Aneurin Bevan University Health Board

SOP for paperwork when a baby is born with signs of life at 20-22+0 weeks

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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(Prior to 22 weeks)

FORM FOR REFERRAL OF DEATH TO HM CORONER 11

1. Introduction/Overview

This document is a clinical guideline to promote safe and effective practice to clinicians working within maternity services and looking after families who experienced perinatal loss.

2. Statement

To provide support for clinical decision making. When a baby is born following medical termination of pregnancy for maternal reasons, termination of pregnancy for fetal abnormalities, or spontaneously, between 20 and 22+0 weeks of pregnancy it is important to be aware of the correct documentation required to process the birth and death. The death of a baby at any stage of pregnancy is upsetting and stressful both for the family and for the staff involved. Therefore, it is imperative to understand the legal requirements. This will enable staff to keep the family fully informed and feel confident in giving this information to them.

3. Aims/Purpose

To ensure staff are aware of the documentation legally required to be completed following the birth of a baby born spontaneously with signs of life between 20 and 22+0 weeks, where survival focussed care is not appropriate, or following a termination of pregnancy where feticide has not been carried out. It aims to reduce the confusion and distress experienced by parents and provides healthcare professionals with guidance for the assessment of new-born babies who are born before 24 weeks of pregnancy. In turn, the guidance will also improve the consistency and accuracy of the registration of births and deaths and reduce the occurrence of paperwork errors. This can cause additional distress to families at an already difficult time.

4. Objectives

The objective of the guideline is to ensure consistent high-quality care. This guidance is to be used as an adjunct to the *ABUHB Integrated Care Pathway For Termination of Pregnancy for Fetal Abnormality and Integrated Care Pathway ABUHB Pathway for Stillbirths, Intra Uterine Deaths (IUD's), Late Miscarriage over 20 weeks,* when supporting families whose baby is born:

- Spontaneously in hospital, with signs of life prior to 22+0 weeks gestation where survival focussed care would not be appropriate
- Following a termination of pregnancy where feticide has not been performed

5. Scope.

This SOP is for the use of all staff involved in the care of families who experience a perinatal loss.

6. Roles and Responsibilities.

It is the responsibility of the maternity and obstetric teams to ensure that this SOP is followed when providing care to families whose babies are born with signs of life (as clarified).

7. Main Body.

Establishing signs of life.
To be considered to have been born alive a baby must have delivered completely from its mother body and have shown sustained signs of life. There is no legal definition of what a sign of life is. However, the following (but not limited to) are generally accepted: breathing, crying, sustained gasps, a heartbeat, pulsing cord, definite movements of voluntary muscles.

Sensitive and effective communication can reduce the distress parents experience at this time. Families who have been counselled prior to a termination of pregnancy will already have been informed of the chance that their baby could be born with signs of life, (if they are between 20 and 22 weeks and have not had feticide). They will also have been counselled that their case will need to be referred to the coroner's office as per Coroner's Guidance 45 (see reference list). They must also have it explained to them that babies who die just before birth sometimes show brief reflex movements, but that these are not signs of life. A baby born with signs of life may do so for a few minutes or several hours. A doctor will be asked to attend to confirm this.

Guidance for staff:
When a baby is born **spontaneously** at 20-22+0 weeks with signs of life (SOL) and survival focussed care is not appropriate an obstetric doctor should be asked to observe sustained signs of life in the baby (see appendix 1). They must then revisit the baby when the signs of life have stopped and confirm time of death. This must be done sensitively and with an appreciation of the wishes of the parents.

The doctor is then requested to send a referral to the Medical Examiner's Service (MES) who will offer guidance and support on the completion of the MCCD (see appendix 3). The bereavement midwife can help with this when available.

NB: In the rare circumstance i.e. due to high acuity that a doctor is unable to observe signs of life in the baby, a referral must instead be made to the coroner directly. The doctor confirming the death would need to notify the coroner of the death citing that the death was being referred as there was no attending doctor to issue the MCCD. They would be asked to give a cause of death to the best of their knowledge and belief. If the coroner feels the death has been unnatural, they will investigate. If the coroner feels that the death does not meet the threshold for investigation, they will then authorise the medical examiner's service to proceed with completion of the MCCD.

If the baby is born with signs of life following a **termination of pregnancy** either for fetal abnormalities or for maternal reasons, an obstetric doctor should observe any sustained signs of life in the baby (see appendix 1). They should then revisit the baby when the signs of life have stopped and confirm time of death. This must be done sensitively and with an appreciation of the wishes of the parents.

They must then complete the 'Form for Referral of Death to HM Coroner' (see appendix 4). This form is available on the '*ABB maternity team*' ABB Maternity Team - Home SharePoint and is to be completed electronically, in full and with the authorisation of the Obstetric Consultant.

When complete, attach it to an email and send it to the Coroner's office (gwent.coroners@newport.gov.uk) and please CC the bereavement midwife (abb.bereavementmidwives@wales.nhs.uk) and the Care After Death team (cadteam@wales.nhs.uk). See appendix 2 for further information about documentation).

8. Resources

There is further information available regarding the paperwork needed for this process in the 'ABB maternity team' SharePoint ABB Maternity Team - Home and in the bereavement information folder on the labour ward.

9. Training

The bereavement midwife is available for training updates as required and there are support videos available on the TIMMS website https://timms.le.ac.uk/signs-of-life/

10. Implementation

This guideline is to be used with immediate effect by all staff responsible for the care of families whose baby is born showing signs of life 20-22 weeks' gestation.

11. Further Information Clinical Documents

For additional clinical care guidance see the *'ABUHB integrated care pathway for loss over 20 weeks of pregnancy'* and *'ABUHB Integrated Care Pathway For Termination of Pregnancy for Fetal Abnormality'*

13. Equality

There are no identified impacts on equality. This SOP ensures equitable care for all those experiencing the loss of a baby.

15. Audit

Compliance will be monitored by the bereavement midwife.

16. Review

This SOP will be reviewed in 3 years.

17. References

National clinical guidance for the determination of signs of life following spontaneous vaginal births before 24 weeks of gestation where active survival-focused care is not appropriate. signs-of-life-guidance-document.pdf (rcm.org.uk)

Visual summary: Visual summary | Signs of life | MBRRACE-UK (le.ac.uk)

Chief coroner's guidance no. 45: Stillbirth, and live birth following a termination of pregnancy.

18. Appendices

Appendix 1

Signs of life guidance for staff

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

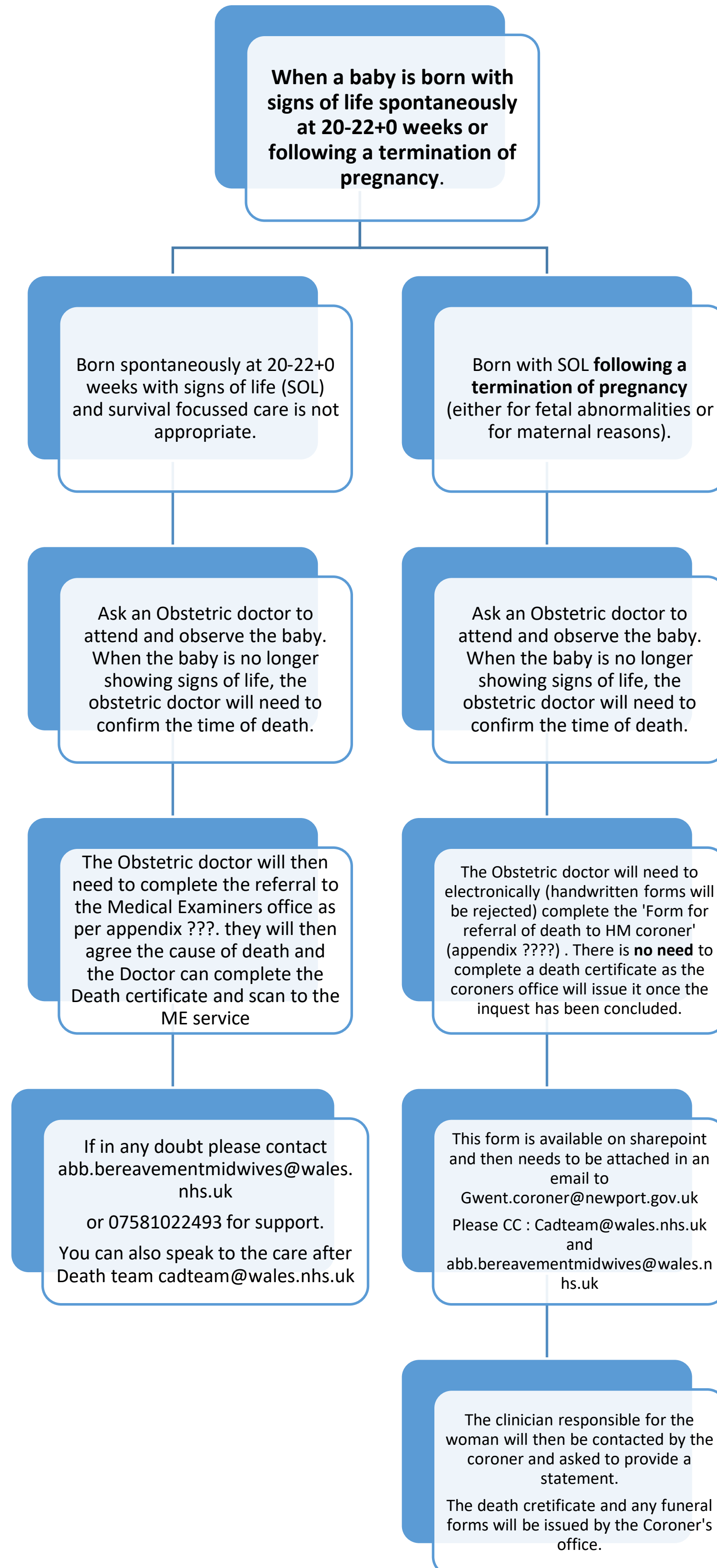
UK-wide:	Document the miscarriage. There is no legal requirement to register births before 24^{+0} weeks but sensitively offer parents informal 'certificate of loss' or 'certificate of birth'.

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
Flow chart for documentation



Appendix 3
Medical Examiners Service process

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 Service (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:

- Referral to the MES office via their 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

- An MCCD for babies born within first 28 days of birth (four pages) once the cause of death has been agreed by the ME.

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 **Coroner's 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 will issue the burial/cremation paperwork. However, there may be occasions where their duty to investigate is not met, and the MES is notified for scrutiny.
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
abb.bereavementmidwives@wales.nhs.uk
07581022493 Mon-Fri 8-4.
If the bereavement midwife is not available please contact the care after death team
01443802406

Appendix 4

Coroners referral form (to be completed electronically. Not to be handwritten)

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:	

5. Summary of previous medical history, including GP details and any prescribed medication

6. Date of admission and nature of admission (Acute/Elective etc.) – was this an unplanned admission after a recent discharge? If so, from what healthcare facility was the patient discharged?

7. Working diagnosis on admission and the reasoning for that

8. Summary of events during admission

9. Circumstances of death

10. Was the death expected?

11. Was there: Any delay in admission of the patient?	Yes ☐ No ☐
(if yes give details)	

12. Any delay in recognition of the patient's condition?	Yes ☐ No ☐
(if yes give details)	

13. Any delay in commencement of appropriate treatment?	Yes ☐ No ☐
(if yes give details)	

14. Any adverse drug reaction?	Yes ☐ No ☐
(if yes give details)	

15. Did the patient develop an infection whilst in hospital?	Yes ☐ No ☐
(if yes give details)	

16. Any injury sustained whilst in hospital?	Yes ☐ No ☐
(if yes give details)	

17. Any complication during surgery or other intervention?	Yes ☐ No ☐
(if yes give details)	
18. Any complication which cannot be explained as an accepted consequence of diagnosis or treatment?	Yes ☐ No ☐
(if yes give details)	

19. Any unplanned transfer from one speciality to another (including ITU)	Yes ☐ No ☐
(if yes give details)	

20. Has there been anything in this patients clinical course which has been described as a "never event"?	Yes ☐ No ☐
(if yes give details)	

21. Has the patient been subject to a POVA, DOLS process or MHA?	Yes ☐ No ☐
(if yes give details)	

22. Has any member of the family, or any person acquainted with the patient expressed any concern regarding the care given by the hospital, or by any other healthcare professional?	Yes ☐ No ☐
(if yes give details)	

23. Having regard to the above, do you consider it more likely than not that the management of this patient has caused, or made a significant contribution to the death?	Yes ☐ No ☐
(if yes give details)	

24. Is the death related to an industrial exposure? (coal dust, asbestos, chemicals etc.)	Yes ☐ No ☐
(if yes give details)	

25. Please set out a proposed cause of death on the balance of probabilities	
1a	
1b	
1c	
2	
If the cause of death cannot be given, on the balance of probabilities, please explain:	

Reporting Doctor Details	
Name:	
Contact number:	
Bleep number:	
Grade:	
Speciality:	
GMC Number:	
Secretary details if applicable (name and number):	

Has the case been discussed with a pathologist?	Yes ☐ No ☐
Name:	

THIS REFERRAL WILL NOT BE ACCEPTED UNLESS ITS CONTENTS HAVE BEEN REVIEWED & APPROVED BY THE RESPONSIBLE CONSULTANT