Stillbirth or Non-Viable Fetus in the Community Setting Clinical Guideline V2.0

October 2018
1. **Aim/Purpose of this Guideline**
   This guideline is to support midwives who may care for a woman who has a stillbirth or non-viable fetus within the community setting. The incidence is very rare.

2. **The Guidance**

   2.1. **Definitions**
   - **Stillbirth**: “A child which has issued forth from it’s mother after the 24th week of pregnancy and which, did not at any time, after being completely expelled from it’s mother, breathe or show any signs of life” Department of Health (1992).
   - **Miscarriage**: A fetus born before the 24th week of pregnancy that does not show any signs of life or a fetus expelled after the 24th week of pregnancy provided it was no longer alive by the 24th week (this fact being known or provable from the stage of development by the dead fetus) (RCOG 2005)
   - **Non-viable fetus (NVF)**: A fetus born before 24th week of pregnancy.

   2.2. **Diagnosis of Intrauterine Death**
   If a midwife caring for a woman in labour in the community setting is unable to auscultate a fetal heart beat she should arrange urgent transfer to the obstetric unit by ambulance so that assessment of the fetal condition can be made by a clinician experienced in the use of ultrasound to detect fetal heart activity. A clear and honest explanation should be given to the parents as to why transfer is necessary.

   2.3. **Unexpected Stillbirth within the Community Setting**
   If a baby is born not showing signs of life when the midwife had previously auscultated a fetal heart beat during the labour, resuscitation should be commenced and a paramedic ambulance called via ‘999’. Transfer to the consultant unit should be made with ongoing resuscitation until paediatric assessment is made and a medical decision to discontinue resuscitation is taken.

   If a midwife is called to attend a woman who has already given birth to a baby who has never shown any signs of life and the birth occurred over ten minutes before their arrival, it is reasonable not to attempt resuscitation. (Resuscitation Council UK 2015).

   2.4. **Unexpected extremely premature baby born before viability in the community setting**
   Decisions about care should be based on the best interests of each baby if they are born alive. There is no legal requirement to provide life-sustaining treatment if parents and staff agree that this care is not in a very premature baby’s best interests. Offering parents opportunities to be involved in decision making may not always be possible before the birth if the mother is in strong labour or the labour progresses quickly and some parents may not want to make decisions (SANDS 2016) (NEW 2018)

   Before the 24th week of pregnancy babies below 500g are highly unlikely to survive and it is professionally acceptable not to attempt resuscitation below the threshold of viability with no signs of life.
2.5. Expected miscarriage or stillbirth in the community setting
If an intrauterine death has been confirmed by ultrasound scan or diagnosis of a lethal condition and the woman chooses to give birth at home or in the community setting this can be supported, provided a full discussion about the risks, benefits and alternatives has taken place. A plan of care should be put in place to support her, her family and the midwifery team.

Support from the RCHT Bereavement Midwives can be sought.

The appropriate folder containing all the mandatory and additional forms, checklists, contact numbers and support literature should be obtained from Wheal Rose.

2.6. Legal Requirements

2.6.1. NVF with no signs of life
The midwife must complete a Cornwall Council Certificate of ‘Medical Practitioner or Midwife In Respect of Fetal Remains’ form.

There is no statutory requirement for a NVF to have a formal funeral although parents may arrange cremation or burial with a local funeral director if they wish.

2.6.2. NVF with signs of life present / Neonatal Death (NND)
A baby showing signs of life at any gestation is legally classified as a live birth and therefore will require registration of both birth and death. Notify the woman’s GP. If the GP does not see the baby before death then they will need to inform the Coroner before they can issue a NND certificate.

If signs of life were present and NND certificate needs to be issued, cremation forms must be completed by the GP (not the midwife) regardless of gestation.

2.6.3. Stillbirth
The attending community midwife who was present at the birth and is able to confirm that no signs of life were shown must issue a stillbirth certificate to the parents. Stillbirth certificates are available for completion on Wheal Rose, please ensure that the certificate stub is also completed. The certificate book must not be removed from the Maternity Unit. (NEW 2018)

The attending midwife should also complete the ‘Penmount Crematorium Committee Certificate of Stillbirth’ which should accompany the baby to RCHT mortuary or the funeral director engaged by the parents.

If there are grounds for suspicion surrounding the baby`s death, the Coroner and police should be informed. If the death appears natural but the cause appears uncertain, the case should be discussed with the Coroner by either the midwife or GP. The Coroner can be contacted via RCHT switchboard.
2.7. Care of the deceased baby

2.7.1. NVF
From the parents perspective a miscarriage can be as significant and devastating as a stillbirth. Therefore when speaking to parents, the term “baby” rather than fetus or fetal remains should be used. A NVF must be treated with sensitivity and dignity in accordance to the Human Tissue Authority Code of Practice.

If the midwife is asked to remove a NVF between 14 – 24 weeks gestation she should wrap NVF in a small blanket and place in suitable receptacle (small caskets are available on Wheal Rose) and take to the licensed satellite mortuary on Wheal Rose. NVF below 14 weeks gestation should be sent to the Pathology Department in a dry histology pot (without formalin) accompanied by a histology request form.

If the parents wish bury a NVF at home or other private land they should contact Cornwall Council for advice.

Please refer to the RCHT Sensitive Disposal of Pre-24 week Fetal Tissue - Clinical Guideline.

2.7.2. Stillbirth / Neonatal Death
If not resuscitated the baby may be transported to Wheal Rose satellite mortuary if requested by parents for hospital arranged cremation or if cytogenetic testing is required. The baby must have an identification label attached prior to transfer.

The baby may be kept at home or await collection by funeral directors if that is the parent’s wish.

Please refer to Clinical Guideline for Pregnancy Loss and Early Neonatal Death (RCHT 2015)

2.8. Support for Health Professionals
For personal support midwives caring for a woman suffering pregnancy loss may contact:
- RCHT Pastoral Care Service – 01872-252883
- Sands (Stillbirth and neonatal death charity ) helpline – 020-7436-5881
- Antenatal Results and Choices (ARC) – 0207 631 0285
- Bereavement Care Network for Practitioners – www.bereavement-network.rcm.org.uk
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>• Was the appropriate folder containing all the mandatory and additional forms, checklists, contact numbers and support literature obtained from Wheal Rose.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Specialist Bereavement Midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>The notes are reviewed after each stillbirth, neonatal death and late miscarriage.</td>
</tr>
<tr>
<td>Frequency</td>
<td>After each event.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The results will be reviewed at the time of clinical incident review meeting.</td>
</tr>
</tbody>
</table>
| Acting on recommendations and Lead(s) | • Any deficiencies identified will be discussed at the maternity patient safety and clinical audit forum and an action plan developed.  
                                      • An action plan lead will be identified and a time frame for the action.                                                              
                                      • The action plan will be monitored by the Maternity Patient Safety Forum and Clinical Audit Forum.                                       |
| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within a time frame agreed on the action plan.                     
                                      • A lead member of the forum will be identified to take each change forward where appropriate.                                    
                                      • The results will be distributed to all staff through the Patient Safety Newsletter/Bereavement Care Newsletter/ Clinical Audit Forum as per the action plan |

4. Equality and Diversity

4.1. 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.

4.2. Equality Impact Assessment

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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Stillborn Or Non-viable Fetus In The Community Setting Clinical Guideline V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>6\textsuperscript{th} September 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>10\textsuperscript{th} October 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>10\textsuperscript{th} October 2021</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Karen Stoyles  
Bereavement Midwife  
Obs & Gynae Directorate |
| Contact details: | 01872-252879 |
| Brief summary of contents | This guideline is to support midwives who may care for a woman who has a stillbirth or late miscarriage within the community setting. |
| Suggested Keywords: | Born, viable, non, community, stillbirth, IUD, death, intrauterine, stillborn |
| Target Audience | RCHT | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 6\textsuperscript{th} September 2018 |
| This document replaces (exact title of previous version): | CLINICAL GUIDELINE FOR THE MANAGEMENT OF A STILLBIRTH OR NON VIABLE FETAL DELIVERY IN THE COMMUNITY SETTING 1.3 |
| Approval route (names of committees)/consultation: | Maternity Guideline Group  
Obs & Gynae Directorate  
Policy Review Group |
| Divisional Manager confirming approval processes | Tunde Adewopo |
| Name and Post Title of additional signatories | Not Required |
| Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings | {Original Copy Signed}  
Name: Caroline Amukusana |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy) | Internet & Intranet | ✓ Intranet Only |
## Related Documents:
- Human Tissue Authority Codes of Practice A and B (2017)
- Resuscitation Council (2015)
- RCOG (2005) Registration of stillbirth and certification for pregnancy loss below 24 weeks gestation. Good Practice No.4
- Institute of Cemetery and cremation management (2015) The sensitive disposal of fetal remains

## Training Need Identified?
No

## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>May 2012</td>
<td>1.0</td>
<td>Initial Issue</td>
<td>Theresa Williams Supervisor of Midwives</td>
</tr>
<tr>
<td>21st May 2015</td>
<td>1.2</td>
<td>Updated according to the latest advice from the Resuscitation Council and Human Tissue Authority</td>
<td>Karen Stoyles Specialist Bereavement Midwife Obs and Gynae Directorate</td>
</tr>
<tr>
<td>6th September 2018</td>
<td>2.0</td>
<td>Updated according to the latest advice from the Resuscitation Council and Human Tissue Authority 2.4 References to Supervisor of Midwives removed</td>
<td>Karen Stoyles Bereavement Midwife Obs and Gynae Directorate</td>
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</table>
Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirth or Non-Viable Fetus in the Community Setting Clinical Guideline V2.0</td>
<td>Obs &amp; Gynae Directorate</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah-Jane Pedler</td>
<td>01872 255019</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   
   **Who is the strategy / policy / proposal / service function aimed at?**
   
   This guideline is to support midwives who may care for a woman who has a stillbirth or late miscarriage within the community setting.

2. **Policy Objectives**

   To ensure appropriate advice and care is given in the circumstances of a stillbirth/non-viable fetus in the community setting.

3. **Policy – intended Outcomes**

   Appropriate and timely care for parents who have experienced a stillbirth or non-viable fetus in the community setting.

4. **How will you measure the outcome?**

   Compliance Monitoring Tool.

5. **Who is intended to benefit from the policy?**

   All pregnant mothers, their families and midwives providing their care.

6a **Who did you consult with**

   Workforce | Patients | Local groups | External organisations | Other
   
   X

**b). Please identify the groups who have been consulted about this procedure.**

- Obstetric Guidelines Meeting
- Obs and gynae Directorate
- Policy Review group
What was the outcome of the consultation?

Guideline agreed

7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

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>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
<td>Any parents experiencing the delivery of a stillbirth/non-viable fetus in the community setting</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 this relates to service redesign or development
8. Please indicate if a full equality analysis is recommended. | Yes | No X

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

No areas indicated

Signature of policy developer / lead manager / director
Karen Stoyles

Date of completion and submission
6th September 2018

Names and signatures of members carrying out the Screening Assessment
1. Karen Stoyles
2. Human Rights, Equality & Inclusion Lead

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**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

**This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.**

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 6th September 2018