Policy for Pregnancy Loss: Miscarriage, Stillbirth and Neonatal Death

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Name of Review/Development Body: Maternity Risk Management Group (MRMG)
Ratification Body: Maternity Risk Management Group (MRMG)
Date of Ratification: September 2013
Review Date: September 2015
Reviewing Officer: Sheryl Roy, Bereavement Midwife
Effective From: September 2013

Signed

Jacqui Tingle
Chair of the MRMG
### Example of a Version Control Sheet

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1. Introduction
Every parent expects to have a safe, happy, live birth of a normal baby. A baby usually signifies new life, hope and promise and the birth is perceived to be a positive and fulfilling experience (Oakley, 1980). In today’s modern society with improved medical care and technology, parents simply do not expect their baby to die (Malacrida, 1997). When pregnancy loss occurs, it is a shock to the parents that such an event could happen (Herkes, 2002).

As pregnancy losses are usually unexpected and sudden, the shock and disbelief experienced has much more impact (Wright, 1991). The grief response is intensified because it is considered a loss of a person who would have been, the ending of dreams, hopes and plan, the loss of a future (Kohner and Henley, 2002). After a pregnancy loss, there are few or no tangible memories that can be shared with other people. It is therefore very important that memories are created in the form of keepsakes and great care should be taken to make sure they are as good as possible.

A woman suffering a pregnancy loss should always be cared for in a single room. It is never appropriate to use a bed in a room with other mothers especially when they have babies with them.

Terminology is very important and being sensitive to the circumstances surrounding the pregnancy loss can make the process and memories of the loss 'less painful' for the parents. Using the word 'baby' rather than 'fetus' can be of extreme importance.

Definitions
Miscarriage
- is a birth up to 23+6 weeks of pregnancy of an infant who did not breathe or show signs of life after complete expulsion from the mother.

Stillbirth
- is the birth of a baby after 24+0 weeks of pregnancy who did not breathe or show signs of life after complete expulsion from the mother.

Livebirth
- is an infant born at any gestation of pregnancy that breathes or shows other signs of life after complete expulsion from the mother.

Neonatal Death
- is a live born infant who dies within 28 days of birth regardless of gestational age. In the maternity unit this will usually be the death of a baby within a very short time after birth

2. Purpose
The aim of this guideline is to ensure all staff are aware of the appropriate management of pregnancy loss.

3. Scope
This policy applies to all clinical staff.

This policy covers the scope of the previous policies for Pregnancy Loss which consisted of 3 policies i.e. Policy for the loss of a baby after Miscarriage, Policy for the loss of a baby after Neonatal Death and the Policy for the loss of a baby after Stillbirth.

Guidance on the management of can be found in the separate Policy for Pregnancy Loss : Termination of Pregnancy for Fetal Abnormality.

Policy for Pregnancy Loss : Miscarriage, Stillbirth and Neonatal Death
Version 1.0 September 2013
4. Roles and responsibilities

4.1 Managers
It is the responsibility of the managers to ensure that the midwives are aware of the guidelines and their application to practice. They will also review and update and them in line with the latest evidence as required, or at least every 3 years.

4.2 Clinical Staff
All clinical staff have a duty to be familiar with this policy and to use it to guide their practice. Specific roles and responsibilities of various staff groups are set out in section 5.

4.3 Local Policy Officer
The Local Policy Officer has a duty to ensure the policy is compliant with the Trust Policy on Policies. The Local Policy Officer must ensure this policy is reviewed within the designated time period or as changes in national guidance arise. The policy should comply with the current base of evidence and best practice guidance and be current and in date.

5. Policy for Pregnancy Loss: Miscarriage, Stillbirth and Neonatal Death

5.1 Management of a Pregnancy Loss
- Admit the woman and partner/birth partner to the Forget-Me-Not Suite. A designated midwife should be allocated to look after the woman. Her consultant or the consultant-on-call should be informed where appropriate. When the Forget-Me-Not Suite is in use a single room should be designated on either Shere Ward or Delivery Suite.

- The registrar on duty should see the woman before any procedures are carried out.

- If the woman is to have her labour induced, she may have been prescribed Mifepristone 200mg which is taken orally 36-48 hours prior to her admission. She should be advised to ring Delivery Suite if experiencing pain or bleeding.

- On admission, a full set of observations (TPR and BP) should be undertaken; then 4 hourly temperature & BP and hourly pulse during labour unless otherwise indicated.

- Full explanation of the pregnancy loss induction process (please see Appendix 1), pain relief and the approximate length of time taken to deliver her baby should be given. The benefits and the woman/partner’s wishes about seeing their baby after delivery should also be sensitively discussed and their decision documented in the notes.

- The possibility of a post mortem could be broached during this time. The parents may want to know more about the post mortem at this stage but fuller explanation and consent is usually done after delivery. A copy of SANDS “Deciding About A Post Mortem Examination: Information for Parents” booklet should be given so that the parents could read it before consent is taken. The ultimate decision for a post mortem lies with the parents unless it is a coroner’s case (eg an unexpected term neonatal death)

- Some parents may value a visit by the hospital chaplain or a religious adviser early in labour and the possibility of this should be offered. The hospital chaplain can be contacted via switchboard.
• Once the woman is ready, blood needs to be taken for the following investigations:
  - Blood Cultures (microbiology) if pyrexial – take these samples first
  - FBC (purple bottle, haematology)
  - Clotting (blue bottle, haematology)
  - Group and Save (pink bottle, haematology)
  - Cardiolipin antibodies (gold bottle, immunology)
  - HbA1c (purple bottle, biochemistry)
  - TORCH screen (gold bottle, microbiology)
  - Parvovirus – if hydrops (gold bottle, virology)
  - Thyroid Function – (gold bottle)
  - Lupus (blue bottles x4 and gold bottle x1, haematology – to be taken without tourniquet. NB Lupus may not be needed in every case. Discuss with Obstetrician to confirm whether this is required or not.
    ▪ state on form if tourniquet is used
    ▪ state gravida and parity on form
    ▪ must be taken within Lab hours and processed within an hour

• A cannula should be sited if there is vaginal bleeding.

• Delivery equipment is stored in the chest of drawers in the Forget-Me-Not suite.

• Ensure the drug regime the woman is on is followed correctly. (See Mifepristone/Misoprostol and Cervagem drug regime protocol – Appendix 3)

5.2 Delivery
• Two midwives should be present at the delivery to offer support to each other and the parents.

• Careful consideration should be made if the parents do not wish to see the baby at delivery – consider the left lateral position with a sheet used as a screen.

• Extra care needs to be taken with delivery of the placenta which can take up to an hour to deliver. Syntometrine should be given unless the woman is hypertensive in which case Syntocinon 10iu should be used. Very gentle controlled cord traction and maternal effort may be required. Careful examination of the placenta is essential and document findings in notes.

• Sometimes an ERPC (evacuation of retained products of conception) may be required, therefore keep the woman nil-by-mouth if there is a delay in delivering the placenta until this has been discussed with the registrar on call.

• The sex of the baby must not be stated unless absolutely certain as it is distressing for the parents if this is wrongly identified.

• Usual post delivery observations and offer of analgesia as required.

5.3 If a Baby is Born Showing Signs of Life
• In some cases of miscarriages, especially in the second trimester of pregnancy, a baby may be born alive. Any baby who shows signs of life and subsequently dies is a neonatal death regardless of gestational age.
• If there is a possibility that the baby may be born alive the parents should be given a full explanation about this and why resuscitation may not be possible. An obstetrician or paediatrician can be asked to see them before delivery to discuss the situation. The decision whether to initiate resuscitation will be made by the senior paediatrician in conjunction with any neonatal nursing, midwifery and medical staff.

• If a baby is born showing signs of life :
  - Call the obstetric registrar/SHO or a paediatric doctor immediately.
  - One of these doctors has to see the baby alive and the same doctor has to sign the death certificate once they certified that the baby has died.
  - If there is a shift changeover, the doctor who has just started his/her shift will also need to see the baby alive as he/she now has the responsibility of certifying the baby’s death

5.4 After Delivery
• All babies, regardless of size or gestation should be treated with respect and dignity.
• All babies should be weighed and the weight documented.
• The following investigations need to be completed to aid finding a possible cause of death :

5.4.1 Microbiology Tests
• baby’s ear swab – for MC & S
• placental swab – for MC & S
• a small piece of placenta in saline (in a universal specimen pot) – for MC & S

5.4.2 Virology Tests
• cord blood if possible – in a pink bottle

5.4.3 Wessex Tests
  - These tests are only required if the fetus/baby looks abnormal. Please obtain consent from the parents and document this in the notes.
  - The samples have to be sent DRY in separate labelled pots. Send these samples to our Path Lab who will arrange a courier to Wessex.
  - Wessex request cards must be used with these samples :
    • cord blood for chromosome (green blood bottle)
    • small piece of amnion (in universal specimen pot)
    • small piece of cord (in universal specimen pot)
    • small piece of placenta (in universal specimen pot)
(Refer to Post Mortem section below as to the correct storage of the placenta for histology)

All large specimens need to have a white label attached to the histology pots detailing woman's name, hospital no, DOB)

5.5 Post Mortem Examination
- All bereaved parents should be given the opportunity to discuss giving consent for a post mortem examination. Please ensure that the parents have been given a copy of SANDS “Deciding About A Post Mortem Examination: Information for Parents” booklet and that they have had a chance to read it before consent is sought.

- Only senior doctors who are knowledgeable about post mortem procedures should obtain consent from the parents. All consent takers must be familiar with the information on the “SANDS Post Mortem Information Folder” which can be found in the MDT room on Delivery Suite.

- If the baby is having a post-mortem, please take both baby and placenta (both dry and labelled) to the mortuary. Please ensure that you label both the placenta container and lid with the woman's name, date of birth and hospital number.

- If the baby is not having a post-mortem, please place the placenta in formaldehyde and send it for histopathology.

- Refer to Appendix 2 Pathway of A Baby's Journey (if having a PM) for further information.

5.6 Creating Memories
Memories play a very important role in facilitating grief as it is difficult to grieve for an unknown person (Too, 1995). Staff can help create memories that will help the parents to mourn. Mementoes of their baby are very important to bereaved parents and can give the parents a focus their grief (Thomas, 1997). Please take time to ensure that these mementoes are of a high standard.

Today it is understood by the health profession that contact with their baby can help make the baby a reality to the parents (Mallison, 1989). If the parents do not wish to see or hold their baby, the offer should remain open and the parents made aware that they can change their minds at any time.

5.6.1 Photographs
Staff should explain in a sensitive manner the importance of taking photographs. Verbal consent should be obtained. Being creative in taking photographs and creating mementoes for the parents is important.

For fetal losses under 24 weeks, please take 3-4 photos and print them out for the parents or leave them in the woman's notes if they are unsure if they want them. For bigger babies over 24 weeks, you could take more photographs, print out 3-4 for the parents and give them the SD card or leave everything in the notes for them to collect later.

The parents may wish to dress their baby in something they have brought with them or there is a selection of clothing in the drawers outside the Forget-Me-Not suite's prep room. Dressing the baby, however small, or wrapping the baby in a blanket...
improve presentation and provide better photographic memories. There are also tiny baskets to lay babies in.

5.6.2 Other Mementoes to include:
- certificate of birth for babies under 24 weeks
- memory box
- hand and footprints
- clay impression of hands and feet
- lock of hair if available
- name band
- cot card
- candle
- bracelet charm
- teddy bears

5.7 Religious and Spiritual Support
Religious and spiritual support is always available through the hospital chaplains. A service of blessing or naming of the baby can be offered soon after delivery or later if the parents preferred. The on-call chaplain can be contacted via switchboard.

5.8 Documentation
5.8.1 For a miscarriage (with no signs of life):
- Complete Fetal Loss: Miscarriage, Stillbirth and Neonatal Death checklist
- Woking Crematorium Form to be completed by delivering midwife or doctor
  - Must be completed even if baby is being buried/cremated privately.
  - Completed form to be taken by hand to the Relative Officer ASAP together with the Notice of Death form.
- Obstetric registrar to complete Post-Mortem Consent Form if PM is required/requested
  - Give parents a copy of SANDS’s “Deciding about a Post Mortem Examination: Information for Parents” booklet.
  - Obstetric registrar to do a covering letter (template on D/Suite desktop) to Dr Jeffery, Neonatal Pathologist, St Georges Hospital, Tooting.
  - Photocopy ultrasound scan reports
- Midwife to complete Notice of Death
  - Please complete the sticker on the back of the top page.
  - Take top copy down to relative officer ASAP (please do not send via internal post or the porters).
  - Two copies to go with baby and one with the porter
- Notify appropriate personnel (see check list)
- Leave notes in the Alice notes trolley in the MDT room on Delivery Suite

5.8.2 For a Stillbirth
- Complete Fetal Loss: Miscarriage, Stillbirth and Neonatal Death checklist
- Midwife to complete Notice of Death
  - Please complete the sticker on the back of the top page.
  - Take top copy down to relative officer ASAP (please do not send via internet post or the porters).
- Two copies to go with baby and one with the porter
  - Delivering midwife to complete Stillbirth Certificate (blue cover);
    - place completed Stillbirth Certificate and baby’s Birth Notification (from Euroking) in the special envelope and give to parents.
    - The parents have to register the death of their baby within 5 days. To do this, the parents need an NHS number for their baby – this is usually on the Birth Notification. If no NHS number is generated, please ring the Jarvis Centre (01483 783200) for one.
- Delivering midwife to complete National Stillbirth Crematorium Form which must be taken down by hand to Relatives Officer (with the Notice of Death)
  - must be completed even if the parents are considering a burial
  - please sign, print name and PIN number
- Obstetric registrar to complete Post-Mortem Consent Form if PM is required/requested
  - Give parents a copy of SANDS’s “Deciding about a Post Mortem Examination : Information for Parents” booklet.
  - Obstetric registrar to do a covering letter (template on D/Suite desktop) to Dr Jeffery, Neonatal Pathologist, St Georges Hospital, Tooting.
  - Photocopy all ultrasound scan reports.
- Complete Datix
- Notify appropriate personnel (see check list)
- Leave notes in the Alice notes trolley in the MDT room on Delivery Suite

5.8.3 For a Neonatal Death
- Complete Fetal Loss : Miscarriage, Stillbirth and Neonatal Death checklist
  - The doctor who attended baby alive and certified the baby’s death to complete Death Certificate (orange cover) after baby has died.
    - Give completed certificate together with our Euroking Birth Notification printout, in the special envelope to parents.
    - The parents have to register the birth and death of their baby within 5 days. To do this, the parents need an NHS number for their baby – this is usually on the Birth Notification. If no NHS number is generated, please ring the Jarvis Centre (01483 783200) for one.
  - The same doctor to fill in Medical Crematorium Form (cremation 4) in the doctor’s own handwriting
    - “Cremation 5” section to be completed by a registrar of another speciality eg paediatrics or anaesthetics in their own handwriting
    - “Cremation 10” section to be left completely blank
    - Completed form to be taken by hand together with the Notice of Death form to the Relative Officer ASAP.
- Obstetric registrar to complete Post-Mortem Consent Form if PM is required/requested
  - Give parents a copy of SANDS’s “Deciding about a Post Mortem Examination : Information for Parents” booklet.
  - Obstetric registrar to do a covering letter (template on D/Suite desktop) to Dr Jeffery, Neonatal Pathologist, St Georges Hospital, Tooting.
- Photocopy ultrasound scan reports
- Midwife to complete **Notice of Death**
  - Please complete the sticker on the back of the top page.
  - Take top copy down to relative officer ASAP (please do not send via internal post or the porters).
  - Two copies to go with baby and one with the porter
- Complete **Datix**
- Notify appropriate personnel (see check list)
- Leave notes in the Alice notes trolley in the MDT room on Delivery Suite

**NB** There is a SAMPLE folder for all the paperwork on Delivery Suite. Please refer to it if required.

### 5.9 Transferring Baby to the Mortuary

All babies, regardless of gestational age, are taken down to the mortuary by a midwife. The baby must have a name band applied and transferred in the blue carrier box which is kept in the prep room of the Forget-Me-Not suite, accompanied by two copies of the Notice of Death forms. Please remember to return the carrier box to Forget-Me-Not suite’s prep room.

- Take baby down to mortuary with all relevant paperwork (notice of death/PM consent form/covering letter/copies of USS reports)
  - Phone first on ext 4046 between 08.00-16.00; out of hours please ring porters
  - Tell mortuary if the baby is going for a PM.
- If baby is born at the weekend/bank holiday, send baby to mortuary with all the paperwork and arrange transport first thing Monday morning/next working day.
- Arrange transport tel 01252 329862, for baby and documents to go to Dr Iona Jeffrey, Neonatal Pathologist, St Georges Hospital, Tooting.
- When transport is arranged, phone Dr Jeffery, tel : #6122 (ext 3447) and let her know that baby is coming.

Once the baby has been taken down to the mortuary, the parents can still see their baby if they so wish. The baby should be collected from the mortuary and brought back up to the Forget-Me-Not suite. Please arrange with the mortuary staff during office hours and the porters during out of hours to collect baby.

### 5.10 Funeral Arrangements

Please discuss funeral arrangements with the parents prior to their discharge.

- all fetal losses up to 23+6 weeks :
  - the hospital will arrange a cremation for these babies at Woking Crematorium. A service is held once a month and only the Relative Officer has the dates for these.

- all stillbirths from 24+0 upwards :
  - as this is a registerable birth, the parents have to arrange their own funeral for their baby. The Relatives Officer will be able to assist the parents with this if required.

- all neonatal deaths regardless of gestational age :
  - as this is also a registerable birth, the parents have to arrange their own funeral for their baby.
5.11 Bereavement Midwife
The bereavement midwife card should be given to the parents prior to discharge. Please inform them that the Bereavement Midwife will be contacting them to arrange a home visit.

5.12 Maternity Rights
Any woman who has had a stillbirth or neonatal death regardless of gestational age has exactly the same right as if her baby was alive. If she is already on maternity leave when her baby was stillborn or dies, she does not have to do anything. Maternity leave will start automatically on the day of the stillbirth or neonatal death.

5.13 Alice Appointment
An appointment with the woman’s consultant will be sent to the parents for 8-10 weeks following their loss where the parents can discuss what has happened, the result of all the investigations and future pregnancy plans.

5.14 Babies delivered to mothers with Known HIV, Hepatitis B or C
- Protective equipment should be worn – kept on delivery suite.
- The baby should be washed to remove all traces of maternal blood and amniotic fluid.
- A biohazard tape should be applied to the wrist and ankle and placed in an cadaver bag (used for infective cases) and transferred to the mortuary in the usual way.
- The placenta should be checked carefully noting any presence of retro placental clots.
- 10mls of clotted blood is placed in a red tube for virology.
- The placenta is then placed in a bucket, NO formalin, biohazard label applied on the bucket and request form.

6. Training
Any necessary training will be provided to all relevant staff by the Bereavement Midwife. The bereavement midwife receives training on taking consent with Dr Iona Jeffrey, Neonatal Pathologist, St Georges Hospital, Tooting, and attends an annual update.

7. Implementation
The processes described within this policy are already in place.

8. Monitoring compliance with and effectiveness of this policy

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<th>Responsible Committee</th>
<th>How changes will be implemented</th>
<th>Responsible for Actions</th>
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<tr>
<td>Appropriate management of all cases</td>
<td>Audit</td>
<td>Bereavement</td>
<td>Annual</td>
<td>MRMG</td>
<td>Policy change, staff training</td>
<td>Head of Midwifery, Matrons, Supervisors of Midwives, Lead Consultant Obstetrician, Clinical Governance Midwife</td>
</tr>
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9. Review, Ratification and Archiving
9.1 The policy will be reviewed every 3 years, or earlier if national policy or guidance changes are required to be considered. The review will then be subject to review and re-ratification.

9.2 The Central Policy Officer or Local Policy Officer is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management: NHS Code of Practice, 2009. (Refer to Policy Development and Management: including policies, procedures, protocols, guidelines, pathways and other procedural documents).

9.3 Please note the authors’ responsibilities for archiving superseded copies. The author will ensure that a review of the document is carried out in the event of a change in circumstances or immediately prior to the expiry date.

10. **Dissemination and Publication**
Dissemination of the final policy is the responsibility of the author. They must ensure the policy is uploaded to the Trust’s Central Library (TrustNet) either via their Local Policy Officer or submitted directly to the Central Policy Officer.

The Head of Communications is responsible for the Trust-wide notification of new and revised working documents.

Clinical Directors, Associate Directors, Specialty Business Unit (SBU) or supporting services management teams, Ward Managers and Heads of Department as applicable are responsible for distributing this policy and ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of the policy.

11. **Equality Impact Analysis**
The author of this policy has undertaken an Equality Impact Analysis and has concluded there is no impact identified. The Equality Analysis Initial Screening has been archived and is available via the Central Policy Officer.

12. **Associated Documents**
Policy for Pregnancy Loss: Termination of Pregnancy for Fetal Abnormality.

13. **References**

Kohner N; Henley A 2002 When a Baby Dies London


Mallinson G 1989 When a Baby Dies Nursing Times 85(9):31-34

Oakley A 1980 Women Confined Martin Robertson Oxford


Too SK 1995 Grief Counselling Following Stillbirth Midwives August 260-262
14. Appendices

Appendix 1  Fetal Loss: Miscarriage, Stillbirth and Neonatal Death
Appendix 2;  Pathway of A Baby's Journey (if having a PM)
Appendix 3 : Mifepristone and Misoprostol Drug Regime
## Appendix 1: Fetal Loss: Miscarriage, Stillbirth and Neonatal Death

Name: ___________________________ Hospital No.: ___________________ Date: ________________

Please circle: Miscarriage/Stillbirth/Neonatal Death

Gestation: ____________

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<th>Procedures</th>
<th>Date</th>
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<tr>
<td>Admit woman and partner/birth partner into Forget-Me-Not Suite</td>
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<td>Take blood with consent for the following investigations:</td>
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a) **Blood Cultures** (microbiology) if pyrexial – take these sample first

b) **FBC** (purple bottle, haematology)

c) **Clotting** (blue bottle, haematology)

d) **Group and Save** (pink bottle, haematology)

e) **Cardiolipin antibodies** (gold bottle, immunology)

f) **HbA1c** (purple bottle, biochemistry)

g) **TORCH** screen (gold, microbiology)

h) **Parvovirus** (if hydrops) (gold, virology)

i) **Thyroid Function** (gold bottle)

j) **Lupus** (blue bottles x4 and gold bottle x1, haematology – to be taken without tourniquet):
   - state on form if tourniquet is used
   - state gravida and parity on form
   - must be taken within Lab hours and processed within an hour
   
   *(Total blood bottles: blue x5; gold x3 (or 4 if hydrops); purple x2; pink x1)*

### After Delivery

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<thead>
<tr>
<th>Fetal Weight: ________</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/Female/Interminate</td>
<td></td>
</tr>
</tbody>
</table>

**Microbiology tests:**

a) ear swab

b) placental swab

c) small piece of placental in saline
**Virology tests:**

- a) cord blood if possible – pink bottle
  
  **Wessex (please use Wessex request cards):**

  Send all samples DRY in separate labelled pots → send to our
  
  path lab (at any time); they will arrange a courier to Wessex
  
  - a) cord blood for chromosomes (green bottle)
  - b) amnion (in universal specimen pot)
  - c) small piece of cord (in universal specimen pot)
  - d) small piece of placenta (in universal specimen pot)

---

### Procedures

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Date</th>
<th>Sign &amp; Print</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer Chaplaincy support/baby blessing: ext 4044</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss <strong>funeral arrangements:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) for all miscarriages: hospital to arrange funeral? □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) for all stillbirths and neonatal deaths: parents would have to arrange their own funeral. □ Burial □ Cremation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the woman want further contact from the Relatives Officer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is baby having a <strong>post-mortem</strong>? □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, doctor to complete consent form with couple.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Consent form completed? □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| a) **Notice of Death** (2 pages with baby, 1 with porter, take top copy to Relatives’ Officer)  
  Please fill in the sticker on the back of the first page |
| b) **Crematorium form**:  
  - for **miscarriage** (up to 23+6 weeks, born without signs of life), complete **Woking Crematorium form** - by delivering midwife  
  - for **stillbirth** (from 24+0, born without signs of life), complete **National Stillbirth Crematorium** form (cremation 3 and 9 – by delivering midwife)  
  - for **neonatal death** (born with signs of life regardless of gestation age), doctors to complete **Medical Crematorium form** (please see sample on how to fill this) |
| c) **Stillbirth Certificate** (for all stillbirth) – to be completed by delivering midwife (sign, print name & PIN number) |
| d) **Death Certificate** (for all neonatal death regardless of gestational age) – must be completed by attending doctor who attended baby alive and certified the death |
| e) **Datix** (for all stillbirths and neonatal deaths) |

**Digital Photographs:**
- for fetal losses under 24/40: please take 3-4 photos and print them out for the parents or leave in notes  
- for bigger babies over 24/40, you could take more photos, print 3-4 photos out for parents and give them the SD card or leave them all in their notes for later

**Momentoes:**
- please give to parents: hand/foot prints, teddy bear, candle, bracelet charms

Ensure admission, delivery and discharge are completed on **Euroking**
- please leave notes in Alice notes trolley in Delivery Suite’s MDT room

For stillbirths and neonatal deaths, please give parents **Euroking Birth Registration Notification** together with **Stillbirth/Death certificate** in special envelope

Administer **Carbergoline 1mg**: single dose within 24 hours of delivery to suppress lactation (over 20 weeks gestation)
<table>
<thead>
<tr>
<th>Procedures</th>
<th>Date</th>
<th>Sign &amp; Print</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If baby is having a post-mortem</strong>, please photocopy ultrasound scan reports and ask obstetric registrar to do a covering letter for Dr Jeffrey. These, together with PM consent form, to be taken with baby and placenta (both DRY and labelled) to the mortuary.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Please make sure you label BOTH the placenta container and lid with the woman’s name, date of birth and hospital number</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby taken to mortuary by midwife</td>
<td></td>
<td></td>
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<tr>
<td>- phone first on ext 4046 between 08.00-16.00; out of hours, please phone porters</td>
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<tr>
<td><strong>Please arrange transport to St Georges.</strong></td>
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<tr>
<td>- telephone transport on 01252 329862</td>
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<td></td>
</tr>
<tr>
<td>Inform Dr Jeffrey’s secretary that baby is on its way :</td>
<td></td>
<td></td>
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<tr>
<td>- # 6122 ext 3447</td>
<td></td>
<td></td>
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<tr>
<td><strong>If no PM</strong>, please send whole placenta in formaldehyde to histopathology</td>
<td></td>
<td></td>
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<tr>
<td>Please hand deliver top copy of Notice of Death and appropriate Crematorium form to Relatives Office</td>
<td></td>
<td></td>
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<tr>
<td><strong>Discharge information leaflets</strong></td>
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<tr>
<td><strong>Bereavement Support Midwives card</strong> must be given – please inform the woman that Sheryl Roy (bereavement midwife) will be contacting them to arrange a home visit</td>
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<tr>
<td>Please notify the following :</td>
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<tr>
<td>a) <strong>Consultant</strong> (via secretary)</td>
<td></td>
<td></td>
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<tr>
<td>- name of consultant : .................</td>
<td></td>
<td>a)</td>
</tr>
<tr>
<td>- name of secretary : .................</td>
<td></td>
<td>b)</td>
</tr>
<tr>
<td>b) <strong>GP</strong> (phone and send Euroking printout)</td>
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<tr>
<td>c) <strong>Community midwife</strong> (via community office : ext 2714/2715)</td>
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<tr>
<td>d) <strong>Antenatal clinic</strong> : ext 4749</td>
<td></td>
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<tr>
<td>e) <strong>USS department</strong> : ext 4920</td>
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<tr>
<td>f) <strong>Relatives Officer</strong> : ext 4306</td>
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</tr>
<tr>
<td>g) <strong>Lesley Rankin</strong> (paediatric liaison HV) : ext 4911 or 07768 220592</td>
<td></td>
<td></td>
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<tr>
<td>h) <strong>Helen</strong> (child health – NHS number) 01483 728201 or 07966 229923 if neonatal death at 23+6 or less</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8-10 weeks Alice Appointment
- appointment will be sent to the woman via secretary

Registrar on duty at time of delivery:

Name of delivering midwife:

**Extentions of consultant secretaries:**
- Brenda (KM/MK) 4747
- Liz (RH/LR) 4582
- Ann (AK) 2062
- Lizzie (EPPC/MF) 4898
- Sally (YD) 4569
Appendix 2: Pathway of A Baby’s Journey (if having a PM)

1. Baby leaves Maternity Unit with midwife and taken to RSCH mortuary
2. Baby gets logged in mortuary’s register
3. Transport to be arranged by Delivery Suite staff
4. Baby leaves RSCH mortuary with transport courier
5. Baby arrives in St Georges or Great Ormond Street perinatal mortuary
6. When baby is ready to return to RSCH, the Relative Office is informed and transport is arranged by the Relative Officer
7. Baby arrives back in RSCH mortuary and is logged in mortuary’s register
8. Mortuary staff to inform Relative Officer and Bereavement Midwife of baby’s return
9. Bereavement Midwife/Realtives Officer to inform the baby’s parents that their baby is back
10. Parents to arrange funeral for their baby
11. Care of baby is handed over to the funeral director for burial/cremation
12. R.I.P.
Appendix 3: Mifepristone and Misoprostol Drug Regime

Mifepristone/Misoprostol

Mifepristone is contraindicated in women with:
- Chronical adrenal failure
- Long term corticosteroid therapy
- Haemorrhagic disorders or treatment with anti coagulants
- Smokers >35
- Porphyria

Used with caution in women with:
- Asthma
- Chronic obstructive airways disease
- Cardiovascular disease
- Hepatic or renal failure.

Stage 1 - Mifepristone

- Maternal observations recorded.
- Mifepristone 200mg is to be swallowed.
- The pack identification number should be recorded on the drug chart and in the women’s notes.
- Observe the women for 20 minutes, if she vomits in this time it is assumed that the process will not succeed and this should be discussed with the registrar/consultant.
- After 20 minutes the woman may go home with arrangements to return in 36-48 hours for the Misoprostol regime.
- If the women returns before 36 hours only symptomatic treatment should be given as the Misoprostol should not be administered before 36 hours after Mifepristone.
Stage 2 - Misoprostol

- Insert Misoprostol 800mcg (200mcg x 4 tablets) into the posterior fornix of the vagina.

- Misoprostol can then be given **3 hourly at a dose of 400mcg ORALLY** until expulsion of the fetus occurs. If the fetus is delivered but the placenta remains, Misoprostol can be continued until the maximum dose has been given. The maximum dose is 1600mcg or 4 doses.

- Vaginal examinations are not necessary following the initial dose. If there are strong contractions and expulsion of the fetus is not apparent, then the woman can be asked to bear down as the fetus may be in the vagina. If the fetus is not expelled after 5 pushes a vaginal examination may be performed to assess the cervix or whether the fetus is palpable.

- If the delivery does not occur after the maximum dose of Misoprostol, vaginal Cervagem will then be used from the following morning.
**Cervagem Regime**

Cervagem is an analogue of prostaglandin E1 and has direct selective action on the cervix and uterus, resulting in cervical dilatation, uterine stimulation and depression of placental and uterine blood flow.

**Vaginal Cervagem**

- Before administration, the pessary should be allowed to warm to room temperature away from direct heat and sunlight in the unopened foil sachet.
- Inserted in to Posterior Fornix of the vagina.
- Dose : 1mg every 3 hours up to a maximum of 5 doses