Scope:

This guideline applies to all UHL staff involved in the care of women who have late intrauterine fetal death or a stillbirth after 24 weeks.

Background:

This guideline has been prepared following extensive discussion of previously circulated documents. Whilst it is hoped that further discussion will be limited, it is recognised that there are areas of contention. The guideline is for guidance only. Where there are clinical grounds to deviate from the guideline good practice dictates that senior input is required in the decision making.

Legal Liability (standard UHL statement):

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional' it is fully appropriate and justifiable – such decision to be fully recorded in the patient’s notes.

Related Documents

Termination of Pregnancy in the Second and Third Trimester

This guideline is based on the RCOG green top guideline No 55 Late Intrauterine Fetal Death and Stillbirth.

Legal requirements:

See “Certification of Stillbirths and Neonatal Death on the Labour Ward” guideline
Recommendations:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Late intrauterine fetal death (IUFD) must be diagnosed using the most appropriate method</td>
</tr>
<tr>
<td>2.</td>
<td>Tests should be directed to identify a scientifically a proven cause of a late IUFD</td>
</tr>
<tr>
<td>3.</td>
<td>A full post-mortem examination should be offered to help explain the cause of an IUFD</td>
</tr>
<tr>
<td>4.</td>
<td>Timing and mode of delivery should take into account the mothers preferences as well as her medical condition and previous Intrapartum history</td>
</tr>
<tr>
<td>5.</td>
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</tr>
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<tr>
<td>7.</td>
<td>All modalities of pain relief should be available</td>
</tr>
<tr>
<td>8.</td>
<td>Appropriate documentation should be completed</td>
</tr>
<tr>
<td>9.</td>
<td>Individualised care should be given in the pueperium</td>
</tr>
<tr>
<td>10.</td>
<td>Processes should be in place for spiritual guidance, burial, cremation and remembrance</td>
</tr>
<tr>
<td>11.</td>
<td>Appropriate interventions should be used to aid psychological recovery</td>
</tr>
<tr>
<td>12.</td>
<td>Parents should be offered a follow up appointment to discuss test results and future pregnancies</td>
</tr>
<tr>
<td>13.</td>
<td>Plans for future pregnancies should be in place</td>
</tr>
</tbody>
</table>
**Recommendation One:**

Late intrauterine fetal death (IUFD) must be diagnosed using the most appropriate method

- Auscultation and cardiotocography should not be used to investigate suspected IUFD
- Real – time ultrasonography is essential for the accurate diagnosis of IUFD
- Real – time ultrasonography should be available at all times
- A second opinion should be obtained whenever practically possible
- Mothers should be prepared for the possibility of passive fetal movement. If the mother reports passive fetal movement after the scan to diagnose IUFD, a repeat scan should be offered

**Recommendation Two:**

Tests should be directed to identify a scientifically a proven cause of a late IUFD

- Clinical assessment and laboratory tests should be recommended to assess maternal wellbeing (including coagulopathy) and to determine the cause of death, the chance of recurrence and possible means of avoiding further pregnancy complications
- Non-sensitised Rh-D negative woman should receive Anti-D Ig from locally held stocks. This includes women who have an IUD. Where IUD is diagnosed the exact time of the sensitising event cannot be established. Therefore a Kleihauer should be taken and Anti D should be given at the time of diagnosis. Fetal karyotyping should be offered. This should be obtained by amniocentesis or chorionic villus sampling. Placental biopsy or cord biopsy can be an option providing it is taken appropriately as per the guidance in Appendix 2. Where there has been an antenatal diagnosis of chromosomal anomaly, placental / cord cytogenetic studies may still be required. This should be discussed and agreed by the consultant
- Parents should be advised that no specific cause is found in almost half of stillbirths
- Parents should be advised that when a cause is found it can crucially influence care in a future pregnancy
- Carers should be aware that an abnormal test result is not necessarily related to the IUFD; correlation between blood tests and post-mortem examination should be sought. Further tests might be indicated following the results of the post-mortem examination
Recommendation Three:

A full post-mortem examination should be offered to help explain the cause of an IUFD

- Parents should be advised that post-mortem examination provides more information than other (less invasive) tests and this can sometimes be crucial to the management of future pregnancy

- Attempts to persuade parents to choose post-mortem must be avoided; individual, cultural and religious beliefs must be respected

- Written consent must be obtained for any invasive procedure on the baby including tissues taken for genetic analysis. Consent should be sought or directly supervised by an Obstetrician or midwife trained in special consent issues and the nature of perinatal post-mortem, including retention of any tissue for clinical investigation, research and teaching

- Parents should be offered a description of what happens during the procedure and the likely appearance of the baby afterwards. This should include information on how the baby is treated with dignity and any arrangements for transport. Discussions should be supplemented by the offer of a leaflet

- Women contemplating prolonged expectant management should be advised that the value of post-mortem may be reduced

- Parents should be informed that post-mortem results normally take up to 6-8 weeks and occasionally over 12 weeks to be available

- Postmortem examination should include external examination with birth weight, histology of relevant tissues and skeletal x-rays

- The placenta should be sent for histology whether or not post-mortem examination of the baby is requested.

- Placental biopsy should be obtained, placed in saline, refrigerated and sent to the laboratory within working hours (see Appendix 2 for procedure)

- The examination should be undertaken by a specialist perinatal pathologist

- Parents who decline full post-mortem might be offered a limited examination (sparing certain organs), but this should be discussed with a perinatal pathologist before being offered

- Less invasive methods such as needle biopsies can be offered, but these are much less informative and reliable than conventional post-mortem
• Ultrasound and magnetic resonance imaging (MRI) should not be offered as a substitute for conventional post-mortem but could be a useful adjunct

Recommendation Four:

Timing and mode of delivery should take into account the mothers preferences as well as her medical condition and previous Intrapartum history

• Recommendations about labour and birth should take into account the mother’s preferences as well as her medical condition and previous intrapartum history

• Women should be strongly advised to take immediate steps towards delivery if there is sepsis, pre-eclampsia, placental abruption or membrane rupture but a more flexible approach can be discussed if these factors are not present

• Well women with intact membranes and no laboratory evidence of DIC should be advised that they are unlikely to come to physical harm if they delay labour for a short period but they may develop severe medical complications and suffer greater anxiety with prolonged intervals. Women who delay labour for periods longer than 48 hours should be advised to have testing for DIC twice weekly

• If a woman returns home before labour, she should be given a 24 hour contact number for information and support

• Women contemplating prolonged expectant management should be advised that the value of post-mortem may be reduced

• Women contemplating prolonged expectant management should be advised that the appearance of the baby may deteriorate

• Vaginal birth is the recommended mode of delivery for most women. Caesarean Section in indicated in certain circumstances. This decision should be made by a senior Obstetrician.

Where IUD is diagnosed the exact time of the sensitising event cannot be established. Therefore a Kleihauer should be taken and Anti D should be given at the time of diagnosis. Following the birth a repeat Kleihauer should be taken as further anti D may be required.
Recommendation Five:

First line intervention for induction of labour should be with a combination of Mifepristone and a prostaglandin preparation. In cases of previous caesarean section a discussion of the safety and benefits of induction of labour should be undertaken by a Consultant Obstetrician.

Medication regimes can be found in Appendix 1

Induction of labour for a woman with an unscarred uterus

- A combination of Mifepristone and a prostaglandin preparation should usually be recommended as the first line intervention for induction of labour
- Misoprostol can be used in preference to prostaglandin E2 because of equivalent safety and efficacy with lower cost but at a lower dose than those currently marketed in the UK

Recommendation Six:

Care for woman should be given by an experienced midwife in a room that pays heed to emotional and practical needs without compromising safety

- Women should be advised to labour in an environment that provides appropriate facilities for emergency care according to their individual circumstances
- Care in labour should be given by an experienced midwife
- Women with sepsis should be treated with intravenous broad-spectrum antibiotic therapy (including antichlamydial agents) (see antimicrobial guidance)
- Routine antibiotic prophylaxis should not be used
- Intrapartum antibiotic prophylaxis for women colonised with group B streptococcus is not indicated
- Carers should avoid persuading parents to have contact with their stillborn baby, but should strongly support such desires when expressed
- Parents who are considering naming their baby should be advised that after registration a name cannot be entered at a later date, nor can it be changed
• If parents do decide to name their baby, carers should use the name, including at
follow up meetings

• Parents should be offered, but not persuaded, to retain artefacts of remembrance

• Photos, palm and hand and foot prints and locks of hair with presentation frames
should be offered

• Parents should be offered a memory card with pictures stored on it

**Recommendation Seven:**

All modalities of pain relief should be available

• Diamorphine should be used in preference to pethidine

• Where IV PCA Morphine is used, it should be commenced using a standard dose of
1mg with a 5 minute lock out and the potential to administer 12mg per hour. Observations
should be performed and documented on the PCA observation form
every 15 minutes for the first hour and then hourly for the duration it is used. These
should include respiratory function, sedation and oxygen saturation. Under NO
circumstances must the relatives be allowed to press the button and they should be
informed of this. A final set of observations should be recorded 30 minutes following
delivery.

• Regional anaesthesia should be available for women with an IUFD

• Assessment for DIC and sepsis should be undertaken before administering regional
anaesthesia

• Womens should be offered an opportunity to meet with an obstetric anaesthetist

**Recommendations Eight:**

Appropriate documentation should be completed

• A loss of baby checklist (Appendix ) should be completed to ensure all appropriate
care options are offered and that the response to each is recorded

• Consent for perinatal post-mortem examination should be documented
• All stillbirths should be reviewed by a member of the quality and safety team along with an obstetric consultant responsible for risk. Where further discussion is required the case may be taken to the perinatal risk group

• All paperwork should be completed as per the "Certification of Stillbirth and Neonatal Death on Labour Ward" guideline

• The GP and Community Midwife should be informed

• All existing appointments should be cancelled and documented in the health record

• A bereavement booklet should be offered

**Recommendations Nine:**

**Individualised care should be given in the puerperium**

• Women should be cared for after birth in an environment that provides safety according to individual circumstance

• Women with no critical care needs should ideally be able to choose between facilities which provide adequate privacy

• Women should be routinely assessed for thromboprophylaxis, but IUFD is not a risk factor

• Heparin thromboprophylaxis should be discussed with a haematologist if the woman has DIC

• Non pharmacological preparations for suppression of lactation should be discussed with the woman

• Information about fertility and contraception should be offered to the mother prior to discharge

**Recommendation Ten:**

**Processes should be in place for spiritual guidance, burial, cremation and remembrance**

• Guidance and support from elders of all common faiths and nonreligious spiritual organisations should be available
• The legal responsibly for the child’s body rests with the parents but can be delegated to the hospital services

• Parents should be allowed to choose freely about attendance at a funeral service

• A leaflet about the options should be offered

• Parents should be informed of the book of remembrance that is available on Ward 30 at LGH and the labour ward at the LRI

• Carers should offer the parents the option of leaving toys, pictures and messages to accompany any the baby to the mortuary

**Recommendation Eleven:**

Appropriate interventions should be used to aid psychological recovery

• Carers should be aware of and responsive to possible variations in individual and cultural approaches to death

• Carers should be vigilant for postnatal depression in women with a previous IUFD

• Counselling should be offered to all woman and their partners

• Other family members, especially existing children and grandparents, should also be considered for counselling

• Debriefing services must not care for women with symptoms of psychiatric disease in isolation

• Parents should be advised about support groups

• Parents should be given the contact number for the Bereavement Midwife (non-emergency number) and the number for labour ward (emergency number)
**Recommendation Twelve:**

Parents should be offered a follow up appointment to discuss test results and future pregnancies

- The wishes of the woman and her partner should be considered when arranging follow up
- All test results should be available prior to the appointment
- Parents should be informed that some investigations take longer than others to be available
- Parents should be advised about the cause of late IUFD, chance of recurrence and any specific means of preventing further loss
- The meeting should be documented for the parents in a letter that includes an agreed outline plan for future pregnancy

**Recommendation Thirteen:**

Plans for future pregnancies should be in place

- The history of stillbirth should be clearly marked in the hospital notes. This is usually in the form of a teardrop sticker
- Carers should ensure they read all the notes thoroughly before seeing the woman
- Women with a previous unexplained IUFD should be recommended to have obstetric antenatal care and delivery at the consultant unit
- Women with a previous IUFD related to a known non recurrent cause merit individual assessment for place of birth
- For women in whom a normally formed stillborn baby had shown evidence of being small for gestational age, serial assessment of growth by ultrasound biometry should be recommended in subsequent pregnancies
- Carers should be vigilant for postnatal depression in women with a previous IUFD
- Carers should be aware that maternal bonding can be adversely affected
## Contact details for relevant support organisations

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHL Bereavement Midwife</td>
<td>07747475441</td>
</tr>
<tr>
<td>Leicester and Leicestershire SANDS group:</td>
<td>01530 839 723 07855 649 185</td>
</tr>
<tr>
<td>The Laura Centre, Counselling service:</td>
<td>0116 254 4341</td>
</tr>
</tbody>
</table>
Appendix 1:

Induction of Labour in cases of intra uterine fetal death or Termination of pregnancy for fetal abnormality

Please note the change in practice when prescribing MISOPROSTOL

NB: women who are, or may become pregnant, should not handle crushed, broken or dispersed tablets

The choice of medication regime should be documented in the health record

These changes are an adaption of the RCOG recommendations (2014) according to the gestation and if cases of previous one caesarean section.

In cases where there has been other uterine surgery (particularly to the upper segment e.g. myomectomy) or more than one previous caesarean section, a consensus regarding the best course of management should be reached by discussion with a senior obstetric consultant. The same applies for women who have had a fetal death at term with a history of upper uterine scar or multiple caesarean sections.

- Misoprostol is issued as 200 microgram tablets; the tablets may be cut using a pill cutter (shown below) and administered as:

- 100 micrograms of misoprostol – cut tablet in half
### Induction of Labour Regime

Give Mifepristone 200mg by mouth followed after 48 hours by:

<table>
<thead>
<tr>
<th>Gestation</th>
<th>REGIME 1</th>
<th>REGIME 2</th>
<th>REGIME 3</th>
<th>REGIME 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 20 weeks</td>
<td>First dose: 800 micrograms per vaginam.</td>
<td>First dose: 200 micrograms per vaginam</td>
<td>First dose: 100 microgram per vaginam</td>
<td>Propess or Prostin 3mg</td>
</tr>
<tr>
<td>First dose: 400 micrograms orally</td>
<td>Second to fifth dose: 100 micrograms orally</td>
<td>Second to fifth dose: 100 micrograms orally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>3 hourly Max of 4 oral doses</td>
<td>4 hourly Max of 4 oral doses</td>
<td>4 hourly Max of 4 oral doses</td>
<td></td>
</tr>
<tr>
<td>One previous C/S</td>
<td>First dose: 100 micrograms per vaginam.</td>
<td>First dose: 100 microgram per vaginam</td>
<td>First dose: 100 microgram per vaginam</td>
<td></td>
</tr>
<tr>
<td>Second to fifth dose: 200 microgram orally</td>
<td>Further doses d/w Consultant</td>
<td>Further doses d/w Consultant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- In women with previous Caesarean section between 20 and 32 weeks, 100 microgram 4 hourly can be given with caution to a maximum of 4 oral doses or a second dose of Mifepristone.

- In women who have had more than one C/S the Consultant Obstetrician should document an individualised management plan.

- The doctor prescribing should document in the notes which regime is being followed.

**Failed induction of labour**

Repeat course of misoprostol after >12 hour gap between courses or give a second dose of mifepristone. Discussion should take place with a Consultant Obstetrician.
Appendix 2:

CYTOGENETIC INVESTIGATION OF INTRAUTERINE FETAL DEATH

The following samples are suitable for the cytogenetic investigation of IUFD. Please send ONE of the following:

- Amniotic fluid or Chorionic villus taken prior to delivery
- Cord biopsy 10mm in length cross section of the cord
  Cut a cross section of the cord 10mm in length from near the cord insertion site

- Full dermal thickness skin biopsy, cut using a scalpel, from the baby (minimum 5mm²). Do not send a skin biopsy if the baby is macerated.

- 10 mm² biopsy from the FETAL SIDE of the placenta only - see below

  **Fetal side of the placenta**
  The fetal side has a smooth surface and is the side of the placenta where the cord is attached
  Send 10 mm² biopsy cut using a scalpel from near the cord insertion site

  **Maternal side of the placenta MUST NOT be sampled.**
  The maternal side of the placenta has a rough, grooved, cobblestone surface

- Complete Cytogenetics Referral Form.
- Include clinical details.
- All skin, cord or placental biopsies must be sent in a sterile white top universal container.
- Use STERILE SALINE ONLY.
- Send samples immediately.
- Store in fridge if taken over weekend.
- DO NOT USE FORMALIN.
### Appendix 3:

University Hospitals of Leicester NHS Trust

Womens and Childrens Clinical Management Group

**LOSS OF BABY CHECKLIST**

**PLEASE SEND ALL RESULTS TO**

<table>
<thead>
<tr>
<th>INVESTIGATIONS</th>
<th>BOTTLE</th>
<th>FORM</th>
<th>TAKEN SIGN/DATE</th>
<th>RESULT BACK DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. MATERNAL BLOODS &amp; HVS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FBC</td>
<td>EDTA KE/2.7ml (small red top)</td>
<td>Chem. Path</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBA1C</td>
<td>EDTA KE/2.7 ml (Purple top bottle)</td>
<td>Chem. Path.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Random Glucose</td>
<td>Yellow Glucose FE/2.7ml</td>
<td>Chem Path</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U&amp;Es, LFTs, CRP, Bile Acids and Urates</td>
<td>Li-Heparin LH/5.5 ml (orange top)</td>
<td>Chem. Path.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>THYROID FUNCTION TESTS</strong></td>
<td>Serum Gel S/4.7ml (brown top)</td>
<td>Chem. Path.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KLEIHAUER Write 'Feto-Maternal Haemorrhage' on form.</td>
<td>2 x 4ml Blood Transfusion (long red EDTA).</td>
<td>Kleihauer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANTICARDIOLIPIN ANTIBODIES IgG + IgM</td>
<td>Serum Gel S/4.7ml (brown top)</td>
<td>Immunology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anticardiolipin Abs. to form and specify IgG and IgM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lupus</td>
<td>3X Green Coagulation 9 NC/4.3ml</td>
<td>Haematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Currently on LGH checklists only</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO.R.C.H. (&amp; Parvovirus B19 if hydrops present)</td>
<td>Serum Z/9 ml ('black' top)</td>
<td>Virology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.V.S. for C &amp; S If required, take before I.O.L.</td>
<td>Culture and Sensitivity Swab</td>
<td>Microbiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMNIO / C.V.S (delete as appropriate)</strong></td>
<td>Universal Bottle or CVS culture medium</td>
<td>Cytogenetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. PLACENTA:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIOPSY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NB:** Paper copies of guideline may not be the most recent version. The definitive version is held on INsite Documents.
### C. BABY.

**External Examination by Obstetric Registrar or Consultant**. Findings to be documented in Notes.

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Department</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin / Ear Swab for C&amp;S</td>
<td>Microbiology</td>
<td></td>
</tr>
<tr>
<td>Skin Biopsy (with consent) for Karyotype. Check CVB/Amnio not already done – If known chromosome anomaly check with Consultant if this indicated</td>
<td>Cytogenetics</td>
<td></td>
</tr>
</tbody>
</table>

### D. DOCUMENTATION FOR BABY

<table>
<thead>
<tr>
<th>Documentation Type</th>
<th>Details</th>
</tr>
</thead>
</table>
| Infant Bereavement Notification – 4 copies  | 1. To Patient and Family Services  
2. Mother’s/ Baby’s notes  
3. Mortuary (to accompany baby).  
4. Retained in Book. |
<p>| FETAL BURIAL FORM (&lt;24 weeks)               | 3 copies to Patient and Family Services                                  |
| STILLBIRTH CERTIFICATE                     | Given to Parents                                                        |
| POST MORTEM Consent Form                   |                                                                         |
| POST MORTEM CLINICAL DETAIL FORM (for Stillbirths and NeoNatal Deaths) | To accompany baby to mortuary if PM Consented. |
| Consider X-Ray Request for fetus, only if PM declined | To accompany baby to mortuary. X-Ray request form signed by Doctor. |</p>
<table>
<thead>
<tr>
<th>Table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parental Consent (obtained).</strong></td>
</tr>
<tr>
<td><strong>MBRRACE Form</strong></td>
</tr>
</tbody>
</table>
| **CDOP Form**  
For all Neonatal deaths >23/40 | To fax to 6701 (Safeguarding Office) |
| **Photography** | • Yellow consent form  
• Moments to remember log completed |

**NB**: Please ensure the following:  
1. Please inform the Community Office to tell the GP and Community Midwife (X4834)  
2. Bereavement booklet/box given to parents  
3. Notes to PAS after coding to arrange Follow Up appointment.  
4. Inform Bereavement Midwife Jo Dickens (07747475441)

**REMEMBER TO SEND THE BABY TO MORTUARY IN BABY MORTUARY BOX.**

Please ensure PRIOR TO TRANSFER:

- Baby is identified with x 2 ID Bracelets  
- Baby Cot Cards X 2  
  1) taped to clothes on chest wall  
  2) taped to outside of ‘inco’ wrap prior to placing baby in box.

- Placenta sent to Pathology Reception for Histology.

- All paperwork for Mortuary given to Porter and accompanies baby to Mortuary ie:
  1) Infant Bereavement Notification  
  2) Post Mortem Consent form if PM requested.  
  3) Postmortem Clinical Detail form (for Stillbirths and NeoNatal Deaths) if PM requested.  
  4) X Ray request form if X Ray required and consented.  
  5) Copy of EuroKing delivery report.

I confirm that all of the above have been completed:

Midwife:…………………………………… Date:…………………………..  
Print Name …………………………….
Appendix 4: Last offices

Time with their baby:

For parents wishing to see their child, ensure that the baby is dressed appropriately and made as presentable as possible. Parents should be given as much time as they feel that they need to spend with their baby and their privacy respected. If they wish extended family to visit this should be accommodated as much as possible.

If the baby is born alive, again the parents should be given time with their child if they wish. Explanations should be given to the parents that the baby may continue to gasp for a considerable time. Reassurance will be needed for the parents. A medical practitioner needs to view the baby alive. Time of death should be recorded in the notes. The doctor is responsible for completing the neonatal death certificate.

An on call Chaplin, can be contacted via switchboard, to attend to perform a blessing/service if the parents so wish.

Mementos:

A variety of mementos can be taken:

- Lock of hair
- Length of baby
- Foot prints
- Casting kits (the success of these is dependent on gestational age of the baby, so discretion is needed before suggesting to parents)

Seek permission from parents before offering mementos

All parents should be offered a copy of the cot card, armband and photograph. If parents do not wish a photograph please document this in the notes. Do not take a photograph without permission. If they are unsure then suggest that a photograph is taken and stored on a memory card which can then be given to the parents. Ensure that this is clearly documented.

Disposable cameras are available for parents but do not use for babies less than 24 weeks as the focus on them is not of good enough quality. Give the camera to the parents to have printed at their leisure, but tell them to explain to the centre where the photographs are developed of the nature of the films contents.

There is a book of remembrance:

Parents can fill in the appropriate card if they wish to make an entry, with an accompanying message or verse, a yearly none religious memorial service is organised by the hospital.
Preparation for the mortuary:

The Midwife should make the initial examination of the baby and then refer to the appropriate medical team (see UHL guidelines for External Examination of Stillbirth and / or Fetal Loss.

Two arm bands should be attached to baby. The baby can be sent to the mortuary with clothes on and with soft toys. Please ensure that the toys are labelled. If the parents wish the baby to remain in the clothes and they are having a post-mortem, then an explanation needs to be given that clothes will be removed and may become soiled. An alternative is to take the clothes to the undertaker. The pathologist will honour any requests made, do include a note with the paperwork of any specific requests.

Wrap the baby in a white sheet, gamgee is available to place around the head and neck for extra support. If any leakage is anticipated place a continence sheet directly underneath the baby prior to wrapping in the white sheet.

Ensure that the sheet is securely taped around the baby, and a completed cot card is attached to the top.

Place baby in transport case, ready for transfer to the mortuary. Enclose a completed bereavement form. If post-mortem is requested a computer print out, a post-mortem information form and the completed consent form also need to be included.

Call the porter to take the baby to the mortuary.

Funeral arrangements:

There is an information leaflet about burial for the parents to read at their leisure (“Your baby’s funeral”). The options are hospital or private burial

Private burial:

The parents contact a funeral director and arrange a funeral of their choice. The costs are variable but generally less than an adult funeral.

Hospital burial:

This will be a shared funeral service that takes place at Gilroes cemetery. The babies coffins are placed in the chapel and there is a short none religious ceremony that lasts approximately fifteen minutes. The coffins are placed in a share grave of sixteen. A plaque is provided to mark the babies grave, other permanent fixtures are not permitted. This service is free of charge. If parents wish to opt for a hospital burial they need to telephone patient affairs in office hours to organize the arrangements.

Cremation:

If parents decide to have a cremation, they need to be aware that there may not be ashes recovered from the cremation process. A cremation form needs to be signed by the doctor and sent to patient affairs.
Removal of baby from hospital:

Occasionally parents wish to take their baby home with them. This is permissible providing that they transport the body in a suitable solid container e.g. a casket. The baby must go to the mortuary; under no circumstances can the baby be discharged home direct from delivery suite. Inform the mortuary prior to sending the baby, and out of hours inform the hospital duty manage and the maternity bleep holder. Ensure that the parents are intending to formally bury the baby.

Stillbirth registration:

If the baby died in utero after 24 weeks gestation then a stillbirth certificate should be issued. Ensure that all parts of the certificate are completed. For cause of death it is acceptable to write unknown. Alongside the signature of the Midwife/Doctor signing the name must be legibly printed, the medical/midwifery qualification must also be complete.

Neonatal death certificate:

All of the above but in the section main diseases of infant, this must be completed, and it is not acceptable to write unknown. This certificate must be signed by a medical practitioner who must see the baby alive and once passed away.

If possible make an appointment for the parents at a convenient time for them at the registrations office, prior to their discharge. The registrations office is able to ask professional more questions then the parents themselves. A neonatal death takes significantly longer to register then a stillbirth. Ensure that the parents are given the death certificate on discharge and are aware that they need to register the death before funeral arrangements can precede.

Discharge home:

Prior to discharge or at a convenient time the General Practitioner and the Community Midwife should be informed. The couple should be made aware that a Midwife will visit the following day.

Ensure that the parents are aware of telephone numbers of support groups/community Midwife. Leaflets are available for them to take home about SANDS, The Laura centre, etc.

Send a copy of the bereavement form to the delivery suite manager, patient affairs, the case notes, and the mortuary. Jo to check

A baby born less then 24wks with no signs of life requires a fetus form; send all copies completed by a doctor to patient affairs.

Complete the CESDI form if required.

If post mortem required send an extra delivery summary, post-mortem consent and information form to the mortuary.
Remind the parents that a follow up appointment will be made with their consultant once results of investigations are complete.

References:


3. Lipitz et al. Late selective termination of fetal abnormalities in twin pregnancies. BJOG 1996;103:1212-1216


## DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT

<table>
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