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

Specialty: Maternity /Gynaecology Services
Date Approved: December 2020 (Version 6.2)
Ratified by: Quality and Safety Group
Date for Review: December 2023

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.

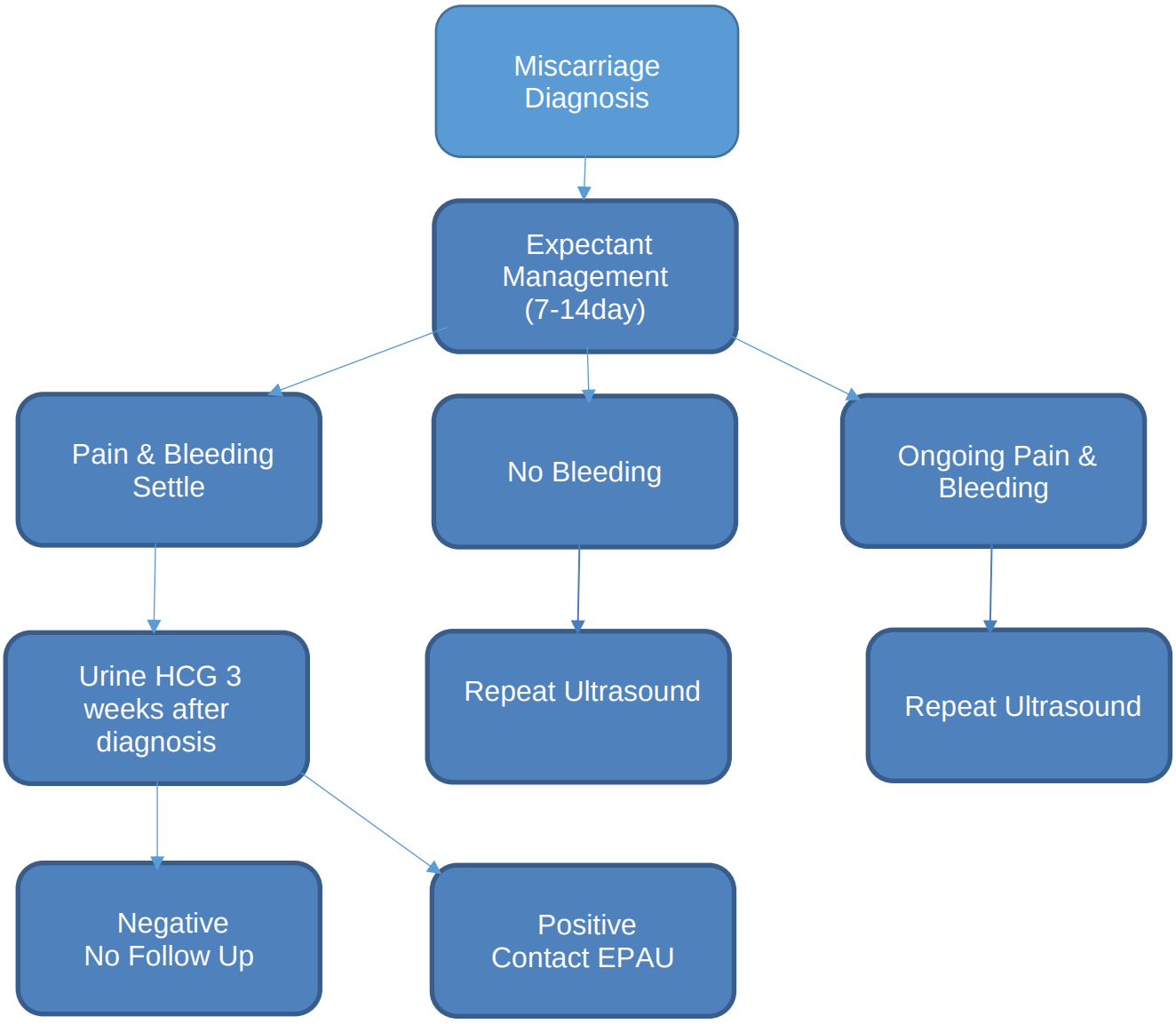
If her bleeding settles she should continue with her routine Ante Natal Clinic (ANC) as planned.

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.

<u>Anti-D Prophylaxis</u>
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:

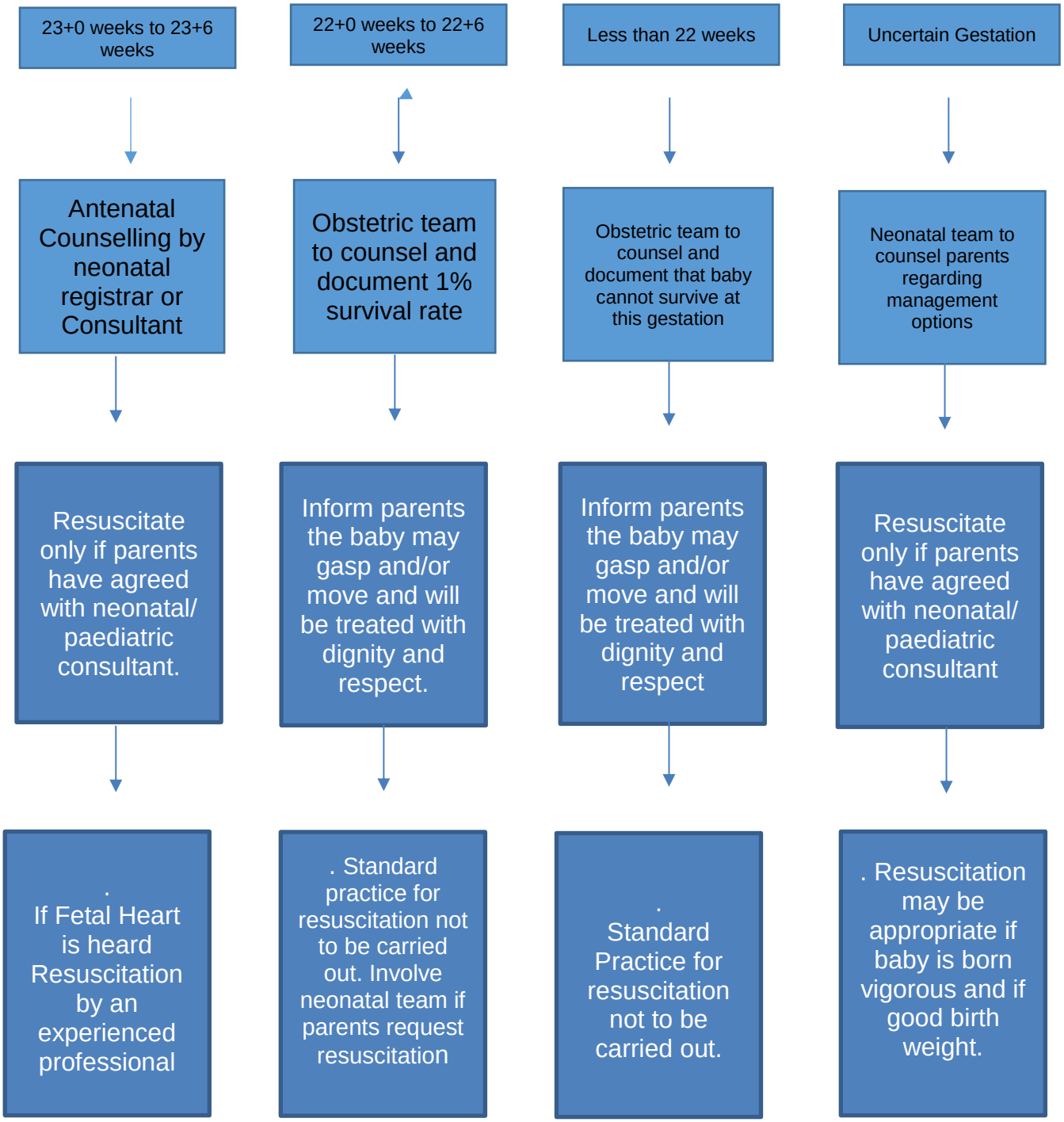
- 100mcg : break the tablet in half down the score line with the tablet cutter and give orally or vaginally
- 50mcg: Either dissolve the 200mcg tablet in 20ml of water and give 5ml (drawn up in an oral syringe) to be taken orally by the patient. Alternatively this can be carefully divided into 4 with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

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.

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

Appendix 1: Flowchart for the management of pregnancy loss below 23+6 where no signs of life are shown

Discussion to have taken place with parents regarding options available in relation to funeral/disposal of fetal remains in relation to individual situation and if Post Mortem is required.

If Post Mortem is requested advise that fetus will go to Cardiff UHW and will return in approx. 3 weeks.. Consent for Post Mortem must be obtained and all paperwork to stay with fetus on transfer to mortuary. Fetus transferred to mortuary by Midwife and documentation completed upon transfer.
If chosen to make own funeral arrangements a post mortem will delay funeral taking place. Post Mortem results will be discussed with parents by a Consultant after results are available in 12weeks. Placenta to be sent to UHW for Histology regardless if Post Mortem is being carried out. Placenta to go to Mortuary within 8 hours of delivery.

Own Arrangements

Obtain name of chosen funeral director if know. (Inform all funerals are free of charge as per Welsh Assembly Government Standards.

Home Burial: Provide information leaflet on home burial and requirements needed. Parents to contact chosen funeral director when able to make further arrangements. No registration of Birth/Death is required.

Undecided

If parents undecided fetus to be sent to mortuary and inform Specialist Bereavement Midwife who will follow up upon discharge

Hospital Arrangement

By communal cremation at Morriston Crematorium after 6 weeks. (MIS 3 Form Required).

Parents cannot attend and will not know when cremation is taking place. Ashes will be scattered at Morriston Children Garden of Remembrance.

Please ensure all Documentation is Complete on transfer to the mortuary in the register that is available. – Please see flowchart for transferring placenta/fetus to mortuary

Appendix 2: Flowchart for the management of fetus born <23+6 showing signs of life

Parents should have been counselled by Obstetric Consultant Prior to Admission to be made aware that fetus maybe born showing signs of. If signs of life are shown then care should be managed appropriately and parents will have to take responsibility for arranging funeral.

Discussion with parents regarding wishes in relation to holding fetus and spending time if signs of life are shown. A Senior Doctor must certify the death.

A discussion with Coroner must be carried out by the senior Doctor if a Medical Termination of Pregnancy has taken place in order to determine if the Dr can proceed in issuing a death certificate or if the Coroner wishes to proceed with further investigations.

Where signs of life are shown following an MTOP referral to the Coroner must take place by a Senior Doctor as Medical Intervention has taken place as per Legal Requirements.

Birth to be registered as a Live Birth on WPAS and Death Recorded when completing discharge notification.

Parents must make own arrangements for funeral to take place if signs of life are shown and will be required to register Birth and Death at County Hall, Swansea Civic Centre. Death Certificate to be issued to parents if no Coroner involvement and Appointment arranged.

If post mortem has been requested by parents ensure consent has been obtained, all documentation complete and maternal notes photocopied and to be kept with fetus on transfer to the mortuary .Placenta is also required. **Placenta to go to mortuary within 8hrs of delivery.** Inform mortuary staff and Cardiff UHW Pathology of transfer of fetus.

If no post mortem requested placenta to be sent to Mortuary for Histology at Cardiff UHW. **Placenta to go to mortuary within 8hrs of delivery**

Please ensure that upon transfer to the mortuary all information is documented in the Register available

Appendix 3: Checklist for pregnancy loss below 23+6 where there are no signs of life.

Mothers Name: **Mothers Hospital Number:**

	Questions/Documentation to be completed	Yes/No	Signature	Date
1	Has plan of care been discussed with parents and documented in notes by Consultant including signs of life, postnatal testing i.e. bloods			
2	Provide contact numbers			
3	Have the parents been informed of time and place to come back following first stage management			
4	Once admitted for 2nd stage management, discuss parent's wishes during labour i.e. memory making, pain relief, chosen wishes.			
5	Has the initial post mortem discussion taken place and information booklet given			
6	If appropriate obtain hand and foot prints, photos, weight and offer memory making items. Discuss holding/seeing their baby following delivery. **Please Use the Camera on CDS & 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.**			
7	Discussion regarding funeral/hospital disposal arrangements/private arrangements			
8	Has consent from for disposal of fetal remains been signed			
9	Has the cremation/burial form been signed and completed (photocopy and place in notes)			
10	If Post Mortem required please obtain: - Fetal examination form - Consent Form - Photocopy relevant notes Placenta to be sent to UHW Histology even if Post-mortem not requested.			
11	Ensure all Antenatal and Scan appointments are cancelled Complete and send Bounty suppression form			
12	Inform GP, antenatal clinic, Community Midwife and arrange community midwife if suitable. Email Bounty: Bereavements@bounty.com			
13	Please offer acknowledgement birth certificate (in place of still birth certificate) as no official document offered if no signs of life shown.			
14	If appropriate offer cuddle cot if parents wish to stay with baby			
15	Offer parents the option to take baby home If parents accept the offer, midwife **must** contact '101' and inform emergency services that stillborn baby going home (provide address) with parents. Document in mothers notes the time call made to '101'			
16	Consider Cabergoline 1mg for Lactation suppression			
17	Provide Bereavement Midwives telephone number and card			
18	Ensure Consultant appointment is made			
19	Offer Post Natal Midwife visit if appropriate			

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

Consent Form for Arrangements for the Disposal of Fetal Remains (MIS 1)

Addressograph

Hospital Responsibility

I/We wish ABMU Health Board to accept responsibility for the sensitive disposal of fetal remains. I/We understand that this will be communal cremation (with other fetal remains).

Signed ..... Date .....

I can confirm that the relatives have been informed of the proposed cremation and have not expressed any objection.

Signed ..... Date .....
Qualified Doctor / Nurse / Midwife

Print name .....

Own arrangements

I/We accept responsibility for making arrangements to dispose of fetal remains. This will be by:

* Cremation / Burial (*please delete as appropriate)

My chosen Undertaker is: .....

Time frame to collect the fetal remains when parents are making own arangements is 2 weeks.
In the event that foetal remains will be left in the mortuary longer then 3 weeks they will be disposed of in line with hospital protocol (cremation).

Signed ..... Date .....

Undecided

I/We are undecided about the arrangements and agree to contact the Ward as soon as we have made a decision. The ward staff will contact you around 6 weeks and again around 10 weeks if no decision has been given.

I/We understand the Health Board will ensure sensitive disposal arrangements are made following 12 weeks of your pregnancy loss unless you advise us otherwise

Signed ..... Date .....

Patient Information Leaflet on method of disposal given? Yes ☐ No ☐

Appendix 5: Certificate of Medical Practitioner, Nurse or Midwife in respect of Disposal of Fetal Remains (MIS 3)

Cremation No (if applicable):
……..……

MORRISTON CREMATORIUM / SWANSEA BURIAL ONLY

Certificate of Medical Practitioner, Nurse or Midwife in respect of Disposal of Fetal Remains (MIS 3)

I, hereby certify that I have examined the fetal remains/products of conception of

(Mother's name): .....

(Address): .....

.....

delivered/miscarried on: ……at ……..am/pm of ..……weeks gestation and that at no time was there any sign of life.

I have no reason to suspect that the duration of the pregnancy was shortened by violence, poison or any unlawful act and I know of no reason why any other examination or enquiry should be made.

Signed by .....

Print name .....

Date .....

Address .....

Post Code …….. Contact Tele No: .....

Registered Qualifications .....

NB: - If remains are to be cremated, this form must be accompanied by the following:

1. FORM A: Application for Cremation (White)
2. Preliminary Application for Cremation (Cream)

Appendix 6: Sensitive Disposal of Products of Conception

Undecided Regarding Sensitive Disposal of Products of Conception

(To be retained by Ward until completion and then filed in hospital notes)

Addressograph	Date products passed ……

Contact Telephone Number ……..

Patient to be contacted twice when no decision made:-

Contact around 6 weeks

Contact date: ..... Contact made by: .....
(Sign and print)

Response: .....

.....

Contact around 10 weeks

Contact date: ..... Contact made by: .....
(Sign and print)

Response: .....

.....

The Health Board will arrange sensitive disposal following 12 weeks of the pregnancy loss if no decision has been made.

Date Mortuary contacted by Gynaecology Staff to inform of decision or to proceed if no decision made by parents …….
Mortuary Staff Member Contacted…….
Date Paperwork taken to mortuary to accompany products of conception to allow sensitive disposal to take place: ……

Appendix 7: Checklist relating to actions required prior to the birth of a stillborn baby

Checklist relating to actions required **PRIOR** to the birth of a Stillborn baby	Addressograph:

PLEASE COMMENCE A PARTOGRAM WHEN IN ACTIVE LABOUR

All Boxes of Checklists to be completed

Actions	Yes/No	Signature	Date
IUD confirmed by scan			
Parents informed of their baby's death			
Consultant on call informed of the IUD			
Consultant or Registrar consultation (please print name below) Name……..			
Plan of care discussed and documented (including blood tests to be taken following delivery)			
Parents asked if they would like to bring in clothes to dress the baby following the delivery			
Parents informed of the time/place to arrive at the hospital (if they have gone home prior to induction)			
Provide Sands Bereavement Book and any other literature necessary			
Discussion regards analgesic requirements for labour			
Bloods taken for full blood count, clotting, and group & save for electronic issue. (Bloods will require repeating for electronic issue every 72 hours)			
Discussion and information provided to the parents regards post-mortem examination			
All Wales information leaflet "Deciding about a post mortem: Information for parents" provided before the birth of the baby if appropriate and parents wish to discuss at this time.			

Appendix 8: Checklist relating to actions required following the birth of a stillborn baby/neonatal death

Checklist relating to actions required **FOLLOWING** the birth of a Stillborn baby/Neonatal Death	Addressograph:

PLEASE COMMENCE A PARTOGRAM WHEN IN ACTIVE LABOUR

Actions	Yes/ No	Signature	Date
Were parents Cared for in a room that was appropriate to their needs away from other crying babies if possible			
Offer Memory Making e.g Memory Box, Ibrahim's Gift, Hand in your Heart, Towels, Photographs, Clay Prints, lock of hair.			
Parents given the opportunity to hold their baby			
Was a Cold Cot Used			
Family members given the opportunity to see / hold the baby (parents' wishes)			
Does Coroner need to be informed? Confirmation of IUD/Neonatal Death Name (please print) ……..……..…….			
Religious and cultural beliefs discussed and respected e.g was hospital Chaplin or own religious leader contacted to offer blessings, naming ceremony			
Maternal bloods taken for investigation as per management plan			
Baby dressed according to the parents' wishes and bathed if skin allows			
Consultant informed of Birth			
Offer Cabergoline to suppress Lactation			
Doctor / Midwife completed the stillbirth certificate			
Complete: - **Identity bands** - **Birth Register** - **Myrddin** - **MBRRACE** - **Cancellation of Bounty**.Email Bounty: **Bereavements@bounty.com** - **Incident Report Form (Datix) and number**			
Obtain: - a lock of baby's hair - a hand and foot print - a photo of the baby			
Weight and measurement of the baby (head circumference)			
Offer of quilt to parents			
Discussion regarding post mortem (PM) examination with the parents			

Name of person who undertakes discussion for Post Mortem			
Person who takes consent for post-mortem is trained and registered on The All Wales national database			
Post Mortem accepted: All Wales PM consent form completed and signed:- - One copy to be given to parents - One copy filed in maternal medical records - One copy to be sent to pathology department with the baby			
- Examine placenta, take swabs for C&S. **Transport to the mortuary within 8 hours of delivery**. Baby can follow if parents memory making			
- Fetal Examination Form completed			
- Photocopy obstetric notes and scans to go with baby in envelope to the mortuary			
- Complete request form for examination of fetus from Department of Pathology (UHW)			
- UHW informed of transfer of baby 02920748421 or email Sharon.Jenkins3@wales.nhs.uk			
If Post Mortem declined: - Forms to mortuary with baby			
- Complete the histology form for the placenta and clearly label for attention Fetal pathology department, UHW. The placenta must be taken to mortuary within 8 hour so of delivery where they will arrange transport of the placenta to Cardiff.			

Appendix 9: Checklist relating to actions required prior to discharge following the birth of a Stillborn baby

Checklist relating to actions required **PRIOR TO DISCHARGE** Following the birth of a Stillborn baby	Addressograph:

ACTIONS	Yes/No	Signature	Date
Community Midwifery Team informed of fetal loss			
General Practitioner informed			
Health Visitor informed			
Bounty Suppression form completed and emailed. **Bereavements@bounty.com**			
Bereavement Specialist midwife emailed using referral form.			
Stillbirth Certificate - During COVID 19 Stillbirth Certificate scanned and emailed to Deathregistrations@swansea.gov.uk. Original certificate then sent to Registry Office by recorded delivery			
Memory Caring Folder given to parents			
Foot/Hand prints and Clay Print Set in Bereavement Box offered to parents			
Baby's photos given to parents			
Memory Box given to parents			
Has Cabergolin 1mg been offered and given to suppress Lactation			
Contact details for the Bereavement Specialist midwife given to parents and referral completed and emailed.			
12 week appointment with named Consultant or Consultant on call (if MLC) arranged through secretary			
12 week appointment provided to parents to discuss PM and/or placenta histology explain maybe delay in results but aim for 12 weeks			
Provide Specific Discharge Paperwork for Bereaved Parents for Community Midwife			

Appendix 10: Examination of Baby

Verbal consent obtained for external examination of baby

MEASUREMENTS
Weight _____g
MACERATION
Fresh: no skin peeling □
Slight: focal minimal skin slippage □
Mild: some skin sloughing, moderate skin slippage □
Moderate: much skin sloughing but no secondary compressive changes or decomposition □
Marked: advanced maceration □
HANDS
Normal appearance □
Abnormal appearance □
If abnormal describe _____
FINGERS
Number present _____
If not 4+4 please describe_____
_____
Abnormal webbing or syndactyly □
If abnormal describe _____
NAILS
All present □
If not, describe _____
THUMBS
Number present _____
If not 1+1 please describe_____
Unusual position of fingers □
Looks like a finger □
If abnormal describe _____
FEET
Normal appearance □
Abnormal appearance □
If abnormal describe _____ _____
TOES
Number present _____
If not 5+5 please describe_____
Abnormal spacing □
If abnormal describe _____ _____
GENITALIA
Anus □ Normal □ Imperforate □ Other □
If other please describe _____
SEX
Male □ Female □ Ambiguous □
MALE
Penis □ Normal □
Hypospadias □ Very small □
If hypospadias describe level of opening _____
Scrotum □ Normal □
Abnormal □ If abnormal describe _____
Testes □ Descended □ Undescended □ Other □
If other describe _____
FEMALE
Urethral opening
Present □ Absent/ □ unidentifiable □
Vaginal introitus Present □ Absent/ □ unidentifiable □
Clitoris Present □ Absent/ □ unidentifiable □
Other □ If other describe _____
Ambiguous sex □ Please describe _____

Appendix 11: Investigations

All cases	Unexplained IUD	Specific to cause
FBC, G&S; **Coagulation** screen including fibrinogen; **Kleihauer;** **Fetal post-mortem** (full / limited); Cytogenetic analysis in relevant cases; **Placental Histology – Sent to UHW** **Person who delivers the baby should document:** • degree of maceration of skin • any obvious external abnormality of features or limbs • baby's weight and overall impression - IUGR/normal/macrosomia • gender and name given by parents, if known; **Fetal anomaly** CARIS form to be completed.	**CRP;** **TORCH**, **Parvo virus, Rubella, Syphilis** (particularly in presence of polyhydramnios and/or fetal hydrops); **Thyroid Function Tests;** **Placental swab for microbiology;** **Placental Histology – Sent to UHW** ; **HbA1c;** **MSSU, HVS or LVS.** *** Blood for anti-platelet antibodies only required if autoimmune thrombocytopenia suspected ***	**Placental abruption** – Placental histology, thrombophilia screen. **Chorioamnionitis** Infection screen including blood cultures, placental swab, swabs from baby. **If IUGR suspected** Lupus-anticoagulant; Anticardiolipin antibodies; Factor V Leiden Prothrombin gene mutation; *Repeat thrombophilia and APLA screen 6 weeks post delivery; Placental Histology; **If h/o itching or jaundice** LFT and bile acid. **Parental karyotyping** Indicated if: - fetal unbalanced translocation; - other fetal aneuploidy, e.g. 45X; - fetal genetic testing fails and history; - Suggestive of aneuploidy (fetal abnormality on post-mortem, previous unexplained IUFD, recurrent miscarriage).

- An abnormal result might not be linked to the IUFD but rather be simply an incidental finding
- Comprehensive investigation can be important even though one cause is particularly suspected
- Parents should be advised that no specific cause is found in almost half of stillbirths
- Parents should be advised that when a cause is found it can crucially influence care in a future pregnancy

NB: An abnormal test result is not necessarily related to the IUFD; correlation between blood tests and post-mortem examination should be sought. Further tests might be indicated following the results of the post-mortem examination.

Investigations

All Cases
FBC – Purple bottle
Coagulation and Fibrinogen – Blue Bottle
Group and Save – Pink Bottle
Kleihaur – Pink
Placental Histology sent to Cardiff in a white tub with Histology form completed with all clinical information and addresses to Cardiff.
If Fetal anomaly please complete CARIS card.

IUGR or below 10th centile

Thrombophilia Screen – 2 purple bottles, 6 Blue Bottles, 1 Gold Bottle
TORCH/Parvovirus – Gold Bottle
Lupus- 2 Blue Bottles
Factor V Leiden – Purple
Anti- CardioLipin Antibodies– Gold Bottle

Infection

Blood Cultures – Blood Culture Bottles
CRP – Yellow
HVS- Black Charcoal Swab
Placental Swabs (fetal and maternal) – Black Charcoal Swabs

Hydrops

Anti Ro/La – Gold Bottle
Parvovirus – Gold
Anti Red Cell Antibodies – 2 Purple Bottles

Hypertension/PET

PCR, U + E, LFT, Urate – Yellow Bottle
Thrombophilia Screen - 2 purple bottles, 6 Blue Bottles, 1 Gold Bottle

Diabetes

HbA1c- Purple

Abruption

Thromboplhillia Screen - 2 purple bottles, 6 Blue Bottles, 1 Gold Bottle

History of Itching or Jaundice

LFT and Bile Acids – Gold Bottle

No Obvious Cause

Bile Acid – Gold Bottle
HbA1c – Purple Bottle
TORCH & Parvovirus – Gold bottle
Thyroid Function - Gold Bottle
Thrombophilia Screen - 2 purple bottles, 6 Blue Bottles, 1 Gold Bottles

Appendix 12: Indications and guidance for sending placentas to histology for reporting

Placentas that **MUST** be transferred for Histology Investigations at Cardiff UHW:

- Medical Termination for Fetal Abnormalities
- Still Birth/Intrauterine death
- Neonatal death shortly after delivery
- • Fetal hydrops

Placentas that **MUST** be sent to histology department at Singleton Hospital:

• Severe fetal distress requiring admission to NNU
• Prematurity (less than 30+0 weeks gestation)
• Fetal growth restriction (birthweight below 3rd centile)
• Maternal pyrexia (>38ºC).

Referral of placenta for examination that may be **Desirable** for Histology Investigation at Singleton Histology Department – to be agreed at time with local clinicians

- prematurity (30+0–36+6 weeks)
- placental abruption
- fetal congenital malformation
- rhesus (and other) isoimmunisation
- morbidly adherent placenta
- twins or other multiple pregnancy (uncomplicated)
- abnormal placental shape (if clinically relevant)
- 2 vessel cord, etc.
- prolonged rupture of the membranes (more than 36 hours)
- gestational diabetes
- maternal group B streptococcus
- pre-eclampsia/maternal hypertension
- maternal coagulopathy
- maternal substance abuse.

Referral of placenta in the following conditions is NOT INDICATED, as pathological examination is unlikely to provide useful information:

• cholestasis of pregnancy
• pruritis of pregnancy
• hepatitis B, HIV, etc.
• other maternal disease with normal pregnancy outcome
• placenta praevia
• post partum haemorrhage
• polyhydramnios
• normal pregnancy.

The placenta is to be placed in a placenta bag and placed in the appropriate placental bucket, which must be secured and clearly labelled with Mothers information. A histology request form must be completed and securely attached to the placental bucket which clearly states whether the investigation is to be carried out at Cardiff UHW or Singleton Histology department along with any relevant antenatal information.

ALL placentas for examination must be taken to the designated mortuary refrigerator within 8 hours. The placenta must be taken to the mortuary by a porter and a member of staff (midwife/health care) and placed in the allocated area and stated if transfer to Cardiff is required. The appropriate paperwork in the mortuary must be completed by the midwife/Health care to ensure transfer of placenta can be arranged as soon as possible. **Porters are to be contacted to take the placenta to the mortuary at any time (Evening, Weekend and Out of Hours).**

Appendix 13: Transfer of Infant to Mortuary following Late Miscarriage, Medical Termination of Pregnancy, Intrauterine Death or Neonatal Death

In All Cases Placenta Must be sent to Cardiff UHW Pathology Department for Histology Investigations

Placenta placed in a placenta bucket with Mums Information labels present and Histology form completed to go to Cardiff Pathology.
Placenta to be refrigerated in Mortuary within 8 hours of delivery. Placenta can be taken separately f parents are memory making with infant.

Ensure Infant/Fetus/Placenta have correct identifiable labels/ ID bands in situ (If NND or Stillbirth Infant/fetus will have own hospital number)

If post mortem is requested all appropriate paperwork present and antenatal notes photocopied and kept with infant at all times upon transfer. Paperwork

If no post mortem requested appropriate paperwork for gestation completed including cremation forms, chosen funeral arrangements of parents' wishes or sensitive disposal if below 24 weeks gestation. PLACENTA TO BE SENT TO CARDIFF UHW FOR HITOLOGY INVESTIGATION. MUST BE TAKEN TO MORTUARY AND SIGNED INTO THE ALLOCATED AREA BY MIDWIFE

Infant wrapped appropriately to maintain dignity and respect and placed in Cot. Transferred to Mortuary with Midwife and porter.

If Mortuary Technician present inform of transfer between 1pm-3pm Monday-Friday. If out of these hours please document all information in the register held in the allocated storage area.

On arrival the porter will direct you to the allocated area where you will place the infant. Please complete the Register situated within the allocated Storage area with all relevant details. Place details on white board on the front of allocated area and state if Post Mortem requested next to name.

Appendix 14: Bereavement Support Following Pregnancy Loss or Neonatal Death Referral Form

Hospital	Singleton ☐	NPTH ☐

Patients Name	
Hospital Number	
Date Of Birth	
Contact Telephone Number	
Address	
G.P	
Named Consultant	
Family Members	
Date of Bereavement	
Name of Baby if relevant	
Gestation	
Post Mortem	Accepted ☐ Declined ☐
Reason for Referral	
Relevant Medical History	
Previous Obstetric History	
Referred By	

Please return completed forms to:

Christie-Ann Lang Specialist Bereavement Midwife.
Christie-Ann.Lang@wales.nhs.uk. Telephone 0776646896.
Antenatal Clinic. Singleton Hospital. Sketty Lane. SA2 8QA.

Appendix 15: Notification to General Practitioner/Health Visitor

Notification to General Practitioner/Health Visitor

Please send this form to the GP and Health Visitor (if applicable) to inform of late miscarriage, medical termination of pregnancy for fetal anomaly, Intrauterine Death, Still Birth or Neonatal Death.

Affix Addressograph of Patient or insert details:
Hospital Number Name Address Date of Birth GP Surgery Address

General Practitioner ☐ Health Visitor ☐

The above patient has experienced :

A Late Miscarriage ☐

Medical Termination for Fetal Abnormality ☐

Intrauterine Death ☐

Stillbirth ☐

Neonatal Death ☐

The above occurred at …….. weeks gestation

Named Consultant …….. Ward Care carried out on ……..

Date of Admission ……Date of Discharge ……..

Relevant Medical/Clinical History

Name of Health Professional informing of above ……
Signature …….
Ward…….
Date …….

Appendix 16: babies book of Remembrance

Babies Book of Remembrance

I wish to enter my child's name into the Babies Book of Remembrance at Singleton Hospital:

Name of Child: ……..

Date of Birth ……**Date of Death**…….

Names of Parents:
……

……

Siblings:
……

……

……

Verse or Message of your Choice

……

……

……

……

……

……

……

Please return to:
Christie-Ann Lang, Specialist Bereavement Midwife, Antenatal Clinic, Singleton Hospital, Sketty Lane, SA2 8QA

Appendix 17: Information leaflet following pregnancy loss

Information leaflet following pregnancy loss

Information Leaflet For Parents Experiencing Pregnancy Loss

Before 24 Weeks of Pregnancy

This information leaflet has been developed to help you make the necessary decisions at this time. We are required to ensure that you are informed of the options available to sensitively deal with your pregnancy loss.

Why do I need to be aware of these options?

Firstly, it is a legal requirement that you make arrangements to deal with the products from your pregnancy loss sensitively.

Secondly, it can help you greatly in coming to terms with the loss of your pregnancy. This can have a great emotional affect on you both now, or later on in life.

What are the options available?

Hospital Management

If you choose this option, we will make all the arrangements for you through the hospital. It is important you understand that the disposal arrangement will be by “communal cremation”. This means that there will be other fetal remains cremated at the same time. Cremation is carried out in a dignified and respectful manner. Following cremation, if there are any ashes, they will be scattered on the Garden of Remembrance at Morriston Crematorium. It is important to realise it is not possible to separately identify any individual cremated remains after cremation or to allow any other option for ashes once cremation has occurred.

Private Management

This means that you wish to make your own arrangements. You will need to contact a Funeral Director of your own choice who will carry out your wishes. If you require help in deciding

about burial or cremation, you can ask the nurse on the ward to contact our Bereavement Specialists who will give you more details or advice.

Burial at Home

If you wish to bury the remains yourselves at home, you must ensure the following:

- ✓ That you own your land
- ✓ That you inform the local council

What if I cannot decide?

If you are too distressed or need more time to decide, then you have up to 12 weeks. Please make every effort to help stay in contact with the ward nurses who can help you.

Singleton Gynaecology Ward 2 - ☎ **01792 285206**

If we do not hear from you after 6 weeks you will be contacted by telephone to ask whether you have made a decision. If you need a longer period, you will receive a further telephone call around 4 weeks later.

If after 12 weeks we do not receive any decision, we will arrange disposal as stated in the Hospital management option above.

Who can support me?

We appreciate there may be lots of decisions you have never faced before at a very upsetting time. Therefore, there are many staff and people who are here to support you.

The ward staff are very well used to managing and advising women in your situation, so please do not hesitate to ask for support. Alternatively, we have dedicated bereavement specialists who support women with pregnancy loss, counselling and advice on burial options. They can be contacted on:

Christie-Ann Lang (Swansea) ☎ 07766466896
Email: Christie-Ann.Lang@wales.nhs.uk

Some women may wish to access support from the hospital chaplaincy service. They can be contacted for you via the hospital switchboard

Appendix 18: Burial at Home

Guidelines to be followed if you wish to carry out your own burial:

- It is essential that you obtain permission to complete a burial where you are not the land owner of the ground involved. If there is any doubt over ownership contact HM land Registry to check who is the registered land owner.
- If you have a mortgage or loan against the property where the baby is to be buried, you should notify any company, or individual who has an interest in the property.
- You should record the date and place of burial in a formal letter which should be attached to the title deeds of your property or land.
- Environmentally friendly and biodegradable material must be used for burial (plastic containers etc must not be used).
- There must be no danger to water courses or supplies and there must be no danger of bodily products leaking onto adjoining land.
- There is no legal requirement to inform the Environment Agency in advance of a burial although you may wish to confirm that the intended burial site meets their safety standards for any local watercourses or other local issues. The burial site should not be within 10 metres of any standing or running water, or 50 metres of a well, borehole or spring that supplies water for human consumption, depth of burial should be at least 45 centimetres.
- You should be aware that such a burial may deter future prospective purchasers or occupiers and affect the re-sale value of the property.

Prior to leaving the hospital, you will be asked to sign a form stating that you are making your own arrangements to dispose of the fetal remains.

Post Natal Discharge Records

Addressograph

Community Team: _____ Contact Number _____

Named Midwife: _____Contact Number_____

Labour Ward: 01792 530862
Specialist Bereavement Midwife: Christie-Ann Lang

Contact Number: 07766466896

Mothers Name……. Father/Partners Name ……..

Gravida …… Parity…… Blood Group……. Rhesus Status …….

Anti D Required: Y/N. Anti D Administered Y/N. Date Administered ……..

Carbagoline Offered to supress Lactation Y/N. Carbagoline Administered Y/N

Date of Birth…….. Time of Birth……

Delivery Type: NVD/Ventouse/Forceps/C-Section. MBL:……..

Perineum: Intact/1st Degree/2nd Degree/3rd Degree. Perineum Sutured: Y/N

Post Mortem Accepted/Declined. Memory Box Provided: Y/N

Photographs/Handprints Given to Parents/Kept in Notes

Gestation at Birth……..

Sex of Baby …… Baby's Weight ……

Baby's Name …….

Discharge Medication:

……
……
……
……

Further relevant information:

……
……
……
……
……

Date	Comments	Name/Signature

Date	Comments	Name/Signature

Support Available

Swansea Bay Baby Loss Support Group - A local support group for anyone who has experienced a pregnancy loss, death of a child or requires support during subsequent pregnancies. A safe and confidential space to meet other parents and support one another the closed group on Facebook: Swansea Bay Baby Loss Support Group.

Christie-Ann Lang: Telephone/Text 07766466896. Email:Christie-Ann.Lang@wales.nhs.uk

ARC Antenatal Results & Choices - Support for parents whose baby is diagnosed with a fetal abnormality in pregnancy.

Helpline: 0845 077 2290 or 0207 713 7486

http://www.arc-uk.org/

MIND - Promoting and supporting people with mental health problems. Freephone : 0161 272 8205

http://www.mind.org.uk/

Bliss for babies born sick or premature - Family support helpline offering guidance and support for premature and sick babies. Helpline: 0808 801 0322 http://www.bliss.org.uk/

Samaritans - Confidential emotional support in times of despair. Telephone: 116 123 http://www.samaritans.org/

Sands Stillbirth & Neonatal Death Charity - Support for families affected by the death of a baby before, during or shortly after birth.

Telephone: 0207 436 5881

http://www.uk-sands.org

Child Death Helpline - For all those affected by the death of a child.

Freephone: 0800 282 986 0808 800 6019

http://childdeathhelpline.org.uk/

Cruse Bereavement Care - For adults and children who are grieving.

Telephone: 0808 808 1677. http://www.cruse.org.uk/bereavement-services/

Contact a Family **-** Support and information about specific conditions. Telephone: 0808 808 3555

http://www.cafamily.org.uk/

Daddies With Angels -Advice and support to male family members following the loss of a child/children.

Telephone: 007513 655134

http://www.daddyswithangels.org

TAMBA (Twins & Multiple Birth Association) - Bereavement and special needs support groups

Telephone: 01252 332344

http://www.tamba.org.uk/bereavement

The Miscarriage Association **-**Support for parents who have experienced miscarriage Telephone: 01924 200 799

http://www.miscarriageassociation.org.uk/

2 Wish Upon a Star - a local charity who aims to support all those affected by a sudden and traumatic death of a child or young adult under the age of 25 throughout Wales to ensure they receive the important support they deserve. *www.**2wishuponastar**.org . Telephone 01443 863125. email:info@2wishuponastar.org*

Tommys - Bereavement-trained midwives available Monday to Friday, 9am to 5pm

Helpline: 0800 0147 800

tommys.org/stillbirth-information-and-support

The Key Hope Centre – *Support for pre-post termination of pregnancy, miscarriage and stillbirth*

31 Market Street, Morrsiton, SA6 8DA. 01792 773800. Info.Keyhope@btconnect.com.

Appendix 20 – Request for fetal, perinatal or infant post mortem examination

Paediatric Pathology Service for Wales

Department of Pathology, University Hospital of Wales, Heath Park, Cardiff CF14 4XW

Dr Sergey Popov, Consultant Paediatric Pathologist, 029 20742703, Sergey.Popov@wales.nhs.uk
Dr Delyth Badder, Paediatric and Perinatal Pathology Specialty Registrar, 029 207448952, Delyth.A.Badder@wales.nhs.uk

Paediatric Pathology Secretary
Tel 029 2074 8490
Fax 029 2074 2701

Fetal Pathology Unit
Tel 029 20 744025
Fax 029 20 744074

Request for fetal, perinatal or infant post mortem examination

Please complete all relevant sections of this form to ensure appropriate examination and avoid delay

Form completed by

Name.....

Signature.....

Hospital / tel no. / bleep no.....

Contact for discussion or further information

Name.....

Signature.....

Hospital / tel no. / bleep no.....

Mother details

Addressograph

Name.....

Address.....

Postcode.....

Hospital No..... Date of Birth.....

Fetus / infant details

Surname.....

First name.....

Date/time of birth.....

Date/time of death.....

Hospital number.....

Date of delivery..... Consultant.....

Consultant; referring hospital & ward.....

Infection risk

This is required information. See "Safe working and the prevention of infection in the mortuary and post-mortem room", HSE, 2003.

Is there any danger of infection (HIV, viral hepatitis, TB, etc) from the baby or placenta? **Y / N**

Specify:.....

Any special points of interest?

Mother's medical history

Blood group.....

Past obstetric history

Date; gestation; weight; details of pregnancy, labour and delivery

Details of current pregnancy

Gestational age LMP..... EDD..... Gest (by dates)..... Gest (by scan).....

Non-viable fetus	☐	**Stillbirth**	☐	**Neonatal death**	☐
Spontaneous miscarriage	☐	Antepartum	☐	Premature	☐
Intrauterine death	☐	Intrapartum	☐	Term	☐
Termination	☐				

Reason for termination.....

Fetal anomaly? Y / N

Please give *full* details & US findings (attach copy of report)

Amniocentesis?	**Y / N**	Poly / oligohydramnios?	**Y / N**	Maternal pyrexia?	**Y / N**
Threatened miscarriage?	**Y / N**	Hypertension or PET?	**Y / N**	Glycosuria / diabetes?	**Y / N**
Antepartum haemorrhage?	**Y / N**	IUGR?	**Y / N**	Other problems?	**Y / N**

Details

Labour & delivery

Last evidence of fetal life Date & time.....Duration of: First stage..... Second stage.....

Rupture of membranes Date & time.....Liquor: **Normal / Meconium / Blood / Poly / Oligo**

Labour: **Spontaneous / induced** Why?..... Presentation: **Vertex / breech / other**

Delivery: **Spontaneous / forceps / ventouse / EICS / EmCS** Indication for operative delivery.....

Fetal distress **Y / N** Details: .....

Other complications:

Fetus / infant details

Birth wt..... Sex..... Gest..... Apgar 1 min.....

Resuscitation? 2 min.....

Other.....

Congenital anomalies

Neonatal course
Brief summary of major problems, investigations and treatment

Suspected cause(s) of death

Appendix 21 – Consent for post mortem examination

CONSENT FOR A POST-MORTEM EXAMINATION OF A FETUS, BABY OR CHILD

Name: _____

Address: _____

Addressograph of mother or baby or child if available

D.O.B. _____

REFERRING HOSPITAL'S REFERENCE NUMBER:

Name of fetus, baby or child: _____

Mothers name: _____

Fathers name: _____

Date of death: _____ Place of death: _____

Consultant/GP responsible for: _____

Religion: _____

This form enables you to consent to a post-mortem examination of the fetus, baby or child identified above. Please read it carefully with the person obtaining consent from you. For each section **INITIAL** the relevant box(s) or **CROSS** (X) if not applicable.

- I confirm that I have had the opportunity to read 'A Guide to the Post-Mortem Examination of a Fetus, Baby or Child'.
- I have had an opportunity to ask questions about the proposed examination.
- Any questions I have asked have been answered to my satisfaction.

Initial ☐

Part 1: Consent to a post-mortem examination

*The reason the examination is being requested has been explained to you. The extent of the examination is your decision after discussion (Initial **ONE BOX ONLY**, either A **or** B **or** C).*

A. I consent to a full examination. **Initial** ☐

B. I consent to an examination, limited to the part of the body as stated: **Initial** ☐

_____

_____

(I understand this might limit the information obtained).

C. I consent to an external examination of the fetus / baby and histological examination of the placenta (I understand this might limit the information obtained). **Initial** ☐

Part 2: Consent for use of samples as part of the post-mortem examination

It is usually necessary to examine small samples in more detail to reach a reliable conclusion. Most tissue samples will be processed into blocks and slides for microscopic examination and may be used for other investigations. If you do not consent, this will significantly limit the value of the examination.

I consent to the retention of tissue samples for processing and further examination as part of the examination. **Initial** ☐

Part 3: Consent for retention of a whole organ(s) as part of the post-mortem examination.

Sometimes it is necessary to examine a specific organ in more detail to reach a reliable conclusion.

I consent to the following organ(s) being retained for the purpose of the examination (tick below as appropriate);

- ☐ Any if the pathologist feels it appropriate
- ☐ Any except _____
- ☐ The following _____

Initial ☐

Please indicate your wishes for the disposal of any retained organ(s) (tick below as appropriate);

- ☐ I consent for future use of the organ(s) (specify in part 4).
- ☐ I wish the organ(s) to be returned to the body (this may delay the funeral).
- ☐ I wish the hospital to dispose of the organ(s) in accordance with the Human Tissue Authority Code of Practice.
- ☐ I will make my own arrangements for lawful disposal.

State arrangements if known: _____

Part 4: Storage and future use of organ(s) and tissue blocks and glass slides

Tissue removed can be stored for use in the future and these samples may be of value to your family in the future. Doctors and scientists also require tissue samples for quality control, teaching, public health monitoring and to advance patient care through audit and research. Although it is not common for tissues to be used in this way it can be very important to have this tissue available when the need arises.

*Your consent is required for the, storage and future use of these samples (initial **ALL** that apply).*

- I consent to tissue being stored and used on behalf of the family if the need arises. **Initial** ☐
- I consent to tissue being stored and used for education relating to human health, quality assurance, public health monitoring and clinical audit. **Initial** ☐
- I consent to tissue being stored and used for research that has been approved by an appropriate Ethics Committee. **Initial** ☐

If you chose not to give consent for future use, all tissue samples will be disposed of: please indicate your wishes for disposal (tick below as appropriate):

- ☐ I wish the hospital to dispose of any retained tissue samples in accordance with the Human Tissue Authority Code of Practice.
- ☐ I will make my own arrangements for lawful disposal of any retained tissue samples.

State arrangements if known: _____

Part 5: Additional Tests (tick below as appropriate);

- ☐ I consent to x-rays.
- ☐ I consent to clinical photographs.
- ☐ I consent to genetic testing including the taking and storing of appropriate samples.

Initial ☐

Part 6: Special requests:

_____

_____

_____

Right to change your mind (see Note 1):

You can change your mind about any of the decisions you have made, although there may be a short time limit for some of these. If you wish to make changes to anything you have consented to, or wish to withdraw your consent, please contact the number as specified below:

Before (time): _____ on (date): _____

Contact: _____ Telephone number: _____

Details of person(s) giving consent:

Initial

Name: _____ Signature: _____ ☐

Address: _____

_____ Tel no: _____

Relationship to the deceased: _____ Date: _____

Second parent if they wish to sign: _____

Details of person(s) obtaining consent (see Note 2):

Name: _____ Job title: _____

Contact details: _____

Health Board: _____ Identifier: _____

- Where appropriate, I have discussed the requirements of the post-mortem examination with:

_____ ***(Pathologist or The Fetal Pathology Unit)***

Statement of the person(s) obtaining consent

- I have made enquiries and believe that the person consenting is the appropriate person and they have parental responsibility (see Note 3).
- I believe that the person consenting has a sufficient understanding of the post-mortem examination procedure for the purposes of giving consent.
- I believe that the person giving consent has sufficient understanding of why material is being removed and stored for future use and understands the options available for the tissue including donation for scheduled purposes and subsequent disposal.
- I have discussed any special requests or conditions concerning the post-mortem examination procedure.
- I have examined the answers and have not identified any ambiguities or conflicts in the way the consent giver has completed the form.
- I have offered a copy of this completed form to the person giving consent.

Signed: _____ **Date:** _____

Note 1: If consent is subsequently withdrawn or amended, each page of each copy of the form (or the relevant section(s)) must be clearly struck through. The person taking the withdrawal must sign and date the form clearly, and note action taken to inform the mortuary (document the date, time and member of mortuary staff informed.)

Note 2: Must be legible and include the Health Board responsible and a unique identifier (e.g. professional registration number or NHS email address).

Note 3: The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the time of the child's conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of a child. Fathers who have never been married to the child's mother will only have parental responsibility if they are registered on the birth certificate as the child's father for births after the 1st December 2003 or if they have acquired it through a court order or parental responsibility agreement. For a child born before 1st December 2003, fathers can also acquire parental responsibility if they marry the mother. **NB** - For advice on specific cases please contact the Human Tissue Authority directly on Tel: 020 7211 3400.

White copy to Pathologist Green copy for medical notes Pink copy for the family Version 2, December 2010

Appendix 22 – certificate of stillbirth

Certificate of stillbirth

Cremation 9
introduced in 2009

01.09

Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 The stillborn child

Full name of child or description

Sex

☐ Male ☐ Female

Date of stillbirth

/ /

Part 2 Certificate of stillbirth

I am a registered

☐ medical practitioner

☐ midwife

I certify that I have examined the body of the stillborn child and can certify that the child was stillborn.

I certify that the information I have given above is true and accurate to the best of my knowledge and belief.
I am aware that it is an offence to wilfully make a false statement with a view to procuring a cremation.

Your full name

Address

Registered qualifications

GMC reference number / Nursing and Midwifery Council Personal Identification number (PIN)

Signed

Dated

/ /

Regulation 20(1)(c)(i) of the Cremation (England and Wales) Regulations 2008

Directorate of Women & Child Health

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

Title of Guideline:	Policy for the Management of Fetal Loss, Stillbirth and Neonatal Death
Name(s) of Author:	Christie-Ann Lang
Chair of Group or Committee supporting submission:	Antenatal forum Labour ward forum Gynae forum
Issue / Version No:	6.2
Next Review / Guideline Expiry:	2023
Details of persons included in consultation process:	Bereavement Midwife, Lead Nurse (Sexual Health), Labour Ward Midwives, Lead Midwives, Consultant Obstetricians, Consultant Neonatologists, Consultant Gynaecologists, Gynaecology Senior Staff, EPAU Staff, Antenatal Clinic Sister, Eilir Jones Pathology Department.
Brief outline giving reasons for document being submitted for ratification	Update of existing policy
Name of Pharmacist (mandatory if drugs involved):	n/a
Please list any policies/guidelines this document will supercede:	Policy for the Management of Fetal Loss, Stillbirth and Neonatal Death
Keywords linked to document:	Fetal Loss, Stillbirth, IUD, Neonatal Death, NND, miscarraige
Date approved by Directorate Quality & Safety Group:	Quality and Safety group
File Name: Used to locate where file is stores on hard drive	Z:\npt_fs2\Maternity Incidents Stats\WISDOM POLICIES\Ratified-Policies & Procedures - Obs