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. It is also to be used in conjunction with the standards recommended by the National Bereavement Care Pathway (NBCP) for Miscarriage, Stillbirth, Neonatal death and Termination of Pregnancy for Fetal Anomaly (TOPFA)

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. Reference should be made to the Extreme Prematurity Guideline

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. There has been an overall reduction in the stillbirth and neonatal mortality rate since MBRRACE perinatal mortality surveillance commenced in 2003 (MBRRACE 2019) 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) are a charity that provides support for grieving families and educational programmes for professionals. SANDS have produced the 10 Principles of Bereavement Care. They have also have supported the development and introduction by the NBCP of a set of standards that underpin the care given to ensure that care is sensitive and standardised throughout the country. 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 and preferences. 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)

Spontaneous Fetal Demise (IUD)

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

5.2. A second scan must be offered to confirm the intrauterine death (this should be a different clinician experienced in USS to that performing the first scan). This can be done with the portable scanner it does not need to be done in the main scanning department. Out of hours this will require calling in the on call Consultant Obstetrician as soon as possible.

5.3. 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.

5.4. 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.

5.5. 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.

5.6. 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).

5.7. 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).

5.8. 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.

5.9. 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.

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

5.11. Provide verbal information on induction of labour.

5.12. 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.

5.13. 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.

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

Spontaneous Severely Premature Labour (Miscarriage)

Always refer to the Extreme Prematurity Guideline

On the threshold of viability (22+0 -23+6 weeks)

5.15. 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.

5.16. 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.

5.17. 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.

5.18. 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.

5.19. 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.

5.20. 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.

5.21. 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 (Use in conjunction with Care of Pregnancy complicated by Lethal Anomaly Guideline)

5.22. 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.

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

5.24. 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.

5.25. Provide verbal information on induction of labour.

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

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

5.28. Commence induction of labour as per drug regime Appendix A or the drug regime from Care of Pregnancy with a Lethal Anomaly guideline as per Consultant decision

5.29. 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.

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

6. Stillbirth (Over 24+0 weeks)

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

6.2. A second ultrasound scan should be performed by a second clinician (experienced in USS) this can be with the portable ultrasound scanner. Out of hours this will require calling in the on call Consultant Obstetrician.

6.3. 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.

6.4. 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.

6.5. 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.

6.6. 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).

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

6.8. 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.

6.9. 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.

6.10. 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.

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

6.12. Provide verbal and written information on induction of labour.

6.13. 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.

6.14. 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.

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

Intrapartum Stillbirth

6.16. 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 individualised basis according to their clinical and emotional needs together with their personal preferences.

Support for staff is also essential.

6.17. All intra-partum deaths are to be investigated thoroughly using the PMRT (Perinatal Mortality Review Tool).

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

6.19. 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).

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 discussions will be documented in the Perinatal Institute notes.

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

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

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

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

8. Intrapartum care for ALL losses:

8.1. Advise the Bereavement Office by telephone or email (NDHT.bereavementsupport@nhs.net) on admission to the ward

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

8.3. Care in labour as per Intrapartum care: care of healthy women and their babies during childbirth Including Fetal Monitoring in Labour guideline individualized to take account of the fetal loss, using the partogram to document progress and observations

8.4. One to one care should be provided at all times in the designated Bereavement room, if this is not possible another room on the delivery suite should be used the family should not be transferred from here until discharge

8.5. 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.

8.6. The third stage should be actively managed using 10 iu Oxytocin given intramuscularly. Oxcytocin 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 10iu Oxytocin 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

8.7. If there is a delay in the delivery of a placenta and bleeding is minimal, up to 1 hours of observation may be given before surgical exploration in theatre under general anaesthesia. The woman may choose earlier intervention.

8.8. 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.

8.9. 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.

9. Post Delivery for All losses

9.1. Following delivery the baby may be placed in the .Abi cold 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. A plan of care should be made to incorporate any personal preferences they may have.

9.2. 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. When they decide they have said goodbye to the baby it must be transferred to the mortuary by a porter only, in a casket with the correct paperwork in the appropriate transfer bag

9.3. 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.

9.4. 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.

9.5. 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.

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

9.7. If the parents wish for post mortem, the baby and the placenta , which must be put in formalin in a white pot, must be labelled and sent to the mortuary with the appropriate forms completed. Consent must be taken only by a trained Consent Taker (names in the Green folder)

9.8. FOR CORRECT DOCUMENTATION FOR POST MORTEM and CREMATION/BURIAL SEE FLOW CHARTS AND FORMS IN YELLOW FOLDER ON LABOUR WARD .

9.9. If the parents do not want a post mortem, the placenta (in formalin) must be labelled and sent to the mortuary with the Bristol Post Mortem Request Form (**marked Placenta only**) fully completed not to NDDH Histology this is to enable histology to be carried out by a Perinatal Pathologist as per NBCP standard, only verbal consent is required from the parents but this must be documented in the notes please email NDHT.bereavementsupport@nhs.net to advise that this has been done

9.10. 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.

9.11. 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.

9.12. 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 takes approximately two weeks.

9.13. 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. It can also be individual either burial or cremation, in these cases the hospital will be responsible for funding.
- 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.

9.14. Private cremation or burial:

- Parents may make their own funeral arrangements according to their own beliefs or religion.
- The midwife must complete all forms and certificates according to the checklist and the relevant flowchart in the yellow folder on labour ward.

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

9.16. A 6-8 week postnatal check appointment must be with an obstetrician, not with the GP do this by phoning or emailing the named consultants secretary. 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.

9.17. Please fill in the form for maternity reception to .cancel further USS and antenatal appointments. APPENDIX D

9.18. All cases must be reported on Datix

9.19. Neonatal deaths must be reported on a Notification of Child Death Form (on BOB) see HM Government Child Death Review Statuary Guidance quality@dh.gsi.gov.uk

9.20. A Perinatal Mortality Review Tool (PMRT) will be completed for:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth to 28 days of life
- All postnatal deaths where the baby dies after 28 days following care in a Neonatal unit

9.21. An initial investigation will be commenced which will inform a multidisciplinary panel review. The review panel will generate a report and action plan that can be shared with the parents during a Consultant debrief appointment. Please ensure that the parents are aware of this process and invite them to input into the process by submitting any questions they have. Give them the NPEU leaflet.

9.22. Parents can be given the list of support resources APPENDIX E on discharge or in the SANDS pack

Suppression of Lactation

9.23. Women should be advised that one third of those who choose non-pharmacological options such as breast support, ice packs and analgesics experience severe breast pain. Current recommendations are that pharmacological methods of lactation suppression are effective and well tolerated by many women (RCOG2010a). Cabergoline 1mg as a single dose within 24 hours of stillbirth should be offered to non-hypertensive women, avoid in women with any history of puerperal psychosis. There is no system for breast milk donation here however it is available in Bristol please discuss with NDDH's Infant Feeding midwife at the time.

Psychological support

9.24. Ensure that all parents have information on local and national support and are given referral forms to use when they feel necessary

9.25. Ensure that there is a discussion before discharge about their needs

Future Pregnancy

8.35 A parent-led bereavement care plan is in place for all families, providing continuity between settings and into subsequent pregnancies.

The history of the loss must be clearly documented within the medical records and should be thoroughly read before seeing the woman.

Women should be recommended to have obstetric antenatal care with extra support and monitoring as required

Maternal request for a scheduled IOL should take into account the gestational age of the previous loss, previous obstetric history and the safety of the IOL

10. Monitoring Compliance with and the Effectiveness of the Guideline

10.1. 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.

10.2. 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.

10.3. 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.

11. References

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

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

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

11.4. MBRRACE (2019) Perinatal Mortality Surveillance UK Perinatal Deaths for births in 2017.

12. 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

Extreme Prematurity Guidelines

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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 can be be dispensed on an individual basis from the CD cupboard on Labour Ward,an inpatient prescription chart must be completed. OR, if no stock in the CD cabinet, then a CD order can be made in the book and sent to pharmacy for stock.

Vaginal Misoprostol regime 36-48 hours later.

- Gestation under 26+6: 100 micrograms 6 hourly PV, up to 24 hours.
- Gestation 27 weeks and over: 25-50 micrograms 4 hourly PV, 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) 1 purple bottle,1x pink bottle,3x yellow bottles, 3x blue bottles. 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 >24/40 Bile Acids	yellow top blood bottle	On Admission	All unexpected fetal losses			
HBA1C	Purple top blood bottle	On admission	All cases			
Virology antibody screen (TORCH)- CMV, Parvovirus, Toxoplasmosis	Yellow top blood bottle (2 x bottles)	On admission	All cases	(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	On admission	All unexpected fetal loses			
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	3 blue 1 yellow and 1 purple	On admission	All unexpected losses Discuss with consultant			
Placental swabs (chorion and amnion sides)	Charcoal swabs	ASAP post delivery	All unexpected fetal losses			
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:

Patient ID Label

Patient name:

NEONATAL DEATH (NND) CHECKLIST

NHS Northern Devon Healthcare NHS Trust

Please tick initial date and time every Yes, No or N/A

Prior to delivery (IUD)	YES	NO	N/A
If expected poor outcome and expected admission to SCBU visit to ward prior to birth			

If early NND ensure delivery notes photocopied as soon as possible

Use Mauve Bereavement Post natal notes, use the NDDH checklist NOT the generic list in postnatal notes, file in medical notes on discharge

Information for parents	YES	NO	N/A
SANDS Booklet (all patients)			
NDDH leaflet Information for Parents following the loss of a Newborn baby (on BOB or in Pack)			
Appropriate Contact numbers given (Bereavement Support Office CDS1)			
Discuss Post Mortem(information in Sands leaflet) advise parents that they do not have to make a decision immediately			
Explain option of taking baby home if appropriate			
Discuss care of baby (inc appearance, parents wishes, time alone) and use of Cuddle Cot			

Tests and Investigation

Maternal Investigations	YES	NO	N/A
Bloods taken (See Investigations list)			
FBC and Group and Save (all patients, on admission if possible)			
Swabs taken if required (particularly if infection suspected)			
Placental swabs take maternal and fetal side (for unexplained losses)			
Kleihauer taken (post delivery all unexplained losses)			

Baby Investigations	YES	NO	N/A
Second discussion about post mortem			
Baby weighed and labelled			
If the baby is going for PM Placenta in Formalin to go with baby If not for PM the placenta must still go in Formalin for histology this then goes to the mortuary with a completed Post Mortem Request form completed marked **Placenta only**. Verbal consent only is required but must be documented in notes Email NDHT.bereavementsupport@nhs.net to advise that this has been done			
Genetic Testing required? If YES -Skin sample in biopsy pot from Bristol (in freezer) send with cytogenetic request form to pathology			

Patient ID Label

Patient name:

Transfer to Mortuary	**YES**	**NO**	**N/A**
Baby, labelled with mothers details in appropriate size casket lined with an inco together with personal items e.g. teddy/blanket			
Placenta (if for PM) labelled with mothers details. Send with baby AND paperwork as per **yellow folder** (consent and perinatal request form)			
Call Porters to transport baby to mortuary. NOT TO BE TRANSFERRED BY ANY OTHER MEANS			
Placenta (if NOT for PM) in formalin as above under investigations ensure Bereavement office are aware it is placenta only to go to Bristol			

Keepsakes for parents	**YES**	**NO**	**N/A**
Memory Box (large) given			
Please complete slip to replace box and send to bereavement Office or leave message on answerphone.			
Photographs of baby (if declined take and place in sealed envelope in medical notes)			
Hand and Footprints taken if possible			
Cot card completed			
Lock of hair if possible			

Notes and Forms: (Follow the yellow folder flow charts)	**YES**	**NO**	**N/A**
Admission, Delivery and Postnatal notes completed			
Birth register completed on CDS1 if applicable			
HM Coroner informed (Contact Coroners office)			
Post Mortem **Consent** form signed for hospital PM (to be done by trained consent taker) **NB If Coroners case NO PM consent needed**			
Perinatal Post Mortem **Request** form (Trained consent taker to complete) **Both forms to go with baby to mortuary**			
Certificate of Death completed by Doctor (Must have seen baby alive and after death)			
Parents advised to contact Bereavement Support Office to discuss Cremation/Burial			
Discuss and offer pastoral services/naming/blessing and inform Chaplain			
Inform Bereavement Officer. Internal extension: 2404 Email: ndht.bereavementsupport@nhs.net as soon as possible			
Inform Community midwife **verbally**			
Inform Health visitor if possible **verbally**			

If for PM see flowchart on CDS1 for paperwork. Will need Perinatal PM request form and PM Consent form completed by trained consent taker

Patient ID Label

Patient name:

Arrange	**YES**	**NO**	**N/A**
Arrange 6/52 Postnatal appointment with named Consultant by emailing or telephoning the named Consultants secretary			
Complete Bounty suppression form			
Offer discussion with Obstetrician and or Paediatrician and document			
On Computer Admit on Trakcare Baby must have an NHS and Trakcare number			
DATIX completed (for all neonatal deaths)			
Duty of Candour, give PMRT information leaflet and advise parents an investigation will take place.			

On Discharge	**YES**	**NO**	**N/A**
Ensure clearly documented discharge care plan to include parents personal preferences			
Anti D given			
Offer discussion with Obstetrician and or Paediatrician and document			
Discuss Physiological changes (eg, vaginal loss, lactation) Offer Carbergoline 1mg within 24 hours of delivery (not to women with hypertension or history of puerperal psychosis)			
Offer CMW visit or phone call if appropriate			
Offer GP follow up			
Discuss that counselling may be available through GP and give the NDDH counselling referral form in the pack for use when required			
Inform CMW **verbally** and give copies of discharge summary			
Inform GP **verbally** and send copies of discharge summary			
Add SANDS teardrop sticker to Medical notes			
Offer visit to Mortuary/CDS1 if parents wish to see baby again, ensure parents have bereavement Support Office number			
Ensure parents have Bereavement Office, CMW and CDS1 contact numbers together with SANDS leaflets and Appendix E for additional support available			
Ensure parents aware of need to register both the birth and the death in the district of the death			
MBRRACE completed online			
Notification of Child Death Form completed (on BOB 'Notification of child death in the South West Peninsula) Refer to HM Government Child Death Review Statuary Guidance (quality@dh.gsi.gov.uk)			

Patient ID Label

Patient name:

UNDER 24 WEEKS (over 18 weeks) CHECKLIST

NHS Northern Devon Healthcare NHS Trust

Please tick initial date and time every Yes, No or N/A

Prior to delivery

	YES	NO	N/A
Confirmed no Fetal Heart by USS by Obstetrician (spontaneous miscarriage)			
Medical TOP (if yes complete forms below)			
Abortion Act forms (Doctors to complete)			
Consent Form medical TOP (Doctors to complete)			
Prescription on drug chart (Doctors to complete)			
Fetocide offered (Gestation over 21+6)			
Accepted?			
Referral to Bristol			
Confirmed fetocide successful			
Anti D required (Rhesus Neg)			
Verbal information on process of Induction of labour			
Discussion and documentation of appropriateness of post mortem by Consultant			

On Admission

Commence Yellow Labour notes then use Mauve Bereavement Post natal notes, use the NDDH checklist not the generic list in postnatal notes, file in medical notes on discharge

Information for parents	YES	NO	N/A
SANDS Booklet (all patients)			
NDDH leaflet Information for Parents following a late fetal Loss (on BOB or in Pack)			
Appropriate Contact numbers given (e.g. CDS1, Petter, screening Co-ordinator)			
Discuss (information in Sands booklet) Post Mortem (Over 12 weeks) advise parents that they do not have to make a decision immediately			
Explain option of taking baby home if appropriate			
Inform Bereavement Officer. Internal extension: 2404 or Email: ndht.bereavementsupport@nhs.net			

Patient ID Label

Patient name:

Tests and Investigations

Maternal Investigations	**YES**	**NO**	**N/A**
Bloods taken (See Investigations list)			
FBC and Group and Save (all patients)			
Swabs taken if required			

Baby Investigations

Second Discussion about post-mortem			
Baby weighed and labelled			
If the baby is going for PM the Placenta goes in Formalin with baby If not for PM the placenta must still go to Bristol in Formalin for histology this then goes to the mortuary with a completed Post Mortem Request form completed marked **Placenta only**. Verbal consent only is required but must be documented in notes Email NDHT.bereavementsupport@nhs.net to advise that this has been done			
Genetic Testing required? -Skin sample in biopsy pot from Bristol (in freezer) defrosted first			

Transfer to Mortuary	**YES**	**NO**	**N/A**
Baby, labelled with mothers details placed in appropriate sized casket, can be larger rather than smaller with blanket/keepsakes			
Placenta (if for PM) labelled with mothers details. Send with baby labelled with mums details AND paperwork as per yellow folder			
Placenta (if NOT for PM), labelled send mortuary as above			
Only Porters to transport baby to Mortuary			

Keepsakes for parents	**YES**	**NO**	**N/A**
Memory Box (small) given			
Please complete slip to replace box and send to bereavement Office or leave message on answerphone.			
Photographs of baby			
Hand and Footprints taken if possible			
Cot card completed			

Patient ID Label

Patient name:

Notes and forms: (Follow the yellow folder flow charts)	**YES**	**NO**	**N/A**
Admission, Delivery and Postnatal notes completed			
Medical Certificate of Examination from completed (Midwife or Doctor)			
Permission for cremation of fetal remains completed by Midwife			
Permission for Burial of fetal remains form completed by **delivering midwife. Sign both, the Bereavement Officer will dispose of unrequired forms**.			
IF for PM, Post mortem **Consent** form signed (to be done by trained consent taker)			
Post mortem **Request** form completed by consent taker. Both forms to go with baby to mortuary.			
Discuss and offer pastoral services/naming/blessing and inform Chaplain			
Inform Bereavement Officer. Internal extension: 2404 or Email: ndht.bereavementsupport@nhs.net if not already done			

Arrange	**YES**	**NO**	**N/A**
Cancel Antenatal appointments and USS appointments using the form on appendix D for Antenatal reception			
Arrange 6/52 Postnatal appointment with named Consultant by emailing or telephoning the named Consultants secretary			
Duty of Candour, give PMRT Information for Parents leaflet and advise that there will be an investigation (Unless TOP)			
Complete Bounty suppression form			
End pregnancy on computer (no NHS number) Complete DATIX for all fetal losses			

On Discharge	**YES**	**NO**	**N/A**
Ensure clearly documented discharge care plan to include parents personal preferences			
Offer discussion with Obstetrician and document			
Discuss Physiological changes (e.g., vaginal loss, lactation) Offer Carbergoline 1mg to be taken within 24 hours (not to women with Hypertension or history of Puerperal psychosis)			
Offer CMW visit or phone call if appropriate			
Offer GP follow up			
Inform CMW **verbally** and send copies of discharge summary			
Inform GP **verbally** and send copies of discharge summary			
Inform Health Visitor **verbally** via the Health Visitor Hub			
Add SANDS teardrop sticker to Medical notes			
Ensure parents have Bereavement Office, CMW and CDS1 contact numbers together with SANDS booklet and list of support Appendix E for additional support available			
MBRACE completed for all loses over 22 weeks gestation			

Patient ID Label

Patient name:

OVER 24 WEEKS IUD / STILLBIRTH CHECKLIST

Northern Devon Healthcare NHS Trust

Please tick initial date and time every Yes, No or N/A

Prior to delivery (IUD)

	YES	NO	N/A
Confirmed no Fetal Heart by USS by Obstetrician (spontaneous IUD)			
Second USS performed?			
Medical TOP for abnormality (if yes complete forms below this is a legal requirement)			
Consent Form medical TOP (Doctors to complete)			
Prescription on drug chart (Doctors to complete)			
Fetocide advised (Gestation over 21+6)			
Accepted?			
Referral to Bristol			
Confirmed fetocide successful (USS)			
Verbal information on process of Induction of labour			
Discussion and documentation of appropriateness of post mortem by Consultant			

For all Intrapartum stillbirths ensure notes photocopied as soon as possible after delivery

On Admission

Commence Yellow Labour notes then use Mauve Bereavement Post natal notes, use the NDDH checklist not the generic list in postnatal notes, file in medical notes on discharge

Information for parents	YES	NO	N/A
SANDS Booklet (all patients)			
NDDH leaflet Information following a Stillbirth (on BOB or in Pack)			
Appropriate Contact numbers given (e.g. CDS1, Petter, screening Co-ordinator)			
Discuss Post Mortem (information in Sands booklet) advise parents that they do not have to make a decision immediately			
Explain option of taking baby home if appropriate			
Discuss immediate care of baby (inc appearance, parents wishes, time alone.)			

Patient ID Label

Patient name:

Tests and Investigation

Maternal Investigations	**YES**	**NO**	**N/A**
Bloods taken (See Investigations list Appendix B)			
FBC and Group and Save (all patients, on admission if possible)			
Swabs taken if required (particularly if infection suspected) Placental swabs take maternal and fetal side (for unexplained losses)			
Kleihauer taken (post delivery all unexplained losses)			

Baby Investigations	**YES**	**NO**	**N/A**
Second discussion about post mortem			
Baby weighed and labelled			
If the baby is going for PM the Placenta must go in Formalin ~~to go~~ with baby If not for PM the placenta must still go to Bristol in Formalin for histology this then goes to the mortuary with a completed Post Mortem Request form completed marked **Placenta only**. Verbal consent only is required but must be documented in notes Email NDHT.bereavementsupport@nhs.net to advise that this has been done			
Genetic Testing required? If YES -Skin sample in biopsy pot from Bristol (in freezer) defrosted first			

Transfer to Mortuary	**YES**	**NO**	**N/A**
Baby, labelled with mothers details in appropriate size casket lined with an inco together with personal items e.g. teddy/blanket			
Placenta (if for PM) labelled with mothers details. Send with baby AND paperwork as per **yellow folder** (consent and perinatal request form)			
Call Porters to transport baby to mortuary. NOT TO BE TRANSFERRED BY ANY OTHER MEANS			
Placenta (if NOT for PM) in formalin as above under investigations ensure Bereavement office are aware it is placenta only to go to Bristol			

Keepsakes for parents	**YES**	**NO**	**N/A**
Memory Box (large) given			
Please complete slip to replace box and send to bereavement Office or leave message on answerphone.			
Photographs of baby (if declined take and place in sealed envelope in medical notes)			
Hand and Footprints taken if possible			
Cot card completed			
Lock of hair if possible			

Patient ID Label

Patient name:

Notes and Forms: (Follow the yellow folder flow charts)	YES	NO	N/A
Admission, Delivery and Postnatal notes completed Admit baby on computer			
Birth register completed on CDS1 if applicable			
Post Mortem **Consent** form signed (to be done by trained consent taker)			
Perinatal Post Mortem **Request** form **Both forms to go with baby to mortuary**			
Medical Certificate of Stillbirth (see yellow folder, **MUST** be signed by Midwife or Doctor who delivered the baby) All sections completed fully and given to parents			
Parents advised to contact Bereavement Support Office to discuss Cremation/Burial			
Discuss can have private funeral arrangement			
Discuss and offer pastoral services/naming/blessing and inform Chaplain			
Inform bereavement Officer. Internal extension: 2404 Email: ndht.bereavementsupport@nhs.net			
Offer chance to take baby home (if yes sign release form)			

Arrange	YES	NO	N/A
Cancel Antenatal appointments and USS appointments using the form on appendix D for Antenatal reception			
Arrange 6/52 Postnatal appointment with named Consultant by emailing or telephone named Consultants secretary			
Complete Bounty suppression form			
On Computer Admit on Trakcare Baby must have an NHS and Trakcare number			
DATIX completed (for all fetal losses)			
Duty of Candour, give PMRT Information for Parents leaflet and advise that there will be an investigation (Unless TOP)			

Patient ID Label

Patient name:

On Discharge	**YES**	**NO**	**N/A**
Ensure clearly documented discharge care plan to include parents personal preferences			
Anti D given if required			
Offer discussion with Obstetrician and document			
Discuss Physiological changes (eg, vaginal loss, lactation) offer Carbergoline 1mg within 24 hours of delivery (not to women with hypertension or history of Puerperal psychosis)			
Offer CMW visit or phone call if appropriate			
Offer GP follow up			
Discuss counselling available may be available through GP and give counselling form for in pack for in house counselling for use when required			
Inform CMW **verbally** and send copies of discharge summary			
Inform GP **verbally** and send copies of discharge summary			
Inform Health Visitor **verbally** via the Health Visitor Hub			
Add SANDS teardrop sticker to Medical notes			
Offer visit to Mortuary/CDS1 if parents wish to see baby again, ensure parents have bereavement Support Office number			
Ensure parents have Bereavement Office, CMW and CDS1 contact numbers together with SANDS leaflets and Appendix E for additional support available			
Ensure parents aware of need to register the baby using the Stillbirth certificate			
MBRRACE completed on line			

Appendix D:

13. Send to Maternity Reception

The Lady below has had a stillbirth/late fetal loss at_____gestation on _____(date).

Please can any booked or remaining antenatal scans and clinic appointments be cancelled.

Completed by _____

Maternal address sticker

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Appendix E:

Resources for bereaved parents and families

Below is a list of resources and contact details for organisations who may be able to help you during this difficult time.

Local contacts

www.facebook.com/North-Devon-Sands

National contacts:

Action on Pre-Eclampsia (APEC)

Helps and supports women and their families who are affected by or worried about pre-eclampsia and aims to raise public and professional awareness of pre-eclampsia.

www.action-on-pre-eclampsia.org.uk

Antenatal Results and Choices (ARC)

Offers non-directive individualised information and support for parents making decisions around antenatal testing, including when a baby has a significant anomaly.

www.arc-uk.org

Baby Mailing Preference Service (MPS) online

Free site where parents can register online to stop or help reduce baby-related mailings.

www.mpsonline.org.uk/bmpsr

Bereavement Advice Centre

Offers information and advice for people with practical concerns after the death of someone close to them.

www.bereavementadvice.org

Bliss

Offers support for families of premature or sick babies, including bereaved families.

www.bliss.org.uk

British Pregnancy Advisory Service (BPAS)

Offers advice and treatment for termination of pregnancy in the UK.

www.bpas.org

Child Benefit Office

Parents can contact the Child Benefit Office at HM Revenues and Customs for information about

eligibility, claiming and stopping Child Benefit.

www.gov.uk/government/organisations/hm-revenue-customs/contact/child-be…

Child Bereavement UK (CBUK)

Provides support for families when a baby or child has died or is dying and offers support for children faced with bereavement. Offers training for professionals.

www.childbereavementuk.org

The Compassionate Friends

An organisation of bereaved parents, siblings and grandparents that offer support to others after the death of a child or children.

www.tcf.org.uk

Cruse Bereavement Care

Offers support to bereaved people and training for professionals.

www.cruse.org.uk

Ectopic Pregnancy Trust

Provides support and information for people who have had or been affected by an ectopic pregnancy, including health professionals.

www.ectopic.org.uk

Federation of British Cremation Authorities (FBCA)

Professional organisation of burial and cremation authorities in the UK.

www.fbca.org.uk

Funeral Payments – NI Direct

Financial help that is available for individuals on low-incomes in Northern Ireland who need help to pay for a funeral that they are arranging.

www.nidirect.gov.uk/funeral-payments

Funeral Payments – UK Government

Financial help that is available for individuals on low-incomes in England, Wales and Scotland who need help to pay for a funeral that they are arranging.

www.gov.uk/funeral-payments

Gifts of Remembrance

Provides photography training for hospital staff and volunteers who support parents after a stillbirth or neonatal death.

www.giftsofremembrance.co.uk

Jobcentre Plus – Bereavement Services Helpline

Provides information about benefits claims.

Telephone: 0345 608 8601

www.gov.uk/contact-jobcentre-plus

Lullaby Trust

Offers support and advice for parents whose baby dies suddenly and advice on safer sleep.

www.lullabytrust.org.uk

Miscarriage Association

Offers support and information for individuals affected by pregnancy loss and health care professionals.

www.miscarriageassociation.org.uk

Money Advice Service

Provides free and impartial money advice, including information for bereaved parents about benefits and

entitlements after the death of their baby.

www.moneyadviceservice.org.uk

Multiple Births Foundation (MBF)

Provides support and information for multiple birth families (including bereavement support) and information for professionals.

www.multiplebirths.org.uk

National Association of Funeral Directors

Provide support and guidance for funeral firms and bereaved families using their services.

www.nafd.org.uk

Our Missing Peace

Resources for bereaved families and a helpful repository of information under ‘useful links’ across the four

Home Nations.

www.ourmissingpeace.org

Remember My Baby Remembrance Photography

UK-based charity who have professional photographers who voluntarily provide their photography services to parents whose baby dies before, during or shortly after birth.

www.remembermybaby.org.uk

SANDS, the stillbirth and neonatal death charity

Provides support and information for anyone affected by the death of a baby, before or after birth. National helpline, local parent-led support, literature and online support. Works to improve care when a baby dies and promotes research to reduce the loss of babies' lives.

www.sands.org.uk

Samaritans

Offers confidential support that is available 24 hours a day to people who need to talk.

Telephone: 116 123 (UK) or 116 123 (ROI) for free.

www.samaritans.org

Tamba Bereavement Support Group

Offers support for families who have lost one or more children from a multiple birth during pregnancy, birth or at any time afterwards.

www.tamba.org.uk/bereavement

(Part of the Twins and Multiple Births Association (Tamba)

www.tamba.org.uk)

Together for Short Lives

Offers support for families with children who have life-threatening or life-limiting conditions and professionals

and services (including children's hospices).

www.togetherforshortlives.org.uk

United Kingdom Association for Milk Banking (UKAMB)

Supports human milk banking and aims to provide safe and screened donor breastmilk for premature and
sick babies.

www.ukamb.org

Winston's Wish

Offer support to bereaved children, their families and professionals.

www.winstonswish.org.uk

Working Families

Helps working parents, carers and their employers balance home and work responsibilities. They also
provide information about parents' rights at work and to benefits after they experience miscarriage, stillbirth and neonatal death.

www.workingfamilies.org.uk/articles/miscarriagestillbirth-