Late Intrauterine Fetal Death (Ultrasound)

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Author:	DAU Midwife Sonographer
Document Owner:	Head of Midwifery and Sexual Health Services
Accountable Executive:	Executive Director of Nursing, Quality, Women and Family Health
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Associated Policies and Written Control Documents
RCOG (2024) Late Intrauterine Fetal Death and Stillbirth MAT 030 - All Wales Midwife Led Care guidelines SCoR/BMUS Standards for the provision of an ultrasound service (2014) SCoR/ BMUS Guidelines for Professional Ultrasound Practice (2021)

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial Issue	June 2023
2	Review – minor changes and addition of equality statement	20/05/2026

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Midwife sonographer
Consultant Midwife

Circulated to the following for Consultation

Date	Role / Designation
16/07/2025	DAU Midwife Sonographers / Consultant Midwife /
16/07/2025	Assistant Head of Midwifery / Governance Lead for Ultrasound, Head of Radiology, Powys Midwives,
16/07/2025	Safeguarding Team
16/07/2025	W&C Guideline group
16/07/2025	Radiology Department
05/08/2025	Health Board Bereavement Lead

Groups approved at

Date	Group
05/08/2025	Maternity Guidelines Group
19/08/2025	Women and Children's Policies and Procedures Governance Group
01/09/2025	Radiology Heads of Service Meeting

1.0 Introduction

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

Compared with rates in 2022, stillbirth rates per 1,000 total births in 2023 were lower across the UK: 3.22 (UK); 3.27 (England); 2.95 (Scotland); 3.32 (Wales); and 2.51 (Northern Ireland)

In 2023, there were 661,008 total births at 24 completed weeks or greater gestational age (excluding terminations of pregnancy) in the UK. This was a decrease of 14,883 births (2.3%) compared with 675,891 in 2022. Since the start of the MBRRACE-UK programme in 2013, births have fallen by 120,924 (18.3%)

There were 2,128 stillbirths and 1,074 neonatal deaths in 2023. This was 1,158 (35.2%) fewer stillbirths and 362 (25.2%) fewer neonatal deaths compared with 2013.

Late fetal loss and stillbirth rates decreased in 2023 across all gestational age groups compared to 2022, with the largest reduction being for babies born at 37 to 41 completed weeks.
76.1% of stillbirths and late fetal losses and 74.5% of neonatal deaths were born preterm (before 37 completed weeks).

Socioeconomic disparities continued to be a major concern, with stillbirth rates for babies born to mothers from the most deprived areas remaining significantly higher than those from the least deprived areas, despite an 8% decline.
Ethnic disparities in perinatal outcomes persisted. Stillbirth rates declined for Black and White babies but increased by 10% for Asian babies. Black babies remained more than twice as likely to be stillborn as White babies.
The leading causes of stillbirth were placental issues, congenital anomalies, umbilical cord complications, and fetal conditions, but 34% of stillbirths had an unknown cause.

2.0 Objective

- To standardize the process when confirming an intrauterine fetal death by ultrasound

- To identify intrauterine fetal death by ultrasound
- To break bad news sensitively when an intrauterine death is confirmed
- To facilitate referral to the District General Hospital to which the woman is booked or wishes to transfer her care
- To accurately document findings

3.0 Equality Statement

Powys Teaching Health Board Maternity Services are committed to:
• The elimination of unlawful and unfair discrimination
• The active promotion of equal opportunities for women and their families and our workforce
• The protection of the human rights of women and their families and our workforce
• The promotion of inclusive relationships between groups who share protected characteristics and those who don't
• The valuing of the diversity inherent in the communities we serve and in our workforce.

The words 'woman' and 'women' have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby. It is recognized that there are many different family arrangements.

When translation services are required, there is the expectation that a face-to-face translator or digital interpretation services will be provided. The Language Line App is available to all maternity staff to use for this purpose. Consideration is required with written documents and leaflets to be provided in a woman's preferred or 1st language.

For further support and advice contact PTHB Equality Team: powys.equalityandwelsh@wales.nhs.uk

4.0 Definitions

- **PTHB** Powys Teaching Health Board
- **IUD** Intrauterine Death
- **RCOG** Royal College of Obstetricians and Gynecologists
- **DGH** District General Hospital

5.0 Responsibilities

5.1 Head of Midwifery and Assistant Head of Midwifery

- Ensure that robust procedures are in place in order that PTHB can discharge its organisational responsibilities in the provision of safe services to the Powys population of pregnant women.
- Ensure the overall implementation of the guidance.
- Ensure all staff read and understand this procedure. Support allocation of resources to ensure compliance with this procedure.

5.2 Training and Governance Lead for Ultrasound

- Audit monthly sets of images for each midwife sonographer
- Provide support and guidance on DATIX investigations
- Support with debriefing midwife sonographer
- Provide training in relation to policy as appropriate

5.3 Midwife Sonographer

- Datix diagnosis of an IUD as per 'Trigger List'
- Assist with DATIX investigations to improve service delivery through learning and recommendations for service improvement
- Assist with training and support of Maternity Support Workers (MSW) and Community Midwives
- Be responsible for collection of data and audit
- Liaise with the DGH Obstetric Team to provide efficient and timely care
- Communication with the community midwife regarding ultrasound findings and any action taken

5.4 Community Midwife

- Appropriate referral to the DGH for assessment
- Attend with the woman if possible and support the woman during or post findings

Contact the woman following the diagnosis of an IUD to offer support and signpost to relevant organisations.

5.5 Maternity Support Worker

- Retrieve medical records for DATIX investigations
- Support midwife sonographer in contacting DGH with referral
- Provide support to the woman and act as a chaperone
- Ensure equipment and environment is maintained and supplies are available
- Assist with data collection and audit
- Act as scribe for times and record keeping
- Assist with ensuring the woman and her attendees are cared for while the midwife sonographer is in communication with the DGH

6.0 Process

6.1 Referral for Ultrasound Scan

In the event of suspicion of intrauterine death:
If a woman attends for an antenatal review and an IUD is suspected the midwife should sensitively discuss their findings with the woman in an open and honest way. The community midwife should refer the woman to the nearest hospital or hospital of the woman's choosing. Referrals should be undertaken through the hospital triage. The woman should not travel to attend assessment and scan on her own and should be encouraged to have someone attend with her.

In the event of a confirmed intrauterine death:
If an IUD is identified at a routine ultrasound scan the sonographer should sensitively discuss their findings with the woman in an open and honest way. The on-call consultant at the respective DGH should be notified and a plan of care agreed. The woman should not travel to attend assessment and scan on her own and should be encouraged to have someone attend with her.

6.2 Scanning Process

Real-time ultrasound is essential in the accurate diagnosis of an intrauterine fetal death. Fetal heart imaging must be augmented with M mode and colour doppler of the fetal heart and umbilical cord. Consideration should be made for poor image quality maternal obesity, abdominal scar, and/or oligohydramnios.

Growth measurements should be attempted to assist with the post-mortem and delivery management. The measurement accuracy may not

be accurate depending on the length of fetal demise and secondary features documented.

Secondary features of fetal death include:

- Overlapping and misalignment of the fetal skull bones (Spalding's sign), and
- Presence of gas in the fetal heart and blood vessels (Robert's sign)

  The Spalding's sign is not usually present until a week after death whereas gas formation may be seen after only 2 days.
- Gross distortion of the fetal anatomy
- Soft tissue oedema skin >5mm
- Echogenic amniotic fluid

An offer should be made to the woman to see on screen the findings but her decision not to must be respected. A second ultrasound scan/opinion for diagnosis should be obtained to confirm findings in accordance with the RCOG (2024) Care of Late Intrauterine Death and Stillbirth guidance.

Suspected

- When IUFD is suspected an ultrasound scan will take place as soon as possible at the woman's planned district general hospital or if she is midwife led care the closet district general hospital.
- For midwife ideally to be present during the scan as a support to the woman
- To be accompanied by person of her choice
- To be given bad news sensitively
- Following confirmation of intrauterine death for referral to the DGH of woman's choice as soon as possible
- A set of observations including blood pressure, maternal pulse, temperature, respirations, and urinalysis should be recorded in the woman's handheld records.

Unexpected

- To give bad news sensitivity
- Following confirmation of intrauterine death for referral to the DGH of woman's choice as soon as possible
- Inform midwife if not present at the scan.
- A set of observations including blood pressure, maternal pulse, temperature, respirations and urinalysis should be recorded in the woman's handheld records.

Giving Bad news

- Offer to show the parent(s) their baby on the ultrasound monitor

- Take a memorial photo that can be retained in the notes if the parent(s) wish to have it later.
- Offer time alone and where possible escort to a private room
- In unexpected circumstances where the woman is unaccompanied, take to a private room and call a person of their wishes
- Written information should be offered to supplement discussions, either from the hospital the woman wishes to birth at and/or the RCOG leaflet 'Information for You' (2012) downloaded from the internet
- Inform the woman that if she starts to feel unwell, she is advised to contact the hospital immediately to avoid sepsis.
- The woman should be prepared for the possibility of passive fetal movements and will be advised that if they occur, she will be offered a further scan.

6.3 Documentation and Information

If the woman is unaccompanied at her midwife appointment an immediate offer should be made to call her partner, relatives, or friends.

Written information should be offered to supplement discussions either from the hospital the women wish to birth at and/or the RCOG 'Information for you, when your baby dies' (2024) (When your baby dies before birth | RCOG) https://www.rcog.org.uk/for-the-public/browse-our-patient-information/when-your-baby-dies-before-birth/

Discussions should aim to support maternal/paternal choice and include signposting to organisations for support if required e.g., SANDS.

- Complete RADIS report and send PACS Images
- File report in the woman's handheld records and copy to community midwife
- Complete DATIX
- Inform community midwife team for follow-up

6.4 Referral to DGH

Referral should be made to the hospital at which the woman is booked or wishes her care to be transferred. The referral should be made by the midwife through the consultant on call and the labour ward coordinator by telephone using an SBAR handover with the recommendation that the woman attends immediately for confirmation and diagnosis, due to the risk of disseminated intravascular coagulation and sepsis.

Attendance at a hospital should be expedited if severe fetal maceration is noted.

- Refer to the chosen DGH via on-call consultant and labour ward coordinator
- If any blood tests are requested by the DGH, including Kleihauer test these should be taken, and blood forms accurately completed. It is essential to write 'intrauterine death' on the request form for Rhesus positive women.
- Contact phone number and contact name for the labour ward the women are being transferred to must be given
- The woman should be reminded to take her handheld records including blood results and scan reports with her.
- The woman should be informed that a repeat scan may be offered on arrival to hospital.
- The designated community midwife or the team members on duty should be informed of the referral as well as the operational team lead.
- The woman should not travel to attend assessment and scan on her own and should be encouraged to have someone attend with her.

6.5 Staff support

Involvement in identification or suspicion of an IUD can also be a distressing event for staff. Support is available for staff as required through clinical supervisors for midwives (CSfM) with support also available through occupational health and Vivup or Canopi where counselling can be accessed.

7.0 Monitoring Compliance, Audit & Review

It is a requirement that a DATIX is submitted for an incident listed on the 'Incident notification List' and any adverse incident that is of concern and requires further investigation. Feedback of findings and trends should be undertaken at regular intervals through the clinical incident meetings held monthly and in the DAU oversight meeting.

Peer/ consultant review of cases will be arranged periodically to monitor practice.

Auditing will be undertaken as appropriate to ensure clinical standards and governance measures meet clinical professional standards. Image audits are to be completed monthly for growth, dating and anomaly

scans and performed by the training and governance lead Sonographer. A monthly report will be sent to the Head of Midwifery, Assistant Head of Midwifery, Head of Radiography and will be fed into the maternity day assessment unit governance oversight meeting/pathways meeting.

Record keeping audits must be performed to ensure compliance with NMC standards using the template created by the Clinical Supervisor for Midwives. Balanced feedback should be provided to DAU staff for reflection and practice review. Review of the audit should recognize trends for further investigation.

Self-audit of ultrasound images and record-keeping forms part of the audit and review process and time must be allocated for this to occur.

8.0 Reference and Bibliography

Confidential Enquiry into Maternal and Child Health (CEMACH).Maternal confidential enquiries | MBRRACE-UK | NPEU

State of the nation report | MBRRACE-UK

RCOG Late Intrauterine Fetal Death and Stillbirth - Care of late intrauterine fetal death and stillbirth (Green-top Guideline No. 55) | RCOG

MAT 030 - All Wales Midwife Led Care guidelines - 2022

Equality Impact Assessment

It is not mandatory to complete an Equality Impact Assessment (EIA) for a written control document. If you feel it would be of benefit, please complete the box below and attach an EIA as an appendix to this document.

Has an Equality Impact Assessment (EIA) been completed		**NO**
Name of the person giving this response	Midwife Sonographer	
If NO:	**N/A**	
If YES:		