="checkbox"/> 9			
<input type="checkbox"/> Other <input type="checkbox"/> 10			
Pain relief/ anaesthetics (tick 1 or more)			
<input type="checkbox"/> None <input type="checkbox"/> Pudendal <input type="checkbox"/>			
<input type="checkbox"/> Nitrous oxide <input type="checkbox"/> Spinal <input type="checkbox"/>			
<input type="checkbox"/> IM narcotics <input type="checkbox"/> General anaesthetic <input type="checkbox"/>			
<input type="checkbox"/> Local to perineum <input type="checkbox"/> Other <input type="checkbox"/>			
<input type="checkbox"/> Epidural/caudal			
Presentation at birth			
<input type="checkbox"/> Vertex <input type="checkbox"/> 1 <input type="checkbox"/> Face <input type="checkbox"/> 3			
<input type="checkbox"/> Breech <input type="checkbox"/> 2 <input type="checkbox"/> Brow <input type="checkbox"/> 4			
<input type="checkbox"/> Other <input type="checkbox"/> 5			
Type of delivery			
<input type="checkbox"/> Normal vaginal <input type="checkbox"/> 1 <input type="checkbox"/> Vacuum extr. <input type="checkbox"/> 3			
<input type="checkbox"/> Forceps <input type="checkbox"/> 2 <input type="checkbox"/> Vaginal breech <input type="checkbox"/> 4			
<input type="checkbox"/> Caesarean section <input type="checkbox"/> 5			
If caesarean section, main indication:			
<input type="checkbox"/> Failure to progress			
- Cx dilatation unknown <input type="checkbox"/> 1			
- Cx 3cm dilated or less <input type="checkbox"/> 2			
- Cx dilated more than 3 cm <input type="checkbox"/> 3			
<input type="checkbox"/> Fetal distress <input type="checkbox"/> 4			
<input type="checkbox"/> Other <input type="checkbox"/> 5			
Perineal status			
<input type="checkbox"/> Intact <input type="checkbox"/> 1 <input type="checkbox"/> 4th deg. tear <input type="checkbox"/> 5			
<input type="checkbox"/> 1st deg. tear/grade <input type="checkbox"/> 2 <input type="checkbox"/> Episiotomy <input type="checkbox"/> 6			
<input type="checkbox"/> 2nd deg. tear <input type="checkbox"/> 3 <input type="checkbox"/> Both tear and episiotomy <input type="checkbox"/> 7			
<input type="checkbox"/> 3rd deg. tear <input type="checkbox"/> 4 <input type="checkbox"/> Other <input type="checkbox"/> 8			
Surgical repair of the vagina or perineum? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
BABY			
Place of birth			
<input type="checkbox"/> Hospital theatre/delivery suite <input type="checkbox"/> 1			
<input type="checkbox"/> Birth centre <input type="checkbox"/> 2			
<input type="checkbox"/> Planned birth centre/delivery suite birth <input type="checkbox"/> 3			
<input type="checkbox"/> Planned homebirth <input type="checkbox"/> 4			
<input type="checkbox"/> Planned homebirth/hospital admission <input type="checkbox"/> 6			
<input type="checkbox"/> Born before arrival <input type="checkbox"/> 6			
Unit Record No. <input type="text"/>			
Birth date: <input type="text"/>			
day month year			
Sex: M <input type="checkbox"/> 1 F <input type="checkbox"/> 2 Indet. <input type="checkbox"/> 3			
Plurality: Single <input type="checkbox"/> 1 Multiple <input type="checkbox"/> 2			
If multiple, total number <input type="text"/>			
If multiple birth, specify baby number <input type="text"/>			
Birthweight (grams) <input type="text"/>			
Estimated gestational age <input type="text"/>			
Apgar <input type="text"/>			
1 min 5 min			
Resuscitation of baby (tick 1 or more)			
<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> IPPR: bag + mask <input type="checkbox"/> 4			
<input type="checkbox"/> Suction <input type="checkbox"/> 2 <input type="checkbox"/> Intubation + IPPR <input type="checkbox"/> 6			
<input type="checkbox"/> O2 therapy <input type="checkbox"/> 3 <input type="checkbox"/> External cardiac massage + ventilation <input type="checkbox"/> 6			
<input type="checkbox"/> Other <input type="checkbox"/> 7			
POSTNATAL CARE - BABY			
Birth defect? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
If yes, specify: <input type="text"/>			
Admitted to NICU? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
Admitted to SCN? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
If yes, observation only? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
If admitted to SCN/NICU:			
Was a birth defect the main reason for admission? Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 0			
DISCHARGE STATUS - MOTHER AND BABY			
Mother			
<input type="checkbox"/> Discharged <input type="checkbox"/> 1 <input type="checkbox"/> Discharged <input type="checkbox"/> 1			
<input type="checkbox"/> Transferred <input type="checkbox"/> 2 <input type="checkbox"/> Transferred <input type="checkbox"/> 2			
<input type="checkbox"/> Died <input type="checkbox"/> 3 <input type="checkbox"/> Stillbirth <input type="checkbox"/> 3			
<input type="checkbox"/> Neonatal death <input type="checkbox"/> 4			
<input type="checkbox"/> Transferred and died <input type="checkbox"/> 5			
Baby's date of discharge or transfer <input type="text"/>			
day month year			
Hospital transferred to: <input type="text"/>			
If baby died, date of death <input type="text"/>			
day month year			
Signature of midwife at discharge <input type="text"/>			



PART A (continued)	PART B (Neonatal deaths only)	MAIN CAUSE OF DEATH AND RELEVANT FACTORS																																																																								
<p>17. Were there cord complications?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>            If yes, describe:</p>	<p>THE MAIN CAUSE OF DEATH (tick one):</p> <p>1. Congenital abnormality <input type="checkbox"/></p> <p>2. Extreme prematurity <input type="checkbox"/>            If yes, was resuscitation carried out?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>	<p>Main cause of death as determined by hospital perinatal death review committee</p>																																																																								
<p>18. Was a major fetal abnormality present?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>            If yes, describe:</p>	<p>3. Cardio-respiratory</p> <p>Hyaline membrane disease <input type="checkbox"/>            Meconium aspiration syndrome <input type="checkbox"/>            Primary persistent pulmonary hypertension <input type="checkbox"/>            Pulmonary hypoplasia <input type="checkbox"/>            Chronic neonatal lung disease <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>Relevant factors:</p> <p>Antenatal:</p>																																																																								
<p>19. Was chorioamnionitis present?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>            If yes, diagnosis was:            Pathological <input type="checkbox"/>            Clinical <input type="checkbox"/>            If yes, specify organism:</p>	<p>4. Infection</p> <p>Congenital bacterial <input type="checkbox"/>            Acquired bacterial <input type="checkbox"/>            Congenital viral <input type="checkbox"/>            Acquired viral <input type="checkbox"/>            Protozoal eg Toxoplasma <input type="checkbox"/>            Spirochaetal eg Syphilis <input type="checkbox"/>            Fungal <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>Intrapartum:</p>																																																																								
<p>20. Infant/ fetal infection?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>            If yes: Streptococcus Group B <input type="checkbox"/>            E Coli <input type="checkbox"/>            Listeria monocytogenes <input type="checkbox"/>            Cytomegalovirus <input type="checkbox"/>            Parvovirus <input type="checkbox"/>            Herpes simplex virus <input type="checkbox"/>            Rubella virus <input type="checkbox"/>            Toxoplasma <input type="checkbox"/>            Syphilis <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>5. Neurological</p> <p>Hypoxic ischaemic encephalopathy/ perinatal asphyxia <input type="checkbox"/>            Intracranial haemorrhage <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>Postpartum:</p> <p>Form completed by:            Name: _____            Date: / /</p>																																																																								
<p>21. Other conditions?            Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>            If yes: Twin-to-twin transfusion <input type="checkbox"/>            Fetomaternal haemorrhage <input type="checkbox"/>            Uterine abnormality <input type="checkbox"/>            Birth trauma <input type="checkbox"/>            Haemolytic disease <input type="checkbox"/>            Idiopathic hydrops <input type="checkbox"/>            Drug dependence/abuse <input type="checkbox"/>            Termination of pregnancy <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>6. Gastrointestinal</p> <p>Necrotising enterocolitis <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>DEFINITION: FETAL GROWTH RESTRICTION</p> <p>Less than the 10th percentile for gestation.</p> <table border="1"> <thead> <tr> <th>Gestation (weeks)</th> <th>Weight (grams) Male</th> <th>10th percentile Female</th> </tr> </thead> <tbody> <tr><td>22</td><td>400</td><td>400</td></tr> <tr><td>23</td><td>500</td><td>470</td></tr> <tr><td>24</td><td>520</td><td>540</td></tr> <tr><td>25</td><td>620</td><td>620</td></tr> <tr><td>26</td><td>720</td><td>680</td></tr> <tr><td>27</td><td>740</td><td>730</td></tr> <tr><td>28</td><td>850</td><td>760</td></tr> <tr><td>29</td><td>950</td><td>890</td></tr> <tr><td>30</td><td>1080</td><td>1045</td></tr> <tr><td>31</td><td>1310</td><td>1140</td></tr> <tr><td>32</td><td>1400</td><td>1340</td></tr> <tr><td>33</td><td>1640</td><td>1520</td></tr> <tr><td>34</td><td>1840</td><td>1760</td></tr> <tr><td>35</td><td>2110</td><td>2030</td></tr> <tr><td>36</td><td>2320</td><td>2220</td></tr> <tr><td>37</td><td>2550</td><td>2430</td></tr> <tr><td>38</td><td>2780</td><td>2660</td></tr> <tr><td>39</td><td>2940</td><td>2820</td></tr> <tr><td>40</td><td>3070</td><td>2950</td></tr> <tr><td>41</td><td>3180</td><td>3050</td></tr> <tr><td>42</td><td>3210</td><td>3080</td></tr> <tr><td>43</td><td>3080</td><td>2950</td></tr> <tr><td>44</td><td>3050</td><td>2930</td></tr> </tbody> </table>	Gestation (weeks)	Weight (grams) Male	10th percentile 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
Gestation (weeks)	Weight (grams) Male	10th percentile 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																																																																								
<p>22. Classification of obstetric cause of death (see Attachment)</p>	<p>7. Other</p> <p>SIDS: Consistent with SIDS <input type="checkbox"/>            Possible SIDS <input type="checkbox"/>            Multisystem failure (only if unknown primary cause or trigger event) <input type="checkbox"/>            Trauma <input type="checkbox"/>            Undetermined <input type="checkbox"/>            Other <input type="checkbox"/>            If other, specify:</p>	<p>Source: Roberts CL, Lancaster PAL. Australian national birthweight percentiles by gestational age. <i>Med J Aust</i> 1999; 170: 114-118.</p>																																																																								

**Australia and New Zealand Antecedent Classification of Perinatal Mortality**

<p><b>1. Congenital abnormality</b> (including termination of pregnancy for congenital abnormality)</p> <p>1.1 Central nervous system 1.2 Cardiovascular system 1.3 Urinary tract 1.4 Gastrointestinal tract 1.5 Chromosomal 1.6 Metabolic 1.7 Multiple 1.8 Other 1.9 Unspecified</p> <p><b>2. Perinatal infection</b></p> <p>2.1 Bacterial 2.11 Group B Streptococcus 2.12 E Coli 2.13 Listeria Monocytogenes 2.18 Other bacterial 2.19 Unspecified bacterial</p> <p>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</p> <p>2.3 Protozoal eg Toxoplasma 2.4 Spirochaetal eg Syphilis 2.5 Fungal 2.6 Other 2.7 Unspecified organism</p> <p><b>3. Hypertension</b></p> <p>3.1 Chronic hypertension: essential 3.2 Chronic hypertension: secondary eg renal disease 3.3 Chronic hypertension: unspecified 3.4 Gestational hypertension 3.5 Pre-eclampsia 3.6 Pre-eclampsia superimposed on pre-existing hypertension 3.7 Unspecified hypertension</p> <p><b>4. Antepartum haemorrhage</b></p> <p>4.1 Placental abruption 4.2 Placenta praevia 4.3 Vasa praevia 4.8 Other APH 4.9 APH of undetermined origin</p> <p><b>5. Maternal disease</b></p> <p>5.1 Termination of pregnancy (other than for fetal abnormality) 5.2 Diabetes / gestational diabetes 5.3 Maternal injury 5.31 Accidental 5.32 Non-accidental</p> <p>5.4 Maternal sepsis 5.5 Other maternal conditions eg Lupus obstetric syndrome</p> <p><b>6. Specific perinatal conditions</b></p> <p>6.1 Twin-to-twin transfusion 6.2 Fetomaternal haemorrhage 6.3 Antepartum cord complications 6.4 Uterine abnormality 6.5 Birth trauma (typically &gt;24 weeks or &gt; 600 grams) 6.6 Haemolytic disease 6.7 Idiopathic hydrops 6.8 Other</p>	<p><b>7. Hypoxic peripartum death (typically &gt; 24 weeks or &gt; 600 grams)</b></p> <p>7.1 With intrapartum complications 7.11 Uterine rupture 7.12 Cord prolapse 7.13 Shoulder dystocia 7.18 Other</p> <p>7.2 No intrapartum complications 7.9 Unspecified hypoxic peripartum death</p> <p><b>8. Fetal growth restriction (FGR)</b></p> <p>8.1 With evidence of uteroplacental insufficiency eg significant infarction, acute atherosclerosis, maternal vascular thrombosis or maternal floor infarction 8.2 With chronic villitis 8.3 Without the above placental pathology 8.4 No examination of placenta 8.9 Unspecified FGR or not known whether placenta examined</p> <p><b>9. Spontaneous preterm</b></p> <p>9.1 Spontaneous preterm with intact membranes, or membrane rupture less than 24 hours before delivery, 9.11 with chorioamnionitis 9.12 without chorioamnionitis 9.13 no examination of the placenta 9.19 unspecified or not known whether placenta examined</p> <p>9.2 Spontaneous preterm with membrane rupture <math>\geq</math> 24 hours before delivery, 9.21 with chorioamnionitis 9.22 without chorioamnionitis 9.23 no examination of the placenta 9.29 unspecified or not known whether placenta examined</p> <p>9.3 Spontaneous preterm with membrane rupture of unknown duration before delivery, 9.31 with chorioamnionitis 9.32 without chorioamnionitis 9.33 no examination of the placenta 9.39 unspecified or not known whether placenta examined</p> <p><b>10. Unexplained antepartum death</b></p> <p>10.1 With evidence of uteroplacental insufficiency eg significant infarction, acute atherosclerosis, maternal vascular thrombosis or maternal floor infarction. 10.2 With chronic villitis 10.3 Without the above placental pathology 10.4 No examination of placenta 10.9 Unspecified unexplained antepartum death or not known whether placenta examined.</p> <p><b>11. No obstetric antecedent</b></p> <p>11.1 SIDS 11.11 Consistent with SIDS 11.12 Possible SIDS</p> <p>11.2 Postnatally acquired infection 11.3 Accidental asphyxiation 11.4 Other accident, poisoning or violence (postnatal) 11.8 Other 11.9 Unknown / Unexplained</p>
---	---