## Maternal Interview

### 1. Study arm?

◯ Case ◯ Control

### 2. Hospital

### 3. Study Number:

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### 4. Date of Interview:

DD MM YYYY

DD/MM/YYYY / /

### 5. Interviewer

### 6. Who else is present during the interview?

## Inclusion Criteria

**7. Cases: Is gestation greater than or equal to 28 weeks at the time of the stillbirth? (Not at time of birth)**

◯ Yes ◯ No

**8. Cases: Did the stillbirth occur 1-6 weeks prior to the interview? (Not eligible if more than 6 weeks previously)**

◯ Yes ◯ No

**9. Controls: Is the gestation within 2 weeks of the gestation specified at the time of interview (or at birth if already given birth)?**

◯ Yes ◯ No

**10. Gestational age?**

Weeks

Days

**11. Singleton pregnancy?**

◯ Yes ◯ No

**12. Major fetal abnormality?**

◯ Yes ◯ No

**13. Consent form signed?**

◯ Yes ◯ No

**14. Fluent in English?**

◯ Yes ◯ No

If not fluent in English, was an interpreter used?

## Maternal Demographics

### 15. What is your date of birth?

DD MM YYYY

DD/MM/YYYY ☐☐ / ☐☐ / ☐☐☐☐

### 16. Which country were you born in?

☐

### 17. If not the United Kingdom: how many years have you lived in the UK?

Years ☐

Months ☐

### 18. If not the United Kingdom: what is your immigration status?

- ☐ UK National
- ☐ EEA National
- ☐ Discretionary leave to remain
- ☐ Indefinate leave to remain
- ☐ Study Visa
- ☐ Work Visa
- ☐ Husband/ Wife Sponsorship
- ☐ Asylum seeker awaiting decision
- ☐ Refugee
- ☐ Humanitarian Protection
- ☐ Declined to answer

### 19. How do you describe your ethnicity?

- ☐ White- British
- ☐ Irish
- ☐ Gypsy or Irish traveller
- ☐ Any other white background
- ☐ Black/ Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other black background
- ☐ Asian/ Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Banladeshi
- ☐ Chinese
- ☐ Any othe Asian background
- ☐ Multiple ethinic group
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Any other multiple ethnic background
- ☐ Declined to answer

**20. What is the postcode of your usual residential address ? (At the time of the interview).**

**21. Which of the following best describes the place you live in? (Lived in most of the time during your pregnancy).**

- ◯ Own house
- ◯ Private rental
- ◯ Council/ Housing Association rental
- ◯ Stay with family or friends
- ◯ No fixed address

Other (please specify)

**22. How many people usually live in your house? (The house you lived in during your pregnancy).**

| | |
|---|---|
| Couples (including yourself) | |
| Children under 10 years | |
| Other adults and children over 10 years | |

**23. How many bedrooms does your house have? (The house you lived in during your pregnancy).**

| | |
|---|---|
| Number of bedrooms | |

**24. Do you feel your house is large enough for your family's needs? (The house you lived in during your pregnancy).**

- ☐ Yes
- ☐ No

**25. What is your highest educational qualification? (Please tick one answer only).**

- ◯ None
- ◯ GCSE level (GCSE, O Level, Standards)
- ◯ A level (A, AS, S-level, Highers)
- ◯ Undergraduate (Diploma)
- ◯ Graduate (Degree, BSc, BA)
- ◯ Post-graduate (MSc, MA, PhD)
- ◯ Vocational education (NVQ, HNC, HND)

## 26. What was your work situation prior to this pregnancy? (Please tick one answer only).

- ◯ Full time work (over 30 hours per week)
- ◯ Part time work (includes casual work)
- ◯ Student
- ◯ Housewife
- ◯ Unemployed
- ◯ Long- term sickness benefit

Other (please specify)

## 27. What was your work situation in the last month? (before your baby died). (Please tick one answer only).

- ◯ Full time work (over 30 hours per week)
- ◯ Part time work (includes casual work)
- ◯ Student
- ◯ Housewife
- ◯ Unemployed
- ◯ Long-term sickness benefit
- ◯ Off-work due to pregnancy complications
- ◯ Maternity leave

Other (please specify)

## 28. If you are currently on maternity leave, how many weeks were you when you began your matenity leave?

Weeks

## 29. Do you or have you ever worked regular night shifts?

◯ Yes ◯ No

Please give details

## 30. Do you consider your work to be of a physical nature?

◯ Yes ◯ No

Please add details

## 31. What was your partner's (not necessarily father of your baby) work situation in the last month? (before your baby died) (Please tick one answer only).

- ◯ Full time work (over 30 hours per week)
- ◯ Part time work (includes casual work)
- ◯ Student
- ◯ Home maker
- ◯ Unemployed
- ◯ Long term sickness benefit

Other/ unknown/ no partner

## 32. What is your combined household income?

- ◯ <£10,000
- ◯ £10,000- £14,999
- ◯ £15,000- £19,999
- ◯ £20,000- £24,999
- ◯ £25,000- £29,999
- ◯ £30,000- £39,999
- ◯ £40,000- £49,999
- ◯ £50,000- £59,999
- ◯ £60,000- £74,999
- ◯ £75,000 +

## Relationships

### 33. What is your marital status? (Please tick one answer only).

- ◯ Single
- ◯ Married
- ◯ Cohabiting

### 34. How old is the father of your baby?

Age in years

Don't know

### 35. How would he describe his ethnicity?

- ☐ Unknown
- ☐ White- British
- ☐ Irish
- ☐ Gypsy or Irish traveller
- ☐ Any other white background
- ☐ Black/ Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other black background
- ☐ Asian/ Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Banladeshi
- ☐ Chinese
- ☐ Any othe Asian background
- ☐ Multiple ethinic group
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Any other multiple ethnic background
- ☐ Declined to answer

### 36. Is this your first pregnancy with this father?

☐ Yes ☐ No

## 37. How long had you had a relationship with the father of your baby when you conceived?

- ◯ Conceived on first episode of intercourse
- ◯ Less than 6 months
- ◯ 6-12 months
- ◯ More than 1 year
- ◯ Declined to answer

## 38. Are you related to the father of your baby? (Other than by marriage).

- ◯ Yes
- ◯ No

If yes what relation are you to each other?

## General Health and Past History

### 39. Did you have any medical conditions before the start of your pregnancy? (Please tick all relevant answers).

- [ ] None
- [ ] Anaemia (prior to booking Hb<10g/L)
- [ ] Asthma
- [ ] Cervical surgery
- [ ] Depression
- [ ] Diabetes type 1- Insulin dependent
- [ ] Diabetes type 2
- [ ] Epilepsy
- [ ] Heart condition- congenital
- [ ] Heart condition- rheumatic
- [ ] Hypertension- Essential
- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Inflammatory bowel disease (Crohn's disease or ulcerative colitis)
- [ ] Polycystic ovarian syndrome
- [ ] Psychiatric disorder (other than depression)
- [ ] Renal disease
- [ ] Sickle cell disease
- [ ] Systemic lupus erythematosus
- [ ] Thalassaemia
- [ ] Thrombophilia
- [ ] Urinary tract infections (recurrent)
- [ ] Uterine abnormality
- [ ] Uterine surgery
- [ ] Venous thromboembolism

Other medical condition

### 40. Did you have fertility treatment to get pregnant with your baby?

- ◯ Yes
- ◯ No

## 41. If yes, what was the treatment? (Please tick one answer only).

- ◯ Artificial insemination
- ◯ Ovulation induction
- ◯ IVF
- ◯ GIFT
- ◯ ICSI

Other (please specify)

## 42. Have you ever been pregnant before?

◯ Yes ◯ No

## Pregnancy History

### 43. If yes how many pregnancies were:

| | |
|---|---|
| Miscarriages or ectopic pregnancies in the first 12 weeks of pregnancy | |
| Miscarriages or ectopic pregnancies between 13 and 24 weeks of pregnancy | |
| Surgical termination of pregnancy below 14 weeks | |
| Medical termination of pregnancy below 14 weeks | |
| Surgical termination of pregnancy between 15 and 24 weeks of pregnancy | |
| Medical termination of pregnancy between 15 and 24 weeks of pregnancy | |
| Termination of pregnancy after 24 weeks | |

### 44. How many other pregnancies have you had?

### 45. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

### 46. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

## 47. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

## 48. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

## 49. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

## 50. If yes, can you tell me about your other pregnancies and births?

| | |
|---|---|
| Year of birth | |
| Gestation | |
| Birth weight (in grams) | |
| Mode of delivery | |
| Outcome (LB/SB/NND) | |
| Were there any complications? | |

## Antenatal care in this pregnancy

### 51. How many weeks pregnant were you when you first saw a health professional about this pregnancy?

Weeks

### 52. Who did you first see ? (Please tick one answer only).

- ◯ GP
- ◯ Midwife
- ◯ Infertility specialist
- ◯ Hospital obstetrician
- ◯ Family planning clinic
- ◯ Pharmacist
- ◯ Nurse
- ◯ Private obstetrician

Other (please specify)

### 53. Did you have morning sickness during this pregnancy?

◯ Yes ◯ No

### 54. If yes, were you admitted to hospital due to your vomiting?

◯ Yes ◯ No

If yes, how many times?

### 55. Did you have any of these common illnesses/ problems during your pregnancy? (Please tick all relevant answers).

| | Anytime during your pregnancy | In the last two weeks of your pregnancy |
|---|---|---|
| High fever | ☐ | ☐ |
| If high fever, was it confirmed to be higher than 38°C by thermometer | ☐ | ☐ |
| Runny nose/ sore throat/ swollen glands | ☐ | ☐ |
| Cough with phlegm | ☐ | ☐ |
| Diarrhoea and/or vomiting | ☐ | ☐ |
| Frequent urge to urinate and/or pain on urinating | ☐ | ☐ |

### 56. Were you unwell in any other way in the last 2 weeks of your pregnancy?

◯ Yes ◯ No

If yes, please describe

## 57. Did you have any vaginal bleeding in your pregnancy? (Please tick one answer only).

- ◯ No bleeding
- ◯ Single episode <20 weeks gestation
- ◯ Recurrent bleeds <20 weeks gestation
- ◯ Single episode >20 weeks gestation
- ◯ Recurrent bleeds >20 weeks gestation
- ◯ Recurrent bleeds throughout
- ◯ Unsure

## 58. During your pregnancy, did you take any antibiotics?

◯ Yes ◯ No ◯ Unsure

If yes, what antibiotics and what did you have them for?

## 59. How many weeks pregnant were you when you took the antibiotics? (If more than one course of antibiotics, record gestation of the most recent course).

Weeks

## Personal Habits

### 60. Do you currently smoke ? (Please tick one answer only)

- ◯ Yes
- ◯ No, stopped in pregnancy
- ◯ No, stopped prior to pregnancy
- ◯ No, never smoked

### 61. If yes, what do you smoke and what is the average amount per day?

| | Yes | No |
|---|---|---|
| Smoke cigarettes | ☐ | ☐ |
| Smoke roll ups | ☐ | ☐ |
| Smoke cannabis | ☐ | ☐ |
| Chew tobacco | ☐ | ☐ |
| Use shisha | ☐ | ☐ |

Average amount per day

### 62. If you smoked at any time during pregnancy, how much a day on average did you smoke?

Amount per day

### 63. If you stopped smoking during pregnancy, how many weeks pregnant were you when you stopped?

Weeks

### 64. Did you use any nicotine-replacement products during pregnancy?

- ◯ Electronic cigarettes
- ◯ Nicotine gum
- ◯ Nicotine inhalators
- ◯ Nicotine lozenges
- ◯ Nicotine microtabs
- ◯ Nicotine nasal spray
- ◯ Nicotine patches

Other (please specify)

### 65. Have you changed you smoking habits during your pregnancy?

- ◯ Yes
- ◯ No

If so, what have you changed?

## 66. If you have stopped or reduced smoking during pregnancy following advice, where did you get this advice from? (Please tick all relevant answers).

- [ ] Midwife
- [ ] GP
- [ ] Hospital doctor
- [ ] Friend/ relative
- [ ] Internet
- [ ] Magazine
- [ ] Pregnancy book
- [ ] TV

Please add details

## 67. Does your partner smoke?

◯ Yes ◯ No ◯ No partner

## 68. Does anyone else living in your house smoke?

◯ Yes ◯ No

## 69. On average, how many standard alcoholic drinks (if any) do you have each week during your pregnancy?

| | < 1 std drink/wk | 1-2 std drinks/wk | 3-4 std drinks/wk | ≥5 std drinks/wk |
|---|---|---|---|---|
| In the first 3 months of your pregnancy | ☐ | ☐ | ☐ | ☐ |
| In the last month of your pregancy | ☐ | ☐ | ☐ | ☐ |

## 70. What was the highest number of standard alcoholic drinks that you had on any one occasion during your pregnancy? (Please tick one asnwer only).

- ◯ None
- ◯ 1 to 2
- ◯ 3 to 4
- ◯ 5 to 10
- ◯ greater than 10

## 71. How many weeks pregnant were you when you had the most drinks?

Weeks

Not Known

## 72. Have you changed your drinking habits during your pregnancy?

◯ Yes ◯ No

If so, what have you changed?

## 73. If you have changed you alcohol intake during pregnancy following advice, where did you get this advice from? (Please tick all relevant answers).

- [ ] Midwife
- [ ] GP
- [ ] Hospital doctor
- [ ] Friend/ relative
- [ ] Internet
- [ ] Magazine
- [ ] Pregnancy book
- [ ] TV

Please add details

## 74. Have you taken any street drugs during pregancy?

- ◯ Yes
- ◯ No

## 75. If yes, have you used any of the following, if so when?

| | In the first 3 months of pregnancy | In the last month of pregnancy | In the last week of pregnancy |
|---|---|---|---|
| Amphetamine | ☐ | ☐ | ☐ |
| Amyl Nitrites | ☐ | ☐ | ☐ |
| Cannabis | ☐ | ☐ | ☐ |
| Cocaine | ☐ | ☐ | ☐ |
| Ecstasy | ☐ | ☐ | ☐ |
| Gas | ☐ | ☐ | ☐ |
| Glue | ☐ | ☐ | ☐ |
| Heroin | ☐ | ☐ | ☐ |
| Ketamine | ☐ | ☐ | ☐ |
| Magic Mushrooms | ☐ | ☐ | ☐ |
| Methadone | ☐ | ☐ | ☐ |
| Tranquillisers | ☐ | ☐ | ☐ |

Other (please specify)

## 76. If yes, how often did you use these drugs?

- ◯ Daily use
- ◯ Weekly use
- ◯ Occasional use
- ◯ Once only

Other (please specify)

## 77. Have you changed your drug habits during your pregnancy?

◯ Yes ◯ No

If so, what have you changed?

## 78. If you have changed your drug use during pregnancy following advice, where did you get this advice from? (Please tick all relevant answers).

- ☐ Midwife
- ☐ GP
- ☐ Hospital doctor
- ☐ Friend/ relative
- ☐ Internet
- ☐ Magazine
- ☐ Pregnancy book
- ☐ TV

Please add details

## 79. Have you taken any prescribed medication during your pregnancy?

◯ Yes ◯ No

## 80. If yes, please list all the prescribed medication you have taken during your pregnancy?

## 81. Have you taken any vitamins? If so, which ones.

| | Prior to pregnancy | During the first 3 months of pregnancy | During the last month of pregnancy |
|---|---|---|---|
| Folic Acid 400mcg | | | |
| Folic Acid 5mg | | | |
| Iron supplement | | | |
| Multi- vitamin | | | |
| Multi-vitamin for pregnant women | | | |
| Omega-3 | | | |
| Vitamin D 10mcg | | | |

Comment

## Perceived Stress Scale

### 82. The questions in this scale ask you about your feelings and thoughts during the LAST MONTH (before your baby died).

| | Never 0 | Almost Never 1 | Sometimes 2 | Fairly Often 3 | Very Often 4 |
|---|---|---|---|---|---|
| 1.How often have you been upset because of something that happened unexpectedly? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 2.How often have you felt that you were unable to control the important things in your life? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 3.How often have you felt nervous and "stressed"? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4.How often have you felt confident about your ability to handle your personal problems? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 5.How often have you felt that things were going your way? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 6.How often have you found that you could not cope with all the things that you had to do? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 7.How often have you been able to control irritations in your life? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 8.How often have you felt that you were on top of things? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 9.How often have you been angered because of things that were outside your control? | ◯ | ◯ | ◯ | ◯ | ◯ |
| 10.How often have you felt difficulties were piling up so high that you could not overcome them? | ◯ | ◯ | ◯ | ◯ | ◯ |

Other (please specify)

## Diet

### 83. On average, how often did you eat the following foods in the month before you were pregnant and during the last 4 weeks (before your baby died)?

| | Pre pregnancy | Within the last 4 weeks |
|---|---|---|
| Rice and pasta (1 portion) | | |
| White bread (1 slice) | | |
| Wholemeal bread (1 slice) | | |
| Crisps (1 bag) | | |
| Processed meat (1 portion) | | |
| Salad vegetables (1 portion) | | |
| Green vagetables (1 portion) | | |
| Other vegetables (1 portion) | | |
| Vegetable dishes/ foods (1 portion) | | |
| Soft drinks (1 glass) | | |
| Diet soft drinks (1 glass) | | |
| Chips (1 portion) | | |
| Fruit (1 portion) | | |
| Full fat spread (for 1 slice of bread) | | |

### 84. Please write how many per day.

| | |
|---|---|
| Total teaspoons of sugar added each day to cereals, tea,coffee etc (tsp) | |
| Full- fat milk on average consumed per day in drinks, cereals etc (pints) | |
| Semi- skimmed milk on average consumed per day in drinks, cereals etc (pints) | |
| Skimmed milk on average consumed per day in drinks, cereals etc (pints) | |

## 85. How many cups (190mls) of coffee/ tea do you drink per day?

| | number of servings/day |
|---|---|
| Instant coffee | |
| Brewed coffee (filter/ percolated) | |
| Decaffeinated coffee (brewed/instant) | |
| Tea | |
| Chai tea | |
| Green tea | |
| Drinking chocolate | |
| Energy drinks/ 250ml serving | |
| Cola (regular/ diet)/ 330ml serving | |
| Chocolate/ 50g bar | |

## 86. Have you changed any aspects of your diet or caffine intake during your pregnancy?

◯ Yes ◯ No

If so, what have you changed?

## 87. If you have changed your diet or caffine intake during pregnancy following advice, where did you get this advice from? (Please tick all relevant answers).

- ☐ Midwife
- ☐ GP
- ☐ Hospital doctor
- ☐ Friend/ relative
- ☐ Internet
- ☐ Magazine
- ☐ Pregnancy book
- ☐ TV

Please add details

## Sleep Practices

If the main period of sleep is in the day ( such as for shift workers) then use the day time for the following questions.

### 88. On average how many hours actual sleep did you usually get at night? (Hours).

| | |
|---|---|
| Before pregnancy | |
| In the last four weeks(* before your baby died) | |
| In the last week* | |
| Last night* | |

### 89. What size bed did you sleep in last night?(the last night before your baby died). (Please tick one answer only).

- ◯ Small single
- ◯ Single
- ◯ Small double
- ◯ Double
- ◯ King size
- ◯ Superking

Other- didn't sleep in bed (specify)

### 90. Did anyone else sleep in the same bed as you last night? (The last night before your baby died).

- ◯ Yes, partner
- ◯ No
- ◯ Yes, other

Other (please specify)

### 91. What side of the bed do you usually sleep on?

- ◯ Left
- ◯ Middle
- ◯ Right
- ◯ Unsure

## 92. Which side of the bed did you sleep in last night? (The last night before your baby died).

- ◯ Left
- ◯ Middle
- ◯ Right
- ◯ Unsure

## 93. How many pillows did you usually use at night in the last few weeks? (Before your baby died).

No. of pillows

## 94. What position did you usually fall asleep in? (Please tick one answer per line).

| | Left side | Back | Right side | Tummy | Variable | Propped up | Don't remember |
|---|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| In the last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last night (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## 95. What position did you usually wake up in? (Please tick one answer per line).

| | Left side | Back | Right side | Tummy | Variable | Propped up | Don't remember |
|---|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| In the last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last night (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## 96. Did you change sleep position during the night? (Please tick one answer per line).

| | Not at all | Possibly once | Possibly twice | More than twice but not lots | Lots of times | Don't remember |
|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| In the last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last night (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## 97. Would you describe yourself as a restless sleeper (i.e move a lot during the night)? (Please tick one answer per line).

| | Not at all | A little | Average | More than average | Very restless |
|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ |
| In the last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last night (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ |

## 98. Have you EVER been told that you snore, or are you aware that you snore?

- ◯ Yes
- ◯ No

**99. If you have been told you snore, or you have woken yourself up snoring, how often has this happened? (Please tick one answer per line).**

| | Occasionally | 1-2 times/week | 3-4 times/week | 5-6 times/week | Every night | Don't know |
|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| During the last 4 weeks (the 4 weeks before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**100. Did you snore last night? (The last night before your baby died).**

◯ Yes ◯ No ◯ Don't know

**101. Has your snoring ever bothered other people?**

| | Yes | No | Don't know |
|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ |

**102. Did your snoring bother anyone last night? (The last night before your baby died).**

◯ Yes ◯ No ◯ Don't know

**103. How loud is your snoring reported to be? (Please tick one answer per line).**

| | Slightly louder than breathing | As loud as talking | Very loud, can be heard in adjacent rooms | Don't know |
|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ |
| Last night (before your baby died) | ◯ | ◯ | ◯ | ◯ |

**104. Have you been told you briefly stop breathing when you are asleep? (Please tick one answer per line).**

| | Never | Rarely | Sometimes | Often | Every night |
|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4 weeks ago (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ |

**105. Were you told you briefly stopped breathing when asleep last night? (The night before your baby died).**

◯ Yes ◯ No

**106. Have you been told that you cough or choke during sleep? (Please tick one answer per line).**

| | Never | Rarely | Sometimes | Often | Every night |
|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4 weeks ago ( before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ |

**107. Were you told you coughed or choked last night? (The last night before your baby died).**

◯ Yes ◯ No

**108. Do your legs twitch or jerk often while you sleep? (Do not count the sudden jerk that sometimes occurs as you fall asleep). (Please tick one answer per line).**

| | Never | Rarely | Sometimes | Often | Every night | Don't know |
|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**109. Did your legs twitch or jerk often while you slept last night? (The last night before your baby died).**

◯ Yes ◯ No ◯ Don't know

**110. Did you take medication for sleep? (Prescribed medication NOT herbal remedies). (Please tick one answer per line).**

| | Never | Occasionally | 1-2 times/week | 3-4 times/week | 5-6 times/week | Every night | Don't know |
|---|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4 weeks ago (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**111. Did you take medication for sleep last night? (The night before your baby died).**

◯ Yes ◯ No

**112. How would you rate your sleep quality overall?(Please tick one answer per line).**

| | Very good | Fairly good | Average | Fairly bad | Very bad |
|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ |

**113. How often do you feel tired or fatigued AFTER your night's sleep? (Please tick one answer per line).**

| | Never | Occasionally | 1-2 times/week | 3-4 times/week | 5-6 times/week | Every night | Don't know |
|---|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**114. During your WAKE TIME do you feel tired, fatigued or not up to par? (Please tick one answer per line).**

| | Never | Occasionally | 1-2 times/week | 3-4 times/week | 5-6 times/week | Every night | Don't know |
|---|---|---|---|---|---|---|---|
| Before pregancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**115. BEFORE YOUR PREGNANCY how likely were you to doze off or fall asleep in the following situations, in contrast to just feeling tired? (Please tick one answer per line).**

| | Would never doze | Slight chance of dozing | Moderate chance of dozing | High chance of dozing |
|---|---|---|---|---|
| Sitting and reading | ◯ | ◯ | ◯ | ◯ |
| Watching TV | ◯ | ◯ | ◯ | ◯ |
| Sitting inactive in a public place (eg cinema, meeting) | ◯ | ◯ | ◯ | ◯ |
| As a passenger in a car for an hour without a break | ◯ | ◯ | ◯ | ◯ |
| Lying or sitting down to rest in the afternoon | ◯ | ◯ | ◯ | ◯ |
| Sitting and talking to someone | ◯ | ◯ | ◯ | ◯ |
| Sitting quietly after lunch without alcohol | ◯ | ◯ | ◯ | ◯ |
| In a car, while stopped for a few minutes in the traffic | ◯ | ◯ | ◯ | ◯ |

**116. IN THE LAST 4 WEEKS (of pregnancy) how likely were you to doze off or fall asleep in the following situations, in contrast to just feeling tired?**
**Even if you have not done some of these things recently try and work out how they would have affected you.**
**(Please tick one answer per line).**

| | Would never doze | Slight chance of dozing | Moderate chance of dozing | High chance of dozing |
|---|---|---|---|---|
| Sitting and reading | ◯ | ◯ | ◯ | ◯ |
| Watching TV | ◯ | ◯ | ◯ | ◯ |
| Sitting inactive in a public place (eg cinema, meeting) | ◯ | ◯ | ◯ | ◯ |
| As a passenger in a car for an hour without a break | ◯ | ◯ | ◯ | ◯ |
| Lying or sitting down to rest in the afternoon | ◯ | ◯ | ◯ | ◯ |
| Sitting and talking to someone | ◯ | ◯ | ◯ | ◯ |
| Sitting quietly after lunch without alcohol | ◯ | ◯ | ◯ | ◯ |
| In a car, while stopped for a few minutes in the traffic | ◯ | ◯ | ◯ | ◯ |

**117. On average how many times would you take a nap during the day? (Please tick one answer per line).**

| | Never | Occasionally | 1-2 times/week | 3-4 times/week | 5-6 times/week | Every day | Don't know |
|---|---|---|---|---|---|---|---|
| Before pregnancy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Last 4 weeks (before your baby died) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## 118. Have you changed your sleeping habits during your pregnancy?

◯ Yes ◯ No

If so, what have you changed?

## 119. If you have changed your sleeping habits during your pregnancy following advice, where did you get this advice from? (Please tick all relevant answers).

- ☐ Midwife
- ☐ GP
- ☐ Hospital doctor
- ☐ Friend/ relative
- ☐ Internet
- ☐ Magazine
- ☐ Pregnancy book
- ☐ TV

Please add details

## Fetal Movements

### 120. Did anyone give you information about fetal movements during your pregnancy?

- ◯ No information was given
- ◯ Verbal information
- ◯ Written information

Other (please specify)

### 121. Was there anytime from 26 weeks of pregnancy that your baby's movements were less than usual?

- ◯ Yes
- ◯ No

## 122. If yes, on how many occasions?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4 or more

## 123. If yes, did you speak to a health professional for advice?

- ◯ Yes
- ◯ No

If did not speak to a health professional, why was that?

## 124. If yes, did you attend hospital?

- ◯ Yes
- ◯ No

If you did not attend hospital, why was that?

## 125. If you did attend hospital, what did they do?

## 126. In the last 2 weeks did the strength of your baby's movements: (The two weeks before your baby died) (Please tick one answer only).

- ◯ Increase
- ◯ Decrease
- ◯ Stay the same
- ◯ Unsure

## 127. In the last 2 weeks did the frequency of your baby's movements: (The two weeks before your baby died)(Please tick one answer only).

- ◯ Increase
- ◯ Decrease
- ◯ Stay the same
- ◯ Unsure

## 128. During the last 2 weeks, did you notice anytime that your baby was more vigorous than usual? (The two weeks before your baby died).

- ◯ Yes
- ◯ No

## 129. If yes, how many times?

- ◯ Once
- ◯ More than once

**130. During the last 2 weeks, did you feel your baby having hiccups? (The two weeks before your baby died).**

- ◯ Yes
- ◯ No
- ◯ Unsure

**131. If yes, how often?**

- ◯ Once
- ◯ Daily
- ◯ Occasionally
- ◯ Unsure

**132. During the last 2 weeks, did you feel uterine contractions (tightenings/ pre-labour contractions/ Braxton Hicks contractions/ false labour) for longer than an hour? (The two weeks before your baby died).**

- ◯ Yes
- ◯ No
- ◯ Unsure

## Injury

**133. Did you experience any physical injury at any time during your pregnancy? (Please tick all relevent boxes).**

- [ ] No injury
- [ ] Slips and falls
- [ ] Road traffic accident
- [ ] Blow to abdomen
- [ ] Self- harm
- [ ] Other non- accidental injury
- [ ] Other accidental injury

**134. If yes, please describe the physical injury.**

**135. If yes, was this during the last two weeks of your pregnancy?**

- ◯ Yes
- ◯ No

**136. Did you see a health professional about your injury?**

- ◯ Yes
- ◯ No

## These questions must be asked only if the woman is on her own

Family Violence

**137. Family violence questions not asked as woman was not on her own?**

◯ Yes

**138. Family violence questions not asked for other reason (specify)**

**139. Woman declined to answer family violence questions?**

◯ Yes

**140. In the past year have you been hurt or frightened by someone close to you?**

◯ Yes ◯ No

**141. In the past year have you felt controlled or always criticized in your relationship?**

◯ Yes ◯ No

**142. In the past year have you been made to do anything sexual that you did not want to do?**

◯ Yes ◯ No

**143. Who in your family controls the money?**

◯ You ◯ Joint- you and your partner

◯ Your partner ◯ Other family member

**144. If disclosure of domestic abuse made, have you followed your local protocol.**

◯ Yes

## Other- for Cases only

Finally I would like to ask you some questions about when your baby died.

### 145. What was the first reason that you thought something was wrong with you pregnancy or that your baby was dying/ had died? (Please tick one answer only).

- ◯ I felt a reduction of kicks/ movements
- ◯ I felt kicks/ movements stop
- ◯ I felt abdominal pain
- ◯ I had vaginal bleeding/ haemorrhage
- ◯ I had discharge of amniotic fluid/ the membranes ruptured/ my waters had broken
- ◯ I had a "feeling that something was wrong", but cannot specify
- ◯ I had a trauma (involved in a physical accident)
- ◯ I had other symptoms (specify below if possible)
- ◯ I was told at an antenatal appointment
- ◯ I was told when I was admitted in labour
- ◯ I was told during labour
- ◯ It was not discovered before my baby was born
- ◯ I do not remember/ know

Other (please specify)

### 146. When do you think your baby died?

DD/MM/YYYY

I do not know when my baby died

### 147. What time of day do you think your baby died? (Please tick one answer only).

- ◯ During the night
- ◯ During a daytime nap
- ◯ In the morning
- ◯ In the afternoon
- ◯ In the evening
- ◯ Not sure

**148. What was the reason you saw a health practitoner at the time that your baby was found to have died?**
**(Please tick one answer only).**

- ◯ Routine scheduled pregnancy visit
- ◯ Routine scan
- ◯ Decreased baby movements
- ◯ In labour
- ◯ In hospital
- ◯ Vaginal bleeding
- ◯ Rupture of membranes
- ◯ Unwell
- ◯ Not recorded/ unknown

Other (please specify)

**149. Were you asked if you would like a post-mortem for your baby?**

◯ Yes ◯ No

**150. If yes, did you choose to have a post-mortem?**

◯ Yes ◯ No

**151. If no, what was the main reason you decided against a post-mortem? (Please tick one answer only).**

- ◯ We already knew why baby had died
- ◯ It would not bring baby back
- ◯ Did not want baby to be taken away
- ◯ Did not want baby to be cut
- ◯ Wanted to bury baby as quickly as possible

Other (please specify)

**152. Would you make the same decision about the post-mortem now?**

◯ Yes ◯ No

**153. Is there anything else that you think might be important you would like to tell us about your pregnancy?**

## MiNESS Feedback Form

Thank you very much for your time and thoughts.

### 154. How did you feel about being involved in this study?

### 155. Is there anything else that you would like to add (Anything that you feel was significant, but was not discussed)?

# Clinical Data Collection

This data is to be collected FROM THE ANTENATAL RECORD.

Current pregnancy

## 156. Study Number:

----

## 157. Date:

DD MM YYYY

DD/MM/YYYY / /

## 158. EDD by LMP:

- ◯ DD/MM/YYYY
- ◯ EDD not known

DD/MM/YYYY

## 159. EDD by USS:

- ◯ DD/MM/YYYY
- ◯ USS not done

DD/MM/YYYY

## 160. Gestation by first USS:

Weeks

Days

## 161. Best agreed EDD:

## 162. Height recorded in notes:

- ◯ Cms
- ◯ Not recorded

Cms

## 163. First weight in pregnancy:

- ◯ Kgs
- ◯ Not recorded

Kgs

## 164. Body Mass Index at booking

## 165. Gestation at first weight:

Weeks

## 166. Last weight:

- ◯ Kgs
- ◯ Not recorded

Kgs

## 167. Gestation at last weight:

- ◯ Weeks
- ◯ N/A

Weeks

## 168. Date of first visit with health care professional:

DD MM YYYY

DD/MM/YYYY / /

## 169. Estimated gestational age at first visit with health care professional:

Weeks

Days

## 170. Initial type of maternity care? (Please tick one answer only).

- ◯ Midwifery-led care
- ◯ Consultant-led care
- ◯ Shared care (between consultant and midwife)
- ◯ Private Obstetrician
- ◯ Private Midwife

Other (please specify)

## 171. Referal to obstetric/ medical specialist?

- ◯ Yes
- ◯ No

## 172. If yes: (Please tick one answer only).

- ◯ Pre-existing condition
- ◯ Complication of pregnancy
- ◯ Maternal request

Other (please specify)

## 173. Transfer of care during pregnancy? (e.g. from midwifery-led care to consultant-led care).

◯ Yes ◯ No

## 174. Booked place of birth? (Please tick one answer only).

- ◯ Tertiary hospital
- ◯ Secondary hospital
- ◯ Primary birthing unit
- ◯ Home

Other (please specify)

## 175. Number of antenatal visits in 1st trimester (0-12 weeks) ? (From antenatal records).

No.

## 176. Number of antenatal visits in 2nd trimester (13-28 weeks)? (From antenatal records).

No.

## 177. Number of antenatal visits in 3rd trimester (29 -42 weeks)? (From antenatal records).

Number

## 178. If no antenatal records available, please give details.

## 179. Ultrasound this pregnancy? (Please tick all relevent answers).

- ☐ First trimester
- ☐ Anomaly scan 18-22 weeks
- ☐ Doppler studies
- ☐ Growth scan
- ☐ None

## 180. Medical conditions in pregnancy? (Please tick all relevent answers).

- [ ] None
- [ ] Anaemia
- [ ] Asthma
- [ ] Cervix surgery
- [ ] Depression
- [ ] Diabetes - before pregnancy
- [ ] Epilepsy
- [ ] Essential hypertension
- [ ] Gestational diabetes - developed during pregnancy
- [ ] Heart condition- congenital
- [ ] Heart condition- rheumatic
- [ ] Hypertension / Pre-eclampsia
- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Inflammatory bowel
- [ ] Laparotomy
- [ ] Other autoimmune
- [ ] Renal disease
- [ ] Rheumatic heart
- [ ] Major psychiatric disorder (Other than depression)
- [ ] Sickle cell crisis
- [ ] Systemic lupus erythematosus
- [ ] Thalassaemia trait
- [ ] Urinary tract infection
- [ ] Uterine abnormality
- [ ] Venous thromboembolism

Other (please specify)

## 181. Blood pressure at booking ?

Systolic

Diastolic

## 182. Last blood pressure prior to interview (controls) or when baby was last know to be alive (cases)?

Weeks

Days

## 183. Was a customized growth chart used?

◯ Yes ◯ No ◯ Don't know

## 184. Was fetal growth restriciton clinically suspected?

◯ Yes ◯ No

## 185. If yes, gestation first suspected?

Weeks

Days

## 186. If yes, were growth scan(s) done?

◯ Yes ◯ No

## 187. Was there evidence on the growth scan of fetal growth restriction?

◯ Yes AC < 10%

◯ Yes EFW < 10%

◯ No

## 188. If yes, what was the management? (Please tick all relevent answers).

☐ No change

☐ Increased antenatal visits

☐ Serial cardiotacography (CTG's)

☐ Ultrasound scan

☐ Doppler's

☐ Admitted

☐ Delivered

Other (please specify)

## 189. Admitted with threatened preterm labour in this pregnancy?

◯ Yes ◯ No ◯ Don't know

## 190. Blood group?

- ◯ A Pos
- ◯ B Pos
- ◯ AB Pos
- ◯ O Pos
- ◯ A Neg
- ◯ B Neg
- ◯ AB Neg
- ◯ O Neg
- ◯ Not known

## 191. Hep B status?

◯ Positive ◯ Negative ◯ Not known

If not know

## 192. HIV status?

◯ Positive ◯ Negative ◯ Not known

If not known

## 193. HbA1c performed?

◯ Yes ◯ No

## 194. If yes:

Result

Gestation

## 195. GTT performed?

◯ Yes ◯ No

## 196. If yes:

Fasting

I hour

2 hour

Gestation

Fasting

1 hour

2 hour

Gestation

## 197. Baby's date of birth?

DD MM YYYY

DD/MM/YYYY ____ / ____ / ____

## 198. Place of birth?

- ◯ Tertiary/ secondary hospital
- ◯ Birthing unit
- ◯ Home

Other (please specify)

## 199. Birth weight in grams?

Grams

## 200. Gestation at birth (for controls) or at DIAGNOSIS of stillbirth (for cases):

Weeks

Days

## 201. Sex of baby?

- ◯ Male
- ◯ Female

## 202. Examination of the cord? (Please tick all relevent answers).

- ☐ Normal
- ☐ Tight knot/ occulded
- ☐ Loose knot
- ☐ Cord round neck tightly
- ☐ Cord round neck loosely
- ☐ Cord round limbs/ body tightly
- ☐ Card round limbs/ body loosely
- ☐ Torsion or spring like cord
- ☐ Marginal/ velamentous insertion
- ☐ Hypocoiled
- ☐ Thin cord
- ☐ Meconium stained
- ☐ Tear
- ☐ 2 vessels

Other (please specify)

## 203. Placenta? (Please tick all relevent answers).

- [ ] Normal
- [ ] Retroplacental clot
- [ ] Gritty/ calcified
- [ ] Vasa praevia
- [ ] Offensive odour
- [ ] Succenturiate lobe
- [ ] Extrachorial/ Circumvallate
- [ ] Bilobate/ Bilpartite placenta
- [ ] Placenta accreta
- [ ] Not examined

Other (please specify)

## 204. Placental weight in grams?

Grams

Placenta not weighed

## 205. If placenta was weighed, was it trimmed weight or full weight?

- ◯ Trimmed weight
- ◯ Full weight
- ◯ Unsure

## Details of Stillbirth (Cases only)

### 206. Date of diagnosis of fetal death?

DD MM YYYY

DD/MM/YYYY ____ / ____ / ____

### 207. Date of last consult prior to death where fetus confirmed alive?

DD MM YYYY

DD/MM/YYYY ____ / ____ / ____

### 208. New findings at last consult prior to diagnosis of fetal death ?(Please tick all relevant answers).

- [ ] No new findings
- [ ] SGA
- [ ] LGA
- [ ] Hypertension
- [ ] Oligohydramnios
- [ ] Polyhydramnios
- [ ] APH
- [ ] Diabetes
- [ ] Decreased fetal movements
- [ ] Urinary tract infection

Other (please specify)

### 209. When did death occur?

- ◯ Antepartum
- ◯ Intrapartum
- ◯ Unknown whether antepartum/ intrapartum

### 210. Post-mortem?

◯ Yes ◯ No

### 211. If yes, where was it done? (Attach copy of results if available).

### 212. Placental pathology?

◯ Yes ◯ No

**213. If yes, where was it done? (Attach copy of results if available).**

## Appendix 1 (amendment 22.07.14)

### 214. During the night how often do you have to get up to use the toilet?

Before you were pregnant?

The last four weeks (before your baby died)?

The last week of your pregnancy?

Last night (the night before your baby died)?

### 215. Since you became pregnant did your level of physical exercise:

- ◯ Stay the same
- ◯ Become less
- ◯ Become more

### 216. How often have you engaged in vigorous exercise in the last month (the month before your baby died)? Exercise which made you breathe harder or puff or pant, such as tennis, jogging, aerobics, heavy gardening, cycling?

- ◯ Never
- ◯ Once a week
- ◯ 2-3 times a week
- ◯ 4-6 times a week
- ◯ Daily
- ◯ More than once a day

### 217. If you have engaged in vigorous exercise, on average how long did your exercise last for (in minutes)?

Minutes

### 218. What type of vigorous exercise have you done?

- ☐ Jogging
- ☐ Tennis
- ☐ Cycling
- ☐ Gym class- aerobics
- ☐ Spinning
- ☐ Weight training- gym
- ☐ Swimming

Other (please specify)

**219. How often have you engaged in less vigorous exercise for recreation, sport or health fitness purposes in the last month (the month before your baby died) which did not make you breathe harder or puff or pant?**

- ◯ Never
- ◯ Once a week
- ◯ 2-3 times a week
- ◯ 4-6 times a week
- ◯ Daily
- ◯ More than once a day

**220. If you did engage in less vigorous exercise, what type of exercise have you done?**

**221. From the anomaly scan, please record placental position.**

- ◯ Anterior- high
- ◯ Anterior- low
- ◯ Posterior- high
- ◯ Posterior- low
- ◯ Fundal
- ◯ Lateral
- ◯ Low lying

Other (please specify)