Reference Number: *UHBOBS135* **Version Number: 5a**	**Date of Next Review:** *11/03/2022* **Previous Trust/LHB Reference Number:**

Guidelines for the management of all childbearing losses (stillbirths, miscarriages, TOP's and neonatal deaths) on the CLU & MLU

Introduction and Aim

- This guideline covers definition of Miscarriage, Medical Termination of Pregnancy, Stillbirth and Neonatal death, including diagnosis, management of the labour, investigations of the pregnant women and her baby and information on disposal of the fetus.
- In addition supporting documents are within the Fetal Remains, Stillbirth and Neonatal Death Policy UHB 218 which underpins this guideline.
- Overall the theme should be one of sensitive communication.
- The All Wales Clinical and Bereavement Care Standards should be considered when providing care to Bereaved parents.

Objectives

- To ensure that the Health Board has appropriate, lawful provision to ensure the dignified and sensitive management and final disposal of all pregnancy remains and fetal material.
- To provide concise guidance to the multi-disciplinary team on how to manage other gestational loss including, stillbirth and babies following neonatal death.
- Parents should always be treated with respect and dignity and should be supported with genuine sensitivity and empathy.
- Each parent's personal preferences and cultural or religious needs should be taken into account.
- To ensure women or couples are made aware that information on disposal options is available, and are consulted with, and given the opportunity to make an informed decision and to express any personal wishes.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Whilst the policy and procedure does not specifically relate to the Health Boards contractors, as a UHB wide policy, elements of it may be used as good practice guidance in Primary Care.

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed. (please delete as necessary) Where it has not been completed indicate why e.g. 'This is because a procedure has been written to support the implementation the ……. Policy.*

	The Equality Impact Assessment completed for the policy found here to be a negative/positive/no impact.
Documents to read alongside this Procedure	• Fetal Remains, Stillbirth and Neonatal Death Policy UHB 218 • UHB 218 Fetal Remains, Stillbirth And Neonatal Death Policy Version 2 • Guidance for Transferring a Deceased Baby or Child
Approved by	*Maternity Professional Forum*

Accountable Executive or Clinical Board Director	*Title of post holder* Ruth Walker
Author(s)	*Teardrop team*
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Dec 2005	Dec 2005	
2	Dec 2008	Dec 2008	Reviewed and amended by A Rees
3	Dec 2011	Dec 2011	Reviewed and amended by A Rees / J Herve
4	Aug 2012	Aug 2012	Reviewed and amended by P Amin
5	Feb 2019	Apr 2019	Reviewed and amended by Monique Latibeaudiere, Consultant Obstetrician and Laura Wyatt, Bereavement Midwife
5a	Mar 2022	Mar 2022	Addition of “Maternal Investigations Following Intrauterine Death” and Teardrop Team Information Leaflet

			included in this guideline as appendices (Section 18). No further change to content.

1 Table of Contents

Contents

1 Table of Contents 4
2 Introduction 7
2.1 Definition: 7
2.1.1 Gestational loss of less than 24 weeks 7
2.1.2 Medical Termination of pregnancy for fetal anomaly 7
2.1.3 Stillbirth 8
2.1.4 Neonatal Death 8
3 Diagnosis of and clinical management of intrauterine fetal demise on presentation to all the clinical areas: 9
3.1 Confirming the Diagnosis of an intrauterine death 9
3.2 When communicating confirmation of intrauterine death with the parents, ...9
3.3 Discussion of Labour and Birth 10
4 Termination of pregnancy 13
4.1 Procedure prior to admission for Medical Termination of Pregnancy 13
4.1.1 Consent: 13
5 Intrapartum stillbirth 15
6 Medical Management of Induction of Labour and Delivery 16
6.1 Induction Regime 16
6.2 On Admission 19
6.3 During Labour 20
6.4 Birth 21
7 Care of the baby following late miscarriage, Medical termination of pregnancy for fetal anomaly, Stillbirth and Neonatal death 22
7.1 Seeing and holding their baby 22
7.2 Multiple births 22
7.3 When parents are undecided about seeing or holding their baby 22
7.4 When the baby has an anomaly or is macerated 23
7.5 Creating Memories 23
8 Post Loss Investigations 27
8.1 Anti D 27
8.2 Maternal Investigations 27

8.3 Placenta to be sent to Histopathology 27
8.4 Post-mortem examination (PM) 28
8.4.1 Transfer of fetus or baby and paperwork required when transferring to FPU or the Mortuary 29
9 Registration and Certification 31
9.1 Registration and Certification for a dead baby born before 24 weeks gestation 31
9.2 Babies born at or after 24 weeks, but had died before 24 weeks 31
9.3 Registration and Certification for a baby born alive before 24 weeks gestation and then dies 31
9.4 Registration and certification for Stillbirths 32
9.5 Registration and Certification following a Neonatal death 33
9.6 Certification for an Intrapartum stillbirth 33
10 If a Baby is Born Showing Signs of Life following a miscarriage or Medical Termination of Pregnancy? 35
10.1 Certification following a termination if the baby is born alive and then dies 36
11 Funeral arrangements 37
12 Postnatal care for women following baby loss 38
12.1 Offering and giving Cabergoline to suppress lactation 39
12.2 Communication to all key staff 39
12.3 Reporting process 40
12.4 Discuss contraception options 40
12.5 Emotional support 40
12.6 Discharge home and aftercare 41
12.6.1 Leaving the hospital 41
13 Rights and benefits following Stillbirth and Neonatal death 43
13.1 For parents who lost a baby before 24 weeks 43
13.2 For parents who lost a baby after 24 weeks, or if the baby was born alive at any stage of pregnancy and then died 43
14 Follow up appointment 44
15 Stillbirth Review Forum 45
16 Next pregnancy 46
17 References 47
18 Appendices 48
18.1 Neonatal Birth Record Following Intrauterine Death 48

18.2 Maternal Investigations following Intrauterine Death (Any Gestation) 49

18.2.1 At diagnosis & with immediate Care – for all women 49

18.2.2 Further Investigations 49

18.2.3 Postnatal Investigations – all women 51

18.3 Teardrop Team Information for Parents 52

2 Introduction

Providing families with good quality care is paramount in supporting them in dealing with the loss of a baby. This guideline covers the definitions of loss, less than 24 weeks gestation, medical termination of pregnancy for fetal anomaly, Stillbirth and Neonatal death. It will include the diagnosis of an intrauterine demise, the management of labour, birth and care in the postnatal period including any further investigations required that should be considered. This guidance will further provide guidance for the registration process and information on the sensitive disposal of fetal remains and funeral arrangements in line with the **UHB Fetal Remains, Stillbirth and Neonatal death Procedure** which can be accessed on the clinical portal http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/315957

Overall the theme should be one of sensitive communication and parents should be treated with respect and dignity and supported with genuine sensitivity and empathy.

Back to Contents

2.1 Definition:

2.1.1 Gestational loss of less than 24 weeks

A miscarriage is defined as 'spontaneous premature expulsion of a fetus from the womb' (https://www.tommys.org/pregnancy-information/pregnancy complications/miscarriage).

Early pregnancy loss may be due to a variety of reasons, including ectopic pregnancy, hydatidiform mole, spontaneous miscarriage and therapeutic termination of pregnancy. Each patient is treated on an individual basis and any intervention, medical, conservative or surgical, is in line with the woman's wishes ensuring informed consent.

Back to Contents

2.1.2 Medical Termination of pregnancy for fetal anomaly

As most women whose baby is diagnosed with a severe fetal anomaly decide to terminate the pregnancy, midwives and other staff working with pregnant women should be aware of all the termination options. This will help to ensure that parents receive the best and most supportive care possible when making decisions about termination.

(N.B. Feticide is a pre requisite prior to induction in cases of termination for fetal anomaly at gestation more than 21+6 weeks.)

Back to Contents

2.1.3 Stillbirth

The Perinatal Mortality Surveillance Report (MBRRACE 2017) define stillbirth as a baby delivered with no signs of life known to have died after 24 weeks of pregnancy, Intrauterine fetal death refers to babies with no signs of life in utero.

Stillbirth is common, 1 in 200 births ends in Stillbirth, with 1 in 3 Stillbirths occurring after 37 weeks gestation. (MBRRACE 2017)

Back to Contents

2.1.4 Neonatal Death

A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born (*MBRRACE-UK Perinatal Mortality Surveillance Report Trusts and Health Boards, UK Perinatal Deaths for 2015 Births)*

Back to Contents

3 Diagnosis of and clinical management of intrauterine fetal demise on presentation to all the clinical areas:

Intrauterine fetal death presents with decreased fetal movements in as many as 50% of cases. Others may present as an unexpected finding at a routine ultrasound or antenatal visit, or with signs of an acute event such as abruption, severe pre-eclampsia, ruptured membranes or the onset of labour.

When an IUFD (intrauterine fetal demise) is suspected it is important to establish the diagnosis as soon as possible. It is also vital to establish whether the mother is clinically well. Severe pre-eclampsia and acute abruptions are the two most common life-threatening conditions associated with IUFD.

On admission to labour ward or the Obstetric assessment unit

Back to Contents

3.1 Confirming the Diagnosis of an intrauterine death

Where, when and what we communicate with families experiencing the loss of a baby can have lasting effects on their process of acceptance and grief. Family centred care means actively listening to and responding to concerns, requests and the story of their loss and their experience of maternity services.

Fetal death must be diagnosed by ultrasound. Cardiotocography can be very misleading; the heart rate tracing of an anxious mother may be mistaken for that of a fetus. Even heart rate tracings achieved by scalp electrode can record the maternal heart rate when the fetus is dead.

A diagnosis of intrauterine fetal demise should be by ultrasound scan and not by a Pinnards stethoscope, handheld Doppler or CTG monitor. Where feasible, a clinician of appropriate seniority (registrar or consultant) and with training in ultrasound scanning should confirm the diagnosis of fetal demise (RCOG best practice). A second opinion should be obtained whenever practically possible.

Back to Contents

3.2 When communicating confirmation of intrauterine death with the parents,

- Ensure that the environment meets the needs of the family's privacy and dignity avoiding any unnecessary interruptions during this time. Ensure there is no delay in obtaining Senior Obstetric review.
- Discuss plan of care with the Consultant Obstetrician for labour ward.

- Keep the language simple, do not use acronyms and all communication whether verbal or written must be provided in lay terms. Offer your condolences and ensure where possible introductions are made to the family of the team providing care. If the woman is unaccompanied, an immediate offer should be made to call her partner, relatives or friends. Discussions should aim to support maternal/parental choice. Trained interpreters and signers should be accessible for parents who need them

- A careful, sensitive explanation and a flexible approach are necessary. It is essential to avoid delay and the diagnosis of an intrauterine death. Adopting a sensitive approach and use unambiguous language. eg "***I am sorry your baby had died".***

- Mothers should be prepared for the possibility of passive fetal movements. If the mothers reports passive fetal movement after the scan to diagnose IUFD, a repeat scan should be offered.

- If there is one or more surviving sibling from a multiple pregnancy, do not focus solely on them. Acknowledge the baby who had died. Recognise the challenge that the parents face in celebrating the arrival of one baby and the tragic death of the other baby or babies.

- Where the woman is rhesus negative, a Kleihauer should be performed at presentation and at 48 hours in case a larger dose of anti D is required. Anti D should be given at presentation to all rhesus negative women with an IUFD. If possible the fetal blood group should be ascertained on cord blood testing. **All women should have a Kleihauer test regardless of rhesus status.**

Back to Contents

3.3 Discussion of Labour and Birth

Recommendations about labour and birth should take into account the mother's preferences as well as her medical condition and previous intrapartum history (RCOG Green –top Guideline No 55 October 2010). The general management of labour will be in accordance with the Intrapartum Care guideline set by the UHB. It is however acknowledged that women who have experienced a fetal loss are more likely to need extra emotional support and encouragement to keep going during the labour and birth. In any situation where there is a choice to be made, parents should be listened to and given the information and support they need to make their own decisions about what has happens to them and their baby.

When the woman is clinically unwell, i.e. in association with an abruption, PET or sepsis, she should be stabilised/ resuscitated and delivered by the safest means after discussion with the on-call consultant. There is seldom place for

caesarean section. A more flexible approach can be discussed if these factors are not present.

Where the woman is well and wishes to go home, her wishes should be respected and appropriate follow-up arranged. Ensure that families have a point of contact if they have any questions or concerns that they may seek support with before admission. Parents should be offered written information to supplement discussions. There is Information packs available, gestation specific on the Obstetric Assessment Unit.

Delivery should be encouraged within 48 hours. DIC is unlikely (10% risk after 4 weeks of fetal death RCOG).

The following conditions are also more common with intrauterine fetal death: (ref)

- Chorioamnionitis
- Pre-eclampsia
- Retained placenta
- Postpartum/Antepartum haemorrhage

Therefore a low threshold should be adopted for:

- Antibiotics
- Manual removal of placenta
- Oxytocics

Vaginal birth is encouraged and can be achieved within 24 hours of induction of labour in about 90% of women (unless contraindicated on medical grounds).

This is usually achieved with a combination of Mifepristone and Misoprostol (See induction table on Page 9).

If the decision for a Post Mortem (PM) has not been made at this time, parents should be warned that the results of PM may be less helpful and that the baby's appearance may have deteriorated.

Ensure care is provided in the safest environment whether this is for induction of labour, labour or caesarean section. The woman and her family should have their place of care discussed to avoid any misunderstanding about their plan of care. Admission should be booked and clearly documented in the IUFD/MTOP diary on the labour ward for the **Snowdrop room.**

Ideally there should be no more than **one** admission booked per day; this is to ensure that the appropriate environment and care can be provided for the patients and to ensure appropriate support for the staff.

Parents should have a point of contact if they have any questions or concerns they may seek support with before admission and on discharge home.

Back to Contents

4 Termination of pregnancy

Women undergoing termination of pregnancy for fetal abnormality will already have been counselled in advance either in the Fetal Medicine Unit or in antenatal clinic.

Feticide is recommended at gestations of more than 21+6 weeks, but is not mandatory (RCOG working party report: Termination for fetal abnormality in England, Scotland and Wales). If feticide has not been performed parents need to know that if the baby is born showing signs of life the law states that the baby must be registered as a neonatal death and a funeral will need to be arranged by the parents.

Back to Contents

4.1 Procedure prior to admission for Medical Termination of Pregnancy

4.1.1 Consent:

• Consent must be taken for the termination of pregnancy and include discussion around any other procedures that may be necessary such as manual removal of placenta. Consent can be taken when the decision to commence the termination is made.

• Consent for post-mortem should be discussed. Couples may wish time to consider their views. The consent form can be signed at any time once the counselling is complete. Consent must be obtained from the woman.

• Ensure a blue **certificate A** TOP form is completed and filed in the notes.

• The yellow HSA4 must be signed by the person who is performing the feticide or if feticide has not been performed, the person taking consent for the termination procedure and prescribing the Mifepristone must sign.

• Take blood for full blood count (FBC) and group and save (G&S)

• Mifepristone should be given according to the protocol and prescribed on the medication chart. The chosen misoprostol regime should be clearly prescribed before admission.

• The woman should be informed of any possible side effects of Mifepristone and Misoprostol before she goes home.

- Make arrangements to return to the labour ward in approximately 48 hours and provide contact details to the woman for support and information. The woman should have access to the Snowdrop room

- Ensure the notes are clearly marked so that the admitting team realises that the woman is coming in for termination of pregnancy, ensuring inappropriate care is avoided (the induction diary should clearly state the reason for admission)

- For all parents care should remain non-judgmental and supportive.

- Document the discussion with parents about the choices for care (e.g. chaplaincy involvement, funeral arrangements, memory box etc.)

- Ensure community midwife is informed in case the woman seeks advice from them.

THE YELLOW HSA4 FORM MUST BE COMPLETED FOLLOWING DELIVERY AND SENT TO THE DEPARTMENT OF HEALTH WITHIN 14 DAYS OF THE TERMINATION. THIS IS A LEGAL REQUIREMENT.

Back to Contents

5 Intrapartum stillbirth

The categorisation for unexpected stillbirths must lie with the resuscitation team who will decide whether there were ever any signs of life in the baby. The documentation must be clear. If a death is categorised as a neonatal death it is the responsibility of the resuscitating team to write the neonatal death certificate. Consent for post-mortem should be sought by the most appropriate person and will be individual to each case. If the death is a stillbirth it is the responsibility of the obstetric team to write the stillbirth certificate and to obtain consent for post-mortem.

An incident form must be completed for all unexplained stillbirths and early neonatal deaths.

Back to Contents

6 Medical Management of Induction of Labour and Delivery

Delivery following intrauterine fetal demise should be discussed as soon as possible following diagnosis.

Options for delivery and place for delivery should be discussed with parents and the risks and benefits of each outlined. Written information should be provided.

Vaginal birth is associated with less maternal morbidity and a more rapid recovery and return to normal activity. Patients may request a Caesarean section based on their history or personal preferences. This request should be respected and there should be an opportunity to discuss this with a senior Obstetrician.

If LSCS is planned, this should be delayed no more than necessary for the maternal safety. This is likely to mean planning for inclusion on the next elective LSCS list. Routine pre-operative care should be undertaken.

Back to Contents

6.1 Induction Regime

	IUFD 17-23+6/40	IUFD >24/40	Scarred uterus> 17/40 (alternative pathway)
Day 1	Mifepristone 200mg po	Mifepristone 200mg po	Mifepristone 600mg po
Day 2 (24 hrs)			Mifepristone 600mg po
Day 3 (48hrs)	Misoprostol 400micrograms every 3 hours until delivery (5 doses)	Misoprostol 200micrograms every 4 hours (6 doses)	Misoprostol 50-100 mcg pv every 4 hours (6 doses) **Or** Cervical ripening balloon/amniotomy/oxytocin (esp if >28/40 or multiple scars)
Third stage	Further dose of misoprostol if placenta not delivered within an hour of fetus. Medical review and consideration of surgical management if patient bleeding or placenta not delivered within 1 hour of misoprostol administration		

- Induction of labour with misoprostol is as effective as induction using Gemeprost/Prostin but at a much reduced cost.

- Using mifepristone prior to administering misoprostol significantly reduces the duration of induced labour.

- Mifepristone is given 24-48 hours before misoprostol. If a reduced interval is used (for example, at the request of the patient), the efficacy may be reduced.

- Higher doses of mifepristone (eg 600mg given in 2 doses at 0 and 24h after diagnosis) reduce the amount of misoprostol required to achieve delivery. This may be of benefit in a patient with a scarred uterus. This is an unlicensed use.

- Misoprostol can be given orally, buccally or vaginally. Oral administration is less effective and may be associated with more side effects (vomiting, diarrhoea, shivering, and pyrexia) but may be the patients' preference.

- The use of misoprostol in patients with a scarred uterus is associated with an increase in the risk of scar rupture and lower doses should be used. Mechanical means (eg cervical balloons) are not associated with increased uterine rupture rates and are an alternative to misoprostol.

- Decisions about induction of labour for IUFD in patients with a scarred uterus should be made by a Consultant Obstetrician.

Discussion should take place with a Consultant obstetrician. Induction of labour with Prostaglandin carries a small risk of scar rupture. Recent guidance (RCOG, NICE) advocates, that "Misoprostol can be safely used for induction of labour in women with a single previous LSCS and an IUFD but with doses not yet marketed in the UK" and "women with more than two LSCS deliveries should be advised that the safety of induction of labour is unknown". The incidence of uterine rupture in women with previous caesarean section during Induction of Labour with Misoprostol is between 3.5%-4.4% compared to unscarred uterus. Hence extra vigilance and regular monitoring is required in women with previous caesarean section

Mifepristone 200 milligrams orally 24-48 hours prior to induction are suitable for all gestations.

The medication can be administered as an outpatient for terminations and women who wish to go home after fetal demise is diagnosed and who are stable and well.

Contraindications to Mifepristone are:

Uncontrolled severe asthma; chronic adrenal failure, porphyria

Must be used with caution in women with:

a) Severe asthma
b) Haemorrhagic disorders
c) Hepatic or renal impairment

Side effects:

a) Nausea
b) Skin rash
c) Uterine activity (tightenings)

Observations and Procedures when giving Mifepristone

a) Record blood pressure and urinalysis.
b) Administer prescribed Mifepristone.
c) Remain in hospital until the tablet has had sufficient time to have been absorbed (usually ½ hour).
d) Record pulse, BP, respirations and temperature prior to discharge home.
e) Allow to go home with instructions about when to return and with the emergency contact numbers for the hospital.
f) Use paracetamol or codeine for initial pain relief if needed (not non-steroidal or aspirin)

Readmit 24-48 hours later for the following management.

The dosage of Misoprostol is dependent on the gestation, as the uterus becomes more sensitive to prostaglandin with increasing gestation. Misoprostol is currently available in UHW in 100 and 200 microgram tablets. To achieve dosages in the range recommended by the RCOG and NICE the 100 microgram tablet must be cut into 2 with a tablet cutter to achieve 50 microgram doses. Gloves should be worn when handling tablets.

Side effects of Misoprostol:

a) Nausea,
b) vomiting,
c) diarrhoea,
d) Pyrexia and flushes.

If delivery is not achieved after 24 hours the course of Misoprostol can be repeated. It may be appropriate to allow a break of 12-24hrs before commencing a second course. Discussion should take place with a Consultant Obstetrician and the team on labour ward.

Back to Contents

6.2 On Admission

- Staff should be expecting the woman on delivery suite so that she does not need to explain herself on arrival. The parents will arrive to labour ward and ask for admission to the **Snowdrop room.**

- It is important for all members of staff including the receptionist and caterers to be aware of the woman's admission to prevent any inappropriate well-meaning comments being made and to allow a more flexible approach to visitors.

- The woman and her birthing partners should be shown immediately to Room 4 - **Snowdrop room.** If this room is already in use an alternative and suitable room should be identified (i.e. a room as far away from other labouring women and babies as is safely possible).

- Continuity of carer is important where possible. Care should be provided by a midwife with support by a senior midwife, senior Obstetrician and the Anaesthetist on duty. They should be informed of the woman's admission and clinical history and review on admission. Introduce any new members of staff

- Discuss with the woman her birth plan if she has made one. If not, this is a good opportunity to provide some information on what to expect during the labour and birth and to discuss their options for seeing, holding and creating memories with their baby. Being involved in decision making may help parents to feel a sense of control at a time when they feel that they have little or none. Document any discussions and decisions made.

  NB A sensitive approach to discussing fetal sexing should be considered when creating memories. Parents should be informed that it may be difficult to ascertain the gender of their baby at an early gestational age.

- If a change in staff or place of care is needed, talk to the parents and try to accommodate their wishes as far as possible.

- Perform a baseline set of observations to include, blood pressure, pulse, temperature, respiratory rate and oxygen saturation, and record on the

MEOWs chart. Commence the Perinatal Institute Intrapartum birth notes. These notes should be used for all fetal losses.

- Explain that there are a number of investigations and tests which we would recommend which may identify the cause of the demise of their baby. These investigations include blood tests as per checklist, postmortem examination and /or placental histology. Parents should have access to the **All Wales a Guide to the Hospital Post-Mortem Examination of a Baby or Child**. Parents can also read the SANDS postmortem information booklet which they can access from the SANDS Family Support pack or the SANDS App.

- The midwife should collect a documentation pack suitable for gestational age from the SANDS cupboard and start to complete the checklist. All intrapartum care should be documented in the yellow Perinatal institute birth notes.

- Commence the induction of labour regime as prescribed on the Prescription chart if the woman is to be induced.

Back to Contents

6.3 During Labour

- Enable the woman to have a partner or support person with her at all times. It is important that the woman and her partner feel completely supported the whole time and are never left alone unless they request privacy.

- With the woman's consent, keep her, the partner or support person informed of progress in labour and rationale for the care provided.

- Provide the partner or support person with emotional support.

- Women, who are scared, frightened or in distress can experience pain more intensely. Induction of labour also increases the pain felt by women. Pain management options should be discussed and documented in advance of labour commencing. The woman should be offered and given the departments **Pain relief following Stillbirth** information leaflet on admission (Appendix). Women should then be offered the opportunity to meet an obstetric anaesthetist to discuss analgesia and her options when required.

- Commence the labour partogram in the yellow Perinatal Institute notes once the woman is deemed to be in established labour. The partogram should be completed in all fetal loss cases and delivery clearly documented (the fetal heart rate section is not applicable).

Back to Contents

6.4 Birth

- Birth may be complicated due to fetal demise. Help, advice and support should be sought from a senior midwife or senior obstetrician if required.
- Two midwives should be present at the delivery to offer support to each other and the parents.
- Careful consideration should be made if the parents do not wish to see the baby at delivery
- Extra care needs to be taken with delivery of the placenta which can take up to an hour to deliver. Syntometrine should be given unless the woman is hypertensive in which case Syntocinon 10 IU should be used. Very gentle controlled cord traction and maternal effort may be required. Careful examination of the placenta is essential and document findings in the notes and placenta sent for histology. Remember to provide concise and accurate details including gestation, maternal and fetal implications (See appendix).
- Sometimes an ERPC (evacuation of retained products of conception) may be required. This should be managed as appropriate to the clinical situation.
- The sex of the baby must not be stated unless absolutely certain as it is distressing for the parents if this is wrongly identified.
- Perform usual post-delivery observations, postnatal check and offer of analgesia as required.
- E3 should be completed
- Datix should be completed following any Stillbirth or Neonatal death.

Back to Contents

7 Care of the baby following late miscarriage, Medical termination of pregnancy for fetal anomaly, Stillbirth and Neonatal death

7.1 Seeing and holding their baby

Parents should be offered the opportunity to create memories and spend time with their baby. The family should be treated with dignity, respect and allowed privacy. Seeing and holding their baby may be important to parents regardless of the size, condition or gestation of their baby. For parents, gestation is not an indicator of feeling for or attachment to their baby and it is important that all babies are handled respectfully and with care. It is important for healthcare professionals to offer all parents the option of seeing and holding their baby while recognising and respecting that some parents may decline this offer. It should be clearly documented in the notes and handed over to staff if the parents wish to see their baby or not. Repetitive questioning could cause further upset.

Back to Contents

7.2 Multiple births

Special consideration is also needed for the parents of twins or multiple babies. It is important that staff acknowledge the importance of the baby (or babies) who have died, and avoid focusing only on the baby or babies that are alive. If parents want to see the baby or babies who have died, it may be helpful to see and perhaps hold the living and the dead babies together if this is possible. Without this opportunity it may be difficult for parents to grasp the reality of what has happened. Later on, the parents may value the memory of being with all their babies together. It is important to ensure that ward staff are aware that the surviving baby/ies is/are part of a multiple birth.

Following birth, allow parents time and privacy with their baby if they wish. Refer to the baby by name. Members of their extended family may wish to visit. This should be facilitated.

Back to Contents

7.3 When parents are undecided about seeing or holding their baby

Some parents will want to see and hold their baby straight away while others may want time to decide. Some parents may choose to see but not to touch or hold their

baby. Some parents will decide that they do not want to see or hold their baby, and their decision should be accepted and respected. They should be told where the baby's body will be kept and that they can ask to see their baby if they change their minds. If there are time limits, this should be explained. Careful notes must be kept about what has been offered to parents and what has or has not been done to avoid parents feeling pressured or not being offered options at all.

Back to Contents

7.4 When the baby has an anomaly or is macerated

If there is a visible anomaly or maceration, parents should be gently told what to expect and be offered a description of their baby's appearance before deciding whether to see the baby. If parents accept the offer of a description, it is important that the explanation is factual and without judgement. Sometimes, it may help if the baby is wrapped in a blanket or dressed and the parents look first at the baby's other features. Some parents may want to see the anomaly. They may find this important for understanding why their baby died. Other parents may want to keep the anomaly covered if this is possible. It is important to respect the parent's choice and follow their lead while also providing them with opportunities to discuss how they feel.

Back to Contents

7.5 Creating Memories

Parents may find making memories following the death of their baby valuable and sharing these memories may be beneficial to the grieving process. Staff should be able to help by offering parents who want opportunities to create positive memories and physical keepsakes.

When suggesting to parents that they might want to create memories of their baby, staff should remember that parental choice is paramount. It is essential to offer genuine choice and not to steer parents towards a particular course of action in the belief that it will help them. However, it is important to let parents know that they can change their minds later if they decline to create memories and to "normalise" the options for creating memories that are available to parents by mentioning that many parents find this helpful. Parents should be reassured that whatever choice they make is okay.

It is important that staff ensure

- Parents are offered genuine choices.
- Parents are given time to reflect and decide what they want.
- Parents who have declined previous offers are not asked repeatedly if they have changed their minds; however parents should be gently offered

different options more than once to enable them to change their minds if they choose to do so.

- Any views the parents may have expressed earlier should be recorded and acknowledged.
- The condition of the baby is considered when discussing memory making with parents.
- Assumptions are not made about what a parent might want depending on gestation or cultural/religious background.

Making memories with the parents

- If parents decide to name their baby, (ask them if they wish to) health professionals should remember to use the name when referring to baby.

- Involve the parents in creating and making memories in the Snowdrop room, otherwise offer to examine and create memories for the parents and for the memory box in the Dignity room. Ask the parents if they wish to have the baby returned to them once the memory box and neonatal check has been completed.

- With parental consent the baby should be examined, weighed, head circumference measured and two identity bands applied. The Neonatal record sheet should be completed with appropriate details including weight, time of birth and gestation. The sex of the baby must not be stated unless absolutely certain as it is distressing for the parents if this is wrongly identified.

- Offer a memory box. We use `4 Louis` memory boxes which are kept in the SANDS cupboard on Delivery Suite. The midwife or Maternity support worker should discuss its contents with the parents and remove any items they do not wish to receive.

- Two ID bands should be applied to the baby following delivery and the Mother's ID band should be securely stapled into Maternity notes. The ID band number should be recorded on the Neonatal Sheet. A further set of baby ID bands should also be offered to the parents for their baby's memory box.

- Complete a 4 Louis cot card and complete the Certificate of Acknowledgement that is in the memory box. Fill it in together with the parents or after discussion with the parents to ensure all the details are correct and it meets the parents` wishes

- Ink and clay imprints of hand and footprints should be offered to parents. Consideration should be taken regarding the condition of the baby particularly if there is severe maceration and depending on gestation.

- Offer and discuss if the parents want to spend time dressing and/or bathing their baby. Support as required.

- Offer parents the option of leaving toys eg teddy bear, pictures and messages with the baby. Offer parents a Heart in their Hand charm. (Kept in the SANDS cupboard with the memory boxes)

- If parents do not wish to have mementos, staff could suggest to still taking them and offer to store them securely with mother's notes in case parents decide at a later date they would like access to them.

- Offer parents the use of the cold cot or cuddle cot. Staff should be aware of how to use these. Please adhere to the instructions of how to use which are attached to the cold cot. (The lid must remain off the cot when it is being used)

- E3, DATIX and GROW should be completed.

Photographs

- Media resources will take and provide photos for the parents; they also offer parents the memory card with the photos on for them to take home. A midwife can complete the green Media Resource request card and get the parents to sign giving their consent.
- There is a digital camera on Delivery Suite kept in the Controlled Drugs cupboard which can also be used. In the `For Louis` memory boxes there is a SIM card for the parents to use with this camera which is theirs to keep. Parents can use the camera and take their own photos.

Chaplaincy support for blessings, religious and spiritual support

- The UHB Chaplaincy team include representatives of different world faiths and can provide support to parents and staff following the loss of a baby.

- If the parents wish to have their baby blessed by a member of the chaplaincy team, they can be contacted via Ext 43230 during office hours or by the hospital switchboard during the evenings, weekends and bank holidays. Further information regarding the Chaplaincy team is available on the Clinical Portal page.

- There is a Book of Remembrance which is kept in The Sanctuary. Parents should be offered whether they would like to write a message to be recorded in the remembrance book. The forms are kept in the fetal loss and parents can complete whilst in hospital or they can be sent via post directly to The Sanctuary on B5.

Back to Contents

8 Post Loss Investigations

Specific clinical assessment and laboratory investigations should be offered to assess maternal wellbeing, to try to determine the cause to the chance of recurrence and possible means of avoiding future pregnancy complications. The midwife looking after the woman in the postnatal period should check that all post loss blood tests, LVS and MSU have been taken either pre or post birth. Verbal consent should be obtained and an explanation of the tests taken should be discussed with the woman. This information must be written on the form when the sample is sent. No samples should be sent without a clear reason for the request, as they will not be processed.

Back to Contents

8.1 Anti D

If the woman is Rh Negative, Anti-D should be offered to every non-sensitised Rh D Negative woman within 72 hours following delivery. The woman should not be sent home before giving the Anti D. It can be very upsetting for the woman to return to the hospital for the injection.

Back to Contents

8.2 Maternal Investigations

See Appendix 18.2.

Back to Contents

8.3 Placenta to be sent to Histopathology

The placenta is an important part of the investigation process. The RCOG state in 88% of stillborn investigations a major contributor to finding the cause was found in the placenta. Record on the post-mortem consent form, (if one is being performed) that the placenta has already been sent to histopathology.

The following details should clearly be documented on the Histopathology Form;

- Gestation
- Obstetric history
- Type of loss - Late Miscarriage, Stillbirth, MTOP or Neonatal death
- Maternal medical conditions

- Document whether fetus/baby is for postmortem examination
- Tissue sent – Placenta

The placenta should be placed in a sealable bag with the mother's addressograph firmly attached to it. The bagged placenta should be transported to histopathology in a sealed white bucket with the completed histopathology form. The placenta can be sent immediately to histopathology via the porter track, it does not need to accompany the baby for post-mortem or to the mortuary/fetal pathology

Back to Contents

8.4 Post-mortem examination (PM)

Parents should be informed that deciding for a post mortem examination will not preclude them from seeing their baby. The baby can be viewed in the viewing room in the Mortuary or at the funeral directors of their choice.

- A discussion regarding post-mortem should ideally take place in a staged manner, i.e. information should be given over a period of time so that the family is able to consider the options available. It is important to note that when a baby is born dead irrespective of gestational age the final decisions regarding the baby rest with the mother. Ensure discussion takes place in a quiet private place and ideally without any potential interruptions.

- The mother and the professional responsible for obtaining consent must sign any consent given. Fathers/Mother may wish to sign the consent in support of their partners but as a second signature. A post-mortem will not be performed if the father/mother has signed the form alone, unless there are exceptional circumstances, which must be reported to the pathologist. (HTA)

- There are three copies of the consent form, the white copy should be sent with the baby for the pathologist, the green copy is for the patient record and the pink copy must be given to the mother for her to keep.

- If the family or clinicians have specific questions which cannot be answered, advice can be sought from the Paediatric pathologists, Fetal Pathology Unit, the bereavement midwife or contact the HTA (Human Tissue Authority) directly.

It is the UHB and Human Tissue Authority licensing requirement that; only staff who have undergone the appropriate accredited training should obtain consent for post-mortem examination. Midwives and Obstetricians should attend Postmortem training biennially. A list of consenters is kept in the Bereavement folder on delivery Suite or alternatively you can contact Cellular Pathology as the consenter's details

are held on the database. This information is accessible via Cellular Pathology Tel: 029 20744277. .

- If cultural or religious reasons mean that it is imperative to arrange the funeral as soon as possible; discuss this with the Paediatric pathology team so that the PM can be expedited. Post-mortem can add additional information or changes the diagnosis in 40%- 50% of cases.

- Placental pathology alone may be helpful but is not always conclusive.

- During the consent process, inform parents of the likely timescales for the return of the baby's body and the results.

- Identify a named contact within maternity who the parents can contact if they wish to withdraw postmortem consent and will be responsible for liaising and supporting with the family to transfer the baby back into their care.

Back to Contents

8.4.1 Transfer of fetus or baby and paperwork required when transferring to FPU or the Mortuary

A fetus which is delivered before 24 weeks and has shown no signs of life, and has been consented for a postmortem examination should be transferred to the fetal pathology unit (FPU) for the examination. It is a good practice to liaise with the FPU to expect the fetus. Contact number is Ext 44025.

Paperwork required for the transfer of the fetus for a Postmortem to the FPU

- Certificate of Medical Practitioner in respect of Fetal Remains
- Postmortem consent form
- Request for fetal, perinatal or infant post mortem examination form
- Chain of custody form
- Consent for sensitive disposal

Babies delivered after 24 weeks or any baby which showed signs of life (neonatal death), should be transferred to the mortuary.

The paperwork that should accompany the baby for transfer to the mortuary is

Paperwork required for the transfer of baby for a Postmortem following Stillbirth to the mortuary (this paperpwork is found in the Fetal remains, Stillbirth and neonatal death procedure http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/315957

- Certificate of Stillbirth (Cremation form 9)
- Postmortem consent form
- Request for fetal, perinatal or infant post mortem examination form

the Death Notification Proforma

Paperwork for the transfer of baby for a Postmortem following a Neonatal Death to the mortuary (any gestation)

- Statutory medical forms 4&5 (for cremation only)
- Postmortem consent form
- Request for fetal, perinatal or infant post mortem examination form
- the Death Notification Proforma

Babies being transferred to either the fetal pathology department or mortuary must be accompanied by a midwife/ MCA with the porter. Transfer to FPU or the mortuary should be requested via the porter track system.

Staff must ensure these departments are aware that a post mortem examination is to take place. Ensure the Paediatric Pathologist's secretary is notified. Tel 029 20748490 or Ext 48490.

All Staff should be aware of the guidelines for the **Guidance for transferring a deceased baby or Child and the Fetal Remains, Stillbirth and Neonatal Death Procedure.** These are accessible via the clinical portal: **.**

Ensure any small objects or keepsakes such as a hat or cuddly toy that parents send with the baby is clearly documented on the PM consent form, chain of custody or Death Notification Proforma.

Fetuses' that are not for PM examination should be transferred to the mortuary with the correct paperwork

- Certificate of Medical Practitioner in respect of Fetal Remains
- Postmortem consent form
- Request for fetal, perinatal or infant post mortem examination form
- Consent for sensitive disposal
- The Death Notification Proforma

Back to Contents

9 Registration and Certification

9.1 Registration and Certification for a dead baby born before 24 weeks gestation

The birth of babies born dead before 24 weeks' gestation are not required or permitted by law to be officially certified or registered. Whilst some parents do not want to register a miscarriage, others may find this upsetting. Parents should be offered an unofficial 'certificate of birth' or 'certificate of pregnancy loss' from the hospital to recognise what has happened but this should not be insisted upon if the parents decline. There are Certificates available in the memory boxes.

A doctor, who was present at the birth, and/or has examined the baby, needs to complete a **Certificate of Medical Practitioner in respect of Fetal Remains** confirming that the baby was born dead at less than 24 weeks' gestation. This will be needed to arrange a cremation, burial or sensitive incineration.
If a miscarriage occurs at home without the presence of a healthcare professional, it is recommended that parents should take the remains to the hospital and a **Certificate of Medical Practitioner in respect of Fetal Remains** confirming that the loss occurred prior to 24 weeks' gestation can be completed once the fetus has been examined by a doctor (Miscarriage Association et al, 2015). Staff should recognise that this can be an extremely distressing situation. If there are questions around the gestation, staff should consult with a colleague or a pathologist.

Back to Contents

9.2 Babies born at or after 24 weeks, but had died before 24 weeks

If it is known or can be proven that a baby died in utero before 24 weeks based on the fetal stage of development, but was delivered at or after 24 weeks, they should not be certified or registered as a stillbirth. This is the accepted interpretation of registration law (RCOG, 2010). A **Certificate of Medical Practitioner in respect of Fetal Remains** should be completed by the examining doctor.

Back to Contents

9.3 Registration and Certification for a baby born alive before 24 weeks gestation and then dies

If a baby is born alive before 24 weeks gestation and subsequently dies, both the birth and the death of the baby must be registered with the registrar of births and deaths (RCOG210b).

The doctor who provided medical care for the baby should issue a medical Certificate for the Cause of Death (Yellow book) which certifies the death. This certificate must be taken to the registrar of births and deaths. The Neonatal death should be registered within 5 days with an exception if it has been referred to the coroner. The birth should be registered within 42 days.

If no doctor saw the baby whilst the baby was still alive the death cannot be medically certified until it has been reported to the coroner. The parents must be informed that their baby's death has been referred to the coroner and the procedure and the reasons should be sensitively explained to them.

Arrangements for registration of a Neonatal death can be made by the Bereavement midwife or midwife caring for the bereaved parents or Neonatal staff before they are discharged home if this is appropriate (excluding weekends and Bank holidays). Appointments can be made to meet with the Registrar in the Bereavement office at UHW Concourse. They can be contacted on **Ext 42789 (internal) 029 20742789 (External).** Alternatively an appointment can be made with the Registrar at City Hall on **029 20871680/029 20871684**

Back to Contents

9.4 Registration and certification for Stillbirths

The doctor or the registered midwife who attended the delivery or examined the baby's body after the birth must give the parents a Medical Certificate certifying the stillbirth (Certificates of Stillbirth Blue Book). The certificate should be completed legibly by the appropriate medical professional and without any abbreviations. This certificate will need to be taken to the registrar of births and deaths by the parents. Healthcare staff can help parents by offering to explain what the registration process involves and alerting them to decisions they may want to make before going to the register office. For example, parents may wish to name their baby as the name cannot be changed after registration.

A stillbirth should be registered within 42 days, though this may be able to be extended under certain circumstances. Contact the local register office, if this may be necessary.

Arrangements for registration of Stillbirth can be made by the Bereavement midwife or midwife caring for the bereaved parents before they are discharged home, if this is appropriate (excluding weekends and Bank holidays). Appointments can be made to meet with the Registrar in the Bereavement office at UHW Concourse. They can be contacted on **Ext 42789 (internal) 029 20742789 (External).** Alternatively an appointment can be made with the Registrar at City Hall on **029 20871680/029 20871684**

Back to Contents

9.5 Registration and Certification following a Neonatal death

If a baby is born alive at any gestation and dies within 28 days of birth, a birth and death certificate must be issued for the baby. The doctor who provided medical care for the baby should issue a **Medical Certificate for the Cause of Death** (Yellow book) which certifies the death. This certificate must be taken to the registrar of births and deaths. The Neonatal death should be registered within 5 days with an exception if it has been referred to the coroner. The birth should be registered within 42 days.

If no doctor saw the baby whilst the baby was still alive or the baby's death was unexpected, the death cannot be medically certified until it has been reported to the coroner. The parents must be informed that their baby's death has been referred to the coroner and the procedure and the reasons should be sensitively explained to them.

Arrangements for registration of a Neonatal death can be made by the Bereavement midwife or midwife caring for the bereaved parents or Neonatal staff before they are discharged home if this is appropriate (excluding weekends and Bank holidays). Appointments can be made to meet with the Registrar in the Bereavement office at UHW Concourse. They can be contacted on **Ext 42789 (internal) 029 20742789 (External).** Alternatively an appointment can be made with the Registrar at City Hall on **029 20871680/029 20871684**

Back to Contents

9.6 Certification for an Intrapartum stillbirth

The categorisation for unexpected stillbirths must lie with the resuscitation team who will decide whether there were ever any signs of life in the baby. The documentation must be clear. If a death is categorised as a neonatal death it is the responsibility of the resuscitating team to write the neonatal death certificate. Consent for post-mortem should be sought by the most appropriate person and will be individual to each case. If the death is a stillbirth it is the responsibility of the obstetric team to write the stillbirth certificate and to obtain consent for post-mortem.

Back to Contents

10 If a Baby is Born Showing Signs of Life following a miscarriage or Medical Termination of Pregnancy?

In some cases of miscarriages or Medical termination of pregnancy, especially in the second trimester of pregnancy, a baby may be born alive. Any baby who shows signs of life and subsequently dies is a neonatal death regardless of gestational age.

If there is a possibility that the baby may be born alive, the parents should be given a full explanation about this and why resuscitation may not be possible. An obstetrician or paediatrician should be asked to see them before delivery to discuss the situation. The decision whether to initiate resuscitation will be made by the senior paediatrician in conjunction with any neonatal nursing, midwifery and medical staff and as agreed with the parents. See the Welsh Health Circular regarding Managing babies on the threshold of survival (September 2017) for further guidance (Appendix)

If a baby is born showing signs of life:

- Call the obstetric registrar/SHO or a paediatric doctor immediately.
- One of these doctors has to see the baby alive and the same doctor has to sign the death certificate once they certified that the baby has died.

- If there is a shift changeover, the doctor who has just started his/her shift will also need to see the baby alive as he/she now has the responsibility of certifying the baby's death.

Any baby showing signs of life following a Medical Termination of pregnancy or when a doctor knows or has reasonable cause to suspect the death is suspicious then it must be reported to the coroner.

- By virtue of s.1 Coroners and Justice Act 2009, a coroner has a duty to investigate a death where there is a reason to suspect that the death is
  i. Violent
  ii. Unnatural
  iii. Of unknown cause
  iv. Has occurred whilst in custody or state of detention.

- The referral to the Coroner must be done by the Consultant responsible for the care of the baby and via the electronic system which is accessible via the Bereavement office in Concourse. A **statement paper** must be completed as part of the referral.

- Parents must be kept updated and debriefed regarding their care and of their baby. Note that this can be very distressing for the parents. Everyone

involved should document all aspects of care and any conversations that have taken place.

Back to Contents

10.1 Certification following a termination if the baby is born alive and then dies

(N.B. Feticide is a pre requisite prior to induction in cases of termination for fetal anomaly at gestation more than 21+6 weeks.)

If a baby is born alive following a termination at any gestation and subsequently dies, both the birth and the death of the baby must be registered with the registrar of births and deaths (RCOG210b).

The doctor who provided medical care for the baby should issue a **Medical Certificate for the Cause of Death** (Yellow book) which certifies the death, however the case may need to be discussed with the coroner before a certificate can be issued to agree a cause of death. The parents must be informed that their baby's death has been referred to the coroner and the procedure and the reasons should be sensitively explained to them.

Once the certificate has been issued it must be taken to the registrar of births and deaths. The Neonatal death should be registered within 5 days with an exception if it has been referred to the coroner. The birth should be registered within 42 days.

Arrangements for registration of a Neonatal death can be made by the Bereavement midwife or midwife caring for the bereaved parents or Neonatal staff before they are discharged home if this is appropriate (excluding weekends and Bank holidays). Appointments can be made to meet with the Registrar in the Bereavement office at UHW Concourse. They can be contacted on **Ext 42789 (internal) 029 20742789 (External).** Alternatively an appointment can be made with the Registrar at City Hall on **029 20871680/029 20871684**

Back to Contents

11 Funeral arrangements

All staff should be aware of the sensitive disposal and funeral options for parents. This guidance can be accessed from the **UHB Fetal Remains, Stillbirth and Neonatal death Procedure** which is accessible on the Clinical portal. When discussing the options for funeral arrangements this guidance, the **UHB Fetal Remains, Stillbirth and Neonatal death Procedure** should be also be used alongside the **Guidance for transferring a deceased baby or Child.** These are all accessible via the clinical portal as separate documents**.**
http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/315957

- All parents should be given the UHB Information following the death of your baby leaflet that is appropriate to the type of their fetal loss.
- Bear in mind, and facilitate where possible, different personal, religious and cultural needs.
- Offer to refer parents to the chaplaincy team for further support
- Record any discussion and decision made by the parents in the notes.
- Ensure that all the correct paperwork has been completed and copies made for the maternity notes as proof.
- Refer the parents to the Bereavement Midwife for further support if required

Back to Contents

12 Postnatal care for women following baby loss

Refer to **`Guidelines for Routine Postnatal Care of Women and their Babies guidelines,** while also being aware (as stated in The Royal College of Obstetrics and Gynaecology Green-top Guideline No.55 Late Intrauterine Fetal Death (IUFD) and Stillbirth) that it is likely that many women with an intrauterine Fetal Death fall into moderate or high risk categories. If there is one or more surviving sibling from a multiple pregnancy, do not focus solely on them. Acknowledge the baby who has died. Recognise the challenge that the parents face in celebrating the arrival of one baby and the tragic death of the other baby or babies.

- Record maternal observations – keep in mind many women in this situation use remifentanil or morphine PCAs as analgesia in labour so women are at an increased risk of respiratory depression during their use
- Consider Thromboprophylaxis as per UHB guideline. If the woman is discharged home needing thromboprophylaxis a self assessment for self administration care pathway should be completed.
- Community midwife should be informed that woman has been discharged home on thromboprophylaxis.

Postnatal Risk assessment

✓ **Tick if present**

Ensure thromboprophylaxis (TEDS & Clexane for 10 days) has been prescribed following birth with one or more factor

Women receiving thromboprophylaxis during pregnancy should continue treatment for 6 weeks postpartum

Signature

PPH >1500ml
Red blood cell transfusion or transfusion of coagulation factors
Caesarean section (elective or emergency)
Still-birth
BMI >45kg/m2
Sepsis
Complex vaginal delivery (Consider thromboprophylaxis)

Delay commencement until 6 hours following epidural catheter removal or completion of spinal anaesthesia. Ensure there is no risk of further bleeding. Encourage early mobilisation, hydration and awareness of symptoms of VTE in all women.

Prescription of postnatal Thromboprophylaxis: Enoxaparin dose (mg)

Booking Weight (kg)	In Patient	Out Patient
<50	20mgs daily	20mgs daily
50-100	40mgs daily	40mgs daily
101-150	40mgs BD	60mgs daily
>150	60mgs BD	80mgs daily

Back to Contents

12.1 Offering and giving Cabergoline to suppress lactation

Lactation is a distressing experience following pregnancy loss

Mothers should be advised about natural suppression of lactation and the option of pharmacological lactation suppression should be considered. Cabergoline is recommended (RCOG Green-top Guideline No.55) and successfully suppresses lactation in a very high proportion of women.

Cabergoline a single dose of 1mg post-delivery is the preferred option. (RCOG 2010) this drug is a stock item on labour ward and on the OAU and should be given within 24 hours of the loss of pregnancy.

If Cabergoline has not been given within the first 24 hours following delivery then, the recommended regime is 0.25mg (one-half of 0.5mg tablets) every 12 hours for 2 days, 1mg being the total dose in 24 hours.

Contraindications

a) Women with hypertension/pre-eclampsia
b) Women who are taking anti-psychotic medication or have a history of mental illness associated with childbirth.

Back to Contents

12.2 Communication to all key staff

With the mother's consent, all key staff should be informed that the woman has experienced the death of her baby. They may include

- Community midwife
- Named Consultant via SBAR communication form
- GP and HV (Yellow GP communication sheet)
- Bereavement midwife
- Antenatal Clinic, physio and Ultrasound department (ensure all appointments and letters are cancelled)
- Support agencies eg Flying Start, Social worker, Perinatal Mental Health team.

Inform primary and secondary care staff where the mother will be staying when she leaves the hospital. Before parents leave the hospital, give them the contact details for the Bereavement midwife, an emergency 24 hour contact number and consider

giving them information on national support organisations which they might find helpful.

Back to Contents

12.3 Reporting process

- A Datix Form for all fetal losses >22 weeks should be completed following delivery.
- All fetal losses >22 weeks are also reportable to MBRRACE.

Back to Contents

12.4 Discuss contraception options

Women should be made aware that with the suppression of lactation, ovulation returns more quickly. A sensitive approach should be considered when discussing contraception with the parents following the loss of a baby.
Parents should be informed that they should consider starting using contraception after the birth. The woman should be aware that she doesn't need to wait for her periods to return or until she has her postnatal check before she can use contraception as she could get pregnant again before then. The woman should be offered and provided with some contraception in hospital after delivery if she accepts.

Back to Contents

12.5 Emotional support

As important as the clinical role in caring for women following fetal loss is the providing of emotional support and monitoring maternal mental health and emotional well-being.

“Care should be individualised so that it is parent-led and caters for their personal, cultural or religious needs…Sensitive, empathetic care is crucial and may involve spending time with parents…Clear communication with parents is key and it should be sensitive, honest and tailored to meet the individual needs of parents.”

Parents should be offered the opportunity to spend time in an area dedicated to their needs and which allows them privacy and dignity to spend time with their baby. Parents may therefore wish to spend time as a family in the Teardrop Suite.

Back to Contents

12.6 Discharge home and aftercare

12.6.1 Leaving the hospital

Leaving the insulated environment of the hospital and going home to face the world without their baby can be frightening and painful. Some parents may want to leave soon after their loss. Others prefer to stay a little longer but some may feel unable to stay. Before discharging a woman from hospital, the availability of support at home should be assessed.

- Parents should not automatically be sent home as soon as possible. It may be helpful to discuss the place and time of leaving the hospital with the parents. Some parents may wish to be debriefed regarding their loss before discharge home. An appropriate person should have this debrief with the parents before discharge home. A postnatal appointment will be offered at approximately 12-14 weeks.

- All parents should be told about the services and support available to them once they are at home. Some may be reassured if they know that a community midwife will visit them at home or the Bereavement midwife will contact them shortly after their discharge from hospital.

- Before parents leave the hospital staff should discuss with them the ongoing physical symptoms the mother may experience (for example bleeding, lactation and pain) and when they should contact a healthcare professional.

- The intrapartum and postnatal discharge should be completed on Euro king. Make sure that all the information entered is correct as incorrect information can cause distress for the parents.

On discharge parents should have the details of all the available support services to them, these should include their named community midwife, contact details for the bereavement midwife and local contact points for third sector support. This support may be obtained from

- The Junction pregnancy loss support (voluntary counselling support group)
- Cardiff and Newport SANDS (Information available in the SANDS Family Support Pack)
- Cardiff MIND

Further support can be accessed from the GP.

These details are included in the Teardrop information booklet.

- A **SANDS** sticker should be stuck to the front of the maternal notes with the name of the baby and date of birth written on it.

- The purple Perinatal postnatal pathway should be used to document all postnatal care whilst in the community.

- Back to Contents

13 Rights and benefits following Stillbirth and Neonatal death

Following the death of their baby it can be difficult to think about the practicalities and financial implications, to find out what support they are entitled you can guide them to a booklet called 'Late miscarriage, stillbirth, neonatal death – A guide to the financial help available', by the Money Advice Service.

13.1 For parents who lost a baby before 24 weeks

For legal purposes, this is known as a late miscarriage and unfortunately mums don't qualify for Maternity Pay. However, they will be entitled to Sick Leave, immediately after the miscarriage. To claim sick pay they will need a Fit Note (previously called a Sick Note) from your GP. If they have had a late miscarriage, they should be entitled to Statutory Sick Pay, paid for up to 28 weeks (depending on their employment contract).

Dads, or a mum's female partner (who has the same rights as a father), may be entitled to Sick Leave and Sick Pay, Compassionate Leave or Time Off for Dependants. They will need to look at their contract and contact their employer about this.

Back to Contents

13.2 For parents who lost a baby after 24 weeks, or if the baby was born alive at any stage of pregnancy and then died

- Mothers are entitled to 52 weeks' Maternity Leave
- If they gave birth before their Maternity Leave started, leave starts the day after they gave birth.
- They may be entitled to Maternity Pay from their employer, Maternity Allowance, or income-related benefits from the state.

Dads, or partners, may be entitled to one or two consecutive weeks' Paternity Leave from their employer. They may also be entitled to Sick Leave and Sick Pay, Compassionate Leave or Time Off for Dependants. They will need to look at their contract and contact their employer.

A copy of the Late miscarriage, stillbirth, neonatal death – A guide to the financial help available', by the Money Advice Service is available in the SANDS Family Support pack or via the SANDS App.

Back to Contents

14 Follow up appointment

All parents should be offered a follow-up appointment to discuss any results from tests or post mortem investigations. It is important to make sure that the parents know the purpose of the follow up appointment. This will ensure that parents know what to expect at the appointment as they may experience distress if their expectations are not met.

- Letters that are sent to confirm the appointment with parents should clearly state the purpose of the appointment. The envelope of any letters that are sent should be marked “Private and confidential.”
- It is useful to ask the parents what questions they would like to have answered prior to attending the appointment.
- It is also helpful to invite them to contribute their recollection of events or point of view prior to or at the discussion as part of the investigation.
- It is also important to ensure confidentiality in situations where other family members may not know about the loss or about post mortem investigations.
- Staff who telephone should check they are speaking directly to the woman.
- Some women may want to bring a partner, relative and/or friend to appointments. If applicable, both parents should be encouraged to attend appointments together.
- When the appointment is booked, parents should also be encouraged to write down any questions and worries and to bring the list with them to the appointment.
- Additionally, they should be told whom to contact if they need to talk to someone urgently in the time before the appointment and be given contact details.
- In addition to the initial follow-up appointment, an offer of ongoing care should be made to all bereaved parents.
- Offer parents the choice to either attend an appointment with the Consultant they have seen antenatally or in The Rainbow Clinic Postnatal debrief clinic at Llandough hospital

Back to Contents

15 Stillbirth Review Forum

A Multidisciplinary case review of all deaths from 22 weeks are carefully reviewed through an appropriate process in order to provide answers for families about why their baby died, and to identify improvements in care for future families. The Stillbirth Review meetings are held monthly and a standardised review for all deaths from 22 weeks (>500grammes) using a national Perinatal Mortality Review Tool (PMRT), available to use for free by the end of 2017 in Scotland, Wales and England is used. The review is feedback to the parents at their postnatal appointment.

Back to Contents

16 Next pregnancy

Parents should feel well supported in any pregnancy following a pregnancy loss and the death of a baby. Health Boards should make provision for planning the next pregnancy and have access to next pregnancy support for the families. At Cardiff and Vale UHB the Rainbow Next Pregnancy Clinic has been set up to provide support to parents in any subsequent pregnancy following the loss of a baby.

- All staff in primary and secondary care settings seeing bereaved parents before, during and after a pregnancy following a loss must be aware of and acknowledge the potential difficulties and challenges these parents might face.
- All staff that care for bereaved parents in subsequent pregnancies should be well-informed about the parent's history so that they can respond sensitively to any anxieties or concerns the parents may express.
- Offering parents continuity of carers and the option of having their notes clearly marked may help to ensure that parents do not need to explain their situation repeatedly.
- If the baby who died had a medical or genetic condition that could affect subsequent babies, the chance of another loss may feel too difficult for some parents to consider. Referral to the fetal medicine unit or the All Wales genetics department should be considered.

Back to Contents

17 References

1. Royal College Obstetrics and Gynaecology (2010) Late Intrauterine Fetal Death and Stillbirth, Green Top Guideline No 55. RCOG, London. **https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf**

2. North West Coast Strategic Clinical Networks (2018) **Management of Stillbirth Version 3** https://www.gmecscn.nhs.uk/attachments/article/56/Management%20of%20Stillbirth%20.pdf

3. North West Coast Strategic Clinical Networks (2018) **Management of Second Trimester Pregnancy Loss Version 2** https://healthinnovationmanchester.com/wp/wp-content/uploads/2018/10/NW-Second-Trimester-Pregnancy-Loss-ICP-V2-March-2018.pdf

4. Royal College Obstetrics Gynaecology (2010) **Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. Report of a Working Party,** May 2010, RCOG, London. https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf

5. MBRRACE (2017) The Perinatal Mortality Surveillance report. https://www.npeu.ox.ac.uk/mbrrace-uk/news/1480-mbrrace-uk-perinatal-confidential-enquiry-2017-report-published-today

6. **UHB Fetal Remains, Stillbirth and Neonatal death Procedure** http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/315957

7. **Human Tissue Authority (2015)** Guidance of the disposal of pregnancy remains. HTA, London. https://www.hta.gov.uk/sites/default/files/Guidance_on_the_disposal_of_pregnancy_remains.pdf

Back to Contents

18 Appendices

18.1 Neonatal Birth Record Following Intrauterine Death

NEONATAL BIRTH RECORD
Following Intrauterine Death

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

ID band number: Maternal	ID band number: Paternal/same sex parent (if unmarried)
Applied by: name, signature, role	

MOTHER'S ADDRESSOGRAPH

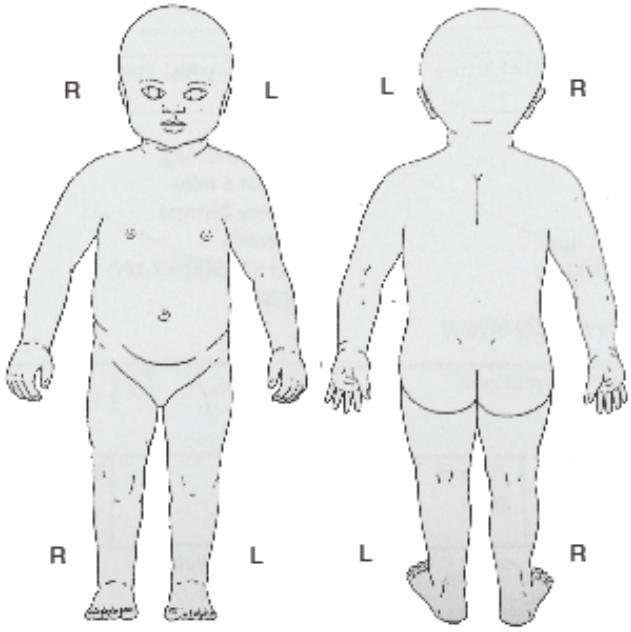
History (eg. gestation at time of death/birth etc.)	Type of pregnancy	
	Singleton ☐	Multiple ☐

Date of birth	Time of birth	Head circumference	Birth weight centile
...../...../.....			

Gender	Mode of birth	Weight
Male ☐ Female ☐ Indeterminate ☐		..... grams

Appearance	Signs of life (if yes, please provide details)
Normal ☐ Abnormal ☐	No ☐ Yes ☐

Record ANY abnormalities on body map (including Mongolian blue spots and birth injuries)	
Details:	
Liquor colour	
Liquor offensive	Yes ☐ No ☐
Placenta sent to histology	Yes ☐ No ☐



Examination by: (name, signature, role)	

18.2 Maternal Investigations following Intrauterine Death (Any Gestation)

All of the below sets should be available in WCP for ease of requesting

18.2.1 At diagnosis & with immediate Care – for all women

Investigations at Diagnosis	Container/Form required	Date/Time & Initials
FBC	Purple x 1 / Haematology	
Kleihauer in ALL women even if RhD positive*	Pink x 2 / Blood Bank	
Blood group & Antibodies	Pink / Blood Bank	
U's & E's / LFT's / CRP	Yellow x 1 / Biochemistry	
Coagulation Screen	Blue x 1 / Haematology – must be full to line	

***Reason for Kleihauer Test:** Lethal feto-maternal haemorrhage. Kleihauer is recommended for **all** women, not simply those who are RhD negative (please ensure laboratory is aware if a woman is RhD positive before sending sample, detail Rh positive woman with intrauterine death). Test needs to be undertaken before birth as red cells might clear quickly from maternal circulation.

Back to Contents

18.2.2 Further Investigations

Please discuss with senior labour ward obstetrician which bloods to take.

Consider the maternal and fetal history.

Abruption	Sample	Container/Form required	Date/Time & Initials
Toxicology Drug Screen	Urine	Universal container / Toxicology	
Thrombophilia Screen – MUST detail 1.Lupus anticoagulant, 2. anti-cardiolipin antibodies and 3. anti B2-GP1 antibodies	Blood	Blue x 3/ Yellow x 1 Blue tubes must be filled to line Haematology	
No obvious association	**Sample**	**Container/Form required**	**Date/Time & Initials**
Bile Acids Thyroid Function	Blood	Yellow x 1 / Biochemistry	
HbA1c	Blood	Purple x 1 / Biochemistry	
TORCH 6 (Toxoplasmosis, Rubella	Blood	Red x 1 / Virology	

IgG and IgM, CMV IgG and IgM,Parvovirus IgG and IgM, Syphilis screen			
Thrombophilia Screen – MUST detail 1.Lupus anticoagulant, 2. anticardiolipin antibodies and 3. B2-GP1 antibodies	Blood	Blue x 3/ Yellow x 1 Blue tubes must be filled to line Haematology	
Toxicology Drug Screen	Urine	Universal container / Toxicology	
Small Baby	**Sample**	**Container/Form required**	**Date/Time & Initials**
Thrombophilia Screen – MUST detail 1.Lupus anticoagulant, 2. anticardiolipin antibodies and 3. B2-GP1 antibodies	Blood	Blue x 3/ Yellow x 1 Blue tubes must be filled to line Haematology	
TORCH 6 (Toxoplasmosis, Rubella IgG and IgM, CMV IgG and IgM,Parvovirus IgG and IgM, Syphilis screen	Blood	Red x 1 / Virology	
Infection / PROM / Offensive liqour	**Sample**	**Container/Form required**	**Date/Time & Initials**
HVS (Culture & Sensitivity)	Swab	Microbiology	
Blood Cultures	Blood	Culture bottles / Microbiology	
MSU	Urine	Red topped urine container / Microbiology	
Hypertension	**Sample**	**Container/Form required**	**Date/Time & Initials**
Thrombophilia Screen – MUST detail 1.Lupus anticoagulant, 2. anticardiolipin antibodies and 3. B2-GP1 antibodies	Blood	Blue x 3/ Yellow x 1 Blue tubes must be filled to line Haematology	
Hydrops	**Sample**	**Container/Form required**	**Date/Time & Initials**
Parvovirus	Blood	Red x 1 / Virology	
Anti-Ro & Anti-La antibodies (Anti-nuclear antibodies)	Blood	Yellow x 1/ Biochemistry	
Anti-red cell antibodies	Blood	Pink x 1 / Blood Bank	
DIABETES	**Sample**	**Container/Form required**	**Date/Time & Initials**
HbA1c	Blood	Purple x 1 / Biochemistry	

Back to Contents

18.2.3 Postnatal Investigations – all women

	Sample	Container/Form required	Date/Time & Initials
Histology	Placenta & membranes	White Bucket / Histology	
Placental Swab	Charcoal Swab	Microbiology form – for culture	
Kleihauer if RhD negative	Blood	Pink x 2 / Blood Bank	

Back to Contents

18.3 Teardrop Team Information for Parents

Starts on next page.

Back to Contents

The Teardrop Team hospital information guide for parents following the loss of your baby.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Being told that your baby has died is a devastating shock and we wish to extend our sympathy to you and your family. You and your family will be given considerable support by our midwives, doctors and support staff. It can be hard to take in all the information given to you at this time and therefore it is often helpful to have it in writing as well.

We hope that this booklet helps to explain the care you will receive during and after the birth of your baby. We willalso provide you with additional resources such as **When a baby dies before labour begins, the Family Bereavement Support Pack** both provided by SANDS, **A Guide to the Hospital Postmortem Examination of the Fetus, baby and Child** and the **Information following the death of your baby leaflet** specific to the gestation of your loss. We will also make sure that you are aware of the hospital contact numbers before discharge home.

Interpreters

If you require an interpreter to be available when you come to the Hospital please discuss with a member of staff.

Your Named Consultant Obstetrician

_____

Secretary contact number _

Arrangements have been made for your admission tolabour ward

On ___

At____in the Snowdrop Suite

How is the death of your baby confirmed?

The death of your baby in the womb is confirmed by an ultrasound scan. The scan is able to show if your baby's heart has stopped beating. In UHW we often scan you twice to confirm that your baby has sadly died and this isdone with two separate practitioners who have scanningexperience.

Feelings

Sadly losing a baby is an experience that many will share,but we all act differently and please remember there is noright or wrong way. Some may express their grief in publicand other will be very private but no less deeply felt.
Partners, family and friends may all find it difficult to showtheir emotions in order to be able to cope with them.
These feelings are real and painful, but they are also acceptable and understandable and are quite normalresponses.

Grief may produce physical symptoms, for example disturbed sleep, lack of apettite, nausea and palpitations. These are all normal reactions and may be eased by sharingthem with professionals, family and friends.

Grief can throw lives out of balance and there are bound to be good and bad days. Try not to panic as this is normaland it is important to take time to think through any decisions.

What happens next?

The midwife and doctor will discuss what needs to happenand plan your admission to the hospital for the delivery of your baby. They will make sure that you are well yourself.They will explain your choices for birth, and the various tests that may be offered. They should give you and your partner time privately to consider your options and supportyour decision. If you have written a birth plan we would behappy to discuss it with you.

How will your baby be born?

The option for delivery will be discussed with you by a doctor and supported by a midwife. Unless there is a medical indication for delivery by caesaraean section we recommend that your labour is induced. Vaginal birth is usually recommended. Although you may find the thoughtof a vaginal birth distressing, you may want to consider that there are fewer risks to you, you will be able to go home more quickly, your recovery is likely to be quicker and more straightforward and future pregnancies are less likely to have complications. We advise that you deliver your baby in hospital, however we are happy to discuss your preference for place of birth and will support your choice with your safety being our priority. If you have written a birth plan we would be happy to discuss this with you and support your choices where it is possible.

Induction and delivery of your baby

If your labour has not already started we will need to use medication to induce it. We know it is a very difficult timeand throughout the procedure your husband, partner, friend or family member can be with you at all times. You will receive support from the midwives, maternity health care support workers, doctors and anaethetists and be offered pain relief when and if required.

Depending on your gestation you may be given a tablet called Mifepristone, which is an anti-progesterone tablet two days prior to the induction. This tablet allows the uterus to become more sensitive to the later medications that we use. After being given the tablet you can go homebut will be asked to return if you feel unwell. You will be admitted for the induction process approximately 36- 48 hours later. Occasionally the tablet may cause some bleeding or even contraction pains and if this occurs you should ring the labour ward on 029 20742686 (24hours) and we will admit you sooner. If you have any mild pain whilst at home you can take Paracetamol.

When you return to the hospital and admitted to our labour ward, we will assess that you are physically well andwith your consent we will do a vaginal examination to assess the neck of the womb (cervix) and determine the most appropriate way to induce your labour.
Your labour may be induced with tablets, pessaries or gel which will be inserted behind the neck of the womb duringa vaginal examination. More than one dose may be neededand labour may take several days to start. You will be supported and kept informed of your progress throughout the process. We may need to ‘break your waters’ and also start an intravenous drip containing medication called syntocinon to stimulate your contractions.

The time interval until delivery can be variable but usuallytakes place within 24 hours.

At the time of delivery of the placenta (afterbirth) it may come away on its own but occasionally it may be necessary totake you to theatre to have it removed. You will be given a spinal anaesthetic for this procedure. The amount of blood loss at the time of delivery is variable and on occasions may be quite heavy and necessitating a blood transfusion, this is rare. The midwives and doctors caring for you will explain allaspects of treatment required to you.

Waiting for labour to start naturally

Some women may wish to wait for labour to start naturally. If there is no medical reason that make inductionnecessary then you can consider waiting. We would however, advise that you consider being delivered within 48 hours following confirmation that you baby has died.
You will be given a plan by the doctor before discharge home and contact numbers if you have any concerns or changed your mind that you wish to start induction sooneror you have started to labour naturally.

Pain relief

Unfortunately labour is uncomfortable and painful and there are different ways that we can manage your pain and discomfort. You may decide to use self help methods in the early stages, for example breathing awareness, massage, different positions, keeping mobile, using a TENS machine, getting into a birthing pool and taking mild pain relief such asParacetamol. If you decide that you need additional help withpain then we offer various options. We have a separate leafletexplaining different methods of pain relief and we will give this to you to read. The midwife can discuss these options further and you can speak to one of our anaesthetists on admission.

Admission to hospital - The Snowdrop Room

During the induction process and labour you will be cared for onour Labour Ward. When you arrive to the Labour Ward and speak to a member of staff, say you are for admission to the Snowdrop Room, even if this room is in use, this will inform people that you are facing a bereavement. You will then meet the midwife that will be looking after you for that shift. Your partner or birth supporter may stay with you at all times duringyour stay with us.

What to bring

Your stay with us in hospital may be for a few days, so bringin enough comfortable clothing, nightwear and toiletries forthis time. You may want to bring in some snacks, music, books/magazines and some home comforts such as your own pillow or bedding. You may like to choose something for your baby to wear and also a blanket. We can provide you with some clothing and blankets for your baby if you wish.

We know that this period of time will be a very difficult onefor you and your family and throughout your stay with us your husband, partner, friend or family member can be with you at all times. They may also wish to bring a bag of clothesand toiletries with them.

Blood Tests

You will be offered a variety of blood tests which may help to determine why your baby has died. These will usually be carried out before the baby is delivered. These tests are to lookfor conditions in your pregnancy, for example pre-eclampsia, infection or any problems with your liver or kidneys.

We will take blood tests to see if there is an underlying medical cause, for example diabetes or thyroid problems. Wewill take blood tests to see if there is an underlying conditionthat makes your blood more likely to clot (thrombophilia or antiphospholipid syndrome). Pregnancy can sometimes affectthe results of the tests and therefore they may need to be done again 12 weeks later. With your consent we will ask to take swabs from your vagina called an LVS and a swab will betaken from the placenta to look for any source of infection.

Rhesus Negative women

If you are rhesus negative then we will take blood fromyou to do a test called Kleuhauer. A dose of Anti D mayneed to be given within 72 hours of delivery and will usually be given before your discharge home.

Postmortem Examination

A postmortem examination can provide very important information on why your baby has died. It may be able totell you whether the same problem is likely to affect another pregnancy and if no cause is found this usually means future pregnancies have a good chance of success.The postmortem examination of your baby can be as limited or detailed as you wish. You will be given further detailed written information **A Guide to the Hospital Postmortem Examination of a Fetus, Baby or Child** about this and a chance to discuss your choices with a doctor ormidwife who is competent and has been trained to obtainconsent for postmortem.

It will be your decision for your baby to have a postmortem examination and you will need to give your consent and sign a form before this examination can be done. Your individual rights, cultural and religious beliefs will always be respected.

A detailed examination of your placenta even without a postmortem examination may also provide valuable information and with your verbal consent we will send theplacenta for investigation.

Creating memories

When your baby is delivered you may notice the silence and this can be difficult for everyone present at this time.You may be anxious about seeing and holding your baby and this can be an overwhelming experience but it can alsobe a very precious moment and memory for you as parents.If you are unsure about seeing your baby or anxious about how your baby will look, you can seek guidance from the midwife caring for you to tell you how the baby looks when he or she is born.

The midwives and Maternity Healthcare Assistants will support and prepare you in being able to spend time withyour baby and help create important keepsake memoriesfor you. You may be unsure about doing this but you can always change your mind when the time comes.
Alternatively you may wish to have any mementoes filed inyour notes and contact us when you wish to receive them.

Photographs and Mementoes

If you wish we can take photographs of your baby for youor you can take some yourself either by using your own camera or one of our hospital cameras.

You may be interested in having Professional photographs taken as an additional memory. You are very welcome to invite a professional photographer into the hospital to take these photographs. There are many charities availablewhich offer this service and there are further details included at the back of this booklet.

We can offer you handprints and footprints in clay moulds and/or ink. You can also have identity bands, possibly a lock of hair and we will give you a memory box as a keepsake. Some parents will buy identical outfits for their baby. Oneto keep in their memory box and another to dress their baby. We offer a choice of memory boxes which are kindlydonated to us by the charities who support bereaved parents, these charities are called **SANDS** and **4Louis**. You may wish to bath your baby, we will also weigh your baby, measure their head circumference and perform a clinical examination of your baby. You can also dress you baby in your outfit of choice. You may wish to be involvedin this process with your midwife.

The Teardrop Suite

You will be offered to spend as much time as you wish withyour baby and we have a designated room for Bereaved parents and your visitors where you can spend time together as a family called **The Teardrop Suite**.

We will provide you with a cold cot or a cuddle cot which enables you to have a longer spending time with your baby.The Teardrop suite is a calm and relaxing room where youcan focus on yourselves as bereaved parents and your baby.

The room has bathroom facilites, a compact kitchen and eating area, sitting area and an electric double bed. It maybe possible for you to take your baby home, so if you would like consider this then please ask your midwife caring for you to explore this option further.

Blessing your Baby

You may wish to have your baby named and blessed by oneof our hospital Chaplains or a religious advisor of your ownchoice. The Chaplains provide an on-call service at any time of the day or night, and can be contacted through a member of the midwifery staff. The Chaplains can also helpthose of other faiths who have differing worship or spiritual needs, and can act as a link to representatives of other denominations when required. The blessing can occur either with or without you being present. A blessing card will then be given to you and you may wish to keep itin your memory box.

Book of Remembrance

You may like to enter your baby's name into the **'Baby book of Remembrance'** this is situated in **The Sanctuary** which is on the **5th Floor in B Block** of the hospital. You may wish to write your own thoughts or a special poem in this book in memory of your baby. We will give you a formto complete and discuss how to forward it to the chaplaincy service. You are very welcome to visit the The Sanctuary whilst you are an inpatient, they provide supportin a multi-faith context.

Registration

If your baby dies after 24 weeks, the law requires you to register the stillbirth within 42 days. If your baby dies afterbirth at any gestation the law requires you to register thebirth and the death within 5 days. A Stillbirth or NeonatalCertificate will be issued by a Midwife or Doctor and givento you. You will need to make an appointment to registeryour baby's death with the registrar, and you will need totake this certificate with you. We can support you in making this appointment. If you are married either of youcan register baby's death; if you are not married, you bothhave to attend.

For babies born before 24 weeks and shows no signs of lifewe can complete an acknowledgement of life certificate for you for your memory box.

Arrangements for your baby's funeral

There are a number of options available to you for your baby's funeral. The midwives caring for you during admission will be able to discuss this with you. The Bereavement midwife will be able to offer further supportand guidance. You should be given a copy of a leaflet to read for further guidance:

Information following the death of you baby (forbabies less than 24 weeks gestation); or
Information following the death of your baby (forStillborn and Neonatal deaths)

There are many funeral directors in the Cardiff and Vale areathat will support parents with arranging their own funeral fortheir baby. There may be some cost implications for you. The Bereavement Midwife and midwives that care for you will support you in finding one for your area.

You can also contact Thornhill Crematorium or visit www.cardiffbereavement.co.uk for further information onhow to arrange your baby's funeral.

Taking your baby home

You may wish to take your baby home to spend time togetheras a family in privacy. If you wish to discuss this option furtherthen the midwife caring for you as an inpatient, Bereavement Midwife or Senior Bereavement Nurse will be able to support and discuss this further with you.

After care

Vaginal bleeding may continue for up to 2-4 weeks after you deliver your baby. You are advised to wear sanitary pads and notuse tampons to assess blood loss and reduce the risk of infection.You are advised not to resume sexual intercourse until the bleeding has stopped. It is important that you contact your GP or the hospital if you experience any of the following;
Prolonged heavy bleeding with clots
Vaginal discharge that looks or smells offensive
Rise in temperature or feeling unwell and shivery
Pain when passing urine
If you have pain, swelling or soreness in your legs.
If you have shortness of breath or chest pain, or cough up blood.

After the birth of your baby you may experience the sensation of breast milk coming into your breasts around 3days after the delivery of your baby, making them feel full and uncomfortable and may obviously cause you some distress. You may want to take a mild painkiller such as Paracetamol and wear a well fitting bra until the process has settled, this can take a few days. You can also buy breast pads to soak up any leaking milk.

Alternatively we are able to offer you medication called Cabergoline to assist in the suppression of lactation. We can give you one tablet soon after the delivery of your baby, however there are situations when we would not recommend this medication such as if you have had raisedblood pressue or pre-eclampsia. It is also recommended that you inform us if you are taking any medication as Cabergoline can cause some unpleaseant side effects and reactions with some medication. You can discuss this further with the midwife caring for you.

Follow up care

The hospital staff will answer any immediate questions youmay have. We will inform your GP and Community midwives about the death of your baby and will make arrangements for a community midwife to visit you at home to offer you support and check you physically. The bereavement midwife can also visit you at home if you wish to discuss certain aspects of your care, provide practical support for funeral arrangements, provide emotional support and how to seek long term support following the loss of your baby. You can also access the Money Advice service for guidance in view of your financialrights and entitlements following the loss of your baby.

An appointment will be made for you to see a Consultant Obstetrician approximately 14 weeks following delivery of your baby. At this appointment you will be able to discuss the results of any investigations that may have been carriedout and any implications for future pregnancies. It is important that you ask any questions that you like to the Consultant. The bereavement midwife can also be presentfor this meeting if you wish her to be present for support.

Stillbirth Forum

A Multidisciplinary case review is done of all the Stillbirths in our hospital. The Stillbirth Forum meet once a month to discuss individual cases. The review includes a timeline of your Antenatal care, any admissions you may have had during your pregnancy, we will review from when your baby's death was confirmed, we discuss your delivery and immediate postnatal care and look at the results of any investigations that you may have consented to. If there are any aspects of your care that you wish to be discussed in this forum, please share this with either your community midwifeor with the Bereavement Midwife and we can discuss it at the forum. Your case review will be written and shared withyou at your postnatal appointment. If there are aspects of the report that you wish to discuss further you can contact the Bereavement Midwife or your Consultant Obstetricains secretary and we can make arrangements to discuss the report further.

Useful Telephone numbers

Bereavement Midwife
Please leave a message and your call will be returned as soonas possible
Office: 029 20742187
Mobile: 07811652307

Obstetric Assessment Unit
029 20744658 (24 hours)

Labour Ward
029 20742686 (24 hours)

Useful Organisations for resources and Support

www.arc-uk
Antenatal Results and Choices support for parents who havea baby who has been diagnosed with fetal abnormality in pregnancy

www.thejunctioncardiff.co.uk
The Junction Pregnancy Crisis Support

www.mind.org.uk
MIND, Cardiff MIND Tel: 029 20402040

www.miscarriageassociation.org.uk
Miscarriage Association- support for parents who haveexperienced miscarriages

www.remembermybaby.org.uk
Remember My Baby

www.uk-sands.org
SANDS- Stillbirth and Neonatal Death Society

www.cardiff-sands.co.uk
Cardiff and Newport SANDS

www.tamba.org.uk
TAMBA (Twins and Multiple Birth Association)

Funeral Support

Advice and Support can be initially sought from theBereavement midwife

http://www.nafd.org.uk
National Association of Funeral Directors Provide support and guidance for funeral firms and bereaved families using their services.

www.cardiffbereavement.co.uk
Cardiff Bereavement Services

www.childfuneralcharity.org.uk
Child Funeral Charity

www.creative-funeral-ideas.com/childs-funeral-songs.html
Ideas for music and eulogies

Financial Support and Advice

www.moneyadviceservice.org.uk
Money Advice Service Provides free and impartial money advice, including information for bereaved parents about benefits and entitlements after the death of their baby.

Paying a compliment

A compliment does a lot for the morale of staff and helps us to maintain high standards. If you have been impressed with the standard of care you have received and would liketo pay us or a particular member of staff a compliment youcan write to Concerns Midwife

Cardiff and Vale University Health BoardUniversity Hospital of Wales Heath Park, Cardiff, CF14 7XB

Alternatively, you can send an email to:concerns@wales.nhs.uk

Raising a concern

If you are unhappy with your treatment or care, it is best to raise your concerns at the time with the nurse in charge of the ward. Alternatively, you can contact a member of the Health Board's Concerns Team on 029 2074 4095 or a Community Health Council (CHC) Advocate on 029 2037 7407

All wards will have copies of the "Putting Things Right" concerns leaflets which has a verbal complaints form on theback pages along with contact details.

Restaurant Facilities

AROMA Café
In the Antenatal clinic department we have a small café thatis open during office hours for snacks and drinks.

Y Gegin Restaurant
Situated in A block on the upper ground floor of UHW

Concourse
The concourse has several shops, a cash point and a post office. You are able to buy snacks, food and hot drinks here. We also have a fruit and vegetable stall called The Grapevinewhich is situated outside the main entrance of the concourse.

Parking
There is patient car parking plus disabled parking availableon site. We are a no fee hospital site. You will need to register your car registration number at one of the terminalpoints that are in the unit after 4 hours of admission. You can ask any of the staff to help you with this.

Notes

Booklet Written by Laura WyattVersion May 2019