Policy for the Management of Fetal loss, Stillbirth and Neonatal Death

Amendment 2021 - Appendix 4 updated: Consent Form for Arrangements for the Disposal of Fetal Remains (MIS 1)

Amendment 2022 – Appendices added:
Appendix 20: request for fetal, perinatal or infant post mortem examination
Appendix 21: consent for post mortem examination
Appendix 22: certificate of stillbirth

Author: Christie-Ann Lang

Approved by: Maternity Services Quality and Safety Meeting September 2022

Date approved: September 2022

Review Date: September 2025

Disclaimer: The term woman is used through this guideline, but covers people identifying as any gender who are pregnant

Contents

Introduction

Swansea Bay University Health Board is committed to ensuring that pregnancy remains are treated with respect regardless of the circumstances of the loss or termination, and that women* are aware that there are disposal options available to them.

It is the intention of the health board that personal, religious or cultural needs relating to the disposal of the pregnancy remains are met wherever possible. Women should be given verbal or written information about the options, given the opportunity to discuss them, and supported in an individual and sensitive manner to ensure that she can make a decision that is right for her.

The disposal of pregnancy remains should take place in line with the woman's wishes as soon as practicable after she has communicated her decision.

Staff who may be asked, or expected, to provide information about disposal should be aware of this policy and prepared to discuss it. They should have detailed knowledge of, and understand the practical aspects of, each form of disposal to be able to properly communicate this information to women.

Staff will be receiving training to equip them to best support the woman in a sensitive and caring manner. Any staff member who feels they require additional training should advise their line manager in order that appropriate training can be arranged.
Staff should also be made aware that access to counselling services can be arranged should they feel the need for support themselves.

**Throughout the policy, we refer to 'woman/women'. Consideration should be made to the fact that a woman may wish to include, or delegate the decision to, her partner, a family member or friend.*

1. Purpose

This policy is intended to inform staff of the correct procedures, advice and documentation required for the sensitive disposal of fetal remains, stillborn babies and neonatal deaths (up to 28 days of age).

This policy should be read in conjunction with the Human Tissue Act 2004 which makes no distinction between the disposal of pregnancy remains and the disposal of other tissue from a living person; pregnancy remains are regarded as the tissue of the woman. Although under the Act, consent is not required for the disposal of pregnancy remains, the particularly sensitive nature of this tissue means that the wishes of the woman, and her understanding of the disposal options open to her, are of paramount importance and should be respected and acted upon.

2. Roles and Responsibilities

2.1 Clinical Director of Women & Child Health and Clinical Director of Pathology

The Directorate Clinical Directors are responsible for ensuring the implementation of this policy. In particular, they are responsible for ensuring that:

- All Staff involved in the management of pregnancy loss are aware of, and are competent in respect to procedures within the policy.
- Adequate arrangements are implemented for the safe and respectful disposal, of non-viable fetal material, and products of conception, and for arrangements for stillbirths and neonates.
- Incidents relating to inappropriate disposal are correctly and promptly reported and investigated.
- Adequate resources are available to operate the policy.
- Systems are in place for staff training.

Consultant Obstetricians, Gynaecologists and Paediatricians

All relevant Consultants are responsible for ensuring:

- That all relevant junior medical staff are aware of and adhere to the policy.
- That appropriate documented evidence of patient consent is obtained as required within the policy.
- Completion of required documentation.

2.2 Midwives, Early Pregnancy Assessment Unit (EPAU) /Gynaecology and Special Care Baby Unit (SCBU)/Neonatal Intensive Care Nurses (NICU)

Midwives and Nurses are responsible for ensuring:

- Parents/families are provided with adequate information in order to empower them through the entire decision making process.
- They provide support and privacy to parents and enable them to spend time with the baby if they so choose.
- Provision of information regarding bereavement / counselling services.
- Completion of all appropriate documentation.
- Provision of advice and support for other nurses encountering fetal loss, still birth or neonatal death.

2.3 Bereavement Specialist

The health board recognises the sensitive nature of the disposal of pregnancy remains and has employed a specialist midwife to support and counsel women who have experienced a pregnancy loss or early neonatal death. It is acknowledged that some women may not wish to know about the disposal of the pregnancy remains or be involved in decisions about disposal, and may decline the offer of information of possible options or support from a specialist midwife.

The Specialist Midwife is responsible for:

- Provision of counselling and support for any individuals requiring it, following stillbirth, neonatal death and late miscarriage or medical termination for abnormalities.
- Providing support and training to staff to assist in caring for women and their families

2.4 Ultra sonographers and Radiographers

Radiology staff are responsible for ensuring:

- Provision of support, early counselling, information and privacy to parents during and following ultrasound, which detects fetal loss or fetal anomalies.
- Appropriate arrangements are in place when scans are undertaken following stillbirth or neonatal death.
- Completion of all appropriate documentation.

2.5 Theatre Matrons (Theatres)

Theatre Matrons (Theatres) are responsible for ensuring:

- That theatre staff are aware of and adhere to the policy.
- That theatre staff are able to provide support and privacy to parents.
- That theatre staff handle and transfer tissue safely and respectfully at all times to the appropriate department.

2.6 Consultant Pathologists

Consultant Pathologists are responsible for:

- Provision of advice on histopathology related issues as required.
- Ensuring that histology procedures are only carried out as stated within the documented consent process.
- Ensuring adequate arrangements are implemented within Histopathology and the Mortuary for the safe handling and respectful disposal of non-viable foetal material, products of conception, stillbirths and neonates.

2.7 Laboratory Staff

Laboratory staff are responsible for:

- Working within departmental standard operating procedures.
- Ensuring that histology procedures are only carried out as stated within the documented consent process.
- Ensuring the safe handling and respectful disposal of non-viable fetal material and products of conception as stated within the documented consent process.

2.8 Mortuary Staff

Mortuary staff are responsible for:

- Working within departmental standard operating procedures.
- Ensuring the safe and respectful arrangements for stillbirths and neonatal deaths as stated within the documented consent process.

2.9 Emergency Department (ED) Staff

Emergency Department staff are responsible for:

- Ensuring that any women presenting in Emergency Department with a miscarriage are transferred to gynaecology ward at Singleton.
- If the woman does not wish to be admitted, liaise with gynaecology staff regarding completion of necessary forms (particularly those giving consent to disposal of the foetus or foetal remains.
- If woman miscarries in Emergency Department follow department procedures, refer to gynaecology and provide information for Miscarriage Association, offer Memory Box if available and information ofr

3. Management of Miscarriage

3.1 Definition of Miscarriage

When a pregnancy ends spontaneously before the end of the 23rd week.
15-20% of clinically confirmed pregnancies will end spontaneously by the end of the 13th week.

National Institute for Health and Care Excellence recommend that:

1. Women are seen within 24 hours of referral

2. Women referred with suspected miscarriage are offered a transvaginal ultrasound to confirm viability

3. Women with miscarriage who have an initial transvaginal ultrasound are offered a second assessment to confirm the diagnosis

Referral Process

Women are referred by the following practitioners for the reasons stated below and should be given the following information

- Usually referred by GP/A&E/midwives
- Pain and/or bleeding in early pregnancy
- Women who have a history of recurrent miscarriage (3 or more) or a previous ectopic or molar pregnancy can self-refer early on to an early pregnancy assessment unit.
- Support and information giving
- During the consultation women should be informed of:
- When and how to seek advice if symptoms worsen or new symptoms develop – 24 hour telephone number should be given for Gynaecology Ward
- What to expect during care/recovery periods
- Likely impact on future fertility
- Where to access counselling/further support ie miscarriage association website

4.1 Clinical Assessment

	History	Speculum Examination	Bimanual Examination	Ultrasound Scan	Management
Complete Miscarriage	Good history of passing products. Bleeding settled following this	Minimal Bleeding, Cervical Os closed. Take HVS, endocervical and chlamydia swabs	Well Contracted uterus. No Adnexal masses	Only if unclear history/examination findings do not fit.	Reassure. Discharge. Info leaflets & miscarriage association contact details. For Urine BHCG (3weeks) if pregnancy never visualised
Incomplete Miscarriage	History of some products passed. Bleeding ongoing.	Ongoing bleeding, maybe heavy.Cervical Os often open. Remove visible products. Swabs as above	Uterus may feel soft/enlarged/tender. No adnexal mass.	Yes to assess size of retained products	If >15mm retained products discuss options – including expectant management. <15mm reassure/urine BHCG as above (can be done by nurse in EPAU up to 15m.>15mm Dr review)
Silent Miscarriage	Non-viable pregnancy on USS. Asymptotic	Cervcial Os Closed, minimal/no bleeding. Swabs as above.	Uterus Soft and size appropriate/small than gestation. No pain/tenderness.	Diagnosed on ultrasound scan	Expectant Management advised unless contraindicated. Written information/advice/contact details. Follow up 1-2/52

4.2 Diagnosis of Miscarriage

Ideally a Trans Vaginal (TV) scan should be performed to confirm the location and viability of the pregnancy. If the women declines this a Trans Abdominal (TA) scan may be offered.
A definite diagnosis may not be possible with just 1 scan, particularly at very early gestational ages.

Serum HCG Measurements:

- Should not be used to determine location of pregnancy alone
- Can be used to determine suitability for USS (HCG>1500iu/ml) in early pregnancy (<6/40) If fall of greater than 50% in 48 hours, advise patient pregnancy is unlikely to continue and ask them to repeat a urine HCG in 2 weeks and contact EPAU if it is still positive.

Threatened miscarriage

If a viable intrauterine pregnancy is noted in the presence of bleeding advise the woman that if her bleeding continues for 14 days she should contact her midwife or GP.

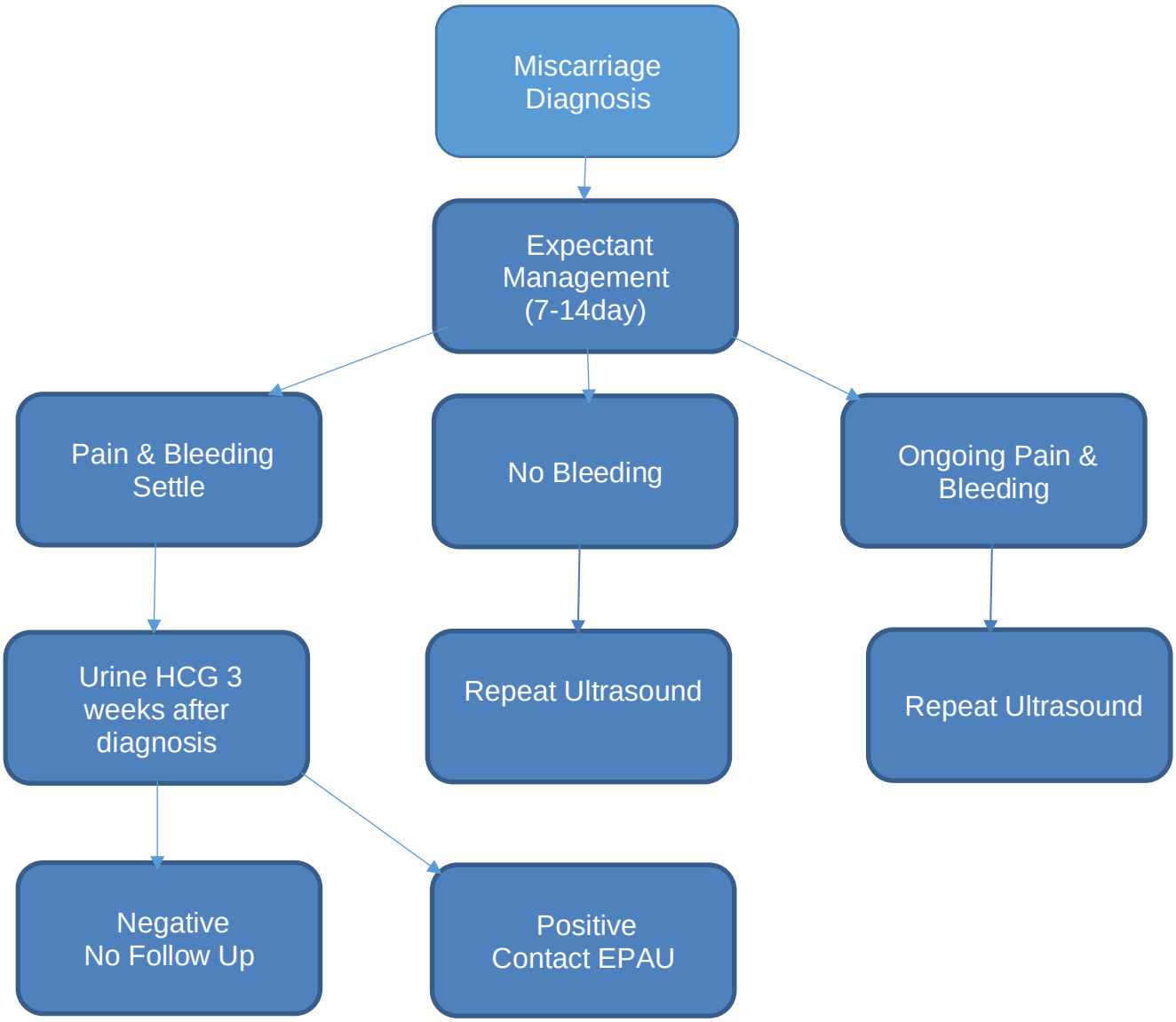
If her bleeding settles she should continue with her routine Ante Natal Clinic (ANC) as planned.

4.3 Management of Miscarriage

Expectant management

Use expectant management as first line management for the first 7-14 days following a confirmed diagnosis of a miscarriage unless:

- She has an increased risk of haemorrhage i.e. late first trimester
- She has previous adverse outcome/traumatic experience of pregnancy i.e. stillbirth, antepartum haemorrhage
- She is at increased risk from the effect of haemorrhage i.e. has coagulopathy or would decline blood transfusion
- There is evidence of infection
- If expectant management is not acceptable to a woman – offer medical management.



If incomplete on rescan discuss all 3 treatment options allowing the women to make an informed choice.

Review women undergoing expectant management of miscarriage a minimum of 14 days after the first appointment

4.5 Medical Management of Miscarriage

Gestation	<9/40	9-12+6/40	13-17+6/40	18-26/40
Place	Home/Hospital	Hospital	Hospital 200mg Mifipristone 36-48 hrs before admission	Hospital 200mg Mifipristone 36-48 hrs before admission
Treatment	800mcg Misoprostol	800mcg Misoprostol	200mcg misoprostol 4doses 6 hourly Double dose if not effective max dose 1600mcg in 24hour	100mcg Misoprostol 4doses 6 hourly Double dose if not effective. Max dose 800mcg in 24 hours.
Ongoing Management		Can consider repeat course of misoprostol following speculum examination if not complete	Speculum Examination after 3 doses and give 4th dose if incomplete	

Offer vaginal misoprostol not mifepristone for the medical treatment of missed or incomplete miscarriage. Oral administration is an acceptable alternative if this is the woman's preference.

Use a single dose of 800 micrograms of misoprostol for both missed and incomplete miscarriage at <9/40

If no contraindications this can be done at home.

Patient should phone EPAU if bleeding has not commenced within 48 hours of treatment.
If patient >9/40 (on scan NOT by dates) will need admission although the treatment is as above for those below 13 weeks gestation.

13-17+6 weeks gestation

- Above 13 weeks gestation can use mifepristone 200mg 36-48 hours before misoprostol
- 200 micrograms misoprostol 6 hourly for 4 doses until products passed.
- Speculum examination should be performed if no products have passed after 3 doses
- If first dose is not effective, dose should be doubled to 400 micrograms
- Maximum dose 1600 micrograms in 24 hours
- 18-26 weeks gestation
- Can use mifepristone 200mg 36-48 hours before misoprostol
- 100 micrograms misoprostol 6 hourly for 4 doses until products passed
- If 1st dose not effective double to 200 micrograms
- Maximum dose in 24 hours 800 micrograms
- All women should be prescribed anti-emetics and analgesia
- Inform women of the potential side effects of treatment including pain, diarrhoea and vomiting.
- Advise women to take a urine pregnancy test 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise the woman that they should contact Early Pregnancy Admissions Unit or Gynaecology Ward sooner for advice/review.
- Advise women with a positive urine pregnancy test after 3 weeks to return for a review to ensure that there is no molar or ectopic pregnancy.
- Medical management has overall lower morbidity than surgical management (1.7% Vs 6.6%) and has an overall success rate of around 90% (greatest in <10 weeks or sac diameter <24mm 92-94%) (De jonge 1995) Up to 99% success in incomplete miscarriage (Saraswat 2014).

4.6 Surgical management

Where clinically appropriate, offer women undergoing a miscarriage a choice of:

- Manual vacuum aspiration (MVA) under local anaesthetic in an outpatient or clinic setting or
- Surgical management in a theatre under general anaesthetic.

MVA is not currently routinely available in Singleton hospital. This may be possible to arrange in exceptional cases or in women with a strong preference for this method.
Provide oral and written information to all women undergoing surgical management of miscarriage about the treatment options available and what to expect during and after the procedure.

Cervical ripening prior to surgical management - either 200mg mifepristone 12-24 hours before the procedure OR 400mcg misoprostol PV 3 hours before or sublingually 2 hours before.

Anti-D Prophylaxis
Below 12 weeks gestation offer 250iu anti-D if ectopic pregnancy, molar pregnancy, surgical management of miscarriage/termination and if repeated or heavy vaginal bleeding with significant associated abdominal pain. A test for fetomaternal haemorrhage is not required.

Between 12 and 20 weeks gestation a minimum does of 250iu anti-D should be administered within 72 hours of a sensitising event. A test for fetomaternal haemorrhage is not required.

Above 20 weeks gestation 500iu anti-D should be administered within 72 hours of the sensitising event.

Ultrasound criteria for miscarriage diagnosis

- If there is no visible heartbeat, measure crown-rump length (CRL)
- Only measure mean gestational sac diameter if the fetal pole is not present.

Trans Vaginal Ultra Sound Scan (TV US)

Repeat scan in 7 days if

- CRL is <7.0mm with TV US and there is no visible heartbeat.
- If the mean gestational sac diameter is <25.0 mm with a TV US and there is no visible fetal pole.

Patients should be informed that further scans may be necessary to confirm their diagnosis.

NICE would also advise either repeat scan in 7 days or to seek a second opinion on the viability of the pregnancy if:

- If the CRL is 7.0mm or more with TV US and there is no visible heartbeat
- If the mean gestational sac diameter is 25.0mm or more using a TV US and there is no visible fetal pole

However as long as the person performing the scan is suitably qualified to do so a diagnosis of miscarriage can be made on these findings. A repeat scan should always be offered in this situation at the patients' request.

Trans Abdominal Ultra Sound Scan (TA US)

Repeat scan in 14 days if

- There is no visible heartbeat when the CRL is measured on TA US o Record the size of the CRL
- If there is no visible fetal pole and the mean gestational sac diameter is measured using TA US or Record the size of the Gestational Sac (GS)

Inform women that waiting for a repeat scan will not affect the outcome of the pregnancy.

Give the woman a 24 hour contact telephone number for advice if require further assistance.

When diagnosing a complete miscarriage on ultrasound scan, in the absence of an earlier scan confirming intrauterine pregnancy be aware of the possibility of an ectopic pregnancy. Therefore she should have follow up planned either in the form of repeat

beta HCG to ensure the levels are falling or a urine beta HCG and to contact the unit if this remains positive. She should also be informed of symptoms to look out for and to contact the unit if she has any concerns.

5 Medical Management of Fetal Demise or Intrauterine Death > 20 weeks

Intrauterine fetal death refers to babies with no signs of life in utero. Stillbirth is defined as a baby delivered with no signs of life known to have died at or after 24 weeks of pregnancy. In addition to any physical effects, stillbirth often has profound emotional and social effects on parents, their relatives and friends. The purpose of this Policy is to outline the medical management of stillbirth and intra uterine fetal demise after 20 weeks.

Suspected IUD should be confirmed by ultrasound imaging of the fetal heart by a practitioner experienced in Ultrasonography (senior obstetrician or radiographer). **A second opinion is recommended where possible.**

5.1 Induction of Labour (IOL)

Options regarding when to deliver should be discussed and choices given where appropriate. The process of IOL may be lengthy and the mother must be advised of this. A combination of mifepristone and a prostaglandin preparation should be recommended as the first-line intervention for induction of labour.

Mifepristone (Day 1): Mifepristone administration before prostaglandin increases sensitivity of uterus
Cautions: asthma, smokers aged over 35, haemorrhagic disorders and anti-coagulant therapy, adrenal suppression
Not recommended in hepatic or renal impairment,
Avoid aspirin and NSAIDs for analgesia.
Side effects: nausea, vomiting, gastrointestinal cramps, uterine contractions, rash, urticaria, vaginal bleeding, facial oedema, malaise, headache, fever, dizziness, hot flushes.

- Mifepristone - Single oral dose of 200mg.
- Observe for 1 hour post administration
  Repeat dose if the patient vomits within 30 minutes of first dose
  Patient should be warned to expect light vaginal bleeding and should be advised to contact Labour Ward earlier than planned should she require stronger analgesia or experience heavy bleeding. **Prostaglandin Administration (48 hrs later)**
  Cautions: cerebrovascular disease, cardiovascular disease
  Side effects: diarrhoea, abdominal pain, nausea and vomiting
  The sensitivity of the uterus to prostaglandins increases with gestation, hence the differing regimes as follows:

20 - 26+6 weeks
Misoprostol: **100mcg** to be given orally or vaginally 6 hourly for a total of 4 doses. (Decision on route of administration to be made following discussion with the woman
If the first dose does not lead to effective contractions then the subsequent dose can be increased to 200mcg.The maximum dose should not exceed 800mcg in 24hrs.

Induction for Intrauterine Death over 27 weeks.

Misoprostol: **50mcg** orally or vaginally every 4 hours up to 6 doses (Decision on route of administration to be made following discussion with the woman)

If the first dose does not lead to effective contractions then the subsequent dose can be increased to 100mcg.The maximum dose should not exceed 600mcg in 24hrs.

- If unsuccessful, repeat the cycle with misoprostol after 24 hours after discussion with the consultant obstetrician
- Monitor hourly- uterine contractions, pulse, temperature, BP and symptoms
- Give 6 hourly paracetamol 1gm (to control maternal temperature)
- Analgesia – Morphine 10 mg 4hrly / PCA / epidural if required
- Do not rupture membranes unless deemed essential (risk of chorioamnioitis)

Note: Misoprostol is available only as 200mcg tablets. Therefore:

- 100mcg : break the tablet in half down the score line with the tablet cutter and give orally or vaginally
- 50mcg: Either dissolve the 200mcg tablet in 20ml of water and give 5ml (drawn up in an oral syringe) to be taken orally by the patient. Alternatively this can be carefully divided into 4 with the tablet cutter if to be given vaginally.

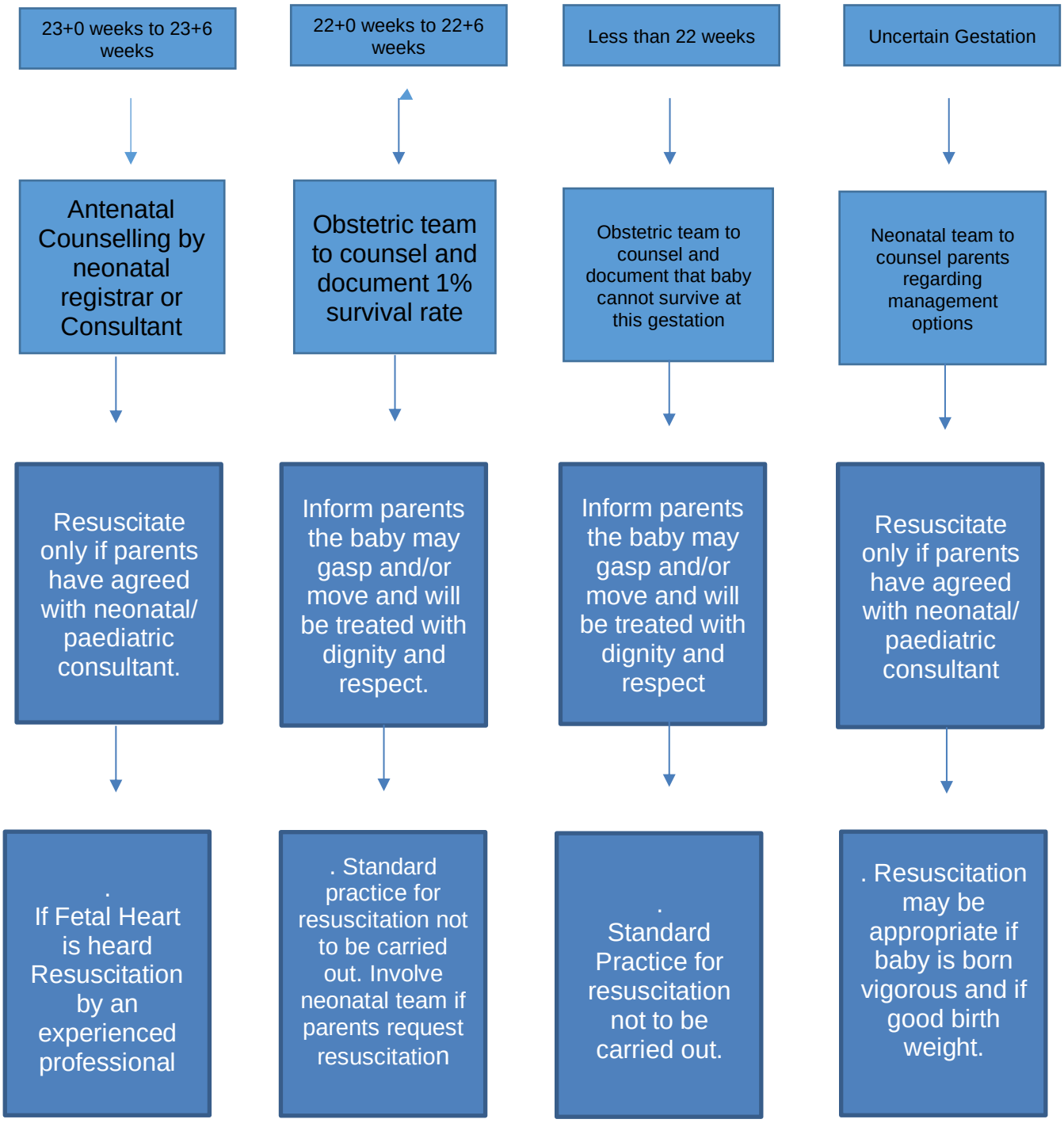
Discard any leftover tablet or solution.
Midwives / Doctors who are, or may become pregnant should not handle the crushed or broken tablets.

For women with previous caesarean section

- A discussion of the safety and benefits of induction of labour should be undertaken by Consultant Obstetrician
- Mifepristone can be used alone to increase the chance of labour significantly within 72 hours (avoiding the use of prostaglandin) - 600mg daily for 2 consecutive days (BNF)
- Consider Propess Pessary for second part of induction of labour
- Misoprostol can be used for induction of labour in women with a single previous LSCS after discussion with Consultant Obstetrician
- Avoid doubling of dose of misoprostol

If the suspected cause of fetal demise is possibly caused by a placental abruption please consider a ROTEM test prior to delivery.

5.2 Delivery at Threshold of Viability



Management of Baby Born with Signs of Life Which is Not for Resuscitation

- **Baby should be treated with dignity, respect and love**
- **Comfort Care should be provided**
- **Wrap the baby to keep baby warm and provide family with the option of holding baby**
- **If family do not wish to hold or see the baby place in an appropriate size Moses Basket in an appropriate area.**

6 Best Practice

6.1 Points for Best Practice

- In high risk cases e.g. 2 or more caesarean sections, low lying placenta/ placenta praevia, transverse lie, the Consultant on call will need to formulate an individualised delivery plan depending on the gestation.
  Note: Placenta praevia / transverse lie etc. will be rare. They may need to be delivered by Elective C-Section. Elective C-Section can be an appropriate mode of delivery with IUFD.
- If the membranes have ruptured, then prolonged retention of the fetus may lead to intrauterine infection and IOL should be commenced as soon as possible, with antibiotic cover if necessary – in such cases IOL with oxytocin can be considered.
- If there is heavy vaginal bleeding or pyrexia, then early delivery should be advised.

6.2 Prevention of Rhesus - D Isoimmunisation

Feto-maternal haemorrhage may have occurred days before clinical presentation. A Kleihauer should be taken at diagnosis and Anti-D given immediately to Rh negative women, as delivery may not occur until 72 hours later. A further dose of Anti-D may be required depending on Kleihauer result.

6.3 Management- Postpartum

- Offer single dose of **Cabergoline (1 mg)** for suppression of lactation as one third of women experience severe discomfort with non-pharmacologic measures. **Dopamine agonists should not be given to women with hypertension or pre-eclampsia**
- All key staff responsible for care of the woman during pregnancy and afterwards should be informed of events. This includes the woman's consultant and GP.
- All existing appointments for the woman should be cancelled
- Women should be routinely assessed for thromboprophylaxis
- Arrange Obstetric follow up- with Consultant within 12 weeks and bereavement specialist midwife in the immediate period following loss. Referrals to be made by telephone or email to Specialist Bereavement Midwife.

7.1 Death of a fetus before 24 weeks of pregnancy but delivery occurred after 24 weeks.

When it is known that one or more fetuses have died in utero, either naturally or through medical intervention such as selective reduction, it can be said that the pregnancy of that fetus (or fetuses) has ended. It may be that there are other continuing pregnancies in the same womb but the pregnancy of the dead fetus is no longer continuing. This means that in a number of situations where it is known that one or more fetuses has died prior to 24 the week of pregnancy (for example where there has been a delay between a diagnosed intrauterine death and delivery, vanishing twins or selective multi-fetal pregnancy reduction in multiple pregnancies), those fetuses known to have died prior to the 24th week of pregnancy would not be registered as stillbirths

7.2 Fetus Papyraceous

In the case of a fetus papyraceous it is known that the fetus must have died before the 24th week of pregnancy and thus it would be incorrect to register it as a still birth.

7.3 The Care of Babies Born Alive on the Threshold of Viability

The threshold of viability is defined as 22-24 weeks gestation (BAPM 2000). **Once a baby has been born showing signs of life, it is to be recorded as a live birth. It acquires legal rights and therefore the right to life regardless of its gestational age.** Advice on the correct procedures to follow should be sought from the resuscitation of the new-born policy.
Disposal of babies at this gestation, in these situations, should be in line with the after 24 week procedure.

8. Management of Disposal of Fetal Remains (up to 24weeks gestation)

It is essential to ensure that arrangements are in place to provide sensitive disposal of all fetal remains. Parents must be informed of all options open to them and that staff are able to consider any personal wishes expressed by the parents. Parents must be given guidance and support whilst making the decisions as to whether they wish the hospital to make arrangements or they wish to make their own arrangements.
In order that all relevant forms are present there is a flow chart (Appendix 1) which staff must follow and a checklist which must be completed at ward level and by mortuary staff.

Documentation includes the following forms:

- Consent for arrangements for sensitive disposal of fetal remains **MIS 1 form to be completed by all women**
- MIS 3 - Certificate of cremation or burial requires completion if taking place in Swansea area or Morriston Crematorium only.

If parents have consented to post mortem, ensure the consent form and investigation procedure form together with a photocopy of the notes are together. Ensure consent for transfer of notes is also completed. Parents must be advised that the time it takes for results to come back is outside of hospital control and should be available by 12 weeks. Parents are asked to consent to additional tests being carried out during the post-mortem (i.e. genetic testing) to allow the Pathologist to carry out a full examination. However, these additional tests are carried out at the discretion of the Pathologist.

All miscarriages must be documented in the ward register and must include disposal arrangements and patient details.

Please ensure all women are issued with the Information Leaflet for Parents Experiencing Pregnancy Loss Before 24weeks of pregnancy

8.1 Hospital Management

If parents wish the hospital to take responsibility for disposal this will be by communal cremation and will be in line with the agreement between the Health Board and crematorium/funeral director in question. Fetal remains are kept by the hospital mortuary for approximately eight weeks prior to the cremation. It is important that when discussing the arrangements that parents understand that the disposal arrangements will be by what is known as a "communal cremation" which means there will be other fetal remains cremated at the same time therefore it is not possible to identify any individual cremated remains after cremation or to allow any other option for disposal.
A council register of all cremations of fetal remains, using the unique case number, will be undertaken by the crematorium in order to provide traceability thereafter. Parents must be made aware that they will not be involved in the communal cremation or be informed when it is going to take place. They will be able to make contact after the cremation to be informed of the date this did take place. The remaining ashes will be scattered at Morriston Crematorium at the Children's Garden of Remembrance.

8.2 Parents own arrangements

If parents decide that they wish to make their own arrangements you must advise them to contact a funeral director of their choice who will make all necessary arrangements for them. The decision, and the date of collection, should be recorded in the woman's medical notes and she should be given written confirmation that she is entitled to take the remains to make her own arrangements. There is no legal documentation required or notification to be made.

Cremation: Any remains can be scattered in the crematorium or parents may wish to follow their own arrangements.
Burial: Late miscarriages above 18/40 may wish to use Morriston or Margam Children's Garden of Remembrance. All advice and information to ensure an appropriate choice would be given by the funeral directors.
Burial at home: If the parents request to bury the fetal remains themselves at home they must be advised that they need to own the land and they will also need to inform the local council. Patient Information Leaflet regarding Burial at home is available as Appendix 9.

The date the fetal remains are collected must be recorded in the woman's hospital records prior to the fetal remains being removed from the hospital.

8.3 Undecided option:

This is a difficult period for parents where they may need time to make this often-difficult decision. If parents feel that they need time, ask them to complete the **MIS 1** form indicating they have not decided and ensure the parents are fully informed on who and where to contact. The nurse /midwife present at the delivery should be aware of this undecided option and the mortuary staff made aware. This is apparent on the disposal form and has to be signed on the checklist
It is recommended by the miscarriage association that a time limit of twelve weeks is appropriate in order for parents to make their decision. After 6 weeks gynaecology staff or the Specialist Bereavement Midwife will ring the woman in question and prompt her that we are still awaiting a decision. If she needs a longer period or is unable to be

contacted the staff will ring around 4 weeks later and use the services of the bereavement midwife. They may be able to offer additional support or help at this time.

All these actions MUST be documented in the case notes

8.4 Hand-over of Specimens or Fetal remains to Mortuary Staff:

- Singleton Hospitals: All fetal remains are to be taken directly to the mortuary not to histology.
- Neath Port Talbot Hospital: All fetal remains will be collected by transport and taken directly to the Mortuary in Singleton Hospital.
- The handling and management of fetal remains is a sensitive and highly important matter. It is therefore imperative that this policy is adhered to by all health personnel involved in the care, transportation and disposal of these remains. This is to ensure that there is a system for ensuring safety and an appropriate auditable pathway for fetal remains whilst they are the responsibility of the Swansea Bay University Health Board.

Procedure

- All fetal and placental remains, which are either for transportation to the Paediatric Pathology Unit at University Hospital of Wales or are for disposal, are to be taken directly to the Mortuary. They must not be taken to Histology. It is the responsibility of the designated nurse/midwife to record at ward level that a fetus has been aborted and the date it is transferred to the mortuary, in the assigned record book. The information must include name of mother and date of delivery and date of transfer to mortuary. This must be available for audit purposes. This will be in addition to the checklist that is completed at ward level and recorded in the patient's hospital records.
- Placenta is to be taken to the mortuary within 8 hours of delivery to be refrigerated to be transferred to Cardiff UHW
- The specimens **must** be accompanied by appropriate documentation in relation to the agreed investigations and decision for disposal i.e. Post Mortem request form and form indicating parents' wishes regarding disposal**. It is the responsibility of the designated nurse/ midwife to ensure that all documentation is completed**. A record of these decisions must be made in the hospital records.
- A registered nurse/midwife accompanied by a porter will be responsible for transferring of the fetal remains to the mortuary. They must not under any circumstances leave the fetal remains until the hand-over procedure is completed.
- The fetal remains must logged in the Mortuary Register within the allocated refrigerated area and details logged to include mother's demographics, date of receipt and who took, to the hospital mortuary. Details of when sent and when returned must be logged in the Mortuary Register for Stillborn Infants by the Mortuary Technician. Upon return the Mortuary will arrange for the disposal of the remains in line with the wishes of the parents. This will either be with the Contract Undertaker if it is to be dealt with by the Hospital or with the designated Undertaker if the parents wish to deal with the funeral. Mortuary staff will liaise with the appropriate Undertaker to determine when the funeral will be conducted. Information as to which Undertaker has responsibility for the funeral and when the remains are removed from the Mortuary will be logged in the Register by the Mortuary staff.

- Where no definitive decision by the patient as to whether or not the fetus is to be sent to Paediatric Pathology Department this must be logged in the Gynaecology/Maternity record book and the Mortuary informed of the indecision. If this exceeds 12 weeks a joint decision will need to be made regarding disposal.
- The Mortuary Department will arrange for the delivery of the fetal remains to Cardiff and its return following post mortem. Upon return the Mortuary will arrange for the disposal of the remains in line with the wishes of the parents.
- The Medical Practitioner may require histological assessment for other clinical management reasons, e.g. hydatidiform mole. This will be requested as per current policies and guidelines.
- In the case of retained placenta or products of conception there may be a need for the patient to undergo a surgical procedure in theatre. **Under no circumstances will the fetus be taken to theatre with the patient**. The fetal remains must remain at ward level locked in the designated storage refrigerator until the woman returns to the ward accompanied with her placenta in the appropriate labelled specimen container. Under no circumstances must formalin be added. The placenta must be placed with the fetus at ward level and the staff must arrange transfer as described previously. The theatre records must clearly indicate that the placenta has been returned to the ward. If staff in theatre are unsure of the correct procedure for individual specimens will they please contact midwifery staff or nursing staff on the gynaecology ward.
- In the event that the products of conception obtained from a woman either at ward level or following a surgical procedure are clearly not fetal or placental tissue (i.e. curetting's) these will be sent to the histology department directly accompanied by an appropriate request form. This must be documented in the case notes.
- Under no circumstances should material be left anywhere un-attended in the laboratory, or at ward level. The ward will have a lockable refrigerated facility for storage of fetal and placental products. Delivery to the Mortuary should be made as soon as possible.

9. Management of Stillbirths (after 24 weeks gestation) or any gestation where signs of life are shown.

A stillbirth refers to the death of a baby born after 24/40 gestation showing no signs of life.

Stillbirths during pregnancy are classed as an antenatal intrauterine death. Those occurring during labour are classified as intrapartum death.

The diagnosis and care parents receive from those looking after them and their baby has a huge impact on their perception of the experience and how they cope and deal with their loss in the long term. In order to provide this care, the following should be observed:

9.1 Diagnosis

- When an intrauterine death is suspected mothers should be seen in a private area.
- At every stage parents need accurate information communicated sensitively and promptly.
- Contact consultant/registrar.

- Initial confirmation of an intrauterine death can be undertaken at ward level by portable ultrasound scanner. These findings must be confirmed in writing by the ultrasonography department. Be aware this is not a 24 hour service and therefore delay in written confirmation may occur. A qualified midwife will accompany the mother when a scan is to be performed in the ultrasound department.

9.2 Breaking Bad News

- It is important for staff to take into consideration the significance and extent of the information being given to parents. The importance of the news should be acknowledged.
- The news should be given in a private place, never in public.
- What is said should be stated clearly but sensitively and parent's questions answered. Always express your sympathy & concern and offer what support you can
- Ensure parents are given adequate time to talk over the implications of the news with staff or they may need time alone. Parents always remember the way that information is given and the attitude of the people involved.
- When a woman's partner is with her discussion should always include both partners.
- A professional interpreter should be involved if necessary.
- Parents may need a lot of detailed information. This maybe overwhelming if it is given all at once and sometimes it helps to give information at stages. Parents should not have to wait for information or for answers to their questions without knowing when they will have the opportunity to talk with the professional concerned.
- Some continuing support from either hospital or community professionals should be offered although not all women will wish to take up the offer.
- No one wants to break bad news and it is always a distressing task. It is important that professional are supported by their colleagues.
- All those involved in breaking bad news to parents should have received some training in the relevant communication skills.

Plan of Care

- The Consultant and Midwife in charge of the Unit must be informed once confirmation of a stillbirth has been received
- The Consultant or Registrar should discuss options of care and a clear management plan documented in woman's notes.
- Parents must be cared for in a bereavement suite or suitable room according to their immediate physical and emotional needs which includes ensuring there are facilities for the father to stay overnight if required. If appropriate and a private family room is available, this should be offered as it gives parents and their families the privacy to spend time with their baby.
- Every effort should be made to fully explain and answer questions ensuring that parents understand every new situation as it arises.
- Induction of labour to be followed as documented individually for each patient. Some parents may wish to delay induction of labour to give them time to prepare themselves. Other parents may wish to proceed with the delivery as soon as possible.

- Bloods for group and save FBC Screening Blood investigations can only be done following delivery, and as per protocol.
- Inform Anaesthetist of patient and ensure that adequate pain relief has been prescribed for use on both Antenatal and Postnatal Wards.
- Checklist prior to the birth of a Stillborn baby should be completed (Appendix 5).

9.3 Preparation for Labour and Delivery

This Policy isdirected to all professionals who are caring for parents and their baby around the time of death. The care that we give to parents is sensitive and appropriate and can help families in their grief, whilst poor care can exacerbate and prolong a family's distress.

- Enquire whether there are any religious or cultural aspects of care and ensure every effort is made to meet their requests and documented in patient's notes. Some families may have strong beliefs that require specific procedures to be carried out. Others, even those who do not regularly practice a religion may find time with a chaplain a comfort. Ask sensitively if parents would like a blessing etc. It is important to honour any cultural traditions the family may have.
- Post mortem: If it is felt to be appropriate, the introduction of this subject prior to delivery may give parents more time to understand this difficult decision. The information booklet gives detailed information for the parents.
- Discuss with parents their wishes regarding seeing /holding their baby, giving time for parents to prepare clothes and discuss any needs they may have. Giving them a choice is very important at this time. The use of mementos and photographs will help support these memories and should be kept even if parents decline them at the time. **Please Use the Camera on CDS to take photographs and provide the parents with the memory card for them to keep. If parents do not wish to see their baby or make memories please offer to take photographs and hand and footprints and place in an envelope in Maternal Notes clearly labelled in case parents change their mind at a later date.**
- Remember My Baby Photography is also available free of charge if parents wish to use this service.
- Always use the babies name if one has been chosen. This will acknowledge that the baby is respected. Referring to "your baby" is much more personal than "the baby". You may also demonstrate your sensitivity in holding and touching the baby. Parents may be afraid to hold their little one and your care will help them to create a relationship.
- **It is the responsibility of the parents to arrange a funeral if baby is born over 24 weeks gestation or at any gestation where signs of life are shown.**. The cost of a funeral is free and is subsidised by the Welsh Government. Parent may have to pay a fee for any extra requirements such as flowers etc. Parents can be supported by the bereavement support midwife to advise them of their choices for arrangements, but the hospital cannot take any responsibility for this. Parents may choose to dress their babies and the midwives can support them in this request. It will be responsibility of the funeral directors to advise to what clothing, toys or mementos are appropriate to be left with the baby if cremation is being planned.
- When the parents are ready the baby must be transferred to the mortuary by the midwife and accompanied by a porter and a record kept in the mortuary. All

appropriate information must be documented. All placentas need to routinely go for histology to Cardiff UHW and sent with an appropriate histology request form.

- If the parents request to take their baby home this is acceptable but the hospital records and the mortuary must keep a log of this. The parents can then contact their chosen funeral director themselves to arrange for the baby to go to the local Funeral Directors chapel of rest until the funeral when they are ready for this. **The midwife visiting the parents to offer postnatal care and support must be informed of this also and it is courteous to inform local police in case any emergency situation occurs whilst the parents have taken baby home such as Road Traffic Collision en-route to or from the Hospital.**
- It is important to encourage parents to talk about their feelings and to cry. Explain to parents that reactions to death can include numbness disbelief sadness and anger. We will provide various leaflets to help give parents information. Please provide parents with the SANDS Information Pack for Bereaved Parents.

9.4 Post Mortem Examination

All parents suffering the stillbirth or late termination of an infant after 24 weeks gestation must be offered a full post mortem examination (or appropriate limited examination). The post mortem must be performed by an appropriately qualified Perinatal Pathologist. University Hospital of Wales, Cardiff is the only centre in Wales where there is an appropriately qualified Perinatal Pathologist. Swansea Bay University HB has an agreement in place for the transport of baby and placenta to UHW.

The process for obtaining consent for PM should be given over a minimum of 2 separate contacts with the parents. Practioners who are obtaining consent must have attended All Wales Post Mortem Training within the last 2 Years and their name must be held on the Database held at the Pathology Department at Cardiff UHW.

1. Parents will be given the all Wales information leaflet “Deciding about a post mortem: Information for parents” as a minimum*. It is recommended that this should be complemented by the leaflet produced by SANDS. It is important that parents are given the appropriate time to consider the information provided and given the opportunity to ask questions.

2. Obtaining consent - The person obtaining consent for the post mortem must have undergone the All Wales consent for post mortem training and be registered on the National Database held at the paediatric pathology department at University Hospital of Wales (UHW).

The All Wales consent documentation will be completed to a high standard and copies filed as followed:

- One copy to the parents
- One copy filed in the medical notes
- One copy sent to the pathology department with the baby

Parents have the right to change their mind about any of the decisions they have made. Parents may make contact with the Labour Ward Co-ordinator within the time specified

in the 'Right to change your mind' section of the Consent Form for a PM Examination of a Fetus, Baby or Child.

The Labour Ward Co-ordinators has overall responsibility to ensure UHW are informed the baby will be transferred for post mortem by telephoning 02920748421/02920742706. The Labour Ward Co-ordinator will be the point of contact for parents should they require information relating to the transport of the baby to UHW.

The Bereavement Specialist Midwife will be the designated named person in place to monitor the progress of the report and communication with the family.

The post mortem report will be shared with families at the earliest opportunity and a copy made available should they wish. The Midwife will make a planned appointment with the named consultant within 12 weeks of the date of the post mortem being completed. The appointment will take place in an appropriate environment away from the clinical area in 'Awel Mor' . A minimum time of one hour should be allocated for this appointment.

The Bereavement Midwife will liaise with the parents if the post mortem report is not available at this time and will re-arrange the appointment with the consultant.

The parents should be given details of who to contact should they wish to arrange a follow up appointment with the consultant in the event of them having further questions.

Post-mortem declined

If a post mortem examination is declined, verbal consent will be obtained from the parents for placental examination. The placenta must be sent for examination to the Perinatal Pathologist at University Hospital of Wales, Cardiff. The placenta will be placed in the appropriate container and addressed Fetal Pathology Department, UHW, Cardiff and taken to the mortuary where transport will be arranged. **A placenta must be taken to the Mortuary within 8 Hours of delivery and refrigerated. If the parents are spending tie with the Baby the placenta can be taken to the mortuary separately and documented in the register held at the mortuary**

9.5 Genetic Counselling

All parents whose baby has abnormalities will be referred to a geneticist for counselling following delivery. Genetic testing is sometimes part of the post mortem procedure although this additional test is carried out solely at the discretion of the Pathologist.

9.6 Bereavement Room

If appropriate and a private family room is available, this should be offered as it gives parents and their families the privacy to spend time with their baby. Some parents may feel more comfortable remaining within the hospital. The use of the Cuddle Cot should be explained to the parents and used in order that parents may spend an extended period of time with their baby before there is deterioration of the body.

When the parents feel they can finally leave their baby you should take the baby to the mortuary accompanied by a porter in a portable cot and it should be covered

appropriately to maintain dignity and respect. The parent's should be told who is responsible for their baby. Leaving their baby will be very hard and it is important for the parents to have the correct information if they were to wish to return to see their baby again. Please offer to accompany the parents to their car when they leave the hospital, as leaving without their baby is one of the most traumatic experiences for grieving parents.

9.7 Follow-up care and support

We should ensure continuity of care and support in the community and parents will receive visits by their team midwife. Completion of the Checklist relating to actions required prior to discharge as well as providing Post Natal Discharge Paperwork for Community Midwives. This will assist in ensuring all appropriate healthcare professionals are notified. The Bereavement Specialist Midwife having been informed via the referral form or by telephone will make contact with the family with their consent. The Bereavement Specialist Midwife will aim to make contact with the family within 1 week. There is no right way to grieve and support needs to be available at any stage. It should be explained that contact with the bereavement counsellors can occur at whatever stage in their grieving they chose.

9.8 Documentation

This should be in line with the flow-charts within the Appendices that must all be completed. **The stillbirth checklists should be completed**. This will support the practitioner in adhering to this policy and best practice principles. Particularly when it is acknowledged that this is a less than common scenario for every day practice.

9.9 Legal Requirements

A stillbirth must be registered within 42 days. It is the responsibility of the parents to register the stillbirth with the registrar. A neonatal death must be registered within 5 days. Exceptions can be made after discussion with the Registrar in complex cases such as Mum remaining an inpatient.

A fetus born dead before 24 completed week's gestation is legally an abortion and does not require a certificate. Please offer certificate of acknowledgement of delivery which is held within the Memory Boxes.

9.10 Children's Garden of Remembrance

Within the Health board there are Children's Remembrance Gardens in Morrsiton Crematorium and Margam Cemetery which are dedicated to babies. The cost of a baby's funeral is now funded by the Welsh Assembly Government but here maybe a minimal fee if family wishes for extra details such flowers etc. A list of local funeral directors is available and parents should be reassured that they will support in making the arrangements with them.

9.11 Memorial Service

A remembrance service is held at a local church annually, which is available to all families' friends and professionals to attend.
A book of remembrance is kept in the chapels at Singleton Hospitals where parents are invited to enter words of their choice.
Non-religious services are held annually in the Children's Remembrance Gardens.

10. Management of Policy

Equal Opportunities Impact Assessment

The EIA has been assessed as low/medium and therefore does not require a fill EIA. For the purpose of this policy where there is a reference to communication the needs of all people in the context of language reading difficulties or disabled groups will need to be considered.

All staff should undertake equality and diversity awareness training.

Training and Education Plan

All personnel involved in implementation of this policy will undergo a 2 hour training programme on its content as a minimum. This policy will then form part of the directorate internal mandatory programme to alert ongoing training needs or changes.

Risk Management

Any incidents occurring as a consequence of noncompliance with the policy will managed in line with the adverse incident policy. This policy will be subject to internal audit requirements and be placed on the Directorate audit business plan.

This Policy is to used in conjunction with the following pathways and patient information leaflets that can be accessed via WISDOM

- ***Care Pathway for the Management of Neonatal Death on Central Delivery Suite***
- ***Care Pathway for the Management of Pregnancy loss from 12 to 23+6 weeks gestation***
- ***Care Pathway for Management of Intrauterine Death and Stillbirth over 24 weeks gestation***
- ***Care Pathway for the Pregnany Loss and Termination of Pregnancy for Fetal Abnormalities within the First Trimester***
- ***Information following the Loss of your Baby***
- ***Information to support families following the decision to end their pregnancy for medical reasons***
- ***Information to Support Parents following the Loss of a Pregnancy in the First Trimester***

11. References

Human Tissue Act 2004

Abortion Act 1967

British Association of Perinatal Medicine Guidelines 2019

NMC Circular 0/3

Welsh Health Circular (92)

Human Tissue Authority Code of practice 5

Late Intrauterine Fetal Death and Stillbirth. RCOG Green top guideline no: 55, Oct 2010.

Gomez Ponce de León R, Wing D, Fiala C. Misoprostol for Intrauterine fetal death. Int J Gynaecology Obstet 2007(99) S190–S193.

National Institute for Health and Clinical Excellence. Clinical guideline no. 70: Induction of labour, 2008

Misoprostol Clinical guidelines - www.misoprostol.org

NHS in Greater Manchester and Eastern Cheshire Strategic Clinical Networks. 2018. Management of Second Trimester Pregnancy Loss. Integrated Care Pathway.

De Jonge EJM (1995) Randomised Controlled trial of medical evacuation or surgical curettage for incomplete miscarriage. BMJ 311 662

NICE Guideline (CG154) Ectopic Pregnancy & Miscarriage:Diagnosis & Initial Management

Qureshi, H., Massey, E., Kirwan, D., Davies, T., Robson, S., White, J., Jones, J. and Allard, S. (2014) BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. Transfusion Med, 24: 8–20. doi:10.1111/tme.12091

Saraaswat L, Ashok PW & Mathur M (2014) Medical management of Miscarriage. TOG 16 79-85

Tinder J, Brocklehurst P, Porter R, Read M, Vyas S, Smith L (2006) Management of miscarriage: Expectant, Medical or Surgical? Results of Randomised Controlled Trial (miscarriage treatment trial). BMJ 1223-1224

Directorate of Women & Child Health

Checklist for Clinical Guidelines being submitted for Approval by Quality & Safety Group

Title of Guideline:	Care Pathway for the Management Of Neonatal Death on CDS
Name(s) of Author:	Christie-Ann Lang
Chair of Group or Committee supporting submission:	Antenatal and Labour ward Forum
Issue / Version No:	7
Date approved by Clinical Guideline Group	September 2022
Next Review / Guideline Expiry:	September 2025
Details of persons included in consultation process:	Antenatal and labour forum Labour Ward Forum
Brief outline giving reasons for document being submitted for ratification	Guideline review
Name of Pharmacist (mandatory if drugs involved):	NA
Please list any policies/guidelines this document will supercede:	Policy for the Management of Fetal Loss, Stillbirth and Neonatal Death. Version 6.2 December 2020
Keywords	Maternity Bereavement Care, Intrauterine Death, Stillbirth, Neonatal Death
File Name: Used to locate where file is stores on hard drive	ABM Group (Z:)\Maternity\policies and guidelines\Obs\2020 onwards