Aneurin Bevan University Health Board

Integrated Care Pathway for Pregnancy Loss over 20 Weeks

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Policy on a Page: Key Messages

Aim:

To provide standardised, evidence-based care and guidance for patients following diagnosis of a perinatal loss over 20 weeks of pregnancy.

Summary of key changes (for revised documents only).

- Integration of two pathways (ABUHB (2023) *Termination for fetal abnormality*; ABUHB (2023) *Pathway for still births, Intra Uterine Deaths (IUD's), Late Miscarriage over 20 weeks*).
- Alignment with contemporaneous practice and current evidence base.

Key Requirements:

- Confirm loss promptly and sensitively, using timely ultrasound and clear compassionate communication.
- Activate badgernet alerts (Sands teardrop for any loss, butterfly for twin multiple losses), complete the bereavement pathways and referral to the bereavement midwife.
- Follow correct legal paperwork.
- Maternal clinical care: full observations, baseline bloods including Kleihauer and TORCH and offer appropriate analgesia.
- Induction and labour care: vaginal birth usually recommended; mifepristone/misoprostol regime by gestation/ uterine scar; 1:1 care throughout.
- Post-birth priorities: memory-making options; Post-mortem/placenta/genetics/investigations; complete e-discharge; lactation suppression; reporting.

Target Audience:

All staff working within ABUHB maternity services.

Training:

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

Contents

1. Introduction/Overview

This Integrated Care Pathway (ICP) is intended to provide best practice for maternity staff providing care and support for birthing people and their families following the death of a baby in utero (Intrauterine death/IUD) and for those undergoing a termination for medical reasons or termination of pregnancy for foetal anomalies (TFMR/TOPFA). It is a multidisciplinary document.

We acknowledge and respect that not all individuals who give birth identify as women. However, for the purposes of this guideline, we will use the terms 'woman' and 'mother' for consistency and clarity.

For clarity and consistency, the term ‘baby’ will be used throughout this document. We recognise that this ICP also support families experiencing the loss of twins or other multiple pregnancies and therefore the term ‘baby’ should be understood to include all babies.

2. Scope

This ICP provides guidance for both medical and midwifery records. It is not a rigid document, and clinicians are free to use their own professional judgement as appropriate, recording as a variance any alterations to the practice outlined, or any deviation from the expected plan. The medical practitioner remains responsible for patient care throughout treatment.

This ICP should be used in conjunction with the Badgernet bereavement pathways (maternal and fetal) which must be completed in all cases. All sections should be completed in full.

Documentation of the patient’s history and clinical assessments should be completed in the digital record. Please note that IV fluids and drugs should

be prescribed on the generic In-patient Medication Administration record, including all pre-existing medication.

Individuals should ensure they identify the professional competencies, additional knowledge, and skills they will need and that they access appropriate education, training, competency assessment and continuing support and supervision. Once competency achieved nurses/ midwives should be able to practise within agreed protocols and guidance, NMC standards.

3. Statement/Background

This ICP is intended for the management of women 20+0 weeks' gestation and above within maternity services following the diagnosis of:

- Late miscarriage (20-23+6 weeks' gestation).
- Intrauterine death/Stillbirth (≥24+0 weeks' gestation born with no signs of life).
- Neonatal delivery-room death (born alive but dies very soon after birth in the delivery room). Please note, the neonatal unit have their own pathway for the death of a baby on their unit.
- Medical termination of pregnancy for medical reasons or fetal anomalies (TFMR/TOPFA) over 20+0 weeks' gestation.

4. Aim

To provide standardised, evidence-based care and guidance for patients following diagnosis of a perinatal loss over 20 weeks of pregnancy.

5. Abbreviations

ABUHB- Aneurin Bevan University Health Board

BP- Blood Pressure

CMV- Cytomegalovirus

CRB- Cervical Ripening Balloon

CRP- C-Reactive Protein

CWS- Clinical Work Station

DIC- Disseminated Intravascular Coagulation

FBC- Full Blood Count

GBS- Group B Streptococcus

GP- General Practitioner

HCSW- Health Care Support Worker

HDU- High Dependency Unit

ICP- Integrated Care Pathway

IUD- Intra-Uterine Death

IV- Intra-venous

LFT- Liver Function Tests

LSCS- Lower Segment Caesarean Section

MBRRACE- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

MES- Medical Examiner Service

NMC- Nursing and Midwifery Council

NRI- Nationally Reportable Incident

PET- Pre-Eclamptic Toxaemia

PMRT- Perinatal Mortality Review Tool

PO- Per/by mouth

PV- Per Vagina

RCOG- Royal College of Obstetricians and Gynaecologists

SL- Sub-Lingual

SOP- Standard Operating Procedure

TFMR- Termination for Maternal reasons

TOPFA- Termination of pregnancy for Fetal Anomalies

U&E's- Urea and Electrolytes

UHW- University of Wales Hospital (Cardiff)

6. Main Body

Definitions and Documentation

Late miscarriage: the birth of a baby before 24+0 weeks of pregnancy born with no signs of life.

Paperwork requirements:

- Badgernet bereavement pathways must be completed in full in each case of perinatal loss.
- Babies born before 24+0 weeks with no signs of life do not need to be registered.
- Babies diagnosed as deceased prior to 24+0 weeks of pregnancy but birthed on or after 24+0 weeks do not need to be registered and are documented as a late miscarriage.

Intrauterine death/stillbirth: the birth of a baby born with no signs of life on or after 24+0 weeks of pregnancy (where the diagnosis of death occurs on or after 24+0 weeks).

Paperwork requirements:

- A Stillbirth Certificate must be completed by a registered doctor or midwife who was present at the birth or examined the baby after birth.
- This certificate must be scanned and sent to the registrar for births and deaths (registrars@torfaen.gov.uk) and to the bereavement

midwife (abb.bereavementmidwives@wales.nhs.uk)with the birthing person's contact details. The Registrar's office will then call the family to arrange an appointment.

- If a death has been confirmed prior to 24 weeks but birth occurs after, it **does not** need to be registered.
- The medical examiner service does not need to be notified of a stillbirth.

Neonatal death: A baby born **at any gestation** of pregnancy who shows sustained signs of life following birth but dies within 4 weeks of birth. For the purpose of this guideline, it will be limited to those who die in the delivery room and are not attended by the neonatal team (following discussion between the neonatal team and the parents if requested).

Paperwork requirements:

- Babies born with sustained signs of life (see Appendix 1) following birth that are not for resuscitation (i.e., 20-24 weeks born spontaneously (where survival focussed care is not appropriate) or following termination of pregnancy where feticide has not been performed) must have the birth and death registered.
- If the baby has been born following **spontaneous labour** the attending doctor should observe signs of life in the baby and then confirm the time of death. They must then complete the referral to the medical examiner service (see Appendix 2). When the MES has agreed the cause of death the doctor will then be able to complete the death certificate.
- If the doctor cannot attend the baby in life a referral must be sent to the coroner.
- If the baby is born showing sustained signs of life following **termination of pregnancy,** the case must be referred directly to the coroner's office for review (Appendix 3).

- Please refer to the SOP for paperwork when a baby is born with signs of life at 20-22+0 weeks on the SharePoint or see flowchart at appendix 4.

Diagnosis and immediate care

Spontaneous loss:

- The suspicion of a loss in pregnancy could happen in many areas i.e., antenatal clinic, GP surgery, home visit, triage etc.
- It is essential that the woman receives an ultrasound scan without delay. If there is any difficulty accessing a timely confirmatory scan, please escalate to staff covering other areas to ensure prompt assessment.
- The loss must be confirmed by two trained professionals who are competent in the ultrasound diagnosis of pregnancy loss. This may be done in the clinic (if that is where the concern has been raised) but may require the woman to be sent into the Grange University hospital for confirmation scans.
- Language used must be clear, sensitive, and honest. For example: "I am sorry, I can see your baby's heart clearly and it is not beating. I am very sorry, but this means your baby has died."
- If the woman is unaccompanied offer to contact a partner, family member, or friend to attend to give support.
- Advise the woman to attend the Grange (if not already) for ongoing discussion about labour and birth.
- Labour ward should be contacted to expect the admission. Staff will meet the women in main reception if they call the labour ward when they arrive in the Grange.

The death of baby in multiple pregnancies:

- In some circumstances, there may be the death of one twin or multiple. This can occur at any gestation and there can sometimes be

a period of time between the diagnosis of the death of the twin/multiple and the birth of the surviving twin/multiple.

- If the death is confirmed at less than 24 weeks gestation, the deceased baby will be considered a non-viable fetus even though they may be born after 24+0 weeks gestation.
- If the death has been confirmed prior to 16 weeks, there may not be a visible fetus following birth and the family should be counselled for this.
- The bereavement midwife should be informed via the Badgernet referral system (Figure 1) so they can provide support for the family.

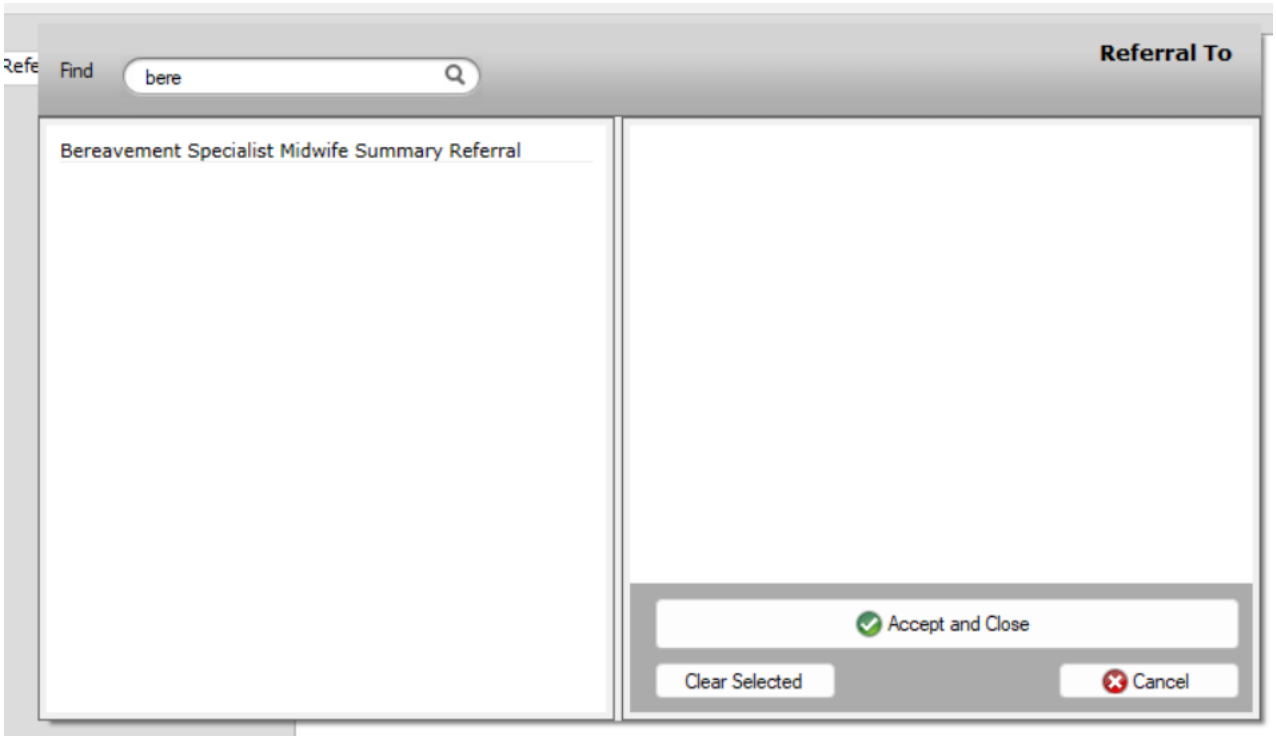


Figure 1 Bereavement Midwife Badgernet Referral

- Parents should be counselled about funeral arrangements and keepsakes prior to the birth of the live twin, along with discussion about what they may or may not be able to see following their birth. This can be done by the bereavement midwife if parents' consent to contact.
- When the death of twin/multiple is confirmed at or over 24 weeks the patient should be seen by a consultant (named or on call) on the

same day for a plan to be made for the surviving twin or multiple. If a consultant clinic appointment cannot be facilitated that day, they should be referred to Labour Ward at the Grange to be seen by the on-call consultant.

- If the death is confirmed at or over 24 weeks, the deceased twin will need to be registered as a stillbirth when the birth of the surviving twin or multiple occurs.

TFMR/TOPFA:

If a decision has been made to terminate the pregnancy for medical reasons in the mother or for anomalies identified in the baby (TFMR/TOPFA) then an 'Abortion Act Certificate A' consent form (Appendix 5) must be completed by two doctors. This is usually done within the Fetal Medicine Unit, and the clinic staff should ensure that labour ward and the bereavement midwife are aware of the date that the woman will attend for the ongoing induction.

In cases of clinical emergency (TFMR for maternal clinical need), care must not be delayed while completing documentation; the priority is always the safety and wellbeing of the woman.

If a live birth is potentially anticipated following TFMR/TOPFA due to the gestation and/or if a feticide is not being performed, the parents should be counselled regarding this. They should be counselled that in these circumstances the case will be referred to the coroner's office for review, in line with our legal obligations.

Badgernet documentation at the time of admission or diagnosis.

(See guidance in the information folder or Click here for detailed badgernet help).

When the diagnosis is made, please ensure the orange teardrop alert (Figure 2) has been triggered on the woman's badgernet account. This alerts all staff accessing the account that there has been a loss.

Figure 2 Orange Teardrop Alert

To do this, search for the bereavement pathway note (Figure 3) and enter the details of the loss. Complete as much of the information as you can. It can be updated throughout the admission.

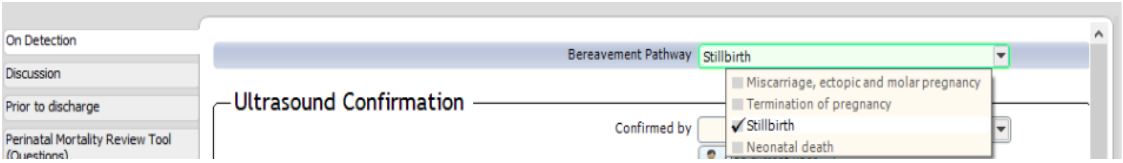


Figure 3 Bereavement Pathway Badgernet Note

When you press save and close the teardrop logo will appear. If there has been the loss of a twin or a multiple the death must be recorded through the scan form by documenting no fetal heart on the form (Figure 4).

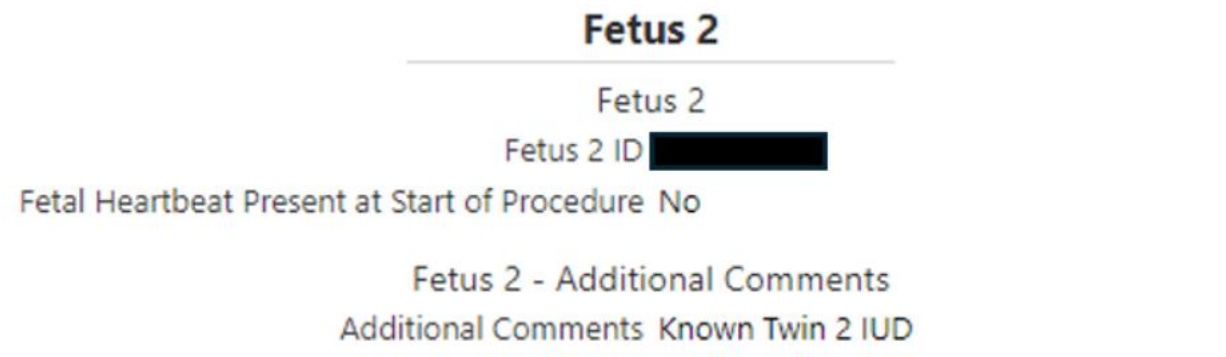


Figure 4 Badgernet Recording of Loss of a Twin/ Multiple

This will trigger the butterfly logo (Figure 5). This indicates that there has been a loss of a twin or other multiple. It must be added along with the teardrop to alert all caregivers.

Figure 5 Badgernet Butterfly Logo

All conversations should be documented in the bereavement pathway on the discussions tab along with a record of the teams/professionals who have been informed of the loss.

Inform foetal medicine, diabetic clinic, neonatal team if their plan of care has involved these clinics and teams, and any other clinicians if they have been involved in providing care during pregnancy (Figure 6).

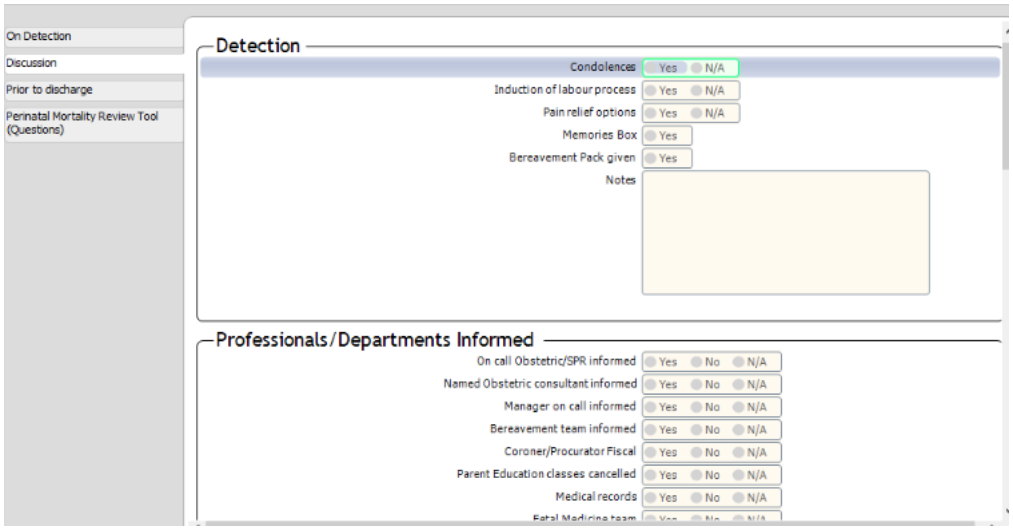


Figure 6 Professionals/ Departments Informed

In all cases (spontaneous loss and TFMR/TOPFA), complete the bereavement midwife referral (via the referral form) (Figure 7) to alert them to the loss.

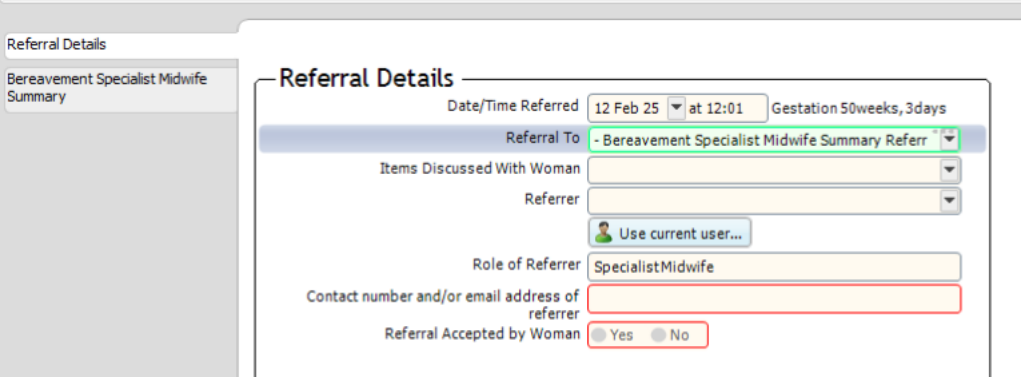


Figure 7 Bereavement Midwife Referral Form

- This will enable the bereavement midwife, where possible, to be available for staff should they need any help.
- The bereavement midwife can be contacted via phone 07581022493 or email (Abb.bereavementmidwives@wales.nhs.uk).
- Ask the ward clerk to cancel all future appointments.

Maternal observations:

- A full set of observations should be taken on admission and recorded in the Badgernet MEWS chart (BP, pulse, respiratory rate, saturation level, and temperature).
- These should be repeated four hourly, following the meows chart guidance for observations outside of the normal range.
- When established in labour maternal pulse should be recorded every hour.
- A partogram should be commenced when established labour is confirmed.
- Contractions should be monitored hourly by abdominal palpation and documented on the partogram.

Blood tests:

- On admission all women following a spontaneous loss should be offered baseline blood tests. TFMR/TOPFA should have bloods taken according to clinical symptoms and need.

- Blood tests must be documented on the badgernet bereavement pathway.
- Click on blood tests in the 'on detection' tab (Figure 8).

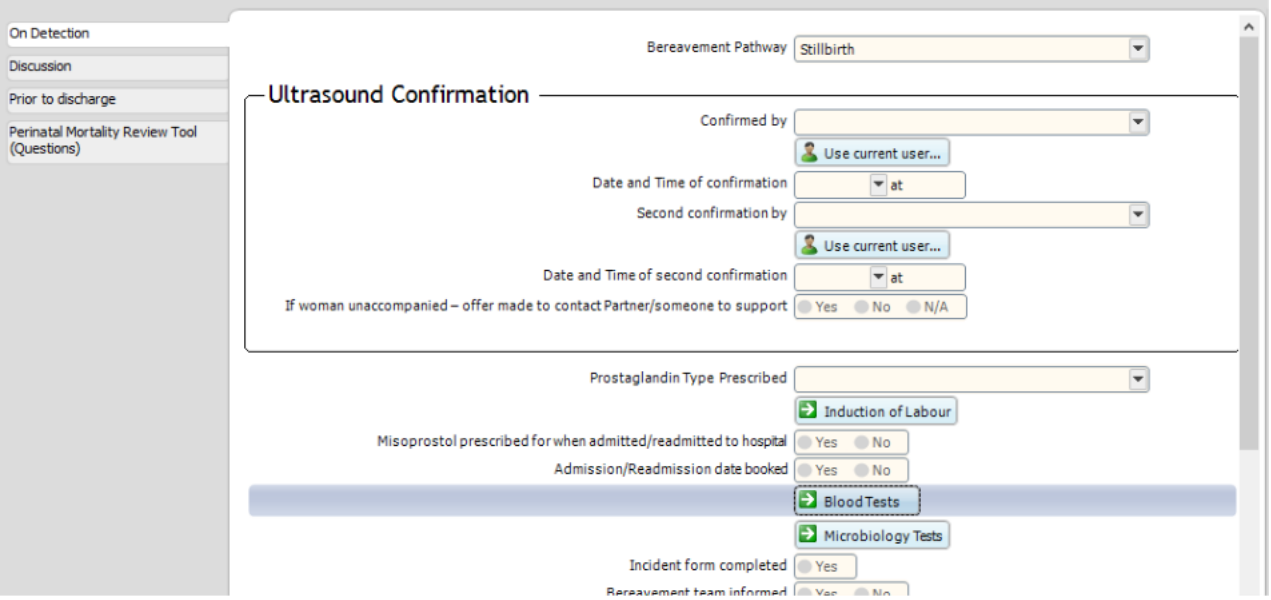


Figure 8 On Detection Tab

You then need to select blood tests offered from the drop-down list. (NB: Some are **auto populated** so you must make sure you **select/deselect** the relevant bloods as per this guideline. See below Figure 9).

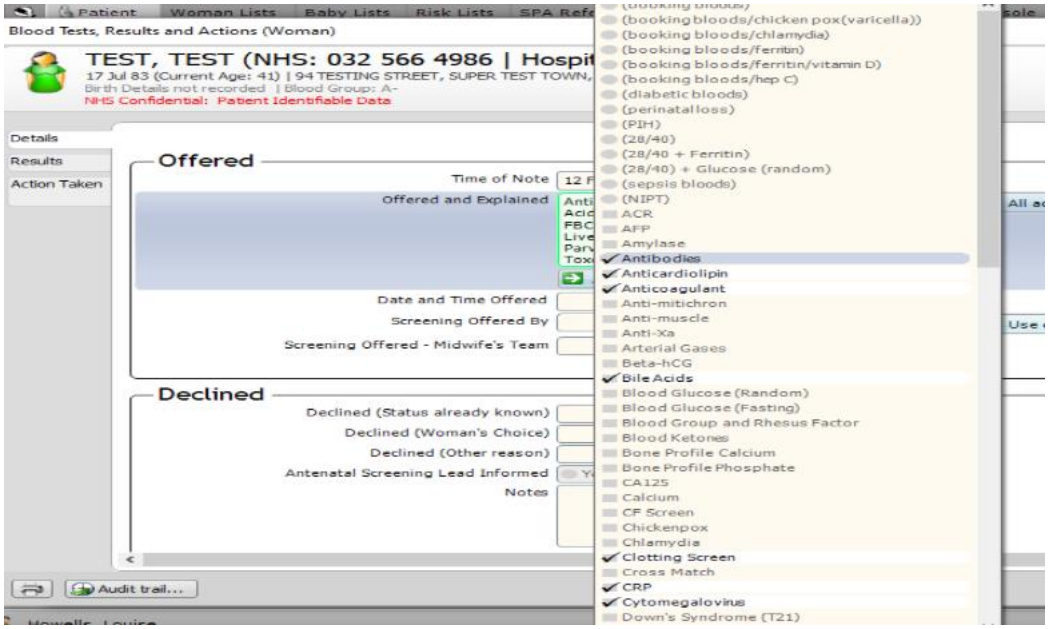


Figure 9 Blood Tests

These tests are available as a sticker set on CWS and include FBC, CRP, Bile Acids, U&E's LFT's, TFT, random glucose and HBA1c, clotting screen lactate.

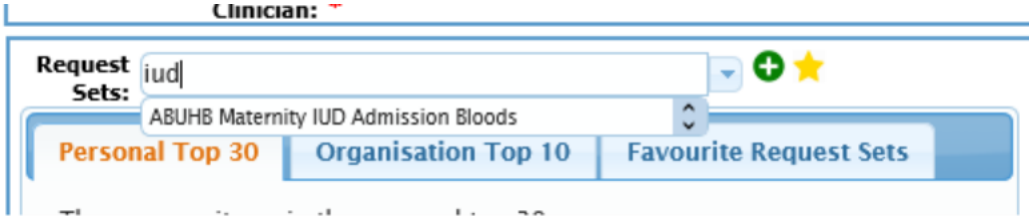


Figure 10 CWS IUD Sticker Set

- All women with a spontaneous loss should have a Kleihauer regardless of rhesus status to rule out feto-maternal haemorrhage.
- All women with a spontaneous loss should be offered a TORCH screening which will look for toxoplasmosis, parvovirus, cytomegalovirus (CMV), syphilis, rubella, and varicella zoster. **Search for Virology**- additional/special request and add this to your sticker set.

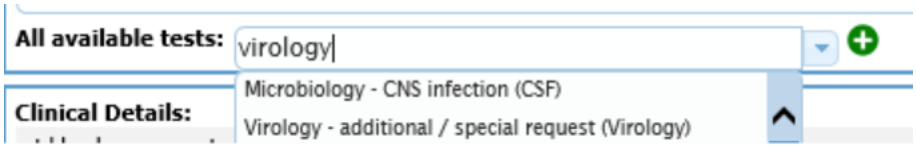


Figure 11 TORCH Screening

- **Type** the bloods needed for the TORCH screen in the clinical details box.

NB: THE TORCH BLOODS MUST BE SENT IN A BLUE MICROBIOLOGY REQUEST FORM (separate to the FBC, CRP, etc) (Figure 12).

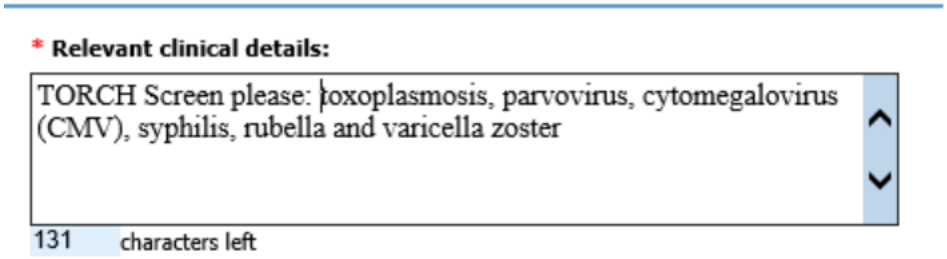


Figure 12 TORCH Bloods

Guidance on how to take these bloods and which bottles to use can be found in Appendix 6.

Pain relief:

- Following admission women should have the opportunity to meet with the anaesthetists to discuss their options for pain relief.
- All appropriate modes of analgesia should be discussed, including regional analgesia and patient-controlled analgesia, considering any specific contraindications for each woman.
- Assessment for disseminated intravascular coagulopathy (DIC) and sepsis should be undertaken before administering regional analgesia.
- Aromatherapy can be considered in line with the 'ABUHB guideline for aromatherapy use in maternity care'.

- Women should be supported to be mobile and to use positions which facilitate a physiological birth.

Recommendations for mode and timing of birth:

- Recommendations for labour and birth should be made with the woman and family support present taking their preferences into account, along with clinical risk factors.
- They should be advised to consider immediate birth if sepsis, PET, or placental abruption are present, but a more flexible approach can be considered if these are not an immediate concern.
- Women with no evidence of DIC and with intact membranes can delay labour and choose expectant management. There is a moderate risk of maternal disseminated intravascular coagulation (DIC): 10% within 4 weeks after the diagnosis of IUD rising to 30% thereafter. This can be tested or by clotting studies, blood platelet count, and fibrinogen measurement. (RCOG green top guideline 55).
- Tests should be repeated twice weekly in women who choose expectant management.
- If a woman returns home before labour begins, she should be given the Labour Ward number for 24-hour contact and her information shared at handover/shift changes.
- Vaginal birth is the recommended mode of birth for most women, and they should be managed on the high-risk pathway on the labour ward.

Induction of labour following spontaneous loss (late miscarriage or stillbirth) and TFMR/TOPFA after 20+0 weeks.

The process of induction of labour may be lengthy, and the couple should be advised of this when exploring options.

A cervical ripening ballon (CRB) can be considered in line with the Induction of labour (IOL) guideline. CRB is linked to a reduced rate of uterine hyperstimulation, higher maternal satisfaction, and a uterine rupture rate comparable to that seen in spontaneous labour.

If pharmacological methods are preferred pretreatment with mifepristone 36-48 hours before giving prostaglandins increases the sensitivity of the uterus and reduces the side effects associated with prostaglandins alone, and the induction to birth interval.

Unscarred uterus:

- A single 200 mg oral dose of mifepristone should be administered, and the mother may return home if appropriate following one hour of observation.
- The interval between mifepristone and misoprostol administration can range from 0 to 48 hours.
- Plans should be made for admission to labour ward 24 to 48 hours after the administration of mifepristone (or sooner if there is an urgent obstetric need for birth).
- There is no evidence to contraindicate earlier induction of labour following mifepristone. Induction can take place at any time within the 0 to 48-hour window after administration.
- The woman should be asked to return to the labour ward earlier if they experience any bleeding, pain, or have any other concerns.

Administration of mifepristone:

A single 200 mg oral dose of mifepristone should be administered, and the mother may return home if appropriate following one hour of observation.

The interval between mifepristone and misoprostol administration can range from 0 to 48 hours.

Misoprostol administration:

- Misoprostol should be administered after a vaginal assessment to determine cervical status.

- Amniotomy and/or the use of oxytocin should be considered where misoprostol is contraindicated or based on clinical assessment.

The dosage of misoprostol depends on the gestational age at which the IUD occurred, or termination of pregnancy is being undertaken (Figure 13).

	Gestation	**Misoprostol**	**Frequency**
Unscarred uterus	20-23+6 weeks	800 micrograms PV/SL/PO Followed 3 hours later by 400 micrograms PV/SL/PO	3 hourly
Unscarred uterus	24+0-24+6 weeks	400 micrograms PV/SL/PO	3 hourly
Unscarred uterus	25+0-27+6 weeks	200 micrograms PV/SL/PO	4 hourly
Unscarred uterus	28+0 weeks and over	50 micrograms PV OR 100 micrograms PO	4 hourly 2 hourly

Figure 13 Misoprostol per Gestational Age

Misoprostol is typically supplied as a 200-microgram scored tablet.

- A **100-microgram dose** can be prepared by splitting a 200-microgram tablet in half using a pill cutter.

- A **50-microgram dose** can be obtained by dividing the half tablet into quarters (¼ tablet), again using a pill cutter for accuracy.

Any remaining portion of the tablet must be disposed of.

There are several administration routes:

- **PV route:** The tablet should be placed into the posterior vaginal fornix. This route has the least side effects.
- **Sublingual/Buccal Route:** The tablet should be placed under the tongue or between the teeth and cheek for 30 minutes, with any remnants swallowed afterward. The vaginal, sublingual, or buccal routes are preferred for administration with PV administration having the least side effects.

If labour is not achieved after **five doses of misoprostol**, the clinical management plan must be reviewed with a Consultant Obstetrician.

Scarred uterus (women with one previous caesarean section or previous uterine surgery):

Women with IUD who have a history of **one previous caesarean section** face a 2-3 times increased risk of uterine rupture. A consultant obstetrician should discuss the safety and potential benefits of inducing labour in these cases.

A cervical ripening ballon (CRB) can be considered in line with the Induction of labour (IOL) guideline. CRB is linked to a reduced rate of uterine hyperstimulation, higher maternal satisfaction, and a uterine rupture rate comparable to that seen in spontaneous labour.

If pharmacological methods are preferred pretreatment with mifepristone 36-48 hours before giving prostaglandins increases the

sensitivity of the uterus and reduces the side effects associated with prostaglandins alone, and the induction to birth interval.

- A single 200 mg oral dose of mifepristone should be administered, and the mother may return home if appropriate following one hour of observation.
- The interval between mifepristone and misoprostol administration can range from 0 to 48 hours.
- Plans should be made for admission to labour ward 24 to 48 hours after the administration of mifepristone (or sooner if there is an urgent obstetric need for birth).
- There is no evidence to contraindicate earlier induction of labour following mifepristone. Induction can take place at any time within the 0 to 48-hour window after administration.
- The woman should be asked to return to the labour ward earlier if they experience any bleeding, pain, or have any other concerns.

Administration of mifepristone:

A single 200 mg oral dose of mifepristone should be administered, and the mother may return home if appropriate following one hour of observation.

The interval between mifepristone and misoprostol administration can range from 0 to 48 hours.

Administration of Misoprostol may be considered for labour induction in women with a single previous LSCS and IUD, though the recommended doses are not currently marketed in the UK.

Scarred Uterus	20+0 to 24+6 weeks	400micrograms PV/SL/PO	3 hourly

Scarred Uterus	25 to 27+6 weeks	200 micrograms PV/SL/PO	4 hourly

Figure 14 Medication for uterine scarring per gestation

If labour is not achieved after **five doses of misoprostol**, the clinical management plan must be reviewed with a Consultant Obstetrician.

Women with Two or More Lower Segment Caesarean Sections (LSCS) or Atypical Uterine Scars:

For women with two or more previous LSCS, the safety of labour induction using prostaglandins is unknown. In such cases:

- The induction regimen outlined above (for scarred uterus) may be applied, with modifications as clinically appropriate.
- A cervical ripening balloon (CRB) can be considered in line with ABUHB IOL guidance. This may be associated with a lower risk of uterine rupture compared to prostaglandins. CRB is linked to a reduced rate of uterine hyperstimulation, higher maternal satisfaction, and a uterine rupture rate comparable to that seen in spontaneous labour.
- While the exact risk of uterine rupture in this group is unknown, it is higher than in women with only one previous LSCS.
- The mode of birth should be carefully discussed on an individual basis with a Consultant Obstetrician, considering the woman's clinical circumstances and preferences.

All induction agents should be documented on the In-patient Medication Administration record and on the Badgernet record (Figure 15).

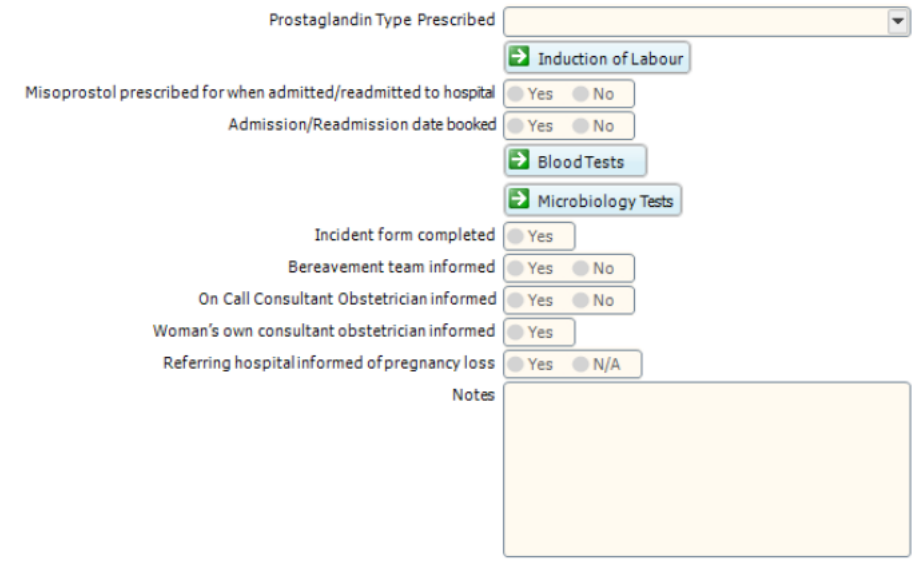


Figure 15 In-patient Medication Administration Record

Care in labour:

- Women with IUD/TFMR/TOPFA should be cared for in the bereavement room on labour ward unless it is already occupied or there are clinical concerns that requirement a higher level of care (i.e., HDU).
- One to one care should be facilitated during the induction, labour and at least for the first 24 hours to support the mother and the family and to undertake necessary paperwork.
- A review should be carried out by the obstetric team at least once during every shift and when there is a change in the clinical condition, until clinically fit for discharge.
- Birth choices remain as for all women in labour and the woman's birth plan should be reviewed with her.
- Blood tests including full blood count (FBC), clotting screen, and group and save should be performed as required.
- Staff should be vigilant to clinical features that may suggest uterine scar dehiscence/rupture: Maternal tachycardia, atypical pain, vaginal bleeding, haematuria, and maternal collapse and escalate appropriately. Ultrasound scan **should not** be used to diagnose uterine rupture.
- The Badgernet partogram should be commenced and completed for all labours.

- Ensure the woman has adequate analgesia for the labour and birth of her baby and offer the opportunity to speak to the obstetric anaesthetist to discuss analgesic options. This should be done before contractions start so the woman has time to consider her options.
- Women with sepsis should be treated with intravenous broad-spectrum antibiotics as per guidelines.
- Women with Group B Streptococcal (GBS) colonisation of the vagina do not require antibiotic prophylaxis in labour.
- The third stage of labour should be managed in line with health board guidance.

Management of a baby born with sustained signs of life which is not for resuscitation:

(Please refer to the SOP for paperwork for babies born with signs of life 20-22 weeks)

NB: This section is for babies born before 22+0 weeks of pregnancy and for those born at 22+0-23+6 weeks gestation where active survival focused care is not appropriate. The family must be thoroughly counselled and involved in all discussions in these cases.

- Any woman undergoing a TOPFA/TFMR should be aware that there is a chance their baby could be born with signs of life if a feticide has not been performed.
- A doctor should attend the birth if possible or see the baby soon after birth to witness the baby alive and then return to confirm the death.
- The baby should be treated with compassion and dignity.
- The family should be informed that their baby has signs of life and be given the opportunity to see and hold their baby if they wish.
- If the parents do not wish to see and hold their baby, a member of staff should remain with the baby until death is suspected and confirmed.

Births following spontaneous labour *(babies born before 22+0 weeks of pregnancy and for those born at 22+0-23+6 weeks gestation where active survival focused care is not appropriate).*

- If the birth was spontaneous (i.e., not following TOPFA/TFMR) then the obstetric doctor must complete the referral form to the medical examiner's office.
- When the Medical Examiner's service has reviewed the case notes they will authorise the doctor to complete the death certificate. This must be scanned and sent to the ME service and the bereavement midwife, to allow registration of the birth and death to go ahead.

Birth following TFMR/TOPFA (where the baby has shown sustained signs of life).

If the baby shows sustained signs of life following a TFMR/TOPFA then the doctor must complete and send a referral to the coroner's office. A death certificate does not need to be completed in these cases. It will be issued by the coroner's office.

Following birth:

The birth information must be documented in the badgernet pathway in the usual way. This will generate a 'baby' section and the fetal bereavement pathway.

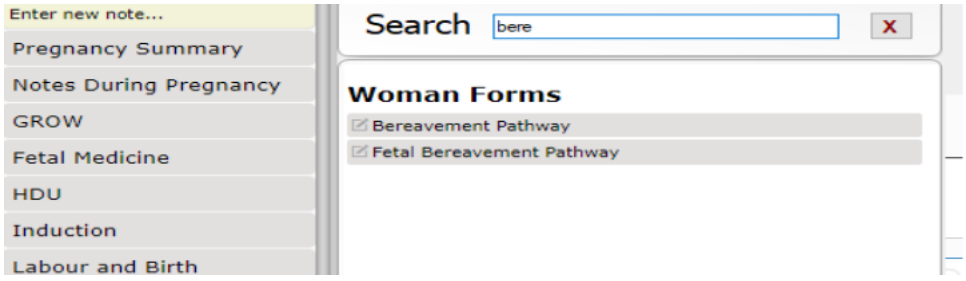


Figure 16 Bereavement Pathways Badgernet

This is where you will need to record memory making, post-mortem discussions, stillbirth certificates etc.

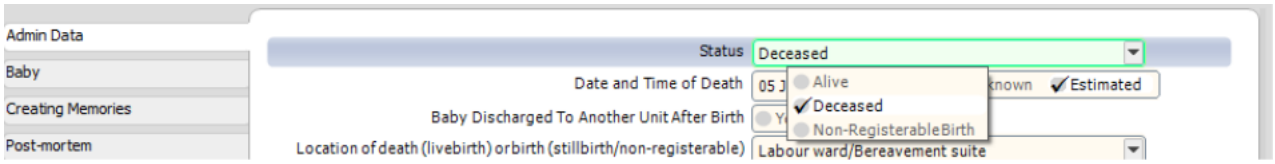


Figure 17 Recording IUD via Badgernet

Sexing of the baby:

- This should be done with caution, and parents should be informed that it is not always clear, particularly at earlier gestations.
- If there is any uncertainty (either due to gestation or condition of the baby), the couple should be informed.
- Errors in sexing the baby can cause emotional distress to the family.

Memory making:

- Following birth there are many opportunities for memory making. These should be discussed with the family prior to birth so they can have time to decide what is right for them.
- They should not be coerced into any memory making activity and have the right to change their mind. They should also be aware that there is no right or wrong thing to do.
- In all cases the use of a cold cot or cuddle cot should be encouraged to slow the deterioration of the baby's condition to allow the family to spend as much time with their baby as they wish.

Parents should be offered:

- A memory box (with a discussion around the items inside) and/or Ibrahim's gift for Muslim families.
- Hand and footprints.
- Lock of hair
- Clay impression kit (over 24 weeks)

- Photographs (on their own devices, on the hospital camera, through the hospital clinical photography department or via the *'Remember My Baby'* charity).
- Chaplaincy visit (24-hour service via Switchboard 100). The family do not have to have a particular faith to be offered a chaplain visit. They offer pastoral support and have a list of faith leaders from many different religions.
- Taking their baby home (refer to the Guideline for Taking a Baby Home following Perinatal Loss).
- Bath or *'top and tail'* the baby and dress them (using their own clothes or offer a selection from the cupboard in the bereavement room).
- Support group information (included in the *'ABUHB Coping with Loss'* booklet) and Sands resource book if not already given.
- On Badgernet, select the memory making you have offered and record which have been accepted, and which have been declined. This will assist staff on subsequent shifts to know what needs to be done. These can be viewed in the baby *'full notes'.*

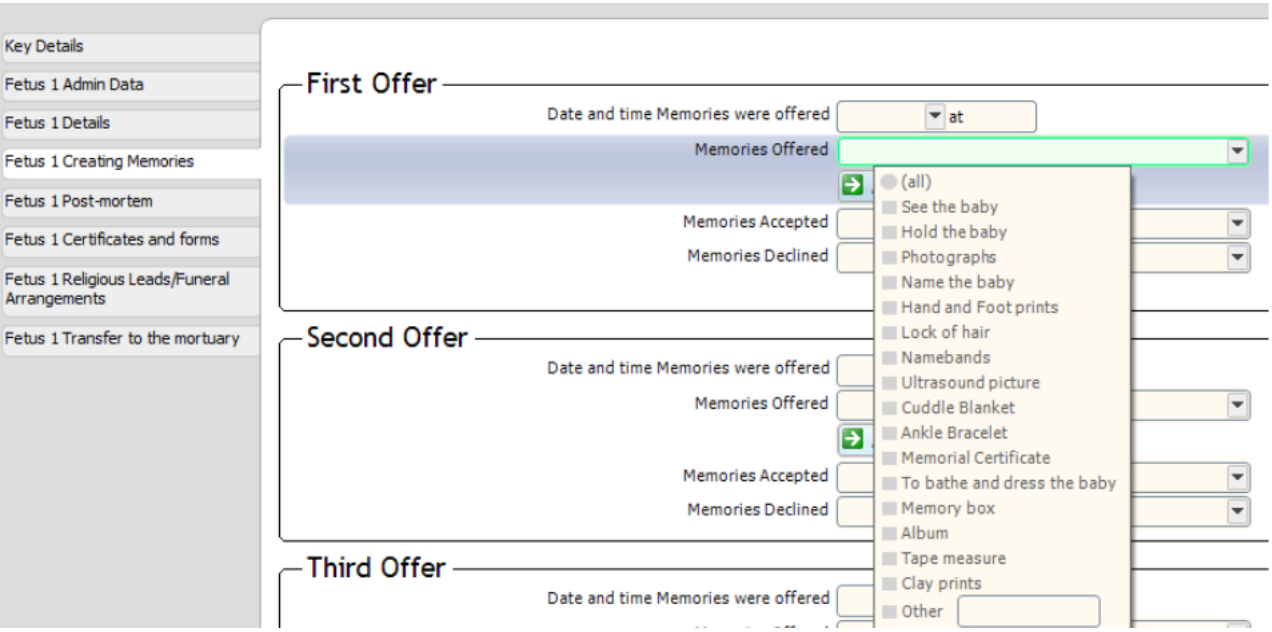


Figure 18 Recording Memories Made via Badgernet

Investigations and finding answers

Parents should be informed that there are several ways to try to establish what happened and try to get information about why their baby died.

Complete the relevant section(s) on the fetal bereavement pathway on badgernet.

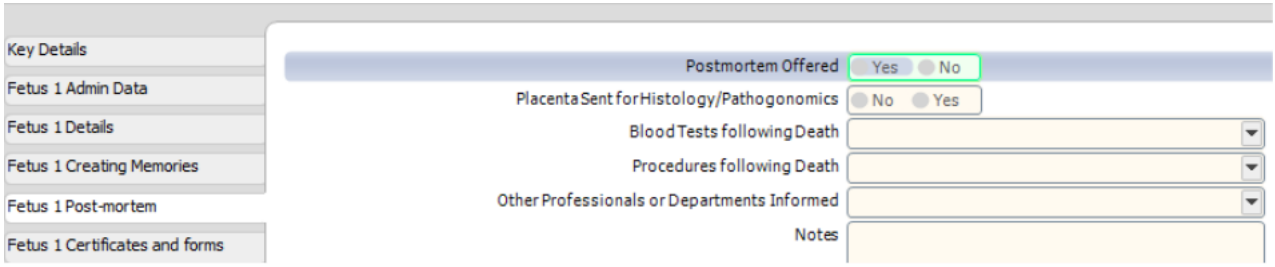


Figure 19 Recording Offered Investigations via Badgernet

Perinatal post-mortem:

All parents following a spontaneous loss should be offered a post-mortem which may provide information about the cause of the loss. Parents should be aware that around 50% of losses are unexplained.

If a TFMR/TOPFA is done for an antenatally diagnosed aneuploidy (T13/18/21) or where a unifying clinical or genetic diagnosis has been determined, then a post-mortem examination is unlikely to give any further information. If parents request this then a discussion with the paediatric pathologist would be appropriate, prior to completing the consent form.

- Parents should be counselled by someone experienced in post-mortem consent.
- Written consent must be obtained for the procedure and must be completed by the mother. It can be counter-signed by the other parent.

- The consent form should only be completed by a member of staff who has attended the training and is on the register kept in UHW.
- Please refer to appendix 6 for guidance on gaining consent for post-mortem.
- Ensure informed choice is supported and that there is no coercion to accept a post-mortem.

Placental histology:

- If parents do not wish to have a post-mortem, then the placenta should be sent to UHW for examination by a paediatric pathologist.
- If the parents are having a post-mortem, then the placenta should be sent to UHW with the baby via the mortuary.
- If the placenta is from a twin or multiple pregnancy, ensure each cord is identified (i.e., Twin 1 etc.)
- All placentas from spontaneous losses should be sent to UHW pathology laboratory for examination, not to our local unit. Please see the guidance posters in the sluice and at Appendix 7.
- This is detailed macroscopic and microscopic examination of the placenta by a paediatric pathologist.
- The placenta should be placed in a bucket with saline and sent via hospital transport directly from the labour ward to fetal pathology in UHW. The ward clerks can help with arranging this. Please complete a Histopathology form (see Appendix 9) and a chain of custody form (see Appendix 10) to accompany the specimen.
- If a placenta does not meet the criteria for sending to UHW (i.e., following TFMR/TOPFA) then please place in formalin in the usual way and send to the local lab for examination.

Genetics:

- If the parents wish for **genetic testing only** then a small sample of placenta, or cord should be sent for examination.

- Cut a small 5p coin sized piece of placenta or cord and place it in a universal specimen pot, with saline.
- Complete the purple Genetics form with as much detail as possible and **ask the mother to sign the back of the form**.
- Send the samples (blood sample and placental sample) via hospital transport to (**NB: address currently out of date on the genetics form**):

  All Wales Medical Genomics Service,
  Wales Genomic Health Centre,
  Cardiff Edge Business Park,
  Longwood Drive,
  Whitchurch. CF147YU

Placental swab:

- This should be taken in all cases of spontaneous loss and in any TFMR where there has been a concern about maternal infection during the induction process and labour.
- Use a black top charcoal swab and sample the fetal side of the placenta.
- Send to the lab in the usual way.
- Document the result on the badgernet pathway.

Thrombophilia screening:

- All women following a spontaneous loss will be offered a thrombophilia screening a minimum of 12 weeks following birth.
- This includes Lupus anticoagulant screen, Antithrombin III, Protein C, Protein S, Anticardiolipin antibodies, anti B2-GP1 antibodies, Factor V Leiden and Prothrombin Variant.
- The bereavement midwife will send out a letter inviting them to have the blood test and will follow up the results.

Results:

- Post-mortem and placental histology reports (UHW) take approximately 12-14 weeks.
- Local placenta reports take around 6 weeks.
- Thrombophilia blood results take 6 weeks.
- Genetic results take up to 6 weeks. Please add bereavement midwives name to the request form so they will receive an update too.
- When the results are available, a debrief appointment will be arranged with the named consultant to discuss the results and discuss care in future pregnancies. This does not need to be requested during the CWS e-discharge.

Datix Reporting:

- Every spontaneous loss over 22+0 weeks should be reported on the Datix system.
- If a baby is born following termination of pregnancy at 24+0 weeks or over, a Datix needs to be submitted, and a stillbirth certificate completed.
- If a baby is born with **signs of life** following TFMR/TOPFA or following a spontaneous loss at 20+0-22+0 weeks and has not received survival focussed or comfort care from the neonatal team, a Datix must be submitted.
- These losses are reportable to MBRRACE and trigger a Nationally Reportable Incident (NRI).
- In all cases, please include brief details of the loss including gestation and the circumstances around discovery of the loss.

Reviews and investigations:

- All spontaneous losses over 22+0 weeks are reported to MBRRACE and will be reviewed using the perinatal mortality review tool (PMRT).

- Parents should be informed about the review process prior to discharge and given information about the review.
- Parents are invited to submit questions they have about their care so they can be included in the review.
- Any cases requiring a more in-depth investigation will be escalated, as necessary.

Postnatal care:

- The woman's GP surgery and community midwife should be informed of the loss via telephone at the earliest opportunity along with their named consultant.
- Ensure an E-discharge is completed in full in all cases.
- Complete the Badgernet bereavement pathways (maternal and fetal) recording offers of support and memory making etc in the relevant places.
- Administer Anti-d if required.
- Options for contraception should be discussed prior to discharge and information about fertility/birth intervals discussed.
- Provide take home medications including (where appropriate) thromboprophylaxis and accompanying sharps box.
- Ask the ward clerk to cancel all future appointments and complete the mailing suppression form at www.bmpsonline.org.uk/registration
- Add the woman to the discharge list on SharePoint in the usual way.
- All women should have a community midwife visit the following day and then frequency of visits can be discussed between the family and the community team.
- The bereavement midwife will contact the family a few days after discharge.
- A debrief will be offered with their named consultant to discuss findings of any tests, post-mortem etc. This should not be booked

until the results are available. The bereavement midwife will arrange this.

Suppression of lactation:

- Women may experience lactation from around 16 weeks' gestation.
- Options for suppression or cessation of lactation should be discussed prior to birth to give the woman time to decide.
- Natural suppression/cessation should be discussed with all women. They should be aware of the symptoms of lactation (i.e., swollen tender breasts around 30-72 hours post birth) and be advised that paracetamol and comfortable supportive bra will help. Breast pads will help with leaking.
- Medical suppression of lactation should be used alongside and not as a replacement for natural suppression.

Cabergoline is contra-indicated in the following circumstances:

- Women with hypersensitivity to cabergoline, lactose or any of the excipients listed in the SPC or any ergot alkaloid.
- Women with a history of pulmonary, pericardial, and retroperitoneal fibrotic disorders.
- Women with hepatic insufficiency.
- Women with a history of puerperal psychosis.

Cabergoline should be used with caution in the following circumstances:

- severe cardiovascular disease
- post-partum hypertension
- Raynaud's syndrome
- renal insufficiency
- peptic ulcer or gastrointestinal bleeding
- history of serious, particularly psychotic, mental disorders

- when administered with other medication known to lower blood pressure (since symptomatic hypotension can occur with cabergoline)

The manufacturers advise that due to cabergoline's long half-life and limited data on in-utero exposure, there should be an interval of one month between taking cabergoline and conception – health professionals should ensure a highly sensitive approach if this information is shared as part of discussion around contraception after pregnancy.
or stillbirth.

DOSE: for lactation suppression cabergoline should be administered on the **first day post-partum**. The recommended dose is 1mg (two 0.5mg tablets) given as a single dose.

Thromboprophylaxis:

- Women should be assessed for thromboprophylaxis throughout their admission as per the ABUHB Guideline for the Prevention and Treatment of Thrombosis in Pregnancy and the Postpartum Period and the VTE assessment on Badgernet.
- Spontaneous perinatal loss is an additional risk factor for VTE.
- When preparing for discharge ensure all women are assessed for their thromboprophylaxis risk and issue the necessary treatment and sharps box are provided to take home.

Transfer to the mortuary:

When the parents are ready to say goodbye, it is important to explain to them where their baby will be taken and the expected time frames. Complete the 'transfer to mortuary' section on the fetal bereavement pathway.

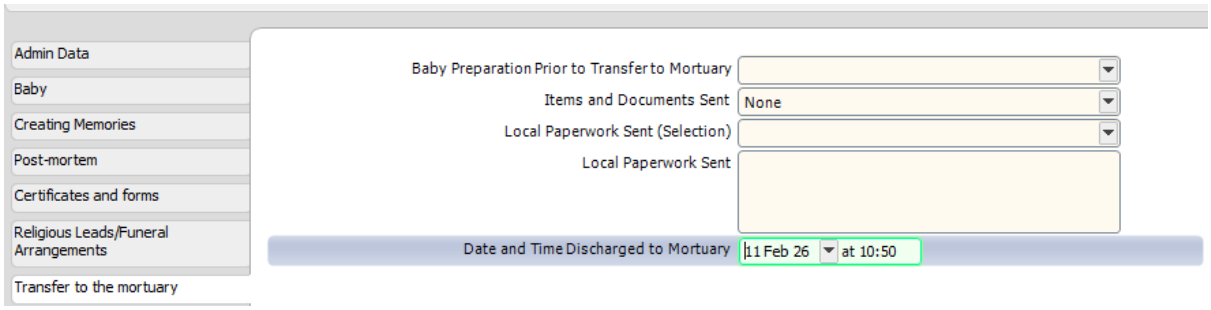


Figure 20 Mortuary Transfer via Badgernet

- If the baby is for post-mortem, they must be transferred to the mortuary and then transported to UHW. They will then be returned to the Grange once the examination is complete. This is usually within a week for babies over 24 weeks and 3-4 weeks for babies under 24 weeks.
- The bereavement midwife will liaise with UHW and arrange transport to and from UHW. They will then ring the family to let them know that their baby is back in the Grange and ready for collection by their chosen funeral directors.
- If the baby is not for post-mortem, they will be available for collection from the mortuary by the family funeral directors as soon as they are able to attend.
- When preparing a baby for transfer to the mortuary ensure they have 2x name bands attached.
- If there are any belongings to be sent with the baby ensure they are enclosed within the gauze wrap/miscarriage bed where possible or placed in a bag, clearly labelled with the mother's details.
- Complete the mortuary notification sheet (Appendix 11) in full (only one form is needed and no longer gets wrapped with the baby).
- Wrap the baby in gauze or use a wooden miscarriage box if appropriate.
- Between the hours of 9-5 you can contact the mortuary on 01633493907 and inform them that you will be bringing a baby

down to them. This ensures there is someone available to assist you.

- Out of these hours complete a 'request the porter' form and a porter will accompany you to the mortuary.
- In all cases ensure you complete the mortuary register with the mother's details (handwritten no stickers).
- Take the completed mortuary notification sheet to the mortuary and place it in the blue paperwork folder.
- Take **all other relevant paperwork** to the mortuary with the baby (PM consent forms, cremation/burial forms etc) and leave in the blue paperwork folder in the mortuary.
- If the baby is for post-mortem take the placenta to the mortuary to accompany them to UHW.

N.B. If the baby is to be collected by the funeral directors directly from labour ward, or if the parents choose to take their baby home, please ensure you add the baby details to the mortuary register in the normal way.

If the parents choose to take their baby home notify the bereavement midwife so she can offer the family support while the baby is at home.

Funerals and registration:

- All families can choose between a burial or cremation. There are separate cremation forms for babies born under and over 24 weeks and also a different form for babies for burial.
- The correct form must be completed prior to discharge and sent with each baby to the mortuary. (See flow charts at Appendix 4 & 12).
- All families should be encouraged to contact their own funeral director. Funeral services in Wales are free for babies and children, with families only expected to pay for additional items (i.e., flowers, casket etc). They should ask their funeral directors

what is included, as it varies, before agreeing to use their services. Many will not charge the parents for a basic funeral.

- Parents whose loss occurred after 24 weeks, or a neonatal death are eligible for a grant of £500 to help with funeral costs. This is not means tested and does not have to be paid back. They will be given help to apply for this when they attend the registrar's office to register the birth.
- Parents should be aware that there are no communal cremations in Gwent Crematorium. There will be a communal scattering of ashes if the parents do not wish to collect them.
- Complete a stillbirth certificate (for babies born with no signs of life over 24 weeks). Include contributary factors if known.
- Use the flow charts at Appendix 4 and 12 to help you.
- Complete the death certificate if required. Use the SOP for paperwork when a baby is born with signs of life at 20-22+0 weeks for guidance.

Support:

- Following birth and discharge home the family will be visited by their community midwife for postnatal checks. Put the woman's details on the hospital discharge list on SharePoint in the usual way.
- The family should be given the perinatal loss booklet and Sands resource book at discharge (if not already given) and be shown where to find the contact details for the bereavement midwife.
- The bereavement midwife will get in touch in the days after discharge and discuss the family's needs and answer any questions they may have.
- The bereavement midwife will ensure the family are aware of the PMRT review process (where appropriate) and how results will be made available to them.
- There is a list of support groups (local and national) in the 'Following the loss of your baby' booklet.

7. Roles and Responsibilities

Midwives

Midwives provide sensitive, holistic, and individualised care following the loss of a baby. They provide clear communication, emotional support, and clinical assessment, ensuring care plans reflect each person's wishes, cultural needs, and informed choices. They also facilitate referrals to specialist services and support continuity of care.

Healthcare Support Workers (HCSWs)

HCSWs assist midwives by providing compassionate, practical support that maintains comfort, and dignity. They observe wellbeing, meet physical care needs, and escalate concerns appropriately.

Obstetricians

Obstetricians provide medical leadership, confirming diagnosis, explaining clinical findings, and supporting informed decision-making. They contribute to individualised care plans, ensure safe medical management, and work collaboratively with midwives to support emotional and physical needs.

Bereavement Midwife

The bereavement midwife offers specialist guidance, supports staff in delivering high-quality bereavement care, and ensures training, education, and practice updates are maintained. They advise on complex cases and provide ongoing support to both families and staff.

Senior Management Team

Senior management is responsible for ensuring that the service has the resources, training, and governance structures required to deliver equitable, safe, and compassionate bereavement care. They support implementation of the guideline, promote staff wellbeing, and ensure continuous improvement through audit, feedback, and organisational learning.

8. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and anaesthetics have been consulted with in the development of this policy.

9. Equality Impact Assessment

This guideline has been developed to ensure that all women and birthing people who experience the loss of a baby after 20 weeks receive equitable, compassionate, and individualised care. It recognises the diversity of personal, cultural, spiritual, and social needs that may influence how families understand and cope with their loss. The pathway aims to promote respectful and non-discriminatory practice, reduce barrier to engagement with support services and ensure that care planning is tailored to each person's preferences, circumstances, and protected characteristics. Staff are expected to provide sensitive, inclusive care that upholds dignity, enables informed choices, and supports the wellbeing of all individuals and families.

10. Training Requirements

Individuals should ensure they identify the professional competencies, additional knowledge, and skills they will need and that they access appropriate education, training, competency assessment and continuing support and supervision. Once competency achieved nurses/ midwife should be able to practise within agreed protocols and guidance, NMC standards.

11. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Maternal/ neonatal outcomes will be monitored via the local maternity dashboard. Adverse maternal/ neonatal outcomes will be reviewed on an individual basis via local governance arrangements. Instances of pregnancy loss that meet threshold for PMRT review will be routinely reviewed on an individual basis via the local PMRT or Morbidity and Mortality forums (case dependent).

Instances of pregnancy loss require reporting as per *'Datix Reporting'* and *'Reviews and investigations'.* As previously stated, instances of pregnancy loss that meet MBRRACE reporting criteria also require escalation to NRI reporting as per national requirements.

12. References

Doherty, C. Parish, A. Levene, I. et al. 2022. Lactation and loss: Management of lactation following the death of a baby. A Framework for Practice. British Association of Perinatal Medicine (BAPM) Lactation and Loss May 2022.pdf

RCOG Green top guideline no:55. Care of late intrauterine fetal death and stillbirth

Signs of life guidance available at: Signs of Life | MBRRACE-UK | NPEU

Coroners' guidance available at: Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy - Courts and Tribunals Judiciary

Best practice in abortion care 2022. Available at: abortion-care-best-practice-paper-april-2022.pdf

13. Appendices

Appendix 1
Signs of life guidance

Determination of signs of life following spontaneous birth before 24+0 weeks of gestational age where, following discussion with the parents, active survival-focused care is not appropriate

NOTE: This guidance is only for births where following discussion with the parents, *active survival-focused care is not appropriate*. For decision-making relating to perinatal care and preterm delivery see British Association of Perinatal Medicine Framework for Practice for Perinatal Management at less than 27+0 weeks of gestation https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019.

Births INCLUDED in this guidance

In-hospital spontaneous births **<22+0 weeks**

In-hospital spontaneous births **at 22+0 to 23+6 weeks** where, following discussion and agreement with parents, active survival-focused care is not appropriate

The same principles also apply to pre-hospital spontaneous births <22+0 weeks - see BAPM framework for practice on pre-hospital management of the baby born at extreme preterm gestation https://www.bapm.org/resources/pre-hospital-management-of-the-baby-born-at-extreme-preterm-gestation

Births EXCLUDED from this guidance

Medical terminations of pregnancy
Spontaneous births of uncertain gestation
Spontaneous births at 22+0 to 23+6 weeks of gestation where initiation of active survival-focused neonatal care is planned or uncertain

Communication with parents

Effective communication can reduce the impact of trauma on parents. Sensitively counsel parents that:

- Babies born before 24 weeks are small and immature and often do not survive birth.
- Babies who die just before birth may show brief reflex movements but these are not 'signs of life'.
- Babies who survive birth may show signs of life for a few minutes or occasionally for a few hours. A doctor will be asked to attend to confirm signs of life and appropriate comfort care will be provided for their baby.

Actively listen and take the lead from the woman and her partner regarding preferred language. Many prefer to be described as 'parents' experiencing the 'loss' or 'death of their baby'. However each situation is unique and there are those who would prefer to be addressed as individuals rather than parents and for the birth to be referred to as 'the end of the pregnancy' or as a 'miscarriage'.

Observing signs of life

- Observe for visible persistent signs respectfully while holding baby
- Use of a stethoscope is not necessary
- Parents' observations of signs of life should be included in discussions if they wish to share them

Live birth is determined by 1 or more persistent visible sign of life:

easily visible heartbeat	definite movement of arms and legs	breathing, crying or sustained gasps	visible cord pulsation

Fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement observed only in the 1st minute after birth does not warrant classification as signs of life.

Following live birth

England, Wales & Northern Ireland:	A doctor should be called (usually the attending obstetrician) to confirm and document live birth. This avoids potential distress when the doctor cannot complete a death certificate because they have not seen the baby alive and there is then a requirement to contact the coroner.
Scotland:	A doctor can rely on an attending midwife's history to confirm live birth and is not required to attend
UK-wide:	Provide appropriate comfort care following a perinatal palliative care pathway. Care should meet baby's physical needs and parents' physical and emotional needs. See "Together for Short Lives" (https://www.togetherforshortlives.org.uk/).

Bereavement care: ALL BIRTHS

- Ensure a parent-led bereavement care plan is in place. Follow the National Bereavement Care Pathway in England (http://www.nbcpathway.org.uk/) and Scotland (https://www.nbcpscotland.org.uk/) and locally developed bereavement pathways in Wales and Northern Ireland.
- Be aware of what choices your hospital can offer.
- Allow time for parents to decide what is right for them.
- Be sensitive to the individual needs of parents.
- Provide choices and support including time and privacy with baby, opportunities to make memories and discuss available options for burial, cremation or sensitive disposal of their baby's body.
- Inform parents about available support services and refer as appropriate.
- Refer parents as appropriate to community postnatal care, GP and mental health teams following local protocols.

Documenting the birth and death

MISCARRIAGE

UK-wide:	Document the miscarriage. There is no legal requirement to register births before 24^{+0} weeks but sensitively offer parents informal 'certificate of loss' or 'certificate of birth'.

LIVE BIRTH

England, Wales & Northern Ireland:	After the baby dies, a neonatal death certificate must be issued by a doctor who witnessed the signs of life. If signs of life have not been witnessed by a doctor, the doctor & midwife should confirm and document the live birth and the doctor must inform the coroner to issue a neonatal death certificate.
Scotland:	The doctor and midwife should confirm and document the live birth. The doctor must complete a neonatal death certificate after the baby dies.
UK-wide	Complete birth notification. Parents must register the birth and death.

For further detail see www.npeu.ox.ac.uk/mbrrace-uk/signs-of-life

Appendix 2

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Death in babies born with sustained signs of life prior to 22 weeks or following MTOP/TOPFA on the Labour Ward.

The new medical examiner services (MES) process.

Neonatal deaths **at any time** whether in the neonatal unit or on the labour ward MUST BE referred to the medical examiners service and in the case of MTOP/TOPFA with signs of life, the Coroner.

When a baby is born showing the signs of life following a SPONTANEOUS birth:

The obstetrician must review the baby when alive, and then return to confirm death. This **must be** documented on badgernet.

The Doctor must then promptly complete the following:

- An MCCD for babies born within first 28 days of birth (two pages, front and back)
  Referral to the MES office via this email address with a proposed **cause of death** and **a brief summary** of events.
- or complete the form accessed via this QR code:

South Wales East (Aneurin Bevan, Powys)

SouthWalesEast.MedicalExaminersOffice@Wales.nhs.uk

02921 500799

Hub MEO: Sophie Hill

South Wales East Medical Examiner QAP Notification of Cause of Death

The MES will then speak sensitively to the family, scrutinise any available notes, and confirm the cause of death. They will provide advice on completion of the MCCD.

PLEASE CHECK YOUR EMAILS FOR THIS CONFIRMATION.

If a baby is **born with signs of life following an MTOP/TOPFA** then **do not** complete an MCCD but complete the coroners referral form (on sharepoint) Coroner Referral - HOSPITAL.docx (sharepoint.com) . and email to the address on the form and CC in the ME Service. The coroner will then make a decision and issue the death certificate, and the burial/cremation paperwork as required.

Please make sure the family know that they will be contacted by the coroner's office for a sensitive discussion about events.

If you need any help completing these forms please contact the bereavement midwife louise.howells3@wales.nhs.uk

07581022493 Mon-Fri 8-4.

If she is not available please contact the care after death team 01443802406

Appendix 3

Coroner Referral - HOSPITAL.docx

(Example of front page. Full document available in the SharePoint folder).

GWENT

FORM FOR REFERRAL OF DEATH TO HM CORONER

To be emailed to gwent.coroner@newport.gov.uk

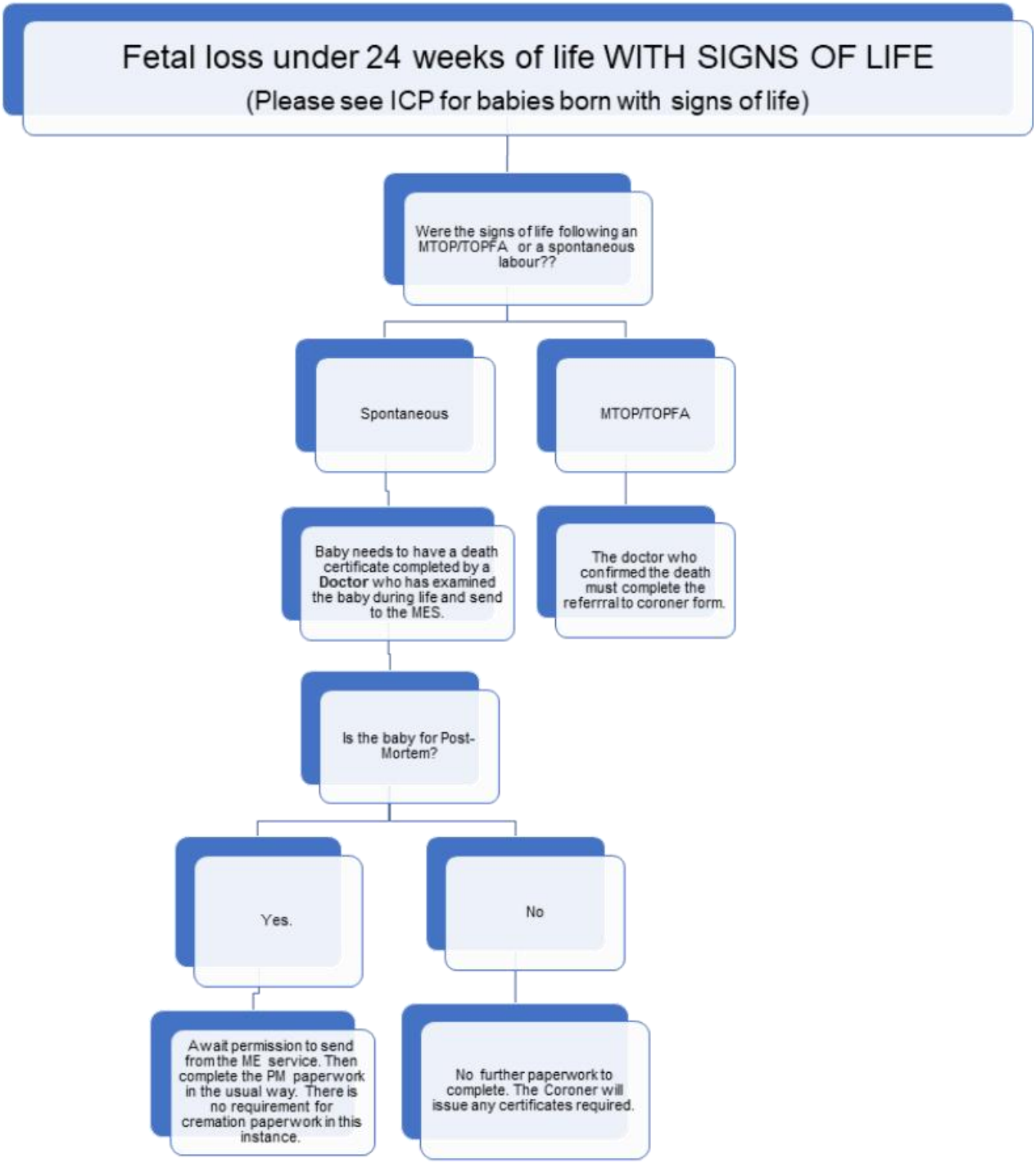
1. Reason for referral

2. Name of admitting Consultant and name of Consultant responsible for the care of the patient. THIS REFERRAL WILL NOT BE ACCEPTED UNLESS ITS CONTENTS HAVE BEEN REVIEWED & APPROVED BY THE RESPONSIBLE CONSULTANT OR MEDICAL EXAMINER (Please indicate so in the box below)

3. Patient and NOK details	
Name:	
Date of Birth:	
NHS Number: Occupation:	
Home Address:	
Next of Kin	
Name:	
Relationship:	
Contact Number: Email address:	

4. Place, date and time of death details	
Place of death:	
Date of Death:	
Time of death:	

Appendix 4
To be used in conjunction with SOP for paperwork for babies born with signs of life 20-22 weeks



Appendix 5.
Abortion Act Certificate C (sample)

IN CONFIDENCE **CERTIFICATE A**

ABORTION ACT 1967

Not to be destroyed within three years of the date of operation
Certificate to be completed before an abortion is performed under Section 1(1) of the Act

I, ...
(Name and qualifications of practitioner in block capitals

of .....

.....
(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....
(full address of place at which patient was seen or examined)

on .....

and I .....
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....
(Full address of place at which patient was seen or examined)

on .....

We hereby certify that we are of the opinion, formed in good faith, that in the case

of .....
(Full name of pregnant woman in block capitals)

of .....

.....(
Usual place of residence of pregnant woman in block capitals)

(Ring appropriate letter(s))

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;

D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;

E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.

Signed .....**Date** .....

Signed .....**Date**.....

* Delete as appropriate

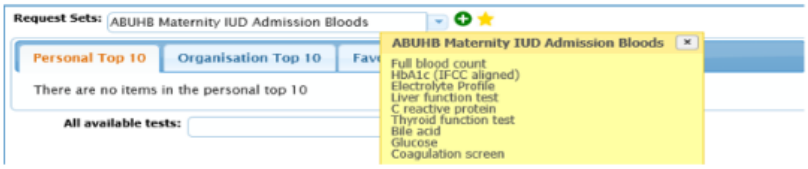
D4E0965329 4/94 C8690 CC30886

Form HSA1 (revised 1991)

Appendix 6
Blood sample guidance

Select IUD in the sets box and press the green plus sign

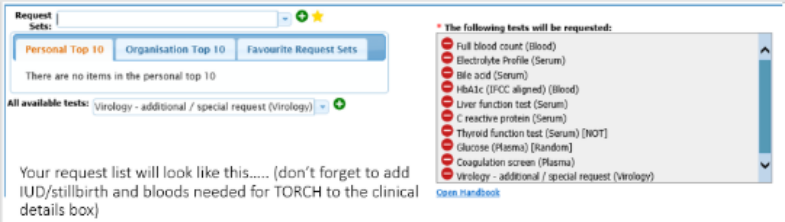
- This will automatically add the following bloods to the requests



NEXT...

THEN.....

In the clinical details box further down the page you need to write IUD and the gestation **and the virology tests needed** (Parvovirus, Toxoplasma, Rubella, Cytomegalovirus, Varicella zoster virus (VZV) and Syphilis) and then the lab will be able to carry these out.

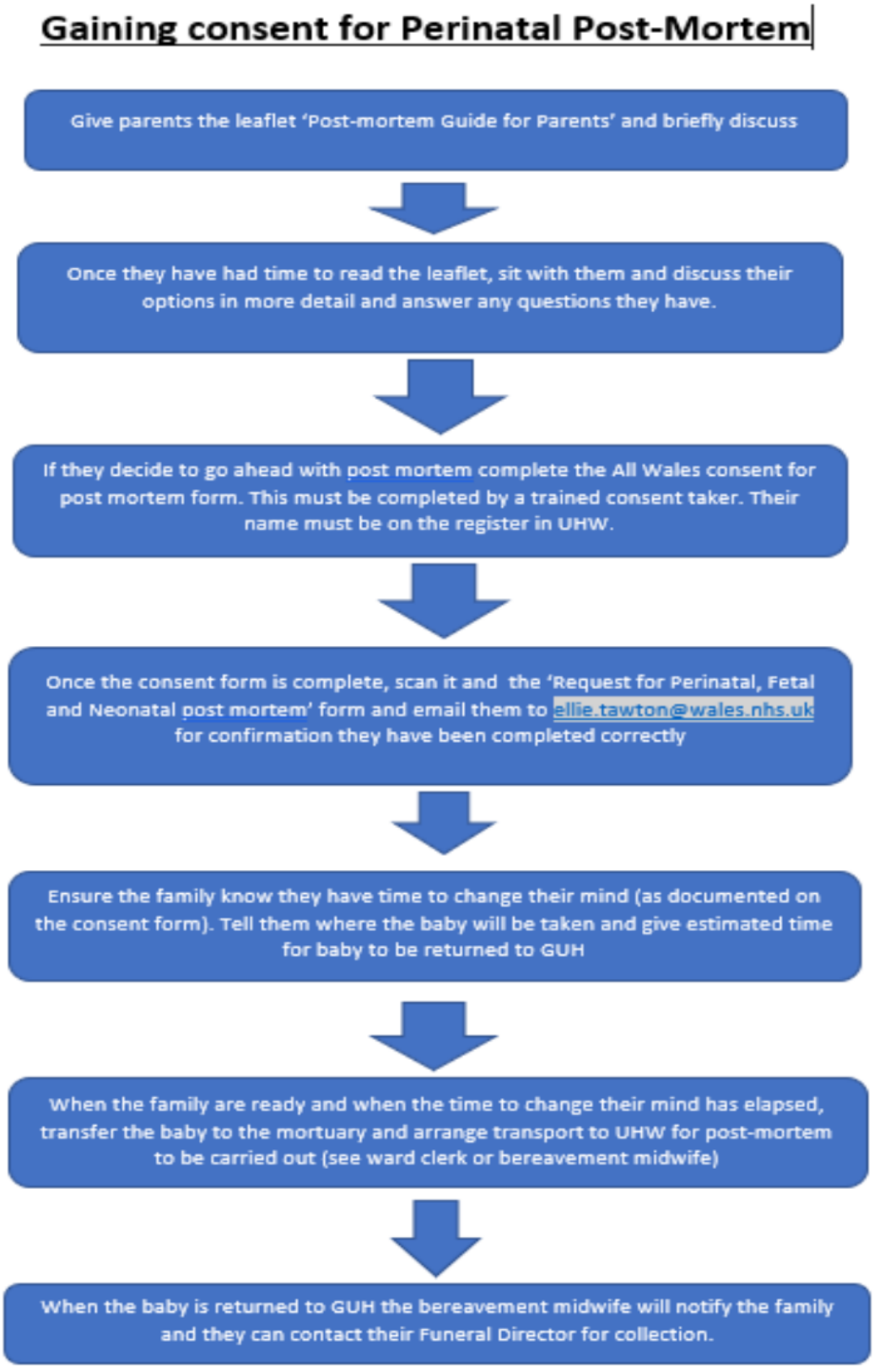


Your request list will look like this..... (don't forget to add IUD/stillbirth and bloods needed for TORCH to the clinical details box)

Remember:

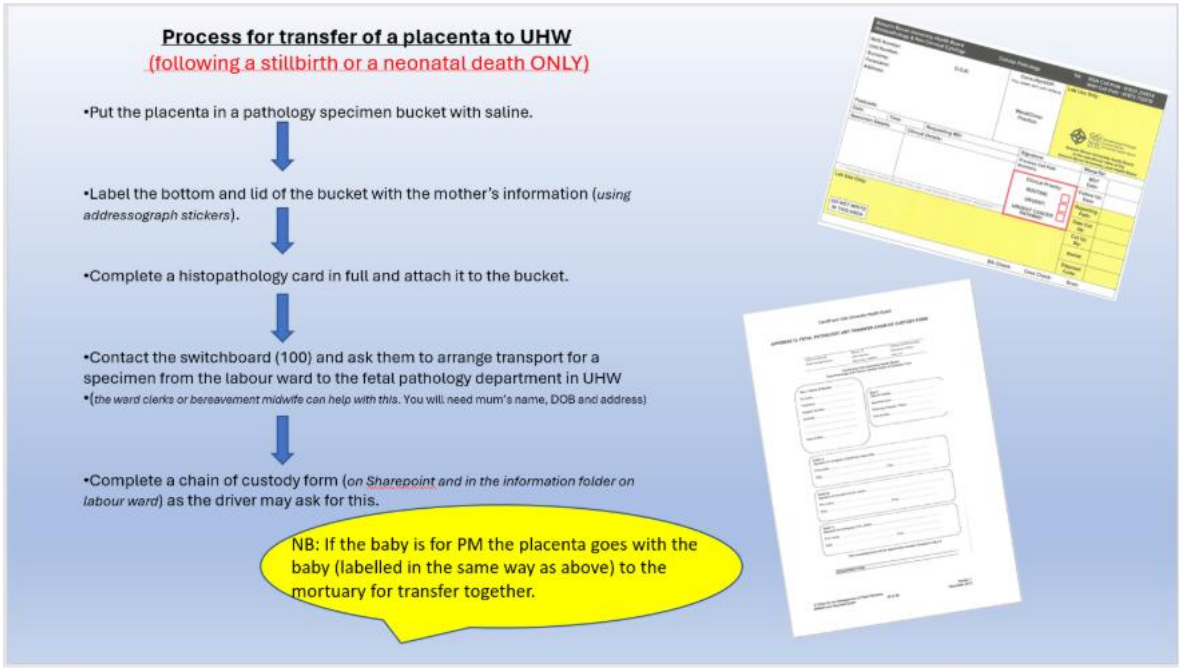
- Put one yellow bottle in a blue microbiology/virology envelope (the one we send swabs etc in) and document on the form which TORCH bloods you want (one yellow bottle is enough for all these bloods).
- Put 1 yellow, 1 purple, 1 blue and 1 grey bottle in the usual bloods bag (for FBC etc).
- Don't forget to take bloods for Kleihauer (for everyone regardless of rhesus status) and group and save too (one Pink bottle is enough for both tests) and request **both tests** on the pink form in the usual way.
- Send to the lab and check and document the results.
- **IN TOTAL**, for the admission bloods you need....
- 1 pink, 2 yellow, 1 purple, 1 blue and 1 grey (6 bottles in total).
- Don't forget the order of the draw and positive patient identification.

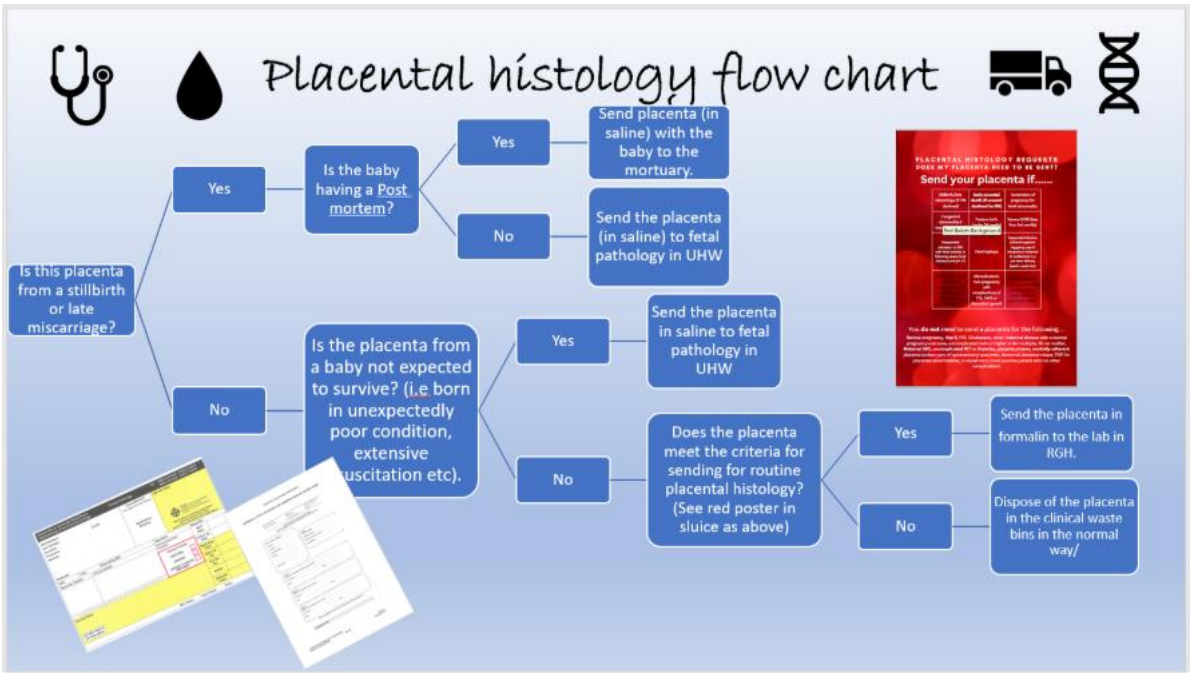
Appendix 7


Gaining consent for Perinatal Post-Mortem
Give parents the leaflet 'Post-mortem Guide for Parents' and briefly discuss
Once they have had time to read the leaflet, sit with them and discuss their options in more detail and answer any questions they have.
If they decide to go ahead with post mortem complete the All Wales consent for post mortem form. This must be completed by a trained consent taker. Their name must be on the register in UHW.
Once the consent form is complete, scan it and the 'Request for Perinatal, Fetal and Neonatal post mortem' form and email them to ellie.tawton@wales.nhs.uk for confirmation they have been completed correctly
Ensure the family know they have time to change their mind (as documented on the consent form). Tell them where the baby will be taken and give estimated time for baby to be returned to GUH
When the family are ready and when the time to change their mind has elapsed, transfer the baby to the mortuary and arrange transport to UHW for post-mortem to be carried out (see ward clerk or bereavement midwife)
When the baby is returned to GUH the bereavement midwife will notify the family and they can contact their Funeral Director for collection.

Appendix 8

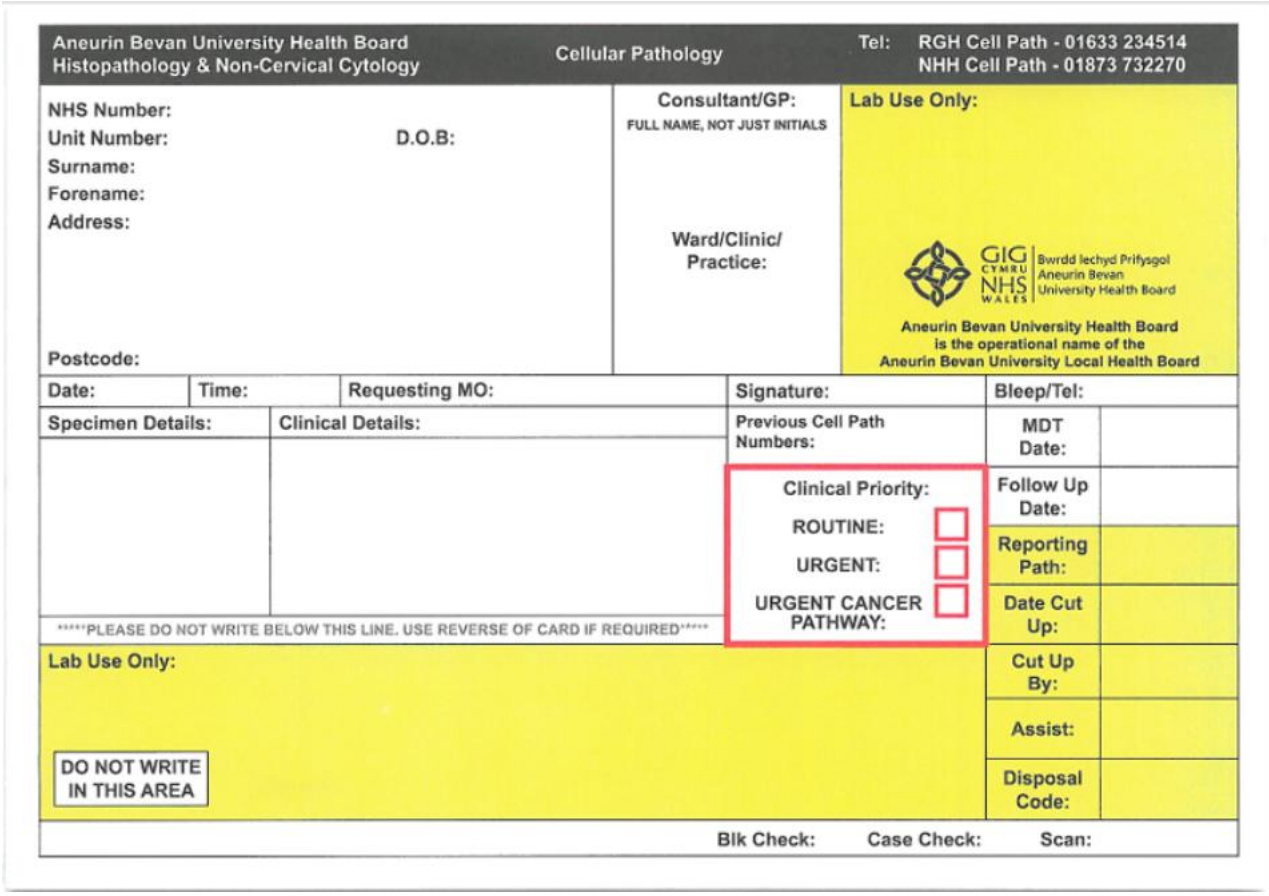
Placenta pathways





Appendix 9

Histopathology form



Aneurin Bevan University Health Board
Histopathology & Non-Cervical Cytology

Cellular Pathology

Tel: RGH Cell Path - 01633 234514
NHH Cell Path - 01873 732270

NHS Number:
Unit Number: D.O.B:
Surname:
Forename:
Address:

Postcode:

Consultant/GP:
FULL NAME, NOT JUST INITIALS

Ward/Clinic/
Practice:

Lab Use Only:

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Aneurin Bevan University Health Board
is the operational name of the
Aneurin Bevan University Local Health Board

Date:	Time:	Requesting MO:	Signature:	Bleep/Tel:

Specimen Details:	Clinical Details:	Previous Cell Path Numbers:	MDT Date:	
		Clinical Priority: ROUTINE: ☐ URGENT: ☐ URGENT CANCER PATHWAY: ☐	Follow Up Date:	
			Reporting Path:	
			Date Cut Up:	
*****PLEASE DO NOT WRITE BELOW THIS LINE. USE REVERSE OF CARD IF REQUIRED*****			Cut Up By:	
Lab Use Only: DO NOT WRITE IN THIS AREA			Assist:	
			Disposal Code:	

Blk Check: Case Check: Scan:

Appendix 10

Chain of Custody form (sample)

Cardiff and Vale University Health Board

APPENDIX 13: FETAL PATHOLOGY UNIT TRANSFER CHAIN OF CUSTODY FORM

Cardiff and Vale UHB	Revision: 1.0	Filename: MF-HIS-FPUPorters
Cellular Pathology Services	Author: B Jenkins	Authorised by: S Gibbs
	Date of issue: 11/09/2012	Page 1 of 1

Cardiff and Vale University Health Board
Fetal Pathology Unit Tissue Transfer Chain of Custody Form

Box 1 Name of Mother

Surname.....

Forename.....

Hospital Number.....

Address.....

.....

.....

Date of Birth.....

Box 2
Date of transfer.....

Specimen type.....

Referring Hospital / Ward.....

Fax Number.....

PART A.
Signature of consigner (Cardiff and Vale UHB).....

Print name.....

Date.....Time.....

PART B.
Signature of transport driver / porter.....

Print name.....

Date.....Time.....

PART C.
Signature of consignee (FPU, UHW).....

Print name.....

Date.....Time.....

The completed form will be faxed to the number included in Box 2.

MANAGEMENT FORM

Appendix 11

Mortuary notification sheet

MATERNITY AND NEONATAL ONLY

Mortuary Notification Sheet (Including infection status)

Ward or Clinical Area..... Hospital.....

TO BE COMPLETED BY MEMBER OF STAFF PREPARING BABY FOR TRANSFER TO GUH MORTUARY

PLACE ADDRESSOGRAPH HERE *If addressograph is unavailable, write Name, Address, DOB and Hospital Number	**BABY'S DATE OF BIRTH:** **GESTATION or AGE AT DEATH:**
Is the deceased or mother a **known or potential** source of infection? (i.e. chorioamnionitis, HIV, Hep B etc) **YES** **NO**	**Name of infection if applicable:**
Is this case a Coroner referral? YES NO Awaiting decision	

Is this baby having a post-mortem? **YES** **NO** **AWAITING DECISION (NEONATAL UNIT ONLY)**

If **YES** confirm the following is complete and will be transferred with the baby to the mortuary at GUH:

- ☐ **COMPLETED PM CONSENT FORM (maternity and neonatal)**
- ☐ **COMPLETED REQUEST FOR FOETAL, PERINATAL OR INFANT POST-MORTEM EXAMINATION (maternity only)**
- ☐ **COMPLETED CHAIN OF CUSTODY FORM (maternity and neonatal)**

IMPORTANT NOTES: Not all infected patients display symptoms; therefore some infections may not have been identified at the time of death.

DECLARATION TO BE COMPLETED BY REGISTERED MIDWIFE/REGISTERED NURSE PRIOR TO TRANSFER TO MORTUARY

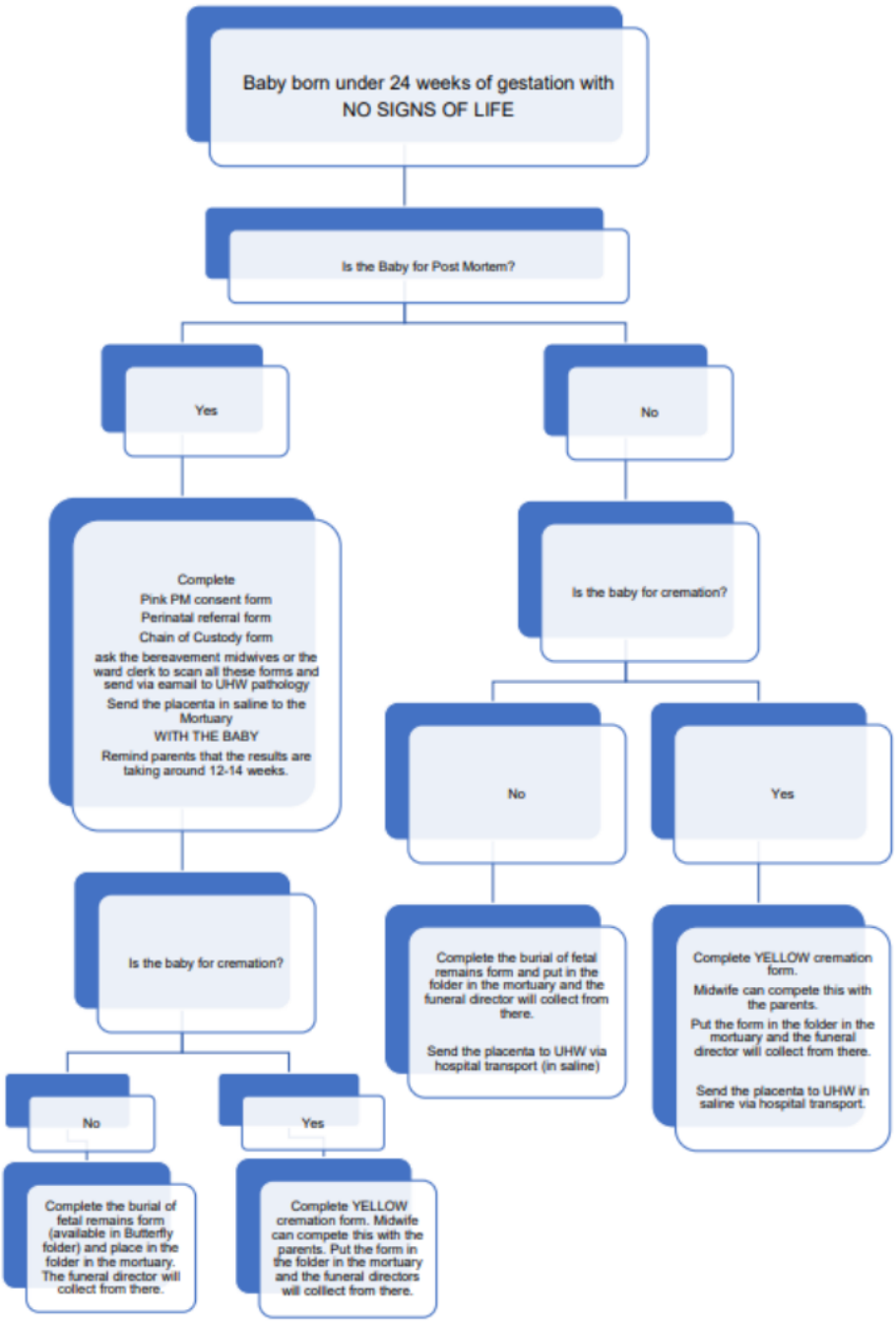
Print name:_____ **Signature:**_____

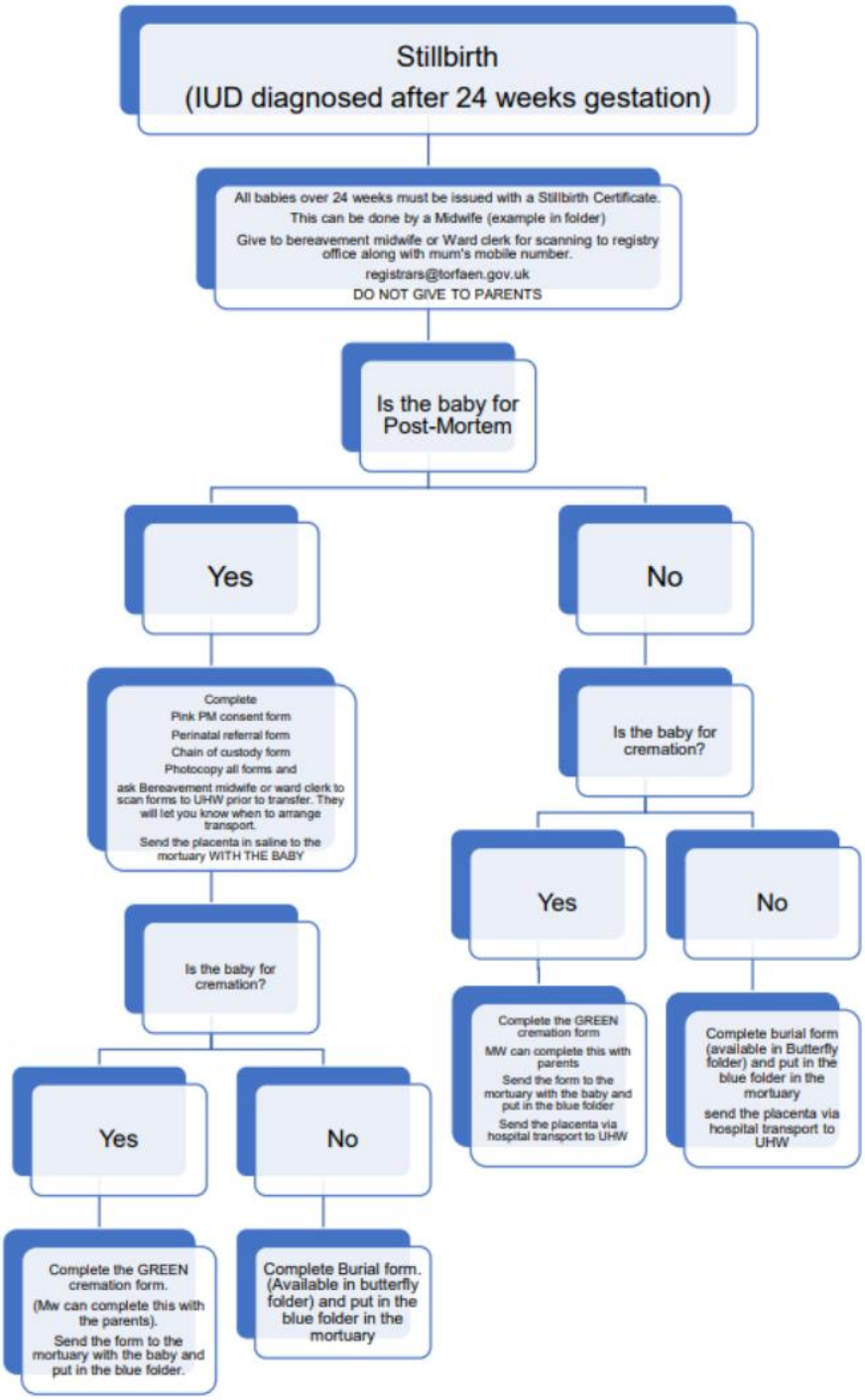
I confirm that:

- ☐ Two identification bands are attached to the baby
- ☐ Baby is dressed or swaddled (and wrapped in wadding or wooden miscarriage box used)
- ☐ This notification sheet is completed in full
- ☐ I have completed the cremation/burial form and put in the folder by the fridge (Stillbirth and late miscarriage only)
- ☐ I will stay until the transfer into cold storage is complete
- ☐ The mortuary register must be completed (handwritten – do not use addressograph label in book)
- ☐ This notification sheet must be placed in the appropriately labelled box in the mortuary, NOT attached to the baby due to infection control
- ☐ Family cannot escort the deceased into the mortuary

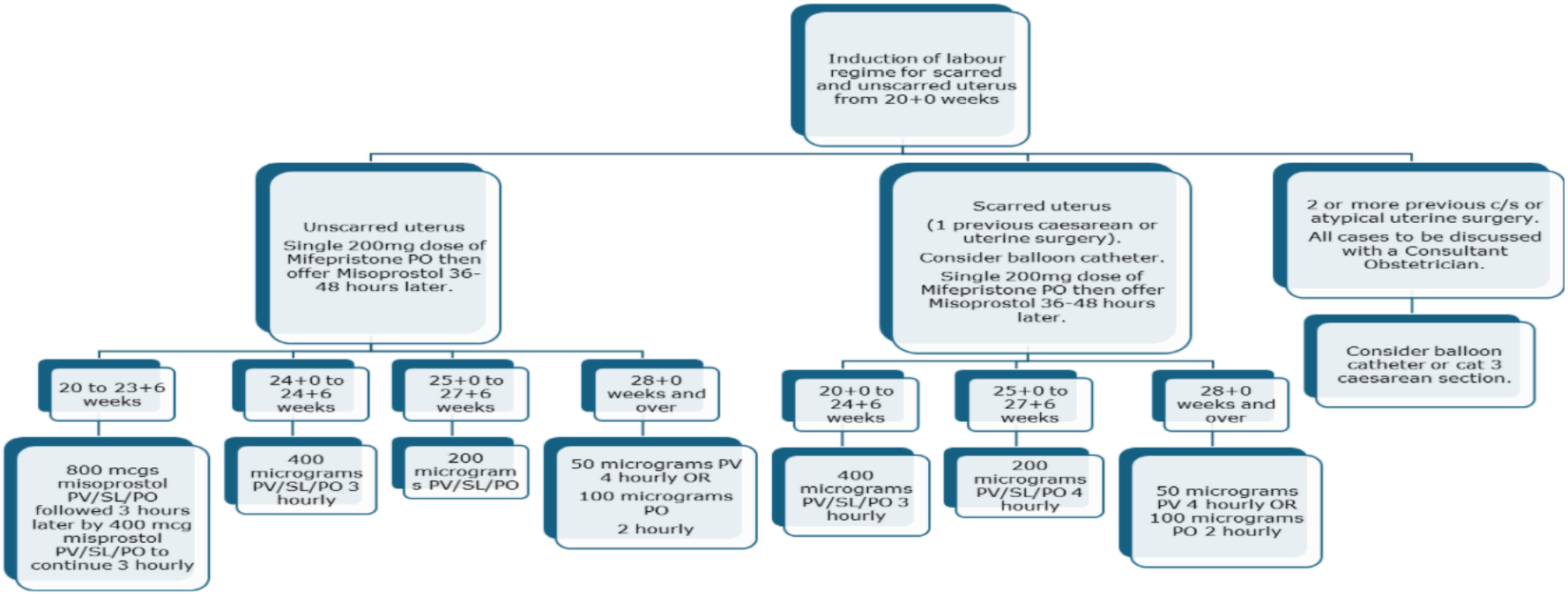
Appendix 12

Flowcharts for paperwork




Stillbirth
(IUD diagnosed after 24 weeks gestation)
All babies over 24 weeks must be issued with a Stillbirth Certificate.
This can be done by a Midwife (example in folder)
Give to bereavement midwife or Ward clerk for scanning to registry office along with mum's mobile number.
registrars@torfaen.gov.uk
DO NOT GIVE TO PARENTS
Is the baby for Post-Mortem
Yes
No
Complete
Pink PM consent form
Perinatal referral form
Chain of custody form
Photocopy all forms and
ask Bereavement midwife or ward clerk to scan forms to UHW prior to transfer. They will let you know when to arrange transport.
Send the placenta in saline to the mortuary WITH THE BABY
Is the baby for cremation?
Yes
No
Complete the GREEN cremation form.
(Mw can complete this with the parents).
Send the form to the mortuary with the baby and put in the blue folder.
Complete Burial form. (Available in butterfly folder) and put in the blue folder in the mortuary
Is the baby for cremation?
Yes
No
Complete the GREEN cremation form
MW can complete this with parents
Send the form to the mortuary with the baby and put in the blue folder
Send the placenta via hospital transport to UHW
Complete burial form (available in Butterfly folder) and put in the blue folder in the mortuary
send the placenta via hospital transport to UHW

Appendix 13
Medication flow chart



NB: If labour has not commenced after five doses of misoprostol, the case must be reviewed by a consultant to reassess the clinical management plan.