Stillbirth and Late Fetal Loss - Bereavement Care UHL Obstetric Guideline

University Hospitals of Leicester NHS
NHS Trust

Trust Reference C275/2016

NB: This guideline was previously known as "Intrauterine Death in Second Trimester or Stillbirth UHL Obstetric Guideline"

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1. Introduction and Who Guideline applies to

This guideline applies to all UHL staff involved in the care of pregnant women and people who have second trimester intrauterine fetal death or a stillbirth.

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.

Related Documents:

- Termination of Pregnancy in the Second or Third Trimester UHL Obstetric Guideline
- Lactation Suppression Following Bereavement UHL Obstetric Guideline
- Deceased Urgent Certification and Release Outside Normal Hours UHL Policy

Legal requirements:

See Certification of Stillbirth and Neonatal Death on Labour Ward UHL Obstetric Guideline

2. Diagnosis

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.

THE STILLBIRTH AND LATE FETAL LOSS INTEGRATED PATHWAY BOOKLET SHOULD BE COMMENCED AT THIS POINT. THIS SHOULD REMAIN IN THE HOSPITAL NOTES

3. Clinical assessment and tests

Tests should be directed to identify a scientifically 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 pregnant women and people who have an IUFD. Where IUFD is diagnosed the exact time of the sensitising event cannot be established. Therefore, a Kleihauer test should be performed 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.

4. Post-mortem

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.

- Pregnant women and people 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 at least 12 weeks and occasionally over 12 weeks to be available.

- Post-mortem examination should include external examination with birthweight, 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. Where a post-mortem is requested, the placenta should be sent to the mortuary with the baby. If a post-mortem is declined or parents are undecided, the placenta should be sent to histopathology.

- 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.

5. Timing & mode of delivery

Timing and mode of delivery should take into account the mother's 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.

- Pregnant women and people 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 pregnant women and people 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. Pregnant women and people who delay labour for periods longer than 48 hours should be advised to have testing for DIC twice weekly (FBC and clotting).

- Prior to administration of Mifepristone the midwife must liaise with delivery suite who will try and ensure a suitable room will be available. The pregnant woman and person should be advised to contact the delivery suite on the day induction is planned. If an appropriate room is not available at this point there may be a delay and the pregnant woman and person should be informed that this might be a possibility.
- If a pregnant woman and person returns home before labour, she should be given a 24-hour contact number for information and support.

- Pregnant women and people contemplating prolonged expectant management should be advised that the value of post-mortem may be reduced.

- Pregnant women and people 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 pregnant women and people. Caesarean Section in indicated in certain circumstances. This decision should be made by a senior Obstetrician.

- Where IUFD is diagnosed the exact time of the sensitising event cannot be established. Therefore, a Kleihauer test should be performed 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.

- All groups stated in the communication pathway must be informed

  This includes:
  - Community Midwife / Specialist Midwife
  - GP
  - Health Visitor
  - Named Consultant
  - Bereavement Midwife
  - Social Care Team
  - Antenatal records re cancelling appointments

6. Induction of labour

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.

7. Care in labour

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

- Pregnant women and people 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.

- Pregnant women and people 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 pregnant women and people 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 participate in memory-making activities.

- Photos, palm and hand and footprints and locks of hair with presentation frames should be offered.

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

8. Pain relief

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.

- Pregnant women and people should be offered an opportunity to meet with an obstetric anaesthetist.

9. Documentation

Appropriate documentation should be completed

- The Stillbirth and Late Fetal Loss Integrated Pathway 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.

- Perinatal Mortality Review: (This section does not apply to late fetal losses below 22 weeks gestation or terminations of pregnancy)
    - All stillbirths and late fetal losses >22 weeks are routinely reviewed within the Trust by a multidisciplinary team of obstetricians, neonatologists, midwives and nurses who were not directly involved in the mother's care*.

    - The process involves a review of the antenatal, intrapartum and postnatal care notes and the use of the 'Perinatal Mortality Review Tool' or 'PMRT', which is the standardised method of review recommended nationally. The PMRT is designed to ensure that all aspects of care are considered and highlight good practice and areas where practice did not meet the standards expected (whether this contributed to the outcome or not), in order to generate an action plan to improve care and outcomes. It is important that parents are given the opportunity to have their views and questions considered as part of the review and are adequately supported to do so.

    - *For intrapartum stillbirths that occur after 37 weeks gestation, (unless the cause of death was an antenatally identified congenital abnormality), an investigation will also be undertaken by the Healthcare Services Investigation Branch

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

- As per recommendation four, all groups stated in the communication pathway should be informed.

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

- A SANDS Bereavement Support Book should be offered.

10. Postnatal care

Individualised care should be given in the puerperium

- Postnatal women and people should be cared for after birth in an environment that provides safety according to individual circumstance.
- Postnatal women and people with no critical care needs should ideally be able to choose between facilities which provide adequate privacy.
- Postnatal women and people should be routinely assessed for thromboprophylaxis using the risk assessment tool, stillbirth is one of the risk factors that increases the risk of venous thromboembolism.
- Heparin thromboprophylaxis should be discussed with a haematologist if the postnatal woman and person has DIC.
- Pharmacological and non-pharmacological preparations for suppression of lactation should be discussed with the postnatal woman and person as well as alternative options for the management of lactation.
- Information about fertility and contraception should be offered to the mother prior to discharge.

11. Funeral, spiritual & religious care

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

- Guidance and support from elders of all common faiths and nonreligious spiritual organisations should be available and can be accessed through the hospital chaplaincy service.
- 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.
- The UHL leaflet "Your Baby's Funeral" about the options should be offered. This leaflet only applies to losses over 16 weeks.
- 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 the baby to the mortuary.

12. Psychological recovery

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 postnatal women and people with a previous IUFD.
- Counselling should be offered to all postnatal women and people and their partners.
- Other family members, especially existing children and grandparents, should also be considered for counselling.
- Debriefing services must not care for postnatal women and people 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) a) and the number for labour ward (emergency number).

13. Follow-up

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

- The wishes of the postnatal woman and person and her partner should be considered when arranging follow up
- Ideally the results of the perinatal review (if PMRT review is applicable) should be available prior to the appointment but the parents may wish to be seen sooner.
- 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.

14. Future pregnancy planning

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 pregnant woman and person.
- Pregnant women and people with a previous unexplained IUFD should be recommended to have obstetric antenatal care and delivery at the consultant unit.
- Pregnant women and people with a previous IUFD related to a known non recurrent cause merit individual assessment for place of birth.
- For pregnant women and people 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.

Pregnant women and people with a small baby (<10th centile) or placental pathology, consider 150mg daily aspirin for the next pregnancy.

Indication for Thrombophilia investigations as follow up:

- SGA <10th centile
- Placental Infarction

1. Lupus anticoagulant & Anti-thrombin on special haematology form
2. Anti-cardiolipin antibodies & Beta 2 glycoprotein antibodies on Immunology form

Thrombophilia testing should be done at the postnatal appointment, not at the time of the birth of the baby, due to the increased risk of false positive results.

Contact details for relevant support organisations

UHL Bereavement Midwife	**07747475441**
Leicester and Leicestershire SANDS group:	**01530 839 723** **07855 649 185**
The Laura Centre, Counselling service:	**0116 254 4341**

15. Education and Training

A session is provided for all preceptor midwives by the Bereavement Midwife
All other midwives are updated via mandatory training every couple of years
SANDS training for any health professional is provided twice a year and staff should be nominated by their line manager

16. Monitoring Compliance

None

17. Supporting References

1. Khare M, Howarth E, Sadler J, Healey K, Konje JC. A comparison of prenatal verus postnatal karyotyping for the investigation of intrauterine fetal death after the first trimester of pregnancy Prenat Diagn 2005;25;1192-5.

2. Neilson JP. Mifepristone for induction of labour. Cochrane Library 2000.

3. Hofmeyr GJ, Gulmezoglu AM. Vaginal misoprostol for cervical ripening and labour induction in late pregnancy. Cochrane Library 2000.

4. RCOG (2010) *Late Intrauterine Fetal Death and Stillbirth: Green-top Guideline No. 55*. London: RCOG.

5. Sands (2016) *Pregnancy loss and the death of a baby : guidelines for professionals.* 4th edition / updated and edited by Amanda Hunter based on original text by Judith Schott, Alix Henley and Nancy Kohner.. edn. Coventry: Tantamount.

6. Human Tissue Authority (2017) *Code of Practice and Standards Code B: Post-mortem Examination*. London: Human Tissue Authority.

18. Key Words

Stillbirth, late fetal loss, bereavement care, mifepristone, post-mortem, mortuary, perinatal care pathway

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Penny McParland			**Executive Lead** Chief Nurse
Original Author/s: F Siddiqui, Consultant Obstetrician, O Navti, Consultant Obstetrician, H Ansar Consultant Obstetrician, L Matthews Clinical Risk and Quality Standards Midwife and J Dickens Bereavement Midwife			
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
15.06.16	**1**		New document
May 2020	**2**	Harriet Jordan, Jo Dickens, Penny McParland	Use of Integrated stillbirth and late fetal loss pathway added.
January 2024	**3**	Penny McParland	Reviewed as unchanged, fit for purpose. Misoprostol dosing to be reviewed within the next 6 months.

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 pregnant women and people 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


PillMate
PillCutter
PillMate
The greatest name in organised pill taking

Induction of Labour Regime

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

Gestation		**REGIME 1** **Below 20 weeks**	**REGIME 2** **20 - 26+6 weeks**	**REGIME 3** **27 - 32 weeks**	**REGIME 4** **Over 32 weeks**
Dose	No previous C/S	First dose: Misoprostol 800 micrograms per vaginam. Second to fifth dose: 400 micrograms orally	First dose: Misoprostol 200 micrograms per vaginam Second to fifth dose: 100 micrograms orally	First dose: Misoprostol 100 microgram per vaginam Second to fifth dose: 100 micrograms orally	Propess or Prostin 3mg
Frequency		3 hourly Max of 4 oral doses	4 hourly Max of 4 oral doses	4 hourly Max of 4 oral doses	
Dose	One previous C/S	First dose: Misoprostol 100micrograms per vaginam. Second to fifth dose: 200microgram orally	First dose: Misoprostol 100microgram per vaginam Further doses d/w Consultant	First dose: Misoprostol 100microgram per vaginam Further doses d/w consultant	Propess for 12 hours **or:** 2nd dose of Mifepristone after 24 hours from first dose and then Propess for 12 hours after 48 hours from 2nd dose of Mifepristone

In pregnant women and people 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 pregnant women and people 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

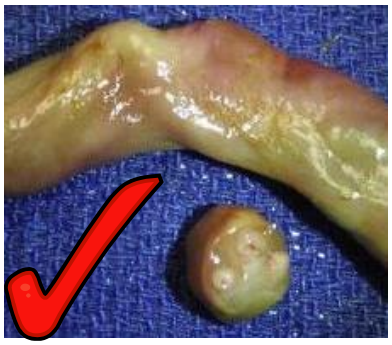
Repeat course of misoprostol after >12 hour gap between courses or give a second dose of mifepristone. Discussion should take place with a Consultant Obstetrician

Appendix 2: CYTOGENETIC INVESTIGATION OF INTRA-UTERINE 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

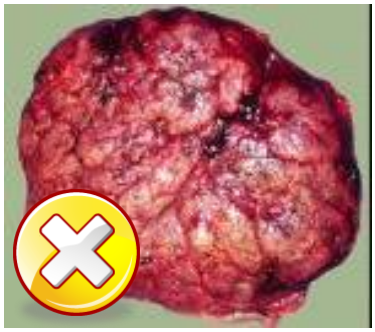
Cut a cross section of the cord 10mm in length from near the cord insertion site



- Full dermal thickness skin biopsy, cut using a scalpel, from the baby (minimum 5mm^2). Do not send a skin biopsy if the baby is macerated.
- 10 mm^2 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 mm^2 biopsy cut using a scalpel from near the cord insertion site



Maternal side of the placenta
The maternal side of the placenta has a rough, grooved, cobblestone surface

MUST NOT be sampled.

- **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: Last Offices

All staff caring for the baby should treat him/her with respect at all times – Please use what Jo has written in her chapter.

Time with their baby:
For parents wishing to see their child, ensure that the parents' wishes for clothing and bathing their baby are facilitated. 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.

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

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 non-religious remembrance service is organised by the hospital in partnership with Leicestershire and Rutland Sands.

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 and removable items 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 funeral director. 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 delivery report, a clinical information for post-mortem form and the completed consent form also need to be included.

Call the porter to take the baby to the mortuary and sign the log book.

Funeral arrangements:

There is an information leaflet about funerals for the parents to read at their leisure ("Your baby's funeral"). The options are hospital or private burial/cremation

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 and the parents may be entitled to help towards costs

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 non-religious ceremony that lasts approximately fifteen minutes. 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. For stillbirths, a cremation form 9 needs to be signed by a doctor or midwife who examined the baby's body and sent to bereavement services.

Stillbirth registration:
If the baby died *in utero* after 24weeks 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 (GMC number/ NMC PIN) must also be complete.

If possible, make an appointment for the parents at a convenient time for them at the Register Office, prior to their discharge. The Register Office is able to ask the professional more questions than the parents themselves. Ensure that the parents are given the stillbirth certificate on discharge and are aware that they need to register the stillbirth before funeral arrangements can proceed.

Discharge home:
Prior to discharge or at a convenient time the General Practitioner, Community Midwife, Heath Visitor, Bereavement Midwife and any other relevant health or social care professionals should be informed. The couple should be made aware that a Community 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.

A baby born less then 24wks with no signs of life requires a non-viable fetal burial form; send all copies completed by a doctor to Bereavement Services.

Complete the MBRRACE 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. This may be between 12 and 16 weeks following birth.