



Perinatal Morbidity and Mortality Policy

1. Background

Australian research suggests that one in every 10 patients suffers a complication of care during their hospital stay, with half of those complications being avoidable. While most complications will only have a minor impact on patients a minority end in permanent disability or death.

For the great majority in Australia, pregnancy and childbirth is a normal physiologic process that culminates in a healthy mother and baby. This means, however, that on those occasions when things do go wrong, the effects can be even more devastating than in other areas of healthcare.

Maintaining maternal and neonatal safety in these circumstances depends on being vigilant for signs of deviation from normal and being prepared to take effective and prompt action when they are detected. However, because of their relative rarity, it may be some time before serious incidents become apparent when the overall local statistics seem unremarkable, yet care may be suboptimal.

It is vital that any and all incidents of perinatal morbidity and mortality are properly reported and are transparently investigated in order to identify contributing care delivery problems. Systematic, multi-disciplinary review of maternal morbidity and mortality can improve maternal outcomes, care delivery problems and prevent unnecessary recurrences.

The WA Health MP 0098/18 [Review of Death Policy](#) outlines perinatal death review requirements for maternity sites in order to identify:

- a) potentially preventable deaths
- b) opportunities for improvement in the delivery of health services.

WACHS further requires perinatal death review to ensure high quality, systematic investigation, and audit of the likely cause/s of the death to reduce future risks and provide appropriate support to the parents / family.

Legislative requirements for perinatal deaths

Effective as of 27 March 2024, the [Abortion Legislation Reform Act 2023](#) (WA) repeals all provisions related to abortion within the [Health \(Miscellaneous Provisions\) Act 1911](#) (WA) and creates a new framework relating to abortion under the [Public Health Act 2016](#) (WA).

The legislative requirements relating to birth notification, birth registration, death registration, notification of abortion, coronial reporting, disposal of products of conception [including cases of abortion and termination of pregnancy (TOP)] and funeral /cremations are outlined in a table at [Appendix 4](#).

2. Policy Statement

This policy provides clinical governance assurance that all events resulting in perinatal morbidity or mortality (M & M) are subject to systematic review with central monitoring of patterns, trends and relevant care recommendations for dissemination and action across all maternity service providers.

Central monitoring of perinatal M & M case patterns and trends, then dissemination of lessons and recommendations for care across maternity services will be undertaken by the WACHS Perinatal M & M Committee.

2.1 Outcomes – maternal, fetal and neonatal morbidity reviews

- Known complications still require case review by senior clinicians (not involved in the care) to determine whether there was preventable harm.
- All cases of significant maternal or neonatal morbidity or mortality, as per the Stork generated monthly Maternal and Infant trigger reports are to be reviewed by the Midwifery manager and /or senior Obstetric doctor – see [Appendix 1](#).
- Where preventable harm is identified, anywhere across the care continuum, the case must be reported as a clinical incident.
- Findings from these case reviews are to be maintained in a local Perinatal M & M trigger review database for record keeping / audit purposes. The local database should be kept on a shared drive with access provided for relevant staff members.
- A template for both the Stork Maternal and Infant Trigger case reviews can be found in the supporting resources on HealthPoint with this policy. Managers should download the templates to their shared drive folder for use.

2.2 Outcomes – severity and assessment code (SAC) 1 incidents

- All perinatal SAC 1 incidents are to be reported and investigated as per WA Health MP 0122/19 [Clinical Incident Management Policy 2019](#) and WACHS SAC 1 Business Rules see [Appendix 1](#).
- SAC 1 investigations should include:
 - at least one senior midwife and/or obstetric doctor from either another WACHS region, central office or another WA public health service provider.
 - the maternity manager at that site provided they were not involved in the actual incident.
- Maternity SAC 1 investigation reports will be tabled at the WACHS Perinatal M & M Committee meeting.

2.3 Outcomes – perinatal death reviews

- All perinatal deaths will be subject to systematic local first and second line review as per the WACHS [Review of Death Procedure](#) and classified in the WACHS Review of Death (ROD) app – see [Appendix 2](#). Perinatal Review of Death tool.
- The second level review should be completed by the most senior midwifery position and lead Obstetric doctor (except where involved in the case).
- These reviews must incorporate care across the continuum (antenatal where records available, intrapartum, and postnatal) and not just for the presenting admission.
- Findings should be reported to the WACHS Perinatal M & M Committee for tabling and discussion at the next committee meeting.

2.4 Conflict of opinion about cases or reporting

Where two clinicians, or Health Service Provider (HSP) staff including non-maternity staff, disagree as to:

- Whether a case should be reported as a clinical incident, and/or the SAC classification of an incident.
- The classification of a perinatal death or whether a death is a reportable death

Then staff should follow the WACHS [Maternity Care Clinical Conflict Escalation Pathway Policy](#). If a staff member remains concerned after following the WACHS [Maternity Care Clinical Conflict Escalation Pathway Policy](#) they can seek advice of the WACHS Central Office Clinical Leads for Obstetrics or Midwifery.

2.5 Resources to support investigation / audit of perinatal deaths

The Stillbirth Centre of Research Excellence have a number of resources / tools to support the high quality and systematic investigation of the causes of perinatal deaths. These can be found here [Care Around Stillbirth and Neonatal Death Clinical Practice Guideline: Perinatal mortality audit and classification \(2024 Edition\)](#) with particular assistance from the:

- [Australian Perinatal Mortality Audit Tool](#).

2.6 Regional maternity care governance

Each region and site are required to establish a maternity clinical governance committee (however titled), that meets regularly with a defined reporting structure, with representatives from:

- Each maternity site – midwifery and obstetric doctor.
- Regional clinical leads for maternity.
- Safety and Quality.
- Education.

The maternity clinical governance committee (however titled) is accountable for oversight, actions, recommendations, and escalation arising from the:

- WACHS Obstetric dashboard.
- Monthly Stork Maternal and Infant trigger case review findings.
- Stork perinatal database routine reports.
- Women's Health Australasia (WHA) Benchmarking Maternity Care reports.
- ACHS Clinical Indicator Reports.
- Health Round Table.
- Local maternity related guidelines /pathways.
- Regional maternity care clinical audit results.
- First and second line review of perinatal deaths.

3. Definitions

Abortion	The process to end or terminate a pregnancy is called abortion.
Livebirth	The birth of a baby who shows signs of life such as voluntary muscle movement, pulsating of the umbilical cord or presence of a heartbeat at birth, regardless of whether the placenta is still attached, or the umbilical cord has been cut (regardless of gestation).
Maternal death	Where a woman dies as the result of pregnancy or childbirth and up to 42 days after birth (WA Health) PLEASE NOTE: <i>These deaths are reportable to the Chief Health Officer (CHO) for WA within 48 hours. This includes the death of a woman following an abortion. Further information on how to make a notification and the information to be provided can be found at: Notification of death of a woman as a result of pregnancy or childbirth.</i>
Miscarriage	A fetal death occurring before 20 weeks of gestation
Neonatal death	The death of a liveborn infant at any gestation that occurs within 28 days of that birth. <i>These births are registerable as a live birth and then registered as a subsequent death.</i> PLEASE NOTE: <i>From 27 March 2024 in WA, a death that is the result of the performance of an abortion, is not to be notified as a neonatal or perinatal death. Further information for reporting induced abortions to the CHO is outlined in Notification of abortion (termination of pregnancy)</i>
Notification of case attended (NOCA)	Also referred to as Form 2 or the Birth Notification. The NOCA contains all information to be notified by a registered midwife to the CHO when an infant was liveborn or stillborn in WA of at least 20 weeks gestation, or of $\geq 400\text{g}$ birthweight if unable to establish gestation. The exception to this is in the case of abortions. Submitting this birth information is a requirement of the Health (Miscellaneous Provisions) Act 1911 and the Health (Notifications by Midwives) Regulations 1994 .

<p>Perinatal death</p> <p>See Appendix 4 for legal requirements</p>	<p>A stillbirth or neonatal death of a baby from 20 or more completed weeks gestation to 28 days following birth or of $\geq 400\text{g}$ birthweight if unable to establish gestation.</p> <p><i>The CHO must be notified whenever any child:</i></p> <ul style="list-style-type: none"> • of more than 20 weeks gestation is stillborn, or • under the age of 1 year dies from any cause whatsoever. <p>Further information on how to make a notification and the information to be provided can be found at: Notification of perinatal and infant deaths.</p> <p>PLEASE NOTE: From 27 March 2024 in WA, a death that is the result of the performance of an abortion, is not to be notified as a perinatal or neonatal death. Further information for reporting induced abortions to the CHO is outlined in Notification of abortion (termination of pregnancy)</p>
<p>Perinatal morbidity</p>	<p>Maternal, fetal or neonatal medical conditions or complications arising during the perinatal period</p>
<p>Perinatal mortality</p>	<p>Maternal, fetal or neonatal death in the perinatal period</p>
<p>Perinatal period</p>	<p>From 20 weeks gestation to 28 days after birth</p>
<p>Preventable harm</p>	<p>Unintended physical or emotional patient harm resulting from an act or omission of health care</p>
<p>Pre-viable fetus</p>	<p>Gestational age is a major factor in determining survivability. A fetus born before 22+0 weeks gestation is considered a pre-viable fetus (i.e. too immature for life sustaining measures). There is a possibility for a pre-viable fetus to be born with signs of life (may include beating of the heart, pulsation of the umbilical cord or respiratory efforts). Comfort measures and palliative care is usually recommended.</p>
<p>Stillbirth (Fetal death)</p>	<p>Birth following the death of an unborn baby of 20 or more completed weeks gestation or of $\geq 400\text{g}$ birthweight if unable to establish gestation.</p>

4. Roles and Responsibilities

Regional Directors of Medicine / Nursing and Midwifery are to establish and maintain a regional maternity clinical governance committee with clear reporting accountability lines.

Midwives and Obstetric doctors are to report clinical incidents as per the Perinatal M & M clinical incident and/or case review trigger list (see [Appendix 1](#)). Any staff member can report a clinical incident even where others disagree as to whether it is reportable.

Midwifery Manager / Senior Obstetric doctor are to:

- To review all Stork Maternal and Infant Trigger report cases monthly to determine if any care delivery problems occur and report the same as a clinical incident.
- Maternity managers are to create a shared folder (Perinatal M & M case reviews) to store the Stork Trigger report case review databases and all other routine Stork reports for the site (see templates in related documents on HealthPoint). The manager should ensure access to the shared folder for others who require it.
- Ensure first line review of all perinatal deaths occur.
- Monitoring of all clinical indicator reports via Stork, Women's Health Australasia (WHA) [WHA Benchmarking Maternity Care Reports](#), the [WACHS Obstetrics dashboard](#) and the WA Health [Safety and Quality Indicator Set \(SQulS\)](#) Maternity dataset.

Central Office Safety and Quality are to:

- Notify the Perinatal M & M Committee of completed Obstetric SAC1 investigation reports and maternity related CIMS data reports.
- Provide a report of all review of death (ROD) reviews conducted in the preceding two months to the Perinatal M & M Committee meeting.

Doctors and nurses in emergency departments and in general wards caring for pregnancy loss under 20 weeks must familiarise themselves with the legislative requirements for these perinatal losses (see Table in [Appendix 4](#)).

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

This policy is a mandatory requirement under the [Health Services Act 2016](#).

Failure to comply with this Perinatal Morbidity and Mortality Policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Integrity Policy Framework](#) issued pursuant to Section 26 of the [Health Services Act 2016](#) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

Clinical: [Health Record Management Policy](#)

7. Evaluation

Evaluation of implementation of this policy is to be carried out by Regional Nursing and Midwifery Director and the Regional Medical Director 12 months post implementation.

Review of the functions of the PM&MC committee will be undertaken following the first 12 months of activity.

8. Standards

[National Safety and Quality Health Service Standards](#) (Second edition 2021) 1.01, 1.07-1.11, 1.28, 6.01, 6.02, 6.11

9. Legislation

The statutory requirement to notify perinatal and infant mortality is specified in Sections 335 1, 5(a) and (c), and 336A of the [Health \(Miscellaneous Provisions\) Act 1911](#) (WA) (Part XIII).

[Abortion Legislation Reform Act 2023](#) (WA) - this Act repeals all provisions related to abortion within the [Health \(Miscellaneous Provisions\) Act 1911](#) (WA) and creates a new framework relating to abortion under the [Public Health Act 2016](#) (WA).

Consequential amendments have also been made to the:

- [Criminal Code Act Compilation Act 1913](#) (WA)
- [Children's Court of Western Australia Act 1988](#) (WA)
- [Coroner's Act 1996](#) (WA)
- [Freedom of information Act 1992](#) (WA)
- Medical Practitioners and prescribing practitioners (Endorsed Midwives and Nurse Practitioners) must notify the Chief Health Officer (CHO) if they perform an abortion via completion of the [Abortion Notification Eform](#) within 14 days of the abortion being performed.
- From 27 March 2024, a death that is the result of the performance of an abortion, is not to be notified as a perinatal or infant death.

10. References

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11. Related Forms

[MR82 WACHS Perinatal Loss Care Plan \(Less than 20 weeks gestation\)](#)
[MR82A WACHS Perinatal Loss Care Plan \(More than 20 weeks gestation\)](#)

12. Related Policy Documents

WACHS [Maternity Care Clinical Conflict Escalation Pathway Policy](#)
 WACHS [Review of Death Procedure](#)

13. Related WA Health System Policies

MP 0098/18 [Review of Death Policy](#)
 MP 0122/19 [Clinical Incident Management Policy 2019](#)
 MP 0129/20 [Release of Human Tissue and Explanted Medical Devices Policy](#)

14. Policy Framework

[Clinical Governance, Safety and Quality](#)

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Version:	1.01	Date Published:	23 February 2026

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Appendix 1: Perinatal M & M incidents requiring Datix CIMS report

An event or circumstance resulting from health care provision (or lack thereof) which could have, or did lead to, unintended or unnecessary physical or psychological harm to a patient should be reported as a clinical incident into Datix CIMS. There are three Severity Assessment Codes:

- **SAC 1** = serious harm or death
- **SAC 2** = moderate harm
- **SAC 3** = minor or no harm

WA Health defined SAC 1 clinical Incidents:

1. Discharge or release of an infant to an unauthorised person or infant abduction.
2. Incorrectly positioned oro/ naso-gastric tube resulting in serious harm or death.
3. Maternal death or serious disability associated with pregnancy, birth and the puerperium (up to 42 days after the birth).
4. Delay in recognising or responding to clinical deterioration (*including CTG*).
5. Fetal complications associated with health care delivery.
 - a. Unrelated to congenital abnormality (birth weight greater than 2500 grams) causing death, or serious and/or ongoing perinatal morbidity.
 - b. Complications not anticipated yet arose, and not managed in an appropriate or timely manner, resulting in death, or serious and/or ongoing morbidity.
 - c. Intrapartum transfer to another facility for a higher care resulting in death, or serious and/or ongoing morbidity.
 - d. Complication of resuscitation.
6. Hospital process issues contributing to serious harm or death:
 - a. Triaging, assessment, planning or delivery of care e.g. miscommunication of test results, response to abnormal test results.
 - b. Delay in transport or transfer.
 - c. Misidentification of patients.

WACHS Stork Maternal and Infant trigger cases requiring clinical review. (If the outcome is a result of health care provision, or lack thereof, the event should be reported in Datix CIMS)

1. Perinatal death not related to lethal congenital anomaly.
2. Apgar score < 7 at 5 minutes or Cord blood pH less than 7.1.
3. Neonatal trauma requiring extra observations e.g. Haematoma, brachial plexus injury, fractures.
4. Unplanned birth at gestation below usual site threshold.
5. Cord prolapse and vasa-praevia haemorrhage.
6. Uterine rupture.
7. Eclampsia.
8. Pregnancy associated DVT or pulmonary embolus (up to 6 weeks postnatal).
9. Peripartum hysterectomy (up to 6 weeks).
10. Attempted operative vaginal birth outside of theatre leading to caesarean.
11. Postpartum haemorrhage > 1500 ml **or** associated with transfusion.
12. 4th degree tear.
13. Postnatal return to theatre i.e. post-LUSCS or perineal repair.
14. Maternal admission to HDU or ICU or requiring a special.
15. Intrapartum or postnatal transfer to another maternity hospital for ongoing management.
16. Bladder (including overdistension), bowel or blood vessel injury associated with birth.
17. Incidents arising from baby co-sleeping (parent or carer).
18. Admission to SCN associated with water birth.

Appendix 2: Perinatal Review of Death (ROD) tool

Case ID:	Region:	Death category: (Y or N)		
Perinatal death – triggers (Maternal, fetal, neonatal) <i>Yes response indicates potential preventability</i>		AN	Labour	PN or Neonatal
Care delivery issues				
Was there delay in diagnosis /assessment or transfer?				
Was there delay in initiating Rx?				
Was the information or communication provided inadequate, incorrect, or misinterpreted?				
Did care deviate from policy or guidelines?				
Was there a complication due to Rx, procedure, or operation?				
Was there a medication error which may have contributed?				
Was there failure to seek help / lack of supervision?				
Were there any clinical risk factors that weren't identified or referred (i.e. Obstetric, medical, social, EPDS, substance misuse etc)?				
Was there a failure to identify / follow up any abnormal test results (imaging, diagnostics or CTG etc)?				
Was there failure to recognise deterioration or respond to deterioration appropriately?				
Was there an adverse event and was it documented in the medical record?				
Staffing issues				
Was no assistance available when required?				
Was the skill mix inappropriate?				
Was there inadequate staff for the activity demand?				
Was there inadequate knowledge or skills?				
Did a staff member fail to maintain their competence?				
Organisation issues				
Was there misuse of, faulty or unavailable equipment?				
Were there barriers to accessing or engaging in services required?				
Was there inadequate training and education?				
Was there lack of policy or guideline?				
Was there inadequate system for information sharing between services?				
Is the building design or functionality inadequate?				
Patient factors:				
Was a parent co-sleeping with newborn?				
Was there poor compliance with recommended care?				
Were modifiable risk factors present – high BMI, smoking, alcohol /drugs, FDV etc?				

Appendix 3: Perinatal death classification

Health Round Table criteria (for fetal deaths – also consider care preceding the death)	
Category 1	Anticipated death due to a life limiting condition (Anticipated by clinicians and family at the time)
Category 2	Not unexpected death which occurred despite the health service provider taking appropriate measures
Category 3	Unexpected death which was not reasonably preventable with appropriate intervention
Category 4	Preventable death where steps may not have been taken to prevent it
Category 5	Avoidable death resulting from health care intervention or omission
Deaths classified as categories 4 or 5 require SAC 1 reporting	

Appendix 4: Legislative requirements for all perinatal deaths (conception to 42 days post birth) – includes Abortion / TOP

< 20 weeks AND less than 400 grams	Born without signs of life	Livebirth	Abortion / TOP requirements
Birth Registration Birth Notification (STORK / NOCA) Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM201) Notify the Office of the CHO (DOH) Respectful disposal / cremation / private funeral / burial NCC Form 3A Consent for Cremation and Mementoes (≤ 28 weeks) available NCC Form 4 Consent for Mementos (Babies for Private Burial or Private Cremation) Form 7 – Certificate of Medical Practitioner WACHS Death in Hospital (MR37A) Recognition of pregnancy loss certificate	N/A N/A N/A N/A Cremation / Funeral not required – optional Respectful disposal / cremation Form 3A at parents’ request N/A Yes, if private cremation N/A Available at parents’ request	Required N/A Required Required Private cremation / funeral is required N/A Form 4 at parents’ request Required Required Available at parents’ request	Required only if a Livebirth N/A Livebirth – BDM201 required Notify the Office of the CHO - Online Abortion E-form No signs of life – Cremation / Funeral optional Livebirth – Private cremation / Funeral is required No signs of life – respectful disposal / cremation AND Form 3A at parents’ request Livebirth – Form 4 at parents’ request Form 7 required – if private cremation and/or livebirth N/A Available at parents’ request
≥ 20 weeks OR more than 400 grams	Stillborn	Livebirth	Abortion / TOP requirements
Birth Registration Birth Notification (STORK / NOCA) Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM201) Notify the Office of the CHO (DOH) Respectful disposal / cremation / private funeral / burial NCC Form 3A Consent for Cremation and Mementoes (≤ 28 weeks) available OR NCC Form 4 Consent for Mementos (Babies for Private Burial or Private Cremation) Form 7 – Certificate of Medical Practitioner WACHS Death in Hospital (MR37A) Birth Certificate at parents’ request Bereavement Claim Form at parents’ request	Required Required Required Required <ul style="list-style-type: none"> < 28 weeks offer cremation at KEMH (option – free) ≥ 28 weeks must have a private cremation / funeral Form 3A at parents’ request OR Form 4 at parents’ request <ul style="list-style-type: none"> No if < 28 weeks & at KEMH Yes if ≥ 28 weeks Yes, if private cremation Required Available Available	Required Required Required Required Private cremation / funeral is required Form 4 at parents’ request Required Required Available Available	Required N/A Required Notify the Office of the CHO - Online Abortion E-form Stillborn – as opposite Livebirth – Private cremation / Funeral is required Stillborn – as opposite Livebirth – Form 4 at parents’ request Stillborn – as opposite Livebirth – Form 7 required N/A Available Available

Table modified from: Department of Health WA Abortion Care Clinical Guideline. © State of Queensland (Queensland Health) 2024

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