An Audit of Perinatal Death Certificate Alteration

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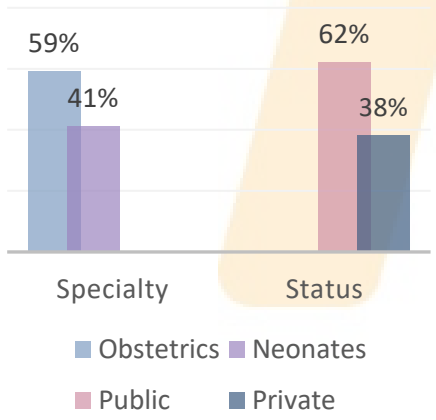
Introduction

Accurate documentation of cause of death (COD) is important in perinatal mortality to ensure correct information for the family and statistics for public health. Change of information on the death certificate involves unnecessary administrative burden and may cause distress to the family.

Aims

To understand the frequency of and reasons for perinatal death certificate amendment.

Graph 1: Categorisation of Amended Certificates



Methods

A retrospective audit of all death certificates for perinatal mortalities between January 2018 – December 2018. Death certifications were reviewed to determine if the COD had been amended, and reasons for amendment categorised into either incorrect initial documentation or new information from investigations.

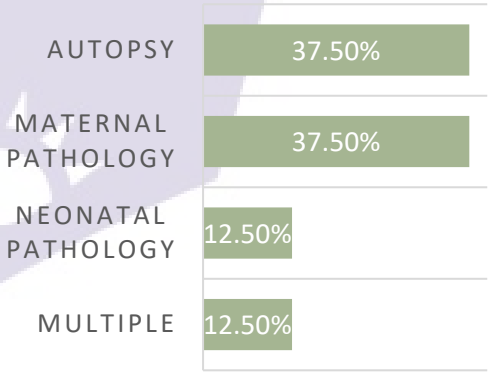
Results

109 perinatal mortality cases were reviewed; 59 were neonatal deaths and 50 were stillbirths. 34 cases (31%) had the death certificate amended, which were categorised into the patient's specialty and status (graph 1). Of the amended certificates, 50% were due to incorrect initial documentation, 47% due to new information and 3% were undetermined. Autopsy and maternal pathology (placenta histopathology and swabs) were the most common source of new information (37.5% each), with neonatal pathology following this (12.5%) (graph 2). The most common cause of incorrect initial documentation was missed information (30%), of which the most common was "fetocide". Following this was change of wording or order (24%) and incorrect information used (24%) (graph 3).

Discussion

Ongoing clinician education to avoid incorrect documentation is needed, which can be targeted for specific groups. Access to new results had a significant change in documentation of COD, supporting the recommendation to thoroughly investigate perinatal mortality.

GRAPH 2: NEW INFORMATION USED



GRAPH 3: DOCUMENTATION ALTERATION REASONS