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<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
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<tbody>
<tr>
<td>Document Title:</td>
<td>Stillbirth Management Clinical Guideline V1.1</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Management of Stillbirth Clinical Guideline V1.0</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>October 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>October 2022</td>
</tr>
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<tr>
<td>Brief summary of contents:</td>
<td>To provide midwives, obstetricians and support workers with guidance in the provision of emotional support and clinical care following stillbirth</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Stillbirth, pregnancy, bereavement, post mortem</td>
</tr>
<tr>
<td>Target Audience:</td>
<td>RCHT: Yes</td>
</tr>
<tr>
<td></td>
<td>CFT: No</td>
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<tr>
<td></td>
<td>KCCG: No</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Maternity Guidelines Group</td>
</tr>
<tr>
<td></td>
<td>Obstetrics and Gynaecology Directorate Meeting</td>
</tr>
<tr>
<td>General Manager confirming approval processes:</td>
<td>Mary Baulch</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings:</td>
<td>Caroline Amukusana</td>
</tr>
</tbody>
</table>
### Information Category

| Links to key external standards: | None |

### Detailed Information

#### References


### Related Documents:


### Training Need Identified?

Bereavement care training and annual update for staff

### Publication Location (refer to Policy on Policies – Approvals and Ratification):

Internet & Intranet

### Document Library Folder/Sub Folder:

Clinical / Midwifery and Obstetrics

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Stillbirth Management Clinical Guideline

V1.1

October 2020
Summary

Intrauterine death > 24 weeks gestation

- Diagnosis confirmed by USS
  2nd scan offered

  - Sensitive discussion by consultant /appropriate SpR re: Individualised management plan
    - Available options including conservative management and induction of labour
    - Timing of induction of labour (IOL)
    - Place of birth (Bereavement Suite / Delivery Suite, Birth Centre or homebirth)
    - Pain relief
    - Induction medication and analgesia prescribed
    - Commence stillbirth checklist now

  - Admission for IOL at time to suit parents
  - Woman to be assigned named midwife
  - Care in labour as RCHT guideline

Baby Born

- Checklist of actions by
  Midwives / Bereavement
  Midwives

  - Clinical care and emotional support for parents
  - Assist parents to see / hold their baby and with memory making
  - Issue Medical Certificate of Stillbirth
  - Referral to outside agencies including MBRRACE-UK
  - Conduct Perinatal Mortality Review using PMRT

- Checklist of actions by
  Medical staff

  - Post mortem pathway initiated if consent given

  - Detailed 2nd discussion on
    post mortem and tissue
    sampling for genetic testing

  - Post mortem report +
    other investigation
    results collated

  - Case review findings
    reported to Trust Board via
    Mortality Review Oversight
    Group.
    Learning feedback to staff

  - Follow up care

Bereavement
Care Co-ordinator
/Mortuary staff

- Bereavement
Midwives

- Community
Midwife

- Chaplaincy

- Perinatal Mortality Case
Review

Follow up appointment with
named Consultant +/-
Bereavement Midwife
Feedback results
Give parents written PMRT
final report

Intrapartum stillbirth

- Sensitive initial
discussion on
investigations including
post mortem
Complete DATIX
Inform GP and
community midwife
Parents questions
answered

- Post mortem report +
other investigation
results collated
1. **Aim/Purpose of this Guideline**

1.1. These guidelines are intended to be used in conjunction with the Stillbirth National Bereavement Care Pathway and RCHT Stillbirth Checklist to provide best practice recommendations for staff providing care and support following the intrauterine death of a baby over 24 weeks gestation. High-quality bereavement care is crucial, as parent’s experience of bereavement care can have long-term implications for their emotional well-being and mental health.

1.2. This version supersedes any previous versions of this document.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals (NEW 2020).

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2. **The Guidance**

2.1. **Best practice in bereavement care**

2.1.1. Parents should be listened to and given time, information and support to make informed decisions relating to their care and the care of their babies.

2.1.2. Care should meet the personal cultural and religious needs of the parents.

2.1.3. Assumptions should not be made about how an individual will feel about their loss.
2.1.4. A partner’s needs for support should be recognised and met

2.1.5. Communication with parents should be clear, sensitive and honest.

2.1.6. Good communication is required between all professionals to ensure that parents do not have to repeatedly explain their situation. Continuity and consistency of care are important

2.1.7. Women and their partners should have their care co-ordinated by staff that are trained in bereavement care and in an environment appropriate to their circumstances. All staff that care for parents before, during or after stillbirth should have opportunities to develop and update their skills in bereavement care

2.1.8. The bodies of babies should be treated with respect at all times

2.1.9. All bereaved parents should be offered opportunities to create memories

2.1.10. Staff should recognise the particular needs of other family members e.g. siblings and grandparents and support them including by signposting to support organisations.

2.2. Diagnosis and delivering news of intrauterine death (IUD)

2.2.1. Prepare parents for difficult news and inform parents something is wrong as soon as IUD is suspected.

2.2.2. When an IUD is suspected, confirmation must be made by two-dimensional ultrasound at the earliest opportunity. If diagnosis is suspected in the community the woman should be referred to the Day Assessment Unit (DAU) where an urgent scan must be performed in the Fetal Medicine Centre. However if out of normal working hours a practitioner with appropriate training may use a portable ultrasound machine. If an obstetrician has any doubt about their abilities he or she should seek urgent assistance.

2.2.3. A second opinion should be sought whenever practically possible although it is recognised that this may not always be possible in emergency situations.

2.2.4. Parents should not be asked to wait in a waiting area with other pregnant women, but should be shown to a private room to await further care.

2.2.5. Following diagnosis and confirmation of IUD the parents must be given time to absorb and accept this news. A clear, sensitive and honest explanation should be given as to what has happened by experienced staff. The language used should be clear of euphemisms or acronyms. For example:
“I`m really sorry, I can see your baby`s heart properly and it is not beating. I am sorry this means that your baby has died”

2.2.6. If the woman is on her own, unless it is an emergency, it may be prudent to delay detailed explanation before support has arrived. An immediate offer to call her partner or other appropriate support person should be made.

2.2.7. 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.

2.3. Initial management after diagnosis

2.3.1. Use the required paperwork and Stillbirth Checklist (Appendix 3) in green “Stillbirth” ring binder found in the satellite mortuary/ nursery on Wheal Rose. Please file forms as they are completed in the medical notes and do not leave in the ring binder (Data Protection).

2.3.2. Take a history and perform basic maternal observations and antenatal examination. Ensure that you have excluded serious underlying diagnoses such as pre-eclampsia, concealed abruption or chorioamnionitis.

2.3.3. Although it is important not to overload the parents with too much detail initially, it is important to give adequate information. It is good practice to have an early discussion about what to expect in terms of induction, analgesia, delivery, appearance of baby, memory boxes and investigations that will be offered.

2.3.4. Laboratory tests are recommended to assess maternal wellbeing and to determine the cause of death, the chance of recurrence and possible avoidance of further pregnancy complications. Certain tests are routinely recommended, others on a selective basis depending on the clinical picture. Note that certain tests are recommended before delivery. Senior advice must be sought when there is uncertainty as to the necessity of an individual test. Women should have venepuncture for maternal investigations following stillbirth (see Stillbirth Checklist – Appendix 1). Test request forms may be printed using Maxim’s dataset - Stillbirth. Kleihauer should be performed on all women urgently (before birth) to detect any feto-maternal haemorrhage that may have occurred.

2.3.5. Women who are rhesus D (RhD) negative with a fetus predicted to be rhesus positive on non invasive maternal blood testing (or where the rhesus status is unknown) should have Anti-RhD gammaglobulin administered as soon as possible after presentation. This includes multiple pregnancies where one or more babies has died and the pregnancy is continuing.
2.3.6. Give parents the Sands Bereavement Support Pack, RCHT leaflet: Following the loss of your baby and Bereavement Midwives / ward contact number card. Discuss the content of leaflets with parents as they may be too overwhelmed to read the information they need. Parents may prefer to use the Sands App for their phone or tablet.

2.3.7. Involve the Bereavement Midwives as soon as practically possible to provide ongoing support.

2.3.8. Inform the GP, Community Midwife and Bereavement Midwives of the diagnosis and management plan (See Stillbirth checklist).

2.3.9. Cancel all outstanding appointments.

2.4. Consultant Responsibility

2.4.1. If previously booked under Midwife led care the woman should be transferred to consultant led care.

2.4.2. The Lead Obstetrician is the consultant with whom the woman has booked for the pregnancy or is responsible for the geographical area where the woman lives.

2.4.3. 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 another consultant during a Delivery Suite session).

2.4.4. 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. Induction of labour and delivery management

2.5.1. The decision regarding mode of delivery should be made in consultation with a consultant or middle grade obstetrician. Parents should be included in discussions about management. Options for management could include induction or expectant management. Many parents are surprised and shocked that they will still have to go through labour. Also that they may go home whilst awaiting delivery and that there may be a delay in giving birth to their baby. The individualised risks and benefits of each option, including the time induction may take, should be discussed with the parents.

2.5.2. It is important that parents are able to make fully informed choices about their care. Being involved in the decision making process may help parents maintain a sense of control at a time when they feel they have little or no control, which may have longer-term implications for their mental health.

2.5.3. Questions should be welcomed and encouraged.
2.5.4. Recommendations about labour and birth should take into account the woman’s preferences as well as her medical condition and previous intrapartum history. Vaginal birth is recommended for most women as this decreased morbidity and will have fewer implications for future pregnancy than a caesarean section. However caesarean birth may be required due to past obstetric or medical history as well as emotional and psychological factors.

2.5.5. Induction of labour is recommended if there are signs of sepsis, pre-eclampsia, placental abruption or if membranes have ruptured as these carry potential risks to the woman’s health. The method of delivery and / or induction under these circumstances should be individualised to the presenting condition and other patient factors including past obstetric history and past medical history.

2.5.6. Significant bleeding should prompt maternal resuscitation and involvement of a senior obstetrician.

2.5.7. If a woman has previously had a caesarean birth, a consultant/senior obstetrician should discuss the risks of induction and may individualise Misoprostol regimen.

2.5.8. Immediate induction of labour with Misoprostol may be appropriate in selected cases e.g. when the woman is already contracting or her cervix is very favourable.

- Parents who are in shock may find it difficult to process and retain information so provide written information and named contact details.

2.5.9. Consent should be taken prior to induction of labour and the use of misoprostol discussed.

2.5.10. Mifepristone is an anti-progesterone steroid used as a pre-treatment. It facilitates uterine response to subsequent administration of prostaglandin and takes time to work so is given before prostaglandin. This drug must only be administered in a maternity unit and patients should be observed when taking this medication. Contraindications include uncontrolled asthma, chronic renal, liver or adrenal failure and acute porphyria.

2.5.11. In the absence of an obstetric complication that necessitates close observation, oral Mifepristone 200mg should be given at a time to suit the parents, with a view to the woman going home and returning to the Bereavement Suite in 36-48 hours to continue induction of labour with Misoprostol. This will reduce the risk of a prolonged and potentially distressing in-patient stay. If the parents are adamant they do not wish to go home or the mother requires closer observation they should be cared for in the Bereavement Suite while awaiting the 2nd phase of induction of labour.
2.5.12. Women should be made aware that they may experience modest bleeding and abdominal cramps following Mifepristone. Women should be advised to take simple analgesia, but to avoid those containing ibuprofen. Headaches, nausea and skin rashes may also occasionally occur.

Misoprostol should be prescribed using EPMA stillbirth > 24 weeks package as per section 2.6.

2.5.13. Complete the pre-admission sections of the Stillbirth Checklist before the parents leave the hospital. Individual items should be signed and dated by the doctor or midwife who provides that care. The checklist should be filed in the medical notes.

2.5.14. Unless the woman declines, the updated maternity notes should be returned to the woman to ensure that clinical information is available if required prior to admission to hospital.

2.6. Induction of Labour Medication regimen:

Following Mifepristone the patient is admitted as above for the following Misoprostol regimen:

2.6.1. Women with an unscarred uterus: No history of lower segment caesarean section:

In women with a very favourable cervix or in early labour, amniotomy followed by oxytocin infusion could be considered.

2.6.1.1. 24+0 – 27+6 weeks: In woman with an unfavorable cervix vaginal Misoprostol 200 micrograms should be given in the posterior fornix every six hours x 5 doses.

2.6.1.2. 28+0 weeks onwards: vaginal Misoprostol 100 micrograms every six hours x 5 doses.

2.6.1.3. If labour not established after 5 doses, the woman should be reviewed by a senior obstetrician – consider repeat Misoprostol at least 12 hours after the last dose.

2.6.2. Women with a scarred uterus: History of caesarean section or atypical uterine scars:

There is a 3-12% increase in risk of uterine rupture in women with IUD who have had a previous caesarean section. Discussion about safety and benefits of induction of labour should be undertaken with a Consultant Obstetrician.

2.6.2.1. Misoprostol 50 micrograms every six hours for 5 doses may be considered for induction of labour

2.6.2.2. If labour is not established after five doses then women should be reviewed by a senior obstetrician
2.6.2.3. 200mcg is the lowest dose tablet available in UK and it’s use for this indication is “off label”. A tablet cutter should be used to enable 100mcg half tablet vaginal administration and 50 mcg quarter tablet doses for cases after 28 weeks and for those with previous LSCS respectively. The other remainder of the tablet should be discarded rather than stored for the next dose.

2.6.2.4. Side effects include nausea, vomiting, pyrexia, tachysystole, itching and hypertension.

2.6.2.5. Once labour is fully established further vaginal misoprostol can be withheld.

2.6.2.6. Consider a cervical ripening balloon as an alternative to misoprostol

2.7. Expectant management

2.7.1. Most women will go into labour within three weeks of IUD. Women should be advised that waiting for labour is generally safe if they are medically well.

2.7.2. Women should be strongly advised not to delay induction of labour if there are signs of sepsis, pre-eclampsia, placental abruption or if membranes rupture.

2.7.3. Women who delay labour for more than 48 hours are advised to have testing for disseminated intravascular coagulation (DIC) twice weekly.

2.7.4. Parents should be advised that if expectant management chosen then the appearance of the baby will deteriorate and the value of some information will be reduced.

2.7.5. Women should be supported in their decision, but be aware that they may change their mind at any time. Arrangements should be made for further review.

2.8. Labour and birth

2.8.1. Care in labour should follow the RCHT Clinical Guideline for Labour First and Second Stage and Delay in Labour first and Second Stage including the use of a partogram.

2.8.2. Admit woman onto E3 and PAS computer systems.

2.8.3. A risk assessment with recommended level of care should be documented in the maternity notes at the beginning of labour.

2.8.4. In the absence of co-existing complications the woman may give birth in the place of her choice; IE, Bereavement Suite on Wheal Rose antenatal ward, the Truro Birth Centre (35 weeks gestation or
more) or home birth could be considered.

2.8.5. If the woman plans to give birth at home it should be clearly documented in the maternity handheld notes and E3 that the baby has died prior to labour.

2.8.6. Regular reassessment for appropriate place of care and appropriate seniority of staff should be made throughout patient admission and documented in the notes.

2.8.7. Ensure that all staff seeing parents during labour and birth are aware of the baby`s death and communicate sensitively.

2.8.8. Display laminated “Daisy” sign on door. To ensure all staff are aware that the room is being used by bereaved parents and are sensitive to noise and prevent inappropriate comments by well-meaning staff.

2.8.9. 1:1 care in labour should be provided by an experienced midwife. Ensure continuity of carer whenever possible.

2.8.10. Inform the Delivery Suite Co-ordinator and on call middle grade obstetrician of the admission and request that the case is recorded on the D/S board.

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

2.8.12. The woman is likely to need extra encouragement and support especially during the second stage of labour.

2.8.13. Avoid routine rupture membranes in labour to reduce infection risk.

2.8.14. 3rd stage should be actively managed. In the case of retained placenta women should be managed as per RCHT Clinical Guideline for Diagnosis and Management of Retained Placenta.

2.8.15. Women should be able to have her partner and / or another supporter with her at all times.

2.8.16. The partner / supporter should be kept fully informed and involved (with woman`s consent). A partner’s grief can be as profound as that of the mother; their needs for support should be recognised and met.

2.9. Pain management

2.9.1. A range of analgesia and anti-emetics should be prescribed. All women should be given appropriate information regarding pain relief options including advantages and disadvantages.
2.9.2. Women should be aware that the place they are receiving care may affect their pain relief options.

2.9.3. Options include, water therapy, TENS machine, Patient controlled analgesia (PCA), oral analgesia, diamorphine/pethidine, epidural.

2.9.4. If patient requires an epidural they should be transferred to Delivery Suite.

2.9.5. Assessment for DIC and sepsis should be undertaken prior to regional analgesia.

2.10. Stillbirth in a community setting

2.10.1. 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.

2.10.2. If a midwife is called to attend a woman who has already given birth to a baby and there are no signs of life, the midwife should summon assistance and use clinical judgement as to whether it is reasonable not to attempt resuscitation. (Resuscitation Council UK 2015).

2.10.3. The Coroner must be contacted via the Police urgently if there is doubt about the status of a birth or in the case of a fresh stillbirth not attended by a healthcare professional (statute). This responsibility may be undertaken by the Paramedic team.

2.10.4. In the case of an expected stillbirth (already diagnosed or fetal abnormality incompatible with life), the baby may remain at home / await collection by the Funeral Director engaged by the parents. A cold cot may be obtained from Wheal Rose ward and loaned to the parents if they wish to keep their baby at home.

2.10.5. If postmortem or cytogenetic tests are requested or the mother is admitted to the maternity unit the baby should be transported to RCH with the mother. Skin biopsy for cytogenetic testing must be taken in Wheal Rose satellite mortuary / nursery.

2.11. Investigations on the baby and placenta

2.11.1. Some parents choose to have investigations to find out why their baby died; to allow their grief to progress, to find out information useful to subsequent pregnancies and for research to prevent stillbirths in the future.

2.11.2. Where there is fetal malformation and the cause known investigation should be advised by the Consultant managing the case.
2.11.3. Postmortem should be offered with written information in all cases even if the cause of death is assumed e.g. true knot, abruption. It is good practice to have a detailed discussion at least twice with the family.

2.11.4. It should be explained to the parents that different types of postmortem are available e.g. full, limited or external.

2.11.5. Parents should be advised that even with full investigation, a specific cause for death may not be found in approximately 15% of cases.

2.11.6. Consent should be sought by a member of staff who has received training in seeking post mortem examination consent and the process and who has a good understanding of the procedures for which they are seeking consent (Appendix 4 Sands Guide for consent takers). It is a process that should involve careful listening and discussion.

2.11.7. Cytogenetic tests should be offered, with written information, if postmortem is declined. Samples of umbilical cord and placenta should be taken.

2.11.8. Umbilical cord and placental biopsy should be taken in the Bereavement Nursery in accordance with guidance: Cytogenetics Samples after Pregnancy Loss (Appendix 5)

2.11.9. If postmortem is declined an experienced clinician should examine the baby and document findings.

2.11.10. If there are any signs of abnormality and post mortem has been declined x-ray of the baby should be considered.

2.11.11. Swabs from the baby and placenta should be taken if infection is suspected.

2.11.12. A cotyledon should be sent to microbiology for culture prior to being placed in formalin.

2.11.13. The remaining placenta should be placed in formalin and sent to the mortuary with the baby to be sent to Bristol for histopathological investigations. The specimen should be accompanied by the postmortem request even if the baby is not undergoing postmortem.

2.12. Caring for the baby and making memories

2.12.1. Labelling baby

2.12.1.1. At delivery label the baby with a name band in accordance with the RCHT Clinical Guideline for Newborn Identification and Labelling.
2.12.1.2. Once the baby is ready to go to the mortuary replace this name band with a mortuary identification label which should have 3 points of reference: - Date of birth, baby’s CR number, and “baby of” (mother’s full name) in indelible ink. Offer the original name band to parents.

2.12.1.3. Put “red sticker” identifier on deceased baby care record, stillbirth checklist, and postmortem consent form if appropriate.

2.12.2. **Cuddle cot cold mattress**

Caring for the baby on a cold mattress allows the family to spend more time with their baby. The appropriate sized cold mattress should be set up to operate at a temperature between 8-13 degrees Celsius. (Appendix 4, p 8: Stillbirth Checklist: *Care of Deceased Babies using Flexmort CuddleCot™*)

2.12.3. **Seeing and holding the baby**

2.12.3.1. It is important to offer all parents the option of seeing and holding the baby while respecting that some parents may decline this offer. It is essential to offer genuine choice and not to steer parents towards a particular course of action in the belief that it will help them.

2.12.3.2. The parents should be aware that they can change their mind at any time.

2.12.3.3. The condition of the baby should be considered when discussing memory making with parents. In cases of prematurity, known abnormality, macerated or severely hydropic babies, parents should be sensitively informed of how their baby may look when born.

2.12.3.4. Parents may want to wash and dress their baby as it gives them an opportunity to “parent” their baby. They should be helped and supported to do this.

2.13. **Creating Memories**

2.13.1. All staff should use the baby’s name if one has been given.

2.13.2. Opportunities to make positive memories and physical keepsakes should be given to all parents as this can be valuable in the grieving process. However some parents may find the idea of creating memories strange and unnecessary. It is important that parents are given the time they need to make the decisions that they feel are right for them.
2.13.3. Items in the Sands Memory Box may include:-

- Photographs – parental consent should be gained first (including clinical photographs). The camera can be loaned to parents to take their own photos if they wish. In multiple pregnancies opportunity should be given for babies to be photographed together. If parents are undecided regarding photos they can be taken but kept in a sealed envelope in the mother’s notes if the parents wish. The camera log book should be completed to comply with Information Governance regulations. Parents should be given the memory card or file it in the medical notes. No images must remain on the camera.
- Hand and foot prints (ink and clay)
- Cot card
- Identification bracelet (previously worn by the baby)
- Teddy bear
- Blankets
- The memory box does not need to be filled as it is designed for the parents to add their own memories.
- Offer “Remember my Baby” photographer if one is available. Telephone 0808 189 2345 to request a photographer.
- Offer parents a leaf engraved with their baby’s name to be added to the Memory Tree situated in the Baby Memorial Garden and the option of having their baby’s name entered in the hospital Book of Remembrance in the Chapel. Complete and forward the relevant request forms as directed.

2.14. Pastoral Care

2.14.1. Staff should be aware of, and open to, different personal, religious and cultural needs. Assumptions should not be made, however, about what any individual will want on the basis of their heritage or religion.

2.14.2. Discuss with parents whether they wish to speak with the hospital Chaplain

2.14.3. Parents should be informed that the Chaplaincy Team will be able to put them in touch with a representative of their faith, wherever possible.

2.14.4. Offer a Blessing/Naming ceremony. The on call Hospital Chaplain may be contacted day or night via Switchboard.

2.14.5. Inform parents of the RCHT annual Service of Remembrance in October and give information / consent for invitation form.
2.15. Taking the baby out/home

2.15.1. There are no legal reasons to prevent parents from taking their baby home unless the death has been referred to the coroner. Parents should be offered the opportunity to take their baby home or out of the hospital. This discussion should be recorded in the Stillbirth Checklist.

2.15.2. There is no legal reason to inform the police if parents take their baby’s body home or out of the hospital. However, for the protection of the parents and to prevent misunderstandings, a Form for parents who take their baby’s body home should be given to the parents confirming that the body has been released to the parents and that they will be taking it back to the hospital or making their own funeral arrangements (Appendix 6).

2.15.3. Parents can take the baby home by car in a Moses basket secured by a seatbelt, in the parents’ arms or in a hospital casket.

2.15.4. A Cuddle cot cold mattress should be offered on loan to the parents.

2.16. Legal Requirements.

2.16.1. The doctor or the registered midwife who attended the delivery or examined the baby’s body after the birth must complete a Medical Certificate of Stillbirth. The book of certificates is stored in the Bereavement Nursery on Wheal Rose. The certificate and stub must be completed entirely by the person who signs the certificate.

2.16.2. The clinician completing the stillbirth certificate must print their name as per signature to enable the Registrar to verify identity with GMC / NMC. Parents should be informed of how to register their baby’s stillbirth and be given the stillbirth certificate before they are discharged.

2.16.3. The Crematorium Committee Certificate of Stillbirth (pink) form must be completed by a doctor or registered midwife who has examined the baby. This form should accompany the baby to the mortuary or funeral director.

2.16.4. The Coroner must be contacted via the Police urgently if there is doubt about the status of a birth or in the case of a fresh stillbirth not attended by a healthcare professional (statute). This responsibility may be undertaken by the Paramedic team.

2.16.5. Fetal deaths delivered later than 24 weeks that had clearly occurred before the end of the 24th week do not have to be certified or registered.

2.17. Reporting and Investigation

2.17.1. A Datix giving details of the stillbirth should be submitted
2.17.2. Complete an MBRRACE-UK reporting form for later submission to the MBRRACE-UK portal by the Bereavement Team. Parents should be informed that their details are being submitted to the national database (Data Protection Act 2018).

2.17.3. A detailed case review using the web-based Perinatal Mortality Review Tool (PMRT) / pathway and involving the parents will be conducted. Parents should be informed that their details are being submitted to the national database (Data Protection Act 2018).

2.17.4. Parents should be invited to contribute to the case review and their perspective of events sought.

2.17.5. The perinatal mortality review findings will be discussed with the parents at their follow up appointment with the named consultant. Parents will also receive a written PMRT report.

2.17.6. A summary of the case review will be submitted to the Trust Board via the RCHT Mortality Review Oversight Group in the quarterly report.

2.17.7. In case of an intrapartum >37 weeks stillbirth, parents should be informed that a statutory external investigation will be undertaken.

2.18. Funerals

2.18.1. UK law states that all stillborn babies must have individual burial or cremation. Parents have a legal responsibility to bury or cremate their baby’s body. RCHT does not offer burial or cremation for stillborn babies.

2.18.2. Parents of babies who are stillborn at or after 24 weeks’ gestation may be eligible for a Funeral Payment. To be eligible, one or both parents must be receiving at least one benefit or tax credit. More information and claim forms are available in the Funeral Payments section of the UK Government website – www.gov.uk/funeral-payments.

2.19. Multiple Pregnancies

2.19.1. Clinicians should appreciate the complexity and mixed emotions of couples who experience stillbirth of one baby with a surviving twin. They will require the same support through delivery and bereavement care.

2.19.2. Remember anti-D administration shortly after diagnosis for a mother who is Rh negative

2.19.3. The timing and mode of delivery for multiple pregnancies in the case of single fetal demise will depend on chronicity, gestation, the position of the fetuses and wellbeing of the surviving baby/babies

2.19.4. If there is one or more surviving sibling from a multiple pregnancy, don’t focus solely on the surviving baby. Acknowledge the baby
that has died and recognise the challenge the parents face in celebrating the birth of one baby and the death of the other baby/babies.

2.19.5. If the pregnancy continued after fetal demise and there is likely to be a body, recognisable remains of the baby/babies who have died or a fetus papyraceous, staff should offer to gently describe to parents how the baby or babies may look.

2.19.6. The Butterfly Project (www.neonatalresearch.net/butterfly-staff-resources.html) supports parents who have lost a baby from a multiple pregnancy. When the loss happens before birth a small butterfly symbol can be placed on the woman`s handheld notes to alert clinicians of fetal demise in a multiple pregnancy.

2.19.7. With the parent`s consent a purple butterfly (TAMBA Butterfly Project) can be placed on the surviving sibling`s cot to alert staff that the baby was part of a multiple birth.

2.19.8. Signpost the parent`s to TAMBA for specialist bereavement support www.tamba.org.uk/bereavement

2.20. Postnatal care

2.20.1. Psychological Support

All parents should be offered bereavement support.

2.20.1.1. Involve the Bereavement Midwives as soon as practically possible to provide ongoing support

2.20.1.2. Ensure that the parents have information on local and national support groups including contact details.

2.20.1.3. If the woman has ongoing psychological concerns the GP should be made aware if not already closely involved

2.20.2. Lactation suppression

Women should be given information about their choices for lactation suppression and be informed of the relative advantages and disadvantages of each approach. Women should be advised that one-third of those who choose non-pharmacological options such as breast support, ice packs and analgesics experience severe breast pain. Current recommendations are that pharmacological methods of lactation suppression are effective and well-tolerated by many women (RCOG 2010a). Cabergoline 1mg as a single dose within 24 hours of stillbirth should be offered to non-hypertensive women.

2.20.3. Contraception

Contraception should be discussed before discharge home
2.20.4. **Discharge from hospital**

Perform a full postnatal examination including maternal observations, VTE assessment, postnatal exercise and contraceptive advice before discharge

2.20.4.1. Ensure that the Stillbirth Checklist is complete before the parents go home.

2.20.4.2. **Ensure that the woman has the RCHT leaflet Following the loss** of your baby for clinical information about the postnatal period and know how to contact her community midwife / Bereavement Midwives (Appendix 7).

2.20.4.3. Signpost the parents to local and national support group and give contact numbers/ websites addresses

2.20.4.4. Inform the GP and community midwife of her discharge home and send a Transfer Summary to the GP

2.20.4.5. The community midwife should contact the woman within 24 hours and offer a postnatal visit. The woman should not be asked to attend a clinical area for a postnatal check.

2.20.4.6. Inform parents that the Maternity Bereavement Experience Measure (MBEM) survey form will be sent to them in approximately six months. Document if this is declined.

2.21. **Transport of the baby and placenta**

2.21.1. When the parents have been discharged / said their final goodbyes, the baby is transferred to the mortuary in a casket lined with a plastic backed absorbent sheet by a porter. Record the porter’s name on the Deceased Baby Care Record. (See Appendix 8)

2.21.2. The placenta, in Formalin, is also sent to the mortuary in a red transport box lined with an absorbent pad.

2.21.3. The Crematorium Committee Certificate of Stillbirth, Deceased Baby Record and Postmortem request and consent forms if applicable go with the baby to the mortuary. If postmortem is declined the postmortem request form is still required to go with the baby for examination of the placenta

2.22. **Further follow up**

2.22.1. Bereavement midwives to provide on-going bereavement support as required

2.22.2. Consultant appointment once all investigation results and PMRT final report available.
3. Monitoring compliance and effectiveness

| Element to be monitored | • Proportion of stillbirths reported as clinical incident (Datix)  
| | • Proportion of parents receiving Sands Bereavement Support pack / local information leaflets  
| | • Proportion of stillbirths having PMRT investigation completed  
| | • Proportion of women receiving 1:1 care in labour  
| | • Proportion of parents offered post-mortem examination  
| | • Proportion of women offered suppression of lactation  
| | • Proportion of women offered a follow up meeting with a senior obstetrician |

| Lead | Bereavement Team |
| Tool | Stillbirth Checklist |
| Frequency | 100% cases to be monitored  
| | Quarterly  
| | Quarterly |

| Reporting arrangements | Perinatal Mortality Meeting / Maternity Forum  
| | Documented in meeting minutes |

| Acting on recommendations and Lead(s) | • Any deficiencies identified on the annual report will be discussed at the Maternity Patient Safety Forum and an action plan developed  
| | • Action leads will be identified and a time frame for the action to be completed by  
| | • The action plan will be monitored by the Maternity Patient Safety Forum until all actions complete |

| 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 of the audits will be distributed to all staff through the Patient Safety newsletter/ 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, Inclusion & 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>Stillbirth Management Clinical Guideline V1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Management of Stillbirth Clinical Guideline V1.0</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>October 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>4th April 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Kate Putman/ Karen Stoyles Bereavement Midwives</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252879</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>To provide midwives, obstetricians and support workers with guidance in the provision of emotional support and clinical care following stillbirth</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Stillbirth, pregnancy, bereavement, post mortem</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT ✓ CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Maternity Guidelines Group Obstetrics and Gynaecology Directorate Meeting</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Mary Baulch</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Midwifery and Obstetrics</td>
</tr>
</tbody>
</table>
| Links to key external standards | References  

| Related Documents: | None |
| Training Need Identified? | Bereavement care training and annual update for staff |
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>April 2019</td>
<td>1.0</td>
<td>Separation into separate guidelines for each category of pregnancy loss / neonatal death to mirror National Bereavement Care Pathways and provide clarity.</td>
<td>Karen Stoyles Bereavement Midwife Sophie Haynes Joint Obstetric Bereavement Lead Consultant</td>
</tr>
<tr>
<td>September 2020</td>
<td>1.1</td>
<td>2.3.5 Update to include non invasive blood test results 2.5.2.6 Update for use of balloon catheter</td>
<td>Mr R Holmes Obstetric Consultant</td>
</tr>
</tbody>
</table>

### All or part of this document can be released under the Freedom of Information Act 2000

**This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing**

### Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
# Appendix 2. Initial Equality Impact Assessment Form

## Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Obstetrics &amp; Gynaecology Care Group</th>
<th>Is this a new or existing Policy?</th>
<th>Existing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of Stillbirth Clinical Guideline V1.1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual/group completing EIA</th>
<th>Karen Stoyles, Bereavement Midwife</th>
<th>Sophie Haynes, Joint Obstetric Bereavement Lead Consultant</th>
<th>Contact details:</th>
<th>01872 25 2879</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1. Policy Aim</th>
<th>Who is the strategy / policy / proposal / service function aimed at?</th>
<th>To provide midwives, obstetricians and support workers with guidance in the provision of emotional support and clinical care following stillbirth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. Policy Objectives</th>
<th>To ensure parents receive appropriate care and support following intrauterine death and stillbirth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Policy Intended Outcomes</th>
<th>Consistent high quality care and support following intrauterine death and stillbirth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. How will you measure the outcome?</th>
<th>• Proportion of stillbirths reported as clinical incident (Datix) • Proportion of parents receiving Sands Bereavement Support pack / local information leaflets • Proportion of stillbirths having PMRT investigation completed • Proportion of women receiving 1:1 care in labour • Proportion of parents offered post-mortem examination • Proportion of women offered suppression of lactation • Proportion of women offered a follow up meeting with a senior obstetrician</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. Who is intended to benefit from the policy?</th>
<th>Bereaved parents following stillbirth of their baby</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6a). Who did you consult with?</th>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b). Please list any groups who have been consulted about this procedure.</th>
<th>Please record specific names of groups: Maternity Guidelines Group Obstetrics and Gynaecology Directorate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>c). What was the outcome of the consultation?</th>
<th>Guideline Agreed</th>
</tr>
</thead>
</table>
### 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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Mr R Holmes

If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: **Section 2. Full Equality Analysis**

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead [debby.lewis@nhs.net](mailto:debby.lewis@nhs.net)
### Appendix 3 Stillbirth (> 24 weeks): Care Checklist

#### On Diagnosis of Intrauterine Death (IUD)

<table>
<thead>
<tr>
<th>Stillbirth discussed including:</th>
<th>Date &amp; Time</th>
<th>Name &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction of labour process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain relief in labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeing/ holding the baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option of awaiting spont. labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making memories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support available for parents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Leaflets given to parents:                                          |             |                  |
| Following the Loss of Your Baby (RCHT)                             |             |                  |
| Sands Bereavement Support pack                                     |             |                  |
| Local Support Groups – The Splash Project / Cornwall Sands         |             |                  |

| Post-mortem examinations discussed (1)                              |             |                  |
| Sands post-mortem information leaflet given                        |             |                  |
| Cytogenetic test information for parents sheet given                |             |                  |

| Maternal investigations (see separate checklist) performed          |             |                  |
| Maternal blood tests should be taken as soon as possible after     |             |                  |
| diagnosis of IUD to get the most information from the results.     |             |                  |
| ALL women require pre-birth Keilhauer                              |             |                  |

| Maternal observations recorded.                                     |             |                  |
| To exclude maternal sepsis / pre-eclampsia                         |             |                  |

| Inform:                                                            |             |                  |
| Community Midwife                                                  |             | Team Consultant   |
| Bereavement Midwives (rcht.bereavementmidwives@nhs.net)             |             |                  |
| GP (Telephone surgery)                                             |             |                  |

If applicable:
- Diabetes Specialist Midwives
- Fetal Medicine Team
- Screening Co-coordinator [www.rch-tr.screening@nhs.net](mailto:www.rch-tr.screening@nhs.net)
- Safeguarding Midwives [www.rcht.maternitysafeguarding@nhs.net](mailto:www.rcht.maternitysafeguarding@nhs.net)
- Healthy Pregnancy Team

Change to [Consultant care](mailto:……………………………………………………..) on E3

Daisy Bereavement Suite
- Parents shown / Given directions to Daisy Suite entrance

Maternity Notes
- Returned to woman
- Remind her to bring notes with her when readmitted
- If woman declines to take her notes please inform CMW

Cancel outstanding clinic and / or scan appointments
- (e-mail the ward clerk to cancel appointments and request a confirmation e-mail)
- Cancellation Request made to: [www.rch-tr.screening@nhs.net](mailto:www.rch-tr.screening@nhs.net)
- Cancellation confirmed
- Cancel CMW Test Alerts

Sands Teardrop Sticker: Put stickers on the inside cover of medical notes and front page of current pregnancy notes. ("Alert" sticker only on front cover)
### On Admission for Stillbirth

#### Induction of Labour

<table>
<thead>
<tr>
<th>Record admission on E3 and PAS</th>
<th>Date &amp; Time</th>
<th>Name &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check all maternal investigations have been taken.
(All women require pre-birth Kleihauer)

Parents wishes for labour and delivery discussed

Parents wish to see baby:
- **Mother:** YES ☐ NO ☐
- **Father:** YES ☐ NO ☐

#### Baby

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Name &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Male** ☐ **Female** ☐ **Unable to ascertain** ☐
- Two staff to examine baby to determine gender if baby macerated / hydrops
- Parents informed: YES ☐ NO ☐

#### Cooling Mattress

Parents advised of benefits in using cooling mattress
- Commenced ☐ Declined ☐ Time commenced: ............
- Record hourly temperatures of cooling mattress while in use

#### Register baby

- onto E3 and gain CR Number & NHS Number
- Do not generate baby notes folder. Complete all E3 screens. Admit the baby onto PAS as 02 (Paediatric) then discharge as stillbirth (No. 5) on discharge screen. **Do NOT cancel pregnancy.**

<table>
<thead>
<tr>
<th>CR: D..........................</th>
<th>NHS: ................................</th>
</tr>
</thead>
</table>

#### Label baby

- with Mortuary Identification Bracelet. *(Please use waterproof ink)*
- **Baby’s Name:**
- **Do not add any of mother’s details**
- Two midwives to check label and sign Deceased Baby Care Record
- Record baby’s name on Sands sticker in notes

<table>
<thead>
<tr>
<th>Baby Identification Sticker</th>
<th>1.</th>
</tr>
</thead>
</table>

#### Baby Examination

- Form completed ☐
- Baby Weighed: .................. g, GROW Centile .......... (>150g)

#### Baby bathed / washed

- Offer to assist parents to bath baby ☐
- Baby bathed by: parents ☐ ward staff ☐

#### Parents offered to take baby home

- Taken home by parents ☐ Explanatory letter given to parents ☐

#### Baby transfer:

- To mortuary by ..................................................
- With: Deceased Baby Care Record ☐
- PM Consent & Request including scan reports ☐
- Certificate of stillbirth (pink form) ☐

Add note to baby record on E3 to ensure Baby Audit Trail complete (HTA requirement): ☐

Direct to Funeral Director ☐ Name: ........................................
If the baby remains in the Maternity Unit for more than a few hours
Please inform the Mortuary Team or Bereavement Care Co-ordinator (Ext 2713) and record on E3

### Investigations

**Cyto genetic tests (To be taken in satellite mortuary on Wheal Rose)**

<table>
<thead>
<tr>
<th>Date &amp; time</th>
<th>Name &amp; signature</th>
</tr>
</thead>
</table>

Samples are only needed if post-mortem is declined
Do NOT refreeze containers. Keep in the fridge until able to post. Please ask Ward Clerks / Bereavement Midwife to order more medium if supplies are low.

Consent & samples taken by Dr / Midwife signed as competent to do so (List of staff in Bereavement Nursery) **before** placenta is placed in Formalin

Tissue Sampling Record Book completed (HTA requirement)

Request to Ward Clerk to post / Message left in diary

### Placenta - Specialist Perinatal Histology in Bristol required

Placenta checked / weighed _______ grams

Cotyledon sent to microbiology for MC&S in universal pot - silver top

Placenta in labelled histology pot with Formalin added once other tests done

PM Request Form labelled “PLACENTA ONLY” (Not Maxims form)

Location: PAWRCH Requester: TRUBMW

Do not put placenta in fridge once in Formalin

Placenta sent mortuary with baby in red specimen transport box accompanied by PM request form (ALL cases)

### Post Mortem

Second discussion re: benefits of PM examination with parents by senior Doctor / Midwife trained in PM consent

Parents are aware baby will be transferred to Bristol for PM

If parents decline, document reasons they choose not to have PM

National consent form completed by Dr / midwife trained in PM consent

National PM Request form completed & scan reports attached

Bereavement Office informed of PM request. (Ext. 2713)

If PM requested please photocopy consent x 2 & request x 1 copies.

1. Copy of consent
2. Original copies for Bristol Pathologist – sent with baby
3. File in medical notes
### Making Memories & Emotional Support

<table>
<thead>
<tr>
<th>Photographs</th>
<th>Date &amp; time</th>
<th>Name &amp; &amp; signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental consent required for all photographs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital photographs</td>
<td>Offer x1 Offer x2 Accepted Declined Actioned</td>
<td></td>
</tr>
<tr>
<td>Prints given to parents:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camera memory card (new cards in drawer in nursery):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Given to parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Filed in medical notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camera images deleted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical photographs – filed in notes</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hand and Footprints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper prints</td>
</tr>
<tr>
<td>Clay prints</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Memory Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photos in SANDS folder</td>
</tr>
<tr>
<td>Clothes / blanket/ toy</td>
</tr>
<tr>
<td>Cot card</td>
</tr>
<tr>
<td>Name band</td>
</tr>
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<th>Chaplaincy Service</th>
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<td>Hospital Chaplin</td>
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<td>Own minister</td>
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<tr>
<td>Blessing/Naming Service:</td>
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<tr>
<th>Baby Remembrance</th>
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<tr>
<td>Memorial Book</td>
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<td>Remembrance Service</td>
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<td>Memorial Tree Leaf</td>
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<tr>
<td>Leaf requested via <a href="http://www.Ellasmemoryleafs@hotmail.com">www.Ellasmemoryleafs@hotmail.com</a></td>
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<tr>
<th>Communication</th>
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<tr>
<td>Sands Teardrop Sticker</td>
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<tr>
<td>- Maternity notes (Page 1 -not green cover)</td>
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<td>- Medical notes (inside cover) + Alert sticker on cover</td>
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<tr>
<th>Support Groups</th>
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<tr>
<td>Check information / leaflets on national &amp; local groups given</td>
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<tr>
<th>Bereavement Care Coordinator</th>
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<tbody>
<tr>
<td>Parents given Bereavement Office contact details - (01872 25 2713)</td>
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<tr>
<td>Parents aware that they need to fund and make funeral arrangements</td>
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</tbody>
</table>
### Registration and Certification

<table>
<thead>
<tr>
<th><strong>Stillbirth Certificate</strong> (Stillbirth certificate book kept in nursery filing cabinet)</th>
<th><strong>Date &amp; Time</strong></th>
<th><strong>Name &amp; Signature</strong></th>
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<tbody>
<tr>
<td>Cause of death as entered on stillbirth certificate: …………………………</td>
<td></td>
<td>Please do not enter “unknown” if possible. (See certificate book cover for guidance)</td>
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</table>

| **Penmount Crematorium Committee: Certificate of Stillbirth** (pink form) Please do NOT attach mother’s ID label - baby’s details only. |  |  |

### Case Review

| **Datix submitted** |  |  |
| **MBRRACE-UK forms completed before woman discharged** |  |  |
| **Parents informed** (Data Protection Act 2018) |  |  |
| **Each Baby Counts forms completed** (> 37/40 IOL or intra-partum IUD) |  |  |
| **Parents informed** (Data Protection Act 2018) |  |  |
| **Data Uploaded - EBC Case number:** ………………… |  |  |

| **Perinatal Mortality Review (PMRT)** |  |  |
| **Parents aware of MDT Case Review and that their views will be included in the review. Inform parents that a Bereavement M/W will ring them.** |  |  |

### Post-natal Care

| **Lactation suppression - Analgesia and support discussed** |  |  |
| **Cabergoline:** | Offered | Given | Declined |
| **Contraceptive / next pregnancy advice given** |  |  |
| **Postnatal exercises leaflet given & discussed** |  |  |
| **Post-natal clinical advice given** |  |  |
| **Anti-D required:** YES / NO |  |  |
| **Anti-D given:** |  |  |
| **VTE assessment completed:** |  |  |
| **Postnatal examination & discharge recorded in notes** |  |  |
| **CMW Postnatal visit arranged** |  |  |

### Patient Feedback

| **Parents aware that they will receive Maternity Bereavement Experience Measure (MBEM) questionnaire in 6 months** |  |  |
| **Parents preferred format for survey** |  |  |
| **Post** | e-mail |  |

| **Patient email address:** .......................................................... |  |  |

### Communication

| **CMW ………………………….. informed of discharge / message left** |  |  |
| **CMW asked to inform GP & Health Visitor** |  |  |
| **Discharge letter printed & send to GP (Do not leave in notes)** |  |  |
| **Complete EDF & file in notes** |  |  |
### Discharge

Parents made aware of Maternity leave / pay / Social fund entitlement

Parents given:
- Stillbirth certificate
- Emergency contact numbers
- Memory box

Check that parents are aware of postnatal advice in the *Following the loss of your baby* leaflet

All paper work filed in medical notes.
Notes sent to Bereavement Midwife. (Remember to tracer notes)

### Follow up after discharge (Bereavement Midwife)

- Perinatal Statistics book completed
- Condolence card signed by Head of Midwifery sent
- Upload details to MBRRACE-UK Log No:………………
- Parents invited to contribute to case review
- All results available and filed in notes:
  - Blood tests
  - Cytogenetics
  - PM
- Case review at Perinatal Mortality Meeting
- PNMRT Review complete and report printed
- Consultant follow up requested
## Investigations following Stillbirth

### Pre-delivery investigations - All cases

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<tr>
<th>Test</th>
<th>Explained</th>
<th>Date</th>
<th>Signature</th>
<th>Result</th>
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<td>Full blood count</td>
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<td>Fibrinogen</td>
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<td>CMV</td>
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<td>Toxoplasmosis</td>
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<td>Syphilis</td>
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<td>Parvovirus</td>
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<td>Lupus anticoagulant</td>
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<td>U &amp; E, LFT, Urate</td>
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### Post birth Investigations

- Examination of baby
- Cytogenetic – skin
- Cytogenetic - placental
- Placenta - histology
- Placental biopsy
- Baby swabs
- HVS
- MSU

### Additional investigations if indicated

- Blood cultures
- Listeria (fever, D & V, early meconium)
- CRP
- Hepatitis screen (Jaundice or foreign travel)
- Rubella (fever, malaise, sore throat)
- Bile Acid / LFT (Puritis)
- Antiplatelet antibodies (Intracranial haemorrhage)
- Anti-Ro/La antibodies (hydrops; endomyocardial fibroelastosis)
Care of Deceased Babies using Flexmort CuddleCot™

To use the Cuddle Cot system:

- Place the silver insulation pad under the cooling pad silver side upwards
- Plug the cooling mat connectors into the end of the hose. There should be a “click”
- Plug the hose into the cooling unit. Again there should be a “click”.
- Open the filler cap and place a couple of drops of biocide into the unit.
- Fill the unit with purified water until the water is near the top of the viewing window
- Switch on the cooling unit by pressing the on/off button. The cooling pad will start to fill and the water level will drop. Ensure that there are no kinks in the hose or pad or the fluid will not circulate. Continue to fill the unit until the tank remains half full. Always keep the unit 1/3 to 2/3 full during operation. An alarm will sound should the water level drop too low.
- Select temperature display. The display will show the temperature of the water in the cooling unit. Set the required temperature to 8 degrees Celsius on the control unit by pressing and holding the down arrow key until 8c, then press “Enter”. 8-13 degrees should be reached in 45 minutes. These are the normal operating temperatures.
- Cover (not wrap) the baby with blankets as this will act as insulation. For longer term use (e.g. through the night), the baby can be fully covered with blankets (including the head).
- Always ensure at least 15cm / 6” space remains around the unit during cooling

Please check and record cooling unit temperature 1 -2 hourly

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<thead>
<tr>
<th>Date &amp; Time</th>
<th>Temperature</th>
<th>Action (if required)</th>
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Appendix 4. Sands Guide for Consent Takers
Appendix 5. Cytogenetics Samples after Pregnancy Loss

Cytogenetic Samples after Pregnancy Loss

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. As a licensed satellite mortuary 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
If post-mortem consent has been obtained, cytogenetic consent and sample acquisition is not needed because cytogenetic analysis is part of the postmortem examination. Written consent is mandatory using the designated consent form (to be found in all Maternity Bereavement Packs, on the Emergency Gynaecology Unit, the gynaecology ward and in the Consent section of the Gynaecology intranet shared drive). Consent should be obtained for both placenta and umbilical cord samples because accurate results are most likely if both are sent to the laboratory.

Cytogenetic Sample Pots
- Universal containers containing specific transport medium (labelled ‘For skin biopsy’) are stored at -20°C in the fridge freezer in the Treatment 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
- Umbilical cord 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 labelled box in the Bereavement room
- Sampling is a gloved non sterile technique with care to minimise contamination
- Samples are obtained using a scalpel blade and forceps
- Cut a full cross section minimum 2cm length of cord. Earlier gestations should have a longer section if possible because it is the total amount of tissue that is important
- The sample is placed into thawed ‘skin biopsy’ transport medium, ensure the lid is secured and label accurately
- Cut a 1cm cube of placenta from the fetal surface 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 are placed in the Bereavement Room fridge, not the freezer compartment
• Samples are boxed up by the Wheal Rose ward clerk and sent before 14.00 week days to the RCH post room for transfer to the Bristol Genetics Laboratory

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 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 6 Form for taking a baby home

## Form for parents who take their baby’s body home

**TO WHOM IT MAY CONCERN**

This is to confirm that (name(s) of parent(s))

Of (address):

Have taken their baby’s body from Royal Cornwall Hospital

Date: __________

I/We, the parent(s), hereby take full responsibility for our baby whilst they are in our care. We will (tick as appropriate):

- [ ] Return our baby to the hospital on (date)
- [ ] Make our own funeral arrangements

Parents(s) Names(s) (please print):

________________________

Signature________________________

________________________

Signature________________________

Signature________________________

Name (please print)________________________

In case of need or concern please contact:

Staff member’s name________________________

Job Title________________________

Direct line: ______________________

24-hour phone contact: Wheal Rose Ward – 01872 252149
Appendix 7. Following the loss of your baby

Following the loss of your baby

We wish to extend our sympathy to you and your family following the loss of your baby. The death of a baby is always a particularly difficult kind of grief.

The days following your loss may be hard but, unfortunately, during this time a number of matters need to be dealt with. Things may seem very confusing at first, so try to avoid making any hurried decisions. Take time and talk to your family before deciding what is best for you.

We hope the information in this booklet will offer you help and guidance during this time. If you need any further help, please do not hesitate to ask any member of staff involved in your care.

Bereavement Midwives: Karen Stoyles and Katie Letcher - 01872 252789 rcht.bereavementmidwives@nhs.net

Wheal Rose Ward: 01872 252149
Bereavement Office: 017872 252713

Will I have to give birth to my baby?

If your labour has not already started, induction of labour will be advised. This is because it is better for you and any future pregnancies to have a vaginal delivery. A caesarean section carries more risks and has a much longer recovery time. We know that this is a very difficult time and throughout the procedure your husband, partner, friend or family member may be with you at all times. You will receive support from the midwives and doctors and may have pain relief when and if required.

You may choose when to start the induction process to suit you or you may decide to wait until labour starts naturally. This may take some weeks and if you do decide to wait, we would advise having weekly blood tests to ensure your physical wellbeing.

If you decide to accept induction you will be given a tablet called Mifeprostone before you are admitted to hospital. This prepares your womb and makes it more sensitive to the medications you are given later. After you have taken the tablet you will be asked to stay in hospital for about 20 minutes, as it may cause nausea and vomiting. The Mifeprostone takes 36-48 hours to become effective, so you will be given a time to come into hospital for the next stage of the induction process 36-48 hours later.

You will be given the Sands Bereavement Support Pack before you go home and the amount of information may seem overwhelming. However we would advise you to look at the leaflet Saying goodbye to your baby before you come into hospital as it can give practical help in how to tell family and friends what has happened, creating memories of your baby and deciding how you want to say goodbye to your baby.

What happens when I come in to hospital?

When you return to hospital you should plan to stay overnight (your partner may stay with you). Where possible you will be admitted to the Bereavement Suite on Wheal Rose Ward. This is a self-contained area with its own bathroom, sitting area and kitchen for making drinks etc. You and your partner will of course
be offered regular meals during your stay, but if you would prefer to bring your own food there is a fridge and microwave for you to use.

We appreciate how difficult it is for you to be cared for on a maternity unit at this time. For this reason the Bereavement Suite is as far away from the Delivery Suite as possible while enabling you to have the specialist midwifery and medical care that you will need. You will be able to stay in the Bereavement Suite throughout your admission unless you need closer observation, when you would be cared for on Delivery Suite e.g. if you choose to have an epidural.

Your labour will be started using Misoprostol. These are hormone tablets that are given vaginally (every 3 hours if your pregnancy was less than 24 weeks or every 6 hours if over 24 weeks) until your contractions become regular or you have had four doses of hormone.

The time it takes for your baby to be born can vary. Sometimes we need to repeat the medication cycle if labour has not started within 24 hours.

You will be given plenty of pain relief if required both by mouth and by injection. Some women may need or request an epidural (an injection of local anaesthetic into the lower back). In this case you would need to be cared for on Delivery Suite.

Are there any risks?

- Chills are a common side effect of misoprostol but this should not last long. Fever is a less common side effect but does not mean that you have an infection.
- Nausea and vomiting may occur but should get better within 2-6 hours of taking misoprostol. You can be given medication to relieve this if necessary.
- The placenta (afterbirth) usually comes away normally. If it doesn’t, you may need to have it removed in an operating theatre, under a local anaesthetic.
- The amount of blood loss varies and can be heavy. On rare occasions you may require a blood transfusion.

What happens after my baby is born?

The midwife caring for you will usually discuss your wishes before your baby is born; for example, whether or not you wish to see your baby or hold your baby immediately or if you wish for your baby to be wrapped/dressed first. Experience tells us that parents, who do see their baby, feel that they made the right decision. However staff will support you to make an informed choice that is right for you. You may also wish to bath and/or dress your baby yourself. We can provide a variety of clothes and blankets in even the smallest of sizes for you to choose from or you may prefer to bring something in yourself.

We advise using a “Cuddle Cot” pad to cool your baby if you wish to spend time with your baby. This is a cooling mattress which fits inside or under a Moses basket allows babies to stay with their families for as long as they wish.
Making memories of your baby

Your midwife will offer to help you make memories of your baby and a Memory Box will be compiled for you with your baby’s blanket, cot card, and identity bands. Footprints and handprints will be offered, along with a lock of your baby’s hair (where possible). Sometimes it is not possible to take hand and footprints where the baby is very tiny and fragile.

In later pregnancy loss we are able, with your consent, to take photographs of your baby. These photographs are taken with a digital camera and will be available to you immediately. You will also be given the SD card so that you can print additional copies. If at this time you do not wish to have the photographs they will be kept in your medical notes indefinitely in case you change your mind later. You can of course take your own photographs if you wish.

If you are unsure whether you would like any of these things, consider having them taken in case you change your mind at later date.

Will you be able to tell why my baby has died?

Investigations
You will be offered a variety of tests that may help to determine why your baby has died. These include:

- Maternal blood tests - to gain as much information as possible from these investigations they will usually be carried out before your baby is born. Please ask your doctor or midwife for more information about the tests that you are offered.

- A full post mortem examination will be offered following a loss in later pregnancy even if the cause of death is thought to be obvious as more information may be gained. Research has shown that post-mortem can find significant information in 60-80% of cases. A post mortem examination can:
  - Confirm the cause of your baby’s death
  - Confirm or change an existing clinical diagnosis
  - Exclude common causes of fetal death
  - Help with planning your care in a future pregnancy
  - Resolve any specific questions you may have and help you come to terms with what has happened.

A senior doctor will give you more information to help you make this decision.

If you choose to have this examination a specialist Paediatric Pathologist will perform the examination in the South West Regional Centre in Bristol. The examination will not be performed without your written consent. Your baby will return to Cornwall in 7-10 days after which a funeral can take place. However the written report of the post-mortem findings will not be available for up to 12 weeks.
Please refer to the Sands booklet: *Deciding about post mortem – Information for parents* which is in your Bereavement Support Pack.

Very occasionally, in certain circumstances, a post mortem must be carried out by law. In these cases your consent is not required. If this should apply to your baby, a senior doctor will discuss the reasons with you.

- Genetic testing of a tiny sample of your baby’s skin and/or placenta can give vital information to explain why your pregnancy has had such a sad outcome. Problems with genes or whole chromosomes can lead to genetic diseases and can cause either death or abnormality of a baby in the womb.

**Review and audit**

- PMRT (Perinatal Mortality Review Tool) – This is a tool used by the multidisciplinary team (consultants, junior doctors, midwives, anaesthetists and paediatricians) to review the care of all babies who were stillborn or died shortly after birth to better understand the cause of death and identify any improvements that could be made to care provision. The Bereavement Midwife will contact you prior to your baby’s case review (usually 4-6 weeks) to offer you the opportunity to both provide information and ask questions of the group. The outcome of these reviews will be shared with you by your consultant at your follow-up appointment.
- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK) – investigation of maternal deaths, stillbirths and infant deaths.
- Each Baby Counts – a national quality improvement programme to reduce the numbers of babies who die as a result of incidents during term labour.

All information is strictly confidential and/or anonymised.

**Will I have to register my baby’s birth or death?**

**Babies who were stillborn or died after birth**

- If your baby was stillborn (pregnancy over 24 weeks gestation), the law requires you to register the stillbirth.
- If your baby died after birth the law requires you to register the birth and death even if you had been less than 24 weeks into your pregnancy.
- A stillbirth or neonatal death certificate will be issued by the midwife or doctor and given to you before you go home. You will need to make an appointment at your local Registration Office (08:30- 18:00 Monday – Friday Telephone: 0300 1234 181) to register your baby’s stillbirth or death within 5 days. [www.cornwall.gov.uk/advice-and-benefits/deaths-funerals-and-cremation/registering-a-stillbirth/](http://www.cornwall.gov.uk/advice-and-benefits/deaths-funerals-and-cremation/registering-a-stillbirth/)
- If you would like further advice from the hospital Bereavement Care Co-ordinator please phone 01872 252713 to make an appointment
Babies born before 24 weeks gestation
Babies born before 24 weeks without signs of life do not require any legal registration. However if your baby was too young for a legal certificate, we will provide you with a certificate in recognition of your baby if you wish.

Can I have my baby blessed?
Yes, you may have your baby blessed or have a naming service by the hospital chaplain or minister of your own choice. Should you choose to use a hospital chaplain, they are available to call 24 hours a day; the blessing can take place when you wish. You can choose whether you and/or your family are present. The Chaplain will give you a blessing certificate; candle and the shell used in the service which you may wish to keep in your memory box.

Baby Remembrance
There is a Baby Garden of Remembrance beside the Maternity Unit (signposted from the Dermatology Unit) which you may visit at any time. The centrepiece of the garden is a Memory Tree surrounded by pebbles, and each leaf and pebble is dedicated to an individual baby. Your midwife will provide you with a form to complete should you chose to have a leaf engraved with your baby’s name added to the tree. If you decide you would like a leaf following you discharge you may also contact our local charity Ella’s Memory direct by e-mail www.Ellasmemoryleafs@hotmail.com. You may choose a copper or stainless steel leaf which will be provided by Ella’s Memory. Leaves are added to the tree every three months.

How do I arrange my baby’s funeral?
Babies under 24 weeks
If your baby died before 24 weeks of pregnancy there is no legal requirement for an individual funeral to be held, but you may choose to engage a Funeral Director to arrange a funeral service for your baby if you wish.

You may wish to take your baby home to bury on private land or in your garden. If you wish to do this, you should contact Cornwall Council for advice. Telephone: 0300 123 21 or e-mail www.communityandenivironmentprotection@cornwall.gov.uk

You may opt for your baby to be cremated with other babies in a collective cremation service organised by Royal Cornwall Hospital. This is a non-denominational service and is conducted by one of the hospital Chaplains at Penmount Crematorium, Truro. Parents are not invited to the service and no individual ashes will be available. The collective ashes will be scattered in the Baby Memorial Garden at the Crematorium.

Before you leave hospital you will be asked to complete a consent form for funeral arrangements. If you are unsure what you wish at this point there is no need to rush your decision, but we ask that you contact the Bereavement Office (01872 252713) within 4 weeks. If you do not make contact, after 4 weeks the hospital will make a decision on your behalf. This will be a collective
cremation with other pregnancy losses at Penmount Crematorium without any further communication with you.

**Babies over 24 weeks gestation and those of any gestation who were born alive**

If your baby was stillborn or died after birth the law requires you to arrange an individual funeral, but you need not attend unless you wish to do so. Do not feel under pressure to make decisions immediately as you have up to six weeks to decide on what arrangements you would like. After this time the hospital Bereavement Care Co-ordinator will write to you to remind you of your choices. If she does not hear from you then she will make arrangements for a funeral via the hospital’s contracted funeral director.

If you would prefer a non-religious service, you may find the British Humanist Association website www.humanism.org.uk helpful.

**Costs**

Parents on a low income and receiving at least one benefit may be eligible for a Funeral Payment. This payment will cover:

- Burial fees
- Cremation fees
- Travel expenses to arrange and attend the funeral
- Up to £700 for funeral expenses

A Funeral Expenses Payment must be claimed within three months of the funeral. Please refer to the *Money Advice Service* leaflet in your *Bereavement Support pack*.

Hospital medical staff will not charge you for completing cremation forms and some funeral directors may charge only a nominal fee or make no charge for a standard private funeral. However there may be other fees.

A local sewing group provide burial gowns for babies made in a range of sizes from donated wedding dresses. Please ask a member of staff if you would like to choose a gown for your baby.

**When can I go home?**

You may go home as soon as you are physically well, but please do not feel pressured to go until you feel ready. The ward staff will inform your community midwife and GP of what has happened and that you are being discharged from hospital. Your community midwife will contact you once you are at home. Please do not hesitate to ask for a home visit for physical or emotional support. You may contact a midwife via the Midwifery Line 01872 258000 at any time if you have concerns.

**What can I expect physically after having my baby?**

You will still experience the physical effects of childbirth even though your baby has died. You are likely to experience some bleeding which may continue for several weeks. If the bleeding increases or you have an unpleasant smelling discharge please contact your midwife or GP.
Some women may produce milk. A well supported bra and pain killers such as paracetamol will ease the discomfort however the midwives at the hospital can also offer you medication to help stop lactation should you feel it would be helpful.

Allow yourself time. You may feel tired while your body recovers from labour and you may find it difficult to sleep. Your body may return to normal quickly, for some women this takes longer, particularly those that have experienced a later loss.

**Will I have a follow up appointment?**

When all investigation results are available you will be sent an appointment to meet with your consultant. This is an opportunity for you to ask any questions that you have and for your consultant to inform you of any test results. The appointment will be in approximately 12 weeks if a post mortem has been requested, it may be sooner if you have decided to not have a post-mortem.

Alternatively if you have had had full consultation with one of the consultants either in the Fetal Medicine Unit or before you went home and have not requested any investigations an appointment may not be necessary.

If you have not received an appointment please don’t hesitate to contact the Bereavement Midwife (01872 252879).

**Coping with your feelings**

Grief is different and unpredictable for everyone and you will grieve in your own way. There is no right way to deal with grief and it can persist for a much longer time than some people expect. It is common for parents to act differently at different times, but that does not mean one partner does not care about the loss or about how their partner feels. It can be difficult but taking time to listen to each other is helpful and important.

**What support is available?**

Royal Cornwall Hospital is unable to provide a counselling service, but the hospital chaplain is available for spiritual and emotional support if you wish to see them. Please ask your GP for referral if you feel you require access to counselling services.

There are also local groups which offer support:

- **Cornwall Sands** - 07582 831478 [www.cornwallsanda.weebly.com](http://www.cornwallsanda.weebly.com)
  There is a meeting every last Sunday of the month at the Alverton Manor Hotel, Truro at 7:30pm. They can provide you with a trained Befriender if you need one to one support after a stillbirth or neonatal death.

- **The Splash Project – Seahawk Pregnancy Loss advice, Support and Help** - [www.thesplashproject.org](http://www.thesplashproject.org)
  Telephone or face to face support for parents whose baby has died at any gestation.
• Penhaligons Friends www.penhaligonsfriends.org.uk – gives support to bereaved children

You may also wish to contact one or more of the following national support groups:
• Action on Pre-clampsia (APEC) www.apec.org.uk
• Antenatal Results and Choices (ARC) www.arc-uk.org
• Babyloss www.babyloss.co.uk
• Child Bereavement Trust www.childbereavement.org.uk
• Miscarriage Association www.miscarriageassociation.org.uk
• SANDS – www.sands.org
Appendix 8

Deceased Baby Care Record
Pathology Directorate

PERSONAL DETAILS OF THE DECEASED TO BE COMPLETED

PLEASE PRINT IN BLOCK CAPITALS

<table>
<thead>
<tr>
<th>Mother's Details</th>
<th>Pathology Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only</td>
<td></td>
</tr>
<tr>
<td>Mother's Surname:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's Forenames:</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Address:</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>Mother's CR No:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baby's Details Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby's Surname:</td>
</tr>
<tr>
<td>Baby's Forenames:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Sex: male/female/undetermined</td>
</tr>
<tr>
<td>Baby's CR No:</td>
</tr>
<tr>
<td>Date of Death:</td>
</tr>
<tr>
<td>Time of Death:</td>
</tr>
<tr>
<td>Gestation:</td>
</tr>
<tr>
<td>Ward:</td>
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</table>

Location of Mortuary ID Bracelets: Left Arm Right Arm Left Ankle Right Ankle Other: 

High risk: Yes/No/Unknown
## PROPERTY DETAILS

<table>
<thead>
<tr>
<th>Item 1:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Item 2:</td>
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<tr>
<td>Item 3:</td>
<td></td>
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<td>Item 4:</td>
<td></td>
</tr>
<tr>
<td>Item 5:</td>
<td></td>
</tr>
</tbody>
</table>

By signing this declaration you are confirming the deceased identity and property details are correct:

1st Midwife signature:  
Print name:  
Date:  
Time:  

2nd signature:  
Print name:  
Date:  
Time:  

Names of Porters transporting deceased to Mortuary:
<table>
<thead>
<tr>
<th>Mortuary Care Record No:</th>
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<table>
<thead>
<tr>
<th>Location of Mortuary ID Bracelets:</th>
<th>Left Arm</th>
<th>Right Arm</th>
<th>Left Ankle</th>
<th>Right Ankle</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
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</table>

If identification of property NOT correct, contact line manager. If unavailable, Head BMS on ext. 2550
Describe action taken:

<table>
<thead>
<tr>
<th>Property on the body checked in the mortuary by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>APT signature:</td>
</tr>
<tr>
<td>----------------</td>
</tr>
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<td></td>
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</table>

Transport of baby from the Mortuary:

<table>
<thead>
<tr>
<th>Date out</th>
<th>Sign</th>
<th>Date returned</th>
<th>Sign</th>
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<tbody>
<tr>
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</table>

Date deceased received into the Mortuary:  

<table>
<thead>
<tr>
<th>Date deceased received into the Mortuary:</th>
<th>Fridge No:</th>
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<tbody>
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<td></td>
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</table>

Length of baby (Head to Toe):  

<table>
<thead>
<tr>
<th>Length of baby (Head to Toe):</th>
<th>Width of baby (Shoulder to Shoulder):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Deceased identification and measurements undertaken by:

<table>
<thead>
<tr>
<th>APT signature:</th>
<th>Print name:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
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<tbody>
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<td></td>
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</tbody>
</table>
## Transfer of Patient Care

<table>
<thead>
<tr>
<th>Authority to release seen: Yes/No</th>
<th>Date deceased released:</th>
<th>Time:</th>
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</table>

Identification/property checked by:

<table>
<thead>
<tr>
<th>APT signature:</th>
<th>Print name:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

Property on deceased collected by: Signature:

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Print name:</th>
</tr>
</thead>
</table>

Funeral Directors signature confirming patient information:

<table>
<thead>
<tr>
<th>Firm:</th>
</tr>
</thead>
</table>