### Brief Summary of Contents
To provide midwives and obstetricians with guidance in the provision of emotional and support following pregnancy loss and early neonatal death.

### Suggested Keywords:
Stillbirth, neonatal death, pregnancy, miscarriage, neonatal, termination, post-mortem, bereavement, IUD, pregnancy loss.
References

These guidelines have been written with the evidence and advice of the following documents:

Training Need Identified? Part of mandatory training

Version Control Table

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Intrauterine Death Diagnosed/ Decision for Termination of Pregnancy for Fetal Abnormality Made

Individualised management plan to include discussion by an appropriate consultant or middle grade re: - Timing and method of induction of labour - Pain relief - Post mortem examination - Induction medication and analgesia prescribed

Admission for induction of labour at a time to suit patient
Patient to be assigned a named midwife
Care in labour as RCHT Guideline
Choice of delivery on Delivery Suite or Bereavement Suite (Wheal Rose)

Baby Born
(Miscarriage/ Stillbirth/ TOP/ Early Neonatal Death)

Checklist of Actions by Bereavement Officer
Checklist of Actions by Midwives
Checklist of Actions by Medical Staff

Detailed explanation of post mortem and tissue sampling by planned appropriate personnel

Support for family – may include viewing of baby, blessing/baptism service, registration of death if >24 weeks gestation or neonatal death, contact with funeral directors, assistance in making memories of baby, and referral to outside agencies

Bereavement Officer/ Mortuary Staff
Chaplaincy
Maternity Unit Staff
Community Midwife & GP

Follow up appointment with Consultant
Community Midwife informed and invited to attend

If PM requested written consent gained
RCHT post mortem pathway initiated
Post Mortem results received

Pregnancy Loss and Early Neonatal Death – Clinical Guideline
Page 4 of 42
1. **Aim/Purpose of this Guideline**

1.1. The death of a baby no matter what the cause, circumstance (spontaneous or termination for fetal abnormality), gestation or age is a particularly difficult kind of grief. As health professionals we recognise this fact and will endeavor to aid the grieving process by being honest, supportive, sensitive and caring for all family members concerned.

1.2. To follow the principles underpinning the Department of Health advice for developing bereavement services:
   - To respect confidentiality and individual preferences, values, culture and beliefs
   - To give information which is accurate and appropriate to patient needs in a clear, sensitive and honest way
   - To promote family centered care within a private, sensitive environment.
   - To recognize the parents’ loss and try to work at a pace dictated by their needs
   - Give parents appropriate and relevant information on all the options available for their baby and themselves.
   - To work in partnership with all relevant agencies using a multi-disciplinary approach
   - Ensure effective communication between all professionals caring for the family and document the same
2.2. Definitions

- **Miscarriage** is the spontaneous expulsion from the uterus of a fetus that shows no signs of life before 24 weeks gestation.

- **Stillbirth** is the birth of a child after the 24<sup>th</sup> week of pregnancy who did not, at any time after being expelled from its mother, show any signs of life.\(^1\)

- **Live birth**: If there are signs of life at birth **at any gestation** it is by law defined as a live birth that will require registration of the birth and death. **A DOCTOR MUST SEE A BABY BEFORE DEATH TO ENABLE A DEATH CERTIFICATE TO BE ISSUED. OTHERWISE, THE CORONER MUST BE INFORMED, IRRESPECTIVE OF THE GESTATION.**

2.3. Diagnosis of miscarriage and intrauterine fetal death

- Auscultation and cardiotocography (CTG) should not be used to investigate suspected intrauterine fetal death (IUD).

- Ultrasound scan should be used for accurate diagnosis of IUD. Confirmation of IUD should be made by a clinician experienced in the use of ultrasound to visualise fetal heart pulsations and who has been assessed as competent to use ultrasound equipment. **If an obstetrician has any doubt about their abilities he or she should seek the urgent assistance.**

- A second opinion should be obtained whenever practically possible.

- Women should be prepared for the possibility of passive fetal movement. If the woman reports passive fetal movement after the scan to diagnose IUD, a repeat scan should be offered.

- **If the woman is unaccompanied, an immediate offer should be made to call her partner, appropriate relatives or friends.**

- **Remember to give the woman and her partner privacy.**

- **It is not helpful to give too much information at this stage because it is unlikely to be assimilated. You will often be asked questions; answer them but be prepared to repeat the discussions as the level of acute distress subsides.**
• It is not possible to predict how the pregnancy loss/ neonatal death will affect individual parents. No assumptions should be made about the intensity or duration of the grief a parent will experience

• Discussion should aim to support maternal/ parental choice and should be supplemented with written information

• If the woman returns home she should be given a 24 hour contact number for information and support

2.4. Consultant Responsibility

• The Lead Obstetrician is the Consultant with whom the woman has booked for the pregnancy or, where the Lead Professional is a midwife, with the Consultant responsible for the geographical area where the woman lives

• For out of county cases, the Lead Professional is the Duty Consultant at the time the woman presents to the hospital (on call consultant unless there has been involvement by a Consultant doing a Delivery Suite session)

• In selected cases, by agreement between Consultants, the entire episode including in-patient care and follow up may be overseen by the ‘admitting’ Consultant to maintain continuity of care

2.5. Initial Management after diagnosis

• Obtain the appropriate set of ring binder notes ( Miscarriage, IUD or Neonatal Death) that are stored in the Bereavement room on Wheal Rose. Follow the checklist

• Take a history, perform basic maternal observations and an antenatal examination (and any other relevant investigations and risk assessments). Ensure that you have excluded serious underlying diagnoses such as pre-eclampsia, concealed abruption or chorioamnionitis. Where clinically indicated, maternal tests should not be delayed until a convenient time for discussing and obtaining less urgent investigations

• Significant bleeding should prompt resuscitation and involvement of a senior obstetrician

• Recommendations about labour and birth should take into account the mother’s preferences as well as her medical condition and previous intrapartum history

• In the absence of an obstetric complication that necessitates close observation; oral Mifepristone 200mg should be given with a view to the woman being admitted to Wheal Rose in 24-48 hours for Misoprostol induction of labour (see Appendix 3). This will reduce the risk of a prolonged and distressing in-patient stay
• Immediate induction with misoprostol may be appropriate in selected cases:
  - Already contracting +/- very favourable cervix
  - The woman is adamant she wishes to stay after you have fully explained the advantages of mifepristone. Be prepared to repeat the discussion once initial acute distress has subsided

• Women who are rhesus D (RhD) negative should have a Kleihauer test undertaken urgently to detect a large feto-maternal haemorrhage that might have occurred a few days earlier. Anti-RhD gammaglobulin should be administered as soon as possible after presentation

• Arrange admission to Wheal Rose at an appropriate time 24-48 hours after ingestion of mifepristone. Explain the necessity of admission to the maternity area of the hospital and acknowledge the possible distress that this may incur

• Perform venepuncture for maternal investigations for pregnancy loss (see appropriate checklist (Appendix 7). Although these can be performed after admission, certain results such as FBC, G&S and kleihauer may be valuable at this early stage

• Give parents information leaflets to be found in the notes relevant to their situation and document this in the clinical notes

• Inform the General Practitioner and Community Midwife of the diagnosis and timing of admission

• Prescribe all necessary medication (see Appendix 3) at time of diagnosis before admission so that delays in commencing misoprostol on the ward are avoided

• Complete the pre-admission sections of the appropriate checklist before the woman leaves the hospital. Individual items should be signed and dated by the doctor or midwife who provides that element of care. The checklist is filed in the medical notes

2.6. Management when induction of labour is declined

• Women should be strongly advised not to delay induction of labour if there is sepsis, pre-eclampsia, placental abruption or membrane rupture.

• Well women with intact membranes and no laboratory evidence of DIC should be advised that they are unlikely to come to physical harm if they delay labour for a short period, but may develop severe medical complications with prolonged delay

• Women contemplating prolonged expectant management should be advised that the appearance of the baby may deteriorate and the value of post mortem reduced
- Women who delay labour for more than 48 hours should be advised to have testing for DIC twice weekly

- A 24 hour contact telephone number should be given for information and support
2.7. Inpatient Management

- Ensure privacy for the parents, ideally allocating them the Bereavement Suite on Wheal Rose for their hospital admission

- Care given to parents should be responsive to and supportive of their individual needs, making them feel in control, working at a pace dictated by their feelings and needs. Information should be communicated clearly and sensitively at an appropriate time

- There should be continuity of caregivers whenever possible. Care in labour should be given by an experienced midwife who has received training to deal with the parent’s emotional needs

- Inform the Delivery Suite Coordinator and on call middle grade obstetrician of the admission and request that the case is recorded on the Delivery Suite white board

- The medical team should visit during the induction process daily (as a minimum), after delivery and before discharge to home. Consultations should be documented in the medical notes

- In cases of prematurity, known abnormality, macerated or severely hydropic babies, parents should be sensitively informed of how their baby may look when born

- Pulse, blood pressure and temperature should be measured 4 hourly on a MEWOS (Modified Early Obstetric Warning Score) chart

- Once labour is fully established, further vaginal misoprostol may be withheld. Avoid routine rupture of the membranes to minimise infection risk

In the absence of a co-existing complication (e.g. abruption, pre-eclampsia), delivery will usually take place on Wheal Rose ward but when there are concerns about the woman’s clinical condition (e.g. vaginal bleeding), the woman requests an epidural or Syntocinon is indicated, transfer to Delivery Suite will occur

- **IF THERE ARE SIGNS OF LIFE AT ANY GESTATION, A DOCTOR MUST BE REQUESTED URGENTLY TO VIEW THE BABY BEFORE DEATH.** If this does not occur, a doctor is not able to issue a death certificate and the case must be referred to the coroner. If live birth is anticipated, the midwife should give forewarning to the parents the reason for the abrupt intrusion of a doctor at such a sensitive moment.

- 3rd stage should be actively managed

- During the admission, the following (see appropriate sections below) will be discussed (*when relevant*) and documented on the checklist and in the medical notes:
  - PM and cytogenetic sample consent
- Maternal tests
- Parental wishes regarding seeing and holding the baby, naming and knowing the sex (warn that this may not be possible)
- Obtaining mementoes
- Possible funeral arrangements- offer the involvement of the Bereavement Officer for discussion of the baby’s care after hospital if required
- Consent for funeral arrangements
- Offer to see the chaplain for a blessing or baptism of the baby

2.8. Management after delivery

- Parents should be supported to see, hold, wash and dress their baby if that is their wish

- The baby must be labelled in accordance with guidance in Appendix 4. Use identity band of type with identifying sticky labels. Do not use the mother’s CR number

- Parents should be offered mementos in a Memory Box: hand/footprints, lock of hair, name band (duplicate), cot card and photographs as mementos for the parents. Support individual requests that parents may have (e.g. leaving toys, pictures and messages in the coffin)

- Take photographs (with parent’s verbal consent) and print a minimum of six in a variety of settings including a close up of hands/feet. Consider the use of soft toy in the photograph, use a Moses basket with pastel coloured blanket as a background and take close up pictures using the camera’s macro facility including hands/feet as these are often the best feature in extreme prematurity. Allow the parents to use the camera to take photographs if they wish. Ensure that there is adequate lighting for photographs (use additional lighting if necessary). If the parents do not wish to have the photographs inform them that they will be available at anytime in the future if they want them

- The camera log book should be completed to comply with information governance regulations. Parents should be given the memory card or the photos deleted

- Babies should not be taken to the mortuary until the parents are ready. The Flexmort cold mattress should be used to aid the preservation of babies while on the ward

- Parents should be supported if they wish to take their baby home. There are no legal reasons to prevent this. (Appendix 8) for further information and guidance. To protect parents from misunderstandings, give them the form to confirm that the body has been released to them (available in the ring binder bereavement pack). Inform the Bereavement Officer (leave a message out of hours) and the community midwife
• Offer a hospital Certificate of Acknowledgement if the baby is born before 24 weeks' gestation as parents will not receive any legal acknowledgement (stillbirth or death certificate) of their baby

• Give the following leaflets: Devastating Loss (Dept of Health), ‘Following the loss of your baby’ (RCHT), ‘What financial help is available?’ (Money Advice Service)

• For miscarriages, obtain written consent from the parents for disposal / funeral arrangements. The completed form ‘What happens to our baby’ must accompany the baby to the mortuary

• For miscarriages, offer parents an appointment with Bereavement Officer if they wish. This service is not automatic prior to 24 weeks gestation

2.9. Spiritual and Religious Needs

• The religious and cultural needs of the parents should be taken into account (Appendix 10). It is important that staff make no reference to their own beliefs unless the parent asks

• Discuss with parents whether they wish to speak with the hospital Chaplain or other religious representative and offer a blessing/baptism service. The hospital Chaplain offers both a religious or Celtic blessing ceremony. The Hospital Chaplains can be contacted day or night via the hospital switchboard

• Parents should be offered the option of having their baby’s name entered in the Book of Remembrance that is displayed in the Hospital Chapel and invited to the annual Service of Remembrance

• Parents may wish the support of a religious leader of their own faith and staff should offer to arrange this if necessary. The hospital Chaplaincy may provide contact details

2.10. Maternal Investigations (refer to appropriate ring binder checklist and Appendix 7)

Laboratory tests are recommended to assess maternal wellbeing, determine the cause of death and if recurrence is likely in a future pregnancy. Certain tests are routinely recommended, others on a selective basis depending upon the clinical picture. Note that certain tests are recommended before delivery. It is efficient and kinder to the woman to obtain her verbal consent for all relevant tests and perform a single venepuncture. Senior advice must be sought when there is uncertainty as to the necessity of an individual test. Occasionally, the clinical picture will change, necessitating further blood
to be obtained. When the presenting picture is one of infection, microbiological investigations will be tailored to the specific circumstances.

A kleihauer is performed in all cases to exclude a feto-maternal haemorrhage. When the mother is rhesus negative, the dose of anti-D given should be adjusted upwards and the kleihauer repeated at 48 hours to ensure the fetal cells have cleared.

2.11. Investigations on the Baby
- **Postmortem**: offer in all cases after 18 weeks’ gestation unless the diagnosis is beyond doubt. In selected cases at less than 18 weeks PM may be indicated. Consent should be obtained in accordance with guidance in Appendix 5

- **Cytogenetics**: offer in all cases in accordance with guidance in Appendix 6, irrespective of the gestation or the degree of maceration. An information leaflet should be given and written consent obtained (in addition to separate PM consent). Encourage a placental sample alone if a skin biopsy is declined

- **Comprehensive external examination**: An experienced clinician should inspect the baby and document their observations on the proforma in the notes. Senior paediatric assistance should be sought if abnormalities are identified. Avoid assigning gender when genitalia are ambiguous. Genetic sex can be tested rapidly on skin tissue, even on macerated babies. When genetic sex testing is being performed, parents should be warned that even when the sex appears to be obvious on clinical examination, there can occasionally be a discrepancy on genetic testing

- **Total body radiograph**: offer when dysmorphic features are noted, and PM is declined

- **Fetal swabs (nasal and auditory meatus)**: offer when infection is suspected

2.12. South West Congenital Abnormality Register (SWCAR)
- In cases where fetal abnormality is diagnosed details must be sent to SWCAR.
- To enter abnormality details on STORK: From main menu > select *Stork Patient Options* (2), Select Maternity Printing (1) > Select Abnormality Register (23) > Complete abnormality details > Complete the outcome for <24 weeks (or >24 weeks as appropriate)
- Print details. File one copy in medical notes, the second copy is sent to SWCAR

2.13. Transport of the baby and placenta
- **Baby**: Transfer the baby to the mortuary in cardboard casket lined with damp “inco” sheet. Label the outside of the box with mother’s identity label
• **Placenta:** Place in Formalin once microbiology and cytogenetic samples have been taken. Placenta to be transported in the red Pathology container and sent to the mortuary at the same time as the baby.

• The following documents should accompany the baby and placenta:
  - Deceased Baby Care Record
  - Consent for funeral arrangements following pregnancy loss
  - PM consent and request form (may be collected later by Bereavement Officer if not complete)
  - Placental histology request form stating either ‘No PM’, ‘PM requested’ or ‘PM decision awaited’
  - Crematorium Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains (white form for <24 weeks; pink for >24 weeks). This form is required for both burial and cremation

2.14 Lactation suppression

Medication is not routinely recommended because serious side effects can occur albeit rarely (hypertension, stroke, myocardial infarction, seizures). Simple analgesics and breast support are effective and are preferable. Carbergoline 1 mg as a single dose within 24 hours of delivery may be considered in non hypertensive women when discussion of lactation is especially distressing.

2.15. Discharge to home and follow up

• The woman should not be discharged until the checklist has been completed.
• Check that the Bereavement Office arrangements have been made.
• Offer contraceptive advice.
• All existing appointments should be cancelled.
• The woman’s GP and community midwife should be informed and a Stork letter sent to the GP.
• The pregnancy must be cancelled on the STORK computer system.
• Parents should be given information leaflets on / signposted to appropriate national and local support groups. This must be documented on the appropriate check list.
• Complete ‘Discharge to Community Midwife Care’ proforma
• Medical notes should be highlighted with a SANDS teardrop sticker placed on the inside of the front cover.
• For stillbirth and early neonatal death complete the form to notify RCH Child Health Department.
• Inform the appropriate Consultant secretary to plan follow up.
2.16. Early Neonatal Death

Early neonatal death is defined for the purpose of this guidance as a death at any gestation that has occurred in the maternity unit soon after delivery rather than in the neonatal unit. This guideline is designed for use when the baby showed some signs of life, but was not able to be resuscitated or that it was inappropriate to attempt resuscitation e.g. following termination of pregnancy for fetal abnormality or pre viability

If the baby dies in the Neonatal Unit the mother will continue to be cared for by midwifery and obstetric staff and, since the cause of the death will often have obstetric origins, investigation of the mother must not be overlooked. Several important principles underpin the management:

- Close liaison between neonatal and midwifery/obstetric staff is paramount
- When the baby dies before admission to NICU, it is appropriate for a Consultant Obstetrician to co-ordinate all investigations
- Unlike cases of IUD, some cases will need to be discussed with the coroner (who may request a PM, irrespective of the parents’ wishes)

2.17. Principles of Maternity Management of Early Neonatal Death

- Unambiguous neonatal or obstetric responsibility for managing the case
- During life, the baby should either stay with the parents or be transferred to the Bereavement Nursery on Wheal Rose ward
- Ongoing postnatal care appropriate for the clinical circumstances (e.g. close surveillance for abruption, pre-eclampsia etc.)
- Care in Daisy Suite on Wheal Rose (or discharge to home) once stable to leave delivery suite
- Appropriate maternal investigations in discussion with neonatal staff
- Follow the appropriate Early Neonatal Death checklist
- Ensure that the Child Death Review Notification is completed (Agency is RCHT)

2.18. Post mortem issues when Coroner involved (see also Appendix 5)

- Most cases will not require the involvement of the Coroner
- There should be discussion between the Consultant obstetrician and paediatrician before the Coroner’s Officer is contacted by one of those senior clinicians. This ensures that there is a full mutual understanding of the clinical situation
- Detailed discussions with parents regarding PM should await the coroner’s opinion. When the coroner does not consider PM to be necessary, a PM can be offered to the parents if the senior clinician responsible for the case considers it to be potentially
informative. This clinician will usually be a neonatologist but in selected cases this may be an obstetrician after discussion between consultants. PM may be unnecessary when the cause of death is beyond reasonable doubt clinically (e.g. large abruption)

- Discussion of a coroner’s PM or parental consent for PM is undertaken by an experienced doctor. If it is not obtained by a Consultant, he or she will only delegate to a junior colleague who has an appropriate level of skill and knowledge. All discussions are documented in the medical notes and the checklist signed and dated
2. Monitoring compliance and effectiveness

<table>
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<th>Element to be monitored</th>
<th>The audit will take into account record keeping by obstetric, anaesthetic and paediatric doctors, midwives, nurse, students and maternity support workers.</th>
<th>The results will be inputted onto an excel spreadsheet.</th>
<th>The audit will be registered with the Trust’s audit department.</th>
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<tbody>
<tr>
<td>Lead</td>
<td>Bereavement Specialist Midwife</td>
<td></td>
<td></td>
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<tr>
<td>Tool</td>
<td>Is there evidence of compassion and care given to women in line with local trust values.</td>
<td>Has the appropriate checklist for the specific pregnancy loss/neonatal death been fully completed.</td>
<td>Has it been documented that a discussion supporting maternal choice e.g. cultural and spiritual needs has taken place.</td>
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<td></td>
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<td>Has it been documented that the woman was given the appropriate written information following diagnosis.</td>
<td>Have all legal requirements been met.</td>
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<td>Frequency</td>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have suffered a pregnancy loss or early neonatal death, over a 12 month period.</td>
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<tr>
<td>Reporting arrangements</td>
<td>A formal report of the results will be received annually at the Maternity Risk Management and Clinical Audit Forum.</td>
<td>During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Maternity Risk Management and Clinical Audit Forum and an action plan agreed.</td>
<td></td>
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<td>Acting on recommendations and Lead(s)</td>
<td>Any deficiencies identified on the annual report will be discussed at the Maternity Risk Management and Clinical Audit Forum and an action plan developed.</td>
<td>Action leads will be identified and a time frame for the action to be completed by.</td>
<td>The action plan will be monitored by the Maternity Risk Management and Clinical Audit Forum until all actions complete.</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within a time frame agreed on the action plan.</td>
<td>A lead member of the forum will be identified to take each change forward where appropriate.</td>
<td>The results of the audits will be distributed to all staff through the Risk Management Newsletter</td>
</tr>
</tbody>
</table>
3. **Equality and Diversity**

3.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the [Equality and Diversity website](#).

3.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
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<tr>
<th>Document Title</th>
<th>Pregnancy Loss and Early Neonatal Death – Clinical Guideline</th>
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<td>17(^{th}) December 2015</td>
</tr>
<tr>
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<td>31(^{st}) December 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>31(^{st}) December 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Karen Stoyles, Bereavement Midwife, Women and Children’s Division</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 255036</td>
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<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>17(^{th}) December 2015</td>
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<tr>
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<td>CLINICAL GUIDELINE FOR SUPPORT FOR PARENTS FOLLOWING PREGNANCY LOSS OR EARLY NEONATAL DEATH</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Meeting</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Head of Midwifery</td>
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<tr>
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16. When a Patient Dies: Advice on Developing Bereavement Services in
Training Need Identified? Part of mandatory training

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### Appendix 2. Initial Equality Impact Assessment Form

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</tr>
<tr>
<td>Name of individual completing assessment: Elizabeth Anderson</td>
<td>Name of individual completing assessment: Elizabeth Anderson</td>
</tr>
<tr>
<td>Telephone: 01872 252879</td>
<td>Telephone: 01872 252879</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   Who is the strategy / policy / proposal / service function aimed at?
   - To provide midwives and obstetricians with guidance in the provision of emotional support and clinical care following pregnancy loss and early neonatal death.

2. **Policy Objectives***
   To ensure parents receive appropriate care and support during a pregnancy loss or early neonatal death.

3. **Policy – intended Outcomes***
   Care and support for parents following a pregnancy loss or early neonatal death.

4. **How will you measure the outcome?***
   Compliance monitoring tool.

5. **Who is intended to benefit from the policy?***
   All bereaved parents following pregnancy loss or early neonatal death

6a) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?***
   - No
   - N/A
   - N/A

7. **The Impact**
   Please complete the following table.

---

Pregnancy Loss and Early Neonatal Death – Clinical Guideline

Page 23 of 42
Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, transgender / gender reassignment)</td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Disability</strong> - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td>X</td>
<td></td>
<td>All bereaved parents following pregnancy loss/early neonatal death</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director
Karen Stoyles

Date of completion and submission 17th December 2015

Names and signatures of members carrying out the Screening Assessment 1. Elizabeth Anderson 2. Karen Stoyles

---

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD
A summary of the results will be published on the Trust’s web site.

Signed: Elizabeth Anderson

Date: 17th December 2015
Appendix 3: Medication for Induction of labour after miscarriage, intrauterine death and for medical termination of pregnancy

**Important:** Prescribe medication at time of diagnosis **before admission** so that delays in commencing misoprostol on the ward are avoided

**Medication regimen**

- **Mifepristone 200mg orally.** Recommended in most cases to reduce the time spent in hospital, the number of doses and side effects of misoprostol and the likelihood of retained placenta. Occasionally, in selected IUD cases (e.g. when there is uterine activity already or ruptured membranes) direct admission for misoprostol may be considered.

- Explain that modest bleeding and abdominal cramps may occur but occasional its severity necessitates early admission. Headaches, nausea and skin rashes may occasionally occur.

- Mifepristone is contraindicated in severe asthma not controlled by therapy, porphyria and chronic renal, liver or adrenal failure.

- Admission arranged for 36-48 hours after Mifepristone.

- Misoprostol in the posterior vaginal fornix;
  1. <24 weeks: **200** micrograms every **three** hours
  2. >24 weeks with no previous LSCS: **200** micrograms every **six** hours
  3. >24 weeks with history of previous LSCS: **100** micrograms every **six** hours (a senior obstetrician should discuss the risks of induction in this situation and may wish to individualise dose regimen)

- Side effects include nausea, vomiting, pyrexia, tachysystole and hypertension.

- If labour is not established after four doses then woman should be reviewed by senior obstetrician.

- 200mcg is lowest dose tablet available in UK and its use for this indication is 'off label'. A tablet cutter is available in the drug trolley on Wheal Rose ward to enable 100 microgram half tablet vaginal administration for cases of previous caesarean section. The other half of the tablet should be discarded rather than stored for the next dose.

**Analgesia**

A range of analgesia and anti-emetics should be prescribed. Diamorphine may be used in preference to Pethidine due to greater analgesic qualities and longer duration of action (but don’t use both drugs in a single case). Assessment for DIC and sepsis should be undertaken before the administration of regional analgesia.
Thromboprophylaxis

Women should be routinely assessed for thromboprophylaxis, but IUD is not a risk factor

Suppression of lactation

Carbergoline 1 mg as a single dose within 24 hours of delivery may be considered in non hypertensive women. It is not recommended for routine suppression of physiological lactation because serious side effects can occur rarely (hypertension, stroke, myocardial infarction, seizures). Simple analgesics and breast support are effective and may be preferable. It may be valuable at later gestations and when discussion of lactation is especially distressing for the woman.
Appendix 4: Identification of a Deceased Baby / Fetus

Checking of the mortuary identification bracelet (Typenex)
Only one mortuary identification bracelet is needed. No other identification label should be applied to the baby. Ideally the label should be checked with one or both parents prior to baby leaving the room of delivery. If parents not able or chose not to check the bracelet another health professional should be asked to perform the check.

If baby is expected to be deceased at birth
- In advance, prepare the correct size cardboard casket or wooden white box.
- Only one mortuary identification bracelet is required, there needs to be 3 methods of identification on the bracelet: ‘Baby of (mother’s full name)’, Date of delivery, Baby’s CR number (this will need to be added later) or time of delivery (if fetus less than 24 weeks gestation)
- Ensure details will not be obscured by the plastic fastener when attached to the baby. Peel off the paper cover leaving smudge information.
- Place the prepared bracelet in the prepared cardboard casket and stick one of the red sticky labels on top of the prepared casket.
- Once bracelet is complete secure on the most appropriate limb (not to be placed loosely around baby’s abdomen)
- Baby to be prepared for the mortuary as per the bereavement check list

Unexpected stillbirth or neonatal death (Maternity unit only)
- If the baby has already had identification labels secured as per Newborn Identification and Labeling Guideline RCHT 2013.
- Prepare one mortuary identification bracelet with 3 methods of identification: Baby of (mother’s full name), Baby CR number, Date of birth
- Remove white newborn identification labels and secure one mortuary identification bracelet securely to one of the baby’s limbs or around waist.
- Stick one of the red sticky labels from the baby’s bracelet on top of cardboard casket.
- Prepare the baby for the mortuary as per the appropriate check list.
- Complete mother’s and baby details clearly indicating where the bracelet is placed
- Complete property list
- Midwife caring for mother and baby along with second professional should sign to confirm all of the mother’s and baby’s details are correct and check the property details. Two signatures are required
- The name of the porter transferring the baby to the mortuary should be added to the bottom of the deceased baby care record, by the midwife. No checks need to be performed by the porter.
Appendix 5: Consent and Practicalities for Perinatal Postmortem

Postmortem (PM) is a valuable investigation after pregnancy loss but uptake remains low. Discussion of the merits of PM, practical details and completing the comprehensive and graphic consent form is stressful for grieving parents and for staff. The clinician seeking consent must be well informed and sensitive and needs to be prepared to give adequate time for discussion and reflection before completing the process. This may take several consultations that should be in the presence of both partners. The parents should have had ample time to read the PM Information leaflet before informed consent can be obtained. All discussions should be documented.

- The HTA approved SANDS consent form should be used. There is an optional separate section ‘Consent to further examination of organs for diagnostic purposes’. This should only be used in discussion with a Fetal Medicine Consultant when certain specific abnormalities have already been identified. This form is not routinely available in the ring binder bereavement packs but is stored in the Bereavement Nursery and in the Fetal Medicine Department.

- Remember to complete the section on the PM consent that gives the parents a date and time until they can change their minds. The pathologist will not proceed without this information.

- SANDS Guidance for Consent Takers is available in the Bereavement Nursery.

- The PM consent form is copied twice, one for the notes and one for the parents. The original accompanies the body to the mortuary with a PM request form.

- The PM request form must contain full clinical information.

- The placenta (placed in saline, NOT formalin) should accompany the body to the mortuary.

- Inform the Bereavement Office on ext. 22713. Do this immediately after consent has been obtained. Leave a message on the answer phone out of hours.

- **NOTE: Consent is not required for a coroner’s PM**

Benefits of Postmortem

- Confirms clinical diagnosis
- Reveals the cause of death (important new information in 20-86%)
- Identifies anomalies relevant to future pregnancy
- Estimates time of death
- Identifies chronic intrauterine disease (e.g. infection, brain damage)
- Gives information on complications of treatment
- (Research, training and audit)
Practical Information regarding Postmortem

- **When?**
  Only once the parents have ‘said their goodbyes’, however long they need. However, excessive delays will reduce the quality of the PM

- **Where?**
  Department of Paediatric Pathology, St Michael’s Hospital in Bristol. Transfer of stillbirths after 24 weeks’ gestation and all neonatal deaths are made by Funeral Directors. Transfers of fetuses less than 24 weeks are made by hospital arranged transport. The baby remains at RCH until the day before the PM.

- **By whom?**
  A consultant pathologist specialising in fetal and infant PMs

- **How?**
  S sensitively, as a surgical procedure, with respect to the dignity of the deceased. Two incisions are made, one anterior midline down the chest and abdomen, the second transversely across the back of the skull above the hairline. Organs are re-united with the body (unless consent for retention is given) and the incisions are sutured, ensuring restoration of pre PM external appearance

- **When will the body be returned?**
  Usually within a week unless more detailed organ examination is required in a case where the consent specifies that all organs should be re-united with the body. Tissue slide examination may continue after release of the body. The Bereavement Care Co-coordinator will contact and inform the parents as soon as the baby is return to RCH.

- **When will results be available?**
  A preliminary PM report is issued within a few days but the final report is only issued after all tests are complete. This may take a few weeks

- **Consent is not needed for a Coroner’s PM:**
  - seek senior advice to ascertain whether there are any issues that might require the input of the coroner. This only applies to live births.

Obstacles to Consent

- Difficulty in discussing during acute distress: be prepared to discuss PM in several consultations, give parents time and individualise the timing of the discussions
- Uninformed professionals: only seek consent if you are well informed
- Personal and religious objections
- Need to transfer babies: explain that the PM is complex work that is not available locally and that transfer is made in a dignified fashion using a local Funeral Director
- Delay in return of baby (and therefore funeral) or results: explain that the PM is only worth performing if comprehensive results are obtained. All attempts are made to minimise delays knowing that this may add to the distress of grieving parents
Organ retention scandals before 2000 (despite Human Tissue Act 2004): reassure that tight controls and the explicit consent form should prevent such issues recurring.

Appendix 6: Cytogenetic Samples after Pregnancy Loss
(see also the Standard Operating Procedure)

Introduction
A vital part of investigation after late pregnancy loss is cytogenetic testing. It may also be offered after recurrent miscarriage, termination of pregnancy for fetal abnormality or early neonatal death. It is essential that tissue samples are obtained in a standardised manner to maximise the chance of accurate, comprehensive results and with due respect to the deceased. Appropriate documentation, training and audit is essential for a high quality service and is monitored by The Human Tissue Authority.

Location for sample acquisition
Tissue samples are taken in the Wheal Rose ward Bereavement room, irrespective of place of delivery. This is the only appropriate setting for dignified and efficient sample collection. The only exception is recurrent first trimester miscarriage investigation which takes place, by necessity, in an operating theatre environment (see below).

Consent for Cytogenetic testing
Written consent is mandatory using the designated consent form (to be found in all Bereavement packs, on the Emergency Gynaecology Unit, the Gynaecology ward and in the Consent section of the Gynaecology intranet shared drive). It is used even if written consent for post-mortem has been obtained. If consent is obtained for skin biopsy, this should include consent for placental biopsy because the laboratory prefers to receive both samples. Consent is sought for placental biopsy alone if parents want the genetic information but are unhappy to give consent for skin biopsy (due to its invasive nature).

Cytogenetic Sample Pots
- Universal containers containing specific transport medium (‘For skin biopsy’) are stored at -20°C in the fridge freezer in the Bereavement room on Wheal Rose ward
- Do not use the CVS medium for any post delivery samples
- The medium is thawed before the sample is placed in the pot
- Skin and placental samples are placed in separate pots
- Pots are stored in the Bereavement room fridge (not freezer) until transfer to Bristol

Technique for sample collection
- All equipment is kept in a labeled box in the Bereavement room
- Sampling is a gloved non sterile technique with care to minimise contamination
- Samples are obtained using an 8mm single use punch biopsy
- Soft tissue of the thigh is held between thumb and fore finger and the punch biopsy gently pushed with a screwing action into the skin and underlying muscle to the full depth of the metal sampling cylinder
- The tissue core is elevated using tissue forceps and its base attachment cut using a disposable blade.
• The sample is placed into thawed ‘skin biopsy’ transport medium, ensure the lid is secured and label accurately
• The same technique is used to obtain a placental biopsy, targeting the placenta close to the cord insertion and placed in a separate pot

Sample handling after collection
• A cytogenetics request form is accurately completed with full details of clinical picture (include known anomalies, growth restriction, family history etc) and referrer
• Samples (in a sealed plastic bag) are placed in the Bereavement room fridge, not the freezer compartment
• Samples are boxed up by the Wheal Rose ward clerk (sealed with Pathological Specimen Fragile With Care tape), addressed to Regional Cytogenetics Centre, Southmead, Bristol BS10 5NB and sent at 0830-1630 week days and 0800-1100 Saturday to the RCH post room for special delivery transfer

Documentation
• The clinician documents discussion of consent, obtaining consent and taking the samples on the ‘Checklist for Doctors’ found in all the Bereavement packs (Termination for fetal abnormality, Miscarriage before 24 weeks gestation, Stillbirth after 24 weeks and Early Neonatal Death)
• The clinician taking the samples records the woman’s name, CR number, date and time of sample collection and their name, designation and signature in the Cytogenetics Ledger in the Bereavement room
• The Wheal Rose ward clerk records in the Cytogenetics Ledger when the samples are transferred to the post room

Recurrent First Trimester Miscarriage
• Documentation of the discussion and obtaining of consent is made in the hospital notes and the designated consent form is used
• ‘Skin biopsy’ medium (not ‘CVS’ medium) is obtained from the Wheal Rose freezer and thawed before use
• Cytogenetic consent forms are available in the Bereavement room and in EGU
• The sample is obtained in theatre during the ERPC operation and placed in the transport medium (without any attempt to distinguish fetal and placental tissues)
• The sample is placed in the Bereavement room fridge with request form
• Full documentation is entered into the Bereavement room Cytogenetics Ledger
• The Wheal Rose ward clerk records in the Cytogenetics Ledger when the sample is transferred to the post room

Training Issues
• Only individuals who have received documented training in Cytogenetic sample consent and collection may undertake the work
• This guideline is placed in the Department Handbook given to all junior medical staff
• Discussion of this guidance and a hardcopy are given to all medical staff at Induction
• Signed confirmation that the doctor has read and understood the guidance and has been given the opportunity to receive satisfactory answers to any questions they have is obtained and held by the Department Medical Staffing Officer
• No doctor performs this work if they are uncertain about their competence
• Further training will be made available by the Bereavement Coordinators at request
Appendix 7: Blood and Microbiological Investigations for 2nd trimester miscarriage, stillbirth and neonatal death

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Indication</th>
<th>Date, time and signature</th>
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<tbody>
<tr>
<td><strong>Blood: All cases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full blood count <em>(Purple tube,)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Clotting Screen <em>(Blue tube &amp; Haematology form)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Group and antibodies <em>(Pink tube)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Kleihauer <em>(same bottle as Group)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>CMV*</td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Toxoplasmosis*</td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Syphilis*</td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td><em>Single yellow tube for all. &amp; microbiology form</em> *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lupus anticoagulant *(blue tube x 2 ) and Anticardiolipin antibodies <em>(yellow tube x 1.)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td>Both on haematology request form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood must be processed within 60 minutes. Ring lab to inform when blood sent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Thyroid function <em>(Yellow tube x 1 &amp; clinical chemistry form)</em></td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td><strong>Blood: If indicated</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parvovirus B19**</td>
<td>Rash with arthropathy; unexplained fetal hydrops</td>
<td></td>
</tr>
<tr>
<td>Rubella**</td>
<td>Fever, malaise, sore throat, rash, occipital nodes</td>
<td></td>
</tr>
<tr>
<td>Hepatitis screen**</td>
<td>Jaundice or foreign travel</td>
<td></td>
</tr>
<tr>
<td><strong>same yellow sample as for CMV/Toxoplasmosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bile acid <em>(same yellow as TFT)</em></td>
<td>Pruritis</td>
<td></td>
</tr>
<tr>
<td>Listeria <em>(blood cultures)</em></td>
<td>Maternal fever/diarrhoea, food history, early meconium</td>
<td></td>
</tr>
<tr>
<td><strong>HBA,C</strong></td>
<td>Macrosomia, glycosuria++, polyhydramnios, antenatal GTT indicated but not performed</td>
<td></td>
</tr>
<tr>
<td>Thrombophilia screen <em>(2 more blue with LAC/ACA bottles)</em></td>
<td>Strong PH or FH</td>
<td></td>
</tr>
<tr>
<td>Anti-Ro/La antibodies <em>(yellowx1)</em></td>
<td>Hydrops; endomyocardial fibroelastosis at PM</td>
<td></td>
</tr>
<tr>
<td>**Antiplatelet antibodies <em>(discuss with extension 3040)</em></td>
<td>Intracranial haemorrhage</td>
<td></td>
</tr>
<tr>
<td><strong>Microbiology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placental biopsy</td>
<td>All cases</td>
<td></td>
</tr>
<tr>
<td><strong>HVS</strong></td>
<td>PV discharge / suspected chorioamnionitis</td>
<td></td>
</tr>
<tr>
<td><strong>MSU</strong></td>
<td>Urinary symptoms / +ve urinalysis</td>
<td></td>
</tr>
<tr>
<td>Blood cultures</td>
<td>Fever &gt;38°C</td>
<td></td>
</tr>
<tr>
<td><strong>Baby ear and nasal swabs</strong></td>
<td>Suspected chorioamnionitis</td>
<td></td>
</tr>
<tr>
<td><strong>Other Investigations</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 8: Guidance When Bereaved Parents Wish to Take Their Baby Home

Some parents find it helpful to have time with their baby after death at home, away from a clinical setting. There is no legal reason to prevent parents from taking their baby’s body home at any gestation and staff should support parents who want to do this.

- For the protection of parents and to avoid misunderstandings parents should be given a form confirming that the body has been released to them. (Form available in bereavement ring binders). Do not file this form in the medical notes.
- There is no longer a legal requirement to inform police
- Record in medical notes that the parents have taken the baby home or that their Funeral Director has collected the baby directly from the ward
- The baby should be taken home in a casket
- Advise parents that it is important to keep their baby cool
- Post mortem can be arranged before or after parent’s have taken the baby home for a short while. (Contact details Appendix 9). Parents need to be aware that a delay in PM may affect the quality of the findings.
- If the body or remains have been placed in formalin, the family should be given advice about avoiding accidental exposure to the fixative and what to do if this occurs
- RCHT Bereavement Office will still arrange and fund funerals for parents who take their baby home (The baby must have been delivered at RCH)
- Parents of babies who were stillborn or who were born alive at any gestation should be informed that there are certain regulations about what can be done with the body.
- There are no regulations governing what can be done with the body or remains of a baby born dead before 24 weeks gestation, but parents should be advised to consult the Environment Agency for advice about suitability of the site.
- Parents should be given the contact number for the Bereavement Office for further advice.
Appendix 9: Bereavement Office and Mortuary Contact Details

Bereavement Office

Extension x 2703 / 2713

Opening hours: Monday to Friday 09.00 – 16.00

The Bereavement Office must be informed by telephone in the event of pregnancy loss or neonatal death. If the pregnancy loss occurs out of hours then leave a message on Bereavement Office answer phone.

The Bereavement staff must be informed if a post mortem is requested. The post mortem paperwork should be taken with the baby when baby is transferred to the mortuary (See checklist).

The Bereavement office will liaise with the family to arrange appointments and arrangements to collect all documentation. (This must be specifically requested in pre-24 week pregnancy loss). The Bereavement Officer will be able to offer advice and support to parents if requested and will attend the ward or arrange to speak to parents by telephone if that is preferred. They can support and advise parents in respect of funeral arrangements and ‘what needs to be done next’. The Bereavement Care Coordinator is available for advice to any member of staff who is unsure/unfamiliar with the paperwork required or as to how to advise parents and next of kin.

The Cornwall County Registrar attends the Bereavement Office twice a week when stillbirths and neonatal deaths can be registered.

During office hours the Bereavement Staff will arrange for parents/family to view a baby if required.

In exceptional circumstances out of hours viewings may be arranged by the Delivery Suite Coordinator via switchboard, who will contact the nominated pathology technician on call. They in turn will either contact the hospital staff or the family to arrange.

Mortuary Service

Extension x 2555

Opening hours: Monday to Friday 07.30-16.00hrs

Out of Hours (On-call) Contact on Call Mortuary Technician via Switchboard

Monday to Friday 16.00-20.00hrs
Saturday/Sunday 10.00-20.00hrs
Bank Holidays 10.00-20.00hrs
Appendix 10: Religious & Cultural Rites

Most religious faiths have Late Rites – common to all is the need to say goodbye – the need to see, touch, hold and talk to the child. These guidelines offer an insight into different religious and cultural rites.

Different Religions
The specific requirements of the main faiths encountered are outlined below. However, **all families should be asked what their own particular wishes are**, as they may not follow the expected practice. To contact faith leaders please contact the Chaplaincy office.

**Buddhism**
- When a child of a Buddhist family dies special prayers usually take place for a period of time before burial. This period depends on the lunar calendar and varies between three to seven days in most schools of Buddhism.
- As their faith does not prevent non-Buddhists touching the body, staff do not need to take particular measures when performing Last Offices. The most important thing to do is to ensure that a Buddhist priest (preferably of the same school of Buddhism) is contacted as early as possible and any specific requests are ascertained from the family.
- There is no specific teaching which would favour burial over cremation, though cremation is more usual in the country of origin of many Buddhist families.
- **Post Mortems and Organ donation**
  Post-mortems are accepted where necessary, and organ donation may be acceptable.

**Christianity**

**Protestants**
- There are no specific requirements for the Last Offices for the child of a Protestant family, except to obtain the services of a chaplain to administer a blessing or baptism or to pray with the family if they so wish.
- Both cremation and burial are acceptable.
- **Post-mortems and Organ donation**
  Post-mortems are usually acceptable if requested and there is no religious objection to organ donations.

**Roman Catholics**
- Infant baptism is the tradition of the Roman Catholic Church. Sacraments are extremely important to Catholics. Roman Catholic parents of a critically ill baby that has not been baptised would wish a Catholic priest or deacon to be called without delay. In an emergency a Christian member of staff may baptise by pouring water over the child's head and saying, 'I baptise you in the name of the Father and of the Son and of the Holy
Spirit. Amen. The Catholic chaplain should be informed in order the baptism be registered.

- If the child is already baptised, prayer, a blessing or the Sacrament of the Sick may be appropriate. The Sacrament (or Anointing) of the Sick is an anointing with blessed oil and laying on of hands together with prayers for healing and strength. For this reason it is no longer referred to as Last Rites. Only a priest may give the Sacrament of the Sick. Catholics would expect a priest to be called it the event of critical illness.

- The Sacraments of Baptism and of the Sick cannot be given after death. In this situation prayers and a blessing by a Catholic priest or a member of the Church may be said. The family may want to stay by the bedside to pray the Rosary.

- As regards an unbaptised child who has died, the Church speaks of the great mercy of God who desires all people should be saved and of Jesus' tenderness towards children which caused him to say, 'Let the children come to me, do not hinder them'. This may help allay fears or guilt the parents may be experiencing.

- An unbaptised child may receive a full Church funeral. There are Catholic funeral services both for burial and cremation.

- Post-mortems and Organ donation.
  There are no religious prohibitions to post-mortem examinations, and organ donation is generally acceptable to Catholics.

Christian Orthodox
- It is very important to ask parents if they would like the Orthodox priest to visit and administer Communion and anointing. If an infant is in danger offer baptism.

- Post mortems and transplants
  No religious objections, although there may be cultural concerns.

Baha'I
- The family may ask for prayers to be said by the Spiritual Assembly of Baha'I. This may be arranged by the family or the chaplain.

- A special ring may be placed on the patient's finger – please do not remove. Otherwise routine last offices with the body wrapped in plain cloth or silk

- Post-mortems and Organ donation
  No religious objections

Hinduism
- Hinduism embraces a way if life and a social system which involves the worship of numerous gods, all of them manifestations of the one Supreme Being. In Hinduism, there is no supreme church authority and no hierarchy. The priest has no pastoral functions but may come to the ward to pray with the relatives of a dying baby. They often wish to give the child water from the River Ganges (Ganga) and read to them from one of the holy
books of Hinduism, this is also the case with babies. They may also tie a thread around their wrist or neck, and this should not be removed. Whenever possible Hindus like to die at home but if this is not possible the following should be remembered:

- Gloves should be worn by non-Hindus when touching the body. The family normally wish to perform Last Offices themselves so wrap the baby in a plain white sheet and await the arrival of relatives.

- Ideally, Hindus are cremated on the day of death but the formalities required in Britain make this impractical. However many families will wish to have the death certificate issued as quickly as possible so they may take the body home or to the funeral directors on the day of death.

- Infants are not cremated but buried.

- **Post-mortems and Organ donation**
  Post-mortems are not generally approved of but are accepted if legally required. There are no religious prohibitions against the giving of organs.

Islam

- Moslems believe in one God (Allah) and regard the religion’s founder Mohammed as the prophet of Allah. The Koran (Quran), is Allah’s word consists of the teachings of Islam. This, along with recorded sayings of Prophet Mohammed and his acts, constitute the Islamic legal system (Sharia) – there being no distinction between religious and secular law. The mosque (masjid) is in the charge of an elected prayer leader (imam). The imam is not required to attend the death or burial of a Moslem but is usually invited to do so. Moslems believe in “life after death” and that a person is judged by Allah according to their deeds as to whether they will go to “heaven or hell”.

- For the baby of a Moslem family it may be helpful before death to turn the foot of the cot in the direction of Mecca (in this country, this is in a south easterly direction), a compass is kept in the chaplaincy office. If it is not possible then the baby’s head should be turned to face this direction. Family members may pray at the bedside of the dying person, whispering into their ear.

- An important point that should be stressed to staff is that the Islamic faith does not prevent women from touching their babies after death.

- If an Islamic woman loses her infant within this time, it is not necessary to encourage the mother to touch or hold her baby’s body if this would cause distress to the woman.

- Gloves should be worn when touching the baby’s body. The families usually wish to perform Last Offices themselves so wrap the baby in a plain white sheet and await the arrival of relatives. The removal of a lock of hair is offensive.

- All Moslems are buried as soon after death as possible. As it is not always possible to comply strictly with Islamic rules for burial in this country, many families will embark on the bureaucratic and often distressing delays of taking their child’s body back to their country of origin.

- The family stays home for the first 3 days and mourning lasts for 40 days.
• **Post-mortem and Organ donation.**
  Post-mortem examinations are not generally acceptable but are reluctantly accepted if legally required. It is important to the family that all organs removed are returned to the body for burial.

• Organ donation is religiously acceptable but refusal may be expressed for personal reasons and should not be assumed.

**Jehovah’s Witnesses**

• Many of their inherent strict beliefs involve the rejection of established authoritarian rulings. Their religion forbids them from accepting many forms of medical treatment including blood transfusion,

• They refer to death as “passing over” and having led a blameless life, have nothing to fear from it. This means they may not demonstrate the emotions our society usually expects.

• Last Offices are usually undertaken by a fellow Jehovah’s Witness. A child may be either buried or cremated according to the family’s preference.

• **Post-mortems and Organ donation.**
  Post-mortems are not freely consented to, and organ donation is unusual

**Judaism**

• Judaism is based on the belief in one God. The love of God and the wish to carry out the Ten Commandments as given in the Torah (the first five books of the Old Testament). Religion and culture are inextricably mixed.

• The Jewish Sabbath begins before nightfall on Friday and ends with the first sighting of three stars on Saturday night (i.e. sunset to sunset). The exact time that the Sabbath ends is indicated on Jewish calendars. During this time strictly Orthodox Jews will not work, travel, write, cook or switch on electrical appliances.

• A point that staff should remember is that if a baby dies during the Jewish Sabbath an orthodox family may not be contactable or able to come to the hospital until after the Sabbath.

• It is Jewish tradition that when a Jewish person dies, a Wach’a (Watcher) may stay with the body from the time of death until the burial, which is usually within 24hrs of the death. This practice should be respected and provision made for the person even when the body is taken to the mortuary. The family will usually wish to burn a candle, but bear in mind safety precautions.

• For the baby of a Jewish family, staff should wear gloves when handling the child's body, wrap the child in a plain white sheet and await the arrival of relatives to perform Tahara (the preparation of the body). In Judaism, it is a member of the same sex as the deceased who will undertake the rituals required, usually accompanied by three members of their community.
• Jewish burials should take place within 24hrs after death and the family will require the death certificate as soon as possible. Very occasionally less traditional families opt for cremation.

• **Post-mortems and Organ donation**  
  Post-mortem examinations are not generally acceptable, unless legally required. Any organs removed from the body for examination should be returned for burial. Organ donation may be acceptable if requested.

**Sikhism**

• There are no ordained priests in Sikhism. The temple (Gurdwara) is in the care of a reader (Granthi) who is appointed and supported by the community. When a Sikh is dying, the family sometimes accompanied by the Granthi, pray and read from the holy book (the Guru Granth Sahib) at the person’s bedside.

• Whilst they have no objections to non-Sikhs touching the child’s body, they usually prefer to perform Last Offices themselves.

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• It is vital for staff to ensure that none of the five symbols of Sikhism are disturbed. These symbols are:
  1. KESH – uncut hair
  2. KANGHA – a semi-circular comb fixing the hair in a bun.
  3. KARA – a steel or gold bangle worn on the right wrist.
  4. KIRPAN – a symbolic dagger.
  5. KACHI – shorts/underpants.

• The baby should be wrapped in a plain white sheet and await the arrival of a relative who will perform the Last Offices.

• Sikh infants dying within a few days of birth are cremated.

• **Post-mortems and Organ donation**  
  There are usually no religious objections to post-mortem examination. Organ donation is generally acceptable to Sikhs.

**Humanists and Atheists**

• Whilst these families have no religious requirements at the time of death, they nonetheless often have very firm ideas of what they would like for their baby, and these should be respected.

**Pagan**

• Patients may ask for prayers to be said by their Spiritual adviser- please contact chaplaincy for pagan chaplain to be called. Individuals should be listened to for requirements.

• Burial is usually preferred.
• Post-mortems and Organ donation
  No religious objections to post-mortem. Most Pagans would donate for transplant.