Document Control

Title **Bereavement in Maternity: Pregnancy Loss from 18 weeks, Stillbirth and Neonatal Death Guideline**			
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CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the care of women and their families experiencing pregnancy loss, neonatal death or actual or suspected poor outcome other than death, following the principles set out by SANDS, (the Stillbirth and Neonatal Death Charity) together with their recommendations for improving bereavement care.

1.2. The policy applies to all Trust staff that are likely to come into contact with bereaved parents, most particularly staff working in the Maternity unit. Staff working within other departments, e.g. A&E and KG5 must also be aware and adhere to this guideline when caring for bereaved parents.

1.3. Implementation of this policy will ensure that:

- Parents receive sensitive individualised care during the loss of their baby.
- The correct procedures are followed and the appropriate forms are completed by care givers within the Trust.

2. Definitions

Viability

2.1. In the UK, the legal age of viability is set at 24+0 weeks gestation. This is the gestation at which a fetus is considered potentially able to survive outside of its mother.

2.2. Any questions about gestation on admission should be managed by a thorough and clearly documented Obstetric and Paediatric assessment.

2.3. Any decisions about resuscitation at the cusp of viability should be directed to the Consultant Paediatrician on-call taking in to consideration the exact gestation, estimated fetal weight (if known) and the wishes of the parents.

Late Fetal Loss

2.4. A baby delivered with no signs of life, from 18 weeks to 23+6 weeks gestation, irrespective of when the death occurred.

Stillbirth

2.5. The RCOG state that the legal definition of stillbirth is:

2.6. "any child expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life".

2.7. This will include:

- A baby delivered with no signs of life, at or after 24+0 weeks gestation, irrespective of when the death occurred.
- Antepartum Stillbirth: A baby delivered with no signs of life, known to have died in utero before the onset of labour.
- Intrapartum Stillbirth: A baby delivered with no signs of life, known to have been alive at the onset of labour.
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Neonatal Death

2.8. A baby born alive that then subsequently dies within 28 completed days of life.

- N.B This will not include babies born before 23 weeks gestation that show physiological responses including primitive agonal gasping, a heartbeat and/or body movements because severe prematurity is incompatible with life.
- N.B This will only include babies born at the cusp of viability between 23+1and 23+6 weeks that have been assessed by the Consultant Paediatrician on call as viable BUT later died within 28 completed days of life.

Actual or Suspected Poor Outcome Other Than Death

2.9. Where an actual or suspected poor outcome other than death has been identified before delivery, reference should be made to the following Trust guidance: Care of Pregnancy Complicated by Lethal Anomaly Guideline

3. Responsibilities

3.1. It is the responsibility of all members of staff who are likely to care for bereaved parents to follow guidelines appropriately, and care for women and their families in a sensitive manner.

3.2. It is the responsibility of the midwife, nurse or attending medical practitioner to complete and sign all required forms and to forward these to the appropriate department or personnel. Staff are required to document appropriately in medical notes and refer to other specialities as required.

4. Introduction

4.1. The loss of a pregnancy is a devastating experience for women and their families, at any gestation. Whether diagnosed before delivery or the death of a baby after birth, women need support from both their families and professionals at this time.

4.2. The rate of still birth in the UK has remained similar since 2000 (RCOG 2010). Investigations by the Confidential Enquiries show that sub-optimal care was a factor in half of these pregnancies. The RCOG launched the quality improvement programme "Each Baby Counts" to reduce the number of babies who die or are left severely disabled as a result of incidents that occur during term labour, with the aim to half stillbirth at term by 2020 (RCOG 2017). However, with up to 6 out of 10 stillbirths, the cause of death is unknown (SANDS 2016).

4.3. Factors such as increasing maternal age and a rise in obesity are thought to contribute to the incidence of stillbirth, and small for gestational age babies are at a significantly higher risk. Antenatal and intrapartum events that can cause stillbirth are not always preventable, such as cord prolapse, antepartum haemorrhage and placental abruption. Other factors such as genetic conditions and infection are not always evident to be diagnosed.

4.4. The experience of stillbirth and the subsequent management can have long term detrimental psychological effects on women, including depression, post-traumatic stress disorder, substance misuse, relationship problems and difficulty bonding with subsequent children. It is therefore of utmost importance that they receive care that is sensitive, dignified, individualised and appropriate.

4.5. SANDS (Stillbirth and Neonatal Death charity Society) is a charity that provides support for grieving families and educational programmes for professionals. SANDS has produced the 10 Principles of Bereavement Care (Appendix C). Should an intrauterine death or stillbirth occur this guideline aims to support staff in caring for these women at a very difficult time.

4.6. **IN MOST CASES THE WOMAN'S EMOTIONAL AND PSYCHOLOGICAL NEEDS SHOULD BE PRIORITISED OVER CLINICAL MANAGEMENT, UNLESS THERE IS IMMEDIATE RISK TO THE MOTHER.**

4.7. Check lists are available for bereavement care Under 24 week's gestation, Over 24 weeks' gestation and Neonatal death. These are mandatory and are designed to be used as a guide, care should be individualised according to each woman's needs. They replace the check list in the mauve notes

5. Managing Late Fetal Loss including Termination of Pregnancy for Fetal Abnormalities (18- 23+6 weeks)

5.1. Use the mauve coloured bereavement notes to document care, investigations and management plans. Please remove the completed pull-out page to be filed in the mothers medical notes or use the clinical checklist in Appendix D.

Spontaneous Fetal Demise

5.2. Fetal demise should be confirmed by Ultrasound Scan (USS), by an experienced sonographer or obstetrician.

5.3. A second scan must be offered to confirm the intrauterine death (this should be a different clinician to that performing the first scan).

5.4. If the woman is alone immediately offer to contact her partner, family or friends to support her, and move to a quiet room, in an appropriate location, to discuss management of care.

5.5. Late fetal loss can be managed expectantly or immediately by inducing labour. Evidence suggests that the majority of women would deliver within 3 weeks of fetal demise, but that there is increasing risk to the mother of DIC (disseminated intravascular coagulation) after this time.

5.6. If the mother is physically well, with no evidence of pre-eclampsia, haemorrhage or sepsis, and the membranes are intact, the risk of expectant management for 48 hours is low.

5.7. However many women choose to be induced sooner than this and there is some evidence to suggest that women's psychological health is negatively affected if induction is delayed more than 24 hours from diagnosis of fetal death (RCM 2016, RCOG 2010).

5.8. If expectant management is preferred by the woman, and there is no immediate risk, blood tests should be taken at least twice weekly to monitor maternal condition (See Investigations Checklist in Appendices) (RCOG 2010).

5.9. Conditions such as pre-eclampsia, major feto-maternal haemorrhage, chorioamnionitis and sepsis, or any other clinical condition that puts the mother at significant risk of harm, must be managed immediately.

5.10. A discussion around post mortem, if appropriate, should take place at a suitable time for the mother. It must be made clear that a post mortem may or may not provide further information as to the cause of death, but that further information could have an impact on future pregnancies.

5.11. If induction of labour is preferred, or advised, continue medical management as per drug regime Appendix A.

5.12. Provide verbal and written information on induction of labour (please use leaflet Induction of labour when the baby has died in the womb).

5.13. Prior to commencing induction of labour investigations should be undertaken for all Intrauterine deaths of unknown cause (See Investigations Checklist in Appendix B). If deemed appropriate by consultant, testing for Factor V Leiden should be done 6 weeks postnatally.

5.14. Provide written information leaflets regarding support groups, such as SANDS. Discuss, if appropriate, what the baby may look like if the baby has been dead for some time.

5.15. Inform the labour ward co-ordinator of woman's details and plan of care.

Spontaneous Severely Premature Labour (Miscarriage)

On the threshold of viability (23+0 -23+6 weeks)

5.16. When a woman labours spontaneously before 24 weeks gestation and a fetal heart is heard during auscultation in labour, the neonatal team should be consulted regarding whether resuscitation of the baby is appropriate (should the baby survive labour) and to have a discussion with the parents. The parents may choose, or be advised not to resuscitate. Parents should be informed survival rates are low for severely premature infants; that long term prognosis is poor for those that live, with on-going health concerns and disabilities.

5.17. Ideally, at the threshold of viability, any woman wishing for resuscitation of the baby, who is potentially going into labour (for example has a positive Fetal Fibronectin Test), should to be transferred (with the fetus in-utero) to an obstetric unit attached to a neonatal unit with appropriate resources. This can only be done if it is safe to transfer.

5.18. Parents should be informed that under 23 weeks gestation, spontaneous delivery is unlikely to, but can potentially, result in a baby born with physiological responses including primitive agonal gasping, a heartbeat and/or body movements.

5.19. The parents should be prepared for, and supported during, this distressing time. This conversation should be undertaken by a clinician suitably trained and with due care for the parents' needs at this time. Some parents will wish to discuss in detail about the pending birth and others may not, this will need to be carefully assessed at the time.

5.20. It is essential that parents are aware that resuscitation is inappropriate as severe prematurity is incompatible with life and that physiological responses, if noted at birth, are not recorded as a livebirth because severe prematurity is incompatible with life.

5.21. The baby should be wrapped and treated with respect and dignity. The parents should be given the opportunity to hold their baby if they wish. The baby can remain in the room with the parents or moved to another room at the parents' request.

5.22. Care should be taken to ensure the baby remains in a suitable room until transfer to the mortuary is completed. Utility rooms are not appropriate.

Termination of Pregnancy

5.23. The termination of a pregnancy, for clinical reasons, is an extremely difficult decision for some women, and can be just as traumatic as a spontaneous intrauterine death. Therefore care should always be given in a sensitive and non-judgemental way, with no assumptions as to how that woman may feel.

5.24. Women should be counselled by an obstetric consultant with all the available evidence when considering terminating a pregnancy.

5.25. Termination late in a pregnancy SHOULD NOT result in a live birth. If gestation is over 21+6, feticide must be completed prior to inducing labour. This is undertaken at St Michaels Hospital in Bristol, and must be confirmed successful. Referral to be made by obstetric consultant.

5.26. Provide verbal and written information on induction of labour (please use 'Induction of labour when the baby has died in the womb' leaflet).

5.27. Provide written information leaflets regarding support groups, such as SANDS and ARC.

5.28. Inform the labour ward co-ordinator of woman's details and plan of care.

5.29. Commence induction of labour as per drug regime Appendix A

5.30. Post-mortem may or may not be advised, or needed, depending on clinical indication for termination of pregnancy. If considered, discuss post-mortem with woman and her partner. It is important to recognise that emotions and preferences of parents vary significantly and that there should not be any assumptions made about what a woman does or does not want during her care.

5.31. Under 24 weeks gestation there is no legal stillbirth certificate issued and no registration of birth.

Intrapartum and Postnatal Care:

5.32. One to one care should be provided at all times.

5.33. Analgesia should be offered as required by each individual woman during labour. Regional analgesia can be considered, when recent blood results have been reviewed by an anaesthetist.

5.34. The third stage should be actively managed using 1ml Syntometrine given intramuscularly. Syntometrine must be prescribed by the Gynaecologist or Obstetrician. This is not covered in the Midwives Exemptions.

- If the woman declines this method, the placenta may be delivered physiologically and 1ml Syntometrine given intramuscularly if the placenta appears complete, if it is deemed appropriate to reduce risk of further bleeding.
- Referral for attendance of the on-call Gynaecologist or Obstetrician should be made where there are any concerns about the 3rd stage

5.35. If there is a delay in the delivery of a placenta and bleeding is minimal, up to 4 hours of observation may be given before surgical exploration in theatre under general anaesthesia. The woman may choose earlier intervention.

5.36. If there is abnormal bleeding, or an incomplete placenta, exploration under anaesthetic should not be delayed. There is a higher risk of retained products with premature gestations.

5.37. Postnatal observations should be conducted to ensure maternal wellbeing, but in as unobtrusive a way as possible. Observations should include: BP, Pulse, Temperature, respirations, PV loss and pain score.

6. Stillbirth (Over 24+0 weeks)

6.1. Use the yellow labour notes to document care. Use the mauve notes for postnatal care. Use the NDDH checklists not the generic list in the mauve notes sign and date every box file in medical notes when complete

6.2. Antepartum stillbirth (or intrauterine death) must be confirmed by ultrasound scan by a senior ultra-sonographer or obstetrician.

6.3. Where possible a second ultrasound scan should be performed by a second clinician.

6.4. If the woman is alone immediately offer to contact her partner, family or friends to support her, and move to a quiet room, in an appropriate location, to discuss management of care.

6.5. Intra-uterine fetal loss can be managed expectantly or immediately by inducing labour. Evidence suggests that the majority of women would deliver within 3 weeks of fetal demise, but that there is increasing risk to the mother of DIC (disseminated intravascular coagulation) after this time.

6.6. If the mother is physically well, with no evidence of pre-eclampsia, haemorrhage or sepsis, and the membranes are intact, the risk of expectant management for 48 hours is low.

6.7. However many women choose to be induced sooner than this and there is some evidence to suggest that women's psychological health is negatively affected if induction is delayed more than 24 hours from diagnosis of fetal death (RCM 2016, RCOG 2010).

6.8. If expectant management is preferred by the woman, and there is no immediate risk, blood tests should be taken at least twice weekly to monitor maternal condition (See Investigations Checklist in Appendices) (RCOG 2010).

6.9. Conditions such as pre-eclampsia, major feto-maternal haemorrhage, chorioamnionitis and sepsis, or any other clinical condition that puts the mother at significant risk of harm, must be managed immediately.

6.10. The preferred mode of delivery is vaginal birth; however the parents may request a caesarean section to avoid labour. Caesarean is not recommended as it impacts on future pregnancies and the physical wellbeing of the mother. However due to the psychological impacts of intra-uterine death, this must be discussed with a Consultant obstetrician and decisions made on an individual basis.

6.11. A discussion around post mortem, if appropriate, should take place at a suitable time for the mother and time given for the parents to ask questions. It must be made clear that a post mortem may or may not provide further information as to the cause of death, but that further information could have an impact on future pregnancies.

6.12. If induction of labour is preferred, or advised, continue medical management as per drug regime Appendix A.

6.13. Provide verbal and written information on induction of labour (please use 'Induction of labour when the baby has died in the womb' leaflet).

6.14. Prior to commencing induction of labour investigations should be undertaken for all intra-uterine deaths of unknown cause (See Investigations Checklist in Appendix B). If deemed appropriate by consultant, testing for Factor V Leiden should be 6 weeks postnatally.

6.15. Provide written information leaflets regarding support groups, such as SANDS. Discuss, if appropriate, what the baby may look like if the baby has been dead for some time.

6.16. Inform the labour ward co-ordinator of woman's details and plan of care.

Intrapartum Stillbirth

6.17. Loss of a baby during labour is a traumatic experience not only for the mother and her family but also for the staff involved in her care. Women must be cared for on an individualalised basis according to their clinical and emotional needs.

Support for staff is also essential.

6.18. All intra-partum deaths are to be investigated thoroughly.

6.19. HM Coroner normally has no jurisdiction over stillbirth, even if cause is unknown.

6.20. However HM CORONER should be contacted if an apparently fresh stillbirth occurs which is unattended by a healthcare professional. HM CORONER also has discretion to be involved in a death if a criminal act is suspected, for example assault, in which cases the local police service should be contacted (RCOG 2010).

Post Delivery:

6.21. Following delivery the baby may be placed in the cuddle cot kept on Labour ward to slow down deterioration. The parents should be offered to have the baby with them for as long as they wish.

6.22. The baby should be wrapped and treated with respect and dignity. The parents should be given the opportunity to hold their baby if they wish. The baby can remain in the room with the parents or moved to another room at the parents' request.

6.23. Care should be taken to ensure the baby remains in a suitable room until transfer to the mortuary is completed. Utility rooms are not appropriate.

6.24. It is important to offer the opportunity to create memories such as taking photographs, hand and foot prints and creating cot cards. Parents may wish to dress the baby.

6.25. Memory making: Parents should be made aware that photographs will be taken even if they do not wish to keep them, and kept securely in maternal notes. This is for future use as sometime parents then regret declining pictures at the time of loss.

6.26. Parents should be counselled on genetic testing if appropriate.

6.27. If the parents wish for post mortem, both baby and placenta (in formalin) must be labelled and sent to the mortuary with the appropriate forms completed.

6.28. FOR CORRECT DOCUMENTATION SEE FLOW CHART IN YELLOW FOLDER ON LABOUR WARD (See supporting documents linked to this guideline).

6.29. If the parents do not want a post mortem, the placenta (in formalin) must be labelled and sent to Histology, with the correct form for histopathology investigation.

6.30. In both cases the midwife, doctor or nurse **who delivered the baby** must sign the forms for burial or cremation, depending on parental wishes. If the parents are undecided, please complete both forms and the Bereavement officer will dispose of the unrequired form.

6.31. Disposal of fetal remains must always be done in a respectful manner. The funeral arrangements may be made by the hospital or the parents, as per the parents' wishes.

6.32. Parents must be informed that burial or cremation will be delayed if they request a post-mortem. Most fetal remains are sent to Bristol for post-mortem, which can take several weeks.

6.33. Hospital cremation:

- Parents may choose not to be involved, in which case the hospital arranges the communal cremation of fetal remains at North Devon Crematorium, and will incur all costs.
- Parents may wish to attend an individual cremation, whereby the hospital will be responsible for the funding and arrangements of the cremation. The parents will be involved and given information as appropriate.

6.34. Private cremation or burial:

- Parents may make their own funeral arrangements according to their own beliefs or religion.
- The midwife, doctor or nurse who delivered the baby must sign the correct form to release the fetal remains.

6.35. Please file the checklist in the medical notes, not to be sent home with parents.

6.36. A 6-8 week postnatal check appointment must be with an obstetrician, not with the GP. If PM results are not available at this appointment, conduct a normal postnatal check and another appointment should be arranged when results are available, unless declined by the woman.

6.37. Please fill in the form for maternity reception to arrange an outpatients' obstetric appointment and to cancel further USS and antenatal appointments.

7. Neonatal Death

7.1. If a poor outcome and admission to Special Care Baby Unit is expected, (for example in the case of severe fetal abnormalities), parents may wish to visit SCBU to familiarise themselves with the ward. Parents with a baby diagnosed with a terminal condition may also wish to take their baby home, in which case they may be supported to do so and be referred to Children's Hospice South West for palliative care.

7.2. All unexpected neonatal deaths are to be investigated thoroughly.

7.3. Early neonatal loss requires investigation of the mother. Bloods and swabs should be taken as required, see investigation checklist and mauve purple notes.

8. Making Memories

8.1. The value of memory making for parents cannot be underestimated. Spending time with their baby, holding the baby and having mementos and keepsakes are all considered incredibly important to grieving parents, both at the time and for the future.

9. Post Mortem

9.1. If parents wish to have a post-mortem, the consent form must be completed by someone experienced and knowledgeable in the process. This is most commonly the Bereavement Officer but may also be a consultant Obstetrician. Any inconsistencies will delay the post-mortem procedure.

10. Actual or Suspected Poor Outcome Other Than Death

10.1. The parents will be offered the opportunity for discussion with an experienced paediatrician within 24hours of their babies admission to the Special Care Unit (SCU) or the earliest opportunity after a problem is identified if the baby does not require admission to SCU.

10.2. The parents will be kept fully informed of their baby's progress by members of the paediatric and midwifery teams.

10.3. All discussions will be documented in the Perinatal Institute notes.

10.4. After discharge the parents will be offered a follow up appointment with the named Consultant Paediatrician in 6-8 weeks where appropriate.

10.5. Follow up with the named Consultant Obstetrician will also be arranged within a similar timescale where appropriate.

10.6. Parents can be offered information from appropriate sources of support from resources supplied by:

- ARC www.arc-uk.org
- Stillbirth and Neonatal Death Charity (SANDS) www.uk-sands.org
- BLISS (For babies born too soon, too small or too sick www.bliss.org.uk
- TOMMYS www.tommys.org

11. Monitoring Compliance with and the Effectiveness of the Guideline

11.1. An up to date copy of this guideline is available to all staff on the Trust intranet. As a matter of routine, this guideline will be reviewed triennially by the Maternity Services Guideline group.

11.2. Reporting for non-compliance and review of effectiveness of the guideline will be identified through the risk process within maternity and led by appointed maternity Risk leads. The maternity services audit process will include review of this guideline.

11.3. All versions of these guidelines will be archived in electronic format by the author within the Maternity Team policy archive. Any revisions to the final document will be recorded on the Document Control Report. To obtain a copy of the archived guidelines, contact should be made with the Maternity team.

12. References

12.1. RCOG. (2010) Late intrauterine fetal death and stillbirth (green-top guideline no. 55). RCOG: London.

12.2. RCM; Coffrey, H. (2016) Parents' experience of the care they received following a stillbirth: a literature review. Evidenced Based Midwifery 14(1): 16-21

12.3. SANDS. (2017) Why babies die – stillbirth. See: uk-sands.org/why-babies-die/stillbirth (accessed 28/06/2017).

13. Associated Documentation

Guidelines for Management of Miscarriage including Medical Management

Care of Pregnancy Complicated by Lethal Fetal Anomaly Guidelines

Intrapartum care: care of healthy women and their babies during childbirth including Fetal Monitoring in Labour

Death of a Neonate cared for on SCU – Management guidelines

Post Mortem and Tissue Retention Policy

Bereavement page on Bob

Induction of labour when the baby has died in the womb Patient Information Leaflet (NDDH)

Appendix A:

Drug Regime

The Royal College of Obstetricians and Gynaecologists (RCOG) recommend a combination of Mifepristone and prostaglandins to induce labour (RCOG 2010).

On diagnosis of Intra-uterine death:

1 x Oral dose 200mg Mifepristone. This needs to be dispensed on an individual basis from Pharmacy, meaning that an inpatient prescription chart must be sent across.

Vaginal Misoprostol regime 72 hours later.

- Gestation under 26+6: 100 micrograms 6 hourly, up to 24 hours.
- Gestation 27 weeks and over: 25-50 micrograms 4 hourly, up to 24 hours.

For woman with a previous caesarean section scar continue with regime of 25-50 micrograms. Oxytocin can be considered, but the decision must be made by the Consultant Obstetrician. Close observation must be made for signs of uterine rupture.

Gemeprost is an alternative medication but should only be used if directed by a consultant obstetrician.

However with women who have more than one caesarean section scar, caution should be taken when using misoprostol. Mifepristone can be used alone orally at a higher dose, or repeat doses. A cervical ripening balloon can be considered.

Mechanical Induction (ARM) should not be routinely used as this may increase the risk of rising infection.

Induction with oxytocin alone should not be routinely used as misoprostol has been found to be more effective (RCOG). The decision for ANY oxytocin augmentation must be by a Consultant Obstetrician.

If the induction of labour is not successful a plan must be made by the on call Obstetric Consultant.

Appendix B:

Maternal and Fetal Investigations List

For all unexpected fetal losses, standard tests on admission require: (Bloods) 2 purple bottle, 2x pink bottles, 3x yellow bottles, 1x blue bottle. Additionally 1x MSU, 1x Vaginal swab.

Following delivery standard tests are: placental swabs, placental tissue sample.

Investigations	Sample taken in	When to Take	Indication	Comments	Taken Date/time	
					Yes	No
Full Blood Count	Purple top blood bottle	On admission	All cases			
CRP	Yellow top blood bottle	On admission	All cases			
Group and Save and Kleihaur	Pink top blood bottle x2	On admission	All cases			
Clotting screen	Blue top blood bottle	Prior to labour/ASAP	All cases			
U&E's and LFTs	Yellow top blood bottle	Prior to labour/ASAP	All unexpected fetal losses			
Uric acid and LDH	yellow top blood bottle	If clinically indicated	All unexpected fetal losses			
HBA1C	Purple top blood bottle	On admission	Gestational or known diabetes			
Virology antibody screen (TORCH)- CMV, Parvovirus, Toxoplasmosis	Yellow top blood bottle (2 x bottles)	If Clinically indicated	Requested by Obstetrician/ viral infection suspected	(microbiology form)		
TSH, T3 , T4	Yellow top blood bottle	If Clinically indicated	Requested by Obstetrician			
Lactate	Grey	If clinically indicated	If sepsis suspected, or requested by obstetrician.			
Vaginal swab	Charcoal swab	Prior to labour	All unexpected fetal losses			
Blood cultures	Blood culture bottles	If clinically indicated	Suspected sepsis (as per sepsis guideline)			
MSU	White top urine bottle	If clinically indicated	All unexpected fetal loses			
HVS	Charcoal swab	If clinically indicated	Rarely, unless maternal sepsis suspected			
Throat swab	Charcoal swab	If clinically indicated	Rarely, unless maternal sepsis suspected			

Factor 5 Leiden	Purple bottle must be separate from FBC	6-8 weeks postnatally	Perform unless cause already known and irrelevant to be arranged by Consultant Obstetrician.			
Thrombophilia screen			If signs of fetal hydrops, or requested by obstetrician. Discuss with Haematologist.			
Placental swabs (chorion and amnion sides)	Charcoal swabs	ASAP post delivery	All unexpected fetal losses			
Placental tissue sample	White Specimen pot	ASAP post delivery	All unexpected fetal losses (See policy) If NOT going with baby for PM.	Label with maternal label using Histology form if **not** going for post-mortem.		
Baby Investigations						
Skin Swabs	Charcoal swab	ASAP post delivery	All unexpected fetal demise, infection			
Cord Blood	Purple blood bottle	ASAP post delivery	Intrapartum Stillbirth, early neonatal loss			
Skin sample Not necessary if a PM is requested	Freezer sample collection	ASAP post delivery	Genetic testing Maternal consent must be taken and documented	Bristol cytogenetics form		

Appendix C:

Sands
Stillbirth & neonatal death charity

5 ways to improve care

Improving bereavement care

The quality of care that bereaved families receive when their baby dies has long-lasting effects. Good care cannot remove parents' pain and grief, but poor care can and does make things much worse.

Sands recommends 5 key ways in which maternity units can improve care for parents whose baby dies before, during or shortly after birth:

1. **Bereavement care training**
   All staff who are responsible for caring for parents whose baby has died should have training to enable them to give supportive, empathetic and sensitive care.

2. **Bereavement care midwives**
   All maternity unit staff should have access to a specially trained bereavement midwife who is responsible for staff training and support, and for monitoring policies and procedures to ensure that bereaved parents receive good quality care.

3. **Dedicated bereavement room**
   There should be at least one dedicated bereavement room or suite, away from celebrating families and the sound of live babies, where a woman whose baby has died can labour and/or be cared for afterwards.

4. **Bereavement care literature**
   Sands' support booklets for parents and the Sands Guidelines (Pregnancy Loss and the Death of a Baby: Guidelines for professionals) should be available on every maternity unit.

5. **Post mortem consent package and training**
   All parents should be offered the opportunity to discuss a post mortem examination of their baby with a senior doctor or midwife. The consent form should be based on the HTA-approved form developed by Sands, with, if necessary, minimal changes to fit the local situation. All staff who seek consent should have had training based on the Sands Post Mortem Consent Package and the Sands Learning Outcomes for Consent Taker Training.

Please see below for new standards that have been rolled out nationally by the National Bereavement Care Pathway and part of CQC requirements:

Bereavement care standards.pdf

SANDS Principles of Bereavement Care

The Stillbirth and Neonatal Death Society (SANDS) is a charity that supports bereaved parents and their families, provides education to professionals, and is an advocate for grieving parents. SANDS have produced 10 principles of bereavement care, aiming to improve care for parents across the country.

1. Care should be individualised so that it is parent led and caters for their personal, cultural or religious needs. Parents should always be treated with respect and dignity. Sensitive, empathetic care is crucial and may involve spending time with parents. This should be recognised by managers and staff.

2. Clear communication with parents is key and it should be sensitive, honest and tailored to meet the individual needs of parents. Childbearing losses can involve periods of uncertainty and staff should avoid giving assurances that may turn out to be false. Trained interpreters and signers should be available for parents who need them.

3. In any situation where there is a choice to be made, parents should be listened to and given the information and support they need to make their own decisions about what happens to them and their baby.

4. No assumptions should be made about the intensity and duration of grief that a parent will experience. It is important that staff accept and acknowledge the feelings that individual parents may experience.

5. Women and their partners should always be looked after by staff who are specifically trained in bereavement care and in an environment that the parent feels is appropriate to their circumstances. In addition to good emotional support, women should receive excellent physical care during and after a loss.

6. A partner's grief can be as profound as that of the mother; their need for support should be recognised and met.

7. All staff who care for bereaved parents before, during or after the death of a baby should have opportunities to develop and update their knowledge and skills. In addition, they should have access to good

support for themselves.

8. All parents whose babies die should be offered opportunities to create memories. Their individual wishes and needs should be respected.

9. The bodies of babies and fetal remains should be treated with respect at all times. Options around sensitive disposal should be discussed and respectful funerals should be offered.

10. Good communication between staff and healthcare teams is crucial in ensuring that staff are aware of parents' preferences and decisions; therefore, parents do not need to repeatedly explain their situation. This includes the handover of care from hospital to primary care staff, which should ensure that support and care for parents is seamless. Ongoing support is an essential part of care and should be available to all those who want it and should continue to be made available to all women and their partners during a subsequent pregnancy and after the birth of another baby.

(SANDS 2017)

Appendix D:

(Beneath the Guideline published on BOB)

Appendix E:

Send to Maternity Reception:

The lady below has had a still birth/ late fetal loss at _____ gestation on _____ (date).

Please can the following be arranged or cancelled:

- 6-8 week postnatal appointment made with Consultant Obstetrician

  To see _____ (Consultant)
  Please liaise with Cons secretary for venue, not for routine clinic apt.

  Appointment Letter sent ☐

- Any booked or remaining antenatal scans and clinic appointments cancelled ☐

Completed by Midwife/ Doctor: _____ (sign and date)

Maternal address sticker

Appendix F:

Bereavement Care Stock Checklist Delivery Suite

CSSD Main Store Room, at the back on the top shelf:

- 1 x Moses Basket
- 1 x Large For Louis Memory Box
- 1 x Small For Louis Memory Box
- Extra clay imprint kit.
- Cardboard Coffins, 2 x small, 2x large
- Box of late fetal loss pouches, cardigans and Blankets.

If a memory box is used, please send the slip accompanying it to Elisabeth Seymore (Bereavement office) for it to be replaced.

Electrical Cupboard, at the back on the shelves above the Baxter pumps:

- Camera and Printer both boxed. Ink in situ in printer, paper in the printer box.

If the paper or ink is running low or there is a problem with the camera or printer, SCBU can loan their equipment in an emergency. However please notify the labour ward co-ordinator, or contact Jo Morgan or Hannah Scrannage, so that stock can be replaced.

Below the Baxter pumps:

- Cuddle Cots x2.

At the front reception desk in the metal filing cabinet:

- All required paperwork:
  - Pregnancy Loss Guideline
  - Checklists and SANDS packs
  - Still birth certificates
  - Post-mortem paperwork (Yellow folder)
  - Cremation and burial paperwork (Yellow folder)
  - Spare leaflets
  - SANDS Audit Tool

If there are fewer than 3 SANDS packs for parents left, please notify Jo Morgan or Hannah Scrannage. Alternatively contact Louise Errol (Petter ward manager) who can then replace these.

Appendix G:

How to use Camera and Printer

- **Please** keep the memory card inside the camera unless in use with the printer.
- Turn camera on (button on top) and take required photos. These can be reviewed before printing by pressing the PLAY button and using the directional arrows.
- When ready to print, plug printer into socket using the mains leads. Insert the paper tray as per instructions on the tray. Ensure photo paper in the tray is shiny side up.
- Hold down the on button to turn on.
- Remove the memory card from the camera (underneath) and insert into card space on the left of the printer.
- The printer will automatically pick up the pictures. Scroll through the photos using the direction arrows to pick the photos you want to print.
- Press print (allow space at the back of the printer for the paper to go back and forth).
- When finished printing please replace the memory card back into the camera.
- Please delete photos from the memory card once back in the camera and no longer needed.

Spare paper is kept in the box with the printer. If you notice the paper is running low please email Eileen Phillips, Hannah Scrannage or Jo Morgan. Likewise if the ink is running low.